

[DRC-IHP Quarterly Report: April-June 2013]

[July 2014]

Keywords: Integrated Health Project; maternal, newborn, and child health; water, sanitation, and hygiene; family planning/reproductive health; malaria, tuberculosis, and nutrition

This report was made possible through support provided by the US Agency for International Development, under the terms of AID-OAA-A-10-00054. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

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DRC-IHP Quarterly Report: Year 3, Quarter 3 (April – June 2013)
USAID Cooperative Agreement Number: AID-OAA-A-10-00054
Revised for USAID/DRC on July 11, 2014

Cover Photo: Maternity clinic in the Tshamala General Referral Hospital in Mwene Ditu

Project Name: Integrated Health Project in the Democratic Republic of Congo
Cooperative Agreement Number: AID-OAA-A-10-00054

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ACRONYMS

AB	Advisory Board	DOTS	Directly Observed Treatment Strategy (TB)
ACT	Artemisinin-combination therapy	DPS	Division Provinciale de la Santé
AEN	Essential Actions in Nutrition (French acronym)	DQA	Data Quality Assessment
AMTSL	Active Management of Third Stage Labor	DQS	Data Quality Self-Assessment
AOP	Annual Operational Plan	DRC	Democratic Republic of the Congo
ARV	Antiretroviral	DTP	Diphtheria, Tetanus, Pertussis (DTC in French acronym)
BCC	Behavior change communication	ENA	Essential Nutrition Actions
BCZS	Health Area Central Offices (<i>Bureaux Centraux des Zones de Santé</i>)	EPI	Expanded Programme on Immunization
CBD	Community-based distribution or community-based distributor	ETL	Education through Listening
CCM	Community Case Management	FFSDP	Fully Functional Service Delivery Point (see FOSACOF below)
CCSAS	Clinical Care for Sexual Assault Survivors	FOSA	<i>Formation Sanitaire (health facility)</i>
CDMT	Medium-term expenditure framework	FOSACOF	<i>Formation Sanitaire Complètement Fonctionnelle (used more frequently in DRC)</i>
CDR	Regional Distribution Center	FP	Family Planning
CHW	Community health worker	GRH	General Referral Hospital
i-CCM	Integrated Community Case Management	HA	Health Area (<i>Aire de Santé</i>)
CLTS	Community-led Total Sanitation	HBB	Helping Babies Breathe
CODESA	Comité de Développement Sanitaire	HIV	Human immunodeficiency virus
CPA	Complementary Package of Activities	HZMT	Health Zone Management Team
CLTS	Community-Led Total Sanitation	IEC	Information, Education and Communication
CPR	Contraceptive prevalence rate	IHP	Integrated Health Project
CSDT	Centre de santé de diagnostic, et de traitement de la TB	IMCI	Integrated Management of Childhood Illness
CSR	Centre de santé de référence (referral health center)	IPS	<i>Inspection provinciale de la santé</i>
CST	Centre de santé et de traitement de la TB (health center and TB treatment center)	IPTp	Intermittent preventive treatment (of malaria) in pregnancy
CUG	Closed User Group	IRC	International Rescue Committee
CURE	Commission on Urgent Relief and Equipment	IT	Head nurse (<i>Infirmier Titulaire</i>)
		ITN	Insecticide-treated Net
		IYCF	Infant and child feeding
		KAPs	Knowledge, attitudes, and practices
		KMC	Kangaroo Mother Care

LDP	Leadership Development Program	PNDS	<i>Plan National de Développement Sanitaire (National Health Development Plan)</i>
LLIN	Long-lasting insecticide-treated net	PNLP	National Malaria Control Program
LMS	Leadership, Management, and Sustainability Program	PNLS	National AIDS Program
MDR-TB	Multi-drug resistant TB	PNSR	National Reproductive Health Program
MEG	Generic and essential medicine	PPDS	Provincial Health Development Plan
MOH	Ministry of Health	PRONANUT	National Nutrition Program
MPT+	Smear-Positive Pulmonary Tuberculosis	PSC	Pre-school consultation
MIP	Provincial Medical Inspector	PSPP	<i>Projet de Santé pour les Populations les plus Pauvres (Health for Poorest Populations)</i>
MNCH	Maternal, newborn and child health	RBF	Results-Based Financing
MOH	Ministry of Health	RDT	Rapid diagnostic tests
MPA	Minimum Package of Activities	RH	Reproductive health
MSH	Management Sciences for Health	RHC	Referral Health Center
MUAC	Mid-upper Arm Circumference	SIAPS	Systems for Improved Access to Pharmaceuticals and Services
NGO	Non-Governmental Organization	SNIS	National health information system
NTD	Neglected Tropical Diseases	SMS	Short Message Service
OCC	Office Congolais de Contrôle	SP	Sulfadoxine-pyrimethamine (malaria treatment)
OSC	Overseas Strategic Consulting, Ltd	TB	Tuberculosis
PBF	Performance-based financing	TFR	Training for Results Framework
PCIMA	Integrated Case Management of Acute Malnutrition (French acronym)	UCOP+	Congolese Union of Associations of Individuals Living with HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief	UNFPA	United Nations Population Fund
PHAST	Participatory Hygiene and Sanitation Transformation	UNICEF	United Nations Children's Fund
PMI	President's Malaria Initiative	USAID	United States Agency for International Development
PMP	Performance Monitoring Plan	USG	United States Government
PMTCT	Prevention of mother-to-child transmission	VVF	Vesicovaginal Fistula
PNC	Post-natal Consultation	WASH	Water /Sanitation/Hygiene
PNCPS	<i>Programme national de communication pour la promotion de la santé</i>	WHO	World Health Organization

EXECUTIVE SUMMARY

This report covers the third quarter reporting period (April through June 2013) of year three of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). Implemented by Management Sciences for Health, the International Rescue Committee and Overseas Strategic Consulting, Ltd (hereafter referred to respectively as MSH, the IRC and OSC), the project supports the country's National Health Development Program. DRC-IHP's two components – component 1, "Services," and component 2, "Other Health Systems" – are designed to create better conditions for, and increase the availability and use of, high-impact



health services, products, and practices in 80 target health zones in four provinces (Kasai Occidental, Kasai Oriental, Katanga and Sud Kivu).

The project's objective is to increase availability and use of high-impact services, products, and practices for family planning; maternal, newborn, and child health; nutrition; malaria and tuberculosis; neglected tropical diseases; HIV; and water/sanitation/hygiene in the target health zones.

Component 1 supports the first strategic focus of the DRC's national health plan: health zone strengthening. Under this component, there are three Intermediary Results (IRs):

- ✓ IR 1: Access to and availability of Minimum Package of Activities/Complementary Package of Activities plus (MPA/CPA-plus) services in targeted health zones increased
- ✓ IR 2: Quality of MPA/CPA-plus services in target health zones increased
- ✓ IR 3: Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target health zones

Component 2 corresponds to the plan's second strategic pillar, support for health zone strengthening in six priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new technologies; and improved health system management. The fourth Intermediary Result is found under component 2:

- ✓ IR 4 : Health sector leadership and governance in target provinces improved

During this reporting period, IHP reports the following key achievements:

- In Kamina, Kofe, and Tshumbe, PMP targets for drinking water access were exceeded (139%, 173%, and 235%, respectively). For improved sanitation in Kolwezi, Mwene Ditu, and Tshumbe, targets were also exceeded (197%, 131% and 163% respectively).
- Immunization coverage was above 90% for all types of vaccinations, and overall above the national average (80%).
- Achievement for Couple Years of Protection (CYP) was significantly greater than the PMP target, reaching a rate of 113%, a 2% increase over the previous quarter (111%). Bukavu, Kofe, and Uvira reported improved CYP results compared to the previous quarter, progressing respectively from 52% to 73%, 767% to 96%, and 63% to 75%.

- In Bukavu, CYP increased from 16,704 to 23,160 between PY3Q2 and PY3Q3, due to the improved quality of services provided, the training of 22 nurses in Minova, and the replication of the Walungu Project to promote the use of Depo-Provera at the community level in the Minova health zone¹.
- The number of women who adopted a modern method of family planning significantly increased compared to the previous quarter, from 125,358 in PY3Q2 to 137,675 in PY3Q3. The PMP target achievement increased from 104% to 114%.
- The number of visits for family planning counseling increased from 127,310 in PY3Q2 to 148,249 in PY3Q3.
- The number of operational CODESAs grew from 1,028 during the previous quarter to 1,230 in PY3Q3, or an increase of 202 operational CODESAs.
- More cases of childhood diarrhea and malaria were treated in community care sites as compared to last quarter. In PY3Q3, 3,718 cases of diarrhea in children under 5 were treated in community care sites, compared to 2,422 in PY3Q2. Among cases of malaria in children under 5, in PY3Q3, 4,654 cases were treated in community care sites, an increase from 3,605 last quarter.
- The number of mothers of children 0 to 23 months who received counseling on child nutrition in PY3Q3, 119,644, surpassed the target of 37,080, for an achievement rate of 332%.
- In PY3Q3, the number of women who received folic acid (108,114) surpassed the PMP target of 96,469, for an achievement rate of 112%. The achievement reported in PY3Q3 also represented an increase from the 104,981 women who received folic acid in PY3Q2.
- In Kamina, 4,284 women were reported to have used antenatal care (ANC) services that have also integrated prevention of mother-to-children transmission (PMTCT) services during PY3Q3, compared to 2,791 women in PY3Q2. Coverage increased in Kolwezi from 3,818 women seen in PY3Q2 to 4,275 women seen during PY3Q3.
- The detection rate for tuberculosis (TB) in Kolwezi surpassed the PMP target, for an achievement rate of 120%.

¹ Factors for success of this approach include the following: (1) good selection of CBDs; (2) keeping the area covered by the CBD manageable; (3) leveraging special occasions; (4) adopting a peer approach, associating youth, scouts, etc.; (5) involving local authorities and recruiting them as CBD agents; and (6) reinforcing non-financial incentives, such as providing each CBD agent with a kit, organizing monthly meetings at the health centers to monitor work and validate data, providing refresher training and paying transport fees. In Walungu, 92 of the original CBD agents trained by IHP are still working, and IHP does not provide financial motivation.

I. PROJECT PERFORMANCE: ACHIEVEMENTS

I.1 COMPONENT 1: HEALTH SERVICES

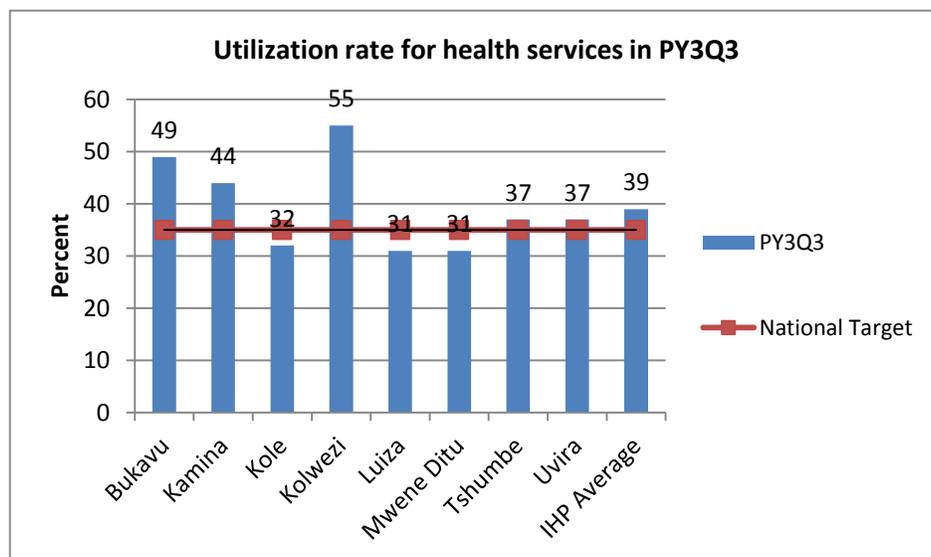
INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MINIMUM PACKAGE OF ACTIVITIES /COMPLEMENTARY PACKAGE OF ACTIVITIES PLUS (MPA/CPA-PLUS) SERVICES IN TARGETED HEALTH ZONES INCREASED

IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased

1. Utilization of curative services

In April and May, all health zones reported curative services utilization data, and 76 health zones reported in the month of June, resulting in a completion rate of 100% for April-May and 95% for June. The data were validated by the health zone management teams (HZMT) during monthly data analysis and validation meetings, with financial and technical support from the project. Curative services utilization rates in three IHP-supported coordinations were below the national average of 35%: Kole (32%), Luiza (31%), and Mwene Ditu (31%). Tshumbe, which performed below the national average during the previous quarter, increased from 32.6% to 37%. Figure 1, below, and table 1, on the following page, provide more detailed information on the utilization rate in PY3Q3.

Figure 1: Utilization rate of curative services by field office in PY3Q3



The average rate for all coordinations increased from 36% during the previous quarter to 37% in this quarter. Curative services utilization improved in Bukavu, Kamina, Kolwezi, Luiza, and Tshumbe. Internal migration, for reasons linked to insecurity or economic opportunities, may have contributed to some of the strong achievements this quarter. For example, internal migration to Kolwezi, where there are employment opportunities in the mining sector, may have contributed to Kolwezi's strong performance. Kolwezi, which

reported the highest curative services utilization rate, benefited, like many of the other coordinations, from the availability of medicines, increased awareness raising within the community on the importance of taking children to health facilities, and an increase in the number of functioning community care sites. This quarter, there are 218 functioning community care sites in IHP-supported coordinations, compared to 148 community care sites last quarter.

Table 1: Curative services utilization by month and by coordination

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira
April 2013 (%)	47	43	33	55	30	29	36	35
May 2013 (%)	52	47	25	59	31	32	37	41
June 2013 (%)	47	42	39	52	32	32	37	34
PY3Q3 Average (%)	49	44	32	55	31	31	37	37
PY3Q2 Average (%)	43	42	34	48	29	29	33	34

In Bukavu, the health zones of Bunyakiri, Kalonge, and Shabunda reported curative utilization rates between 95% and 113.5%, which contributed to Bukavu’s overall performance of 49%. International NGOs, such as the International Medical Corps and Medecins Sans Frontières Espagne (MSF-E), provide free curative services and essential medicines in refugee camps situated in the Bunyakiri, Kalonge, and Shabunda health zones, and may have contributed to the high performance there. However, the five remaining health zones in Bukavu reported results well under 30%: Walungu (26.5%), Nyangezi (27.8%), Mubumbano (22.3%), and Kamituga (23.2%). The project will assess the disparities in curative service utilization during the next quarter.

Mwene Ditu and Luiza reported the lowest rates of utilization. However, compared to last quarter, in PY3Q3 utilization rates in Mwene Ditu and Uvira improved from 29% to 31%. This improvement in Mwene Ditu and Luiza was due to the availability of medicines and awareness raising activities in the community. In comparison to other coordinations, however, Luiza and Mwene Ditu’s achievement still lags behind and is below the national average. The health zone management teams in both coordinations will provide regular supervisory visits as well as provide support for commodity management of medicines. In addition, in two health zones in Mwene Ditu, Mpokolo and Lusambo, the rates of service use fell from 34% to 30% and 31% to 29%, respectively, between last quarter and this quarter. The project will assess the reasons for this decrease next quarter, though there are two factors that may have contributed to the poor performance: the unavailability of medicines and the non-compliance with the curative services pricing system. Despite the availability of commodities in the CDRs, drugs were unavailable in some health centers due to the delay in ordering and delivering products. In the meantime, the health zone management teams will ensure that medicines are properly distributed and the two health zones properly quantify their needs.

2. Support health zones Annual Operational Plans (AOP)

As of PY3Q3, nearly all Annual Operational Plan (AOP) drafts have been validated, with the exception of two Bukavu health zones and two health zones in the Kamina coordination. Among the 80 health zones with AOP drafts in 2013, 76 had their plans validated by their advisory boards by June 30, 2013, or an average of 95%, as shown in table 2, below.

Insecurity in the Bukavu coordination prevented advisory board meetings from taking place, and as a result Mulungu and Lulingu's AOPs could not be validated. However, the Katanga province's five health zones-- Kayamba, Kitenge, Lwamba, Malemba Nkulu and Mulongo--had their AOPs validated, leaving only two health zones (Kabongo and Mukanga) with non-validated AOPs. The Kabongo and Mukanga health zones experienced delays due to increased movements among the Mai Mai militias, which have restricted staff movements.

Table 2: Number and percentage of AOP drafts developed and validated by province and field offices

Provinces	Field offices	Health zones	AOP drafts 2013	%	AOP validated 2013	%
Sud Kivu	Bukavu	22	22	100	20	91
	Uvira	5	5	100	5	100
Kasaï Occidental	Luiza	11	11	100	11	100
Kasaï Occidental	Kole	4	4	100	4	100
	Tshumbe	10	10	100	10	100
	Mwene Ditu	11	11	100	11	100
Katanga	Kolwezi	8	8	100	8	100
	Kamina	9	9	100	7	78
Total		80	80	100	76	95

Coverage plans for MPA/CPA-Plus

Sixty-seven general reference hospitals (GRH) among the 80 IHP-supported GRHs offer the complementary package of activities (CPA) coverage, or 84% of IHP-supported GRHs. This situation remains unchanged from the previous quarter, as in 13 health zones, GRHs do not meet CPA criteria due to insufficient infrastructure and inadequate medical equipment. Table 3, below, displays the number of GRHs implementing CPA by coordination.

Table 3: Percentage of general reference hospitals (GRH) implementing a complementary package of activities (CPA)

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	21	6	4	6	11	9	6	4	67
Target	23	9	4	8	11	11	9	5	80
Achievement	91%	67%	100%	75%	100%	82%	67%	80%	84%

The following health zones are not equipped to provide the four primary health care services: Bunyakiri health zone in Bukavu; Kayamba in Kitenge Mukange zones in Kamina; Fungurume and Lualaba in Kolwezi; Mpania

Mutombo and Mpokolo in Mwene Ditu; Djalo Djeka, Omendjaji, Ototo, and Vangakete in Tshumbe; and the Hauts Plateaux health zone in Uvira. Through its renovation and rehabilitation efforts, IHP focuses on improving coverage. For example, IHP is supporting the rehabilitation of GHR maternity clinics in the four Tshumbe health zones mentioned above. Achieving significant improvements in increasing CPA coverage requires assistance from other entities, including the government, and the private and public sector. The Tenke Fungurume Mining Company, a private organization, built a hospital in Fungurume; although it is not yet functional, it is expected to offer CPA coverage.

The CPA-plus coverage rate has remained constant in most coordinations, as very few GRHs in the IHP-supported zones have integrated the required technical elements (CPA-plus package of activities). The integration process is largely dependent on the Ministry of Health, with the creation of specialized units where major equipment is available in the GRHs. Table 4, below, displays the number of GRHs offering CPA-plus by coordination in PY3Q3.

Table 4: Number and percentage of GRHs offering CPA-plus by coordination offices

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	11	0	1	2	2	5	0	1	22
Target	23	9	4	8	11	11	9	5	80
%	48	0	25	25	18	45	0	20	28

An improvement of quality towards a good CPA-plus coverage requires the purchase of heavy equipment and materials, which the project, alone, is unable to provide.

The achievement in the minimum package of activities (MPA) coverage remained the same since the previous quarter, with 81% of IHP-supported health centers having integrated the MPA, or 1,238 centers of out 1,509. 100% of IHP-supported health centers are integrating MPA in Kole, Kolwezi, Mwene Ditu and Tshumbe. In Bukavu and Uvira, the rates remain low at 59% and 76%, respectively, as insecurity has impeded accessibility of some health zones and health areas. A slight improvement was observed in Bukavu (226 to 253 centers), Uvira (76 to 83 centers), and Kamina (201 to 202 centers) compared to PY3Q2. Table 5 shows the number of health centers offering MPA by coordination office.

Table 5: Number and percentage of health centers offering MPA by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	253	202	55	105	177	191	156	83	1,222
Total no. of health centers	431	216	59	113	200	202	179	109	1,509
%	59	94	93	93	89	95	87	76	81

The quality of services (MPA-plus) remains a challenge for the supported health facilities, with 9% of all IHP supported health facilities having the ability to integrate MPA-plus activities. Table 6, on the following page, shows the number of health centers offering MPA-plus by coordination office. The project will continue to provide equipment to the poorest-performing centers, as possible.

Table 6: Number and percentage of health centers offering MPA-plus by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	48	20	0	29	5	23	0	12	137
Total no. of health centers	431	216	59	113	200	202	179	109	1,509
%	11	9	0	26	3	11	0	11	9

The coverage of CPA+ and MPA+ is weak compared to the initial targets, as there are elements of both that are not controlled by the project (e.g., large investment in medical equipment). These two indicators will continue to be discussed with USAID to come to an agreement about how to adjust the targets. While the content of the CPA+ package, for example, cannot be revisited, it would be acceptable to revisit the target more realistically, i.e., how many health care facilities that already have CPA and MPA integrated are capable of integrating CPA+ and MPA+, based on the situation analysis before the IHP interventions began. The IHP Agreement Officer's Representative is determining with the Agreement Officer whether this change in targets will necessitate a modification in the IHP Program Description.

3. Availability of medicine, commodities, other health supplies and basic equipment in supported health facilities

During this quarter, the following supply chain coordination activities were carried out in coordination with the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) program.

- SIAPS continued to receive medicines ordered by the project in the regional distribution centers (CDR). These medicines include those ordered from MEG for Year 2 and medicines from ASRAMES for Year 3. ASRAMES has not delivered any pharmaceuticals since May 2013.
- SIAPS worked closely with IHP to ensure the distribution of drugs from the CDRs to the health zones, according to approved distribution plans. For example, the 11 IHP-supported health zones in Kasai Occidental each received large batches of essential general medicines (MEG).

SIAPS also oversaw the order of 7,000,000 ACT treatments (for all age groups), a batch originally ordered in October 2011 intended for all project-supported health zones. More than 2.5 million ACT treatments were received in the CDRs this quarter. An additional delivery of 4.4 million ACT treatments (for all age groups), as well as an order of 3 million tablets of Sulphadoxine-Pyrimethamine (SP) that was ordered on December 14, 2012, are expected to be delivered next quarter. SIAPS also supported capacity building in warehouse management to improve storage conditions.

Table 7, on the following page, shows the improvements made during PY3 regarding the maintenance of commodity records in IHP-supported health facilities (1,509 facilities and 80 GRHs) as a result of the supervisory visits carried out every quarter.

In PY3Q3, SIAPS briefed project staff and district health staff on techniques for monitoring drug commodity consumption. SIAPS followed up on the trainings and briefings with joint supervision visits to 27 project-supported health zones. The trainings and briefings covered the following topics:

- Increasing providers' awareness on best practices for drug storage and distribution

- Detecting irregular distribution of Presidential Malaria Initiative (PMI) commodities from the health zone central offices to the health facilities, which can lead to stock outs and overstocks in some facilities
- Disseminating monthly reporting tools for commodity management
- Ensuring proper management of receipts from drugs
- Being aware of lost or stolen commodities, and discrepancies in quantities noted in the distribution plan and in the quantity actually received by the health facilities
- Raising awareness of the over- or incorrect prescription of medicines.

Table 7: Follow-up on medicine management tools

Indicators	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	June-13
No. of health centers with accurate and up-to-date stock records	236	277	362	531	630	653	736	721	708
No. of general referral hospitals with accurate and up-to-date stock records	32	34	48	35	43	42	63	50	56
% of health centers with accurate and updated stock records	17%	20%	26%	38%	45%	46%	52%	51%	50%
% of referral hospitals with accurate and updated stock records	40%	43%	60%	44%	54%	53%	79%	63%	70%

Table 7 shows a clear and steady improvement made during PY3 regarding the maintenance of commodity records in IHP-supported health facilities. From November 2012 to April 2013, for example, the number of health centers with accurate and up-to-date stock records increased from 277 to 736, and in the same period, the number of hospitals with accurate and up-to-date stock records increased from 34 to 63.

During this period, SIAPS assisted with supervision visits that focused on pharmaceutical management. SIAPS and IHP collaborated on conducting refresher training on pharmaceutical management. The project printed, copied, and distributed management tools in the health facilities.

During this quarter, SIAPS customized a monthly reporting tool for medicine management, which IHP had started to provide to its supported facilities. Table 8, on the following page, demonstrates the percentage of health facilities experiencing a stock out of each tracer medication in PY2 and PY3. An improvement in the percentage of health facilities experiencing stock outs of tracer medications can be seen between the two project years. In this table, we used the following denominator: 1,415 health facilities (health centers plus general reference hospitals) where reports are available. It would be difficult to evaluate the health facilities that did not provide reports. IHP has already planned with the DPS and SIAPS to conduct a joint supervision visit in September 2013, targeting those health facilities that have not provided their reports, to do an active collection. In addition, IHP coordination teams are ensuring that sending reports is linked with the provision of full health zone grants.

Table 8: Number and percentage of USG-supported health facilities experiencing stock out of tracer drugs per month²

Tracer medicine	Jan	Feb	Mar	Average no. of stock outs	Apr	May	June	Average %	Q2 Average % of HFs with stock-out	Q3 Average % of HFs with stock-out
Rifampicin/isoniazid	73	82	22	59	12	10	11	11	4	1
Depo-Provera	64	71	47	61	45	22	36	34	4	2
Lofemenal	437	743	482	554	496	662	656	605	39	43
Ovrette	440	412	393	415	471	515	480	489	29	35
Male condom	79	871	100	350	75	83	125	94	25	7
Cotrimoxazole 480	532	159	786	492	151	203	102	152	35	11
Zinc sulfate	1,027	803	1,265	1,032	909	853	575	779	73	55
ORS	135	138	94	122	173	144	109	142	9	10
ASAQ child (1-5 years)	257	242	195	231	169	257	136	187	16	13
Paracetamol	209	169	143	174	206	247	113	189	12	13
SP	242	308	532	361	408	301	376	362	25	26
Oxytocin	164	121	107	131	131	187	170	163	9	11
Fluconazole	950	1,029	409	796	497	467	534	499	56	35
HIV test kit	344	317	229	297	250	255	250	252	21	18
RHZE (rifampin, isoniazid, pyrazinamide, and ethambutol)	186	207	187	193	432	161	149	247	14	17

IR 1.2: Increased community health care services and products in the target health zones

1. i-CCM (Integrated management childhood illnesses)

1.1. Pneumonia and diarrhea case management in USG-supported health facilities

During PY3Q3, the health zones provided 233 of the 240 expected reports on pneumonia, diarrhea, and malaria case management for children under 5. The health zone of Kalehe did not report in April, May, and June, and the health zones of Kalonge, Uvira Hauts Plateaux, Ruzizi, and Lemera did not report during the month of June due to strikes among nurses and other health care providers regarding their salaries. As nurses and other health care providers are responsible for sending data, the project did not receive data for the month of June. The hospital of Bon Berger in Tshikaji and the Mutshatsha hospital also did not report in June. In Tshikaji, disputes over

² It should be noted that Lofemenal will be replaced by Microgynon and Ovrette by Microlut.

appointed leadership positions between the hospital team and the central office team impeded reporting as the hospital refused to report data. In Mutshatsha, the National Railway Company (*Société nationale de Chemin de fer du Congo*), which is responsible for paying salaries in the private hospital of Mutshatsha, was unable to make payroll. As a result, health care providers, who normally collect data, were on administrative leave.

During PY3Q3, 122,724 pneumonia episodes in children under 5 were treated in USAID-supported facilities, including 119,286 in health centers and hospitals and 3,438 in community care sites. Table 9, below, provides the number of pneumonia cases treated in facilities and care sites in PY3Q3. Compared to the previous quarter, this represents an overall decrease in treated cases of approximately 6,728. This drop in the number of treated cases is, first, due to the return of displaced populations in the health zones of Kaniola and Mulungu, where children were no longer exposed to weather conditions in the camps, and, second, to reduction of standing flood waters in Malemba Nkulu territory. Given the improvement in environmental conditions, the decreased number of treated cases may be partly due to overall improved health among children previously living in camps.

Table 9: Number of cases of childhood pneumonia treated with antibiotics in facilities and i-CCM supported by the U.S. Government

Coordination Office	PY3Q3				
	Health facilities	i-CCM sites	Total	PMP target	% of target achieved
Bukavu	40,587	250	40,837	39,712	103
Kamina	29,140	1,014	30,154	18,328	165
Kole	3,346	530	3,876	3,877	100
Kolwezi	7,456	114	7,570	9,045	84
Luiza	11,500	379	11,879	17,468	68
Mwene Ditu	15,826	771	16,597	29,105	57
Tshumbe	8,390	301	8,691	12,055	72
Uvira	3,041	79	3,120	9,544	33
TOTAL PY3Q3	119,286	3,438	122,724	139,134	88
TOTAL PY3Q2	125,814	3,638	129,452	139,134	93

Regarding pneumonia case management at the community care sites, an increase was observed in the coordinations of Kamina and Kole, following the capacity building of community care sites. Capacity strengthening activities included training 149 health care providers in the correct case management of pneumonia, diarrhea, and malaria. However, the reported number of treated cases in community care sites in Uvira and Mwene Ditu decreased during this quarter, as there was a low level of reporting at the health sites in Uvira and Mwene Ditu. In the Mwene Ditu coordination area, in the health zones of Mwene Ditu, Luputa, and Mpokolo, health care providers have not yet systematically mastered how to count and take the frequency of respiration in order to correctly diagnose pneumonia because they are not using the ordinograms. As a consequence, IHP plans to reinforce the use of the ordinograms, including care of pneumonia, during the review meetings from July-August 2013, as well as during supportive supervision visits to the health centers.

The following activities will be carried out during the next quarter:

- Carry out supervisory visits, provide medical supplies, and support commodity monitoring in the coordinations of Bukavu, Kamina, Kole, and Kolwezi
- Support providers in evaluating, identifying and correctly treating pneumonia cases, with a particular focus on the coordinations of Mwene Ditu, Tshumbe, Luiza and Uvira
- Supply cotrimoxazole to the health zones and monitor distribution to the health facilities and community health sites
- Increase the involvement of CHWs in the health zone reviews to better capture data and improve internal reporting.

In PY3Q3, 68,495 new episodes of diarrhea in children under 5 were treated with oral rehydration solution (ORS), including 3,718 cases treated in community care sites. Table 10, below, provides the number of diarrhea cases treated with ORS. This represents an overall increase of 8,528 new cases treated, compared to the previous quarter. Over 1,000 new episodes of diarrhea were assessed and treated in community care sites. Disseminating training materials for diarrhea case management and ensuring the availability of ORS and zinc sulfate contributed to the improvements seen in PY3Q3.

Table 10: Number of children under 5 years old with diarrhea treated with oral rehydration solution (ORS) or ORS plus zinc supplements in USG-supported facilities

Coordination Office	PY3Q3				
	Health facilities	i-CCM sites	Total	PMP target	% of target achieved
Bukavu	23,639	367	24,006	52,949	45
Kamina	10,455	1,002	11,457	24,438	47
Kole	1,377	212	1,589	5,169	31
Kolwezi	6,446	562	7,008	12,060	58
Luiza	7,047	453	7,500	23,291	32
Mwene Ditu	7,638	486	8,124	38,807	21
Tshumbe	2,743	364	3,107	16,074	19
Uvira	5,432	272	5,704	12,726	45
PY3Q3 Total	64,777	3,718	68,495	185,514	37
PY3Q2 Total	57,545	2,422	59,967	185,514	32

There was an increase in the availability of ORS and zinc sulfate in health facilities and community care sites, compared to the previous quarter. Most health facilities with ORS stock outs were located in health zones with armed conflict (Bunyakiri, Mulongo, etc.). However, the health areas served by the CDRs--FODESA and CADMEKO--had not yet received zinc sulfate supplies as a plane that was to be used to distribute the medicines from the CDRs was not available. The zinc sulfate will be distributed by next quarter.

The following activities will be carried out during the next quarter:

- Continue distribution and monitor ORS utilization in the health zones, the health centers, and the community care sites
- Strengthen community awareness for seeking rapid care in diarrhea cases
- Accelerate the zinc sulfate delivery process in CDRs and health facilities.

In PY3Q3, 175,250 ACT doses were distributed in health facilities and in community care sites to children under 5 years. This quarter, 4,654 doses were distributed in community care sites, which represents an increase of more than 1,000 doses distributed in community care sites as compared to last quarter. Table 11, below, provides the number of children under 5 treated for malaria in PY3Q3. The rehabilitation of health sites, which involved trainings on the proper case management of malaria in the coordinations of Kamina and Tshumbe, played an important role in this increased performance.

Table 11: Number of children under 5 years old with malaria treated in facilities and i-CCM supported by the U.S .Government in PY3Q3

Coordination Office	PY3Q3				
	Health facilities	i-CCM sites	Total	Target	% of target achieved
Bukavu	36,337	1,052	37,389	124,706	30
Kamina	34,678	1,517	36,195	65,582	55
Kole	6,049	20	6,069	12,174	50
Kolwezi	18,694	490	19,184	28,403	68
Luiza	16,175	467	16,642	49,793	33
Mwene Ditu	32,673	606	33,279	64,753	51
Tshumbe	14,058	47	14,105	23,257	61
Uvira	11,932	455	12,387	29,971	41
TOTAL PY3Q3	170,596	4,654	175,250	398,639	44
TOTAL PY3Q2	184,625	3,605	188,230	398,639	47

The following activities will be carried out during the next quarter:

- Monitor ACT distribution in all coordinations
- Analyze malaria data jointly with the health zones and compute the average monthly consumption.

1.2. A Promise Renewed

With very high infant, child and maternal mortality rates, the DRC must increase its efforts to accelerate the reduction of maternal, newborn, and child mortality. Therefore, on May 31, 2013, the DRC government pledged to focus all efforts on reducing women and children mortality rates. This objective is described in the acceleration framework document to reduce infant and maternal mortality, and will be achieved through a package of high-impact interventions targeting mothers, infants and children. The focus will be placed on priority health zones or areas exhibiting low growth potential.

Among the 80 IHP-supported health zones, 37 are classified as “red,” or low development potential, and they have been defined as priority zones that require specific interventions identified in the MOH acceleration framework. In these 37 priority health zones, 12 are among the 27 health zones selected as intervention zones for the UNICEF-funded Health for the Poorest Populations (HPP) project. For the 25 remaining priority health zones, IHP has begun implementing specific activities agreed with USAID and included in IHP workplan.

For the 27 health zones with the most vulnerable populations, the MSH Health for Poorest Population (HPP) project, identified in the MOH Action Framework to accelerate the reduction of maternal, neonatal and child

mortality, will include the distribution of pre-packaged family kits with essential medicine commodities for the case management of pregnancies, deliveries, and fatal diseases for children under 5, and will promote the use of vouchers that subsidize care. Successful implementation of the HPP project will contribute to IHP results as the 27 health zones selected for HPP are also supported by IHP. The overlap in the activities to these 27 health zones provides the foundation for the partnership between USAID and UNICEF in jointly supporting the implementation of the DRC MOH action framework in these selected health zones.

The following activities were carried out during this quarter:

- Signed cooperative agreement with UNICEF and MSH
- Developed HPP project database
- Hired HPP project staff: 4 field coordinators and one national coordinator
- Ordered pre-packaged family kits.

During the next quarter, the following activities are planned:

- Select health zones included in the project launch
- Conduct orientation meetings on implementation strategies for staff at the central, provincial and field level as well as implementation partners
- Count target population and map new community care sites.

For the 25 priority health zones that IHP supports, the following activities were carried out:

- **Rehabilitated 70 community care sites** in the health zones of Lodja (10 i-CCM sites), Djalo Ndjeka (9 i-CCM sites), Tshumbe (10 i-CCM sites), Vangakete (12 i-CCM sites), Bena Dibebe (8 i-CCM sites), Kitenge (7 i-CCM sites), Songa (7 i-CCM sites), and Kabongo (7 i-CCM sites), which involved the training of 149 health care providers in proper management of childhood illness. These health care sites are supplied with medicine and commodities to prevent, diagnose, and treat malaria, diarrhea, and pneumonia.
- **Integrated neonatal resuscitation (Helping Babies Breathe) in 7 hospitals** (Mukanga, Kole, Bena Dibebe, Djalo Ndjeka, Bibanga, Kalomba, and Minova); supply 8 ball and mask ventilation kits for neonatal resuscitation for the health facilities in these health zones.
- **Created support groups for infant and young children feeding** in the health zones of Mutshatsha, Bunkeya, and Bibanga.
- **Strengthened human resources capacities for child health** during supervision visits in the health zones of Kitenge, Songa, Kabongo, Mutshatsha, Bibanga, Ruzizi, Lemera and Nundu. Capacity building will focus on case management of pneumonia, diarrhea, and pneumonia for CHWs and nurses.
- **Procured 13 essential medicines to save the lives of mothers, infants and children** (including oxytocin 10UI, ORS, zinc sulfate 20 mg, magnesium sulfate 500mg/10ml, ceftriaxone 1g for injection, dexamethasone 4mg for injection; chlorhexidine solution 7.1%, amoxicillin 250mg tabs, low-osmolarity ORS solution). Seven of these commodities are already included in the medicines that IHP orders, and they are distributed to the health zones and available in the health facilities (magnesium sulfate 500mg/10ml, amoxicillin 1g injectable, dexamethasone 4mg injectable, ORS packets, oxytocin 10UI and zinc sulfate 20mg. Levonorgestrel 200µ (impant), Levonorgestrel 750µg (emergency contraception), and female condoms (latex, with lubricant) are provided directly by USAID to the health zones via IHP. It should be noted that as of this report, there is a stock out of the last two commodities. Chlorhexidine digluconate solution 7.1%, misoprostol, and amoxicillin dispersible tablets are not yet registered on the list of essential medicines in DRC and are therefore not available in the health facilities. It should be noted that the MOH, supported by MSH, will conduct a sensitization in August 2013 to introduce chlorhexidine digluconate solution 7.1%. The MOH, with support from SIAPS, will conduct a workshop in

September 2013 to revise the pneumonia treatment guide to include amoxicillin dispersible tablets as the first-line treatment for pneumonia.

- **Finalized guidelines documents, tools, and approaches for the Government of DRC and MOH Acceleration Framework:** IHP provided technical support to the development of the task force the MOH implemented in order to finalize the voucher system used to subsidize health care services for mothers and children under 5. The project also provided support to the national workshop on innovative approaches to quality improvement of primary health care services, and shared its experiences with FOSACOF, Leadership Development Programs (LDP) and the Collaborative Approach.

We have begun tracking and highlighting the results of key interventions that contribute to APR. The project is in the process of reconciling, harmonizing, and using the same indicators used by the MOH to present the same analyses and results as the project evaluates progress in the IHP-supported health zones. IHP has begun to provide USAID with the results of these analyses.

2. Scale up evidence-based pilot WASH activities

In PY3Q3, 83 community water springs were capped, and 14,091 family latrines were renovated as part of the IHP project’s community-based WASH activities. The water springs and latrines have provided improved water and sanitation access for 73,357 people and 97,887 people, respectively. The achievement rate for the number of people benefiting from family latrines reached 117% of the expected result for the period. Compared to achievements in PY3Q2, in PY3Q3 fewer people benefited from access to drinking water, as 73,357 people benefited in this quarter compared to 96,251 in PY3Q2. However, an improvement in the number of people benefiting from access to improved sanitation (family latrines), was reported, from 68,044 people in PY3Q2 to 97,886 this quarter. See table 12, below, for the number of people with access to drinking water and improved sanitation. Given that the new zonal WASH strategy targets different health zones with different populations each quarter, fluctuations in the number of people benefiting from access to improved water and sanitation from quarter to quarter are possible.

Table 12: IHP WASH indicators results per IHP coordination for PY3Q3

	Target for number of people with first time access to drinking water	Number of people in target areas with first-time access to improved drinking water supply as a result of USG support	Achievement rate for water sources (%)	Number of people in target areas with first-time access to improved sanitation facilities as a result of USG support	Achievement rate for latrines (%)
Bukavu	14,844	0	0	23,532	159
Kamina	9,064	12,246	135	1,343	15
Kole	8,771	15,213	173	17,388	198
Kolwezi	5,723	0	0	11,244	197
Luiza	7,365	5,502	75	6,958	95
Mwene Ditu	16,708	17,065	102	21,854	131
Tshumbe	7,994	18,767	235	13,012	163
Uvira	13,481	4,564	34	2,555	19
PY3Q3 total	83,950	73,357	91	97,886	117

Access to improved latrines decreased in the Kamina and Uvira coordinations, with achievement rates of only 14.8% and 19%, respectively, which translates to reaching 1,313 people out of a targeted 9,064 in Kamina, and 2,555 people out of a planned 13,481 in Uvira. Uvira is in the process of rehabilitating latrines, and is expected to demonstrate a higher achievement rate next quarter when more latrines will have been completed. In Kamina, the rainy season delayed latrine rehabilitation as many routes were destroyed by natural conditions, preventing materials and staff from accessing these areas. The coordinations of Bukavu and Kolwezi did not capture or protect any water sources in the communities during this quarter. However, Kolwezi and Bukavu were in the preparatory phase, including procuring materials, during PY3Q3, and are expected to begin water source protection and capturing work next quarter.

Since the beginning of PY3, the project has reported consistent improvements in WASH indicators, suggesting that the zonal WASH strategy promotes ownership within the community. Increased ownership and strong results are particularly evident in the province of Kasai Oriental, and most significantly in Sankuru, where politico-administrative and religious leaders are fully involved in the project's WASH activities. In addition, five villages in Sankuru will each receive an "Open Air Defecation Free" certificate next quarter. Once all households in a village have latrines, the health zone administration can confer a certificate to the village acknowledging the improvements made in household sanitation. These communities will receive certificates signed by the medical director of the zone, the administrator of the territory and the head nurse of the health zone. Appendix 2 provides an example of the Open Air Defecation Free certificate provided to qualifying villages. It should be noted that the "Open Air Defecation Free" certificate does not replace the certification provided by the Clean Village and School program, as the process is different and is based on a checklist that is signed by the chief zonal medical officer and the local administrator.

Communities that are not explicitly involved in the project's WASH activities have benefited from IHP-supported WASH activities in other health zones through the sharing of best practices between communities, including encouraging hand washing and promoting the use of latrines, when available. Some communities, such as those involved in the Champion Community approach, are working on improving WASH conditions even though the community is not situated in a WASH selected health zone. For example, Dibanga (Kasai Oriental) and Luiza (Kasai Occidental), both involved in the Champion Community approach, have selected WASH issues as priorities, and have reported many improvements. Also, as a result of project-supported WASH efforts, including training and skill building, community members, including masons and CHWs in multiple areas, have developed the skills to improve access to sanitation and safe drinking water even once the project is over.

The project has also continued to monitor the bacterial levels in water sources. The results of testing of 68 water sources in four IHP-supported health zones in the Sankuru health district (Ototo, Lodja, Dikungu and Vangakete) are provided in Appendix 3. The project found that 58 analyzed sources (85%) were contaminated with fecal bacteria, so the 43,892 people who access these water sources may have been affected. In the case that all the water sources cannot be made safe quickly, the project has started awareness-raising activities to continue to discourage open air defecation, and to encourage community members, if possible, to boil water before drinking it. It should be noted that IHP has systematically analyzed water before and after rehabilitation, and for the health zones listed above, the first analysis showed that 85%, or 58 water sources, were contaminated with fecal bacteria. Of these 58 sources, IHP rehabilitated only 4, and the analyses carried out after rehabilitation revealed only one source contaminated by non-fecal coliform bacteria. This particular source had not been protected by an enclosure or greenery. Water sources are analyzed every six months.

The project plans to rehabilitate drinking water systems in Uvira, and to support ongoing water system improvement efforts in the coordination of Bukavu. The project continues to seek alternative technical solutions to rehabilitate water wells in the health zone of Kanzenze. In addition, the coordination offices are sending health workers to sensitize the communities about the importance of protecting water sources. It is not enough to ensure the supply of water; the project must take actions to improve the sanitation and hygiene and change the behaviors at the community level.

IHP is waiting for USAID validation and approval for the survey protocol for the two new WASH indicators: the number of households with improved drinking water access and the number of households with improved sanitation. This discussion will be held during annual workplanning to include the study protocols in the planned activities for the affected coordination offices in PY4.

IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased

1. Percentage of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP

In PY3Q3, eight project teams in the Kolwezi health district carried out their leadership and development projects as part of their participation in the Leadership Development Program (LDP), and six of them achieved their expected results. Members of the senior LDP team are the health zone management teams who have engaged in the LDP process. Fifty teams from the health zones in four coordinations, including eight teams from Kolwezi, nine from Kamina, three from Tshumbe, four from Uvira, four from Kole, 11 from Luiza, and 11 from Mwene Ditu have developed new LDP projects during this quarter. Table 13, on the following page, provides more information about the LDP teams. Within the leadership projects, the senior teams are working to address challenges in their health zones in order to improve the services and the work climate. By striving to maintain open communication between all team members, planning activities together, carrying out follow-up sessions as a team, and sharing information, the teams are improving their respective work environments.

Table 13: Number of health zone teams that carried out and finalized their LDP projects during PY3Q3

	PY3Q1	PY3Q2	PY3Q3	Comments
Expected number of health zone teams with LDP projects (PMP)	18	18	18	According to the PMP, 18 health zone teams of the 8 IHP coordinations which conducted and completed leadership projects
Number of health zone teams with LDP projects	36	39	50	50 health zone teams developed new leadership projects: 8 in Kolwezi, 9 in Kamina, 3 in Tshumbe, 4 in Kole, 4 in Uvira, 11 in Luiza and 11 in Mwene Ditu
Number of health zone teams which conducted and completed their LDP projects	29	3	8	8 health zone teams from Kolwezi have completed their leadership project
Number of health zone teams which have conducted, completed, and carried out the expected performance	22	3	6	Among the 8 teams having completed an LDP project, 6 teams achieved 80% of their expected performance

Compared to 39 teams in PY3Q2, 50 health zone teams developed new leadership projects this quarter. In addition, eight health zone teams in Kolwezi completed their LDP projects. Last quarter, three teams in Mwene Ditu completed their LDP projects. Compared to the PMP target, eight health zone teams, all in Kolwezi, out of an expected 18 health zone teams, completed their LDP projects during PY3Q3, for an achievement rate of 44%, compared to 17% during PY3Q2. As the LDP functions as a 6-month project and as not all of the 50 teams that developed projects this quarter started exactly at the same time nor are at the same point in their project development, more teams can be expected to complete their projects in the next reporting periods.

Six teams in the health zones of Fungurume, Mutshatsha, Bunkeya, Lualaba, Manika, and Lubudi achieved at least 80% of their expected results by the end of their LDP projects. See table 14, on the next page, for details on the teams' LDP project topics and achievements. The Dilala health zone team, which did not achieve its expected results, had few experienced team members, many of whom had not benefited from the regular training process in leadership practices due to team member turnover. Also, the Kanzenze health zone team did not achieve its expected result, as the team did not successfully involve the politico-administrative and religious leaders in the health center building process in Mpala during the steering committee development phase. The project will support these two teams to help them achieve their desired LDP performance in the next quarter.

Table 14: Evolution of LDP project expected results- indicators completed and evaluated during PY3Q3

Health zone team	Activity	Indicators	Baseline (%)	Target Performance (%)	Performance achieved (%)	Achievement rate (%)
Fungurume	EPI	VAR Immunization coverage	69	85	97	114
Mutshatsha	EPI	VAT2+ Immunization coverage	61	85	79	93
Bunkeya	EPI	VAR Immunization coverage	66	8	85	137
Lualaba	MNCH	Increase in assisted deliveries	32	60	59	99
Manika	Curative services	Referral rate	7	15	13	87
Lubudi	MNCH	Increase in assisted deliveries	63	70	68	97
Dilala	EPI	Reduction of drop-out rate DTP-Hep-Hib	13	5	13	80
Kanzenze	Rehabilitation	Health center built		Health center built	Health center under construction	Still under construction

As shown in table 15, on the next page, the LDP teams provided self-evaluations in November and June regarding their work climates. Successful teams experienced improvements in work climate, with the help of LDP practices, as opposed to the two teams that noted negative changes in their work environments. The teams in Dilala and Kanzenze, both of which did not achieve their expected results, were able to identify, through the LDP process, the factors contributing to the challenges in their work climate. For example, in Dilala, the identified weakness was in human resources, with a new chief health zone medical officer, a team that had not participated in the LDP, and insufficiently qualified technical staff/supervisors who should have been training head nurses during supportive supervision—all weaknesses in the organization of the health zone that had negative consequences for planning and allocation of tasks in the health facilities.

In response to some of the challenges faced this quarter, the project will carry out the following activities next quarter:

- Follow up with the LDP teams each quarter with mixed teams of facilitators comprised of project staff and health district staff
- Provide supervision of the senior staff in the health zones of Kanzenze and Dilala
- Provide assistance with monitoring results, and facilitate stakeholder involvement in the process

- Organize workshops to present completed LDP projects in province capitals and/or health districts in Bukavu and Uvira for health and politico-administrative authorities and other health partners with the aim of increasing awareness of LDP achievements, and boosting MOH ownership of LDP activities.

Table 15: Work climate development among the IHP Kolwezi teams

Team	November 2013		June 2013		Change in work quality	Change in team productivity	Conclusion
	Work quality	Team productivity	Work quality	Team productivity			
Bunkeya	2.8	3.2	4	4	1.2	0.8	Improvement
Dilala	4	4	3	3	-1	-1	Regression
Fungurume	3.6	3.2	4	4.3	0.4	1.1	Improvement
Kanzenze	3.6	4	3.5	3.6	-0.1	-0.4	Regression
Lualaba	4	3.8	4	3.8	0	0	No change
Lubudi	3.8	3.8	4.2	4.3	0.4	0.5	Improvement
Manika	3.8	3.8	4	4	0.2	0.2	Improvement
Mutshatsha	2.8	3.2	4	3.8	1.2	0.6	Improvement

The work climate is the perception of the members of the team of the quality and productivity of their work group. To evaluate work climate, the project uses a work climate assessment tool (WCA), which is simple, reliable, and validated. Team members fill out the template individually, which maintains confidentiality and objectivity. Quality is measured by respect of established norms and commitment of each member of the team, while productivity is measured quantitatively by looking at measures of timeliness and completion rates.

INTERMEDIATE RESULT 2: QUALITY OF KEY FAMILY HEALTH SERVICES (MPA/CPA-PLUS) IN THE TARGET HEALTH ZONES INCREASED

IR 2.1: Clinical and managerial capacity of health care providers increased

1. Family planning

The achievement in Couple Years of Protection (CYP) for PY3Q3, at 124,714 CYPs, surpassed the expected PMP target of 110,000, for an achievement rate of 113%. In the coordinations of Bukavu and Kole, there were increases from 70% to 72% and from 78% to 95%, respectively, from last quarter to PY3Q3. In Bukavu, the improvement is due to the training of 42 providers on communication techniques and basic family planning information in June and July in the 11 health zones that had not yet received training. The project also carried out post-training supervisory visits to the health zones of Katana, Kaziba, Minova, and Mubumbano, in the Bukavu coordination. Uvira also reported an increase from last quarter, from 64% achievement of the target to 75%. Trainings for community-based distributors (CBD) in Uvira on communications techniques and basic family planning method information contributed to this increase. As reported last quarter, Kamina, Kolwezi, Luiza, Mwene Ditu, and Tshumbe continued to report achievements over the target. Family planning training will be

conducted in the remaining 11 health zones in Sud Kivu from June-July (Mulungu, Lulingu, Kalole, Shabunda, Kalonge, Bunyakiri, Kamituga, Mwenga, Kitutu, Idjwi, and Mwana). Training for Kamina was postponed until November 2013 due to the lack of trainers available at the provincial level. Table 16, below, shows the number of CYP by coordination and the achievement rate for PY3Q3.

Table 16: Couple years of protection (CYP) in USG-supported programs

Coordination	PY3Q3 CYP	Quarterly target	Achievement (%)
Bukavu	23,160	31,900	73
Kamina	23,700	16,500	144
Kole	3,158	3,300	96
Kolwezi	13,408	6,600	203
Luiza	19,269	13,200	146
Mwene Ditu	23,270	20,900	111
Tshumbe	12,963	9,900	131
Uvira	5,786	7,700	75
PY3Q3 Total	124,714	110,000	113

In Kole, CBDs used bicycles that the project provided to conduct household visits, contributing to the number of new acceptors of contraceptive methods in Kole and Dibebe. In Luiza, nine health zones, including Bilomba, Bulape, Dekese, Dibaya, Kalomba, Luambo, Lubondaie, Tshikaji, and Yangala, performed well on this indicator as a result of the availability of family planning commodities, the lack of which has been a primary reason for reported under-utilization of family planning methods in the past. IHP has distributed bicycles in all of the health areas, and CBDs can use them for family planning to conduct home visits and follow up of clients. All contraceptives are distributed free of charge. However, in some facilities in Sud Kivu, PSI/ASF supports five health zones where the facilities and their associated community mobilizers sell contraceptives through social marketing.³

Kolwezi was the only coordination with a 38% increase from the previous quarter, from 10,915 to 13,408. The strongest performance has been observed in the health zones of Fungurume with 3,627 and Manika with 2,543. The Manika health zone has integrated family planning activities, including CBD activities, into two new health areas, and the Tenke Fungurume Mining Company supported awareness raising activities in the Fungurume health zone.

³ These PSI/ASF health zones and facilities include the following: Uvira (Kalundu Etat health center, Uvira General Reference Hospital, and Kasenga Hospital Center); Ibanda (5 Celpa Hospital Center and 8 Chepac Chai Hospital Center); Kadutu (Communaute Baptiste au Centre de l’Afrique-CBCA); Nyamugo (8 Cepac Buholo health center); Bagira (Bagira health center, Bagira General Reference Hospital); and Miti Murhesa (Muresha health center, Kavumu, and Lwiro Hospital Centers).

The health zones of Lemera, Hauts Plateaux and Ruzizi, all in the Uvira coordination, and the health zone of Kalonge, Luiza, and Ndekesha in the Bukavu coordination were unable to reach the results of the previous quarter for various reasons, including insecurity in Bukavu, a low level of involvement of the head nurses and senior staff in the health zone, poor efficiency of the community-based distributors (CBD), and non-availability of contraceptives at the points of service in Mona, Kamayi, Mukuandianga, and Kazeya, in Ndekesha, IHP Luiza coordination.

To improve the performance in poor performing health zones, the project plans to carry out the following activities in the next quarter:

- Increase family planning awareness in the health zones with poor performance with awareness raising activities in the community
- Provide the health zones with FP commodities
- Organize trainings for CBDs and other health care providers in the health zones of Kaziba, Kaniola, and Mubumbano
- Plan mini awareness campaigns on family planning in Katana
- Facilitate joint supervision with the health district and the health zones management teams
- Provide the community-based distributors with CBD kits
- Train providers in the use of long-term methods, such as intra-uterine devices (IUDs) and implants

The achievement rate for the number of new acceptors of any modern contraceptive method surpassed the PMP target in PY3Q3 due to increased availability of commodities, and the efforts of 103 newly-trained health care providers in five health zones in Kamina (Kikondja, Malemba Nkulu, Luamba, Kayamba, and Kamina) on basic family planning and communication techniques. Sixty-seven health care providers in five other health zones in Uvira received similar training (Hauts Plateaux, Lemera, Nundu, and Ruzizi), and 42 providers in the health zones of Bunyakiri, Kalole, Kamituga, Kitutu, Lulingu, Mwenga, Shabunda, and Idjwi, all in the coordination of Bukavu, also received training. In addition, the project conducted follow-up training with the head nurses in Uvira, and provided additional support for CBDs. See table 17, on the following page, for information on the number of new acceptors of modern family planning methods by coordination.

Table 17: Number of new acceptors of any modern contraceptive method in USG-supported family planning service delivery points

Coordinations	April 13	May 13	June 13	Total PY3Q3	Target	Achievement %
Bukavu	8,369	6,870	7,419	22,658	35,011	65
Kamina	9,639	10,133	8,780	28,552	18,109	158
Kole	1,900	2,188	2,261	6,349	3,622	175
Kolwezi	4,538	3,730	4,534	12,802	7,244	177
Luiza	7,835	5,774	6,969	20,578	14,487	142
Mwene Ditu	7,093	8,357	10,049	25,499	22,938	111
Tshumbe	4,824	5,016	5,732	15,572	10,866	143
Uvira	1,968	2,257	1,440	5,665	8,451	67
PY3Q3 Total	46,166	44,325	47,184	137,675	120,728	114

Several health zones did not meet the expected targets, including Tshudi Loto and Lomela, due to incomplete data; attention focused on the malaria epidemic (described further in the malaria monitoring and evaluation section of the report); insufficient supervision provided by the health zone management team; and poor community mobilization. In Ruzizi, no data were received in June. In the Bukavu IHP coordination, the poor performance can be explained by the lack of family planning training in some health zones (Kalonge, Kamituga, Mwenga and Kitutu), low population awareness, and irregular post-training follow-up.

Next quarter the project will carry out the following activities to address challenges faced in PY3Q3, including:

- Organize mini family planning awareness-raising campaigns
- Increase the functionality of the CBDs in the health zones through trainings on family planning method information and increased supportive supervision in Bukavu and Uvira, where CYP results have been the weakest
- Provide support to the health zone central offices to integrate FP activities with private sector partners, maintain reporting tools, and ensure FP commodity availability
- Organize a family planning training during the fourth quarter for CBDs and health care providers on all family planning methods, but with an emphasis on ways to promote long-term methods, such as IUDs or implants
- Increase the supportive supervision and the post-training follow-up of all FP providers on long-term methods in the health zones of Bukavu, Kamina, Mwene Ditu, Uvira and Kolwezi.

During PY3Q3, the number of family planning counseling visits surpassed the expected target more than two-fold due to the involvement and project ownership of some health care providers, CBDs, and local NGOs. An information campaign on the Tiaht Amendment in Mwene Ditu strengthened counseling services at the

provider and community level. Table 18, below, shows the number of counseling visits that occurred in PY3Q3 by coordination office. The number of counseling visits provided was 148,249 out of the target number of 65,000 (228%).

Table 18: Number of counseling visits for family planning

Coordinations	April 13	May 13	June 13	Total PY3Q3	PMP Target	Achievement %
Bukavu	9,535	8,626	10,840	29,001	18,850	153
Kamina	7,042	8,633	9,829	25,504	9,750	261
Kole	1,925	2,233	2,644	6,802	1,950	348
Kolwezi	4,765	4,038	4,031	12,834	3,900	329
Luiza	9,087	8,064	8,082	25,233	7,800	322
Mwene Ditu	7,939	7,954	10,014	25,907	12,350	209
Tshumbe	5,583	5,626	5,209	16,418	5,850	280
Uvira	2,200	2,900	1,450	6,550	4,550	143
PY3Q3 Total	48,076	48,074	52,099	148,249	65,000	228

During this quarter, the total number of service delivery points providing family planning in the 80 health zones was 1,815 out of 1,950 health facilities and community care sites (93%). The number of facilities providing family planning services was 1,451 out of the target number of 1,600 (91%). The number of community service delivery points was 364 out of 350 (104%). Table 19, below, and table 20, on the following page, show the number of service delivery points that offered family planning services in health facilities and in community care sites, respectively.

Table 19: Number of USG-supported delivery points providing family planning counseling or services in health facilities

Coordinations	PY3Q3 Average	Target	% of target achieved
Bukavu	403	480	84
Kamina	204	224	91
Kole	57	64	89
Kolwezi	105	112	94
Luiza	208	208	100
Mwene Ditu	196	208	94
Tshumbe	165	176	94
Uvira	113	128	88
PY3Q3 Total	1,451	1,600	91

Table 20: Number of USG-supported delivery points providing family planning counseling or services in community care sites

Coordinations	PY3Q3 Average	Target	% of target achieved
Bukavu	31	105	30
Kamina	20	17	118
Kole	10	3	333
Kolwezi	32	27	118
Luiza	38	46	83
Mwene Ditu	10	34	29
Tshumbe	73	38	192
Uvira	163	21	776
PY3Q3 Total	364	350	104

Uvira’s achievements in the number of community care sites that provide family planning counseling or services is due to the availability of family planning supplies, and that fact that all CBDs in the coordination have completed all planned trainings. The low performance reported in Mwene Ditu is linked to the fact that not all CBDs have receiving training. In response, the project will continue to train CBDs in Mwene Ditu on basic family planning commodity information and communication techniques.

Compared to the past quarter, which reported 44 health facilities experiencing stock outs, 18 health facilities reported stock outs this quarter. Table 21, on the next page, provides more details on the Depo-Provera stock outs in PY3Q3.

Table 21: Number of USG-assisted health facilities experiencing stock outs of Depo-Provera

Coordinations	April 13	May 13	June 13	PY3Q3 Average	PMP target
Bukavu	24	15	10	16	48
Kamina	1	0	5	2	22
Kole	0	0	0	0	6
Kolwezi	0	0	0	0	11
Luiza	0	0	0	0	21
Mwene Ditu	0	0	0	0	21
Tshumbe	0	0	0	0	18
Uvira	0	0	0	0	13
PY3Q3 Total	25	10	15	18	160

In Bukavu, health facilities experienced Depo-Provera stock outs in remote health zones, as transportation by airplane is the only access to the following health zones: Kadutu (2 health facilities), Lulingu (17 health facilities), Bunyakiri (22 health facilities), and Ibanda (5 health facilities). In Kamina, the number of Depo-Provera stock outs decreased in the health facilities for the health zones of Kabongo, Mulongo (from 15 health facilities to none), Malemba Nkulu (from 1 health facility to none), Mulanga (from 1 facility to none), and Kitenge (1 health facility to none). The improvements in the regular supply of Depo-Provera are due to support from the project to health zone management teams on the proper quantification of needs. Appendix 4 provides figures on the distribution of family planning commodities in PY3Q3.

The project will continue to support the correct and regular quantification of needs by organizing joint training sessions with SIAPS program and the national reproductive health program (PNSR in the French acronym) in all coordination offices.

2. Expanded program on immunization (EPI)

In PY3Q3, 233 of the 240 expected reports were received and analyzed, and data was provided by the National Immunization Program of the Ministry of Health. It should be noted that IHP does not validate this data; rather, this happens at the health zones, where they have responsibility to validate the data during their monitoring meetings. Following these meetings, the data are provided to the EPI sites and shared with the IHP coordination offices. Overall, immunization coverage was satisfactory this quarter, with immunization coverage above 90% for all types of vaccinations. Between PY3Q2 and PY3Q3, an overall improvement was observed from 90% to 95% coverage of the tetanus vaccine, 98% to 101% coverage of the BCG vaccine, 100% to 106% coverage of the Hib1 vaccine, 94% to 101% coverage of the Hib3 vaccine, 93% to 96% coverage of the TOPV3 vaccine, and 89% to 93% coverage of the measles vaccine. On the following page, table 22 displays immunization coverage by coordination.

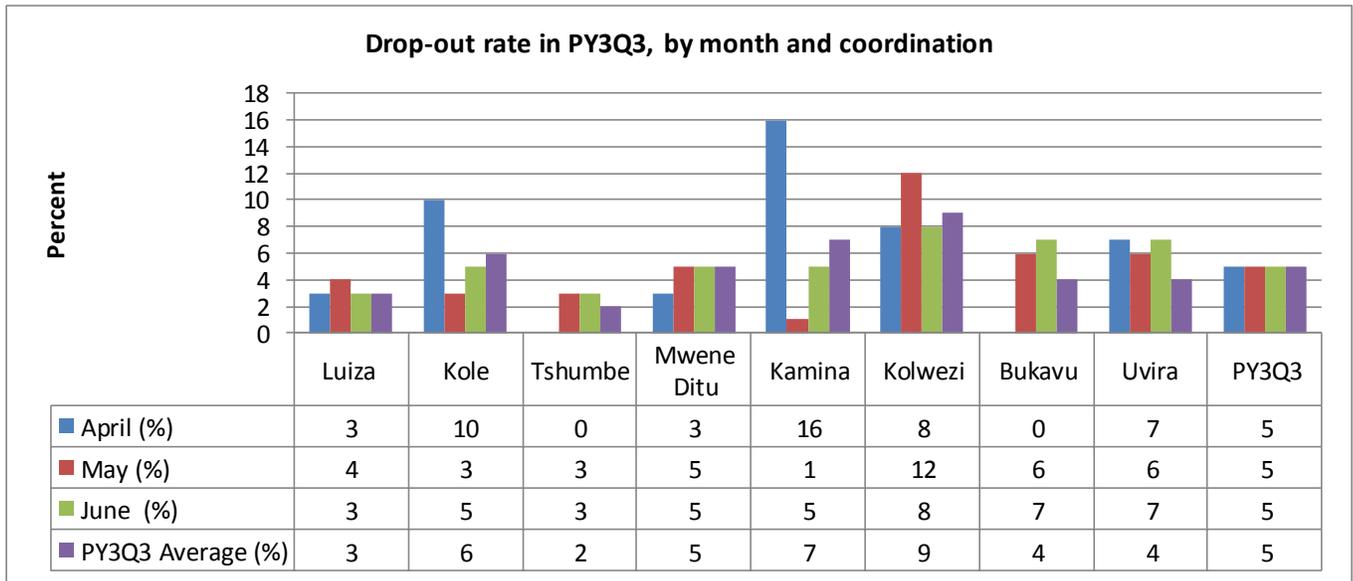
Table 22: Immunization coverage by coordination and vaccination type

Coordination Office	Tetanus vaccine 2+	BCG (%)	DTP HepB-Hib1	DTP HepB-Hib3	TOPV 3 (%)	Measles (%)
Bukavu	94	114	111	107	105	97
Kamina	106	110	118	111	108	106
Kole	85	62	96	91	69	87
Kolwezi	110	154	131	122	118	101
Luiza	100	104	109	105	104	99
Mwene Ditu	85	84	86	82	81	81
Tshumbe	103	91	104	102	101	104
Uvira	77	91	89	83	81	70
PY3Q3 coverage (%)	95	101	106	101	96	93
PY3Q2 coverage (%)	90	98	100	94	93	89

In the Uvira coordination, low coverage rates were reported in June, due to a lack of data reporting from the health zones of Ruzizi, Lemera, and Hauts Plateaux, as nursing personnel were on strike for non-receipt of their risk bonus. Similarly, Kole reported low performances for BCG coverage, with rates that ranged from 62% to 75%. The health zones of Kole, Lomela, and Bena Dibele experienced stock outs of vaccinations in the EPI unit in Lodja, which contributed to the low performance in Kole. The Lodja EPI unit receives vaccination supplies directly from the national level, rather than from the EPI provincial coordination level, as is the case with other EPI antennae units, and due to poor communication between the two, stock outs occur. As the Sankuru health district is far from the EPI provincial coordination office in Mbuji Mayi, the national EPI felt it would be easier for this district to get supplies directly from Kinshasa. IHP has requested that the Lodja unit communicate when stocks are low so that the project can provide support for transport of vaccines.

For PY3Q3, the drop-out rate for DPT-HepB-Hib1 and DTP-HepB-Hib3 remained satisfactory, as shown in figure 2 on the next page, and has improved compared to last quarter. All coordinations reported a drop-out rate between 0 and 10%, which falls within the MOH's recommendations. Kamina and Kolwezi registered very low drop-out rates due to the availability of vaccination commodities and strong utilization of immunization services. The health zones of Mulongo, Kayamba, Mukanga, Manika, Bunkeya, and Dilala, which all previously registered a high level of drop-out rates, improved significantly during this quarter. The improvement seen this quarter is linked to a high rate of recovery of "drop-out" children, due to the community approach of identifying and locating children who had not received all vaccinations in the health areas and health zones, and the availability of immunization services, properly functioning cold chains (gas, wicks, glass, etc.), and support for monitoring supplies.

Figure 2: Drop-out rate between DTP HepB-Hib1 and DTP HepB-Hib3



During this quarter, DPT-HepB-HiB3 coverage rates were reported at around 100%, and nearly all coordinations improved their performance. See table 23, below, for the DPT HepB-Hib3 coverage by coordination in PY3Q3. Compared to last quarter, coverage rates in Uvira decreased from 88% to 83%, due to under-reporting in the health zones of Ruzizi, Lemera, and Hauts Plateaux. The technical support the project provided to the health zones, logistics support for vaccine transport to the EPI units, and the support provided during the coordination meetings and monitoring sessions contributed to strong performance in coverage.

Table 23: DPT HepB-Hib3 immunization coverage by coordination: April-June 13

Period	Bukavu (%)	Kamina (%)	Kole (%)	Kolwezi (%)	Luiza (%)	Mwene Ditu (%)	Tshumbe (%)	Uvira (%)	PY3Q3 average (%)
April 13	112	118	105	133	106	79	108	100	106
May 13	110	105	88	118	112	82	99	100	102
June 13	99	109	83	114	98	84	99	50	95
PY3Q3 Average (%)	107	111	92	122	105	82	102	83	101

Nearly all coordination offices reported an improvement in TOPV3 coverage in PY3Q3, with an overall rate of 99%. Table 24, on the next page, provides the TOPV3 coverage by coordination office. Coverage in Uvira decreased from 87% in PY3Q2 to 81% in this quarter, as three health zones in Uvira, Ruzizi, Lemera and Uvira Hauts Plateaux, did not report results. Kole reported a large decrease in coverage, from 102% in PY3Q2 to 89% in PY3Q3 as the Lomela health zone only reported a 61% coverage rate, the result of gaps in antigen procurement during PY3Q3 in these health zones and the Lodja unit in particular.

Table 24: TOPV3 immunization coverage by coordination and by month for PY3Q3

	Bukavu (%)	Kamina (%)	Kole (%)	Kolwezi (%)	Luiza (%)	Mwene Ditu (%)	Tshumbe (%)	Uvira (%)	PY3Q3 Average (%)
April 13	110	114	104	132	109	78	106	95	104
May 13	106	104	80	117	112	82	99	97	100
June 13	98	107	82	107	91	83	100	51	93
PY3Q3 Average (%)	105	108	89	118	104	81	101	81	99

Compared to a coverage rate of 89% for measles immunizations during the last quarter, a significant improvement of immunization coverage to 94% was reported. Notably, coverage in Tshumbe increased from 94% to 104%, from 77% to 81% in Mwene Ditu, 96% to 106% in Kole, and 96% to 101% in Kolwezi. Uvira, however, noted a decrease from 77% to 70 in PY3Q3, as three health zones failed to report due to health care provider strikes.

The strong performances are linked to the support the project provided to stock the EPI units (Uvira, Luiza, Mwaka, Kamina, and Kabondo Dianda) with vaccines and other immunization commodities, as well as support for supervision and monitoring meetings.

Table 25: Measles immunization coverage by coordination and by month for PY3Q3

	Bukavu (%)	Kamina (%)	Kole (%)	Kolwezi (%)	Luiza (%)	Mwene Ditu (%)	Tshumbe (%)	Uvira (%)	PY3Q3 Average (%)
April 13	101	108	106	106	105	82	111	85	99
May 13	97	102	83	102	104	80	98	81	94
June 13	93	108	75	95	88	81	105	43	90
PY3Q3 Average (%)	97	106	88	101	99	81	104	70	94

Table 26, on the following page, demonstrates that in April, more than 75% of the health zones were in Category 1 and 19% in Category 2, for a total of 94% of the health zones reporting good access to immunization services. In May, 96% of the health zones reported good access to immunization services, with 85% of the health zones in Category 1 and 11% in Category 2. During the month of June, over 75% of the health zones were in category 1 and 11% in category 2.

Table 26: Health zone performance by coordination offices: April-June 2013

Provinces	Field offices	Health zones	Performance	Number of health zones		
				April	May	June
Sud Kivu	Uvira	5	Category 1 ⁴	3	4	1
			Category 2	1	0	0
			Category 3	1	1	1
			Category 4	0	0	0
	Bukavu	22	Category 1	14	17	14
			Category 2	5	5	5
			Category 3	2	0	2
			Category 4	1	0	0
Kasaï Oriental	Tshumbe	10	Category 1	8	10	10
			Category 2	2	0	0
			Category 3	0	0	0
			Category 4	0	0	0
	Kole	4	Category 1	2	3	2
			Category 2	2	0	0
			Category 3	0	1	2
			Category 4	0	0	0
	Mwene Ditu	11	Category 1	10	11	9
			Category 2	0	0	1
			Category 3	1	0	1
			Category 4	0	0	0
Kasaï Occidental	Luiza	11	Category 1	9	11	11
			Category 2	2	0	0
			Category 3	0	0	0
			Category 4	0	0	0
Katanga	Kamina	9	Category 1	8	8	8
			Category 2	1	1	1
			Category 3	0	0	0
			Category 4	0	0	0
	Kolwezi	8	Category 1	6	4	5
			Category 2	2	3	2
			Category 3	0	1	1
			Category 4	0	0	0

⁴ The categorization is as follows:

- Category 1: Health zones with a vaccination coverage rate for pentavalent 1 that is greater or equal to 90% and the drop-out rate is between 0% and 10%
- Category 2: Health zones with a vaccination coverage rate for pentavalent 1 that is greater or equal to 90% and the drop-out rate is greater than 10%
- Category 3: Health zones with a vaccination coverage rate for pentavalent 1 that is less than 90% with a drop-out rate between 0% and 10%
- Category 4: Health zones with a vaccination coverage rate for pentavalent 1 that is less than 90% with a the drop-out rate is greater than 10%

These data reflect a steady performance, which can be attributed to access to and utilization of immunization services. The project contributed to an improvement in vaccination logistics by providing six months' worth of petrol to support the supply chain, as well as support for ensuring availability of vaccines, auto disabling syringes, gas, wicks, and glass. The project also provided support for immunization sessions to recover children who had originally "dropped out" in the health zones.

In order to improve data quality the project will carry out the following activities:

1. Support joint data monitoring missions with audits and data quality supervision (DQS) in Kolwezi and Kole; data quality supervision visits will eventually be carried out in all coordinations
2. Increase participation in the monitoring, analysis, and validation meetings by emphasizing that those administering vaccinations should also be responsible for collecting and validating data
3. Continue support of quality vaccine procurement as well as other commodities at the EPI unit level, at the storage sites in the health zones, and in the health zone secondary warehouses
4. Support maintenance of the cold chain equipment and materials
5. Support immunization services in health zones and health areas
6. Monitor epidemiological trends and patterns in relation to immunization coverage
7. Strengthen the overall approach with supportive grants for cold chain materials.

3. Maternal, Neonatal and Child Health (MNCH)

Helping Babies Breathe

During the PY3Q3, the project performed follow-up activities in several GRHs with trained providers in Helping Babies Breathe (HBB) activities, to increase the project's contribution to the reduction of neonatal mortality. Eight GRHs were visited: Tshamala and Luputa (Mwene Ditu coordination), Tshikaji and Luiza (Luiza coordination), Kabongo (Kamina coordination), Bagira and Kavumu (Bukavu coordination), and Uvira. Table 27, on the following page, displays the number of health zones per coordination with GRH providers trained in HBB protocols, and table 28, also on the next page, presents findings from visits to GRHs regarding the numbers of babies resuscitated.

Following two rounds of training, providers capable of carrying out HBB neonatal resuscitation are now present in 46% of the targeted health zones. Providers trained in HBB are present in more than half of the IHP-supported health zones in the coordinations of Kamina, Kole, and Kolwezi. While more workshops are planned for the next quarter, the project organized previously trained providers to provide briefings and support to project teams that did not have the opportunity to attend the course, in order to share neonatal resuscitation practices. The project provided supervision and feedback to nine health teams in Mwene Ditu and two teams in Luiza, after the teams demonstrated the skills they had learned from the HBB training.

Table 27: GRH/health zone per IHP coordination with providers trained in HBB for neonatal resuscitation

IHP Coordination	Total no. of GRH/health zone	Number of GRH with HBB trained providers	No. of GRH visited in PY3Q3	GRH visited in IHP Y3Q3
Mwene Ditu	11	4	2	Mwene Ditu, Luputa
Luiza	11	5	2	Luiza, Tshikaji
Bukavu	22	10	3	Bagira, Kavumu, Kaziba
Kamina	9	5	1	Kabongo
Uvira	5	2	1	Uvira
Kolwezi	8	4	1	Mwangeji
Tshumbe	11	5	0	-
Kole	4	2	0	-
PY3Q3 Total	81	37	10	

Table 28: Number of babies with neonatal asphyxia registered during the period of January 2012 to June 2013 in the GRHs visited during IHP PY3Q3

Coordination	GRH visited	No. of registered births	No. of babies resuscitated in the GRH visited	Percentage of babies with neonatal asphyxia	Comparison to national average of neonatal asphyxia (3.5%)
Mwene Ditu	Mwene Ditu	628	34	5.41%	Above average
	Luputa	402	48	12%	Above average
Luiza	Luiza	558	34	6.09%	Above average
	Tshikaji	319	20	6.26%	Above average
Uvira	Uvira	3377	141	4.17%	Above average
Bukavu	Bagira	1325	58	4.37%	Above average
	Kavumu	5202	91	1.74%	Under reporting of cases
	Kaziba	3884	230	5.92%	Above average
Kamina	Kabongo	400	58	14.5%	Above average

According to birth records in the GRHs visited, overall, one out of ten babies delivered suffered from neonatal asphyxia. The low percentage of babies requiring resuscitation in the Bukavu GRH suggests an under-reporting of cases. Babies with moderate asphyxia, as indicated by an Apgar score of 6, are not included in the reporting procedure, but should be reported. An Apgar test is a standard assessment of overall newborn well-being that ranges from 0 to 10, with 10 serving as the highest score. General reporting tools provided by the MOH in maternity clinics do not include a neonatal asphyxia indicator. Following HBB workshops, the project provided a data collection tool for neonatal asphyxia, which has contributed to an increase in the number of providers reporting resuscitation cases in the maternity clinics.

Among GRHs visited, HBB training for maternity clinic providers contributed to the increase in the survival rate of babies requiring resuscitation. Table 29, below, provides the numbers of babies resuscitated during periods before and after HBB trainings. The survival rate observed is over 90% in six of the nine GRHs visited. Two GRHs reported a survival rate of over 80%, and only one GRH had a rate of 67%. The low rate observed in the Kavumu GRH in the Miti Murhesa health zone is due to the fact that the person in charge of the maternity clinic, who was trained in HBB, was on maternity leave and was ill shortly after the training ended. Therefore, she was unable to provide technical support to the other providers at that time. During the initial training, the provincial level had agreed to take on responsibility for the follow up for the training; nevertheless, to avoid such a situation in the future, IHP can provide training to additional personnel to ensure that trained providers are available to train others.

Table 29: Number of resuscitated babies before and after the HBB training courses

GRH visited	Babies resuscitated prior to HBB training		Babies resuscitated after HBB training		Date of HBB training
	Successful resuscitation	Unsuccessful resuscitation	Successful resuscitation	Unsuccessful resuscitation	
Mwene Ditu	5 (63%)	3 (37%)	25 (96%)	1(4%)	April 2012
Luputa	14 (58%)	10 (42%)	20 (83%)	4 (17%)	April 2012
Luiza	9 (64%)	5 (36%)	19 (95%)	1 (5%)	April 2012
Tshikaji	2 (50%)	2 (50%)	15 (94%)	1 (6%)	April 2012
Uvira	29 (76%)	9 (24%)	98 (95%)	5 (5%)	April 2012
Bagira	31 (94%)	2 (06%)	25 (100%)	0 (0%)	October 2012
Kavumu	25 (48%)	27 (52%)	20 (67%)	10 (33%)	October 2012
Kaziba	36 (90%)	4(10%)	184 (97%)	6 (3%)	October 2012
Kabongo	15 (54%)	13 (46%)	24 (80%)	6 (20%)	October 2012

The survival rate of over 75% observed in the three GRHs of Kaziba, Bagira, and Uvira before the IHP-supported workshops in April and October 2012 can be explained by the fact that the providers in these three GRHs had already benefited from another training session on active management of third stage labor (AMTSL) during the AXes project, which also covered proper neonatal resuscitation methods. Some trained providers had already received complete neonatal resuscitation kits. In the GRH of Kavumu, 10 unsuccessful resuscitations were noted, which is the highest amongst the GHRs visited. As noted above, the head of the maternity clinic did not have the opportunity to train other health care providers and to provide technical support after receiving the training herself as she was on maternity leave and then was ill.

As many health care providers learned outdated or incorrect protocols elsewhere, the recent HBB trainings organized by IHP instructed health care providers to abandon previous, incorrect practices in neonatal resuscitation, including the use of alcohol, tapping the baby with its head down, over-manipulating the baby after a C-section, and the use of harmful medicines such as dexamethasone, bicarbonate, and hypertonic glucose solution. IHP's updated trainings also contributed to the increase in the number of resuscitated babies in the IHP-supported GRHs.

To continue and expand upon HBB activities, the project plans to carry out the following activities in PY3Q4:

- Extend the HBB training program to other GRH providers in all IHP-supported coordinations (including post-training follow-up to increase the number of highly-trained providers)

- Continue to provide briefings and trainings to all providers who did not benefit from formal workshops on HBB in all maternity clinics
- Advocate for the procurement of HBB kits in all the health facilities with trained HBB providers.

Pregnant women attending at least one antenatal care visit

Compared to the previous quarter, PY3Q3 reported an increase from 126,167 pregnant women attending at least one antenatal care visit to 127,356. In the Uvira coordination, however, a drop in the attendance rate was observed in June, following the absence of reports from the health zones of Ruzizi, Lemera, and Hauts Plateaux, as the nursing staff was, at the time, on strike over salaries. Overall, the achievement rate for this indicator, 104%, surpassed the PMP target of 85%. Table 30, below, provides information on this indicator by coordination area.

Table 30: Number of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 total
April 13	13,608	6,640	1,263	2,937	5,211	6,845	4,091	3,013	43,608
May 13	13,201	6,826	1,208	3,128	5,341	6,940	3,881	3,254	43,779
June 2013	11,496	6,310	1,310	2,806	5,377	7,108	3,956	1,606	39,969
PY3Q3	38,305	19,776	3,781	8,871	15,929	20,893	11,928	7,873	127,356
Target PY3Q3	35,365	18,292	3,658	7,317	14,634	23,170	10,975	8,536	121,949
Achievement rate (%)	108	108	103	121	109	90	109	92	104

The strong results seen this quarter were essentially due to commodity availability (ANC kits⁵, iron and folic acid); the implementation of the ANC advanced strategy in some health zones (Uvira, Kole); regular supervision of health zone management staff in the health zones; the involvement of the CHWs and community leaders in social mobilization; the Champion Community approach in Luiza, Dibaya, and Bilomba; the acquisition of bicycles for the health areas, allowing the CHWs to conduct awareness sessions; head nurses promoting ANC advanced strategy; and the introduction of the Closed User Group (CUG) approach, specifically in the Dibaya and Tshikaji health zones. We observed, however, that several health areas reported results were well below targets, due to the low number of and irregular ANC sessions.

To maintain what has been learned, the project recommends the following actions:

- Continue awareness education for women and community awareness through the CHWs
- Encourage ANC visits and prevent stock outs by implementing a commodity supply tracking system

⁵ The content of the kit includes iron folate, SP, mebendazole, and a LLIN. The kit is provided free of charge.

- Establish more effective quantification for medicines
- Intensify data monitoring supervision
- Increase the quality and quantity of ANC visits
- Collaborate with community-based organizations to advocate low risk pregnancy among pregnant women with an increased number of ANC advanced strategy sessions in the remote health zones
- Provide the ANC schedule to all health facilities
- Continue advocacy meetings with the MOH to standardize the price of commodities among the different providers and partners (which can occur at the provincial level, where the MOH can bring together partners and stakeholders to discuss and make decisions on harmonizing costs, support partners to reduce the administrative burden required to obtain commodities, issue an administrative note to all health zones and health centers that includes the costs that need to be adopted, monitor the implementation of the note through supervision visits by the DPS, health zones, and health district, and enforce sanctions against GRH and head nurses who do not implement the new directives.

Pregnant women attending at least four antenatal care visits

During PY3Q3, the attendance rate for at least four ANC visits was 73% (51,775) compared to the PMP target (70,809), as reflected in table 31, below. Although other coordinations reported relatively strong rates, the coordination offices in Bukavu, Kamina, Kolwezi, and Uvira only registered 53%, 43%, 58%, and 55%, respectively. We observed little change in the number of women benefiting from all antenatal consultations (51,775) compared to the results obtained in the previous quarter (51,634). Health care providers continue to face challenges in correctly reporting on the indicator as it is not collected in the HMIS or GESIS data collection systems. Last quarter, the project introduced the patient attendance registry and proper tools for collecting data on this indicator; however, more time and training is needed before health care providers will be able to correctly collect data with the new tools.

Table 31: Number of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 Total
April 13	3,631	1,567	812	705	2,793	4,054	2,737	953	17,252
May 13	3,630	1,945	536	892	2,726	4,185	2,649	1,084	17,647
June 13	3,600	1,108	773	887	2,801	4,405	2,592	710	16,876
PY3Q3	10,861	4,620	2,121	2,484	8,320	12,644	7,978	2,747	51,775
Target PY3Q3	20,535	10,621	2,124	4,249	8,497	13,454	6,373	4,957	70,809
Achievement rate (%)	53	43	100	58	98	94	125	55	73

Low performance on this indicator is due to the lack of reporting in the health zone of Haut Plateaux in the Uvira coordination, insecurity in the Bukavu health zones, the delay in women seeking antenatal consultations until

the last trimester of pregnancy, and women not attending consultations during the harvest season when they work in the fields.

Several health facilities also report to the HMIS network, which does not currently include four ANC visits in its indicators, which contributing to the level of poor reporting. In the Uvira coordination, the decrease is explained by a change in the data collection system to the Performance Indicator Reference and Tracking Sheet (PIRTS). Previously, Uvira did not have a tool to properly capture ANC 4 data. The new tool was introduced last quarter, and this quarter, health zone staff providing briefings to health care providers on how to use the tool. The staff and project will provide further briefings as some health care providers continue to have issues in using it correctly. In addition, insecurity in the zones of Lemera, the Hauts Plateaux of Uvira, and Ruzizi health zones contributed to low levels of reporting.

The project will carry out the following activities next quarter to maintain the success rate and improve performances:

- Monitor reporting completeness in the health zones
- Support the coordination offices in implementing the advanced antenatal care strategy
- Reinforce community awareness on the importance of ANC4 with information dissemination in the media, CUGs, and mini-campaigns
- Accelerate the duplication process of data collection tools, and provide briefings on the indicator definition and data collection methods.

In order to improve the performance in each coordination, the project will ensure regular data audits and reinforce the advanced antenatal care strategy in which nurses and health care providers seek out women in harder-to-access areas in the community to provide ANC. The project will also plan activities with multiple goals, for example, by making ANC and family planning commodities available during the routine EPI activities. The project will also strengthen training follow-up with supervisory visits to providers, emphasizing data collection techniques and the proper use of data collection tools.

Number of deliveries with a skilled birth attendant present

Regarding the number of deliveries with a skilled birth attendant present, the results were 91%, 95%, and 89% in the coordinations of Kamina, Mwene Ditu, and Uvira, respectively, as shown in table 32, on the following page. These results reflect improvements from last quarter during which achievement rates for Kamina, Mwene Ditu, and Uvira were 88%, 90%, 83%, respectively.

Table 32: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 total
April 13	10,381	4,604	1033	3,285	4,920	6,084	3,662	2,484	36,453
May 13	10,783	4,851	962	3,350	4,847	6,388	3,559	2,666	37,406
June 13	10,104	4,839	1,128	3,198	4,950	6,493	3,642	1,373	35,727
PY3Q3 Total	31,268	14,294	3,123	9,833	14,717	18,965	10,863	6,523	109,586
Target PY3Q3	30,422	15,735	3,147	6,294	12,588	19,931	9,441	7,343	104,902
Achievement rate (%)	103	91	99	156	117	95	115	89	104

The following activities will be carried out to maintain and improve these performance results:

- Monitor and improve reporting completeness in the health zones, especially in the Uvira Hauts Plateaux health zone
- Strengthen community awareness on the danger of home delivery and the advantages of deliveries performed with the help of qualified staff in the health facilities
- Improve provider supervision skills and the quality of health services through trainings on improving communication techniques and by providing supervision to those who supervise other health care providers
- Expand the HBB services to all health areas and provide delivery kits and other commodities to the various health facilities
- Organize joint supervision sessions in the health areas and accelerate the rehabilitation of maternity clinics

Number of women receiving Active Management of the Third Stage of Labor (AMTSL)

For PY3Q3, the AMTSL achievement rate for the project is 108%. This rate is significantly above the target of 80%. See table 33, on the following page, for more details on the number of women receiving AMTSL by coordination. The number of women who benefited from AMTSL (101,860) has increased compared to the previous quarter (95,292). In the Uvira coordination, the achievement rate for this indicator is 84%, a result of the poor reporting from the health area of the Hauts Plateaux.

Table 33: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 total
April 13	9,574	4,586	919	2,969	4,819	5,707	3,455	2,137	34,166
May 13	10,088	4,842	733	3,191	4,665	5,966	3,100	2,146	34,731
June 13	9,422	4,480	965	2,961	4,442	6,144	3,277	1,272	32,963
PY3Q3	29,084	13,908	2,617	9,121	13,926	17,817	9,832	5,555	101,860
Target PY3Q3	27,290	14,116	2,823	5,646	11,293	17,880	8,469	6,587	94,105
Achievement rate (%)	107	99	93	162	123	100	116	84	108

The increased coverage was due to consistent supportive supervision, oxytocin availability, training of head nurses on AMTSL procedures during the supervision visits, and systematically integrating the AMTSL protocols in all health facilities.

In order to maintain the strong performances reported this quarter, the project plans the following activities for next quarter:

- Increase community awareness for all women to plan their deliveries in health facilities
- Improve the completeness of reports in every health zone
- Increase monitoring and data auditing
- Provide a regular supply of oxytocin to health facilities
- Strengthen provider capacity during supportive supervision visits
- Intensify joint supervision and integrate AMTSL, essential newborn card, partograms, and HBB activities

Number of postpartum visits within three days of birth

The number of mothers and newborns who received a visit within 3 days of delivery increased from 94,429 in PY3Q2 to 103,306 in PY3Q3, which translates to a 79% achievement of the PMP target of 131,127. While the Luiza coordination office reported having 89% of mothers and newborns receive a visit within 3 days of delivery, the Uvira and Kamina coordination areas reported less than 75%. Table 34, on the next page, provides more details on newborn visits by coordination.

Table 34: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 total
April 13	9,446	4,669	963	3,075	4,685	5,703	3,394	2,029	33,964
May 13	9,832	4,835	619	3,193	4,706	6,249	3,351	2,383	35,168
June 13	9,721	4,847	1007	3,152	4,685	6,340	3,395	1,027	34,174
PY3Q3	28,999	14,351	2,589	9,420	14,076	18,292	10,140	5,439	103,306
Target PY3Q3	38,027	19,669	3,934	7,868	15,735	24,914	11,801	9,179	131,127
Achievement rate (%)	76	73	66	120	89	73	86	59	79

The results demonstrate a significant improvement for the Uvira coordination in particular: during the current reporting period, 5,439 mothers and newborns received visits, as compared to 4,556 mothers and newborns in PY3Q2. Despite this increase in Uvira, the overall rate remains low, as women, particularly those with other children, are unable to stay overnight after delivery due to household obligations, and home visits by providers remain low.

The project plans the following activities to improve achievements:

- Disseminate MNCH standards and guidelines
- Increase awareness with mini-campaigns targeting women and involving community leaders on the importance of postpartum care
- Increase number of supervisory visits
- Brief providers on post-natal consultation protocols
- Accelerate the rehabilitation of maternity clinics.

The number of newborns who received essential care

In PY3Q3, the number of newborns who received essential care was 101,593, or 103% of the target set for this period (98,837). The Kolwezi coordination reported a rate of 159%, well above the achievement rate of 115% in PY3Q2. Strong performance such as that reported in Kolwezi is due to briefings on essential care for newborns conducted during the monthly supervision visits carried out by the project. The project's training sessions on Emergency Obstetric and Neonatal Care and MISGAV caesarian methods also contributed to the strong achievement. See table 35, on the following page, for more details on newborn care provided by coordination.

Table 35: Number of newborns receiving essential newborn care through USG-supported programs

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 total
April 13	9,226	4,164	915	3,075	4,760	5,690	3,585	2,475	33,890
May 13	9,591	4,347	863	3,193	4,387	5,821	3,375	2,640	34,217
June 13	9,493	4,278	950	3,152	4,417	6,288	3,542	1,366	33,486
PY3Q3	28,310	12,789	2,728	9,420	13,564	17,799	10,502	6,481	101,593
Target PY3Q3	28,663	14,825	2,965	5,930	11,861	18,779	8,895	6,919	98,837
Achievement rate (%)	99	86	92	159	114	95	118	94	103

The project will carry out the following activities next quarter:

- Organize facilitative supervision sessions on MNCH
- Support the MOH in standardizing the data collection tools and disseminating these tools in all health facilities
- Provide mannequin kits to train new mothers, and newborn essential care kits to all health facilities
- Conduct health care provider training in Emergency Obstetric and Neonatal Care.

Number of newborns treated with antibiotics

The number of newborns treated with antibiotics in PY3Q3 was 7,682, compared to the target of 7,888 newborns. See table 36, on the next page, for more information on the number of newborns treated with antibiotics in PY3Q3. Although most coordination areas met 100% or more of the target number, the Bukavu, Uvira, and Tshumbe coordinations registered 55%, 65%, and 50% respectively. These low rates are the results of the unavailability of antibiotics and data collection tools for this indicator, as well as the poor understanding of the indicator by providers. The project is continuing supervisory visits and supportive efforts to ensure that health care providers in all facilities understand the indicators.

Table 36: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs

Period									
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 Total
April 2013	519	198	103	183	414	1,109	110	110	2,746
May 2013	340	248	61	192	191	839	156	170	2,197
June 2013	396	535	164	153	159	330	86	78	1,901
PY3Q3	1,255	981	328	528	764	2,278	352	358	6,844
Target PY3Q3	2,282	1,180	236	472	944	1,495	708	551	7,868
Achievement rate (%)	55	83	139	112	81	152	50	65	87

In order to improve these results, IHP will carry out the following activities in the next quarter:

- Increase the facilitative supervision in the health facilities
- Ensure regular procurement of essential medicines to fight neonatal infections
- Brief providers on the antibiotic dispensation criteria
- Increase technical support and supervision of providers in newborn care protocol compliance
- Accompany the health zone office staff in disseminating the PIRTS during monthly reviews
- Increase number of trainings on the understanding of protocol standards regarding the use of antibiotics to fight newborn infections (standards and guidelines)
- Technically and financially support joint data auditing missions to strengthen reporting

Fistula Care

In PY3Q3, only the Kaziba GRH in Bukavu carried out fistula repair activities for 60 women, as part of its routine fistula repair activities. The majority of women who received surgical repair were between the ages of 35 and 45 years. Complications from home births accounted for 33% of this quarter’s fistula cases seen in the Kaziba GRH, and dystocia accounted for 38% of the cases. Vesico-vaginal fistulas represented 58% of the type of fistulas seen this quarter. Table 37, on the following page, provides more information about fistula care provided in the Kaziba GRH in PY3Q3.

Of the 60 fistula repairs carried out, 58 cases were successfully repaired, and 2 cases were not. Fifteen of all fistula cases seen were determined to be repaired, but due to continued incontinence, these cases will require further non-surgical rehabilitation⁶.

⁶ A fistula can be repaired successfully, and incontinence can remain an issue. In these cases, the women will receive further care to address incontinence.

Table 37: Fistula care results and information from the Kaziba GRH in PY3Q3

Age				Etiology				Diagnosis						Result			PY3Q3 Total	
Under 20 years	20-35 years	35-45 years	Over 45 years	Home Birth	Curettagge	Acc Dyst	Post Hop	FW	FUW	FVVR1	FVVR2	FUVVR3	FCV	FUVR1	Incontinent	Cured	Unrepaired	
4	25	16	15	20	0	23	17	35	10	0	0	2	0	0	15	58	2	60

In PY3Q4, fistula repairs will take place in multiple GRHs as a part of a fistula repair campaign, including the GRH in Tshikaji (Kananga), Katako Kombe and Dikungu (Tshumbe), Kole, Maika (Kolwezi), Mwene Ditu, Malemba Nkulu, and Kabongo (Kamina). The campaign will be preceded by awareness raising activities in the community, supported by the project.

Malaria prevention

Number and percentage of pregnant women who received at least two doses of SP during ANC visits⁷

For this quarter, 68 targeted health zones reported data on malaria indicators; ten of the 80 IHP-supported health zones receive support from and report to the Global Fund Malaria program. The Kalehe and Lulingu health zones in the Bukavu coordination were unable to report during the entire quarter due to insecurity. See table 38, on the following page, for the number of pregnant women who received two SP doses by coordination.

⁷ This indicator is calculated as follows: **Number of pregnant women who received at least two doses of SP during ANC visits:** Service providers include all women who receive their second dose of SP during the quarter. It is possible that a woman could receive two doses during a quarter; the national protocol says that a pregnant woman can receive SP at intervals of 4 to 12 weeks. Such women would not be counted twice during the same semester, but rather be counted as IPT1 and IPT2. ITP2 was not retained as an indicator in the IHP PMP. **Percentage of pregnant women who received at least two doses of SP during ANC visits:** This represents the proportion of the number of pregnant women having received IPT2 over the number of pregnant woman expected in prenatal consultation during the quarter. To determine the number of pregnant women expected each quarter, IHP divided by 4 the number of pregnant women expected during a year, taking into account that the months of the first quarter reflect the population of the previous year.

Table 38: Number and percentage of pregnant women who received at least two doses of SP during ANC visits from April to June 2013

Coordinations	Indicators		
	Number of pregnant women who received at least two doses of SP during ANC visits	Number of expected pregnant women at ANC visits	Percentage of pregnant women who received at least two doses of SP
Bukavu	25,337	36,784	69
Kamina	15,076	19,345	78
Kole	2,435	3,591	68
Kolwezi	4,570	8,378	55
Luiza	9,386	16,180	58
Mwene Ditu	15,415	24,592	63
Tshumbe	5,899	11,167	53
Uvira	3,474	8,841	39
PY3Q3Total	81,592	128,878	63
PY3Q2 Total	79,387	128,878	62

The percentage of pregnant women who received two doses of SP (IPT 2) during PY3Q3 increased by 1% to 63%, compared to 62% in PY3Q2. Several coordinations performed better compared to the previous quarter. Bukavu (61% to 69%), Kamina (72% to 78%), Kole (62% to 68%), and Kolwezi (50% to 55%) all increased coverage. However, this indicator remained the same for the Mwene Ditu coordination (63%) and decreased in the coordination of Tshumbe (58% to 53%), Luiza (63% to 58%), and Uvira (51% to 39%). Although the Kamina coordination reported 78%, no coordination reached the PMP target of 80% of the number of pregnant women receiving two doses of SP.

At the health zone level, 19 of 68 health zones far exceeded the 80% target:

- Seven health zones in the Bukavu coordination: Mulungu (120%), Kaniola (155%), Walungu (154%), Shabunda (121%), Mubumbano (85%), Kalole (129%), and Bunyakiri (120%)
- Six health zones in the Kamina coordination: Kayamba (95%), Malemba Nkulu (99%), Lwamba (80%), Mukanga (99%), Mulongo (80%), and Songa (94%)
- One health zone in the Kolwezi coordination: Fungurume (137%)
- One health zone in the Luiza coordination: Kalomba (84%)
- Three health zones in the coordination of de Mwene Ditu: Bibanga (77%), Luputa (92%), and Lusambo (82%)
- One health zone in the coordination of Tshumbe: Wembonyama (116%)

Overall, 27 health zones reported an increase (between 50% and 79%), towards the 80% PMP target. They are as follows:

- Six health zones in the Bukavu coordination: Kamituga (73%), Idjwi (67%), Minova (67%), Katana (55%), Lulingu (51%) and Nyangazi (54%)
- Two health zones in the Kamina coordination: Kitenge (64%) and Kabongo (68%)
- One health zone in Kole coordination: Tshudi Loto (61%)
- Five health zones in the Kolwezi coordination: Dilala (64%), Kanzenze (56%), Lualaba (52%), Lubudi (56%), Mutshasha (50%)

- Seven health zones in the Luiza coordination: Bilomba (56%), Dibaya (67%), Lubondaie (64%), Ndekesha (77%), Tshikaji (57%), Luambo (60%), and Yangala (77%)
- Three health zones in the Mwene Ditu coordination: Kalenda (51%), Pania Mutombo (51%), and Wikong (63%)
- Two health zones in the Tshumbe coordination: Tshumbe (78%) and Vangakete (59%)
- One health zone in the Uvira coordination: Uvira (50%)

Twenty-two health zones were below 50%, which lowered the general average:

- Seven health zones in the Bukavu coordination: Mwana (43%), Miti Murhesa (36%), Kitutu (35%), Ibanda (46%), Mwenga (46%), Kadutu (43%), and Kaziba (38%)
- One health zone in the Kamina coordination: Kinkonja (45%)
- One health zone in the Kole coordination: Lomela (29%)
- Two health zones in the Kolwezi coordination: Bunkeya (30%) and Manika (18%)
- Two health zones in the Luiza coordination: Bulape (25%) and Dekese (20%)
- Two health zones in the Mwene Ditu coordination: Kamiji (44%) and Mpokolo (46%)
- Four health zones in the Tshumbe coordination: Djalo Djeka (17%), Minga (37%), Ototo (10%), and Omendjadi (39%)
- Three health zones in the Uvira coordination: Nundu (49%), Lemera (26%), and Ruzizi (34%)

The slightly higher percentage of SP coverage observed during this quarter as compared to the previous reporting period can be explained by the fact that several health zones purchased SP supplies locally with the funds from medicine sales, and that other organizations provided SP, either for free or as a loan. Health zones receive SP for free from the MOH, and once they are sold, the health zones provide 30% of the proceeds of the sales to the CDRs to enable them to purchase more medicines. In reality, this process remains challenging for most health facilities. Nevertheless, there are some health zones that are indeed doing so; for example, the Kalomba health zone has a performance of 84% with CADIMEK. Several health zones in the Bukavu coordination (Lulingu, Kitutu, Kaniola, Bunyakiri, Kalole, Kamituga, and Mulungu), for example, received free SP doses from other organizations such as People in Need (PIN), Malteser International and Louvain Development. In the Kamina coordination, Kitenge received support from Doctors Without Borders. In the Luiza coordination, Medecins du Monde supported the health zone of Luambo; and in the coordination of Kolwezi, the Fungurume and Tenke health zones received free SP from the Fungurume Mining Company. In addition, two health zones in the Kole coordination received 7 packages of 1,000 SP tablets as a loan from IMA to IHP. The project will replace IMA's loan once it receives its own SP supplies.

Project-wide SP stock out remains the main reason for not meeting target coverage (80%). The stock outs are due to SP procurement gaps in all CDRs since February. Unfortunately, IHP has little control over this issue. In addition to stock outs, many pregnant women postpone their first antenatal visit to a later date, as seen in several health zones in the Bukavu and Kamina coordination areas. While the project waits for the arrival of more SP and long-lasting insecticide-treated nets (LLINs) from an order placed by USAID that is expected to arrive next quarter, health zones continue to try to locally procure SP.

To ensure that women receive antenatal care earlier in their pregnancies, which IHP can influence, the project will carry out the following activities next quarter:

- Continue awareness raising activities, including mini-campaigns, in the community to encourage women to attend ANC sessions earlier so that they can attend more than one ANC visit during their pregnancies

- Continue door-to-door visits and CUG messages on SP and ANC
- Continue to garner support and involvement from community leaders to promote the use of antenatal care
- Support and expand efforts of Champion Communities in Minga, Djalo Ndjeka (Tshumbe), Luiza, Ndeksha, Dibaya (Luiza), Wikong, Bibanga (Mwene Ditu), Ruzizi, Uvira, Nundu (Uvira), Walungu, Katana (Bukavu), Dilala, Fungurume, Kanzenze (Kolwezi), Kitenge, Malemba Nkulu, Songa (Kamina), and Bena Dibebe (Kole) to carry out awareness raising activities to improve antenatal care service utilization.

Number of LLINs distributed during PY3Q3

LLIN beneficiaries are pregnant women and children under one year of age who have been completely immunized according to schedule. This distribution takes place during the first ANC visit for pregnant women and during the preschool consultation (PSC) for children under one year of age who receive a measles vaccine. No LLIN supply was received during the current reporting period, but several health zones are still distributing leftover nets from project year two (PY2). Table 39, below, shows that during the current reporting period, 49,414 LLINs (an increase from 41,571 last quarter) were distributed in the health zones during ANC and PSC visits.

Table 39: Number of LLINs purchased with USG funds and distributed from April to June 2013, as compared to PY3Q2

Period PY3Q3	Coordination										
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	IHP		
									ANC	PSC	Total
April 2013	1,269	1,060	733	230	7,732	8,007	1,949	505	12,838	8,647	21,485
May 2013	1,986	361	479	244	5,842	6,385	412	519	10,230	5,998	16,228
June 2013	3,271	96	1,134	82	2,750	4,067	204	102	8,320	3,381	11,701
PY3Q3 Total	6,526	1,517	2,346	556	16,324	18,459	2,565	1,126	31,388	18,026	49,414
PY3Q2 Total	1,574	8,881	3,494	977	3,418	12,743	6,781	3,563	27,420	14,151	41,571

As of the end of PY3Q3, LLIN stocks have been depleted in several health zones, while others are expected to experience stock outs between August and September 2013. The project requested a loan of LLIN supplies from SANRU, but SANRU had already delivered their LLINs to their supported health zones.

Malaria Case Management

Number of ACT treatments of children under 5 distributed during PY3Q3

During PQ3Y3, 175,250 doses of ACTs for children under 5 were distributed, with 170,706 doses to health facilities and 4,654 doses to community health sites. Table 40, below, provides details on ACT treatments distributed to children under 5 in PY3Q3.

For all age groups, 484,163 doses of ACTs were distributed to health facilities during this quarter. The dose breakdown is as follows:

- Infant (2-11 months/AS-AQ 25/67.5mg FDC 3 tabs): 60,269 doses
- Toddler (1-5 years /AS-AQ 50/135mg FDC 3 tabs): 110,327 doses
- Child (6-13 years/ AS-AQ 100/270mg FDC 3 tabs): 129,404 doses
- Adolescent and adult (> 13 years/AS-AQ 100/270mg FDC 6 tabs): 184,053 doses

Table 40: Number of ACT treatments for children under 5 purchased with USG funds and distributed to the health facilities and community health care sites from April 2013 to June 2013

Coordination	Quantity of ACT for children under 5 distributed through community care sites	Quantity of ACT for children under 5 distributed to health facilities	Quantity of ACT for children 2-11 months distributed to health facilities	Total quantity distributed for children under 5
Bukavu	1,052	24,412	11,925	37,389
Kamina	1,517	25,354	9,324	36,195
Kole	20	1,945	4104	6,069
Kolwezi	490	12,160	6,534	19,184
Luiza	467	8,994	7,181	16,642
Mwene Ditu	606	19,430	13,243	33,279
Tshumbe	47	7,625	6,433	14,105
Uvira	455	10,407	1,525	12,387
PY3Q3 Total	4,654	110,327	60,269	175,250
PY3Q2 Total	3,605	131,880	52,745	188,230

The total quantity of ACTs for children under 5 (175,250 doses) distributed during PY3Q3 was slightly less than the quantity distributed during PY3Q2. This is essentially due to insufficient reporting from several health zones in the Bukavu coordination. Mulungu, Kalonge, Mwenga, Kitutu, Bunyakiri, Kalole, and Kalonge did not report any data for the month of June as nurses, who collect the data, were on strike.

In the Kole coordination, the two IHP-supported health zones (Tshudi Loto and Lomela) significantly increased the number of ACT doses dispensed during this quarter, with 6,069 doses for children under 5, in comparison

with the previous quarter when only 303 doses were dispensed. Last quarter, during a joint supervision session carried out with the medical director of the Sankuru district, the project recommended increasing compliance of malaria case management with the national protocol.

As of the end of PY3Q3, at the CDR level, for all age groups, 1,940,683 doses of ACT were distributed. The distribution breakdown is as follows:

- Infant (2-11 months/AS-AQ 25/67.5mg FDC 3 tabs): 68,896 doses
- Toddler (1-5years /AS-AQ 50/135mg FDC 3 tabs): 861,642 doses
- Child (6-13 years/ AS-AQ 100/270mg FDC 3 tabs): 639,306 doses
- Adolescent and adult (> 13 years/AS-AQ 100/270mg FDC 6 tabs): 370,839 doses

As there are no more stocks of ACTs at CADIMEK, the project borrowed 500,000 doses for all age groups from PMI Extension to ensure coverage while awaiting the next shipment.

Number of malaria-RDTs distributed during PY3Q3

The national protocol recommends that all fever and suspected cases of simple malaria be tested by RDT before receiving an ACT treatment. Therefore, the consumption of RDT should be greater than the consumption of ACT (for all age groups) at the health facility level.

As shown in table 41, below, during the current reporting period, the project distributed 293,070 RDT, which is a decrease from the previous quarter (329,914). This is due to the fact that several coordination offices did not report on distributed RDT. Multiple coordination offices redistributed their quantities of RDTs, both within and between health zones, based on needs. The redistribution was not properly recorded, and in many cases the coordinations did not monitor the quantities being redistributed and were unable to report. With the support of SIAPS, the project has since recorded the quantities distributed, and will provide support to the coordinations on properly monitoring the number of RDTs distributed, either directly to the population or to other facilities. The Luiza and Kolwezi coordination offices did not report in June, while the Uvira coordination did not report in April.

Table 41: Number of USG-funded malaria-rapid diagnostic tests (malaria-RDTs) purchased and distributed

Period	Coordination								
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
April 13	6,067	15,668	1,254	17,075	11,683	16,531	4,423	0	72,701
May 13	4,782	61,937	91	44,985	11,983	13,368	3,419	2,053	142,618
June 13	9,243	20,461	2,001	0	734	17,932	23,087	4,299	77,757
PY3Q3 Total	20,092	98,066	3,346	62,060	24,400	47,831	30,929	6,352	293,076
PY3Q2 Total	26,322	109,630	3,310	56,250	4,324	47,420	21,133	61,525	329,914

For this quarter and for all age groups, the total quantity of ACTs distributed (488,770) was higher than the RDT consumption at the health facility level. This low level of RDT utilization at the health facility level can be explained by the fact that some health facilities in these coordinations did not adhere to the national protocol

regarding malaria diagnosis. The microscopy diagnosis was used instead of RDT for simple malaria. RDTs are provided to patients for free, but health care providers charge for the microscopy diagnosis, and as a result tend to promote the microscopy method for the financial benefit of the clinic. The project continues to emphasize to providers, during supervision visits, the importance of using the RDT for all cases of fever, rather than the microscopy method.

At the end of June, the reported stock balance of RDTs was 136,681, with an expiration date of January 2014. A large quantity of this stock is held at the CDR FODESA (122,975 doses). Much of this stock will be shipped to Sud Kivu, according to its needs, as it is expected to experience a stock out at the end of July. Results of this shipment will be reported in the next period.

For the Luiza and Mwene Ditu coordinations, an inter-zonal redistribution of RDTs is being carried out to balance stock in health zones where several health facilities have stocks that will not be used prior to January 2014, which is the expiration date for these RDTs. There is a major challenge in quantifying RDT needs in the health zones, but even more important, there is still low use of the RDT to diagnose malaria. Some health centers continue to insist on using the thick blood smear rather than the RDT because clients have to pay for the microscopy diagnosis, as noted above.

Number of USG-supported service delivery points with ACT stock outs for the under 5 age group

Table 42, below, shows that 188 USG-supported service delivery points had stock outs of ACTs for children from 1 to 5 years old during the current reporting period. Performance for this indicator did not meet the quarterly target of 160.

Table 42: Number of USG-supported service delivery point with ACT stock-out for children 1-5 years

Period PY3Q3	Coordination								
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	TOTAL
PY3Q2	7	44	12	23	79	20	43	28	256
PY3Q3	16	22	11	9	31	61	34	4	188

As compared to last quarter, during which 256 service delivery points reported stock outs, fewer ACT stock outs were reported for children ages under 5 years old, mainly due to the availability of these commodities at the health facility level during the entire quarter. In Bukavu, which saw an increase in delivery points with stock outs from 6 to 16 this quarter, some health zones failed to order sufficient supplies of ACT, namely Mulungu and Mubumbano.

Due to a higher incidence of malaria in health zones in the Luiza and Tshumbe coordinations, ACT stock outs were experienced as all supplies were consumed. The project plans to decrease the number of stock outs by supplying the health zones before the end of each quarter and readjusting the quantity delivered for all health zones which experienced outbreaks.

Children under 5 treated for malaria according to the national protocol

During this quarter, 88% of children under 5 were treated for malaria according to the national protocol at the health facility level. This is a slight improvement from last quarter's 86% coverage. With an improvement in ACT availability for children under 5, the Kolwezi, Tshumbe, Kole, Uvira, and Luiza coordinations maintained or increased the number of malaria management cases for children under 5, according to the national protocol, with improvements of 95% to 99%, 88% to 92%, 90% to 96%, 72% to 83%, and 76% to 96%, respectively. See table 43, below, for percent of children under 5 who were treated according to national malaria protocols.

Table 43: Proportion of children under 5 with malaria treated correctly following the national protocol

Period		Coordination								PY3Q3 Total
		Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	
PY3Q3	Children < 5 years admitted for malaria treatment	46,815	48,290	7,127	16,630	20,146	47,212	26,711	19,327	232,258
	Children < 5 years treated for malaria according to national protocol	41,577	45,925	6,815	16,606	19,269	34,697	24,492	16,012	205,393
	Percentage treated according to national protocol	89%	96%	96%	99%	96%	73%	92%	83%	88%
PY3Q2	Children < 5 years admitted for malaria treatment	52,765	53,612	6,110	17,069	20,705	46,970	19,066	21,953	238,250
	Children < 5 years treated for malaria according to national protocol	48,357	51,314	5,475	16,268	15,762	34,316	16,868	15,887	204,247
	Percentage treated according to national protocol	92%	96%	90%	95%	76%	73%	88%	72%	86%

The Bukavu coordination reported a decrease from 92% to 89% due to non-compliance to the national malaria protocol by some providers. The corrective action recommended is to increase facilitative supervision and training or refresher courses, and emphasize early detection of malaria. The project will also emphasize appropriate and efficient case management, as recommended by the PNLP, during trainings and supervisions.

Health care providers trained in malaria prevention and case management, and in malaria-RDT use

A total of 55 providers, all men, were trained in the Uvira coordination on malaria prevention and case management during the month of June 2013. Following the mid-term review, the project organized refresher course workshops on malaria prevention and case management for all the health zones trained during project years 1 and 2. Health zone staff who have not yet received any training will be prioritized. These training sessions have been carried out since July in the Kamina coordination. Workshops are underway in the health zones where insecurity has not been a major issue.

In the Tshumbe coordination, 73 CHWs, of which 70 were men and 3 were women, were trained to perform malaria rapid diagnosis tests in 70 community care sites. The following health zones benefited from this training: Kitenge (8 CHWs), Kabongo (10 CHWs), Songa (6 CHWs), Bena Dibebe (8 CHWs), Vangakete (11 CHWs), Djalo Ndjeka (9 CHWs), Lodja (10 CHWs), and Tshumbe (10 CHWs).

Next quarter, the project will explore ways to ensure that more women are trained on malaria prevention and case management, as well as on malaria rapid diagnostic test methods. The project will also collaborate with the Ministry of Health to increase the participation of women in these trainings.

Malaria Commodity Monitoring and Evaluation

Monitoring and supervision sessions for malaria commodity management were carried out in the Uvira and Luiza coordinations. The observations from this quarter's supervisory visits are as follows:

- Management and data collection tools are available, but were not updated regularly or were poorly filled out in several facilities
- ACTs and RDTs were available in the majority of the visited health facilities, but monthly consumption is not quantified
- Providers do not consistently follow all cases of fever with an RDT diagnosis or when they do, they do not take the RDT results into account before proceeding with an ACT treatment.

In response, the project will continue to provide briefings to health care providers during training or refresher course sessions to emphasize the importance of RDT use, appropriate use of the data collection tools, and commodity quantification.

Since January 2013, the Sankuru district has been experiencing outbreaks of fever suspected to be malaria in several health zones. A number of deaths were reported, as follows:

- In the coordination of Kole, more than 40 deaths among children under 5 were reported in the health zone of Lomela, and in the Kole health zone, 21 deaths of children under 5 were reported, as well as one adult death.
- In the coordination of Tshumbe, in the Lodja health zone, 96 deaths were reported, of which 95 were among children under 5. In the Omejandi health zone in Tshumbe, 51 deaths were reported, of which 46

were children under 5. In the health zone of Vangakete, 60 deaths were reported, of which 40 were children under 5.

Project staff noted that for the majority of reported deaths, the malaria cases were not confirmed with a biological test (RDT or microscopy test), simple malaria cases were not adequately treated as not all patients received ACTs, and kits were not available for severe malaria cases at the health facility level.

- Under the PNLP coordination, an investigative mission was organized with a collaborative team in the Bulape, Mweka, and Kakenge health zones (Yoolo health area). A joint visit was organized with the IHP team and the Luebo health district in the Bulape health zone. These missions confirmed the malaria outbreak, and awareness activities were intensified along with the distribution of ACTs.
- The investigation report of the multidisciplinary team (Faculty of Medicine, Pharmacy, Pharmacovigilance, the National Malaria Control Program, an anthropologist, and a communications specialist) that went to the field in Kasai Occidental excluded other pathologies such as salmonella before confirming malaria. More in-depth investigations would be needed to determine other causes of death.
- In order to reduce the morbidity-mortality rate in the Sankuru district, which experienced the most severe outbreak, with a mortality rate of over 5% in the health zones, commodities were provided on loan from a Global Fund SANRU partner: 22,000 doses of glucose serum at 5% and 47,000 quinine 600 mg vials for injection, to cover a period of 3 months. The Kasai Occidental province purchased glucose serum and quinine for injection supplies. The IHP project provided logistic transport for commodities from Mbuji Mayi to Lodja.

Next quarter, the project will provide monitoring and evaluation support to Kamina, Kolwezi, Bukavu, and Uvira.

Support clinical care to survivors of sexual violence

In PY3Q3, a total of 190 providers, doctors, head nurses, other nursing staff, and birth attendants have been trained in the clinical case management of sexual assault survivors, including 66 women and 124 men. Table 44, on the following page, provides the number of health care providers by sex and coordination who have received training. The project plans to provide more training sessions in Luiza and Kamina, and to organize refresher courses in clinical care for sexual assault survivors in Bukavu for current and for new staff.

For the indicator of the number of people impacted by gender-based violence (GBV), data provided are largely complete for Mwene Ditu (91%), Tshumbe, Kolwezi, Luiza, and Kole (100%), and Bukavu (98%). In Uvira, the data are complete at 40%, because health care providers in the health zones of Lemera, Ruzizi, and Hauts Plateaux went on strike for higher salaries in June, resulting in a reduction of reported cases, as compared to previous quarters.

Table 44: Number of health service providers trained in the clinical care of sexual assault survivors

Province	Health zones	Number of head nurses		Number of nurses or midwives		Number of doctors		Number of members of the health zone management team		PY3Q3 Total	
		F	M	F	M	F	M	F	M	F	M
Kasaï Oriental	Mwene Ditu	3	1	1	0	0	3	1	1	5	5
	Luputa	3	4	0	0	0	1	0	2	3	7
	Wikong	2	5	0	0	0	1	0	2	2	8
	Kanda Kanda	2	4	0	0	0	2	0	2	2	8
	Kamiji	1	4	2	0	0	1	0	2	3	7
	Dibindi	4	1	0	0	1	2	0	2	5	5
	Kole		12	12	0	1	4	0	6	13	22
	Lomela	0	19	17	2	0	3	0	6	17	20
	Tshudi Loto	0	11	11	0	1	2	1	7	2	20
	Bena Dibebe	0	12	12	0	1	4	1	6	14	22
TOTAL		15	73	55	2	4	23	3	36	66	124

Regarding the number of people impacted by GBV services, table 45, on the following page, provides information by month and by coordination. In Bukavu, the reported number of people impacted by GBV services increased from 881 in PY3Q2, to 1,534 this quarter. The increase in people reported can be explained by increased data collection from the Panzi GRH, which specializes in providing care for survivors of sexual violence. In the past, the Panzi GRH has followed a different reporting schedule from the project. Following a discussion between the chief doctor of the hospital and IHP leadership, the Panzi GRH agreed to a timely sharing of data this quarter. In Luiza, all reported cases came from the Luambo health zone, where cases of rape were reported after an influx of refugees from Angola. The reported sexual assault cases were allegedly perpetrated by Angolan soldiers at the border. The number of cases reported in Mwene Ditu increased from last quarter, and mini awareness-raising campaign activities and clinical care for sexual assault trainings for providers and community health workers may have contributed to this increase.

Table 45: Number of people impacted by GBV services funded by the U.S. Government

Health zone	January 2013	February 2013	March 2013	PY3Q2 Total	April 2013	May 2013	June 2013	PY3Q3 Total
Bukavu	238	330	313	881	557	663	314	1,534
Kamina	1	0	0	1	125	0	0	125
Kole	8	6	5	19	5	1	2	8
Kolwezi	0	0	0	0	0	0	0	0
Luiza	51	4	21	76	36	15	18	69
Mwene Ditu	0	0	0	0	0	0	14	14
Tshumbe	0	0	0	0	0	0	0	0
Uvira	43	32	45	120	29	42	24	95
TOTAL	341	372	384	1,097	752	721	372	1,845

As shown in table 46, on the following page, 1,735 people impacted by GBV, including 1,687 women and 48 men, received care in IHP-supported health facilities. One thousand and forty-six cases, or 61%, arrived in the health facilities within 72 hours, and 704 cases, or 41%, arrived between 72 and 120 hours. Eight hundred and seventy cases (84%) were treated with anti-retrovirals (ARV) and 830 cases (48%) received emergency contraceptives. However, post-exposure preventive (PEP) kits are only available in Sud Kivu due to the great need in the region, but reports of stock outs are frequent. Some kits have expired, which has contributed to the unavailability of PEP kits. In response, UNICEF has agreed to loan the project 100 PEP kits that the project will be expected to replace once its own stock arrives. IHP ordered PEP kits in May 2013 to be distributed to all facilities. The project has also requested support from other organizations, such as UNFPA, to provide kits.

Table 46: Number of people impacted by GBV services funded by the U.S. Government, disaggregated by sex and period of arrival at a health facility

Health zone	Number of people reporting sexual violence in USG-supported health clinic		Number of people reporting sexual violence in USG-supported clinic within 72 hours	Number of people reporting sexual violence in USG-supported clinic between 72 and 120 hours	Number of people reporting sexual violence in USG-supported clinic given ARVs	Number of people reporting sexual violence in USG-supported clinic given emergency contraceptive
	Females	Males				
Bukavu	1,495	39	909	625	819	772
Kamina	15*					
Kole	8	0	8	0	0	0
Kolwezi	0	0	0	0	0	0
Luiza	61	8	50	19	0	0
Mwene Ditu	14*		14	0	0	0
Tshumbe	0	0	0	0	0	0
Uvira	94	1	65	30	51	58
PY3Q3 Total	1,687	48	1,046	674	870	830

* Note: Kamina and Mwene Ditu did not report or collect data disaggregated by gender. The non-disaggregated 29 people impacted by GBV services have now been confirmed to be female. The total reported is 1,735, of which 15 reported after 120 hours.

4. Nutritional rehabilitation

Support and collaborative work with the National Nutrition Program (PRONANUT)

During this quarter, the project provided support to the MOH for the National Nutrition Program (PRONANUT in the French acronym) in Sud Kivu and Katanga, and in the health district of Kolwezi. Along with the PRONANUT team, the project led a post-training follow-up in Essential Nutrition Actions (ENA, or AEN in the French acronym) between March 26 –April 30, 2013, in the health zones of Katana, Miti Murhesa, Mwana Idjwi, Nundu, Uvira, Lemera, and Ruzizi; and another post-training follow-up session from June 17-July 2, 2013, in the health zones of Manika, Kanzenze, Mutshatsha, and Dilala, in the coordination of Kolwezi.

Responding to a request from senior PRONANUT staff, the project provided financial logistical support to for a workshop held in Kinshasa regarding the revision of all training modules for Infant and Young Child Feeding (IYCF) and Integrated Case Management of Acute Malnutrition (PCIMA in the French acronym).

A. Nutrition indicators analysis

1. Number of children under 5 years who received vitamin A supplements (campaign)

The semi-annual mass vitamin A campaign was initially planned for the month of June, but was postponed to July 2013 by the MOH. However, 23,283 children under 5 received vitamin A supplements in several health zones during the PSC, as vitamin A supplements remaining from last year's mass campaign were used.

Number of pregnant women who received iron and folic acid supplements

In PY3Q3, the number of women who received folic acid (108,114) surpassed the PMP target of 96,469, for an achievement rate of 112%. Kolwezi registered the highest achievement rate with 220% of the PMP target achieved, then 146% in Uvira and 122% in Mwene Ditu; the remaining coordinations registered rates between 55.8% and 70%.

The performance reported in Kolwezi, Uvira, and Mwene Ditu was due to the availability of folic acid in the health facilities. The folic acid commodities were delivered as part of MEG deliveries in PY3Q3. In addition, the project recommended that folic acid be distributed to pregnant women during ANC visits, reiterating the national norm. In Uvira, the project also provided support to the health zone management team with its distribution plan and the follow-up of commodity supplies in the health facilities. Several health zones, including Tshudi Loto, Lomela Dibebe, Bunyakiri, Kamituga, Kalole, Kalonge, Kitutu, Mwenga, Nyangezi, Bagira, Ibanda, Miti Murhesa, and Minova, reported stock outs of iron and folic acid over 1 to 3 months and did not receive additional supplies. The health zones of Tshudi Loto, Lomela, Dibebe, and Bunyakiri were negatively impacted by the stock out of supplies in the FODESA. The remaining health zones experienced stock outs due to poor management and quantification of needs on the part of the health zone management teams.

In response to the challenges faced in regularly providing folic acid, the project will:

- Maintain the health facilities folic acid supplies by provisioning health facilities and by helping health zone management teams to properly quantify needs
- Provide supervision of health care providers and support for commodity monitoring and management
- Supply the health facilities that experienced stock outs during this quarter.

B.3. Mothers of children 0 to 23 months who received counseling on child nutrition

In PY3Q3, the number of mothers of children 0 to 23 months who received counseling on child nutrition, 119,644, surpassed the PMP target of 37,080, as well as the results reported in PY3Q2, 101,398. Kole reported a strong performance, particularly in the Dibebe and Kole health zones, where health care providers and the community were heavily involved in the IYCF support groups. In the Bukavu coordination, strong performance was mainly observed in the health zones with operational IYCF support groups in Idjwi, Katana, Mwana, Miti Murhesa, and Shabunda. Kolwezi, Tshumbe, Mwene Ditu, and Uvira saw similarly high results as the project has held training sessions for CHWs in AEN, continued to provide data collection tools, and has held IYCF support groups.

The post-training team also attended culinary demonstrations provided by the IYCF support groups. During the culinary demonstrations, group members learned how to prepare meals with ingredients available nearby. In

PY3Q3, the project supported 380 operational IYCF support groups throughout the 28 health zones where CHWs had been trained. However, no IYCF support group was created in the Kamina and Luiza IHP coordinations, which is a gap in the ENA or IYCF training plans. In addition to the culinary demonstrations from the IYCF support groups, mothers were counseled on nutrition during pregnancy as well as on nutrition for other members of the household during preschool visits, in maternity clinics and during health care visits. The number of women who started exclusive breastfeeding within an hour after delivery increased from 94,863 in PY3Q2 to 100,633 in PY3Q3. In maternity clinics, where the providers have received training in ENA and explain the importance of breastfeeding during counseling sessions for pregnant women, exclusive breastfeeding became a regular practice within the hour after delivery⁸.

The following activities will be carried out during the next quarter:

- Sustain the awareness efforts and providing the operational IYCF support groups with data collection tools and communication aids (cards with illustrations, key messages on nutrition, posters, etc.)
- Reinforce awareness with an increased number of BCC sessions at the level of the health facilities as well as the households
- Carry out ENA post-training follow-up and joint visits by IHP and PRONANUT teams to the health zones which have not yet been reached with ENA activities
- Expand the IYCF integration to other health zones where the population has not yet received nutrition counseling
- Support CHWs in the creation of IYCF support groups.

B.4. Number of breastfeeding women who received vitamin A supplements

The number of breastfeeding women who received vitamin A supplements in PY3Q3 (38,501) was below the PMP target of 131,127, resulting in an achievement rate of 29%. The poor performance is due to an insufficient supply of vitamin A supplies. Routine vitamin A is not systematically distributed in all health zones as it is not always regularly available outside of campaigns.

Only the Luiza and Bukavu coordinations exceeded an achievement rate of 50%, with rates of 82% and 60.3%, respectively. The remaining coordinations reported achievement rates between 6% and 39%. Bukavu's strong performance, relative to other coordinations, was due to increased awareness efforts on the part of IYCF support group members regarding the importance of vitamin A supplements for breastfeeding mothers in the health zones with integrated ENA, as well as availability of vitamin A leftover from campaign distributions. In order to improve this indicator, vitamin A supplies must be made available in the health facilities as well as the CDRs. Following recommendations from USAID, the project will consider procuring vitamin A in project year 4.

⁸ IHP did not conduct a survey to collect breastfeeding initiation data. Initiation of breastfeeding within one hour after birth is common in these health zones, particularly where maternities have integrated the IYCF approach, where there are functional IYCF support groups, and community health workers routinely make home visits to counsel on IYCF. The information is routinely collected and is included in the partogram, the birth register, and the IHP database. The field experience has been, since the training on essential nutrition actions, that some data are under-reported in some facilities because they are not recorded on the register in the postpartum period, even when the practice is being applied.

B.5. Number of health facilities with iron and folic acid stock out

The PMP target was not reached, with an average of 279 health facilities which experienced stock outs in iron and folic acid in PY3Q3, but this value is lower than the result registered during the last quarter (644). The project will carry out the following activities to avoid iron and folic acid stock outs in the future, as follows:

- Provide regular iron and folic supplies to the CDRs
- Provide management support to health facilities to monitor levels of iron and folic acid.

Table 47: Nutrition indicators by coordination for PY3Q3

Indicators	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3 Total
Number of children under 5 years who received vitamin A supplements	18,972	965	0	849	563	683	77	1,174	23,283
Number of children under 5 years who received vitamin A supplements (<i>routine</i>)	18,972	965	0	849	563	683	77	1,174	23,283
Number of children under 5 years who received vitamin A supplements (<i>campaign</i>) ⁹	0	0	0	0	0	0	0	0	0
Number of pregnant women who received iron and folic acid supplements	38,485	8,566	1,537	12,705	11,248	19,649	6,096	9,828	108,114
Mothers of children 0 to 23 months who received counseling on child nutrition	38,740	17,789	3,469	6,188	12,807	19,680	12,303	8,668	119,644
Number of breastfeeding women who received vitamin A supplements	22,947	4,465	0	3,103	1,318	3,452	688	2,528	38,501
Number of newborn breastfed within one hour of birth	27,001	14,049	2,836	8,263	13,697	17,846	10,460	6,481	100,633
Number of breastfeeding women who received iron + folic acid supplements	21,646	3,927	728	6,657	3,840	9,512	2,467	2,529	51,306

⁹ The national vitamin A campaign was postponed from June 2013 to July 2013. Results from the campaign will be reported in the next quarter.

Number of children 0-11 months admitted in PSC	43,141	21,613	3,697	30,470	26,268	29,989	16,438	7,628	179,244
Number of children 12- 59 months admitted in PSC	41,751	38,081	5,510	6,634	32,692	43,756	23,561	1,020	193,005
Number of children < 5 years with malnutrition	17,416	748	899	1,250	3,073	5,463	2,492	2,138	33,479
Number of children < 5 treated for malnutrition who survived	5,115	41	248	232	929	1,960	1,593	514	10,632
Number of drop-out cases in malnutrition case management	310	25	27	16	22	359	34	22	815
Number of relapse cases in malnutrition case management	139	0	3	0	6	271	22	3	444
Number of cooking demonstration sessions	288	7	92	20	40	99	112	0	658
Number of health facilities with iron and folic acid stock out	57	25	27	3	22	96	34	8	279

Table 48: Nutrition PMP indicators by month for PY3Q3: April to June 2013

Indicators	April	May	June	PY3Q3	Target PY3Q3	PY3Q3 Achievement rate (%)
Number of children under 5 years who received vitamin A supplements (campaign)	0	0	0	0	562,500	0
Number of pregnant women who received iron and folic acid supplements	36,175	37,864	34,075	108,114	96,469	112
Number of mothers of children 0 to 23 months who received counseling on child nutrition	36,029	42,964	40,651	119,644	37,080	323
Number of breastfeeding women who received vitamin A supplements	11,242	11,967	15,292	38,501	131,127	29
Number of health facilities with iron and folic acid stock out (average)	382	280	175	279	160	57

HIV – PMTCT

In accordance with the new PEPFAR strategic pivot, the project’s HIV activities are currently carried out in two coordinations in the Katanga province, Kamina and Kolwezi. There were 25 functional PMTCT sites in Kolwezi, and, after the recruitment of new local HIV specialists, 7 new sites (out of 8 planned) were added. There were 20 PMTCT sites in Kamina. In the three non-priority provinces, pregnant women on ARVs or ARV prophylaxis continued to benefit from ARVs until an agreement is reached between PEPFAR and the Global Fund. All screening activities, including Early Infant Diagnosis (EID), ceased in the non-priority provinces, until/unless there is new guidance. The HIV test kits in the provinces were redistributed to Katanga to the coordination offices, and some were provided to ProVIC.

Number of pregnant women seen for ANC in health facilities that offer PMTCT services

Table 50, on page 69, presents the reported results on PEPFAR indicators for Kamina and Kolwezi. Compared to the previous quarter, an increase in women using ANC services from 6,609 women in PY3Q2 to 8,889 women during PY3Q3 was reported. The increase in coverage is due to an increased availability of HIV commodities. In Kamina, 4,284 women were reported to have used ANC services during PY3Q3, compared to 2,791 women in PY3Q2. Coverage increased in Kolwezi as well, from 3,818 women seen in PY3Q2 to 4,275 women seen in PY3Q3.

As seen in table 49 below, the project has 212 sites in the four provinces where PMTCT activities have been integrated.

Table 49: Number of sites and locations where PMTCT activities have been integrated into ANC services

	Kasaï Oriental			Kasaï Occidental	Katanga		Sud Kivu	
	Tshumbe	Kole	Mwene Ditu	Luiza	Kamina	Kolwezi	Uvira	Bukavu
Number of sites per coordination office	12	2	28	26	19	28	22	75
	14 sites		28 sites	26 sites	19 sites	28 sites	97 sites	
Number of sites by province	42			26	47		97	

Number of pregnant women receiving HIV counseling

Among the 4,284 women in Kamina who used ANC services, 3,422 (80%) of them received counseling. The gap in those using services and not receiving HIV counseling is due to the fact that some health care providers who offer ANC services may not have received training, or received only briefings on providing HIV counseling. In response, the project will hold a workshop for health care providers in Kamina and Kolwezi on the full package of HIV services during July and August 2013. This workshop will also focus on best practices for providing individual HIV counseling.

In Kolwezi, a decrease in the number of women using the services was observed, with 2,791 women who benefited from counseling during the current reporting period, compared to 4,284 during the previous quarter. A much greater number of women registered for these services during ANC visits but only some actually received counseling. The project has been investigating the reasons for the low rate of HIV

counseling since PY3Q1 to find solutions to reduce the gap between ANC attendance and pregnant women receiving HIV counseling. The key reasons for this result are the following: (1) poor quality of counseling provided by health care providers who had not yet been trained; (2) delay in training because qualified trainers were not yet available; and (3) stock outs of tests. IHP therefore plans to conduct training for health care providers and provide commodities to the PMTCT sites as rapidly as possible, and a series of trainings is planned for July and August, as well as delivery of commodities to all sites. The project will continue to monitor how the health providers are organizing ANC activities in each facility to take into account environment confidence, communication and messaging during the ANC sessions, and other factors that may be affecting client compliance.

Number of pregnant women receiving HIV counseling and testing

This quarter, a total of 5,462 pregnant women received HIV counseling and testing, compared to a PMP target of 3,675, for an achievement rate of 149%. In Kamina, the return rate increased from 97% to 100%. It should be noted that the sites reported the results the same day. In Kolwezi, during the current reporting period, 81% of pregnant women were tested after receiving counseling, an increase from last quarter's 75% testing after receiving counseling. The increase of 6% can be attributed to the greater availability of tests. In order to aim for the PMP target of 95% of pregnant women getting testing after receiving counseling, IHP must increase the quality of service provided as well as the treatment of clients by providers. Therefore, IHP will conduct additional training on the HIV package of services to help strengthen service provider capacity in offering quality services and also increase the number of trained health care providers. IHP also will increase sensitization activities at the community level and increase the frequency of supportive supervision.

Number of pregnant women who tested positive for HIV

This quarter, out of a total of 5,462 pregnant women who were counseled and tested, a total of 41 tested HIV positive (38 in Kolwezi and 3 in Kamina). The proportion of HIV positive pregnant women among those counseled and tested is approximately 0.75%. In Kamina, 0.12% of pregnant women tested HIV positive for HIV this quarter compared to 0.3% during the previous one. In Kolwezi, during the previous quarter, HIV prevalence was approximately 3.2%. During this quarter, this rate decreased to 1.3%.

As noted above, the 3.2 prevalence was in PY3Q2, during which 2,795 pregnant women were counseled and tested, and 90 tested HIV positive.

In PY3Q3, of the 41 women who were counseled and tested and who tested HIV positive, 19 were placed on ART, and 16 were started on ARV prophylaxis. It is important to note that despite awareness that ARV prophylaxis needs to begin as 14 weeks, many health care providers remain hesitant to prescribe AZT in early pregnancy for fear of side effects. Six HIV positive women received cotrimoxazole.

In PY3Q4 and beyond, IHP will continue to follow the trend, particularly focusing on quality control activities. The project will carry out activities next quarter to verify the quality of lab and testing services, and will provide trainings for lab technician and biologists to improve the quality of their work.

Number of HIV-positive pregnant women who received antiretroviral treatment (ART) to reduce risk of mother-to-child transmission

In Kolwezi and Kamina, 19 pregnant women received antiretroviral treatment (ART). Only 16 of 41 HIV positive pregnant women started ARV prophylaxis. Despite the awareness of the standard of providing ARV prophylaxis from 14 weeks of pregnancy, many providers are hesitant to prescribe AZT in early pregnancy because of fear of managing side effects. Nevertheless, in PY3Q4, all of the sites will receive refresher

training on HIV to reinforce the capacity of providers in the monitoring of HIV+ pregnant women, whether they are or are not eligible to receive ARVs.

Number of HIV-positive pregnant women who received Combination Therapy to reduce risk of mother-to-child transmission

In PY3Q3, in Kamina, 13 HIV positive pregnant women, compared to zero in PY3Q2, benefited from combination therapy treatment. This is a result of recommendations made during joint supervision visits with the health zones and the health district. Through the workshops on the HIV package of services planned for July and August, the project will strengthen health care provider capacities. Three HIV positive women received combination therapy in Kolwezi.

Number of newborns who received ARVs to reduce risk of mother-to-child transmission

In Kolwezi and Kamina, 35 newborns benefited from ARV treatment.

Number of partners/husbands of pregnant women who receive HIV counseling and testing and received their results

In Kamina, 17% of male partners were involved in PMTCT activities, including HIV counseling and testing for themselves in addition to their partners, and in Kolwezi, 4% of male partners were reported to have been involved in PMTCT activities. As engaging male partners continues to pose a challenge, the project will intensify awareness-raising efforts in the community through radio announcements and SMS messages during the next quarter and Year 4. The project will also coordinate with implementing partners such as ProVIC to discuss new approaches to male involvement.

It should be noted that IHP developed and tested SMS messages for awareness-raising and reminders for male partners, and the project has noted their effectiveness in relation to the number of couples and women keeping their appointments. The SMS messages focus primarily on males and couples who have agreed to receive such messages. Only the male partners of pregnant women who have been counseled and who have received their results are targeted. During PY4, IHP may broaden the strategy to include male partners of all pregnant women attending antenatal care.

Number of HIV+ pregnant women receiving cotrimoxazole

This quarter, nine HIV positive women received cotrimoxazole.

Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth

This quarter, only two infants born to HIV positive women were started on CTX prophylaxis within two months of birth. Despite the recent availability of cotrimoxazole syrup for children, very few children benefit from this treatment. We anticipate that this situation will significantly improve once health provider capacity is strengthened, through training led jointly with local authorities (from the PNLs at the provincial level as well as the health district level, who have been very involved in training activities) and IHP. A stronger focus on monitoring will also help to achieve better results for this indicator. We observed low performance on monitoring for mothers and children with HIV, due to the fact that the providers and senior teams had not yet benefited from capacity strengthening allowing them to integrate new approaches. This capacity strengthening effort is planned for the next quarter.

Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth

Zero infants received an HIV test within 12 months of birth during this quarter. This activity was hindered by the non-availability of Dried Blood Spot (DBS) kits, which are used for the collection, storage, and transportation of samples. This quarter, the project ordered more DBS kits, which pass through SCMS. Again, IHP plans to coordinate with other implementing partners to discuss the challenge of identifying the cohorts for follow up. One suggestion is to use the infant and mother register to monitor the exposed infant cohort.

Number of HIV-positive pregnant women assessed for ART eligibility

Twenty-two (22) pregnant women were assessed for ART eligibility this quarter, due to PIMA kit¹⁰ availability and an improvement in sample transport from the sites without CD4 kits to the sites with CD4 kits.

Table 50: HIV voluntary counseling and testing recipients by sex and age group in Kamina and Kolwezi

	April 13	May 13	June 13	PY3Q3 Total	PY3Q3 Target	Achievement rate (%)
45. Number of people who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	2,330	2,364	2,327	7,021	4,780 ¹¹	147
45.1 Number of men who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	316	211	336	863	663	130
45.2 Number of women who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	2,014	2,153	1,991	6,158	4118	150
45.3 Number of people under 15 who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	6	6	4	16	3	533
45.4 Number of people aged 15 and over who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	2,324	2,358	2,323	7,005	4,778	147
45.5 HIV/PMTCT: Number of seropositive people who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	86	63	85	234	96	245
45.6 HIV/PMTCT: Number of sero-negative people <15 who received HIV counseling and testing and who	6	6	4	16	4,682	3

¹⁰ The PIMA machines are functioning, but the project is waiting for USAID's guidance on their disposition.

¹¹ It should be noted that for PY3, the target was set at 91,050 for the four provinces, but following the strategic pivot of PEPFAR, Katanga is the only priority province (Kamina and Kolwezi); this represents just 21% of the previously-established target for PY3Q3 (91,050x21/100=19,121/4 quarters=4,780).

received their test results (P11.1 D PEPFAR)						
45.7 HIV/PMTCT: Number of couples who received HIV counseling and testing and who received their test results (P11.1 D PEPFAR)	173	102	179	454	478	95
45.8 HIV/PMTCT: Number of single individuals who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	264	589	35	888	3,822	23

In Table 50, above, PMTCT does not clearly emerge as the main entry point in line with the strategic pivot in PEPFAR programming, given that indicators 45, 45.1, 45.2, and 45.3 include not only women who are seen in ANC but also women who are counseled and tested and who received their results following PICT and voluntary counseling and testing. The number of people who received counseling and testing and received their results is 7,021. Of those, 5,095 are pregnant women attending ANC (72.5%), and the rest, 1,926, or about 27%, represent the general population, including male partners and co-infected clients.

The strategic pivot in PEPFAR programming had an influence on project performance in the priority and non-priority provinces, with the cessation of testing of new clients and the suspension of the provision of all related pharmaceutical commodities. In addition, although the project informed officials in these areas about the change, USAID did not provide official correspondence to all levels of the Ministry of Health to this effect. As of the end of this reporting period, local authorities were waiting for an official communication from PEPFAR and/or USAID to inform them of any changes.

IHP is concerned about who will ensure that HIV+ clients are maintained on ARVs after IHP leaves its original intervention areas. If the Global Fund will be responsible for these clients, the schedule was not yet clear, nor was it clear whether Global Fund had sufficient stock to cover the treatment of these clients. IHP is also concerned about who will procure tests in the context of TB/HIV co-infection in the sites in which IHP no longer focuses.

In Katanga, IHP has 45 functional PMTCT sites, including 25 in Kolwezi (plus 7 new sites) and 20 in Kamina. The project plans to implement 8 new sites in Kolwezi, for a total of 33 sites. In PY4, IHP plans to open 7 new sites in Kamina, for a total of 60 sites—33 in Kolwezi and 27 in Kamina. IHP will integrate other activities such as provider-initiated counseling and testing (PICT), care and treatment, strengthening early diagnosis for children, and focus on key populations such as sex workers, miners, and fishermen. The project recruited two focal points for HIV and AIDS who are located in Kamina and Kolwezi. These two new staff members are supervised by the directors of the coordination offices but work closely with the technical advisor based in Kinshasa.

Current challenges to service delivery include the following: (1) long distances between PMTCT sites, particularly in Kamina; (2) difficulty in obtaining commodities during the rainy season, particularly for Malemba Nkulu, Kilondja, and Mukanga; and (3) persistent insecurity along the Malemba Nkulu and Bunkeye corridors, which makes both access and reporting challenging.

Strengthen the fight against TB, HIV/TB co-infection, and MDR-TB

At 62%, the detection rate was low for this quarter, but represents an improvement compared to the detection rate of 50% from the previous quarter. The PMP target for this indicator is 70%, and only the Kole, Tshumbe, and Kamina coordinations were able to achieve results above this rate. Table 51, below, provides detection rates by coordination for PY3Q3.

Table 51: TB detection rate by coordination for PY3Q3

Coordination	MPT+ new cases	Expected	Detection rate (%)
Bukavu	438	1,379	32
Uvira	146	333	44
Mwene Ditu	474	920	51
Luiza	414	606	68
Kole	102	135	76
Tshumbe	325	420	77
Kamina	869	726	120
Kolwezi	213	314	68
TOTAL	2,981	4,833	62

Low levels of TB detection are due to numerous stock outs in lab commodities. Improved security in the Malemba Nkulu health zone contributed to the 120% achievement rate in Kamina this quarter. The Malemba Nkulu health zone generally reports high numbers of TB cases. The high numbers of cases, along with project-supported training on case detection and support for sample transport, contributed to the level of performance in Kamina. The link between these two facts is explained by the movement of the population toward more secure areas during the periods of insecurity in Malemba-Nkulu, particularly in Mulongo, Luamba, and Mukanga. The situation has had a significant impact on attendance at the health facilities, including the CSDTs. For example, in January, February, and March 2013, the Kamina coordination office reported only 293 new cases of MPT+, and in October, November, and December 2012, there were 402 cases. In PY3Q3, the coordination office reported 869 cases of MPT+. The project must continue to monitor this trend to determine whether it indicates positive performance.

The supply of commodities is just one element of the strategy IHP developed to increase the rate of detection; there are other challenges, such as the low involvement of the community in advocacy and social mobilization, and coverage remains low for CST and CSDT in some of the project-supported health zones. Despite these challenges, an improvement of 12% (50% in PY3Q2 and 62% in PY3Q3) was reported, although the project has not yet attained the target of 70%.

To address the low performance in TB detection rates, the project plans to carry out the following activities in PY3Q4:

- Implement capacity strengthening activities for health care providers and the health zone management teams, including training on sample collection in Bukavu, Uvira, Mwene Ditu, and Luiza
- Maintain adequate supplies for trained CHWs, provide BCC kits to health care providers, and provide teams with bicycles to extend the CHWs' geographic reach
- Support CHWs in carrying out mini-campaigns to raise awareness of TB warning signs and symptoms
- Support capacity building among community organizations to raise awareness of TB, and to collect TB samples.

The number of notified cases of smear-positive pulmonary tuberculosis (MPT+) cases increased between PY3Q2 and PY3Q3, from 74 in PY3Q2 to 90 this quarter. Kamina reported the strongest results, followed by Tshumbe and Kole.

Bukavu, Uvira, Mwene Ditu, and Kolwezi coordinations reported the lowest rates, with only 48, 66, 73, and 61, respectively, as shown in table 52, below. As reported last quarter, low detection rates are due in part to the end of the Global Fund Round 5 program, managed by the PNLT, which provided capacity strengthening for the providers in all health zones. While the stock out of TB lab commodities and TB medicines from Year 2 impacted results, particularly in Bukavu, Uvira, Kolwezi, Kamina, and Mwene Ditu, the situation is improving as the project has procured the necessary TB supplies. The project has also carried out a series of training workshops during the expansion of DOTS coverage, and has actively engaged the community. The trainings were held for health care providers, including doctors, nurses, and CHWs, on identification of TB cases, sample collection, and proper sample transportation.

Table 52: Notification rate in PY3Q3

Coordination	Total population	MPT+ new cases	Notification rate
Bukavu	919,608	438	48
Uvira	221,016	146	66
Mwene Ditu	614,808	474	77
Luiza	404,514	414	102
Kole	89,772	102	114
Tshumbe	279,168	325	116
Kamina	483,618	869	180
Kolwezi	209,448	213	102
PY3Q3 Total	3,221,952	2,981	93

Results observed in PY3Q3 for the percent of TB patients who were tested for HIV, at 56%, were slightly lower than the previous quarter, during which IHP reported a rate of 59%. This situation is consistent with

the Guide on the management of TB/HIV co-infection (2012 version), which recommends counseling for both confirmed and suspected TB patients, and to test only those who accept, while continuing to counsel those who are reluctant to accept the HIV test during the six months they are in treatment for TB.

As seen in table 53, below, the number of tested patients was slightly lower than the total number of acceptors in voluntary counseling and testing due to the low availability of rapid HIV tests, as delivery was delayed. At the end of PY3Q3, in June, 100 HIV Determine kits, as a loan from the Blood Transfusion Center, were delivered to all sites with HIV/TB co-infection in all IHP-supported coordinations.

Table 53: Number and percentage of TB patients tested for HIV in PY3Q3

Coordination	Counseled	Tested	% Tested
Bukavu	438	194	44
Uvira	146	88	61
Mwene Ditu	474	303	46
Luiza	414	281	46
Kole	102	46	68
Tshumbe	325	139	64
Kamina	869	534	43
Kolwezi	213	99	60
PY3Q3 Total	2,981	1,684	56

Despite the slight decrease in the testing rate as compared to last quarter, there has been a steady improvement in this indicator since PY2, as shown in table 54, on the following page. During Year 2 as well as in the first quarter of Year 3, the observed rates had always been below 40% (PY2 28% and PY3Q1 34%), but during the previous two quarters, the reported rate improved to more than 56%.

Workshops on co-infection organized in Mwene Ditu and Kamina contributed to improved results, as the rate of TB patients also tested for HIV in these two coordinations during Year 2 were around 13% and 17% in Kamina and Mwene Ditu, respectively. By the end of PY3Q3, testing rates have reached 61% in Kamina and 64% in Mwene Ditu. The project-supported trainings on co-infection and the availability of HIV tests in the field have contributed to the improvements in co-infection testing rates.

Table 54: Number of TB patients counseled and tested for HIV from PY2Q2 to PY3Q3

	PY2Q2		PY2Q3		PY2Q4		PY3Q1		PY3Q2		PY3Q3	
	Counseled	Tested										
Bukavu	259	175	317	251	409	332	221	98	275	271	438	194
Uvira	21	13	26	15	23	29	222	51	143	91	869	534
Mwene Ditu	395	12	444	167	424	12	421	74	451	232	102	47
Luiza	431	76	387	131	429	108	457	343	456	221	213	99
Kole	71	9	91	12	72	52	100	47	102	34	414	281
Tshumbe	316	55	261	48	320	14	315	112	278	133	474	302
Kamina	795	274	725	143	632	70	606	83	482	264	325	139
Kolwezi	10	10	39	16	0	0	250	74	216	166	146	88
Total	2,298	624	2,290	783	2,309	617	2,592	882	2,403	1,412	2,981	1,684

Still, particular attention must be placed on integrating co-infection in all the case management facilities, especially in the Bukavu, Kole, Luiza, and Tshumbe coordinations, where testing rates are among the lowest. Training on counseling and managing co-infection rates have not yet been completed in these coordinations. In response, the project will support the integration of 30 new TB/HIV sites, with 11 in Bukavu, 4 in Kole, 3 in Uvira, 7 in Luiza, and 5 in Tshumbe; ensure a regular supply of commodities; and conduct a workshop series for health care providers on counseling and managing co-infection rates.

Number of Multi-Drug Resistant (MDR)-TB cases detected

During PY3Q3, a temporary halt to MDR-TB activities (sample analysis) occurred at the PNL National Mycobacteria Reference Lab (LNRM) due to administrative and technical challenges at the lab. As a result, no new MDR-TB detected cases were reported this quarter, as compared to seven in PY3Q2. As of May 2013, these activities have resumed, and the project has intensified its efforts in data collection and sputum transport to the CPLT in all IHP-supported provinces.

Regarding the advocacy efforts to equip the CPLT in Katanga and Kasai Occidental with GenExpert equipment for rapid MDR-TB detection, IHP will continue to advocate with USAID for this equipment, which can provide improved MDR-TB diagnosis and will strengthen program capacity in terms of the new approach to implementing the fight against TB in the DRC Congo. The project plans the following activities to increase the number of MDR-TB cases detected:

- Negotiate the expansion of the coverage and the utilization of GenExpert in Kamina, Kolwezi, Lodja, Mbuji Mayi and Kananga
- Complete a series of training sessions on MDR-TB in all the CSDT in the 80 project supported health zones (Mwene Ditu, Luiza, Bukavu, Kole, Tshumbe and Uvira)
- Sustain the MDR-TB sample transport network, including the transport of the samples from the CSDTs to the labs in Kinshasa and Lubumbashi in cooperation with the TB 2015 program, which is expected to run until July 2014, and the World Health Organization (WHO).

During PY3Q3, the number of health facilities that reported TB commodity stock outs decreased from PY3Q2, during which IHP reported 60, 74, and 75 stock outs of rifampicin/isoniazid in January, February, and March, respectively (in terms of delivery points, there are 1,217 CST and 250 CST). See table 55, on the next page, for information on stock outs in PY3Q3. Still, occasional stock outs were reported in Bukavu, Kamina, Uvira, Tshumbe, and Kole during PY3Q3, as transport of commodities from the CPLT to the health areas remains an issue. IHP provided the Bukavu coordination with logistics support for commodity transport while discussions with CPLT were held. Following talks between the project and CPLT, CPLT agreed to contact IHP when TB commodities will need to be transported in the health zones so that the project can provide transportation support. This approach will be duplicated in other health zones facing similar issues, such as Lodja and Kamina.

Table 55: Number of USG-assisted service delivery points experiencing stock-out of RH (rifampicin/isoniazid) combination

Coordination	April 2013	May 2013	June 2013
Bukavu	8	5	5
Uvira	2	0	0
Mwene Ditu	0	0	0
Luiza	0	0	0
Kole	0	0	1
Tshumbe	1	0	1
Kamina	1	5	2
Kolwezi	0	0	0
PY3Q3 Total	12	10	9

In order to further reduce the number of stock outs, the project plans the following activities in PY3Q4:

- Increase TB medicine and commodity surveillance
- Improve TB case management in the health facilities through strengthened communication with the CPLT and consider providing phones to facilities so that they can send a daily SMS to alert the CPLT of their supply levels
- Ensure that commodities can be transported to project health zones and all health facilities as needed, upon request from the CPLTs.

IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted

1. Percentage of health centers meeting all nine FOSACOF minimum standards, disaggregated by type of health facility

1.1. Sustaining the integration of the Fully Functional Service Delivery Points (FOSACOF)

During PY3Q3, 15 new health facilities integrated the FOSACOF approach in the health zones of Uvira, Ruzizi, and Lemera in the Uvira coordination. As of this quarter, the project has 485 health facilities that have integrated the FOSACOF approach out of the targeted 939 health facilities set forth in the PMP. Table 56, below, demonstrates the number of health that integrated the FOSACOF approach by quarter in project year three (PY3).

Table 56: Health facilities integrating the FOSACOF approach by coordination offices by quarter in Year 3

Coordination	PY3Q1	PY3Q2	PY3Q3	Total
Bukavu	33	48	48	48
Kamina	29	29	29	29
Kole	49	49	49	49
Kolwezi	14	40	40	40
Luiza	93	93	93	93
Mwene Ditu	97	97	97	97
Tshumbe	93	93	93	93
Uvira	21	21	36	36
PY3 Total	429	470	485	485

In PY3Q3, Uvira was the only coordination that integrated the FOSACOF approach. The project had planned to integrate the approach in Hauts Plateaux, but insecurity and the presence of armed rebels prevented the activities from taking place. The number of FOSACOF health facilities in Uvira increased from 21 in PY3Q2 to 36 this quarter. Other IHP coordination offices had prioritized different activities, namely MNCH activities and results-based financing (RBF) preparations. The project plans to integrate the FOSACOF approach into 15 facilities in Bukavu next quarter.

FOSACOF evaluation of the health facilities within the results-based financing implementation

This quarter, the MOH and IHP carried out a baseline assessment in preparation for the RBF implementation start up in the eight target health zones. The MOH and IHP agreed to conduct the baseline assessment using the FOSACOF evaluation method in 34 health zones, including the eight RBF pilot health zones and 26 health zones without any RBF scheme implemented in the past and from which comparison health zones would be selected as needed. A total of 357 health facilities that have already integrated the approach were assessed.

Table 57: Number of assessed health facilities by performance level

Coordination	Number of health facilities evaluated	Class D (<25% performance) health facilities	Class C (25--49% performance) health facilities	Class B (50-79% performance) health facilities	Class A (>80 performance) health facilities
Bukavu	38	4	33	1	0
Kamina	25	8	17	0	0
Kole	35	6	24	5	0
Kolwezi	31	9	22	0	0
Luiza	65	22	40	3	0
Mwene Ditu	70	22	37	11	0
Tshumbe	72	14	47	11	0
Uvira	21	9	10	2	0
PY3Q3 Total	357	94	230	33	0
% in each class		26	64	9	0

The evaluations found that of the 357 health facilities with FOSACOF integration assessed, 94 or 26% fall under D category (<25% performance); 230 or 64% are C category (25-49% performance); 33 or 9% are B category (50-79% performance) and none are A category (>=80% performance). The majority of health facilities (230 or 64%) are in C category (25-49% performance), due to regular supervisory meetings and activity monitoring to improve the quality of services and care in the health facilities. The infrastructure and community engagement approach categories pose the most difficulties for the facilities in terms of achievement rates. Facilities often have trouble motivating and involving communities without financial incentives, and renovations of facilities, supported by the project and MOH, occur gradually. Among the 33 facilities that were evaluated to be “Class B,” they tended to demonstrate strong relationships with the community, exhibit good management practices, and have well-organized and well-trained staff.

In PY3Q4, the project plans the following activities:

- Continue the FOSACOF approach integration in low performing health facilities, namely those in Kamina, Bukavu, Uvira, and Kolwezi

- Continue performance evaluations for the remaining FOSACOF health facilities in all coordinations Consider adapting and integrating the FOSACOF approach as a national tool, and to consider linking incentives (in the RBF domain) to improvements in the 9 FOSACOF criteria.

2. Implement a results-based financing (RBF) program

The project is still preparing for the implementation of results-based financing (RBF) activities, which will occur once performance-based contracts are signed with partners and once the independent evaluation firm, International Business and Technical Consultants, Inc. (IBTCI), completes the RBF baseline survey. IBTCI is expected to finish the baseline study by PY3Q4 or the beginning of PY4. The activities of the RBF program during the third quarter of PY3 are process oriented and are detailed in table 58, below.

Table 58: Progress of RBF activities in PY3Q3

Activities	Expected (number)	Achieved (Number)	% Achievement
Develop basic FOSACOF evaluations in 117 health centers of 24 health zones chosen for the baseline model by IHP staff and MOH personnel	117	115	98
Data collection from primary sources in the health center	117	115	98
Analyze data from the evaluated health facilities during the basic assessment for the third quarter and the previous quarter	32	32	100
Evaluate the CBOs selected by the project's contract team in Sud Kivu	4	0	0
Support MOH RBF module and IHP in developing the RBF database	1	1	100
Cooperate with the external evaluator recruited by USAID to develop the baseline	1	1	100
Develop a contract template for the CBO and RBF implementation	1	0	0
Determine RBF target performance indicators for the health centers in reference to HMIS results for the first quarter of 2012	160	54	43
Organize a workshop on target identification, contract signing and workplan development for the first quarter on RBF implementation in 8 RBF health zones	8	0	0

The following three activities were not completed during this this quarter:

- Evaluate the CBO selected by the project's contract team in Sud Kivu
- Develop a contract template for the CBO and RBF implementation
- Conduct a workshop on target identification, contract signing and workplan development for the first quarter on RBF implementation in 8 RBF health zones.

The three activities that were not carried out are planned to begin before RBF activities start in the selected health zones and after IBTCI's evaluation activities have been completed. The workshop cannot occur until after the evaluation has been finalized, and the other two activities were delayed due to misunderstandings in what was required for a contract for CBO and RBF implementation. The process has since been clarified.

IR 2.3: Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized

Overall, the percentage of health centers with accurate and up-to-date inventory records increased from 41% in PY3Q2 to 51% in PY3Q3, as shown in table 59, below. Progress was reported in most of the coordinations due to the availability and use of data management tools provided by the project (RUMER, inventory cards, stock registries) that aid in recording and reporting the referrals that are made from the community to health centers. During supervision visits, the project continues to emphasize the importance of using data collection tools. The project will continue to conduct supervisory visits to ensure that that data collection tools are used correctly.

Table 59: Number and percentage of health centers with accurate and up-to-date inventory records

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	109	84	48	18	98	134	154	77	722
Target (80%)	408	207	55	105	189	191	156	104	1,415
Achievement rate	27%	41%	87%	17%	52%	70%	99%	74%	51%

During PY3Q2, 40 of the 80 hospitals, or 50%, met the requirement of maintaining accurate and up-to-date inventory tools. In PY3Q3, these results increased to 56 hospitals out of 80, or 70% of hospitals possessing up-to-date inventory records. Table 60, below, shows the number of hospitals in each coordination with accurate data inventory records. In addition to providing data management tools to the hospitals, the project carried out briefings for hospital pharmacy directors in all coordinations on keeping medicine dispensation records.

Table 60: Number and percentage of hospitals with accurate and up-to-date inventory records

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
PY3Q3	14	4	4	6	7	8	9	4	56
Target	23	9	4	8	11	11	9	5	80
Achievement rate (%)	61%	44%	100%	75%	64%	73%	100%	80%	70%

Little improvement has been noted between PY3Q2 and PY3Q3 regarding the number of patients referred to GRHs, as the achievement rate in PY3Q2 was also 3%. See table 61, on the page below, for details. Also, three health zones in the Uvira coordination (Lemera, Ruzizi, and Hauts Plateaux) were unable to report in June 2013, due to insecurity and health care provider strikes. In hospitals and health centers, nurses are responsible for noting that a patient has been referred; however, referrals are not always recorded. Sometimes existing data collection tools are not used properly, or at all. To address the stagnation in achievement, the project plans to intensify supervisory visits to ensure that data collection tools are filled out regularly and correctly.

Table 61: Number and percentage of patients referred to GRHs

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
Patients referred to GRH	12,490	4,111	1,167	3,155	2,619	9,928	7,777	2,572	43,819
Patients seen by a CHW or health care provider	419,902	219,811	28,810	114,920	124,714	189,945	103,650	67,490	1,269,242
PY3Q3 (%)	3%	2%	4%	3%	2%	5%	8%	4%	3%

During this quarter, CHWs used referral tokens to better track patient referrals to health facilities. The CHW provided a referred patient with a token, which the patient would then give to a health care provider in a health center, indicating that one referral should be recorded. In Bukavu, each health area has three bicycles for CHWs to use for promotional efforts. In some cases, CHWs used the bicycles provided by the project to bring patients directly to the health centers.

Table 62: Number and percentage of patients referred to health centers

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3Q3
Patients referred to health center by a CHW	605	388	352	142	394	325	60	100	2,366
Patients seen by a CHW	1,327	9,511	602	1,014	1,330	2,504	1,531	839	18,658
PY3Q3 (%)	46	4	58	14	30	13	4	12	13

INTERMEDIATE RESULT 3: KNOWLEDGE, ATTITUDES, AND PRACTICES TO SUPPORT HEALTH-SEEKING BEHAVIORS INCREASED IN TARGET HEALTH ZONES

IR.1.2: Increased community health care services and products in the target health zones

Activity 1: Integrate the CODESAs in activities to strengthen health zones

IHP continues to provide support to the revitalization of CODESAs. Table 63, on the following page, provides information on revitalized CODESAs by coordination. Highlights from this quarter and progress to-date include:

- Twelve CODESAs were revitalized during the third quarter.
- The number of CODESAs revitalized this quarter is notably lower than the last quarter due to the fact that BCC staff in nearly all field offices prioritized preparing for the national vaccination campaign. This campaign was originally planned for June but has been rescheduled for July, as insufficient funds had been raised by June.

- The total number of CODESAs revitalized to date for project year three is 1,230, which represents 87% of the annual PMP target of 1,415.
- Out of the 1,230 CODESAs that have been successfully revitalized, 887 (or 72%) have developed and put in place action plans. The increase in the number of CODESAs with action plans is due in part to the support IHP has provided the health zone management teams in their role as CODESA supervisors in Tshumbe and Uvira.
- During the third quarter, there was a 15% increase in the number of CODESAs with action plans in Tshumbe and a 19% increase in Uvira.
- In Bukavu, IHP staff provided training to the health zone management team, including community mobilizers and health zone doctors, on community participation. This training helped participants learn to view the community as a partner and become aware of how they can promote community participation in the management of the health zone.

Table 63: Number of revitalized and functional CODESAs

Field Office	Number of CODESAs identified	Number of CODESAs revitalized and functional	Functional CODESAs (percentage)	Number of revitalized and functional CODESAs with an action plan	Functional CODESAs with an action plan (percentage)
Kole	55	48	87	34	71
Mwene Ditu	191	191	100	185	97
Tshumbe	156	131	84	78	59
Luiza	189	169	89	157	93
Kamina	207	180	87	97	54
Kolwezi	105	63	60	57	90
Uvira	104	82	79	82	100
Bukavu	408	366	90	197	54
TOTAL	1,415	1,230	87	887	72

IR 3.1: Evidence-based health sector-community outreach linkages established — especially for women, youth, and vulnerable populations

Activity 1: Implement the Education through Listening (ETL) approach through training members of the community, organizing ETL session on different themes, and the organization of post-training follow-up visits

IHP continues to organize ETL sessions in order to foster community-level behavior change and community-led outreach. During the third quarter, BCC staff continued to focus on youth organizations as part of IHP's youth outreach and awareness-raising strategy. Highlights from this quarter include:

- Six additional youth organizations were identified, exceeding the quarterly target of four. Four new organizations were identified in Tshumbe (OMEKA, SHENGA, and EKANGA), two new organizations were identified in Kole (AJERKO and AJAS), and one in Luiza ("La Colombe").
- In total, 147 organizations have been identified, as shown in table 64, on the next page. Among these, 119 (81%) collaborate with IHP. The six new organizations identified this quarter have begun collaborating with IHP.
- In Luiza, the youth association "La Colombe" from the health area St. Therese (in the health zone of Tshikaji) held 18 health awareness-raising sessions in which ETL techniques were taught to 400 teenagers and young adults (280 male and 130 female) about HIV/AIDS and early marriage. As a

result of these sessions, 20 youth (16 male and 4 female) were referred to testing centers, 85 young men expressed a desire to use condoms during casual sexual encounters, and around 115 young women in attendance expressed a favorable view of abstinence at the end of the sessions.

- In Tshumbe, the three new identified youth organizations were selected to help support the implementation of the Champion Community approach in the Minga and Dikungu health zones. Five representatives from these organizations were integrated into the Champion Community pilot committee. Their participation helped ensure that health issues important to youth in the area, such as HIV/AIDS prevention and malaria prevention, were taken into consideration by the committee. Additionally, these representatives were able to become leaders and positive role models among their peers, securing youth support to help the community achieve the goals it set for itself.

Table 64: Number of youth organizations participating in the youth awareness raising

Province	Field Office	Number of associations identified	Number of active associations
Sud Kivu	Bukavu	21	9
	Uvira	14	10
Kasaï Oriental	Mwene Ditu	76	65
	Kole	4	4
	Tshumbe	5	5
Kasaï Occidental	Luiza	19	18
Katanga	Kamina	3	3
	Kolwezi	5	5
TOTAL		147	119

Activity 2: Establish a coordination mechanism for local NGOs/CBOs and health zone management teams

IHP continues to work with local NGOs in establishing coordination mechanisms. The BCC team continued to focus on incorporating women and youth into the CODESA leadership structures this quarter, and slight increases in the number of participating local organizations were sustained. Highlights include:

- Of the 172 identified local NGOs across IHP's 8 field offices, 84 (48%) are participating in CODESA coordination meetings.
- Over the course of the quarter, IHP staff successfully encouraged four new NGOs to participate in local coordination meetings: three women's groups (*Projet des femmes en action* in Luiza, *Association des veuves et orphelins de Lodja* in Tshumbe, and *Centre de formation pour une femme capable* in Kole) and one youth group (*Organisation des jeunes de Tshitadi pour le développement* in Luiza).
- The major health issues discussed during these coordination meetings included WASH (latrine construction and water source improvement), awareness raising on and community mobilization for malaria, exclusive breastfeeding, and diarrhea.
- During the third quarter, IHP also continued providing technical assistance for coordination meetings for community-based organizations across a variety of levels (at the health zone, district, village council, and CARITAS' NGO collective levels).

IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched

Activity 2: Implement BCC campaigns in health zones and health areas for IHP's domains of intervention

IHP continues to implement mini-BCC campaigns on a wide variety of the project's health areas. See table 65, below, for the number of campaigns by topic carried out in PY3Q3. Highlights from this quarter include:

- Fourteen campaigns were organized across IHP's eight field offices on HIV prevention, WASH, TB, breastfeeding, voluntary blood donation, and family planning (see breakdown by field office and health topic below).
- Over the course of the quarter, BCC staff in most field offices prioritized preparing for the national vaccination campaign, which was originally planned for June but has been rescheduled for July. Preparatory activities included providing technical assistance and support to the health zone management teams in order to prepare for the national campaign which will cover vaccinations against polio, de-worming, and vitamin A supplements for children under the age of five.
- In Tshumbe, IHP collaborated with the health zone authorities and Champion Community members to conduct a mini-campaign on the importance of WASH (latrines and improved water sources). WASH awareness-raising activities were held in 10 villages in the rural health zone of Dikungu, and 1,964 individuals participated (397 men, 412 women, 548 young women, 607 young men), among them the 10 village chiefs.

Table 65: BCC campaigns implemented during the PY3Q3 by health issue and field office

Health Topic	Field Office								TOTAL
	Bukavu	Kamina	Mwene Ditu	Kole	Tshumbe	Luiza	Uvira	Kolwezi	
HIV prevention		-	-	-	-	-	-	1	1
WASH	-	1	-	1	1	-	-	4	7
TB	-	-	1	-	-	-	-	-	1
Breastfeeding	-	-	-	1	-	-	-	-	1
Voluntary blood donation	-	-	-	-	-	1	-	-	1
Family planning	2	-	-	-	-	-	1	-	3
Total	2	1	1	2	1	1	1	5	14

Activity 3: Conduct pilot programs on mobile phone-based information dissemination campaigns

IHP continues to implement its mHealth initiatives. During the third quarter, project staff continued to successfully transmit SMS messages on malaria prevention, TB, HIV prevention, WASH, family planning, breastfeeding, GBV, and voluntary blood donation. See breakdown by health area and field office in table 66 on page 86. An evaluation of the project's SMS campaigns and pilot closed user groups (CUGs) was completed this quarter. Highlights from this quarter include:

- 66,424 SMS messages were transmitted out of a quarterly PMP target of 250,000 (26% completion). This completion rate is slightly higher than last quarter (25%).

- IHP followed up on discussions that were held during the second quarter about adjusting the quarterly PMP target for SMS messages to 30,000 (as the target is believed to have been overestimated at the beginning of the project year) by sending an official request to the USAID Mission in Kinshasa regarding this adjustment. IHP is waiting for feedback from the Mission in order to schedule a meeting to finalize and formalize this adjustment.
- Uvira was responsible for disseminating over half of the messages sent this quarter (36,294 SMS messages, or 55%), which were transmitted throughout the health zones of Uvira, Nundu, and Ruzizi. Uvira's success was driven by both the field staff's decision to prioritize SMS campaigns, and by the fact that the local population is receptive to receiving health SMS messages. This receptivity is due to in part to awareness-raising efforts on the part of the Champion Community pilot committee members. Starting in the second quarter, IHP staff requested that the Champion Community pilot committee members in those three health zones raise awareness in their communities about the utility of receiving valuable health information on personal cell phones. As a result, IHP staff report that local residents have become more receptive to health SMS messages and are more willing to give their cell phone numbers to IHP. To date, Uvira has collected approximately 15,000 phone numbers that it uses for its targeted SMS campaigns.
- In Luiza, IHP used SMS messages to support a pre-certification Champion Community in the health area of Mupoyi working to achieve one of the health goals it set for itself (increasing the number of pregnant women who received preventive treatment for malaria). IHP incorporated malaria prevention messages targeting pregnant women into its SMS campaign in that area and sent 300 SMS messages with the following information:

In Tshiluba: Bana betu ambuluishayi bamamu badi kulu kule bua kuya ku tshipimu tshia bena mafu bua kupeta buanga bua maleya leya, bua kudikuba, ne kukuba mwana udi munda ku disama edi.

In French: Chers membres de la communauté, aidons les femmes enceintes à fréquenter la CPN au moins une fois afin de recevoir les deux doses de sulfadoxine pour se protéger et protéger l'enfant à naître contre la malaria.

In English: Dear community members, let us help pregnant women visit the health center at least once in order to receive the two doses of sulfadoxine needed to protect them and their unborn child against malaria.

- In order to promote the long-term sustainability of the project's mHealth initiatives, IHP continued to involve non-IHP staff in the dissemination of SMS campaigns. Notably, IHP field staff continue to install FrontlineSMS on the computers of select health zone management team offices. During the third quarter, several health zone management teams successfully disseminated SMS messages without IHP support. The health zone management team in Tshumbe sent 194 messages on malaria; the team in Ndeksha sent 68 messages on family planning; and the team in Tshikaji sent 50 messages on malaria.
- IHP also completed a qualitative assessment of its SMS campaigns and pilot CUGs during the third quarter. This assessment was conducted between January and July 2013 and consisted of focus group discussions (FGDs) with 362 participants in 11 health zones. Demographic surveys were also

administered to focus group participants and additional information, including on ease of implementation, was collected from IHP BCC and M&E staff. The executive summary of the report is found as Appendix 5. The finalized draft of the report will be shared with USAID separately.

- FGDs were conducted in 11 out of the 51 health zones where IHP has introduced an mHealth initiative (either SMS campaigns or CUGs or both). All six health zones in which IHP has established a CUG system (Bibanga, Kanda Kanda, Wikong, Dibaya, Tshikaji, and Uvira) were included in the assessment. The remaining five health zones (Mpokolo, Kalenda, Bilomba, Ndekesha, and Lemera) in the assessment did not have an established CUG system but were included to gauge community interest in the establishment of a CUG system.

Table 66: Number of SMS messages sent by health area and by field office during PY3Q3*

Health topic	Number of SMS messages sent									PY3Q3 Total
	Bukavu	Uvira	Mwene Ditu	Kolwezi	Tshumbe	Luiza	Kamina	IHP-Kinshasa	Operators	
Malaria prevention	-	-	1,000	3,400	3,000	2,000	2,000	1,000	-	12,400
HIV prevention	-	-	-	-	-	-	-	-	-	-
WASH	-	10,600	1,000	2,100	2,000	-	1,000	500	-	17,200
TB	-	8,506	-	-	-	-	1,047	-	-	9,553
GBV	-	-	-	-	-	-	-	-	-	-
FP	6,611	14,188	1,000	-	1,004	68	400	-	-	23,271
Nutrition (exclusive breastfeeding)	-	3,000	-	-	-	-	-	-	-	3,000
Voluntary blood donation	-	-	-	-	-	1,000	-	-	-	1,000
PY3Q3 Total	6,611	36,294	3,000	5,500	6,004	3,068	4,447	1,500	0	66,424

* Kole remains unable to disseminate SMS messages due to lack of network coverage.

Major assessment findings included:

- Beneficiaries generally perceived SMS campaigns and CUGs as beneficial, interesting, educational, and useful tools that facilitated intra- and inter-community dialogue on health issues.
- CUG systems have generated high levels of community interest and enthusiasm in both those health zones in which they have been established and in those where they have not been established. In those areas with CUG systems in place, the CUG phones were credited with helping community members solve a variety of health issues (including, among others, health emergencies, malaria prevention, and accessing family planning services).
- Message sharing was generally widespread. Beneficiaries reported sharing the health information that they received via IHP SMS message and/or during conversations using a CUG phone with family, friends, and neighbors.
- The main implementation challenges identified with respect to SMS campaigns included (1) low volume of SMS message dissemination, (2) source confusion and misperception of message costs on the part of recipients, (3) gendered and generational disparities in cell phone access, and (4) limited access to electricity (to recharge cell phones).
- Although some of these challenges cannot be addressed by IHP (namely, the lack of electricity to recharge personal cell phones), IHP has begun to better monitor credit levels on field staff computers and modems to ensure that SMS campaigns are not delayed. Those implementation challenges that can be addressed through changes to message content or campaign design (such as more clear attribution) will be discussed during the fourth quarter and incorporated into the work plan for the following project year as needed.
- CUG systems experienced some of the same the implementation challenges as the SMS campaigns (namely, disparities in CUG phone access and limited available electricity). Several additional challenges were also identified during the course of the assessment, including (1) the relatively low supply of CUG phones is insufficient to meet the high demand for access and information; and (2) a lack of awareness regarding the identify of CUG phone holders.
- Although demand for CUG phones outpaces IHP's capacity to supply phones, IHP can work to increase access to those CUG phones already available by increasing the visibility of CUG phone holders. Increasing the community's familiarity with who they are will likely make community members feel more comfortable approaching them to use the CUG phone, thereby increasing access over time without adding phones. IHP will also explore how to best leverage the community-led efforts to increase the number of CUG phones available in a community (such as the example of one community that raised funds to purchase a phone for incorporation into an existing CUG in the area).
- In order to ensure that key health messages are also reaching women and youth, IHP is currently exploring how to best address the gender and generational disparities identified during the course of the assessment. One option under consideration is to incorporate the issue into IHP's existing work and outreach with women's and youth organizations. The goal would be to both help group members learn to better advocate for equal access (to shared household phones) and to help the group brainstorm how to raise funds to purchase a shared phone for the organization.

Activity 5: Selecting and training Champion Communities

IHP continues to select, train, and establish Champion Communities throughout the project's targeted health zones. Highlights from this quarter include:

- Out of a quarterly target of four, two Champion Communities were established in Luiza (in the health zones of Dibaya and Ndeksha).
- The quarterly target was not met in part due to reductions in spending in Mwene Ditu that led to the rescheduling of planned activities (for example, trainings planned for the third quarter were postponed).
- IHP currently has 25 Champion Communities established across its targeted health zones. One Champion Community was certified this quarter (the "Rhugwasanye" Champion Community in Bukavu), and one other Champion Community was certified earlier in the project year (the "Afya Kwa Wote" Champion Community in Uvira).
- The remaining 23 Champion Communities are currently working towards certification and considered to be "pre-certified." Certification assessments are planned for 15 Champion Communities for the fourth quarter.

IHP also continues to support established Champion Communities in developing and implementing action plans. Highlights from the third quarter include:

- All 25 established Champion Communities have developed and implemented an action plan. These actions plans help communities map out how they will achieve the objectives they have set for themselves as part of the certification process.
- In Tshumbe, IHP provided additional technical support for two pre-certification Champion Communities at the request of the regional administrative authorities.
- In Kole, support for the Champion Community initiative remains low among the adult population due to their resistance to becoming involved if they will not be paid for their participation. The initiative has nonetheless been well-received by youth. In order to get community buy-in, four active community-based organizations assisted the Champion Community pilot committee in developing their action plan.
- In Uvira, the "Afya Kwa Wote" Champion Community (one of two certified Champion Communities) is the only certified community to have received IHP funding to design and carry out income-generating activities. Once a Champion Community is certified, IHP provides \$500 for the design, development, and implementation of community-led projects and activities that raise money to be used for local health services and development activities. Following a six-month progress report, a second and final round of funding is provided (\$500). Eventually, all certified Champion Communities will receive funding for income-generating activities.
- The "Afya Kwa Wote" Champion Community began developing plans for community agricultural initiatives beginning in the second quarter (February 2013), and since receiving funding have been able to cultivate two hectares of cassava and raise several cows.
- Additionally, the "Afya Kwa Wote" Champion Community began making strides towards becoming self-sufficient during the third quarter by drafting a statute and organizational procedures to

become a non-profit organization. These documents are currently being reviewed by the regional administrative authorities.

- This same Champion Community in Uvira also successfully requested financial assistance from ADRA in order to improve a water source in the Kala health area, which is comprised of 6 villages and has a population of 5,600. Construction is currently underway and is being carried out using local labor.

During the third quarter, IHP also assessed the progress of several pre-certification Champion Communities that had been operational for six to eight months in order to gauge their progress towards certification. Highlights from these assessments included:

- In Tshumbe, improvements were observed in several health issues that two of the Champion Communities had set out to address. In the health zone of Dikungu, 30.76% of existing water sources were improved and 21% of the community's latrines were constructed by community members (and these latrines were observed to be clean). In the health zone of Ndjalo Djeka, use of family planning services increased to 20% of the population (as compared to a baseline level of 1%). Additionally, use of pre-natal services rose to 26% of pregnant women (as compared to the baseline of 14%).
- In Luiza, the "Tudisange" Champion Community successfully raised funds to contribute to the improvement of three water sources. As a result, a decrease in diarrhea in children under the age of five was reported (the number of treated cases fell from 102 in April 2013 to less than 10 in June 2013).
- In Bilomba, Champion Community members collaborated with local leaders and political-administrative authorities in order to weed public spaces and mobilize community members to build their own family latrines. As a result of these efforts, 1,775 latrines were constructed in PY3Q3 (out of a target of 1,800).
- In Dibaya, increases were observed in the usage of curative health services in the health areas of Tshimayi, Mupoyi, Kabeya Madi, and Dibaya. A total of 3,540 individuals were referred to the health center for treatment (out of an action plan target of 1,155): 1,160 in April, 1,180 in May, and 1,200 in June. Additionally, IHP facilitated 100 ETL-based health awareness-raising sessions in Tshimaya on family planning and sent 500 SMS messages on the subject, which contributed to the number of couples (100) who visited the health center to use family planning services over the course of the quarter.
- By the end of the third quarter, the general service usage rate of health services in Dibaya had increased from 35% of the population to 46%. This notable result was due in large part to the involvement of local leaders, including pastors and traditional leaders, in health awareness-raising activities during which people were referred to the local health center for service.

During the third quarter, IHP also developed the sustainability plan for the project's Champion Community initiative. The sustainability plan aims to provide guidelines for Champion Communities to leverage the high levels of local involvement and enthusiasm generated by the Champion Community framework (goal setting, collective contributions, goal achievement, and celebration) and become self-sufficient, thus fostering sustainable community development over time. The plan can be broken down into four main components:

- Disseminate a sample statute and organizational procedure for a non-profit organization to Champion Communities (templates will include organization's objectives, membership and member's rights and responsibilities, funding, organizational structure, and financial management).

Existing Champion Communities will use these templates as guides in their efforts to become not-for-profit organizations, an essential step to securing external support and funding. Non-profit status will better enable them to advance the sustainable development of their communities once IHP support has ceased.

- Establish youth programming in existing Champion Communities that focus on overall personal development in order to encourage better decision-making and personal responsibility from a young age. This program will combine peer mentoring and parental counseling
- Encourage economic self-sufficiency through the identification and implementation of income-generating activities appropriate for each Champion Community. The community will choose its own activities and select individuals, particularly those with prior training and experience, to help lead the implementation of these activities.
- Leverage the “Champion Man” initiative being rolled out by IHP in order gain male support to promote the incorporation of women into Champion Community activities. The “Champion Man” approach will involve IHP selecting a small group of male Champion Community members (around ten) who will put together a list of three or four specific behaviors that promote gender equality, such as allowing wives to attend community meetings, and will then raise awareness about the importance of these behaviors among other Champion Community men. This initiative will be used to encourage men within the Champion Communities to treat their wives and other women as equals and facilitate their participation in achieving community goals.

COMPONENT 2: HEALTH SYSTEMS STRENGTHENING

INTERMEDIATE RESULT 4: HEALTH SECTOR LEADERSHIP AND GOVERNANCE IN TARGET PROVINCES IMPROVED

IR 4.1: Provincial health sector policies and national level policies aligned

1. Support the MOH in the distribution of policies and protocols for public health at the national, provincial and health zone levels

During this quarter, the National HIV/AIDS Control Program (PNLS) requested financial support from IHP for the reproduction of documents outlining the finalized national policy and guidelines pertaining to HIV/TB co-infection in DRC; IHP provided technical contributions mainly from its TB Senior Technical Advisor. IHP committed to reproduce these documents for the 80 health zones supported by the project. Following a written request from PNLS, IHP has begun printing the national policy and guidelines, and will distribute them next quarter.

IHP helped disseminate the policies agreed between MOH and the Inter-Donors Health Group (GIBS) concerning rates applicable to MOH staff conducting project activities including field visits, trainings, etc. to provincial, district and health zone levels.

2. Support the health zones in finalizing health development plans (strategic plans) and the development of 2013 AOPs which are aligned with the MOH

All IHP-supported health zones have an AOP 2013, following the PNDS template and the Directorate of Studies and Planning (Direction d’Etudes et de planification, or DEP in the French acronym) guidelines. Since the beginning of the year, IHP provided technical and financial support to this planning process with the

PNDS as the guiding principle. After one quarter, IHP is performing the mid-term evaluation, as required by the PNDS. The results will be included in next quarterly report.

IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted

IHP provided health facilities with HMIS data management and transmission tools in most of the IHP-supported health zones. In Kamina, the risograph machine required repair in Lubumbashi, and as a result, data management tool reproduction and distribution was delayed. In response, outside services were procured to duplicate the data tools while the machine is being repaired.

During this quarter, the project continued to provide financial support as well as in-kind donations to the four provincial health divisions, 16 health districts, and 80 health zones. Furthermore, IHP revised the sub-grants to these entities to ensure that the grants align with the policies agreed between MOH and the GIBS. The project is also considering the following recommendations from the IHP project year 3 mid-term workplan review: 1) double the financial support to health zones for monthly monitoring meetings; and 2) provide financial support to the health areas to enable them to transport the commodities they collect monthly from the health zone, so that they report on the management of pharmaceuticals provided by IHP on a monthly basis. IHP issued the amended sub-grants accordingly, and has communicated with all concerned entities the changes that will be in effect next quarter.

IR 4.3: Community involvement in health policy and service delivery institutionalized

With 1,230 successfully revitalized CODESAs, of which 887, or 72%, have developed and implemented action plans, and 84 local NGOs that actively participate in these CODESA activities, IHP contributes to reinforcing the functioning of civil society groups and continues to strengthen their involvement in the planning process and provincial politics.

IHP identified three local NGOs (one in Kole and two in Kamina) that will implement a pilot program to increase their institutional capacity in addressing GBV needs at the community level. Upon approval from USAID of these small grants, IHP will provide implementation support to the three local NGOs.

II. PROJECT MANAGEMENT

1. Success stories

The project wrote seven success stories this quarter, which focused on MNCH, WASH, and community participation issues. See table 67, on the following page, for information on stories by theme and coordination.

Table 67: Success stories by coordination office and topic

FIELD OFFICE	TOPIC	PY3Q3
Bukavu	MNCH	1
Kole	WASH	1
	MNCH	1
Luiza	WASH	1
	MNCH	2
Mwene Ditu	WASH	1
Total		7

2. Cost share

During IHP’s third quarter of Year 3, the cost-sharing activity consisted of medical equipment donations. In the second quarter of Year 3, Project Cure shipped two containers of medical equipment. The containers arrived in PY3Q3, and will be distributed among four hospitals in the health zones of Dibindi, Kalenda, Mwene Ditu, and Kitenge. Originally, the project had planned to send a container to Lodja. However, given the high cost of sending materials to Lodja, the project decided to distribute equipment to Kitenge in the coordination of Kamina. IHP will book the value of the cost sharing opportunity once the containers leave customs and the equipment is distributed.

3. Pharmaceutical procurement

The replacement Hepatitis B test Determine kits were delivered from Missionpharma from the PY 1 pharmaceutical order. However, only 13% of the kits arrived at the final destination as it appears that the majority, i.e., 1,333 out of 1,541 test kits, were stolen in transport, similar to the situation encountered with the HIV test kits delivered by Missionpharma. The project is still awaiting a detailed report on the matter from SDV and Missionpharma. Should further replacement kits be needed, an order will be placed with a different supplier and shipped with a different forwarder.

In PY3Q3, MEG has continued to make deliveries of the Year 2 pharmaceutical order to the final destinations. MEG has repacked a shipment of pharmaceuticals that was shipped from one of their manufacturers (Sanderson) without notification, has rearranged transport to the final destination and is currently awaiting the *Note Verbale* for Nystatin and Gentamycin. This quarter, the IHP team also identified the PY 3 pharmaceutical needs. A vendor and freight forwarder has been selected and the project awaits USAID approval before placing the pharmaceutical order. Tables 68 and 69, on the following page, provide updates on the status of ASRAMES deliveries.

Table 68: Status of ASRAMES deliveries

Province	Warehouse/CDR	Cost of the Order (in USD)	Value of the delivery End of June 2013	Delivery In %	Remaining balance (in USD)	Percentage (%) of balance
Sud Kivu	APAMESK	\$446,363.18	\$341,713.27	77	\$104,649.91	23
Katanga	CEDIMEK	\$343,309.48	\$17,606.13	52	\$164,703.35	48
	Kolwezi	\$207,075.67	\$130,131.45	63	\$76,944.22	37
Kasaï Occidental	CADIMEK	\$302,484.32	\$174,616.12	58	\$127,868,20	42
Kasaï Oriental	CADMEKO	\$235,525.12	\$152,831.97	65	\$82,693.14	35
	FODESA	\$230,865.98	\$132,230.43	57	\$98,635.55	43
TOTAL order/delivery		\$1,765,623.74	\$1,110,129.37	623	\$655,494,37	37

Table 69: Emergency procurement with ASRAMES: Delivery rate

Warehouse/CDR	Delivery rate at the end of June 2013	Comments
APAMESK Bukavu	98%	Non-delivered items are several cold chain commodities including insulin and blood test grouping tests
CADIMEK Kananga	Over 80%	Non-delivered items include cold chain commodities
CADMEKO Mbuji Mayi	96%	Non-delivered items include consumables and several cold chain commodities
FODESA Lodja	85%	Non-delivered items include consumables and several cold chain commodities
Kolwezi	70%	The situation remains unchanged since last May
CEDIMEK Kamina	86%	The situation remains unchanged since last May

As of the end of this reporting period, ASRAMES had delivered only 65.3% of the IHP order. There was no valid explanation offered for this delay despite many reminders by the MSH country representative. ASRAMES is categorized as a “Class C” supplier, which means that it needs more training and serious technical assistance before it can become a Class B or Class A supplier. This capacity building was initiated and carried out by SIAPS, and the plan is that ASRAMES will achieve a class B rating by April 2014. Nevertheless, ASRAMES also needs to increase its financial sustainability and keep a sufficient stock to respond to urgent needs from different clients and to avoid short expiration dates of its products (less than two years). As a result of these issues, IHP decided to competitively award its next drug order to IDA.

4. Non-pharmaceutical procurements

During this quarter, the 112 motorcycles that were pending exoneration and shipment from South Africa arrived in country and cleared customs. This quarter has also seen the clearance of 11 of the 12 vehicles and the blood transfusion kits. The only other procurement handled from the home office was 10 additional

solar fridges placed with the same vendor (Dometic International) from whom IHP purchased the solar fridges that arrived in February 2013.

III. FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

The project continues to carry out monitoring activities to ensure compliance with the Tiahrt amendment. During this quarter, IHP and National Reproductive Health Program (PNSR in the French acronym) staff, with staff from the Uvira Health district, conducted an investigation in two health facilities, the Uvira GRH and the Kiliba health center in Ruzizi. The two health facilities were suspected of failing to follow proper family planning protocols.

The investigation discovered that in the Uvira GRH, two health care providers were leveraging and collecting fees from clients for IUD and implants. In addition, it was found that, in the same facility, health care providers were not carrying out sufficient counseling for the IUD method so that clients could be well informed on the method. In response to these findings, the project and PNSR staff conducted refresher trainings for all staff in the Uvira GRH on the consequences of failing to adhere to the Tiahrt amendment. The head physician of the Uvira health zone also circulated a letter to all health care providers in the health zone to reinforce the importance of adhering to national policies and the Tiahrt amendment.

In the Kiliba health center, health care providers also collected fees from clients for implants as they had acquired commodities from the private sector to then sell for a profit. The project and PNSR staff instructed the health center care providers not to purchase contraceptives on their own and to then charge patients, but to use the stock provided by the project, which covers the needs of all health facilities in the Uvira health district.

The project continues to closely monitor the situation, working with USAID, and to ensure that national policies and the Tiahrt amendment are adhered to by health facilities. This guidance was reinforced during the project's mid-year workplan review. The project informed the AOR and has shared a separate report to USAID on this investigation.

IV. ENVIRONMENTAL MONITORING AND MITIGATION PLAN

The project continues to implement the Environmental Monitoring and Mitigation (EMMP) plan. However, environmental management remains a challenge for the health facilities supported by the project. During PY3Q3, the project carried out multiple visits to health facilities to support the improvement of hospital hygiene, biomedical waste management, and disposal of liquids.

The project provided support to all GRHs in Luiza to align their activities with EMMP guidelines. The project will provide EMMP-related support to other coordination offices; in Mwene Ditu, project staff provided technical and supervisory support in the health zones of Dibindi and Wikong.

During PY3Q3, 16 placenta pits, 15 incinerators, 12 Ventilated Improved Pit (VIP) latrines with separate areas for men and women were constructed with support from the project. The majority of the construction occurred in Sankuru. Mwene Ditu and Kamina did not report any improvements in environmental management during the quarter. Since the beginning of Year 3, Mwene Ditu and Kamina have progressed slowly in relation to EMMP activities. Table 70, on the following page, summarizes the EMMP activities carried out in PY3Q3.

Table 70: EMMP-related results by coordination in PY3Q3

	Luiza	Mwene Ditu	Kole	Tshumbe	Kamina	Kolwezi	Bukavu	Uvira	PY3Q3 Total
Latrines VIP	0	0	1	3	0	5	0	3	12
Hand washing stations	1	0	1	3	0	0	0	0	5
Incinerators	2	0	2	4	0	3	0	4	15
Placenta pits	0	0	2	3	0	1	7	3	16
Indoor waste disposal	0	0	0	0	0	0	0	0	0
Outdoor waste disposal	0	0	0	0	0	0	0	0	0
Hospital hygiene training	0	0	0	0	0	0	0	0	0

At the community level, the Champion Community approach led to the construction and use of latrines and the reduction of open air defecation. Behavior change communication efforts led to an increase in toilet use as well. In Sankuru, community-led construction of household latrines, using local materials, as well as an increase in access to drinkable water, supported by the project, led to improvements in sanitation and environmental management.

Next quarter, the project plans to reinforce the capacity of the health zone management teams in Kamina in the planning and implementation of BCC activities and the promotion of hospital hygiene and environmental management. The project will continue water assessment activities, as well as awareness raising activities in the community to promote rehabilitation and use of household latrines.

V. CHALLENGES ENCOUNTERED

Burn rate: As agreed upon with USAID, the project has reduced its spending rate. Some activities have been postponed to Year 4, which has had an impact on the timely implementation of priority activities, project staff motivation, and project support to MOH annual operational plans.

MEG commodities: IHP and SIAPS received a report from the CDRs in Kolwezi, Kamina, Sankuru, Mbuji Mayi, and Kananga that among the shipments of essential medicines that MEG delivered, there are three different commodities with the same manufacturing and expiration dates. This labeling does not comply with the set standards for manufacturing drugs in the same plant. There is a risk of cross-contamination between the products, and it is possible that due to the same label, box, and batch numbers, health facility workers may be confused. IHP and SIAPS instructed the CDRs to quarantine the drugs, and take samples for quality assessment testing. SIAPS also requested authorization from the MOH to send the samples out of the country for quality compliance tests. In the case that the drugs do not meet quality standards, the project will replace the medicines, and may consider placing an emergency order if the quarantine process is prolonged. In this case, SIAPS wrote a letter to the MOH/DPM and copied the health team leader at USAID to present the facts related to this issue, specifically sharing the actions that had been taken.

Stock outs of malaria commodities: This quarter, the project experienced stock outs of anti-malarial commodities, including Sulfadoxine-Pyrimethamine (SP) and quinine for severe malaria treatment. The project worked with the USAID/DRC PMI team to resolve the issues, and as the PMI order of SP and quinine is not expected to arrive until the next quarter, PMI and IHP agreed to explore the option of borrowing

commodities from projects funded by the Global Fund (GF) and World Bank. The project obtained supplies of quinine from SANRU through an official request from the MOH. However, the quinine commodities were insufficient, and only served the needs of some health zones in the Sankuru health district where there were multiple severe malaria cases and deaths during the quarter. The project considered procuring SP from ASRAMES, which already had SP in its warehouse. However, following a two-week quality assessment, requested by DELIVER, ASRAMES had already sold the SP supplies. An order of SP from DELIVER is expected to arrive next quarter.

Charges from Congolese Control Office: Despite receiving a letter from USAID requesting that pharmaceutical testing charges be dropped, the Congolese Control Office (Office Congolais de Contrôle) has not reconsidered the high fees it leverages to test the generic and essential medicines that MEG shipped to the Lubumbashi port. MSH issued a letter to the OCC on June 10, 2013, to inquire into the procedures used to sample and test the medicines, which led to the project incurring charges of \$43,000. The OCC has not yet responded to IHP.

Delays in FODESA commodity deliveries: In the Sankuru health district, the FODESA/CDR was delayed in delivering some essential medicines that it had received as a part of a larger MEG shipment in PY3Q3. FODESA was unable to manage the large shipment, and in response, SIAPS assisted FODESA with the technical aspects of delivering the medicines. The performance of FODESA is related to a number of challenges, as follows:

- Insufficient capacity of the staff recruited to work at the CDR
- The director is not full time; he works part-time as a pastor
- The space available in storage is not sufficient for the commodities stored; there is not enough space to prepare the different orders for the health zones at the same time

FODESA signed a contract with the project which outlines its responsibility to deliver and manage project commodities; IHP requested via a formal letter that FODESA review this contract as a reminder of its obligation to provide health zones with commodities when available and per the needs of the health zone. IHP and SIAPS are working with FODESA to address the deliveries requested by the health zones. The SIAPS employee in Lodja began to train and reinforce the capacity of the staff and prepared a proposal to transfer the warehouse to a more spacious building. IHP also recommended to the CDR to increase the staff to be able to respond to the needs of its clients.

Implementation of new PEPFAR strategy: The project has faced challenges in enforcing the PEPFAR decision to halt IHP support to PMTCT activities in Kasai Occidental, Kasai Oriental, and Sud Kivu. While complying with the decision and informing provincial authorities of the halt of activities, the project did not receive an official letter from PEPFAR to share with the national HIV and AIDS program provincial, district, and health zone authorities until many months after PEPFAR's decision. As a result, the project was not able to collect HIV tests from the health facilities until it received the official mandate letter. As a consequence, the project cannot guarantee that health care providers in PMTCT sites in the three provinces mentioned above halted their counseling and testing services when the project first requested that they cease these activities. Since receiving the letter, the project has successfully coordinated with the CDRs and health zones to ensure that HIV commodities from the available supplies are sent to Kolwezi and Kamina.

VI. PLANNED ACTIVITIES FOR NEXT QUARTER

As coordination offices have developed unique priority activity workplans specific to each coordination area's needs, highlights of planned activities are listed below, and a more detailed list of next quarter's activities can be found in Appendix 6.

IR1:

- ✓ Organize a briefing during a pharmaceutical systems strengthening meeting of 453 providers from 23 health zones in Bukavu on the use and appropriate management of RUMER and other pharmaceutical management tools.
- ✓ Rehabilitate 6 maternity wards in 2 health zones (3 health centers/health zone) of Kabongo and Songa in Kamina.
- ✓ Equip 59 maternity wards with MNCH kits (55 health centers and 4 GRHs) in Kole.
- ✓ Collect, analyze, and understand data on the water quality in the eight health zones of Kolwezi.

IR2:

- ✓ In Luiza, provide a two-day briefing to the head nurses on various MNCH components (use of partogram, eclampsia management, AMTSL, newborn health care, HBB, etc.) through supportive supervision.
- ✓ In Mwene Ditu, scale up the Helping Babies Breathe (HBB) methodology in all 16 of the health facilities in 4 of the health zones supported by the coordination office (Bibanga, Mwene Ditu, Dibindi, and Luputa).
- ✓ Broadcast outreach messages on vaccination, ANC, PSC, assisted deliveries, PMTCT, and other health topics in Tshumbe.
- ✓ Organize an awareness campaign for the communities on fistula repair in Uvira.

IR3:

- ✓ In Bukavu, conduct a follow-up visit of the CPCC training in health zones trained as Champion Communities (Walungu and Katana).
- ✓ Provide fees for phone credits to send 2,500 health messages via SMS during mini-campaigns (WASH, MNCH, EPI, and FP) in Kamina.
- ✓ In Kole, accompany the health zone management teams (community agent, supervisor, and the health zone medical director) in the planning and implementation of BCC activities and the promotion of hospital hygiene and environmental management.
- ✓ In Kolwezi, arrange with the health district and the health zone management teams the evaluation of the biannual action plan for 6 selected Champion Communities (in Kanzenze and Dilala) in the Kolwezi coordination (3 Champion Communities per health zone).

IR4:

- ✓ Provide funding for monthly supervision visits for the head nurses to the community care sites in Uvira.
- ✓ Provide technical and financial support for the monthly monitoring review (120 meetings) of the 10 health zones supported by the Tshumbe coordination office.
- ✓ Organize 660 monthly regular monitoring meetings in 55 health areas (55 health areas during 12 months) to review health center activities in Kole.
- ✓ In Bukavu, provide 23 health zones with modems and data credit for data collection.

VII. LIST OF APPENDICES

- Appendix 1: DRC-IHP Performance Monitoring Plan
- Appendix 2: Open Air Defecation Free certificate
- Appendix 3: Results from water analysis conducted in Tshumbe
- Appendix 4: PY3Q3 Distribution Plan for family planning commodities*
- Appendix 5: Closed User Group Evaluation Report executive summary
- Appendix 6: DRC-IHP Field Offices' Workplan (July-September 2013)
- Appendix 7: DRC-IHP International Travel/STTA Plan*
- Appendix 8: DRC-IHP: Organization Chart
- Appendix 9: DRC-IHP SF425 April to June 2013
- Appendix 10: DRC-IHP Accruals Report April to June 2013

*Appendices 4 and 7 are attached separately as Excel files.

VIII. SUCCESS STORIES

The DRC-IHP Success Stories appear on the following pages.



SUCCESS STORY

Increasing Child Survival with the “Helping Babies Breathe” Technique

With more than 4,000 babies born in the health zone of Lomela each year, quality delivery services are essential.



Photo: Management Sciences for Health

Maternity nurses reviewing some of the materials used in the Helping Babies Breathe approach.

“I now volunteer my time to educate other women about the importance of regular health care and giving birth in a hospital.”

***- Basele Koso,
whose infant was saved
thanks to the Helping Babies
Breathe approach***

The health zone of Lomela, in the Sankuru district of Kasai Oriental province in the Democratic Republic of Congo, is home to more than 21,000 women of childbearing age, and around 4,000 babies are born annually here. Health workers in the maternity ward of Lomela General Hospital have been struggling to address the care of infants born with respiratory problems for many years.

Last year, the USAID-funded DRC-Integrated Health Project (IHP) provided assistance to Lomela as part of its efforts to improve maternal, newborn, and child care. With DRC-IHP’s support, Madame Bernadette, head of maternity at the Lomela hospital, was one of 44 health care providers trained in the “Helping Babies Breathe” approach, an evidence-based neonatal resuscitation approach designed for resource-limited areas. It trains health workers to effectively treat newborns suffering from respiratory distress.

Bernadette trained four colleagues in the technique. She also sensitized them to the risks of traditional practices that were sometimes used in neonatal care, including the use of alcohol to resuscitate babies. After three months of using the Helping Babies Breathe technique, four infants who experienced critical respiratory problems at delivery had been saved.

Basele Koso is the mother of one of those infants. She said, “I gave birth after receiving regular prenatal care in Lomela, and my child, who almost died, was saved. I now volunteer my time to educate other women about the importance of regular health care during pregnancy and giving birth in a hospital.”

Investing in the Helping Babies Breathe training is one example of how USAID is supporting the DRC’s national commitment to child survival, known as “A Promised Renewed.” This is a government-led call to action to reduce under-five mortality by 48% and maternal mortality by 31% between 2012 and 2035, which will save the lives of 430,000 children and 7,900 mothers.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.



SUCCESS STORY

Helping Babies Breathe at the Luiza General Reference Hospital

Babies born with respiratory problems were dying at the hospital, until staff were trained in a life-saving approach.



Photo: Management Sciences for Health

Baby girl Mujinga Manga, born at the Luiza General Reference Hospital, was saved thanks to the “Helping Babies Breathe” technique.

“The Helping Babies Breathe technique significantly reduced neonatal mortality.”

**- Judith Kambuyi,
head of maternity services,
Luiza General Reference
Hospital**

Neonatal mortality is about 97 deaths for every 1,000 live births in the Democratic Republic of Congo (DRC), and the issue is widespread across the country. In the health zone of Luiza in Kasaï Occidental province, the General Reference Hospital has struggled with a high infant mortality rate, and babies born in respiratory distress were as likely to die as to live. In one eight-month period in 2012, six of the 14 infants born with respiratory problems died.

That situation began to change last year, thanks to the USAID-funded DRC-Integrated Health Project (IHP). DRC-IHP supports the Congolese Ministry of Health’s National Health Plan, and among other priorities is working to improve maternal, newborn and child care in targeted areas including Luiza.

In August 2012, DRC-IHP helped to support 12 days of training in the “Helping Babies Breathe” method in the DRC. Helping Babies Breathe is an evidence-based neonatal resuscitation approach designed for resource-limited areas. It teaches health workers how to handle newborns’ breathing in their first minute of life, a critical period known as the “Golden Minute.” The medical director of the Luiza General Reference Hospital took part in that training, and then returned to the hospital and trained his colleagues in the technique.

“The Helping Babies Breathe technique significantly reduced neonatal mortality,” says Judith Kambuyi, the Luiza General Reference Hospital’s head of maternity services, who was trained by the medical director. In the six months following the training, from September 2012 to March 2013, 19 of the 20 babies born with respiratory problems were saved using the Helping Babies Breathe approach.

Investing in the Helping Babies Breathe training is one example of how USAID is supporting the DRC’s national commitment to child survival, known as “A Promised Renewed.” This is a government-led call to action to reduce under-five mortality by 48% and maternal mortality by 31% between 2012 and 2035, which will save the lives of 430,000 children and 7,900 mothers.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.



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SUCCESS STORY

Providing Better Care for Children through “Community Care Sites”

Since children under age 5 are more vulnerable to diarrheal and other diseases, access to timely care for them is a critical need in DRC



Photo: Management Sciences for Health

A community health worker administers a rapid malaria test to a young girl.

“I can now recognize danger signs in children under age five who are suffering from diarrhea, malaria and pneumonia, thanks to IHP.”

***- Community Health Worker
Mattheus Damamba***

The Lubondaie health zone, located in the Democratic Republic of Congo’s Kasai Occidental province, has a widely dispersed population of 144,495. For families living far from a health center, receiving timely, high quality care was nearly impossible, a situation particularly grave for children under age five, who are vulnerable to diarrheal diseases, malaria, and pneumonia. Lubondaie desperately needed to make health services more accessible for its children.

The USAID-funded DRC-Integrated Health Project is working with the DRC’s Ministry of Health to facilitate the development and revitalization of small facilities called “community care sites” specifically designed to ensure the treatment of young children in areas where long travel times to get to health facilities are severely endangering child health. The goal is to place these sites so that all children can get to a community care site within one hour.

Lubondaie now has a community care site, which was established with DRC-IHP support and local residents’ contributions of labor and materials. With the site in place, DRC-IHP facilitated a training in August 2012 in community management of diarrhea, pneumonia, malaria, and detection of malnutrition. Twenty nurses and 24 community health workers were trained in Lubondaie.

In the four months following the training, health care providers treated 301 cases of pneumonia, 144 cases of diarrhea and 1,086 cases of malaria in children under age 5 at the new site; these represent 29% of all cases of these illnesses in children under 5 treated in Lubondaie for that period. That nearly a third of all cases were treated in the new site demonstrates the ability of these sites to provide basic, yet essential, health services to people without access to larger facilities.

Community health worker Mattheus Damamba was pleased with the training, noting, “I can now recognize danger signs in children under age five who are suffering from diarrhea, malaria, and pneumonia, thanks to IHP. I have treated many children with pneumonia.”

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.



SUCCESS STORY

Reducing the Number of Low Birth Weight Babies in Ihimbi

Due to their mother’s poor nutrition, 10 percent of babies born in Ihimbi were born at low birth weights.



Photo: Management Sciences for Health

Thanks to improved nutrition, Nzigire gave birth to a healthy baby.

“I am very happy because I gave birth to a child who weighed 2.9 kilograms.”

***- Nzigire,
young mother who benefitted from the essential nutrition program implemented by DRC-IHP***

Nzigire is a young mother in the village of Ihimbi in the Katana health zone in Sud Kivu province. Her first two children were “low birth weight” babies, both born weighing less than 2.5 kilograms (about 5 pounds). Infants this size have a greater risk for complications including respiratory problems and impaired vision. Approximately one in every 10 babies born in Ihimbi is born at a low birth weight, a problem exacerbated in this case by the mothers’ poor nutrition.

In July 2012, the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) began a program in Katana to build awareness of essential nutrition for those most vulnerable, including mothers and children. DRC-IHP supported training for 20 health care providers and community health workers in proper nutrition. When Nzigire found she was expecting her third child, she also found a new kind of support at the local clinic: For the first time, maternity nurses there were counseling pregnant women on their special nutritional needs, recommending consumption of a wide variety of foods and the use iodized salt on their meals.

Nzigire also benefitted from home visits organized by trained community volunteers and participation in a locally-led support group focusing on infant and young children nutrition. Thanks to all these efforts, she gave birth to a healthy baby.

“I am very happy because I gave birth to a child who weighed 2.9 kilograms,” said Nzigire, “thanks to the advice that I received from the nurses and support group. I encourage them to continue to support pregnant women and I thank DRC-IHP.”

In the first seven months following the essential nutrition training, there were 107 babies born in Ihimbi, and only two of the new arrivals weighed less than 2.5 kilograms.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces, including access to, and quality of, maternal and child health care services.



SUCCESS STORY

Improving Sanitation and Hygiene in the village of Mongosenge

With a training on community-led hygiene, the residents of Mongosenge have banded together to clean up their village



Photo: Management Sciences for Health

The woman shown here is a member of Kole's water, hygiene and sanitation committee. She has been instrumental in initiating community-led hygiene in Mongosenge.

"My family and I have overcome diarrhea with the proper use of latrines."

***- Parine Esthindo
Mongosenge resident***

The village of Mongosenge in the Kole health zone has been having diarrheal outbreaks for years, and in January 2013 alone, 193 cases of diarrhea were reported. This number represented 15% of the village's entire population of 1,227, and the health zone team determined it was time to rid the village of this persistent problem.

Kole's health team realized that village residents were not following basic good hygiene practices, and also noted that there were only 86 latrines in the village. Most people were, in fact, defecating in the open air—even those who had access to latrines. The health team worked with the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) to organize a training for 18 people in community-led hygiene. This training is part of the DRC-IHP's overall strategy to support the Congolese Ministry of Health in its national plan to improve sanitation and hygiene.

The newly-trained volunteers blanketed the village with a communication campaign that targeted homes, churches and schools. They shared good hygiene practices and discussed the consequences of open air defecation. As a result, the community members mobilized resources to build new latrines and develop clean water points; they also committed to ending open air defecation and developing other good personal hygiene practices, such as frequent hand washing.

As a result of these efforts, families who already had latrines are now using them regularly, and the total number of latrines has increased from 86 to 179, improving the sanitation conditions for 630 people. There are also 179 new water points for hand washing in the village. There have been no recorded cases of diarrhea in Mongosenge since the hygiene and sanitation campaign was completed.

"My family and I have overcome diarrhea with the proper use of latrines, hand washing at critical times, such as before eating and after using the toilet, and drinking water from safe sources," said Mongosenge resident Parine Esthindo.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.

SUCCESS STORY

New Latrines Improve Hospital Hygiene in Tshamala

A community education campaign led by the health team brings four new latrines to a hospital in great need.



Photo: Management Sciences for Health

A health worker leaves one of the newly constructed latrines at the Tshamala General Reference Hospital.

“DRC-IHP is a great partner of the Tshamala General Reference Hospital.”

***- Medical Director
Dr. Joddy Ngimbi***

The Tshamala General Reference Hospital is located in the health area of Mwene Ditu in the Democratic Republic of Congo (DRC) and serves a population of more than 392,000. It has 80 beds but only three latrines, an inadequate number that results in many patients and the families that visit them defecating in the open air on the hospital grounds. The problem was particularly acute in the hospital's gynecology ward, which had no latrines nearby at all.

With the support of USAID's DRC-Integrated Health Project (DRC-IHP), which is collaborating with the Congolese Ministry of Health to increase hospitals' access to safe drinking water and improve sanitation and hygiene, the Tshamala General Reference Hospital was able to address this serious health issue earlier this year.

Medical Director Joddy Ngimbi led a community awareness campaign that focused on the importance of proper hygiene and sanitation. He and his health team asked local residents to participate in the construction of four new latrines and six water points at the hospital. Community members donated their time, labor and resources, including sand and gravel, to make all the bricks needed for the project. DRC-IHP provided metal sheeting, cement, PVC pipes, and skilled masons, carpenters and painters.

Hospital patients are much more comfortable these days, and up to 150 people per day – inpatients and outpatients – are benefiting from clean drinking water and easier access to sanitation. Frequent hand washing is now being observed at the water points.

"DRC-IHP is a great partner of the Tshamala General Referral Hospital," said Dr. Ngimbi. "It brings a lot of support in terms of medicines, capacity building, and the rehabilitation of our buildings to improve the quality of care for our people. These new latrines are an important contribution, because they help the hospital meet the standards of being a sustainable health infrastructure and we could not have afforded them without IHP."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.



SUCCESS STORY

Community Mobilizes to Fund Health Services Projects in Luiza

Community members in Luiza raised 194,400 CDF to contribute to local water source improvement and continued raising funds for future projects through the sale of latrine hole covers.



“We are very pleased with the Champion Community’s contributions to the improved water sources, as they will bring the community good health and wealth.”

- Member of the water management committee in Luiza

In the Democratic Republic of Congo (DRC), communities are often dependent on external funding to cover the costs of much-needed health services. Grassroots efforts are hampered by low levels of health knowledge, lack of local leadership, and low levels of community participation. To encourage community engagement, the USAID-funded DRC-Integrated Health Project (DRC-IHP) introduced the Champion Community initiative.

To participate, a community must decide on health goals that can be achieved within six to twelve months, accomplish these goals, and then they are certified by local authorities as a Champion Community. A certification festival is held for the community, and DRC-IHP provides funding for the community to design, develop, and implement community-led activities that raise money to be used for health services projects. In Luiza, members of a Champion Community raised money themselves to contribute to the improvement of three water sources that would increase access to potable water.

As part of their efforts to be certified, members of the “Tudisange” Champion Community raised 194,400 CDF (approximately \$215) between March and May 2013 to contribute to the improvement of local water sources. Money was raised through collections in local churches, as well as through door-to-door solicitations by teams of health workers and community mobilizers. These funds were used to purchase cement and PVC pipes. Community members also volunteered their labor and a motorcycle to move materials to the water sources.

The three improved water sources led to increased access to potable water, which led to a decrease in diarrhea in children under the age of five. In April 2013, the number of cases treated at three local health centers was 102. In June 2013, this number was fewer than 10.

Additionally, the community formed a water management committee and established a nominal fee of 50 CDF (approximately \$0.05) for every 20 liters of water. Between mid-May and mid-June 2013, the committee collected 70,100 CDF (roughly \$77) across all three water sources. This money was used to fund the building of wooden latrine hole covers, which were sold for a reduced price of 903 CDF (roughly \$1).

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones in four provinces.

APPENDIX 1: DRC-IHP Performance Monitoring Plan PY3Q3

Indicator	Definition	Apr-13	May-13	Jun-13	PY3Q# Total	PY3Q3 Target	PY3Q3 Achievement (%)	
USAID/DRC/IHP Objective: Increase use of high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, NTDs, TB, HIV&AIDS, and WASH in target health zones								
1	FP: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	43,488	39,560	41,667	124,714	110,000	113
1.1	FP: Couple years of protection (CYP) after exclusion of LAM and self-observation methods (NFP) for FP in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	16,470	15,144	16,687	48,300	40,000	121
2	FP: Number of new acceptors for any modern contraceptive method in USG-supported family planning (FP) service delivery points	Number of new FP acceptors of a modern method will be calculated based upon records from USG-supported FP clinics in the IHP target areas	46,166	44,325	47,184	137,675	120,728	114
3	FP: Number of counseling visits for FP/RH as result of USG support	Number of FP/RH counseling visits at USG-supported service delivery points	48,076	48,074	52,099	148,249	65,000	228
4	FP: Number of USG-supported delivery points providing family planning (FP) counseling or services	Number of USG-supported service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service	1,818	1,813	1,815	1,815	1,950	93
	Disaggregated by type of service delivery:	(a) Health facility based	1,452	1,452	1,449	1,451	1,600	91
		(b) Community-level based	366	361	366	364	350	104
5	FP: Number of USG-assisted health facilities experiencing stock-outs of Depo-Provera	Maximum number of USG-supported health facilities experiencing stock-outs of Depo-Provera	25	15	15	18	160	

6	MNCH: Percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	43,608	43,779	39,969	127,356	121,949	104
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	42,959	42,959	42,959	128,878		
		Numerator/ Denominator (in percentage)	102%	102%	93%	99%	93%	106
7	MNCH: Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	17,252	17,647	16,876	51,775	70,809	73
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	42,959	42,959	42,959	128,878		
		Numerator/Denominator (in percentage)	40.2%	41%	39%	40%	54%	74
8	MNCH: Percent of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Numerator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	36,453	37,406	35,727	109,586	104,902	104
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	42,959	42,959	42,959	128,878		
		Numerator/ Denominator (in percentage)	85%	87%	83%	85%	80%	106
9	MNCH: Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG supported programs	Numerator: Number of women giving birth who received AMSTL through USG-supported programs in IHP target area	34,166	34,731	32,963	101,860	94,105	108
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	36,453	37,406	35,727	109,586		
		Numerator/ Denominator (in percentage)	94%	93%	92%	93%	90%	103

10	MNCH: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs	Number of postpartum/newborn visits within 3 days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery) (4% Tot Pop)	33,964	35,168	34,174	103,306	131,127	79
11	MNCH: Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area	33,890	34,217	33,486	101,593	98,837	103
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	42,959	42,959	42,959	128,878		
		Numerator/ Denominator (in percentage)	79%	80%	78%	79%	100%	79
12	MNCH: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/IHP target area (4% of Total Population *6% Infection rate-MICS 2010)	2,746	2,197	1,901	6,844	7,868	87
13	MNCH: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	Number of children under five years old with pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs/IHP target area (20% Tot Pop*6% infection rate-MICS 2010)	39,558	45,654	37,512	122,724	139,134	88
14	MNCH: Number of cases of child diarrhea treated in USG-supported programs	Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) or ORT plus zinc supplements in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	20,848	24,031	23,616	68,495	185,514	37

15	MNCH: Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs =	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	39,216	38,097	35,463	112,776	102,000	111
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	37,482	37,482	37,482	112,446		
		Numerator/ Denominator (in percentage)	105%	102%	95%	100%	89%	113
16	MNCH: Drop-out rate in DPT-HepB-Hib3 among children less than 12 months of age	Numerator: Number of children less than 12 months who did not complete the full regimen of DPT-HepB-Hib1-3 vaccination	1,831	1,803	1,951	5,585	5,100	110
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	41,047	39,900	37,414	118,361		
		Numerator/ Denominator (in percentage)	4%	5%	5%	5%	5%	
17	MNCH: Percent of children less than 12 months of age who received measles vaccine from USG-supported programs	Numerator: Number of children less than 12 months of age who received measles vaccine from USG-supported programs/IHP target area	37,084	35,141	33,579	105,804	102,000	104
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	37,482	37,482	37,482	112,446		
		Numerator/ Denominator (in percentage)	99%	94%	90%	94%	89%	106
18	MNCH: Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	166	59	31	256	160	
19	NUTRITION: Number of children under 5 years of age who received vitamin A	Number of children under 5 years of age who received vitamin A from USG-supported programs/IHP target area	0	0	0	0	562,500	0

20	NUTRITION: Proportion of pregnant women who received iron-folate to prevent anemia	Numerator: Number of pregnant women who have received iron-folate tablets to prevent anemia during the last five months of pregnancy	36,175	37,864	34,075	108,114	96,469	112
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	42,959	42,959	42,959	128,878		
		Numerator/ Denominator (in percentage)	84%	88%	79%	84%	74%	113
21	NUTRITION: Number of mothers of children 2 years of age or less who have received nutritional counseling for their children	Number of mothers of children 2 years of age or less who have received nutritional education within group support (8% of Total Population X 15% Malnutrition Prevalence Rate)	36,029	42,964	40,651	119,644	37,080	323
22	NUTRITION: Number of breastfeeding mothers receiving vitamin A	Number of breastfeeding mothers attending post natal visits during the 8 weeks following delivery who received vitamin A	11,242	11,967	15,292	38,501	131,127	29
23	NUTRITION: Number of USG-supported health facilities experiencing stock-outs of iron-folate	Number of USG-supported health facilities that experienced stock-outs of iron-folate tablets	382	280	175	279	160	
24	TB: Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year (150 cases for 100,000 people)	789	909	1,283	2,981	6,491	46
		Denominator: Total population in the specified geographical area	1,073,983	1,073,983	1,073,983	3,221,952		
		Numerator/ Denominator (per 100,000 population)	73	85	119	93	198	47
25	TB: Percent of all registered TB patients who are tested for HIV through USG-supported programs	Numerator: Number of TB patients who are tested for HIV	427	468	789	1,684	3,765	45
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	789	909	1,283	2,981		
		Numerator/ Denominator (in percentage)	54	51	61	56	58%	97

26	TB: Case detection rate	Numerator: Number of new smear positive TB cases detected	789	909	1,283	2,981	3,442	87
		Denominator: Estimated number of TB cases expected	1,611	1,611	1,611	4,833		
		Numerator/ Denominator (in percentage)	49%	56%	80%	62%	70%	88
27	TB: Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	0	0	0	0	10	0
28	TB: Number of USG-assisted service delivery points experiencing stock-outs of RH (rifampicin, isoniziad) combination	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of TB drugs at any time during the defined reporting period	12	10	9	10	5	
29	HIV/PMCT: Number of pregnant women seen for ANC in facilities that offer PMTCT	Number of pregnant women seen for ANC in facilities that offer prevention of mother-to-child transmission services	2,668	2,766	3,125	8,559	4,594	186
30	*HIV/PMCT: Number of pregnant women receiving HIV counseling	Number of pregnant women who received counseling services for HIV (advice to prevent mother -to-child transmission)	1,939	2,443	2,543	6,925	4,594	151
31	*HIV/PMCT: Number of pregnant women receiving HIV counseling and testing	Number of pregnant women who received counseling and testing services for HIV	1,732	2,028	1,702	5,462	3,675	149
32	*HIV/PMCT: Number of pregnant women with known HIV status	Number of pregnant women who were counseled and tested for HIV and know their results (Number of pregnant women with known HIV status) (includes women who were tested for HIV and received their results; Number of known positives at entry; Number of new positives identified)	1,693	1,850	1,552	5,095	3,675	139
33	*HIV/PMCT: Number of pregnant women who tested positive for HIV	Number of pregnant women who tested HIV positive	14	9	18	41	74	56

34	*HIV/PMCT: Number of pregnant women with known HIV status	The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period	0	5	0	5	74	7
35	*HIV/PMTCT: Number of health facilities providing ANC services that provide both HIV testing and ART for PMTCT on site	The number of health facilities in IHP target areas where antenatal services, HIV counseling and testing, and ARV to prevent mother-to-child transmission of HIV are provided in the same site	46	46	46	46	13	350
36	*HIV/PMTCT: Number of HIV-positive pregnant women who received antiretroviral treatment (ART) to reduce risk of mother-to-child transmission	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission during the reporting period disaggregated by regimen type	7	6	6	19	51	37
36.1	*HIV/PMTCT: Number of HIV-positive pregnant women who received Combination Therapy to reduce risk of mother-to-child transmission	Number of HIV-positive pregnant women who received Combination Therapy to reduce the risk of mother-to-child transmission during the reporting period	2	5	9	16	36	44
37	HIV/PMTCT: Number of newborns who received ARVs to reduce risk of mother-to-child transmission	Number of newborns whose mothers are HIV-positive and who received antiretroviral prophylaxis at birth	8	15	12	35	87	40
38	*HIV/PMTCT: Number of partners/husbands of pregnant women who receive HIV counseling and testing and received their results	Number of husbands/partners of pregnant women who received HIV counseling and testing in health centers and hospitals and know their results within the IHP target area	173	102	179	454	368	124
39	*HIV/PMTCT: Number of HIV+ pregnant women receiving Cotrimoxazole (CTX) prophylaxis	Number of HIV-positive pregnant women who received Cotrimoxazole prophylaxis, disaggregated by age (<15, 15+)	3	2	4	9	87	10

40	*HIV/PMTCT: Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	Numerator: Number of infants born to HIV-infected women that are started on Cotrimoxazole prophylaxis within two months of birth at USG supported sites within the reporting period	1	0	1	2	53	4
		Denominator: Number of HIV- positive pregnant women identified in the reporting	2	8	9	19	74	
		Numerator/ Denominator (in percentage)	50%	0%	11%	11%	59%	18
41	*HIV/PMTCT: Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	Numerator: Number of infants born to HIV-infected women who received HIV test within 12 months of birth.	0	0	0	0	5	0
		Denominator: Number of HIV- positive pregnant women identified in the reporting period (including known HIV- positive at entry)	2	8	9	19	74	
		Numerator/ Denominator (in percentage)	0%	0%	0%	0%	2%	0
42	*HIV/PMTCT: Number of HIV-positive pregnant women assessed for ART eligibility	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing in USG-supported sites	12	6	4	22	3	855
43	*HIV/PMTCT: Number of USG-supported service delivery points experiencing stock-outs of Nevirapine	Number of USG-supported service delivery points (SDPs) experiencing stock-outs of Nevirapine at any time during the defined reporting period	4	5	4	4	2	36
44	*HIV/PMTCT: Number of USG-supported service delivery points experiencing stock-outs of AZT	Number of USG-supported service delivery points (SDPs) experiencing stock-outs of AZT at any time during the defined reporting period	4	5	4	4	6	145
45	*HIV/PMTCT: Number of individuals who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of individuals who received T&C services for HIV and received their test results during the reporting period	2,330	2,364	2,327	7,021	4,780	147

45.1	*HIV/PMTCT: Number of males who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of males who received T&C services for HIV and received their test results during the reporting period	316	211	336	863	663	130
45.2	*HIV/PMTCT: Number of females who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of females who received T&C services for HIV and received their test results during the reporting period	2,014	2,153	1,991	6,158	4,118	150
45.3	*HIV/PMTCT: Number of individuals <15 who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of individuals <15 who received T&C services for HIV and received their test results during the reporting period	6	6	4	16	3	610
45.4	*HIV/PMTCT: Number of individuals 15+ who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of individuals 15+ who received T&C services for HIV and received their test results during the reporting period	2,324	2,358	2,323	7,005	4,778	147
45.5	*HIV/PMTCT: Number of HIV (+) individuals who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of HIV(+) individuals who received T&C services for HIV and received their test results during the reporting period	86	63	85	234	96	245
45.6	*HIV/PMTCT: Number of HIV (-) individuals <15 who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of HIV(-) individuals <15 who received T&C services for HIV and received their test results during the reporting period	6	6	4	16	4,682	0
45.7	*HIV/PMTCT: Number of couples who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of couples who received T&C services for HIV and received their test results during the reporting period	173	102	179	454	478	95

45.8	*HIV/PMTCT: Number of single individuals who received testing and counseling (T&C) services for HIV and received their test results (P11.1 D PEPFAR)	Number of single individuals who received T&C services for HIV and received their test results during the reporting period	264	589	35	888	3,822	23
Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)								
IR 1.1: Facility-based health care services and products (provincial hospitals and district health centers) in target health zones increased								
46	***L+M+G: % of general reference hospitals GRHs implementing complementary package of activities CPA	Numerator: # of GRHs implementing CPA	67	67	67	67	48	140
		Denominator: Total # of GRHs	80	80	80	80		
		Numerator/ Denominator (in percentage)	84%	84%	84%	84%	60%	140
47	***L+M+G: % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	22	22	22	22	16	106
		Denominator: Total # of GRHs	80	80	80	80		
		Numerator/ Denominator (in percentage)	28%	28%	28%	28%	20%	106
48	***L+M+G: % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	1,217	1,221	1,221	1,221	905	135
		Denominator: Total # of health centers	1,509	1,509	1,509	1,509		
		Numerator/ Denominator (in percentage)	81%	81%	81%	81%	60%	144
49	***L+M+G: % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	114	137	137	137	302	30
		Denominator: Total # of health centers	1,509	1,509	1,509	1,509		
		Numerator/ Denominator (in percentage)	8%	9%	9%	9%	20%	32
50	MALARIA: Percent of pregnant women who received at least two doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Number of pregnant women who received at least two doses of SP for IPT during ANC visits/	28,761	27,529	25,302	81,592	104,902	78
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	42,959	42,959	42,959	128,878		
		Numerator/ Denominator (in percentage)	67%	64%	59%	63%	80%	79

51	MALARIA: Number of USG-supported service delivery points experiencing stock-outs of ACT for 1-5 year olds	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of ACT for 1 – 5 years at any time during the defined reporting period	169	257	136	188	160	
52	MALARIA: Number of insecticide treated nets (ITNs) purchased by other partners that were distributed with USG funds	Number of ITNs purchased by other partners that were distributed with USG funds	5,112	23,035	2,419	30,566	TBD	
53	MALARIA: Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	12,205	1,693	675	14,573	TBD	
54	MALARIA: Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	21,485	16,228	11,701	49,414	TBD	
54.1		<i>(a) through campaigns</i>	0	0	0	0	TBD	
54.2		<i>(b) through health facilities</i>	21,485	16,228	11,701	49,414	TBD	
54.3		<i>(c) through the private/commercial sector</i>	0	0	0	0	TBD	
54.4		<i>(d) through other distribution channels</i>	0	0	0	0	TBD	
54.5		<i>(e) through voucher schemes</i>	0	0	0	0	TBD	
55	MALARIA: Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female)	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	0	0	55	55	TBD	
		<i>Male</i>	0	0	55	55	TBD	
		<i>Female</i>	0	0	0	0	TBD	
56	MALARIA: Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	136,922	119,449	40,984	297,355	TBD	
57	MALARIA: Number of ACT treatments purchased by other partners that were distributed with USG funds	Total number of ACT treatments available for distribution using USG funds	5,172	1,916	2,616	9,704	TBD	
58	MALARIA: Number of SP tablets purchased with USG funds that were distributed to health facilities	Number of SP tablets purchased with USG funds that were distributed to health facilities (hospitals, health centers, health posts/stations, clinics)	114,081	75,206	47,758	237,045	TBD	

59	MALARIA: Number of health workers trained in case management with ACTs with USG funds	Number of health workers (doctor, nurse, nurse's assistant, clinical officer or community/village health worker) trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	0	0	55	55	TBD	
60	MALARIA: Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	101,162	83,449	59,145	243,756	TBD	
61	MALARIA: Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	48,349	40,523	26,209	115,081	TBD	
61.1	Disaggregated in 3 sub-categories:	<i>(a) to health facilities</i>	47,216	39,268	23,943	110,427	TBD	
61.2		<i>(b) to community health workers (HBMF, CCM)</i>	1,133	1,255	2,266	4,654	TBD	
61.3		<i>(c) to the private/commercial sector</i>	0	0	0	0	TBD	
62	MALARIA: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds. Disaggregated in 3 sub-categories:	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	0	0	128	128	TBD	
	<i>(a) Number of health facility workers trained (male/female)</i>	<i>Male</i>	0	0	55	55	TBD	
		<i>Female</i>	0	0	0	0	TBD	
	<i>(b) Number of community members trained. Disaggregated by sex</i>	<i>Male</i>	0	0	70	70	TBD	
		<i>Female</i>	0	0	3	3	TBD	
	<i>(c) Number of lab technicians trained. Disaggregated by sex</i>	<i>Male</i>	0	0	0	0	TBD	
		<i>Female</i>	0	0	0	0	TBD	
63	MALARIA: Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	67,531	45,950	90,117	203,598	TBD	

64	MALARIA: Number of RDTs purchased with USG funds that were distributed to health facilities	Number of RDTs purchased with USG funds that were distributed to health facilities	72,707	142,613	77,756	293,076	TBD	
65	**NTDs: Number of Neglected Tropical Disease (NTD) Treatments delivered through USG-funded programs	Number of cures of any NTD (helminthes-whipworm, hookworm and roundworm) specific drug administered to an eligible person in a defined geographic area. Each drug dose is counted as a single treatment such that an individual may receive multiple treatments if treated for multiple diseases and with multiple drugs	823	1,055	1,234	3,112	170,728	2
IR 1.2: Community-based health care services and products in target health zones increased								
66	***L+M+G: % of communities with CODESAs actively involved in management of priority health services	Numerator: # of communities with CODESAs with active involvement in management of priority health services for their communities/	1,230	1,230	1,230	1,230	1,434	86
		Denominator: Total # of communities in IHP target area	1,415	1,415	1,415	1,415		
		Numerator/Denominator (in percentage)	87%	87%	87%	87%	95%	
67	WASH: Number of people in target areas with first-time access to improved drinking water supply as a result of USG support	# of people in target areas with first-time access to improved drinking water supply (Improved drinking water technologies are those more likely to provide safe drinking water)	15,243	26,082	32,032	73,357	83,950	91

68	WASH: Number of people in target areas with first-time access to improved sanitation facilities as a result of USG support	# of people in target areas with first-time access to improved sanitation facilities. (Improved sanitation facilities include those more likely to ensure privacy and hygienic use, e.g., connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine)	20,884	27,338	49,664	97,886	83,663	117
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased								
69	***L+M+G: % of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	Leadership Development Program (LDP) team made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas. Numerator: Number of HZ with leadership that has undergone LDP training	29	3	8	40	18	251
		Denominator: Total number of IHP health zones	80	80	80	80		
		Numerator/ Denominator (in percentage)	21%	21%	13%	50%	88%	63
IR 2: Quality of key family health care services in target health zones increased (Component 1)								
IR 2.1: Clinical and management capacity of health care providers increased								
70	***L+M+G: Percent of health zones (HZs) with validated action plans	Numerator: # HZ with validated actions plans	71	71	76	76	80	95
		Denominator: Total # HZs in IHP target area	80	80	80	80		
		Numerator/ Denominator (in percentage)	89%	89%	95%	95%	100%	95

70.1	***L+M+G: Percent of health centers with accurate and up-to-date inventory records	Numerator: Number of health centers with up-to-date and accurate record of inventory of essential drugs and supplies ("accurate" means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	736	721	708	722	1,207	60
		Denominator: Total number of health centers in IHP areas	1,415	1,415	1,415	1,415		
		Numerator/ Denominator (in percentage)	52%	51%	50%	51%	80%	64
70.2	***L+M+G: Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies (Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	63	50	56	56	64	88
		Denominator: Total number of hospitals in IHP areas	80	80	80	80		
		Numerator/ Denominator (in percentage)	79%	63%	70%	70%	80%	88
71	GENDER: # of health workers clinically trained in case management of sexual violence	# of health workers at HCs and GRHs who successfully completed clinical training sessions on sexual violence case management in IHP target health zones	190	0	0	190	125	152
72	GENDER: Number of people reached by a USG-supported intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Number of people reached by a USG-supported intervention providing GBV health services	752	728	365	1,845	2,080	89

73	GENDER: # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	1	0	13	14	4	350
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted								
74	*** L+M+G: % of health centers meeting all nine FOSACOF minimum standards, disaggregated by type of health facility (Please create another row for hospitals with same indicator)	Numerator: # of health centers meeting all nine FOSACOF minimum standards	485	485	485	485	521	93
		Denominator: Total # of facilities	1,415	1,415	1,415	1,415		
		Numerator/ Denominator (in percentage)	34%	34%	34%	34%	69%	50
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized								
75	% of patients referred to HCs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to health centers by a CHW	1,011	634	721	2,366	9,468	25
		Denominator: Total # of patients seen by a CHW	3,814	4,263	10,581	18,658		
		Numerator/ Denominator (in percentage)	27%	15%	7%	13%	NA	
76	% of patients referred to GRHs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to GRHs by a CHW or health care provider	13,941	15,205	14,673	43,819	10,538	416
		Denominator: Total number of patients seen by a CHW or health care provider	410,767	448,944	409,531	1,269,242		
		Numerator/ Denominator (in percentage)	3.4%	3.4%	3.6%	3.5%	1.3%	266
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased (Component 1)								
IR 3.1: Evidence-based health sector-community outreach linkages –especially for women, youth and vulnerable populations– established								
77	*** L+M+G: % of NGOs representing women, youth and vulnerable groups participating in coordination meetings	Numerator: # of NGOs representing women, youth, and vulnerable groups attending NGO coordination meetings	119	119	119	119	TBD	

		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	147	147	147	147		
		Numerator/ Denominator (in percentage)	81%	81%	81%	81%	1000%	8
78	***L+M+G: # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	11	6	15	32	4	753
79	***L+M+G: # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	28	6	9	43	243	18
80	***L+M+G: # youth organizations participating in youth education outreach strategy	# youth organizations conducting member outreach and health education as part of IHP youth health education strategy	85	58	118	119	4	2047
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched								
81	BCC: # of CODESAs supported by IHP and which have a "Communications action plan"	# of CODESAs supported by IHP within the IHP target area and which have a "Communications action plan" developed	437	462	530	476	243	196
82	BCC: # of educational SMS messages during BCC campaigns or mini campaigns on malaria, nutrition and/or family planning	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	16,541	29,398	20,485	66,424	250,000	27
IR 4: Health sector leadership and governance in target provinces improved (Component 2)								
IR 4.1: Provincial health sector policies and national level policies aligned								
83	***L+M+G: % of health zones with an annual operational plan based on National Development Plan ("PNDS")	Numerator: # of health zones with an annual operational plan based on National Development Plan ("PNDS")	80	80	80	80	80	99
		Denominator: Total # of health zones	80	80	80	80		
		Numerator/ Denominator (in percentage)	100%	100%	99%	99%	100%	99

84	***L+M+G: % of health zone management teams with a performance management system that includes essential components	Numerator: # of health zone management teams with a performance management system that includes any of the three essential components: 1) up-to-date job descriptions and organograms, 2) work plans (including supervision plan and guide), and 3) performance review reports	52	52	51	52	60	86	
			Denominator: Total # of health zones	80	80	80	80		
			Numerator/ Denominator (in percentage)	65%	65%	64%	65%	75%	86
Project Management									
85	PM: Number of success stories developed	Number of success stories developed disaggregated by technical components and sub-components where applicable (HIV/AIDS, TB, Malaria, NTD, MNCH, FP/RH, Nutrition, WASH, GBV, Gender, HSS, BCC, Commodities, Coordination, M&E, etc.)	1	2	4	7	8	93	



PROCES VERBAL DE CERTIFICATION DU STATUT DE FIN DE DEFECATION A L'AIR LIBRE (FédAL)

Projet de Santé Intégré
en République Démocratique du Congo



L'an deux mille treize et le.....du mois de..... Nous:

- ⇒ Administrateur du territoire de KOLE
- ⇒ Médecin Chef de Zone de la zone de santé rurale de KOLE
- ⇒ Infirmier Titulaire du centre de santé de DUKA

Après avoir constaté qu'au village MONGOSENGE:

- ⇒ Chaque famille est doté d'une latrine équipée d'un dispositif qui limite la prolifération des mouches à partir des fosses;
- ⇒ Tous les membres de chaque famille ainsi équipés n'utilise que cette latrine pour déféquer;
- ⇒ Chaque latrine est équipée d'un poste lave-main (eau + savon / eau de cendre)

Déclarons avoir certifié officiellement le VILLAGE MONGOSENGE: FédAL

Fait à KOLE leJuillet 2013

Pour le territoire de KOLE

L'Administrateur du territoire

Pour la Zone de santé de KOLE

Le Médecin chef de Zone

Pour l'aire de santé de DUKA

L'Infirmier Titulaire

Appendix 3: Water analysis results from Tshumbe

Integrated Health Project
in the Democratic Republic of Congo

COORDINATION: TSHUMBE



Reporting Period : Quarter 3, Year 3

Health zones assessed :OTOTO, LODJA, DIKUNGU, and VANGAKETE



Total number of water sources: 1022

Number of water sources analyzed: 68

Water Contamination Risk	Number of spots (Bacteria colonies/Coliforms)
Weak	Less than 1 in 1ml of water
Moderate (+)	1 to 9 in 1 ml of water
Elevated (++)	10 per 1ml of water
Severe (+++)	More than 10 per 1 ml of water

Water quality evaluation

Drinking Water Analysis												
N°	Health Zone	Health Area	Village/Community name	Water source name	Population benefiting from the source	Total Coliforms [-/ml]	Fecal Coliforms (E. Coli) [-/ml]	Analysis date [day/month/year]	Operator name	Arsenic [µg/ml]	Analysis date [day/month/year]	Operator name
1	OTOTO	ONEMA-OTOTO	OTOTO-MISSION	TSHUKA	644	(+++)	(-)	02/05/2013	PIUS KINUMBE	0	02/05/2013	PIUS KINUMBE
2	OTOTO	ONEMA-OTOTO	OTOTO-CITE	AFUKAMENGO	712	(+++)	(+)	02/05/2013	RENE SHAKO	0	02/05/2013	RENE SHAKO
3	OTOTO	SHELE	SHELE	ONGANGALA	986	(+++)	(+)	02/05/2013	EZECHIEL UTSHUDI	0	02/05/2013	RENE SHAKO
4	OTOTO	SHELE	SHELE	SHOLALOMENGE	411	(+++)	(-)	02/05/2013	EZECHIEL UTSHUDI	0	02/05/2013	RENE SHAKO
5	OTOTO	OKAKONYOMBE	PEMBE	LOKUKA	1119	(+++)	(+)	02/05/2013	RENE SHAKO	0	02/05/2013	RENE SHAKO
6	OTOTO	EKOLO	EKOLO	HIANGATSHANGA	677	(+++)	(-)	04/05/2013	JUSTIN EWALA	0	18/06/2013	
7	OTOTO	EKOLO	EKOLO	LALEKONGO	532	(+++)	(+)	04/05/2013	JUSTIN EWALA		18/06/2013	
8	OTOTO	NGOMOLODI	NGOMOLODI	NGENGELO	944	(+++)	(+)	04/05/2013	JUSTIN EWALA		21/06/2013	
9	OTOTO	NGOMOLODI	NGOMOLODI	DIKONGABONGO	491	(+++)	(+)	04/05/2013	JUSTIN EWALA		21/06/2013	
10	OTOTO	ONEMA-LOTAHE	ONEMA-LOTAHE	OPINGA	765	(+++)	(-)	04/05/2013	RENE SHAKO		21/06/2013	
11	OTOTO	ONEMA-LOTAHE	ONEMA-LOTAHE	LAATSHA	582	(+++)	(-)	04/05/2013	RENE SHAKO		21/06/2013	
12	OTOTO	LODIBANGI	LODIBANGI	OKITA	610	(+++)	(-)	09/06/2013	RENE SHAKO		21/06/2013	
13	OTOTO	LODIBANGI	LODIBANGI	LALO	533	(+++)	(+)	09/06/2013	RENE SHAKO		26/06/2013	
14	OTOTO	NGEMBE	NGEMBE	OLOLO	768	(+++)	(+)	09/06/2013	RENE SHAKO		26/06/2013	
15	OTOTO	NGEMBE	NGEMBE	ELONGO	954	(+++)	(+)	09/06/2013	RENE SHAKO		26/06/2013	
16	OTOTO	YOMBO	YOMBO	LOVILE	802	(+++)	(+)	09/06/2013	RENE SHAKO		26/06/2013	
17	OTOTO	KONGO	KONGO	TSHETEMBO	726	(+++)	(+)	09/06/2013	RENE SHAKO		26/06/2013	
18	OTOTO	KONGO	HIOKAMBOLOKO	TOSHITENA	731	(+++)	(+)	09/06/2013	RENE SHAKO		29/06/2013	
19	OTOTO	MBAKA	MBAKA	TAKIRI	933	(+++)	(+)	09/06/2013	RENE SHAKO		29/06/2013	
20	LODJA	OKITANDEKE	OKITANDEKE	OTEBE	944	(+++)	(-)	23/06/2013	VICTOR OKONDA	0	23/06/2013	JOSEPHINE NENDE

2												
1	LODJA	OKITANDEKE	OKITANDEKE	DJESE-ABENDE	491	(+++)	(+)	23/06/2013	JOSEPHINE NENDE	0	23/06/2013	JOSEPHINE NENDE
2				SEMBE-								
2	LODJA	OKITANDEKE	OKITANDEKE	ONATSHUNGU	765	(+++)	(-)	23/06/2013	VICTOR OKONDA	0	23/06/2013	GABRIEL WEDIONDO
2												
3	LODJA	OKITANDEKE	OKITANDEKE	SEMBE-OFUKETEMBE	582	(+++)	(+)	23/06/2013	GABRIEL WEDIONDO	0	23/06/2013	GABRIEL WEDIONDO
2												
4	LODJA	OKITANDEKE	OKITANDEKE	DOMENE	610	(+++)	(+)	23/06/2013	GABRIEL WEDIONDO	0	23/06/2013	GABRIEL WEDIONDO
2												
5	LODJA	OKITANDEKE	OKITANDEKE	YONGONGO	533	(+++)	(+)	23/06/2013	GABRIEL WEDIONDO	0	23/06/2013	GABRIEL WEDIONDO
2												
6	LODJA	OKITANDEKE	OKITANDEKE	LAMANA	768	(+++)	(+)	23/06/2013	VICTOR OKONDA	0	23/06/2013	GABRIEL WEDIONDO
2												
7	LODJA	LOKENYE	LOKENYE	LOKANDOLA	954	(+++)	(+)	23/06/2013	VICTOR OKONDA	0	23/06/2013	JOSEPHINE NENDE
2												
8	LODJA	LOKENYE	LOKENYE	YEMAYEMA	726	(+++)	(-)	23/06/2013	VICTOR OKONDA	0	23/06/2013	JOSEPHINE NENDE
2												
9	LODJA	LOKENYE	LOKENYE	MAS	731	(+++)	(+)	27/06/2013	ALBERT KOYELONGO			
3												
0	LODJA	LOKENYE	LOKENYE	KOYIMIKE	933	(+++)	(+)	27/06/2013	ALBERT KOYELONGO			
3												
1	LODJA	LOKENYE	LOKENYE	DJESE-LOMBELA	944	(+++)	(+)	27/06/2013	ALBERT KOYELONGO			
3												
2	LODJA	LOKENYE	LOKENYE	KOKA	491	(+++)	(+)	27/06/2013	ALBERT KOYELONGO			
3												
3	LODJA	LOKENYE	LOKENYE	LAKAPONGE	765	(+++)	(+)	27/06/2013	VICTOR OKONDA			
3												
4	LODJA	LUMUMBA	LUMUMBA	LUTUMBA	582	(+++)	(+)	27/06/2013	VICTOR OKONDA			
3												
5	DIKUNGU	ODUMBE	ODUMBE	KANDJO	610	(+++)	(+)	10/04/2013	ALBERT MBAKA			
3												
6	DIKUNGU	ODUMBE	ODUMBE	ETOMBA	533	(+++)	(+)	10/04/2013	ALBERT MBAKA			
3												
7	DIKUNGU	ODUMBE	ODUMBE	NDJALA	768	(+++)	(+)	10/04/2013	ALBERT MBAKA			
3												
8	DIKUNGU	ODUMBE	ONDJADI	LANU	954	(+++)	(+)	10/04/2013	ALBERT MBAKA			
3												
9	DIKUNGU	ODUMBE	TONGO	MBOLOKO	726	(+++)	(+)	10/04/2013	ALBERT MBAKA			
4												
0	DIKUNGU	ODUMBE	SALONGO	KIKINA	731	(+++)	(+)	10/04/2013	ALBERT MBAKA			
4												
1	DIKUNGU	ODUMBE	SALONGO	TSHIMAKA	933	(+++)	(+)	10/04/2013	ALBERT MBAKA			
4												
2	DIKUNGU	OAHAMBE	OAHAMBE	WONGOLA	944	(+++)	(+)	06/05/2013	BERTHOLD YOHA			
4												
3	DIKUNGU	OAHAMBE	OAHAMBE	OMBOLO	731	(+++)	(+)	06/05/2013	BERTHOLD YOHA			
4												
4	DIKUNGU	OAHAMBE	OAHAMBE	AMINGA	933	(+++)	(+)	06/05/2013	BERTHOLD YOHA			
4												
5	DIKUNGU	OAHAMBE	YELO	YELO	944	(+++)	(+)	06/05/2013	BERTHOLD YOHA			
4												
6	DIKUNGU	OAHAMBE	DIHATA	OTALALA	491	(+++)	(+)	07/05/2013	BERTHOLD YOHA			
4												
7	DIKUNGU	OAHAMBE	ONYALODU	NDJEKENDEKE	765	(+++)	(+)	07/05/2013	BERTHOLD YOHA			
4												
8	DIKUNGU	OAHAMBE	ONYALODU	PEKELE	582	(+++)	(+)	07/05/2013	BERTHOLD YOHA			
4												
9	DIKUNGU	OMEONGA	OMEONGA	LOVIYA	726	(+++)	(+)	07/05/2013	BERTHOLD YOHA			
5	DIKUNGU	OMEONGA	OLANGA	LONYA	731	(+++)	(+)	07/05/2013	BERTHOLD YOHA			

0												
5												
1	VANGAKETE	OSOMBA	ONGELE	LOHEYI	933	(+++)	(+)	28/06/2013	PIUS KINUMBE	0	28/06/2013	PIUS KINUMBE
5												
2	VANGAKETE	OSOMBA	ONGELE	TOSAMBENONGO	944	(+++)	(+)	28/06/2013	JEAN MUTSHE	0	28/06/2013	JEAN MUTSHE
5												
3	VANGAKETE	ONEMA-KOTO	OKIDALOKUKA	LOKUKA	491	(+++)	(+)	29/06/2013	JEAN MUTSHE			
5												
4	VANGAKETE	VANGAKETE	HIANDJA	WANYI	765	(+++)	(+)	29/06/2013	HILAIRE SHUTSHA			
5												
5	VANGAKETE	VANGAKETE	VANGAKETE	EHANDJE	582	(+++)	(+)	29/06/2013	EVARISTE TOLEMBO			
5												
6	VANGAKETE	MONGE	PONGO	DJEPALE	768	(+++)	(-)	29/06/2013	BLAISE EKONGAMBELA			
5												
7	VANGAKETE	MONGE	MONGE	DEMBE	954	(+++)	(+)	28/06/2013	JEAN MUTSHE			
5												
8	VANGAKETE	DIKONDA	DIWONGI	PETSHI	726	(+++)	(+)	28/06/2013	JEAN MUTSHE			
5												
9	VANGAKETE	DIKONDA	DJANGA	LOKALANGO	731	(+++)	(+)	28/06/2013	JEAN MUTSHE			
6												
0	VANGAKETE	DIKONDA	ONGONDO WETSHINDJADI	ODIDI	933	(+++)	(+)	28/06/2013	HILAIRE SHUTSHA			
6												
1	VANGAKETE	DIKONDA	DIKONDA	LOMBE	944	(+++)	(+)	28/06/2013	HILAIRE SHUTSHA			
6												
2	VANGAKETE	TOMBOLA	TOMBOLA	OPONDE	731	(+++)	(+)	28/06/2013	HILAIRE SHUTSHA			
6												
3	VANGAKETE	TSHUNU	TSHUNU	TSHEKAHONDA	933	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			
6												
4	VANGAKETE	OKOLO	ONYAKOY	MANDJI	944	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			
6												
5	VANGAKETE	OKOLO	TOKO	OPONDE	491	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			
6												
6	VANGAKETE	OKOLO	OKOLO-VILLAGE	MANGANYAMA	765	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			
6												
7	VANGAKETE	OKOLO	OKIDIWOKOLONGO	OKOLONGO	582	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			
6												
8	VANGAKETE	OKOLO	OKOLO-MISSION	EMBOWA	726	(+++)	(+)	28/06/2013	BLAISE EKONGAMBELA			

APPENDIX 4: PY3Q3
Distribution plan for family
planning commodities

IHP FAMILY PLANNING COMMODITIES SITUATION (April -June 2013, PY3Q2)

Coor dina tion	Heal th Zone	Total Pop ulation 2012	Total FP Tar get	Monthly Tar get	Depo provera			Jadelle + Trocard			IUD			Cycle Beads			Female Condom			Microgynon			Combinaison 3 /COC Lo-femenal			Male Condom			Ovrette			Microlut												
					Bal ance Q2	Qty rec eiv ed Q3	Qty distr ibut ed Q4	Bal ance end of Q4																																				
TSHUMBE	Dikungu	127,959	26,871	2,239	1,651	1199	419	2,431	0	0	0	0	0	0	519	425	113	831	696	729	93	1,332	471	412	115	768	932	801	441	1,292	11,272	6510	6688	11,094	774	684	187	1,271	0	0	0	0		
	Djalo Katakomb	73,238	15,380	1,282	282	225	397	110	0	0	0	0	0	0	93	105	30	168	0	47	0	47	87	27	53	61	327	303	206	424	13,217	2,757	15,260	714	0	100	0	100	10	0	0	10		
	Lodja	172,998	36,330	3,027	403	776	386	793	0	0	0	0	0	0	262	254	90	426	1,699	1,574	237	3,036	478	724	130	1,072	10	172	91	91	9,125	12985	15,542	6,568	428	429	246	611	40	0	9	31		
	Minga	143,379	30,110	2,509	601	707	292	1,016	0	0	0	0	0	0	192	153	70	275	953	547	746	754	255	161	55	361	292	861	65	1,088	9,287	9,273	8,529	10,031	1,149	1,067	55	2,161	0	0	0	0		
	Omenjadi	122,060	25,633	2,136	572	383	227	728	0	0	0	0	0	0	776	760	141	1,395	439	268	0	707	83	82	54	111	974	2,138	307	2,805	17,391	13,109	9,702	20,798	0	743	68	675	0	39	39	0		
	Ototo	121,162	25,444	2,120	380	298	179	499	0	0	0	0	0	0	489	574	85	978	425	403	96	732	1,214	1,039	151	2,102	0	0	0	0	8,514	6,221	7,638	7,097	313	288	83	518	132	56	0	188		
	Tshumbe	91,119	19,135	1,595	2,174	2501	188	4,487	0	0	0	0	0	0	1,561	1,354	39	2,876	1,523	749	2,036	236	0	0	0	0	0	1,709	2,226	200	3,735	11,470	9,387	15,979	4,878	760	746	43	1,463	0	0	0	0	
	Vanga kete	116,118	24,385	2,032	458	467	190	735	0	0	0	0	0	0	318	453	126	645	274	387	0	661	291	253	92	452	271	0	28	243	9,642	7,929	13,068	4,503	509	630	227	912	729	642	24	1,347		
	Wembonya	77,093	16,190	1,349	2,798	2932	267	5,463	0	0	0	0	0	0	574	495	76	993	1,166	5,773	78	6,861	654	646	19	1,281	2,245	2,311	156	4,400	96,704	50,523	13,635	133,592	938	1,954	232	2,660	0	0	0	0		
	S/TOTAL 1		1,168,202	245,322	20,444	9,654	10,117	3,023	16,748	0	0	0	0	41	20	0	61	6,175	5,485	2,125	9,535	8,765	12,432	6,164	15,033	3,533	3,344	669	6,208	6,904	8,931	1,558	14,277	261,105	181,551	158,132	284,524	5,020	6,747	1,245	10,522	911	1,607	212
KOLE	Kole	88,639	18,614	1,551	9,687	900	150	10,437	110	0	0	110	165	0	0	165	825	738	0	1,563	234	3,900	0	0	4,134	5,248	6,480	0	0	11,728	24,571	2,600	6,000	21,710	17,500	0	0	0	0	0	0	0		
	Dibele	97,520	20,479	1,707	3,929	900	0	4,829	0	0	0	0	1	0	0	1	806	817	0	1,623	542	4,200	0	0	4,742	2,836	7,200	0	0	10,036	27,250	2800	350	29,700	3,578	0	0	3,578	0	0	0	0		
	Tshudi loto	68,050	14,291	1,191	5,758	900	5550	1,108	10	0	0	10	50	0	0	50	1,114	758	680	1,192	5,545	2,000	4,890	2,655	1,149	6,480	2,359	0	0	22,100	2,600	16,600	8,100	10	0	0	10	0	0	0	0			
	Lomela	103,971	21,834	1,819	9,075	1300	5250	5,125	50	0	0	50	52	0	0	52	288	1,167	50	1,405	5,450	4,000	450	9,000	6,475	10,080	14,955	0	0	33,700	4,000	7,400	30,300	9,300	0	100	9,200	0	0	0	0			
S/TOTAL 2		358,180	75,218	6,268	28,449	4,000	10,950	21,499	170	0	0	170	268	0	0	268	3,033	3,480	730	5,783	11,771	14,100	5,340	20,531	15,708	30,240	6,870	39,078	0	0	0	107,621	12,000	30,350	89,271	30,388	0	100	30,288	0	0	0	0	
MWENE DITU	Bibanga	139,388	29,272	2,439	2,850	0	564	2,286	20	0	0	20	141	0	0	141	1,739	139	1,600	2,870	0	765	2,105	935	0	259	676	3,159	0	183	2,976	29,205	0	14,475	14,730	1,157	0	341	816	178	0	88	90	
	Wikong	112,127	23,547	1,962	4,673	0	294	4,379	16	0	0	16	13	0	1	12	557	0	145	412	0	188	2,482	2,685	0	269	2,416	3,525	0	49	3,476	17,271	0	5,844	11,427	447	0	105	342	304	0	11	293	
	Dibindi	245,919	51,643	4,304	858	0	519	339	1	0	0	1	94	0	22	72	816	0	180	636	1	1263	2,038	2,535	0	27	2,508	358	0	266	92	16,556	0	11,161	5,395	402	0	348	54	132	0	0	132	
	Kalenda	195,462	41,047	3,421	5,111	0	388	4,723	28	0	0	28	0	0	0	9	0	31	2,568	1,246	0	19	1,227	3,119	0	394	2,725	2,497	0	111	2,386	5,349	0	3,305	2,044	925	0	105	820	85	0	18	67	
	Kamiji	92,183	19,358	1,613	3,485	0	100	3,385	13	0	0	13	71	0	0	71	493	0	45	448	0	28	1,102	155	0	12	1,434	3,914	0	9	3,905	41,473	0	2,396	39,077	158	0	36	122	40	0	19	21	
	Kanda Kanda	216,288	45,420	3,785	6,555	0	330	6,225	30	0	0	30	72	0	0	72	2,162	0	152	2,010	1,358	0	40	1,318	1,094	0	311	783	4,459	0	308	4,151	48,706	0	32,000	16,706	2,227	0	216	2,011	123	0	0	123
	Luputa	268,068	56,294	4,691	3,435	0	317	3,118	38	0	0	38	9	0	1	8	917	0	117	800	6	504	2,292	1,210	0	175	1,035	105	0	80	25	20,440	0	12,322	8,118	138	0	128	10	518	0	73	445	
	Lusambo	89,875	18,874	1,573	3,074	0	161	2,913	12	0	0	12	108	0	0	108	2,407	0	68	2,339	3,715	0	263	3,452	3,266	0	304	2,962	4,281	0	49	4,232	54,548	0	3,807	50,741	242	0	145	97	239	0	56	183
	Mpokolo	284,156	59,673	4,973	2,215	0	619	1,596	41	0	0	41	170	0	0	170	2,580	0	492	2,088	435	0	1413	-978	1,823	0	697	1,126	4,668	0	99	4,569	33,603	0	23,185	10,418	4,447	0	290	4,157	3,440	0	40	0

	Mwene Ditu	392,247	82,372	6,864	4,656	0	492	4,164	57	0	0	57	122	0	0	122	2,326	0	202	2,124	5,600	0	738	4,862	1,764	0	456	1,308	3,043	0	248	2,795	38,902	0	12,094	26,808	1,227	0	208	1,019	63	0	1	62			
	Pania Mutombo	73,119	15,355	1,280	2,150	0	112	2,038	10	0	0	10	42	0	0	42	269	0	281	-12	970	0	128	842	2,052	0	178	1,874	0	0	0	0	0	13,877	0	11,940	1,937	226	0	32	194	232	0	73	159		
		2,108,831	442,855	36,905	39,062	0	3,896	35,166	266	0	0	266	842	0	24	818	16,865	0	1,852	15,013	26,091	0	5,349	20,742	20,638	0	3,082	17,556	30,009	0	1,402	28,607	319,930	0	132,529	187,401	11,596	0	1,954	9,642	5,354	0	379	4,975			
LUIZA	Luiza	154,689	32,485	2,707	4,359	4800	308	8,851	0	0	0	0	80	0	3	77	742	90	111	721	5,154	5,000	532	9,622	8,098	3,600	63	11,635	4,042	0	84	3,958	84,126	1,500	33,640	51,986	3,654	0	102	3,552	2,241	0	16	2,225			
	Yangala	144,271	30,297	2,525	11,651	4400	425	15,626	42	0	0	42	187	0	2	185	5,080	80	172	4,988	2,042	5,000	962	6,082	9,735	3,600	348	12,987	9,285	0	0	9,285	21,621	1400	19,146	53,875	0	0	0	945	0	262	683				
	Dekese	131,507	27,616	2,301	1,632	4800	922	5,510	0	0	0	0	97	362	80	168	274	80	168	274	1,392	5,000	168	6,224	6,091	3,600	633	9,058	787	0	259	528	27,716	1,300	6,145	22,871	0	0	0	0	0	0	0	0			
	Bulape	148,522	31,190	2,599	4,590	4000	375	8,215	0	0	0	0	73	0	2	71	1,475	90	35	0	1,530	4,727	4,000	1,515	7,212	5,898	2,880	0	8,778	9,670	0	392	9,278	20,503	1500	5,700	16,303	374	0	0	374	0	0	0	0		
	Bilomba	81,313	17,076	1,423	4,196	2400	395	6,201	0	0	0	0	65	0	0	65	483	50	155	378	7,029	3,000	1,301	8,722	5,383	2,160	181	7,362	6,946	0	258	6,688	91,871	800	20,848	71,823	1,193	0	54	1,139	776	0	69	707			
	Luambo	252,700	53,067	4,423	1,866	10400	494	11,772	0	0	0	0	48	0	2	46	161	200	87	274	2,703	10,000	3,191	9,512	1,583	7,200	0	1,782	7,001	836	0	286	550	36,696	2,300	15,190	23,806	1,187	0	141	1,046	34	0	0	34		
	Kalomba	135,701	28,497	2,375	4,323	4400	462	8,261	0	0	0	0	115	0	7	108	512	90	203	399	1,654	5,000	1,047	5,600	6,833	3,600	212	10,221	2,859	0	0	2,859	28,723	1,200	10,255	19,668	2,089	0	432	1,657	0	0	0	0			
	Dibaya	128,451	26,975	2,248	4,814	5200	889	9,125	0	0	0	0	83	0	0	83	881	90	198	773	3,575	6,000	1,164	8,411	7,478	4,320	1,212	10,586	998	0	197	801	58,901	1,200	16,146	43,955	1,167	0	233	934	519	0	38	481			
	Lubondaie	144,495	30,344	2,529	4,845	4400	705	8,540	0	0	0	0	78	0	0	78	958	90	132	916	5,055	5,000	1,447	8,600	6,775	3,600	721	9,654	4,448	0	177	271	54,618	1,400	23,791	32,227	350	0	265	85	731	0	3	728			
	Ndekesha	143,979	30,236	2,520	5,029	4000	485	8,544	0	0	0	0	77	0	0	77	951	80	133	898	2,538	5,000	855	6,683	7,318	3,600	0	10,918	4,039	0	397	3,642	48,186	1,400	11,193	38,393	2,241	0	272	1,969	0	0	0	0			
Tshika ji	105,303	22,114	1,843	5,537	3200	280	8,457	0	0	0	0	120	0	0	120	621	60	41	640	72,044	4,000	380	75,644	9,438	2,880	401	11,917	669	0	486	183	32,002	1000	26,405	6,597	663	0	184	479	400	0	122	278				
S/TOTAL 4		1,570,931	329,897	27,493	52,842	52,000	5,740	99,102	42	0	0	42	1,023	0	16	1,007	12,226	1,000	1,435	11,791	107,913	57,000	12,562	152,351	74,630	41,040	5,553	110,117	40,579	0	2,536	38,043	554,963	15,000	188,459	381,504	12,918	0	1,683	11,235	5,646	0	510	5,136			
BUKAVU	Bagira-Kasha	91,902	19,299	1,608	1,414	0	0	1,414	45	0	0	45	20	0	0	20	-32	0	0	-32	3,275	2,000	0	0	3,275	2,000	0	0	2,000	-41	0	0	-41	-	-	-	13,125	-81	0	0	0	0	0	0	0		
	Bunya-kiri	142,525	29,930	2,494	474	0	0	474	23	0	0	23	9	0	0	9	36	0	0	36	2,000	0	0	2,000	2,673	0	0	2,673	-156	0	0	-156	-	-	-	1,464	-105	0	0	-105	0	0	0	0	0		
	Ibanda	298,026	62,585	5,215	1,212	0	0	1,212	-125	0	0	-125	9	0	0	9	-86	0	0	-86	3,860	0	0	3,860	3,947	0	0	3,947	-38	0	0	-38	-	-	-	1,158	-140	0	0	-140	0	0	0	0	0		
	Idjwi	228,817	48,052	4,004	-715	0	0	-715	16	0	0	16	20	0	0	20	38	0	0	38	1,970	0	0	1,970	0	0	0	0	0	0	0	0	280	0	0	-280	950	0	0	-950	0	0	0	0	0		
	Kadutu	187,608	39,398	3,283	1,964	0	0	1,964	-5	0	0	-5	19	0	0	19	-249	0	0	-249	4,000	0	0	4,000	3,992	0	0	3,992	-18	0	0	-18	-	-	-	4,400	-19	0	0	-19	0	0	0	0	0		
	Kalole	97,542	20,484	1,707	205	0	0	205	5	0	0	5	9	0	0	9	-67	0	0	-67	1,405	0	0	1,405	1,934	0	0	1,934	-168	0	0	-168	-	-	-	9,592	-348	0	0	-348	0	0	0	0	0		
	Kalonge	171,878	36,094	3,008	319	0	0	319	-17	0	0	-17	10	0	0	10	34	0	0	34	1,960	0	0	1,960	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Kamituga	148,073	31,095	2,591	756	0	0	756	15	0	0	15	15	0	0	15	-56	0	0	-56	1,995	0	0	1,995	3,833	0	0	3,833	-113	0	0	-113	-	-	-	4,195	-3	0	0	-3	0	0	0	0	0		
	Kanio-la	164,497	34,544	2,879	162	0	0	162	5	0	0	5	10	0	0	10	-60	0	0	-60	929	0	0	929	1,965	0	0	1,965	-14	0	0	-14	-	-	-	4,025	-57	0	0	-57	0	0	0	0	0		
	Katana	188,523	39,590	3,299	1,270	0	0	1,270	26	0	0	26	20	0	0	20	-119	0	0	-119	2,000	0	0	2,000	5,836	0	0	5,836	-712	0	0	-712	-	-	-	2,388	-626	0	0	-626	0	0	0	0	0		
	Kaziba	111,461	23,407	1,951	259	0	0	259	2	0	0	2	8	0	0	8	10	0	0	10	1,965	0	0	1,965	1,916	0	0	1,916	-8	0	0	-8	-	-	-	1,219	-140	0	0	-140	0	0	0	0	0		
	Kitutu	123,479	25,931	2,161	940	0	0	940	10	0	0	10	15	0	0	15	-12	0	0	-12	1,841	0	0	1,841	0	0	0	0	0	0	0	0	0	9,419	0	0	9,419	0	0	0	0	0	0	0			
	Lulingu	149,035	31,297	2,608	655	0	0	655	15	0	0	15	20	0	0	20	44	0	0	44	2,000	0	0	2,000	3,808	0	0	3,808	-60	0	0	-60	-	-	-	560	0	0	-560	195	0	0	-195	0	0	0	0
	Minova	184,500	38,745	3,229	1,134	0	0	1,134	24	0	0	24	13	0	0	13	43	0	0	43	3,995	0	0	3,995	3,847	0	0	3,847	-231	0	0	-231	-	-	-	5,047	-82	0	0	-82	0	0	0	0	0		
	Miti-Murhesa	192,853	40,499	3,375	385	0	0	385	2	0	0	2	14	0	0	14	-28	0	0	-28	2,996	0	0	2,996	5,140	0	0	5,140	1,079	0	0	1,079	-	-	-	4,003	-661	0	0	-661	0	0	0	0	0		

	Mulongo	268,800	56,448	4,704	0	5,600	1,269	4,331	0	100	0	100	0	61	0	61	378	1,200	602	976	0	6,200	22	6,178	0	4,000	0	3,000	0	0	3,000	8944	1,300	10,438	-194	872	0	1,037	-165	0	0	0	0	
S/TOTAL 8		1,939,493	407,294	33,941	10,604	42,000	3,617	48,987	111	600	9	702	75	400	0	475	3,622	8,415	1,192	10,845	636	52,000	4,126	48,510	38,181	23,760	916	61,025	0	16,800	643	16,157	499,011	12,000	75,994	435,017	6,022	0	1,947	4,075	2,687	0	54	2,633
TOTAL GENERAL		10,303,756	2,007,738	167,313	201,965	118,802	32,627	288,140	1,589	730	187	2,132	3,486	470	40	3,916	44,755	18,380	8,197	54,938	371,909	169,532	61,607	479,834	341,699	136,784	28,264	449,935	118,033	25,731	7,337	136,427	2,104,026	571,051	681,081	1,993,996	72,174	6,747	14,129	64,792	16,228	5,207	2,410	19,025

Integrated Health Project
in the Democratic Republic of Congo



An Assessment of the Integrated Health Project's SMS Campaigns and Community-Based Closed User Groups

Executive Summary

Summary of Background and Assessment Questions

This report is an assessment of two cell-phone-based mHealth (mobile health) initiatives implemented by the USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). The initiatives include short service message (SMS) campaigns as well as the establishment of closed user groups (CUGs). As a component of IHP's Tuendeni Kumpala behavior change communications (BCC) strategy, the purpose of IHP's mHealth initiatives is to use cell phone-based communications to increase the reach and frequency of BCC messaging and to support dialogue among community members about health concerns and behaviors. In this way, such mHealth initiatives are intended to advance IHP's goal of increasing the use of health services for issues including family planning; maternal, newborn, and child health; nutrition; malaria and tuberculosis; neglected tropical diseases; HIV; and water, sanitation, and hygiene (WASH). IHP is active in 80 health zones across four provinces of the DRC (Sud Kivu, Katanga, Kasai Oriental, and Kasai Occidental). Of these, IHP has begun implementation of its SMS campaign initiative in 51 health zones, and its CUG initiative in six health zones. A third mHealth initiative consists of "hotlines," which are currently in a pilot testing stage and outside the scope of this assessment.

The purpose of this assessment was to identify lessons learned on the following questions:

- *What have been the main successes of these mHealth initiatives? In particular, how has the project impacted the lives of the beneficiaries in targeted communities?*
- *Which elements of the mHealth initiatives have been the most effective and which could be improved?*
- *What have been the main challenges in the implementation of these mHealth initiatives and, if applicable, how have they been surmounted?*
- *How can IHP strengthen participation in the CUG initiative by both community members and CUG phone holders?*

Appendix 5: Executive Summary of Closed User Group Assessment Report

- *Is there any community feedback available to IHP to support the scale-up and sustainability of these two mHealth initiatives?*

This assessment of IHP's SMS campaigns and CUG initiatives established to date was carried out in eleven out of the fifty-one health zones where mHealth implementation has begun. IHP's SMS campaign initiative, to varying degrees, has been active in all eleven health zones. A CUG system had been established in six of these eleven health zones but not in the remaining five. The latter were included in this assessment to gauge community interest in the establishment of a CUG system.

As further detailed in the "Methodology Summary" below, this assessment was conducted and analyzed from January 2013 to July 2013, and consisted of focus group discussions with 362 participants who completed demographic participant questionnaire surveys. It also included written survey questionnaires from BCC staff, as well as other written and verbal information from BCC and other IHP staff.

The SMS campaign initiative consists of both bulk SMS messages sent by mobile operators as well as targeted SMS messages sent by IHP's project staff, on a variety of health topics in order to increase positive behavior change on health issues. "SMS" is the technical name for "text messages" sent to cell phone users.

As discussed above, the other mHealth initiative evaluated in this assessment was the use of CUGs. In IHP's CUG model, these closed user groups are generally comprised of six to eight cell phones equipped with SIM cards that allow for unlimited airtime within the group of phones. These phones are then given to a pre-selected group of community leaders, health service providers, and local supervisors. IHP's CUG model restricts calling access such that CUG phones are only enabled to call other phones within the same CUG. These phones provided the group with a cost-free communications network that allows them to direct local residents to the most appropriate CUG member for health information and medical advice, recommendations for where to access more information, and/or a referral for services.

Methodology Summary

Focus Group Discussion Design

The primary method used to collect information for this assessment was focus group discussions (FGDs). FGDs were conducted in 11 out of the 51 health zones where IHP has introduced its mHealth initiatives. IHP has begun implementation of health SMS message campaigns in all 11 of these health zones. All six health zones in the DRC in which IHP has established a CUG system (Bibanga, Kanda Kanda, Wikong, Dibaya, Tshikaji, and Uvira) were included in this assessment. The remaining five health zones (Mpokolo, Kalenda, Bilomba, Ndekesha, and Lemera) in this assessment did not have an established CUG system but were included to gauge community interest in the establishment of a CUG system.

Three hundred and sixty-two individuals participated in the FGDs, and 68% reported owning or having access to a cell phone. All FGDs were disaggregated by gender and age (young adults were below the age of twenty-five, and adults were aged twenty-five and above) in order to maximize homogeneity among participants. Four FGDs were held per health zone and each FGD contained an average of eight participants. The focus group guide that was provided to instruct facilitators is attached as Annex A.

FGD Participant Demographic Questionnaires

A demographic questionnaire was administered to each FGD participant, which collected basic personal and household information as well as health service and cell phone usage information. This

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data provided useful context for the qualitative material gathered during the discussions and provided insight into how the sample's demographics varied from national averages. This was important for determining potential selection bias (see "Demographic Overview – Potential Sample Bias"). The sample demographic questionnaire, aggregate responses to the questionnaire, and analysis of demographic data, are attached as Annexes E, F, and G, respectively.

BCC Staff Survey Questionnaire

In order to complement the information collected from community beneficiaries, electronic questionnaires were circulated among IHP's BCC field staff to assess the functionality and effectiveness of the mHealth initiatives from the perspective of the implementers. A sample questionnaire is attached and an overview of BCC staff responses are attached as Annexes B and C, respectively.

Data Collection Obstacles and Data Quality

This assessment of IHP's SMS campaigns and CUGs encountered significant obstacles with respect to its ability to collect detailed, high-quality data. Three tools were used to collect data for this assessment: (1) written demographic questionnaires completed by participants within the eleven health zones of this assessment, (2) focus group discussion reports produced by IHP facilitators following discussions with the same participants, and (3) written questionnaires completed by IHP BCC staff. As detailed in "Methodology – Data Collection Obstacles and Data Quality," the data collected, while informative, did not meet the level of quality and reliability necessary to draw conclusions about IHP's SMS and CUG programs with a high degree of confidence in all instances.

Summary of Lessons Learned

This assessment identified the following lessons learned with respect to each of its assessment questions:

- *What have been the main successes of these mHealth initiatives? In particular, how has the project positively impacted the lives of the beneficiaries in targeted communities? Which elements of the mHealth initiatives have been the most effective?*

Overall, the IHP mHealth initiatives studied in this assessment (both SMS campaigns and the use of CUGs) succeeded in being perceived by community members as beneficial, interesting, educational, and as useful tools to facilitate intra- and inter-community dialogue on health issues. A significant number of participants expressed enthusiasm and confirmed meaningful engagement with respect to these initiatives.

With respect to the SMS campaigns, a significant number of participants confirmed that they had conveyed received health SMS messages on to family, friends, acquaintances, and colleagues. In some cases, this had a direct positive impact on beneficiaries. The SMS campaigns appeared to also have an indirect positive effect of increased self-esteem among SMS recipients. In some instances, these feelings appeared to correlate with improved community activism.

The CUG initiative also generated positive interest, including in health zones where a CUG system had not yet been established but participants demonstrated openness to such a project. CUGs were credited with helping community members solve a wide variety of health issues. Some issues were immediate and pressing, some were longer-term household issues, and others were more sustained, community-level concerns.

In addition, some community members expressed a sense of empowerment to take on responsibility for CUG phones. Some also correctly recognized the "communal" nature of them. Enthusiasm in one community was high enough, according to field staff, that the community had begun mobilizing

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funds to purchase CUG phones to add to their local CUG system. Lastly, field staff confirmed that the implementation of CUG systems has been straightforward, that CUG phones have been kept in good condition and none have been lost, and finally that CUG phone logs suggest high levels of use.

- *What have been the main challenges in the implementation of these mHealth initiatives and, if applicable, how have they been surmounted? What elements could be improved?*

Though many participant responses demonstrated a range of awareness, engagement, and feelings of inclusion with respect to the two mHealth initiatives, other participants had no awareness of them. In addition, some participants had awareness of one or both initiatives, but expressed limited interest in getting involved, while others appeared deterred from engagement by non-IHP SMS messages, as discussed below.

SMS Campaigns

With respect to the SMS campaign initiative, this assessment identified four implementation challenges: (1) low volume of SMS message dissemination, (2) recipient confusion over message sources and erroneous concerns about message costs, (3) gender and generational disparities among those with access to cell phones, and (4) limited electrical recharging capacity.

A significant number of participants confirmed interest in receiving more IHP health messages via SMS, and their feedback suggests that SMS messages are having a positive impact on health awareness and health seeking behaviors. There are at least two elements regarding SMS volume. First, in some health zones, SMS message campaigns have been precluded altogether due to lack of cell phone network coverage, which is beyond IHP's power to address. Second, a previously cited problem which has been resolved, was IHP's local coordinating offices outspending their cell phone credit before sending all intended messages in a particular campaign. IHP corrected this problem by establishing a credit disbursement system.

The second challenge confronting the SMS campaigns initiative is SMS message avoidance by recipients, of which this assessment identified two causes: cost and "commercial" SMS fatigue. With regard to cost, some recipients have been conditioned to believe that reading any sort of "commercial" or "non-personal" SMS messages may cost money. Although the reading of IHP's health SMS messages is free, some participants mistakenly believe it will consume phone credit and are ignoring or deleting them. IHP can attempt to resolve this issue by adding prominent language to its messages to make it clear that they are free. With regard to "commercial" SMS fatigue, it may be difficult to overcome, but it speaks to an inherent challenge of the SMS platform in many developing countries — the medium's competing SMS advertisement messages may lower engagement with IHP's health SMS messages.

The third challenge is the gender and generational disparities among those with access to cell phones capable of receiving IHP SMS messages. This assessment found that men are somewhat more likely to have access to a cell phone than women. A similar problem was observed with respect to generational disparity. In some health zones, adults were far more likely than youths to have been exposed to an IHP health SMS message. In order to reach all demographic groups, IHP may consider sending SMS messages that encourage recipient outreach to women and youth on issues of concern to such target populations.

The fourth challenge, voiced by a few participants, is the difficulty of charging cell phones when access to electricity is irregular. This concern arose more often with respect to recharging CUG phones, and overcoming this challenge is therefore discussed below in the CUG context.

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CUGs

With respect to the CUG initiative, this assessment identified four implementation challenges: (1) the low number of CUG phones compared to public usage interest, (2) the lack of awareness of who held CUG phones, (3) gender and generational disadvantages in obtaining access to CUG phones, and (4) limited electrical recharging capacity.

The most common complaint by participants was the low number of CUG phones available. IHP's CUG model distributes six to eight CUG phones within a CUG system to a pre-selected group of community leaders, health service providers, and local supervisors. Surmounting this challenge will require scale-up to increase the number of CUG phones within existing groups and establish new CUG systems.

Second, many participants stated that they did not know the identities of the CUG phone holders in their community. One way to solve this issue could be to hold community meetings when the CUG phones are distributed in order to introduce the CUG phone holders and maintain their visibility. IHP should encourage CUG phone holders to promote themselves as being accessible to all age and gender groups.

Third, this assessment found some gender and generational disparities in awareness and access to CUG phones in certain health zones, not unlike the disparities discussed earlier within the SMS campaign. In some health zones, awareness and access to CUG phones appeared to be dominated by men. Conversely, several health zones were characterized by a relatively lower use of CUG phones by men.

With respect to generational disparities, a number of health zones were characterized by adults dominating awareness and access to CUG phones. Surmounting this challenge will require IHP to be gender and generational inclusive to ensure that all age and demographic groups feel comfortable.

Finally, as is the case with mobile phones more generally, limited access to electrical recharging capacity limits the use of CUG phones in certain rural areas. IHP field staff has addressed this in some locations by reaching agreements with local health zone management team members, health center workers, and priests to allow phone charging at their locations.

- *How can IHP strengthen participation in the CUG initiative by both community members and CUG phone holders?*

IHP can strengthen participation in the CUG initiative by taking the actions recommended above under the bulleted "*What have been the main challenges...*" question above; namely, raising awareness of the identity of CUG phone holders, and ensuring gender- and generational-inclusiveness.

- *Is there any community feedback available to support IHP's scale-up and sustainability of these two mHealth initiatives?*

Virtually all of the community feedback discussed in response to the earlier three assessment questions is relevant to inform a successful scale-up of IHP's mHealth initiatives. Feedback on sustainability, however, was limited to the example of one community which has begun mobilizing funds to purchase additional CUG phones.

Appendix 6: IHP FIELD OFFICES WORKPLAN FOR THE NEXT QUARTER (July-September 2013)

Yellow highlighting indicates priority activities identified during the May 2013 review.

BUKAVU

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased
2	Renovate 19 infrastructures in 8 target health zones: Katana (3: Iko and Nuru, Maternity GRH), Miti-Murhesa (2), Walungu (3: Lurhala Maternity GRH: neonatal service and Walungu health center), Kaziba (3: Mushyeni and Cibanda health centers, Labo GRH), Mwana (2: Kimalamjala and Luchiga), Bagira (2: Ciburhi and Burhiba), Mubumbano (1: Tumbimbi) Shabunda (maternity GRH)
3.1	Quantify and order essential drugs while monitoring the shipping in order to avoid delays in tracer/priority drugs
3.6	Organize a briefing during an SSP meeting of 453 providers from 23 health zones (113 providers/6 health zones/quarter) on the use and appropriate management of RUMER and other pharmaceutical management tools
3.7	Insure the tracking of lines of credit and stocks of MEG in the 23 health zone central offices
	IR1.2: Community-based health care services and products in target health zones increased
3.2	Finance 80 villages/communities to implement their Clean Village action plans which includes capacity building and achieving planned activities in the 2 health zones (Walungu and Katana)
3.5	Collect, analyze and enter data on water quality in the 8 IHP-supported health zones
3.6	Build 80 drinkable water sources in the two health zones (Walungu and Katana) targeted in the new IHP WASH strategy
3.7	Promote the construction of latrines in up to 80% of households in the 80 communities provided with water
4.2	Provide financial and technical support for the organization of monthly cooking demonstrations in 25 communities from 5 health zones (see 4.1 for list) targeted by IHP, where CHWs have been trained in essential nutrition actions and support groups have been implemented and are functional
6.2	Finance blood collection activities in 8 health zones (Bagira, Kadutu, Ibanda, Katana, Miti-Murhesa, Walungu, Mubumbano, Mwana, selected in the same manner as described under IR 1.1, 5.1) at the community level with the national blood transfusion program (PNTS)
1.1	Finance the training of 140 people, including the district, zonal, and administrative levels, in LDP for 3 days to support the implementation of project activities in the Katana, Mubumbano, Bunyakiri, Minova, Walungu, Kalonge, Shabunda, Ibanda, Bagira, and Kadutu health zones
	IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery
1.3	Conduct 40 visits to monitor the 10 LDP action plans (Minova, Bunyakiri, Shabunda, Walungu, Mubumbano, Nyangezi, Ibanda, Bagira, and Katana health zones)
1.4	Accompany 5 health zones in the achievement of measurable results from the LDP action plan (Idjwi, Mwana, Kaziba, Kaniola and Kamituga health zones)
	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones

	increased (Component 1)
	IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved
2.4	Organize the monitoring and evaluation visits of CBD activities for head nurses from the health centers and the Health Zone Management Teams (HZMT)
2.5	Organize 30 joint monitoring and evaluation visits on the implementation of activities for managing FP/SR commodities with the National Program for Reproduction in the Bagira, Mubumbano, Idjwi, Minova, Kamituga, Kaniola, Katana, Mwana, Miti-Murhesa, Ibanda, and Shabunda health zones
3.3	Supply the 115 refrigerators with 230 glasses (1 glass/semester/refrigerator)
4.6	Ensure the follow-up of the training in Helping Babies Breathe (HBB), including coordination with CRS in Walungu and Nyangezi health zones (note: IHP's HBB support extends to Mwana, Kaziba, Miti-Muresha, Minova, and Katana health zones, and it was in coordination with CRS that health zone selection was made)
4.7	Ensure 6 monitoring and evaluation visits for KMC units (minimum of 2 visits per unit/quarter)
5	Strengthen the monitoring of child growth and development
8	Support malaria treatment in the health facilities: training, distribution of pharmaceuticals and commodities (ACT, RDT) and supervision
8.5	Distribute 40 microscopes and reactive kits, slides and accessories to reference health facilities in the IHP-targeted health zones in accordance with the means described in the inventory report
10.1	Contribute to the transport of nutritional treatment commodities from PRONANUT towards the 23 health zones of the coordination office
10.3	Conduct 20 quarterly supervision visits in conjunction with PRONANUT in the 5 health zones (one visit per quarter in 5 health zones)
11.1	Finance the referral system for 20 cases of fistula in the Center of Excellence (Kaziba)
14	Strengthen the quality of HIV services
14.3	Build 11 incinerators in the 11 health facilities of the 5 health zones to be renovated (Katana (3: Iko and Nuru, GRH maternity ward, 2: Miti-Murhesa), Walungu (3: Rukwende, GRH maternity ward and Muku), Kaziba (1: Labo GRH), Mwana (2: Kimalanjala, Luchiga)
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
2	Implement a Results-based Financing (RBF) Program
2.5	Organize the quarterly joint verification of the health zone management team and the coordination office for three quarters
1.2	Finance the implementation of the communication action plan for CODESA from 15 health zones (5 old health zones: Walungu, Miti, Idjwi, Katana and Shabunda)
	Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)
	IR 3.2: Health advocacy and community mobilization organizations strengthened
2.1	Conduct 11 quarterly BCC mini-campaigns on one of the priority intervention areas in 2 health zones of the coordination office
4.2	Finance the transmission of SMS awareness messages every quarter in accordance with priority health areas in the communities Katana, Ibanda and Walungu

5.1	Conduct a follow-up visit of the CPCC training in health zone trained as Champion Communities (Walungu and Katana)
5.2	Finance the implementation of action plans from 2 Champion Communities (1 Champion Community/health zone)
Intermediate Result 4: Health sector leadership and governance in target provinces improved (Component 2)	
IR 4.1: Provincial health sector policies and national level policies aligned	
2.1	Provide technical and financial support to the 52 meetings of the CCIA at the provincial level
IR4.2: Evidence-based tools for strategic planning and management decision-making adopted	
3.4	Finance a monthly review for 23 health zones (support is provided to 23 HZMT)
3.5	Provide 23 health zones with modems and data credit for data collection
3.6	Finance monthly the baseline monitoring (425 monitoring meetings)
3.7	Finance monthly the meetings of CBOs (425 CBO meetings)
4.1	Contribute to the monthly operations of the Provincial Health Division (DPS) of Sud Kivu
4.2	Contribute to the monthly operations of the 4 health districts
4.3	Support the monthly operations of the 23 HZMT
M&E	
Organize monthly joint missions with the MOH M&E team to improve data quality with audits	
5.1	Contribute to the achievement of the supervisory visits of the DPS/programs/offices of the health zones (13 offices x 2 visits/office/year/23 health zones)
5.3	Contribute to the achievement of HZMT supervisions of the health facilities
4.2	Multiply formative supervision visits focused on M&E
6	Organize monthly data validation sessions
PM.1 Staff development to improve the quality of projects is reinforced	
1.1	Conduct work support sessions in different departments (program, administrative and finance) for the IHP coordination office: supervision to ensure conformity
1.2	Hold 52 monthly meetings for the management team
1.3	Hold 12 monthly meetings for all the coordination office staff
1.7	Participate in 52 monthly meetings for provincial coordinations of IRC projects
1.8	Elaborate and monitor 4 quarterly plans for the coordination office
3.2	Organize and/or support specific staff trainings according to identified need (MDF, AXYOM...)
3.3	Organize monthly scientific days for the coordination office staff
3.4	Participate in yearly staff meeting - Team building
3.6	Periodically orient the staff depending on responsibilities
PM.2 Coordination office operational	
4.1	Manage the Bukavu office daily
5.2	Reinforce the security of infrastructure and equipment to respond to the norms and regulations required for the Bukavu coordination and Shabunda antenna
5.3	Recycle the staff responsible for managing security as well as all the staff in security norms

KAMINA

Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)	
IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health	

	zones increased
1.5	Participate in the mid-term and final evaluations of 9 AOPs 2013 in two pools: Malemba and Kabongo
2.1	Rehabilitate 6 maternities in 2 health zones (3 health centers/health zone) of Kabongo and Songa
3.3	Ensure the transport of MEG and other medical commodities to supply the 9 health zones
	IR1.2: Community-based health care services and products in target health zones increased
3.2	Provide material and financial support to refurbish 57 water holes in the Songa health zone
5.4	Provide two NGOs with sensitization kits (DVDs, CDs, movies, CD/DVD players, condoms, T-Shirts, small generator, phallus, handouts, registers...)
6.1	Provide 20 peer recruiters with sensitization kits (T-shirts, megaphones, handouts, badges, etc.)
6.2	Insure transport to provide the 9 health zones in transfusion kits (security markers, blood bags, kits, grouping tests)
	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)
	IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved
1.1	Reinforce the capacity of providers during monitoring visits and monthly/quarterly reviews during follow-up visits
4.1	Provide technical support to vaccination campaigns during the National Vaccination Days of Vaccination in the 9 health zones and to the independent monitoring activities during those days
6.1	Equip 9 GRH (1 GRH/health zone) with 9 Kangaroo Mother Care (KMC) kits
11.2	Provide CD4 analysis fees to pregnant women who are HIV+ and for 40% of PMTCT sites that are not able to provide free testing in their health zones (Malemba axis and Kabongo axis)
11.3	Ensure transport of blood samples to Kamina - Lubumbashi - Kinshasa for early diagnosis of children born to HIV+ mothers
12.2	Provide the Kitenge and Mulongo health zones with 2 PIMA kits
14.2	Finance the transport of TB samples in the 9 health zones for treatment health centers (of tuberculosis)(CST) to the diagnosis and treatment health centers (CSDT) and from the health zone central offices to the Provincial coordination for the fight against TB (CPLT)
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
3.5	Organize the quarterly joint verification of the health zone management team and the coordination office for three quarters
3.7	Organize three quarterly counter-verifications of PBF data and of promotional health activities implemented by the 2 CBOs for 3 quarters
3.8	Provide quarterly performance payment in the 29 health centers, 1 GRH and 1 health zone management team for 3 quarters
4.5	Lead a 7-day supervision visit of RBF program activities with a joint team: IHP, health district and RBF committee
	Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)
	IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations--established
1.3	Provide financial support towards the implementation of the quarterly action plans for the selected NGO/CBOs that are active in GBV (awareness, medical treatment, judicial measures, psycho-social reinsertion) in the Malemba and Kabongo health zones (2 NGOs/CBOs per health zone)
1.1	Revitalize 40 CODESA in the Lwamba, Malemba, Kabongo and Mukanga health zones (10 CODESA/health zone)
	IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched
2.1	Provide fees for phone credits for to send 2500 health messages via SMS during mini-campaigns (WASH, MNCH, EPI, FP)

2.4	Finance informational transmission fees for health activities on 6 community radios in the Kabongo, Malemba and Kitenge health zones (2 radios/health zones)
3.3	Organize evaluations for 6 quarterly meetings of Champion Community Steering Committee (CPCC) (2 meetings/CPCC)
3.4	Organize a festival for the three Champion Communities in 3 health zones: Songa, Kabongo and Malemba
Intermediate Result 4: Health sector leadership and governance in target provinces improved (Component 2)	
IR 4.1: Provincial health sector policies and national level policies aligned	
1.1	Organize 192 monthly follow-up missions with the members of the health zone management team in 9 health zones
1.2	Provide the district with support to apply instructions on the use of lines of credit and funds generated by the health facilities within the framework of IHP
1.3	Organize quarterly joint supervisions with members of the health district and provincial health division in the 9 health zones
1.4	Finance the provincial health division to cover operational costs
3.1	Provide financial support to the health districts for operational costs
3.2	Provide financial support to the 9 health zones for operational costs
4.1	Finance the provincial health division for supervision costs
4.2	Provide financial support for the maintenance of motorcycles in the 9 health zones and 1 motorcycle for the health district
4.3	Finance the health zones for supervision costs
6.1	Ensure transport of vaccines and other EPI commodities towards EPI antennas and 9 health zones
6.2	Supply the 9 health zones in gas (37,332 liters) for cold chain maintenance in 68 warehouses (average of 30.5 days and 1.5 liters/day): (Kabongo (7sites) 3840 liters/year, Kayamba (5 sites) 2748 liters/year, Kitenge (13 sites) 7137 liters/year, Kinkondja (7 sites) 3840 liters/year, Lwamba (7 sites) 3840 liters/year, Mukanga (6 sites) 3300 liters/year, Mulongo(7 sites) 3840 liters/year, Malemba Nkulu (8 sites) 4392 liters/year and Songa (8 sites) 4392 liters/year)
M&E	
Organize monthly joint missions with the MOH M&E team to improve data quality with audits	
1.2	Conduct an evaluation/monitoring of the evolution of indicators in the 9 health zones (from 2012)
1.3	Organize a quarterly consultative meeting with 9 health zones and the health district for a situational analysis of the project
1.4	Participate in the mid-term evaluations of in the 9 supported health zones
2.5	Provide 9 telephones monthly with 5\$ of credits to transmit data
3.4	Participate in 108 monthly monitoring/review meetings in 9 health zones
PM.1 Staff development to improve the quality of projects is reinforced	
1.1	Determine the needs in IHP staff development and elaborate the training plan
1.4	Hold quarterly meetings with staff to ensure their comprehension of MSH administrative and financial procedures
1.5	Conduct monthly follow-up missions on funding provided by the project
1.6	Elaborate and expedite monthly budgetary forecasts for operations and activities
1.7	Elaborate monthly the financial report and expedite vouchers to Kinshasa
PM.2 Coordination office operational	
2.1	Monitor the office daily
2.2	Participate in the meetings organized at the health district and provincial levels
2.3	Hold 52 weekly planning meetings with the staff
2.4	Develop quarterly/monthly coordination office workplan

2.5	Monitor quarterly/monthly the workplan
2.6	Ensure reporting in accordance with the norms (monthly reports, quarterly reports and success stories)
2.7	Provide monthly support to follow-up missions by staff in the supported health zones
3.1	Reinforce means of communication between staff and other partners
3.2	Secure infrastructure and equipment to comply with security standards and regulations of MSH (fleet tracking, alarm system, set up office to have one "safe haven")
3.3	Reinforce the visibility of the project in the 9 supported health zones (IHP signs, stickers...)
PM.6 All offices are equipped with proper technology and communication commodities according to needs	
4.1	Organize the maintenance and repair of IT and other equipment (plan for vehicle repair)
4.2	Supply all staff with adequate equipment (3 computers, 7 digital cameras, 3 Airtel modems...)
4.3	Equip each coordination office with necessary equipment (2 vehicles, 16 motorcycles, 4 printers, 2 video projectors, 1 TV...)

KOLE

Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)	
IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased	
2.3	Renovate 4 health facilities with maternities in targeted health zones (renovate a maximum of 2 health facilities in the health zones of Kole: Ishenga and Banda health centers and in the health zone of Bena Dibebe, the GRH maternity ward and Ototo)
3.1	Provide basic equipment to 4 renovated health facilities
4	Equip 59 maternity wards with maternal, newborn, and child health (MNCH) kits (55 health centers and 4 GRHs)
5.1	Provide the health facilities with management tools for medicines, supplies, and equipment
5.2	Organize 16 supervisory visits every quarter with the health district (PID) on management of medicines in the health facilities
5.3	Organize 48 joint monthly supervisory visits with health zones on the management of medicines management in the health facilities
6.3	Organize quarterly follow-up for lines of credit and IHP stock in the regional distribution centers (CDR), 4 health zone central offices, and 59 health facilities with the health district
IR1.2: Community-based health care services and products in target health zones increased	
4.4	Collect, analyze and process information on water quality in 4 health zones quarterly (note: activities 4.2-4.4 are part of a cost share that provides quick, simple wins that are very accessible to the communities, so while outside of the zone selected for the strategy, they have a visible impact on water quality in these health zones)
4.5	Renovate 47 water sources in 5 health areas in the Kole health zone
4.6	Promote the construction of latrines in up to 80% of households in the 47 communities provided with water in Kole health zone
5.4	Provide support groups with supplies (notebooks, pens, report forms, etc.) and a reporting kit
6.3	Organize 2 follow-up training visits for diagnostic and treatment health centers for TB (CSDT) and treatment health centers (CST) on MDR TB care and treatment, tuberculosis, and referral of possible TB cases
IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery	

1.5	Provide financial support for the implementation and monitoring of health facility action plans (31 health facilities for 4 quarters/\$100 for the average cost planned by the health facilities in their previous action plans)
3.1	Provide 13,608 liters of gas for 35 refrigerators in 4 health zones (45 liters/month/refrigerator)
Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)	
IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved	
3.2	Provide 4 health management teams with 1,000 liters of gas for immunization transport and 11 liters of SAE 40, and recovery costs for vaccines at the EPI branch in Lodja
7.2	Equip 4 maternity wards (GRH) with newborn kits, heating tables, birthing tables, and resuscitation kits (oxygen mask, self-inflatable ambu self bags, and manual suction pump)
8.1	Train 10 health care providers from 3 health facilities in the Kole health zone in Kangaroo Mother Care (KMC)
10.1	Distribute 11,874 LLINs during pre-natal and pre-school consultations in 2 health zones (Tshudi Loto and Lomela) of the Kole coordination area that are not covered by the Global Fund
15.1	Support financially the medical repair and care for 35 cases of urogenital fistula per month in the GRH of Kole
15.2	Raise awareness of available medical support for 35 cases of urogenital fistula/month
IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted	
1.2	Construct 25 incinerators for 2 GHR and 23 health areas in the Kole and Bena Dibebe health zones
2.1	Organize a 6-day training for 21 providers in the Lomela health zone to cover 19 health centers and 2 GRHs on RBF
2.5	Organize a 5-day workshop to negotiate targets and to sign agreements and to develop work plans for Quarter 1 in the implementation of RBF in 19 health centers, GRHs and health zone management teams in the Lomela health zone
2.6	Provide RBF management tools to 19 health centers, GRH and health zone management teams in the Lomela health zone
2.9	Support the quarterly joint verification with IHP and health zone management team in the 20 health facilities in the Lomela health zone
2.11	Provide quarterly performance payment in the 19 health centers, GRH and health zone management teams and the coordination office in Lomela for 3 quarters
5.1	Conduct a study visit to exchange experiences with one coordination that has had an RBF experience (ex.: Bukavu) to examine best practices in RBF (2 IHP staff for one week)
IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized	
3.1	Fund the transport, hospital stay, and repair and treatment of urogenital fistula cases to the GRH
Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)	
IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations--established	
1.2	Organize and fund 70 community ETL session on SMNE in 70 villages in 2 health zones (Kole et Lomela)
1.3	Organize and fund 40 community ETL session on malaria in 40 villages in 2 health zones (Kole et Lomela)
1.4	Organize and fund 40 community ETL session on family planning in 40 villages in 2 health zones (Kole et Lomela)
1.7	Conduct joint supervision with the health zone management teams for the community listening club activities
1.8	Provide ETL facilitators with tool kits for the monitoring and evaluation of ETL on a quarterly basis
2.3	Organize 4 exchange meetings between Champion men and non-Champion men
3.1	Provide technical support (planning, execution, monitoring and evaluation of activities) to 3 NGOs/CBOs having demonstrated the effective implementation of health activities in target health zones (CEFOFECA, EBEGLOM and AJAS-Espace jeune)

3.2	Fund 4 BCC actions plans of 3 NGOs/CBOs active in IHP intervention activities at the level of targeted health zones
3.3	Fund quarterly meetings to evaluate action plans for NGOs/CBOs and to ensure conformity with the Tuendeni-Kumpala strategy at the level of target health zones
3.4	Organize 4 follow-up and support visits for the implementation of local NGO/CBO action plans
IR 3.2: Health advocacy and community mobilization organizations strengthened	
1.1	Fund the implementation of CODESA action plans in 4 health zones (\$50.00 per CODESA per quarter), to purchase record-keeping notebooks, pens, megaphones, etc.
1.2	Organize follow-up visits for CODESA action plans at the community level (IHP and ECZ teams)
1.3	Organize and fund quarterly reunions to evaluation action plans for each CODESA in target health zones
IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched	
1.3	Fund monthly visits to monitor the implementation of communication plans in 4 target health zones
2.13	Accompany the health zone management teams (community agent, supervisor and the health zone medical director) in the planning and implementation of BCC activities and the promotion of hospital hygiene and environmental management
3.2	Fund 96 advertisements over the radio on health activities, via community radios
3.4	Organize monthly supervision visits for community radio activities in health zones covered by the program (media monitoring)
4.2	Fund 2 pilot committees for Champion Communities operating in 4 health zones
IR4.2: Evidence-based tools for strategic planning and management decision-making adopted	
1.1	Organize two bi-annual reviews in Lodja for 4 supported health zones (Dibebe, Kole, Lomela and Tshudi Loto)
1.2	Organize 12 monthly reviews in 4 supported health zones
1.3	Organize 660 monthly regular monitoring meetings in 55 health areas (55 health areas during 12 months) to review health center activities
1.4	Organize 660 monthly meetings of CODESA in 55 health areas to review CODESA activities
2.1	Fund the monthly functions of 4 health zones/coordinations over 12 months with \$250/health zone central office/month
2.2	Fund 12 missions to take out funds from SOFICOM with \$75/month/health zone central office
3.1	Organize 48 supervisions from the health district in Sankuru to Kole, Lomela, Tshudi Loto and Bena Dibebe health zones/coordination offices and GRHs with 2400\$=200\$X12 months
3.2	Organize 720 supervisions in 4 health zone central offices for 60 health facilities and Kole, Lomela, Tshudi Loto and Bena Dibebe's GRH (with 24000\$ =500\$X12monthX4 health zones)
3.3	Provide 4 health zones 360 liters of SAE 40 (30 liters a month)
3.4	Provide 4 health zones 3600 liters of gas (75 liters of gas *4 health zones =300 litres per month) to ensure supervision
3.5	Provide 3,120 liters GO for coordination office vehicles/health zone of Lomela (260 liters per monthx12) to ensure the supervision of 60 health facilities by 4 health zone central offices
3.6	Provide the Sankuru health district with 3,120 liters of fuel (260 liters of fuel x 12 months) to ensure supervision
M&E	
Organize monthly joint missions with the MOH M&E team to improve data quality with audits	
5	Support a verification and standardization meeting for quarterly information in the Lodja health district (4 health zones/quarter)

8.1	Produce 2,468 SNIS frameworks (1,964 in health centers, 280 in GRH, and 224 in health zone management teams), 605 monitoring images (following indicators), 185 curative care records, 300 GBV consultation posters and instructive posters for health facilities, 4000 referral documents from health centers to GRHs, 360,000 posters of illness, 59 monthly frameworks for PMP/IHP indicators
1.1	Carry out grant monitoring visits in health zones every month
1.2	Conduct monthly monitoring of subgrants given to health zones by the project
PM.2 Coordination office operational	
1.3	Manage daily office operations
1.4	Ensure the monthly follow-up of activities and time management of staff in the field according to project objectives (verification and analysis of timesheets)
1.5	Hold 4 weekly meetings and 1 meeting to analyze problems and to plan each month
1.6	Participate in the monthly CCIA meeting in Lodja (2 staff from Lodja will participate each month)
1.8	Develop monthly provisional budgets for activities
1.9	Develop monthly the financial report and send the justifications to Kinshasa
1.10	Present the project in different meetings with political health authorities and partners
2.1	Recruit new positions under the supervision of Human Resources in Kinshasa in case of need
2.2	Orient new employees
3.6	Work with Kinshasa to ensure that the budget is followed, with QuickBooks
3.7	Ensure staff vacations
3.8	Ensure that timesheets are completed and sent on time
4.1	Ensure everyday management in offices
4.2	Hold 52 weekly planning meetings with staff
4.3	Develop an office workplan every quarter/month
4.4	Monitor the office workplan every quarter/month
4.5	Ensure reporting on activities based on standards (monthly reports, quarterly reports, and success stories)
4.6	Conduct monthly support visits for staff activities in 4 health zones
PM.5 Manage security of staff in all offices	
5.1	Strengthen communication between staff and all project partners
5.2	Secure infrastructure and equipment to comply with security standards and regulations of MSH (fleet tracking, alarm system, set up office to have one "safe haven")
PM.6 All offices are equipped with proper technology and communication commodities according to needs	
6.1	Provide and equip all staff with adequate equipment package (computers, software)

KOLWEZI

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health

	zones increased
1.2	Organize a 5-day mid-year review with health district of the 2013 AOP along with a review of indicators
2	Renovate 6 structures in the targeted health zones (3 health facilities in Kanzenze health zone; GRH in Manika health zone; pediatric and maternity facilities in Mwangeji health zone; Kangaroo Mother center in Dilala health zone) (note: the water pump in the GRH in Kanzenze is not repairable and must be replaced during the dry season--July/August)
3	Provide medicines, medical supplies, and basic equipment to the health facilities
3.1	Provide technical assistance to CDMEK in the management and provision of essential and generic medicine to health zones
3.2	Provide the health facilities with medication management tools
3.4	Disseminate medication and lines of credit management procedures during supervisory visits
3.5	Provide health facilities with inputs for specific programs and medical equipment (small equipment used for treatment)
3.6	Monitor health facilities, health providers, and communities in drug management system (ordering, receiving and daily management)
3.7	Collect, analyze, and produce monthly reports on drug management
3.9	Supervise jointly with the health district drug management in health facilities and health zones on a quarterly basis
4.1	Provide follow-up on support to warehouse facilities (CDMEK) for the transportation of drugs and other inputs in the health zones
4.2	Monitor lines of credit and drug stocks at warehouse facilities (CDMEK) and in the health zones
4.3	Collaborate with SIAPS and MOH to discuss and finalize the construction project for a regional distribution warehouse (CDR) in the Kolwezi health district and decide what support can be provided by IHP given that the project cannot construct
5.2	Keep track of health providers trained in the use of flowcharts during supervision visits
	IR1.2: Community-based health care services and products in target health zones increased
2.4	Organize 3 follow-up/post-training group visits to health providers trained in health centers
3.2	Improve 30 water sources
3.5	Collect, analyze, and understand data on the water quality in the eight health zones
5.1	Finance 8 outreach activities (conferences, sports days for teenagers, especially girls, radio broadcasts of conference debates, etc.) with one outreach per health zone throughout the year
	IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery
1.4	Provide technical support for the monitoring of various LDP projects in the 8 health zones and health districts
1.6	Provide 48 family planning insertion kits to the 8 health zones
	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)
	IR 2.1: Minimum standards for physical infrastructure—achieved at general reference hospitals and health centers in target zones
1.7	Provide health center providers with the tools necessary to manage CBD activities (good reference books, health records, summary data sheets of data collection, etc.) in the 106 health areas

1.8	Conduct monitoring and evaluation activities with CBD head nurses
1.9	Accompany the health district and health zone in the joint supervision of the implementation of family planning activities and monitoring of the reproductive health commodities to be included in the monitoring plan
1.10	Provide family planning supplies to 156 health facilities in 8 health zones
2.1	Provide 12,000 liters of fuel for 40 refrigerators the health zones and EPI antenna
2.2	Provide 200 liters of fuel needed for 2 EPI antennas in Kolwezi and Likasi for the operation of the cold room per quarter
2.3	Provide 8 health zones with cold chain materials at the rate of 1 refrigerator every 3 months; 1 glass per refrigerator every 3 months; and 1 burner per refrigerator every 3 months (160 bits, 160 glasses, 80 burners)
2.4	Organize one joint supervision (IHP and EPI) per quarter on immunization activities (data quality assessment)
2.7	Supply the health zones with data management tools to facilitate the data quality self-assessment (DQS) (scorecard, F1, F2, F3, F4, temperature data, table tracking rate of loss of antigen, and EPI indicators)
2.8	Support the EPI branch from Kolwezi in supplying hard-to-access health zones with vaccines and other inputs by providing transportation (Lubudi and Mutshatsha)
4.2	Provide technical assistant to the health district focused on supervision of emergency management of pregnancy and the completion of partograms
5.2	Evaluate quarterly, in conjunction with the health district, the quality of EmONC (labor and delivery, including AMTSL, availability of oxytocin, and kits for the care of newborns in the health facilities) in 8 health zones
5.6	Provide technical assistance to health district supervisors that will lead the supervision focused on integrated care of the mother and the newborn (using the revised MNCH guidelines and procedures) in the 8 health zones
6.2	Provide technical and financial support for 12 monitoring and evaluation visits to two referral hospitals that perform KMC
7.4	Reproduce 20,000 health records for the 8 health zones
7.5	Provide technical assistance to the health district and the health zone management teams in supportive supervision of health providers and the technical monitoring of pre-school consultation (CPS)
8.1	Provide 161,000 SP to health facilities for pregnant women during prenatal consultations in the 8 health zones
8.2	Provide 25,500 LLINs to health facilities for pregnant women during prenatal consultations in the 8 health zones
9.7	Organize the quarterly post-training follow-up for health providers and community health workers trained by the health zone management team during supervision
9.8	Supply the health zone with ACTs, RDTs, paracetamol, and quinine (provided by PMI)
9.10	Provide tools for data management (forms for health zone management teams, health centers, GRHs, 2 per month for each health facility)
12.2	Arrange the transport from Lubumbashi to the targeted health zones of ready-to-eat therapeutic foods (F75, F100, Plumpy Nut, etc.) provided by UNICEF
12.3	Assist the health zone management teams technically, logistically, and financially to ensure follow-up visits to the 60 trained providers (2 visits of 5 days each per year)
13.1	Provide technical support for the meetings on epidemiological surveillance and reporting of epidemiological data
13.2	Supply the health zones and health district with tools for the collection and transmission of epidemiological data
14.2	Supply the 8 health zones with PMTCT products (tests, ARVs, Cotrim, and other products) at 27 PMTCT sites

14.3	Pay for the cost of CD4 analysis for HIV positive pregnant women in the GRH in Dilala for PMTCT sites that are not able to perform the analysis for free in their health zones
15.1	Organize 4 joint supervision missions in the fight against HIV (IHP, NACP, and health district)
17.2	Provide the 8 health zones with transfusion supply kits (blood bags, kits, 4 markers, and compatibility antigens)
18.3	Provide training materials and commodities for operations (including Ziehl-Neelson kit) to 7 CSDT
18.8	Provide funding quarterly to TB Coordination (CPLT - KTO) in the implementation of microscopic quality control activities (transport blades monthly from health zones to the CPLT and quarterly supervision)
18.8	Assure the transportation of TB-MDR suspected samples from the communities to the CST-CSDT and from health facilities to CPLT
18.9	Assure the transportation of TB suspected samples from the communities to the CST-CSDT
18.10	Organize a 4-day training for two members from the 8 health zone management teams, 5 executives of the CPLT, and 2 staff in IHP RDQA (audit data quality TB) in Kolwezi
18.12	Organize in collaboration with the CPLT a quarterly supportive supervision post-training follow-up at CST and the community levels of health providers trained in PATI 4 (in Lubudi, Fungurume, and Lualaba), and MDR-TB and TB/HIV (in all 8 health zones)
IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted	
1.1	Organize in collaboration with the health district a 3-day briefing for 16 members of the health zone management teams on the hygiene practices in health centers, taking into account the origin of infections and clinical implementation of the IHP EMMP
2.8	Provide financial and technical support to joint quarterly cross-checking activities with the health district for RBF data and health promotion activities by 2 CBOs
2.9	Provide quarterly performance payments to the 14 health centers in the Kanzenze health zone
2.10	Ensure quarterly performance payments to the GRH in the Kanzenze health zone, 1 GRH, and 1 health zone management team for 3 quarters
3.2	Train those responsible for the program, the RBF focal points and the M&E staff from the coordination offices, in the use of the database for the RBF program (20 people for 5 days)
IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized	
1.2	Organize in collaboration with the health district the case reference system from the community to health facilities (monthly meetings at health facilities and in the community)
2.1	Create an inventory of NGOs active in the field of GBV (education, medical care, legal support, and psycho-social rehabilitation)
2.2	Disseminate for the partners of the MOH (health district and health zone) the results and challenges identified in the gender study conducted in June 2012
3.3	Monitor activities in cooperation with the health zone management teams during field visits
4.2	Provide technical assistance to the health zones in the dissemination of awareness-raising messages on family planning through CBD networks in the 8 health zones
5.1	Organize the monitoring and evaluation of the CBD by head nurses (including Tiaht/informed choice)
Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)	

	IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations--established
5.2	Organize in collaboration with the health district and the health zone management teams monitoring missions and joint supervision in the 8 health zones
1.3	Monitor and evaluate ETL activities during supervisory visits with the health zone management teams
1.2	Provide technical and financial support to CODESAs in the implementation of their communication action plans
	IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched
1.1	Provide technical and financial support for 10 international day (e.g., AIDS, TB, Malaria, Woman, Hand washing, etc.) and international week (e.g., vaccination, breastfeeding) celebrations at the field office level
1.2	Accompany the health zone management teams in establishing and monitoring the activities of 8 listening groups (men, women, girls, and boys) located in 2 health zones of Kolwezi (4 in Dilala and 4 in Fungurume)
2.4	Organize in collaboration with the <i>Enseignement Primaire, Secondaire et Professionnel</i> (EPSP) the diffusion of messages about malaria prevention in communication notebooks in 20 schools in the city of Kolwezi (coordination meeting with EPSP)
4.1	Organize in collaboration with the health zone management teams 8 mini-campaigns in the priority areas of intervention as problems are identified: family planning (including promotion of modern methods), MNCH, EHA, and EPI in 4 health zones in the health district of Kolwezi
5.1	Transmit 3,000 SMS messages using the FrontLine SMS software to the mobile phones of identified partners in the community in 8 health zones (each zone is targeted according to its particular health problems)
6.4	Monitor and evaluate the terms of the contracts with local radio stations
7.3	Arrange with the health district and the health zone management teams the biannual action plan evaluation of 6 selected Champion Communities (in Kanzenze and Dilala) in the Kolwezi coordination (3 Champion Communities per health zone)
7.4	Participate in the organization of the biannual Champion Community festival (diploma printing and contribution to income-generating activities)
	Intermediate Result 4: Health sector leadership and governance in target provinces improved (Component 2)
	IR 4.1: Provincial health sector policies and national level policies aligned
2.5	Provide technical and financial support for 4 CCIAs meetings at the PEV Kolwezi branch
1.3	Provide technical and financial support for the monthly monitoring of 8 health zones (96 meetings, support for 8 central health zone offices)
	IR4.2: Evidence-based tools for strategic planning and management decision-making adopted
1.4	Provide technical and financial support for monthly monitoring at the community level
1.5	Provide technical assistance and financial support for community-based organization (CBO) monthly meetings (1,272 meetings total)
2.1	Contribute to the monthly operational costs of one DPS (Katanga)
2.2	Contribute to the monthly operational costs of one DS (Kolwezi)
2.3	Contribute to the monthly operational costs of one PEV branch of the health district (Kolwezi)
2.4	Provide financial support for the monthly operational costs of 8 health zone central offices

2.5	Provide financial support for the monthly operational costs of 8 GRHs
3.1	Contribute to the supervision of the Katanga DPS for the 8 health zones of the Kolwezi field office
3.2	Contribute to the supervision of the health district for the 8 health zone central offices and 8 GRH/referral health centers
3.3	Contribute to the health zone central offices supervisory visits to the health facilities
3.4	Provide fuel and oil to the health district and health zones for supervisory visits
	M&E
	Organize monthly joint missions with the MOH M&E team to improve data quality with audits
3	Supply the 8 health zones with the tools for collecting and transmitting data in the SNIS format
3.2	Provide specific training to staff according to the results of the analysis
4.1	Ensure the daily management of Kolwezi office
5.1	Strengthen communication between staff and other partners
5.2	Enhance the security of infrastructure and equipment to meet the organization's standards and regulations (fleet tracking, alarm system, fire extinguisher, door locks, office layout for a safe room, etc.)
6.1	Support the Kolwezi office in IT maintenance and equipment repair

LUIZA

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased
1.5	Fund mid-term 3-day AOP assessment for Kananga health zones during with the 11 health zone management teams of the 11 supported health zones
2.1	Rehabilitate 3 maternity clinics in GRH (Luiza, Kalomba and Dibaya)
2.3	Rehabilitate 6 health facilities, 2 per health zone in 3 health zones supported by IHP in Luiza (Kalomba, Ndekesha and Yangala)
2.5	Build 11 placenta pits, 11 showers and 11 latrines in the 11 rehabilitated health facilities (5 health facilities rehabilitated in Year 2 and 6 health facilities to be rehabilitated during Year 3)
2.6	Fund the construction of water collection, pumping and storage systems in the 6 health facilities
2.8	Rehabilitate/build incinerators in the 6 GRH (Luiza, Bilomba, Dibaya, Kalomba, Ndekesha and Yangala)
3.7	Provide health facilities with drug management tools, commodities and materials
4.1	Provide financial support, along with other partners such as SIAPS, TB 2015, for quarterly reviews with CADIMEK, PIP, PID and CPP GT
4.2	Provide quarterly transport of essential generic drugs from Kananga to the 11 health zones

5.2	Conduct 6 monthly follow-up missions for training in ordinograms, PATI 4, HIV kit, Integrated Management of Adult Illnesses (IMAI), MNCH, drug management, EPI, FP, GBV, etc.
IR1.2: Community-based health care services and products in target health zones increased	
2.4	Fund 12 awareness sessions/meetings on family planning for men
4.4	Brief 24 members of the WASH committee in 3 health zones on bacterial analysis of water (Bilomba, Tshikaji and Luiza) (3 per health zone)
5.3	Organize 5 sessions of culinary demonstrations in 5 communities of the target health zones
IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery	
1.4	Organize 4 joint missions for LDP follow up activities with provincial management team in the health zones of Ndekesha, Kalomba, Bilomba and Yangala
Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)	
IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved	
3.1	Provide quarterly the following support: 11, 610 liters of gas for 86 refrigerators in the health zones and EPI satellite branches (86 x 45 x 3 = 11,610 liters)
3.2	Provide quarterly 900 liters of diesel to the Mueka EPI branch for the cold room
3.3	Fund quarterly the transport of vaccines and other EPI commodities from Kananga to the Mueka EPI antenna
3.4	Provide fuel (200 liters) and oil (10 liters) quarterly for the outboard motor and the two motorcycles of the Dekese health zone in support of the mobile EPI strategy
3.6	Organize briefing for certified nurses on EPI technical briefs during two supplemental meetings
6.2	Provide a two-day briefing to the head nurses on various MNCH components (use of partogram, eclampsia management, AMTSL, newborn healthcare, HBB, etc.) through supportive supervision
14.1	Brief head nurses in 197 health facilities on vesico-vaginal fistula during monthly reviews (identification and referral to GRH for treatment)
16.3	Fund the transport to Kinshasa of blood samples for early diagnosis of HIV+ mothers (12 samples/month)
16.4	Fund the transport of CD4 samples of HIV+ pregnant women for testing, in health zones lacking CD4 count equipment (20/month)
IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized	
4	Improve the family planning referral system for community-based distribution (CBD) agents to increase use of family planning methods in the health facilities of the 11 health zones (See IR1.2 2)
5	Strengthen monitoring and evaluation for head nurses in community based distribution (CBD) activities in the 11 health zones
6	Strengthen referral for MPA-plus activities between health facilities and the community (immunization, ANC, CPS, assisted deliveries, MNCH, etc.)
Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)	
IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations—established	

1.1	Conduct a 2-day training on the ETL approach for 60 community members (20 people per health zone) in 3 health zones: Tshikaji, Kalomba and Dibaya
1.2	Conduct 20 ETL sessions in 4 health zones (10 per health zone) on various topics (family planning, prenatal consultation, malaria, TB, WASH, GBV, nutrition, HIV, MNCH, immunization, danger signs, essential nutrition actions, i-CCM) in the health zones of Bilomba, Tshikaji, Kalomba and Dibaya
1.3	Conduct 4 ETL post-training follow-up visits (one visit per health zone)
IR 3.2: Health advocacy and community mobilization organizations strengthened	
2.1	Conduct 2 5-day BCC campaigns on TB detection in 5 health areas of the Bilomba and Bulape health zones
1.1	Support the celebration of 10 World Days (Malaria, TB, AIDS, Women, Hand washing, Children) at the coordination office level
IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched	
2.1	Fund 10 BCC mini-campaigns covering 9 themes (family planning, TB, HIV, nutrition, MNCH, gender, WASH, etc.) in challenging health zones
3.1	Send 10,000 awareness and education SMS relating to the 9 IHP health topics in the health zones covered by cellular networks (Tshikaji, Luiza, Bilomba, Lubondaie, Dibaya, Kalomba, and Bulape)
5.1	Fund the training of 6 Champion Communities in 6 health zones (1 Champion Community per health zone in Kalomba, Luambo, Dibaya, Bilomba, Luiza and Tshikaji)
4.1	Fund bi-annual provincial reviews
IR4.2: Evidence-based tools for strategic planning and management decision-making adopted	
4.2	Fund district quarterly reviews (16 reviews, 4 per health district)
4.3	Fund monthly monitoring reviews of the 11 health zones (132 meetings) at the health zone central office
4.4	Fund monthly monitoring meetings at grass-root level (2,364 monitoring meetings)
4.5	Provide technical and financial support for monthly monitoring at GRH level (132 monitoring meetings)
4.6	Fund monthly CBO meetings for a total of 2,364 meetings
5.1	Contribute to monthly operations of the provincial health division
5.2	Contribute to monthly operations of the 4 health districts (Luiza, Kananga, Lulua, Kasai)
5.3	Contribute to monthly operations of the three EPI branches (Luiza, Kananga and Mueka)
5.4	Contribute to monthly operations of the 11 health zone central offices
5.5	Contribute to monthly operations of the 11 GRH
6.2	Provide financial and technical support for health zone central office supervision of the health facilities
6.3	Supply on a quarterly basis 292 liters of gas to the health districts (160 to Luiza district and 132 to Kananga district) for health zone supervision
6.4	Supply on a quarterly 585 liters of diesel fuel to the health districts (225 to Luiza district, 180 to Luiza district and 180 to Kasai district) for health zone supervision
6.5	Supply on a quarterly 2,610 liters of gas to the health zones for the health facilities supervision
6.6	Supply on a quarterly basis 78 liters of motor oil to the health zones for the health facilities supervision

7.1	Provide funding for monthly supervision visits for the head nurses to the community health care sites
1	Work with civil society organizations to strengthen their participation, representation, and accountability in provincial policy and planning processes
2	Implement a pilot program of small grants to eligible NGOs to increase institutional capacity and service delivery at the community level
	M&E
	Organize monthly joint missions with the MOH M&E team to improve data quality with audits
1.1	Organize joint 6-day data audit missions to one health zone per month with the health zone central office, the GRH and 4 health centers in 11 health zones (DQS, RDQA, Tanahashi model to assess health system bottlenecks and develop strategies): 1 health zone/month
1.3	Orient IHP staff and health zone management teams on the IHP PMP
1.4	Reproduce Performance Indicators Reference Sheets for 208 health facilities, 4 health districts, 4 EPI branches and the provincial health division in all health zones
5.1	Duplicate and supply health facilities with data collection tools
5.2	Duplicate and supply health facilities with data transfer tools
	Project management
	PM.1 Follow standards and norms of administrative and financial management for all departments in the IHP coordination office (program, administration and finance)
1.1	Conduct quarterly staff meetings to ensure understanding of MSH administrative and financial procedures
1.2	Develop and transmit monthly operating budget and planning
1.3	Develop monthly financial report and transmit supporting documents to Kinshasa
1.4	Represent the project in at least 70% of meetings with health and political authorities as well as partners meetings
3.5	Collaborate with Kinshasa office to ensure adherence to QuickBooks budget
3.6	Coordinate staff vacation dates
3.7	Ensure that timesheets are adequately filled out and sent
4.1	Ensure daily management and supervision office duties (Luiza and Kananga)
4.2	Conduct 52 weekly staff planning meetings
4.3	Produce quarterly/monthly office work plans
4.4	Evaluate the workplans quarterly/monthly
4.5	Ensure standard reporting (weekly, monthly, quarterly and annual reports as well as success stories, etc.)
4.6	Provide monthly support to the monitoring visits of the staff in the 11 health zones
6.4	Ensure monthly preventive maintenance of the two generators in Luiza and Kananga
6.5	Ensure monthly preventive maintenance of the motorcycles (11 in the health zones and 4 in Luiza and Kananga)
6.6	Ensure monthly preventive maintenance of the three vehicles in Luiza and Kananga
6.7	Ensure quarterly complete preventive maintenance of the two vehicles in Luiza and Kananga
6.8	Supply diesel quarterly to the Luiza office for the cold chain
6.9	Supply gas quarterly to the Kananga office for the cold chain
6.10	Supply motor oil quarterly to the Luiza and Kananga offices for the cold chain, vehicle and motorcycles

6.11	Pay monthly bills for coordination office security in Luiza and Kananga
6.12	Provide the coordination offices of Luiza and Kananga with office supplies monthly
6.13	Provide the coordination offices of Luiza and Kananga with water and cleaning supplies
6.14	Purchase monthly cell phone units for the 5 modems

MWENE DITU

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased
2.1	Renovate 12 health facilities in 10 health zones (excluding Lusambo, where the renovation is undertaken by GAVI) from the coordination office
3.1	Supply pharmaceuticals to 222 health facilities
4.1	Transport essential medicines (MEG) and other commodities towards the Lusambo, Mpania Mutombo, Wikong, Bibanga, and Kamiji health zones
	IR1.2: Community-based health care services and products in target health zones increased
4.2	Construct 68 water sources in 68 selected communities from Wikongo health zone
5.2	Organize monthly sessions and cooking demonstrations in Kanda Kanda and Luputa health zones
5.3	Sensitize 30 groups to support breastfeeding mothers, pregnant women, husbands and grandmothers on exclusive breastfeeding in 2 health zones in Mwene Ditu
8.2	Hold monthly awareness campaigns for the populations in 4 health zones (Mwene Ditu, Dibindi, Mpokolo, and Wikong) on blood donation and collection
	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)
	IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved
1.3	Ensure that commodities are available in the 222 health facilities of the coordination office
1.4	Support the training follow-up visits for 84 providers trained in the insertion and removal of IUD and implants
1.5	Scale up the Tiaht amendment for nurses and CBD in the 194 health areas of the coordination office (2 sessions/health area)
1.6	Organize 22 quarterly follow-up missions grouped with the head nurses and the CBD in the 6 health zones of the coordination office
3.1	Ensure integrated supervision in the sector of maternal and child health in the health facilities
3.2	Organize follow-up visits of 3 providers trained in MISGAV C-sections
5.4	Scale up the Helping Babies Breathe (HBB) methodology in all of the health facilities in 16 health facilities in 4 of the health zones supported by the coordination office (Bibanga, Mwene Ditu, Dibindi, and Luputa)
6.1	Distribute 52,5000 LLIN during prenatal consultations in the 8 health zones that are not covered by the Global Fund in the Mwene Ditu coordination office area
7.1	Distribute antimalarial commodities in the health zones supported by PMI (438 boxes of SP, 611,809 doses of ACT, 1,199,626 RDT and kits for treatment of severe malaria) from the CDRs

8.1	Organize 11 follow-up visits to the trainings in severe malaria diagnosis in 28 referral health facilities in the 11 health zones
9.1	Organize 52 awareness campaigns on the 2 registered community radio stations on the responsibility of the community towards sexual violence
9.5	Organize follow-up visits for health zone management teams and providers on sexual violence
10.3	Conduct follow-up visits of 120 providers trained under 15.1, including the supervision of trainings for the remaining personnel involved in nutritional treatment in the 12 selected health zones
11.1	Provide technical and financial support to the referral system for fistulas to the GRHs established in 2 health zones of the coordination offices (Mwene Ditu and Dibindi) that are equipped and capable of providing the elevated level of services needed as a result of a campaign
12.4	Ensure the transport of blood samples for early diagnosis of children born to HIV+ mothers
3.3	Organize a distribution of performance payments for the highest performing health facilities (FOSACOF health centers, GRH FOSACOF, and community satisfaction health centers)
IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized	
3.1	Provide care for 50 cases of fistula in the GRH of Dibindi and Tshiamala (Dibindi and Mwene Ditu)
4.2	Disseminate outreach messages on family planning and fistula
6.1	Organize 22 mini awareness campaigns in 11 health zones of the coordination office
6.2	Finance 104 broadcasts on 2 radio stations on the 9 intervention areas
1.3	Conduct a monthly monitoring visit to 170 members of the community trained in ETL in the 10 health zones
Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)	
IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations--established	
2.2	Organize 25 outreach sessions in the 3 health zones (Wikong, Mwene Ditu, and Kamiji)
1	Develop and implement communication campaigns on health
IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched	
1.2	Contribute to the organization of 10 international days (malaria, tuberculosis, HIV/AIDS, women, hand washing, etc.) and special weeks (vaccination, breastfeeding, water, etc.) at the provincial level
3.4	Organize 2 WASH mini-campaigns in 2 health zones (Luputa and Mwene Ditu)
4.1	Send 137,500 SMS messages to support BCC mini campaigns in 10 health zones
	Evaluate the implementation of the Champion Community approach on a quarterly basis
IR 4.1: Provincial health sector policies and national level policies aligned	
4.1	Provide technical and financial support for two steering committee meetings
4.3	Organize 6 meetings of the CPP commissions in the province
M&E	
1.1	Organize monthly reviews in 11 health zones to analyze transmitted data
1.2	Organize monthly reviews in 11 health zones to analyze data from 194 health centers

1.3	Provide technical and financial support for the monthly monitoring at the CBO level for 194 health areas
	Provide technical and financial support to the SNIS
2.1	Contribute to province monitoring meetings which take place on a biannual basis
3.1	Provide support for the monthly operations of the provincial health division
3.2	Finance the monthly operations of 3 health districts
3.3	Finance the monthly operations of 2 EPI branches
3.4	Finance the monthly operations of 11 health zone central offices
3.5	Finance the monthly operations of the GRH in the 11 health zones
4.1	Organize the supervisions of the provincial health division of the coordination office
4.2	Contribute to the supervision of the 3 health districts to the health zones
4.3	Contribute to the supervision visits of the health zone central offices to the health centers
4.4	Contribute to the monthly maintenance of motorcycles in health zones
4.5	Provide fuel to the district and health zones for supervision
4.6	Provide health zones with fuel for supervisions
4.7	Provide health zones with motor oil for supervision visits
4.10	Supply diesel fuel to provincial health division for supervision visits
5.1	Organize supervision visits of head nurses to the community health sites (SSC) and provide fuel for field visits in the Kanda Kanda and Kalenda health zones
5.2	Organize coaching visits to the community health care sites
4.1	Reproduce priority management tools for 222 health facilities
1.1	Hold quarterly meetings with staff to ensure comprehension of MSH administrative and financial procedures
1.2	Conduct monthly visits to monitor grants provided by the project
1.3	Develop and send monthly budget forecasts
1.4	Develop the financial report on a monthly basis and expedite vouchers
1.5	Represent the project in at least 70% of the meetings with political and health authorities and partners
3.2	Participate in 2 biannual consolidation meetings of data and reports with the other coordination offices and Kinshasa
3.4	Monitor staff leave time
3.5	Monitor the completion and submission of timesheets
4.1	Ensure daily management of the office
4.2	Hold monthly planning meetings with the staff
	Equip health facilities with management tools (data collection and coverage monitoring)
4.3	Develop on a quarterly/monthly basis office workplans
4.4	Evaluate on a quarterly/monthly basis office workplans
4.5	Ensure the transmission of reports in line with fixed due dates
6.5	Ensure on a monthly basis the maintenance of equipment in line with the maintenance plan
6.6	Provide diesel oil to the coordination office to ensure the functioning of the vehicles and generator

TSHUMBE

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased
2.1	Finance the renovation of 10 health centers in 5 health zones (Dikungu, Djalo, Ototo, Tshumbe and Lodja)
2.3	Build 15 VIP latrines in the 10 renovated health centers (Dikungu, Djalo, Ototo, Tshumbe and Lodja) and the 5 renovated maternity wards (Djalo, Lodja, Dikungu, Ototo and Vangakete)
2.4	Build 15 incinerators in the 10 renovated health centers (Dikungu, Djalo, Ototo, Tshumbe and Lodja) and the 5 rehabilitated maternity wards (Djalo, Lodja, Dikungu, Ototo and Vangakete)
2.5	Construct 5 placenta pits in the 5 renovated maternity wards (Djalo, Lodja, Dikungu, Ototo and Vangakete).
2.6	Finance the renovation of the Tshumbe health zone central office and the Sankuru health district office
3	Provide essential generic medicines (MEG), commodities and other medical supplies
3.1	In collaboration with SIAPS, assist the health zones with quantifying drug needs (budget included in the monitoring and supervision budget for the health zone central offices)
3.3	Provide the health facilities with pharmaceutical management tools, commodities and equipment
3.4	Collect monthly management reports on pharmaceuticals and other health products
3.5	Conduct a quarterly joint supervision (health district, health zone management teams, IHP and SIAPS) on pharmaceutical management in the selected health zones and health facilities supported by IHP (5 health zones/quarter)
3.7	Conduct monthly pharmaceutical management supervision in the health zones and health facilities supported by IHP
3.9	Provide quarterly transport of pharmaceuticals and other commodities to the 10 health zones in the Tshumbe coordination from the Lodja FODESA
3.10	Monitor on a quarterly basis the lines of credit and IHP stocks in the FODESA warehouse and in the health facilities in conjunction with the Sankuru health district and SIAPS
	IR1.2: Community-based health care services and products in target health zones increased
1.3	Conduct 3 follow-up visits in the 3 trained health zones during supervision visits to providers and the newly-trained CHWs
2.1	Provide technical support to 20 villages/communities identified in PY2 in the implementation of action plans for the Clean Village approach and provide appropriate capacity building to them to construct their selected projects
2.3	Build 30 water sources in the Dikungu health zone
2.5	Provide technical support to water quality data collection, analysis and reporting in Dikungu
3.2	Organize three 3 day post-training follow-up visits in the health areas from 3 health zones
3.3	Provide technical support to 20 support groups for breastfeeding women, pregnant women, husbands and grandmothers on exclusive breastfeeding (one group/health zone)
3.4	Equip 120 CHWs with MUAC measuring tapes and other tools (documents with key message for nutrition, reference files, etc.)

	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)
	IR 2.1: Minimum standards for physical infrastructure at general reference hospitals and health centers in target zones achieved
2.3	Organize a quarterly joint supervision visit (MOH and IHP) in the different project interventions
1.2	Provide 169 health centers with tools necessary to manage community-based distributor (CBD) activities (references, health records, data synthesis templates, data collection sheets) in the 169 health areas of the Tshumbe coordination office (see M&E)
1.3	Provide technical support to head nurses to support the monitoring and evaluation of CBD activities
2.1	Provide 9,615 liters of oil for 63 health zone refrigerators and 2,160 liters of fuel to the EPI branches in Lodja to maintain the cold chain
2.3	Organize joint IHP/EPI branch supervision visits to monitor vaccination activities in the health zones
4.2	Conduct a 10-day monthly integrated supervision of activities (MNCH) in 10 health zones to reorient supervision towards a coaching approach) and monitor quality improvement targets as identified in the FOSACOF
6.1	Orient providers in 10 health zones on the effective use of health records during supervision visits and monthly monitoring of health zones
7.1	Distribute 2,315 LLIN on a monthly basis during antenatal care in the 7 health zones that are not covered by the Global Fund (GF) (Djao, Katako, Dikungu, Tshumbe, Minga, Ototo, and Vangakete)
8.2	Ensure the quarterly distribution of antimalarial commodities from the FODESA to the 7 health zones benefitting from PMI support.
11.4	Finance monthly transport from the health zones to Kinshasa of blood samples for early diagnosis of children born to HIV+ mothers
11.5	Improve tracking of HIV positive women who choose a family planning method after delivery by ensuring the availability of selected methods, providing management tools, linking facility staff to ongoing family planning training to build their capacity, and ensure follow up and involvement of CHWs at the community level
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
14.2	In collaboration with the WHO, financially support the transport of suspected samples of MDR-TB from the health zones to the health district laboratory in Lodja (PNLT)
	IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized
14.3	Ensure on a quarterly basis the transport of slides from the health center for diagnosis and treatment (CSDT) to the health zones, and from the health zones to the provincial coordination unit for leprosy and TB (CPLT) for quality control
1.2	Monitor the community health referral system for health sites during monthly meetings for the health sectors
2.2	Broadcast outreach messages on family planning (see IR 3)
3.1	Organize monitoring and evaluation of CBD by the head nurses (including Tiaht/informed choice)
4.2	Broadcast outreach messages on vaccination, CPN, CPS, assisted delivery, PMTCT etc.
	Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)
	IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations—established

1.2	Conduct a 3-day follow-up visit per health zone in 6 health zones (Wembonyama, Dikungu, Minga, Djalo, Tshumbe and Lodja) on ETL and BCC techniques
2.2	Finance on a biannual basis the implementation of operational action plans from 4 local NGOs/CBOs (minimum 50% of the NGO/CBO focused on women, children and other vulnerable groups) from the Lodja health zone (see IR 2.1 1.3)
IR 3.2: Health advocacy and community mobilization organizations strengthened	
1.4	Reactivate the existence and operations of the 85 CODESA in 5 health zones (Dikungu-17, Minga-18, Ndjalo-Djeka-14, Tshumbe -14, and Lodja-22) while considering the balance between men, women and young children
1.2	Organize 10 international days (malaria, tuberculosis, HIV/AIDS, women, hand washing, etc.) with the Tshumbe coordination office
IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched	
2.1	Organize 12 BCC mini-campaigns in the 10 Tshumbe health zones (1 BCC mini-campaign/month/health zones/targeted health area) on the IHP intervention areas (particularly focusing on the health areas which lowered the performance indicators of the coordination office)
6.1	Send SMS 15,000 messages on IHP priority intervention areas in the 4 health zones covered by the cellular network (Lodja, Katako, Tshumbe, and Wembonyama) (1 SMS campaign/health zones/month) in the Tshumbe coordination office
IR4.2: Evidence-based tools for strategic planning and management decision-making adopted	
2.2	Provide the health zones with data collection and data transmission tools
4.2	Provide technical and financial support for the monthly monitoring review of 10 health zones (120 meetings in 10 health zones supported by the Tshumbe coordination office)
4.3	Provide technical and financial support for monthly monitoring at the base level (2,028 monitoring meetings in the 169 health areas)
4.4	Provide technical and financial support to monthly meetings of CBOs (2,028 CBO meetings in the 169 health areas).
5.1	Provide technical and financial support for the operations of the Sankuru health district
5.2	Provide technical and financial support for the operations of 10 health zones supported by the Tshumbe coordination office
6.1	Provide monthly financing for the health districts to supervise the 10 health zones supported by the project
6.2	Provide monthly financing to the 10 zonal coordination offices to conduct monthly supervision of each health facility
6.3	Provide fuel to the health district and health zones to ensure supervision visits
6.4	Provide quarterly funding for the transport of fuel products
7	Provide monthly support to supervision visits by the multi-purpose teams of the health center to community health care sites, the CBDs, the CHWs for LLIN distribution, and social workers for the monitoring of PMTCT activities
1	Work with the civil society groups to reinforce their voices, their implication and their responsibility in the planning process and provincial politics (rehabilitate the COGES)
2	Implement a pilot program of small grants for eligible NGOs to increase institutional capacity and service delivery at the community level
M&E	
2.3	Organize 1 quarterly PHC review to validate health district data
1.1	Hold quarterly meetings with staff to ensure comprehension of MSH administrative and financial procedures
1.2	Conduct monthly visits to monitor grants provided by the project
1.3	Develop and send monthly budget forecasts
1.4	Develop the financial report on a monthly basis and expedite vouchers
1.5	Represent the project in at least 70% of the meetings with political and health authorities and partners

3.2	Participate in 2 biannual consolidation meetings of data and reports with the other coordination offices and Kinshasa
3.4	Monitor staff holidays
3.5	Monitor the completion and submission of timesheets
4.1	Ensure daily management of the office
4.2	Hold monthly planning meetings with the staff
4.3	Develop on a quarterly/monthly basis office workplans
4.4	Evaluate on a quarterly/monthly basis office workplans
4.5	Ensure the transmission of reports in line with fixed due dates
6.5	Ensure on a monthly basis the maintenance of equipment in line with the maintenance plan
6.6	Provide diesel oil to the coordination office to ensure the functioning of the vehicles and generator

UVIRA

	Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)
	IR 1.1 Facility-based health care services and products (zonal hospitals and health centers) in target health zones increased
2.1	Fund renovations of health centers in 4 of the IHP-supported health zones (Ndunda and Mangwa health centers in Ruzizi health zone; Kenya, Kabumbe, and Abeka health centers in Nundu health zone; Kibungu and Katogota health centers in Lemera; and Rubuga, Rubemba, Muranvya, and Mukumba in Hauts-Plateaux d'Uvira)
2.2	Fund renovations of maternities in 4 of the IHP-supported health zones (GRH Katanga and Bijombo in Hauts-Plateaux d'Uvira, the maternity at GRH Nundu et Pungu in Nundu health zone; GRH Mulenge in Lemera health zone; GRH Mugaja in Ruzizi health zone; and GRH Mulongwe et Kalundu Etat in Uvira)
3.10	Train/Monitor 112 pharmacy technicians and health zones pharmacy managers on drug management
3.12	Provide logistic support for essential general medicines and other commodities transport to the health zones
	IR1.2: Community-based health care services and products in target health zones increased
2.1	Conduct monthly supervision visits with the health zone management team (head nurses) and quarterly visits with the health zone central office and the provincial health division, to monitor and provide supportive supervision to activities in 27 community health care sites of Lemera, Nundu, Ruzizi, and Uvira
3.2	Support the health zone management team on renovation activities to expand the water supply network in Biriba, Kimuka, Kajoro, Namijembwe and Kihanama (Ruzizi health zone)
3.3	Support the health zone management team in healthy village activities in the 25 villages involved in the process to declare them healthy villages
3.13	Collect, analyze and entering data on water quality quarterly in the 5 health zones
4.6	Support and organize quarterly community weighing of children in 25 target health areas with i-CCM activities (5 per health zone)
5.1	Supply blood transfusion sites with specific commodities (blood bags, blood transfusion kits, ABO antigens for blood typing, and markers--HIV and RPR tests, etc.)
	IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery
1.3	Increase sensitization meetings to raise community awareness of LDP projects during various contacts in health zones
1.4	Organize 2 evaluation meetings with CODESA and health providers
	Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased (Component 1)

	IR 2.1: Minimum standards for physical infrastructure—at general reference hospitals and health centers in target zones achieved
4.4	Supply 45 stock sites with 93 #23 wicks and 42 #32 wicks every quarter and 62 #23 glasses and 28 #32 glasses every six months, and 45 burners to maintain the cold chain
7.1	Supply 80 health facilities with 36,000 oxytocin vials and vitamin K1 for Active Management of Third Stage Labor (AMTSL) and vitamin A for post-natal consultations
7.2	Supply 104 health facilities integrating prenatal consultation activities with specific commodities (Fefol, SP, Vermox, and LLIN)
8.5	Provide 2-day supportive supervision visits on MNCH 6 times per year in each health zone
11.3	Distribute anti-malaria medicines: 4,281 ACT doses for newborns under 12 months; 68,499 doses for children 1 to 5 years old; 53,515 doses for 6 - 13; and 58,867 doses for children over 13
12.1	Distribute 462,905 RDT and 462,905 gloves at 112 health facilities and 27 health sites for malaria rapid diagnosis testing
15.1	Organize an awareness campaign for the communities on fistula repair
15.2	Fund fistula repair interventions at a Center of Excellence (Uvira GRH)
18.3	Conduct 2 quarterly visits with the health district to monitor the "Mother2Mother" approach
19.2	Provide 25 sites with data collection tools
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
1.5	Organize 4 FOSACOF evaluations in 43 health facilities which have integrated the approach (23 in Nundu health zone and 5 per health area for the other health zone)
2.4	Provide quarterly performance payments in the 24 health centers and 1 GRH for two quarters (to commence after the baseline survey is completed)
	IR 2.3 Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized
2.2	Provide CBOs/NGOs with awareness and follow up tools for GBV cases
4.1	Organize follow up and supervision of community-based distribution activities by head nurses (including Tiaht/informed choice)
5.2	Disseminate awareness messages on immunization, prenatal consultation, assisted delivery and PMTCT, etc.
6	Strengthen community best practices for the survival of mother and newborn and ensure community surveillance
	Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)
	IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations--established
1.2	Organize 3 post-training follow-up visits
	IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched
1.2	Fund the celebration of 10 world days or national days (malaria, TB, AIDS, women, hand washing) and special weeks (immunization) at the coordination level
2.1	Fund SMS information campaigns in the community on selected health topics in the 5 health zones
2.2	Support weekly local radio shows broadcasted by community radios in 5 health zones (Fizi, Lemera, Mboko, Mitumba, and Sange)
2.5	Organize monthly supervision activities on community radios in collaboration with health zone management team
3.2	Ensure the implementation of the actions plans of the 5 Champion Communities

3.3	Reward the Champion Communities with the best performance during bi-annual evaluations
1.1	Support one joint quarterly supervision and follow-up visit with the district to the 5 health zones
Intermediate Result 4: Health sector leadership and governance in target provinces improved (Component 2)	
IR 4.1: Provincial health sector policies and national level policies aligned	
1.2	Supply the health zone with data collection and data transmission tools on all 9 areas of IHP work
1.1	Provide technical and financial support to organize 60 meetings of the management committee (COGE) in the 5 health zones, with 1 monthly meeting in each health zone
IR4.2: Evidence-based tools for strategic planning and management decision-making adopted	
2.1	Provide technical and financial support for 60 data analysis meetings at the health zone central office (this data analysis includes the team of supervisors)
2.2	Provide technical and financial support for 60 monthly indicator review meetings (monitoring of PHC) with the head nurses at the health zone central office
2.3	Provide technical and financial support for 1,248 monitoring meetings at the health center level
3.1	Contribute to MOH operations (DS/Sud)
3.2	Contribute monthly to the Uvira EPI branch operations
3.3	Contribute monthly to the health zone central office operations of 5 health zones
3.4	Contribute monthly to coordination operations of 5 GRH
4.1	Fund monthly integrated supervision conducted by the 5 health zone management teams in the health facilities
4.2	Supply the health zone management team and EPI branch of the Sud health district with fuel (gas) for the supervisions by motorcycle to the facilities
1	Work with the civil society groups to reinforce their voices, their implication and their responsibility in the planning process and provincial politics (rehabilitate the COGES)
2	Implement a pilot program of small grants for eligible NGOs to increase institutional capacity and service delivery at the community level
M&E	
1.2	Provide support to health zone central office to conduct least 4 supervision visits to health facilities monthly, to improve data quality, and to produce supervision reports
1.3	Provide support on a monthly basis to 3 health facilities in the Routine Data Quality Analysis (RDQA)
2.1	Support quarterly data validation meetings at each health zone central office (provide transport and meals for the head nurses and CODESA)
2.2	Increase financial support for monthly monitoring meetings to improve data quality, if appropriate (this increase has been proposed but not yet validated; if validated, it will start later in PY3)
1.1	Hold quarterly meetings with staff to ensure comprehension of MSH administrative and financial procedures
1.2	Conduct monthly visits to monitor grants provided by the project
1.3	Develop and send monthly budget forecasts
PM.1 Achieve the standards and norms of administrative and financial management for all departments in the IHP coordination office (program, administration and finance)	
1.4	Develop the financial report on a monthly basis and expedite vouchers
1.5	Represent the project in at least 70% of the meetings with political and health authorities and partners
3.2	Participate in 2 biannual consolidation meetings of data and reports with the other coordination offices and Kinshasa
3.4	Monitor staff leave time
3.5	Monitor the completion and submission of timesheets
4.1	Ensure daily management of the office
4.2	Hold monthly planning meetings with the staff

4.3	Develop on a quarterly/monthly basis office workplans
4.4	Evaluate on a quarterly/monthly basis office workplans
4.5	Ensure the transmission of reports in line with fixed due dates
6.5	Ensure on a monthly basis the maintenance of equipment in line with the maintenance plan
6.6	Provide diesel oil to the coordination office to ensure the functioning of the vehicles and generator

Appendix 7

Integrated Health Project (IHP) Year 3 International Travel and STTA Plan Oct 2012 - Sept 2013								
#	TECHNICAL AREA	SUGGESTED PERSON	ORG	Travel dates	INDICATIVE SCOPE OF WORK	Origin/destination	Length of trips	STATUS
						to	days	
STTA/PROJECT MANAGEMENT AND MONITORING								
Quarter 1 Oct-Dec 2012								
1	Program Management	Kristin Cooney	MSH	November 1 - 19, 2012	Provide technical and management support and visit project sites.	Boston/Kinshasa	19	Completed
2	BCC	Vololoniaina Razaka	OSC	October 20 - November 10, 2012	Evaluate the implementation of the Community Champion approach in Uvira and finalize the M&E tools and the drafts of the IEC materials for community festivals that will commemorate the 6-month anniversary of the pilot's initiation.	Antananarivo/Kinshasa/Uvira/Nundu/Bukavu	21	This this trip was rolled over from PY2 approved travel. Completed.
3	HIV	Erik Schouten	MSH	November 12-23, 2012	Provide technical and management support to IHP HIV Advisor and visit project supported PMTCT sites.	Lilongwe/Kinshasa	12	Moved to March 10 - 24, 2013, Completed.
4	M&E	Elena Chopyak	MSH	October 27 - November 16, 2012	Provide technical and management support in the drafting of the Quarterly Report.	Boston/Kinshasa	21	Completed
5	BCC	Amelie Sow-Dia	OSC	November 2012	Finalize the Tuendi-Kampala communication strategy, focusing on amplifying the strategy to integrate the communications strategies piloted during PY1 and PY2.	Dakar/Kinshasa	15	Completed

6	WASH	Bob Metcalf	IRC	November 25 - December 4, 2012	Conduct TOT on water analysis techniques using microbiology and chemical test kits (Colilert, Petrifilm, and arsenic testing kits).	Sacramento/Kinshasa	21	This this trip was rolled over from PY2 approved travel. Completed.
7	Project Management	Steve Morgan	MSH	December 9 - 22, 2012	Operations Management Assessment DRC	Kabul/Kinshasa	15	Postponed
8	M&E	Sarah Castle	MSH	December, 2012	Provide M&E support	London/Kinshasa	15	Moved to January 26 - February 9, 2013. Completed.
Quarter 2 Jan-Mar 2013								
9	RBF	Alfred Antoine	MSH	January 19 - January 28, 2013	Provide short-term technical assistance for the RBF database.	Kigali/Kinshasa	9	Completed
10	BCC	Paul Neely	OSC	February 10 - March 3, 2013	Evaluate the implementation of the CUG systems, continue to evaluate the mini SMS campaigns and produce at least 2 success stories as result of the Technical support to IHP.	Los Angeles/Kinshasa	21	Completed
11	M&E	Megan Rauscher	MSH	January 2013	Provide capacity building to the M&E staff in creating a health systems alignment plan.	Boston/Kinshasa	15	Cancelled
12	M&E	Elena Chopyak	MSH	January 20 - February 16, 2013	Provide technical and management support in the drafting of the Quarterly Report.	Boston/Kinshasa	27	Completed
13	Program Management	Kristin Cooney	MSH	February 3 - 16, 2013	Provide technical and management support and visit project sites.	Boston/Kinshasa	15	Completed

14	RBF	Jean Kagubare	MSH	February - March, 2013	Follow up implementation of RBF. Conduct trainings and orientation for the health services cost study implementation.	Boston/Kinshasa	20	Postponed
15	RBF	Alfred Antoine	MSH	March 2 - 20, 2013	Finalize and install the database with local information technicians. Provide trainings on the use of the database.	Kigali/Kinshasa	18	Postponed
16	Health	Lara Ho	IRC	February 18 - March 5, 2013	Technical visit to monitor progress of IHP program in Kolwezi. Produce at least 2 success stories as a result of the Technical support to the IHP Kolwezi team.	Geneva/Kinshasa	21	Cancelled
17	M&E	TBD	MSH	March 2013	Provide M&E support	Boston/Kinshasa	20	Cancelled
18	RBF	Zina Jarrah	MSH	March 1 - 13, 2013	Conduct trainings and orientation for the health services cost study implementation.	Boston/Kinshasa	12	Postponed until PY4
19	RBF	TBD	MSH	March 1 - 30, 2013	Develop RBF Database for MOH and Train MOH and IHP staff.	Nairobi/Kinshasa	21	Cancelled
Quarter 3 Apr-Jun 2013								
20	MNCH	Ciro Franco	MSH	April 1-15, 2013	Analyzing results of MNH Quality of Care Assessment and contributing to the study report. ICCM sites visits. Follow-up Collaborative approach implementation.	DC/Kinshasa	15	Postponed

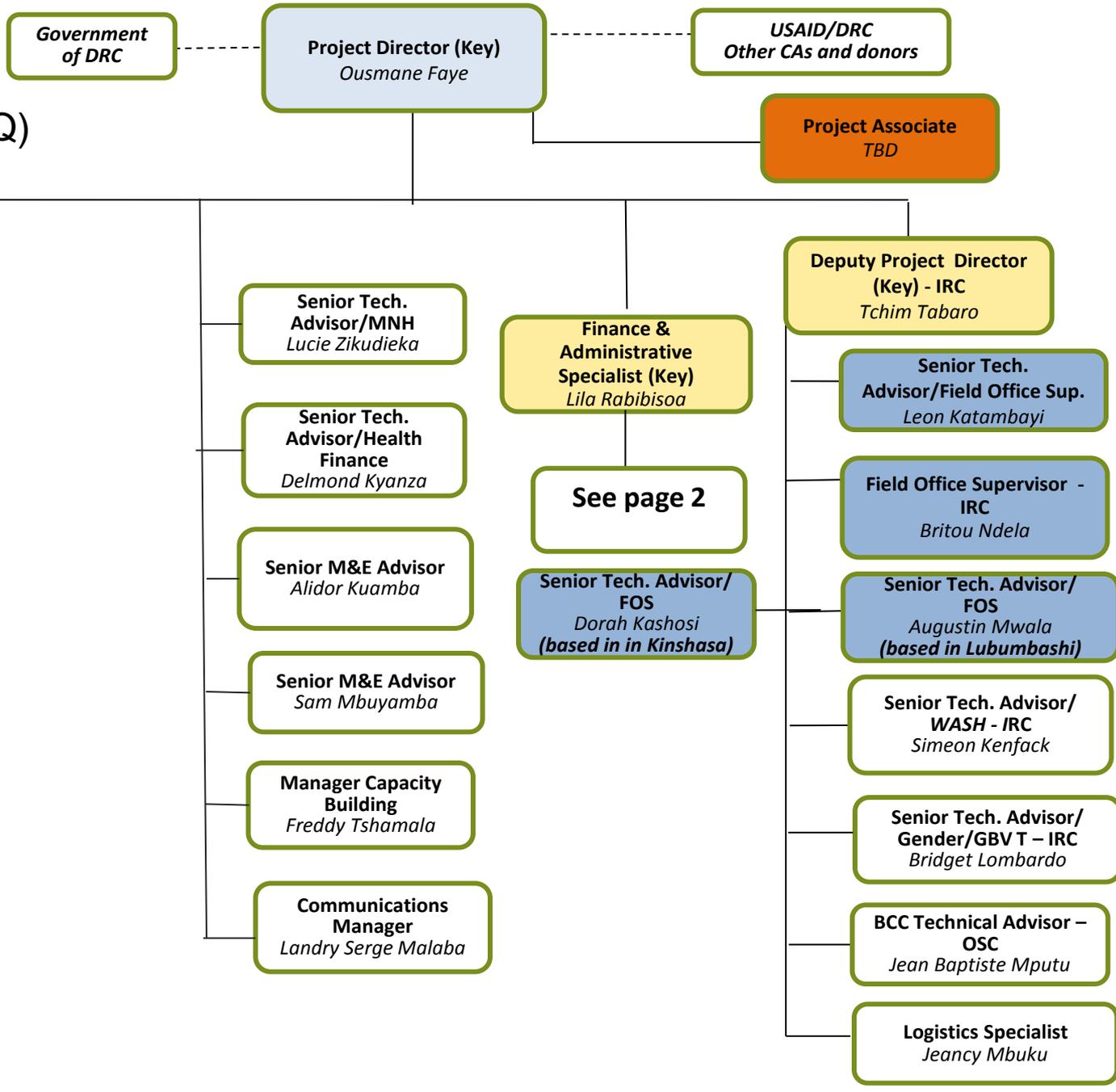
21	HSS	Megan Rauscher	MSH	April 27 - May 9, 2013	Provide capacity building to the M&E staff in creating a health systems alignment plan.	Boston/Kinshasa	14	Cancelled
22	M&E	Sarah Castle	MSH	May 5- May 19, 2013	Provide M&E support	London/Kinshasa	15	Completed
23	Program Management	Kristin Cooney	MSH	May 13 - 25, 2013	Provide technical and management support and participate in the semi-annual workplan review meeting with USAID.	Boston/Kinshasa	12	Completed
24	BCC	Vololoniaina Razaka	OSC	May 5 - 19, 2013	Evaluate new Community Champion pilots, in particular those that were set up during the previous trip 6 months prior.	Antananarivo/ Kinshasa	14	Completed
25	M&E	Elena Chopyak	MSH	May 4 - 18, 2013	Provide technical and management support in the drafting of the Quarterly Report.	Boston/Kinshasa	14	Completed
26	FISC	Christelle Celestin	MSH	May 4 - 18, 2013	Provide financial support in the reviewing of financial documents during Year 3.	Boston/Kinshasa	14	Completed
27	Teambuilding	Abibata Handley	MSH	May 19 - 26, 2013	Facilitate the mid-year review process and team building workshops with DRC-IHP staff, transferring the capacity to conduct basic team building exercises to IHP staff.	Washington DC/Kinshasa	8	Cancelled
28	M&E	Sarah Castle	MSH	June 15 - 30, 2013	Provide M&E support	London/Kinshasa	15	Postponed

29	BCC	Amelie Sow-Dia	OSC	June 2013	Evaluate the implementation for the EPE approach to date. Evaluation efforts will be focused on the RACJ youth association network in Mwene Ditu.	Baltimore/Kinshasa	15	Postponed
Quarter 4 July - Sept 2013								
30	RBF	Alfred Antoine	MSH	July 1 - July 7, 2013	Follow up and provide complementary training to IHP and the MOH after 3 months of implementation.	Kigali/Kinshasa	7	Postponed
31	M&E	Megan Rauscher	MSH	July, 2013	Provide capacity building to the M&E staff in creating a health systems alignment plan.	Boston/Kinshasa	15	Cancelled
32	Program Management	Kristin Cooney	MSH	July 1 -15, 2013	Provide technical and management support and visit project sites.	Boston/Kinshasa	15	Cancelled
33	BCC	Paul Neely	OSC	July/August 2013	Evaluation of the implementation of CUG and SMS systems, focusing on long-term sustainability and scale-up options. Continue to explore options for integrating an hotline into the existing mobile communications system.	Los Angeles/Kinshasa	15	Postponed until October
34	RBF	Jean Kagubare	MSH	July 2-17, 2013	Follow up implementation of RBF. Conduct data analysis and share results of the health services cost study with stakeholders.	Boston/Kinshasa	15	Postponed
35	TBD	Ciro Franco	MSH	July 11-25, 2013	Provide technical support to DRC-IHP MNCH projects.	Boston/Kinshasa	15	Completed
36	TBD	Christele Joseph-Pressat	MSH	July 29- August 18, 2013	Provide financial management support and coverage for Lila Rabibisoa's R&R	Boston/Kinshasa	21	Planned

37	M&E	Elena Chopyak	MSH	August 2 - August 16, 2013	Provide technical and management support in the drafting of the Quarterly Report.	Boston/Kinshasa	15	Planned
39	Health	Lara Ho	IRC	August 2013	Provide technical and management support during workplanning workshop.	Geneva/Kinshasa	15	Postponed until September 15-16
40	M&E	Sarah Castle	MSH	August 17 - September 1, 2013	Provide M&E support	London/Kinshasa	20	Postponed
41	RBF/Workplanning	Jean Kagubare	MSH	September 16-21, 2013	Conduct an annual visit of internal evaluation of the program at the central level/provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	15	Planned
42	Workplanning	Andrea Spakauskas	OSC	September 14 - 27, 2013	Provide technical and management support during workplanning workshop for PY4.	Philadelphia/Kinshasa	15	Planned
43	Workplanning	Elena Chopyak	MSH	September 14 - 27, 2013	Provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	15	Planned
44	Workplanning	Marlie Sarr	MSH	September 1-15, 2013	Provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	15	Cancelled
45	Workplanning	Kristin Cooney	MSH	September 14-27, 2013	Provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	15	Planned

46	Workplanning	Joan Marshall-Missiye	MSH	September 23 - October 6, 2013	Provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	15	Cancelled
47	Workplanning	Aboubakar Mama Sambo	MSH	September 16 - October 2, 2013	Provide technical and management support during workplanning workshop for PY4.	Boston/Kinshasa	21	Planned
48	RBF	Alfred Antoine	MSH	September 2013	Provide technical support and training for RBF database set-up	Kigali/Kinshasa	15	Planned
		New trips requiring approval are indicated in olive green (these trips have been added or more precise details provided)						

Appendix 8: DRC- IHP ORG CHART



Kinshasa Office (HQ)

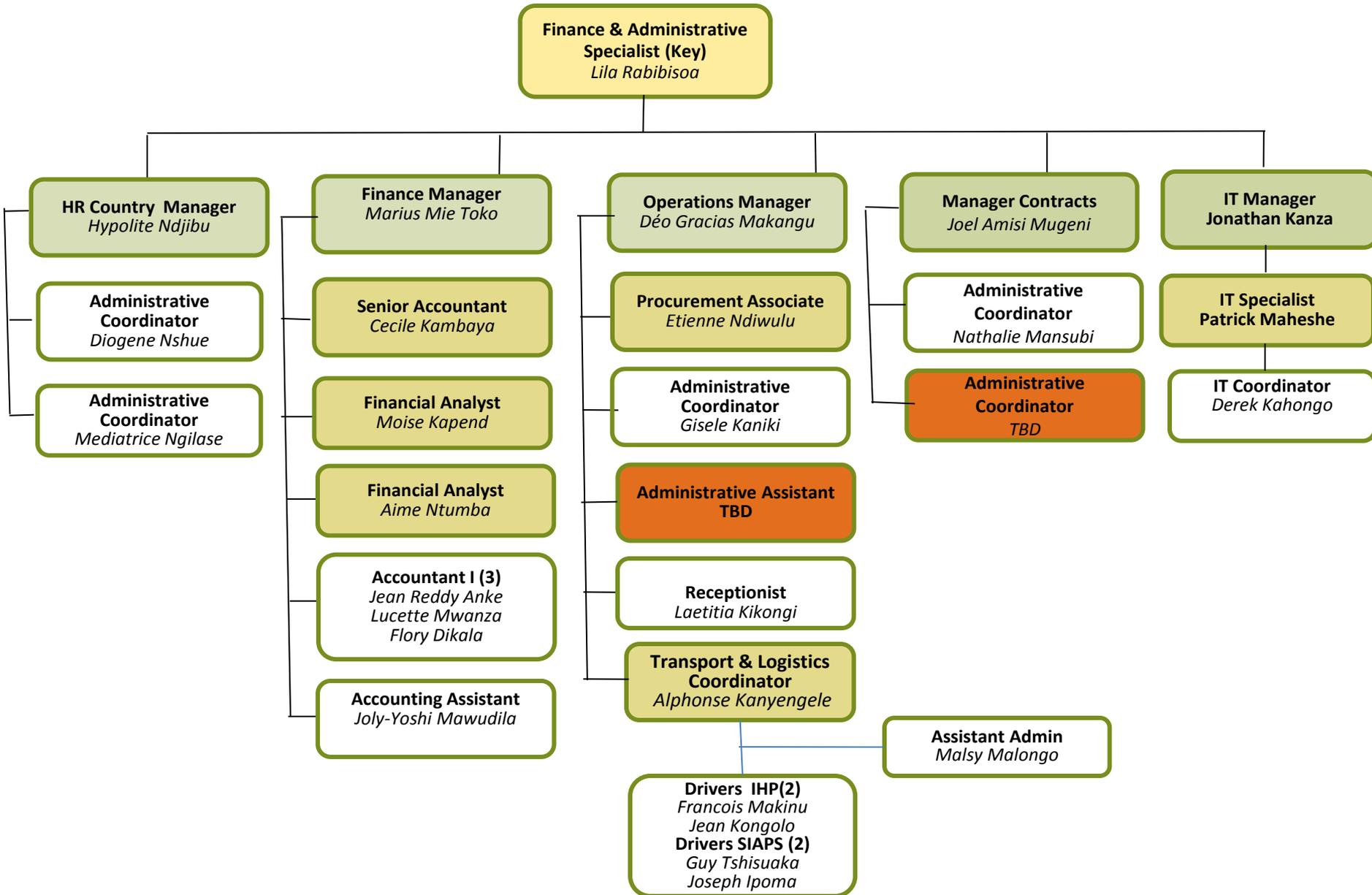
- Senior Technical Advisor,
Primary Health Care (Key)
Gilbert Andrianandrasana
- Senior Tech. Advisor/FP/RH
Colette Losso
- Senior Tech. Advisor/
Child Health
Narcisse Naia Embeke
- Senior Tech. Advisor/
HIV/AIDS
Raoul Ngoy
- Senior Tech. Advisor/Malaria
Jeanine Musau
- Tech Adv. /Malaria
Sud-Kivu
Rose Bokashanga
- Senior Tech. Advisor/
Nutrition
Matthieu Koy Matili
- Senior Tech. Advisor/TB
Simelo Kahodi
- Senior Tech. Advisor/Polio & EPI
Joseph Kongolo

- Senior Tech. Advisor/MNH
Lucie Zikudieka
- Senior Tech. Advisor/Health Finance
Delmond Kyanza
- Senior M&E Advisor
Alidor Kuamba
- Senior M&E Advisor
Sam Mbuyamba
- Manager Capacity Building
Freddy Tshamala
- Communications Manager
Landry Serge Malaba

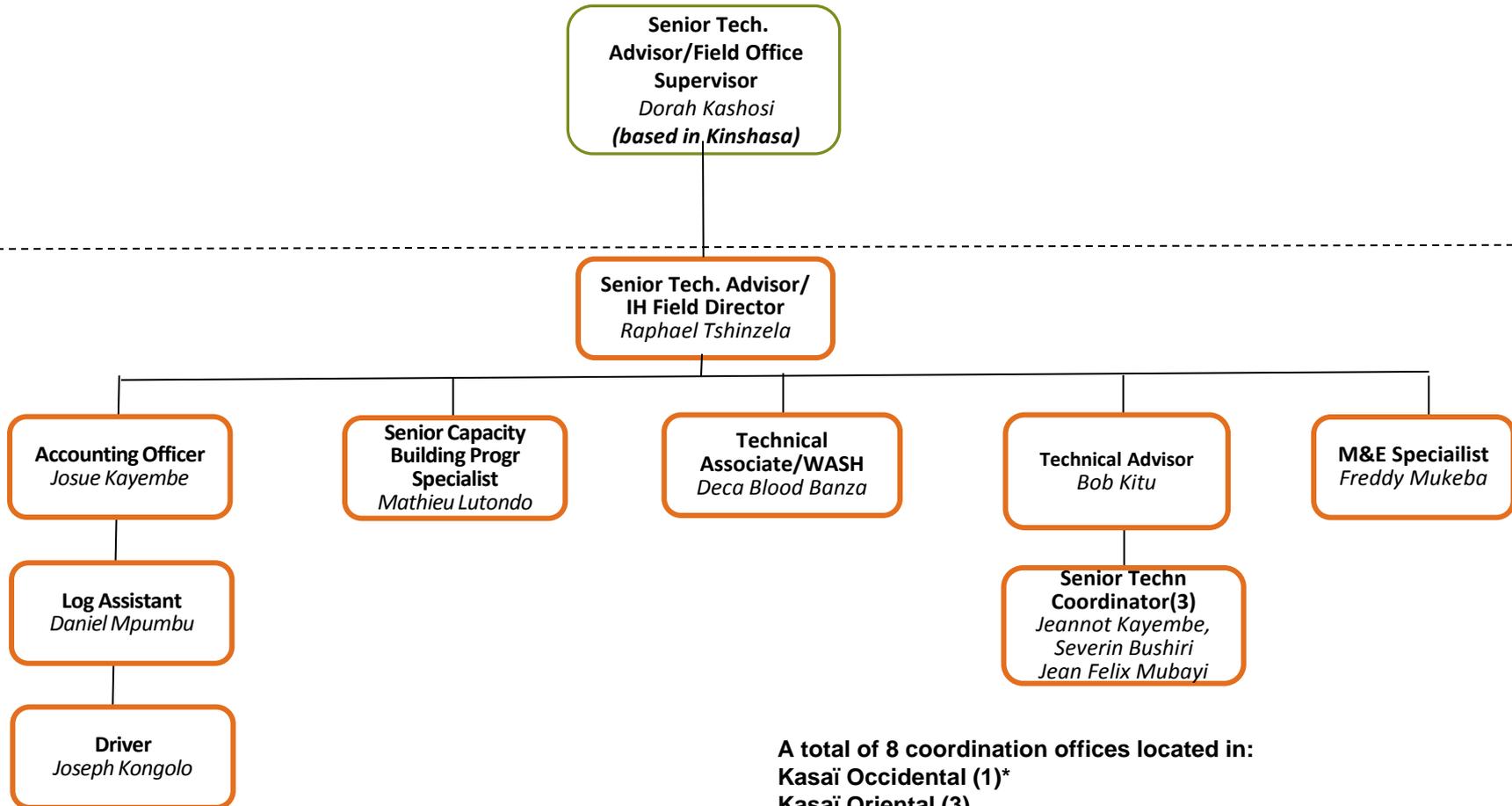
- Finance & Administrative Specialist (Key)
Lila Rabibisoa
- See page 2
- Senior Tech. Advisor/
FOS
Dorah Kashosi
(based in Kinshasa)

- Deputy Project Director (Key) - IRC
Tchim Tabaro
- Senior Tech. Advisor/Field Office Sup.
Leon Katambayi
- Field Office Supervisor - IRC
Britou Ndela
- Senior Tech. Advisor/
FOS
Augustin Mwala
(based in Lubumbashi)
- Senior Tech. Advisor/
WASH - IRC
Simeon Kenfack
- Senior Tech. Advisor/
Gender/GBV T - IRC
Bridget Lombardo
- BCC Technical Advisor - OSC
Jean Baptiste Mputu
- Logistics Specialist
Jeancy Mbuku

Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasai Occidental

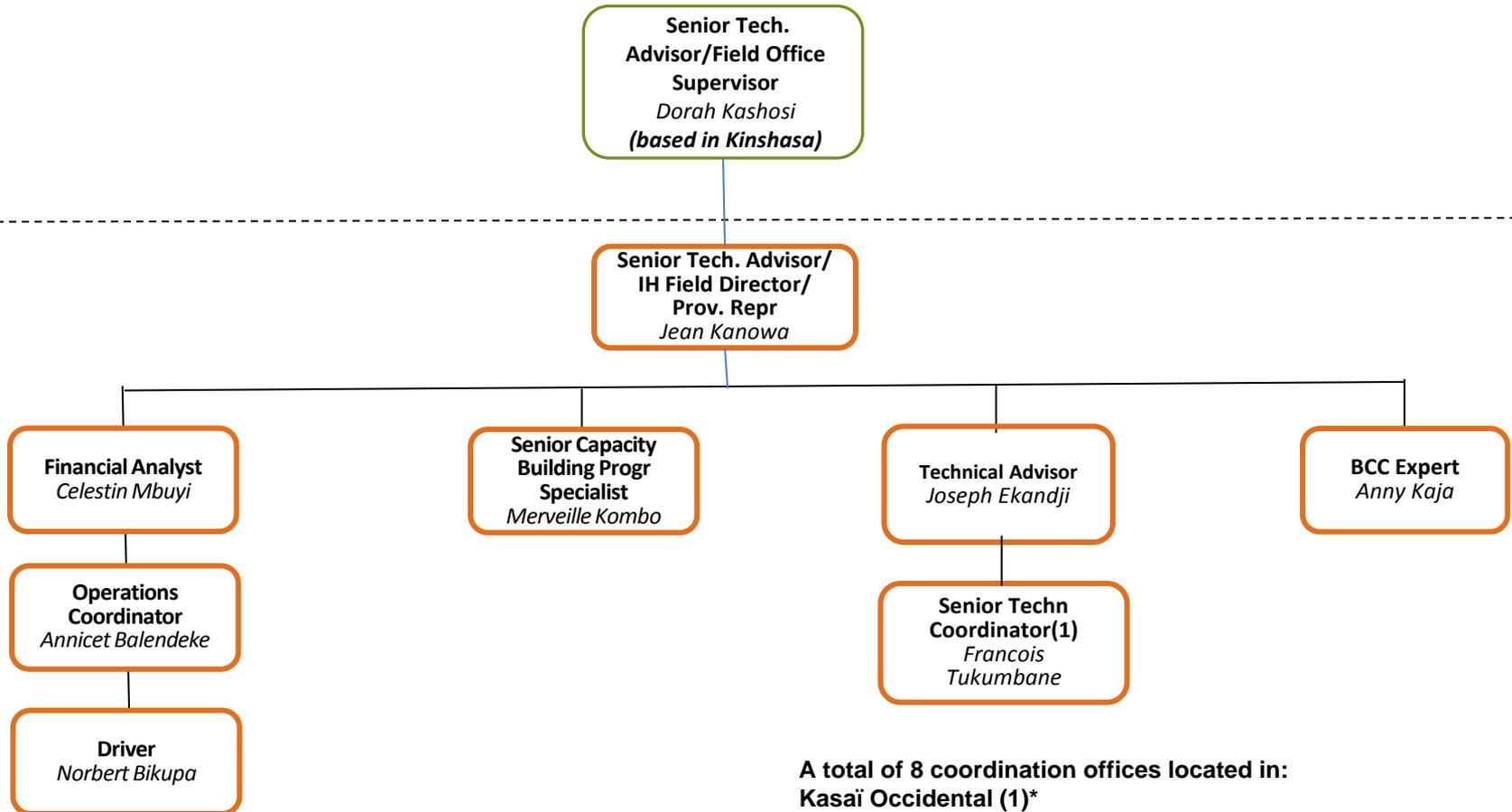


A total of 8 coordination offices located in:
Kasai Occidental (1)*
Kasai Oriental (3)
Katanga (2)
Sud Kivu (2)

One Representative Office is located in Kananga
Two offices are located in Lubumbashi and in Mbuji mayi

**Mwene Ditu office in Kasai Oriental will cover part of Kasai Occidental*

IHP Field Office: Kananga, Kasai Occidental

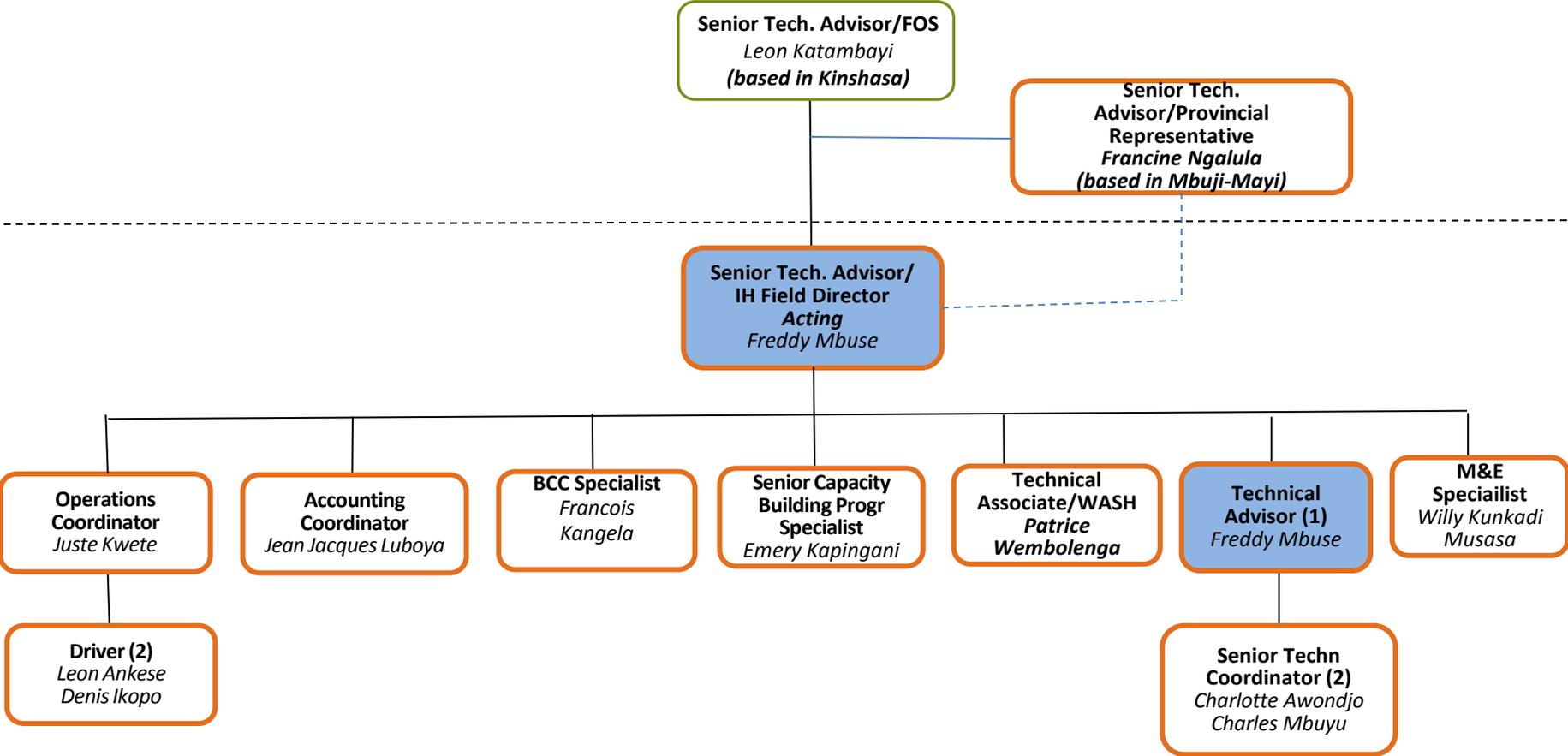


A total of 8 coordination offices located in:
Kasai Occidental (1)*
Kasai Oriental (3)
Katanga (2)
Sud Kivu (2)

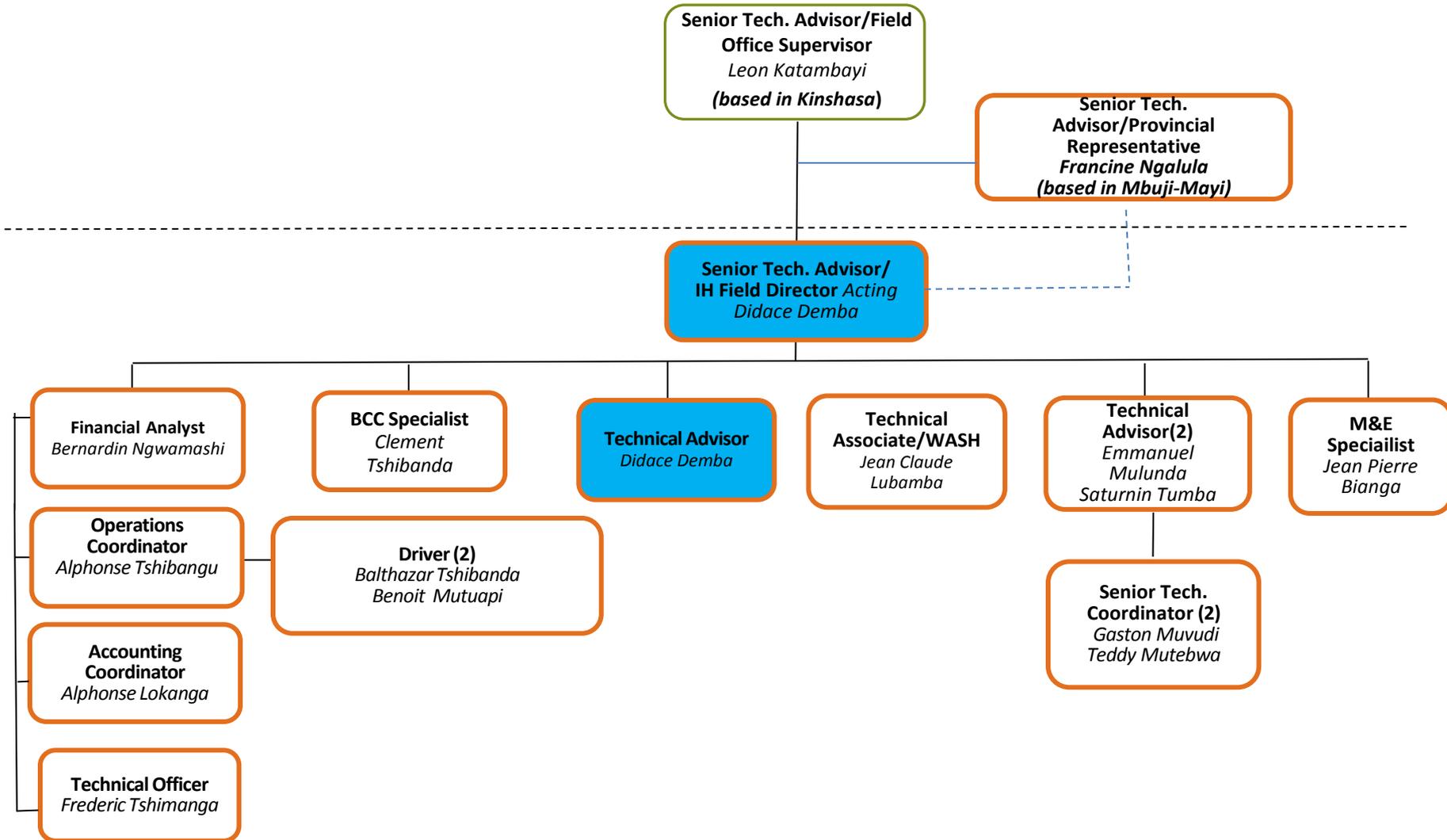
Two satellite offices are located in Kananga and Lubumbashi.

*Mwene Ditu office in Kasai Oriental will cover part of Kasai Occidental

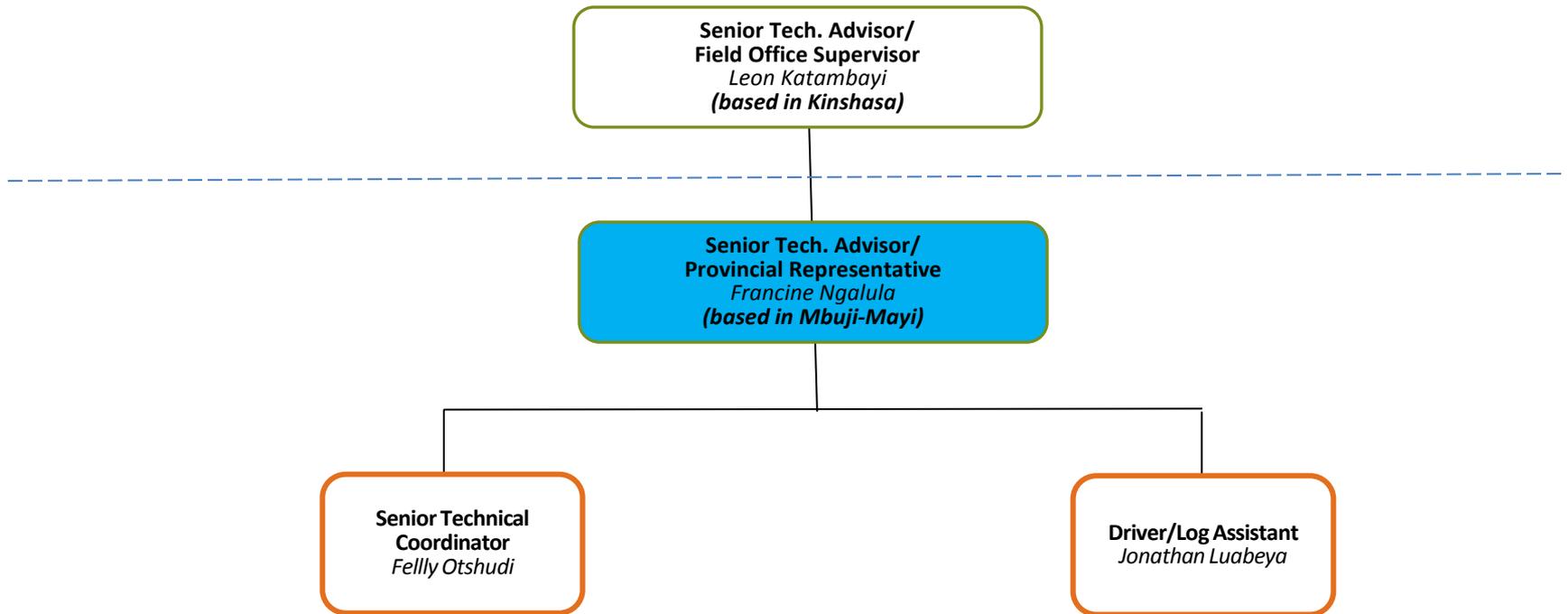
IHP Field Office: Kole, Kasai Oriental



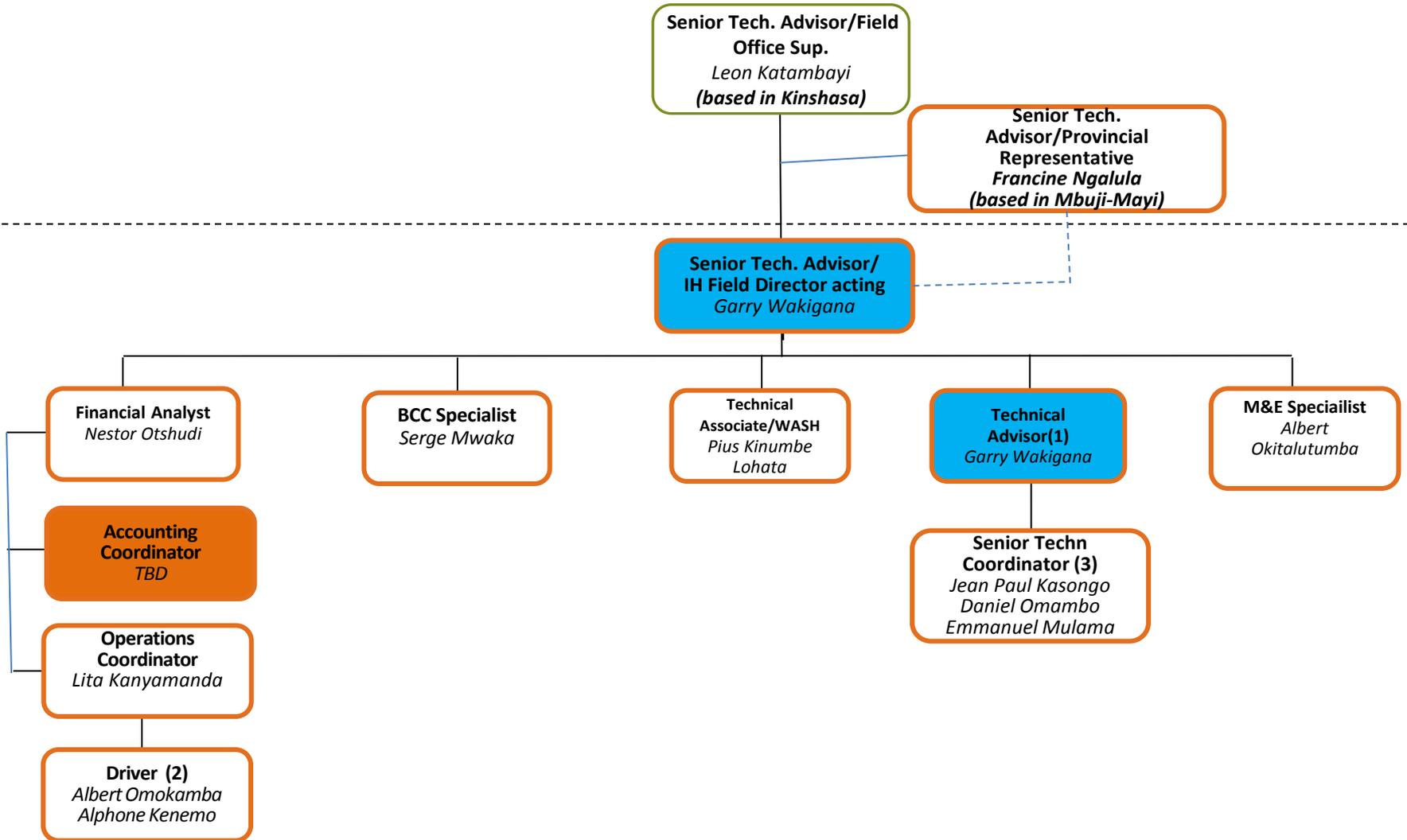
IHP Field Office: Mwene-Ditu, Kasai Oriental



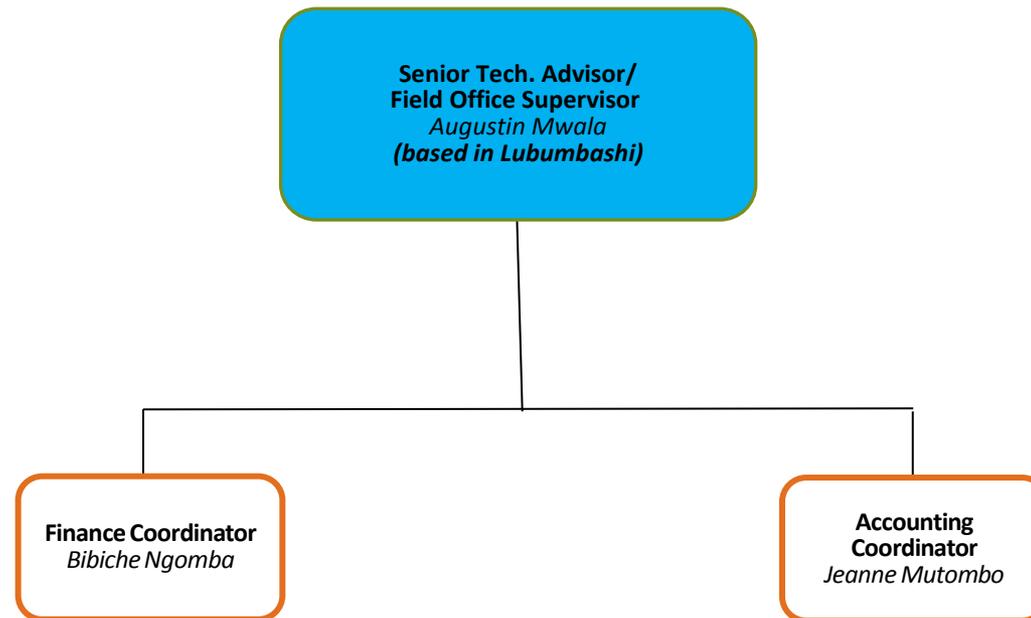
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



IHP Field Office: Tshumbe, Kasai Oriental



IHP Field Satellite Office: Lubumbashi, Katanga



IHP Field Office: Kamina, Katanga

**Senior Tech. Advisor/
Field Office Supervisor**
Augustin Mwala
(based in Lubumbashi)

**Senior Tech. Advisor/
IH Field Director Acting**
Sylvain Kasonga

Financial Analyst
Paulin Cimpaka

**BCC
Specialist**
*Gustave
Numbi*

**Senior Capacity
Building Progr
Specialist**
Faustin Bushabu

**Technical
Associate/
WASH**
TBD

**Technical
Advisor(2)**
*Doudou Tubaya
Sylvain Kasonga*

**M&E
Specialist**
Alexis Ndumbi

Technical Officer
*Thym's
Nsibasumba*

**Administrative
Coordinator**
Lusuna Barthelemy

**Operations
Coordinator**
Blaise Mana Mana

**Senior Techn
Coordinator(3)**
*Gaetan Ngoy
Paul Olongo
Jean Claude Nsangwa*

Driver (2)
*Jacques Kasongo
Emmanuel Mukadi*

IHP Field Office: Kolwezi, Katanga

**Senior Tech. Advisor/
Field Office Supervisor**
Augustin Mwala
(Based in Lubumbashi)

IHP Coordinator
Adamo Fumie Bonay

Operations Manager
TBD

Accountant
Christian Mpembele

**Construction
Engineer**
John Ndaya

**Capacity Building
Specialist (1)**
Lievin Bangali

Technical Specialist (2)
1. *Akongela Ofeka*
2. *Yves Ilunga Banze*

Operations officer procurement
Gode ZUKA MAKIADI

Drivers (2)
1. *Valentin KAPONDO KAPINI*
2. *TBD*

Operations officer Admin-log
TBD

Cleaners (2)
1. *Suzanne Kabila Mwilambwe*
2. *Gardener: Clément Musoka*

**Grants Manager/Quality
Assurance**
*Willy Mbemba
Ndolumingi*

M&E Officer
Adolphe Lubila

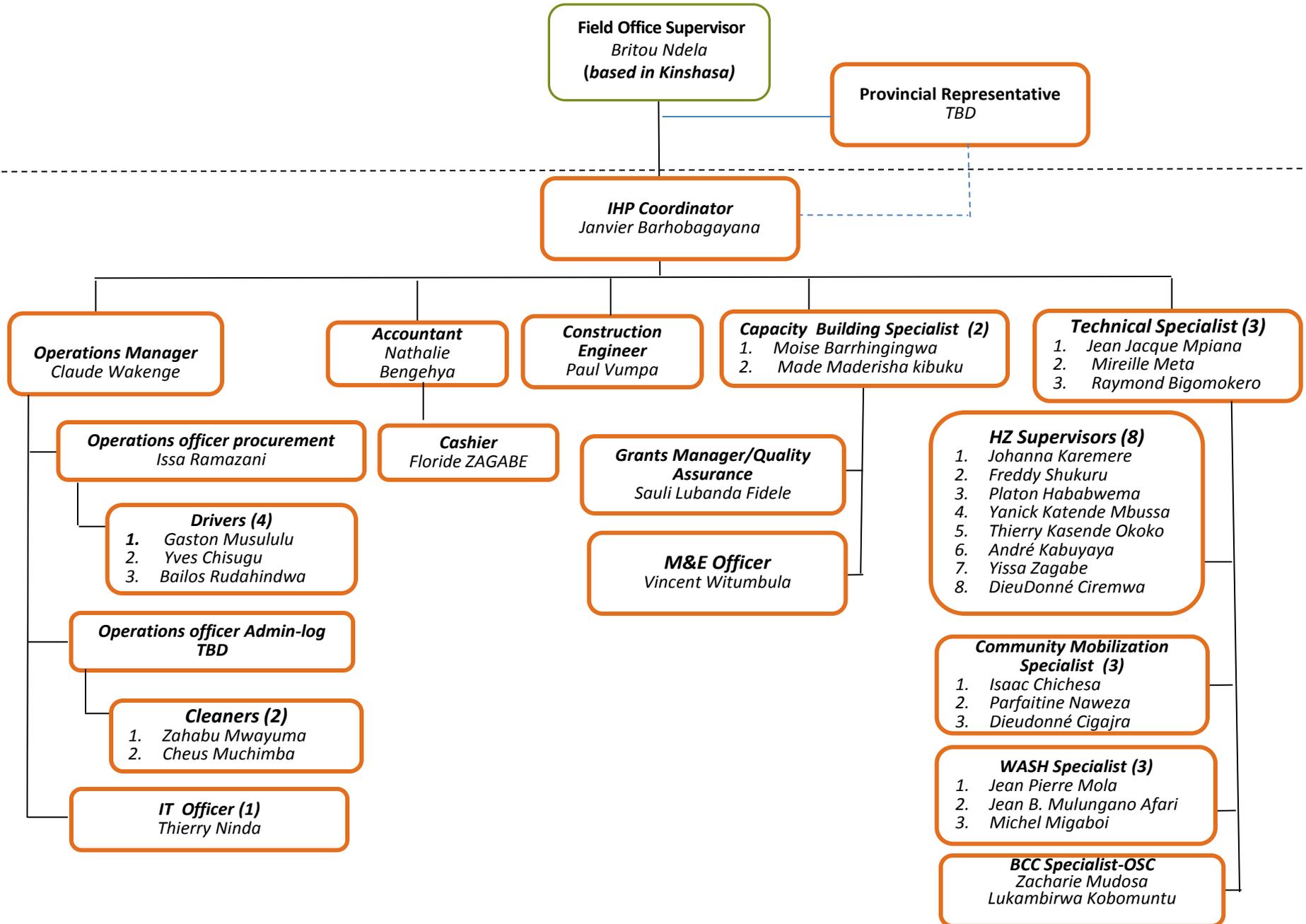
Health Zone Supervisors (3)
1. *Paulin Mebwa*
2. *Dieudonné Maleshele*
3. *Crispin Mboyi Mulumba*

**Community Mobilization
Specialist (1)**
Jean Pierre Kyungu Kalonda

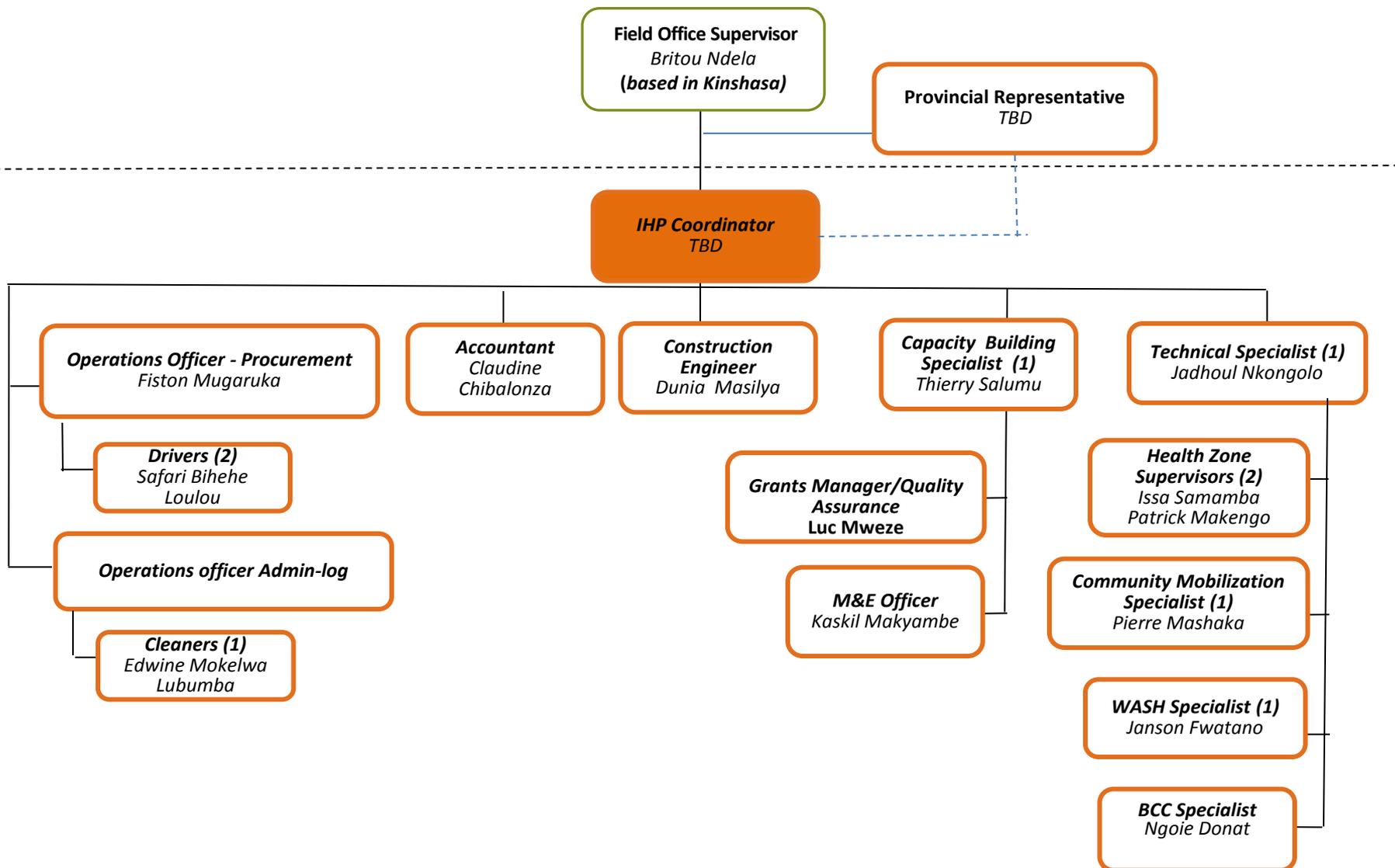
WASH specialist (1)
Daniel Ngoy Lusanga

BCC Specialist-OSC (1)
Benjamin Mutombo

IHP Field Office: Bukavu, Sud Kivu



IHP Field Office: Uvira, Sud Kivu



USAID/DRC
 Financial Management Office
 Accruals Worksheet for the period
 April 1, 2013 - June 30, 2013

Document #: AID-OAA-A-10-00054

Vendor: MANAGEMENT SCIENCES FOR HEALTH, INC

RFA OAA-10-000006

			A	B	C	D	E	F= (C + D+ E)	G = B - F	H=A-F
Program Area	Program Element	BFY Fund	Estimated LOP Budget	Obligations	Disbursements (Oct 2010 - March 2013)	Quarter 3 - Disbursement (April -June 2013)	Quarter 3 accruals June 2013	Project Total to Date (including accruals)	Obligations remaining (Pipeline)	Estimated Award Balance
A11	A047- HIV/AIDS	GH-AIDS/2010/201	\$ 14,743,405.00	\$ 6,584,113.00	\$ 5,582,159.44	\$ 467,937.68	\$ 306,392.07	\$ 6,356,489.19	\$ 227,623.81	\$ 8,386,915.81
A11	A048 - TB	GH-C/2010/2011	\$ 17,286,763.00	\$ 10,280,000.00	\$ 7,028,234.59	\$ 839,447.30	\$ 697,693.86	\$ 8,565,375.76	\$ 1,714,624.24	\$ 8,721,387.24
A11	A049 - Malaria	GH-C/20102011	\$ 20,245,000.00	\$ 12,535,000.00	\$ 8,908,258.78	\$ 1,021,200.40	\$ 850,738.58	\$ 10,780,197.76	\$ 1,754,802.24	\$ 9,464,802.24
A11	A052- MCH	GH-C/20102011	\$ 45,731,306.00	\$ 29,226,385.00	\$ 20,991,219.81	\$ 2,881,990.71	\$ 2,124,032.51	\$ 25,997,243.04	\$ 3,229,141.96	\$ 19,734,062.96
A11	A053 - FP/RH	GH-C-POP/2010/201	\$ 20,625,615.00	\$ 12,725,615.00	\$ 9,011,462.07	\$ 1,045,866.16	\$ 863,675.44	\$ 10,921,003.67	\$ 1,804,611.33	\$ 9,704,611.33
A11	A054 - WASH	ES/2010/2011	\$ 12,610,800.00	\$ 7,110,800.00	\$ 5,622,798.34	\$ 747,409.77	\$ 482,603.26	\$ 6,852,811.37	\$ 257,988.63	\$ 5,757,988.63
A11	A142- Nutrition	GH-C-GFSI/2010/201	\$ 8,524,240.00	\$ 4,324,240.00	\$ 2,840,950.04	\$ 358,357.04	\$ 293,482.07	\$ 3,492,789.16	\$ 831,450.84	\$ 5,031,450.84
Grand Total			\$ 139,767,129.00	\$ 82,786,153.00	\$ 59,985,083.08	\$ 7,362,209.06	\$ 5,618,617.79	\$ 72,965,909.93	\$ 9,820,243.07	\$ 66,801,219.07

*** Note: Data contained in this report may change since accounting has not closed the books for the month June 2013 (MSH year end activities).

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted USAID/OFM	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) AID-OAA-A-10-00054	Page 1	of pages
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3. Recipient Organization (Name and complete address including Zip code)
**Management Sciences for Health, Inc.
 784 Memorial Drive, Cambridge, MA 02139**

4a. DUNS Number 071713085	4b. EIN 04-2482188	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment) FRLC 72 00 1329	6. Report Type <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual
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8. Project/Grant Period From: (Month, Day, Year) 09/30/2010	To: (Month, Day, Year) 09/29/2015	9. Reporting Period End Date (Month, Day, Year) 06/30/2013
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10. Transactions Cumulative

(Use lines a-c for single or multiple grant reporting)

Federal Cash (To report multiple grants, also use FFR Attachment):	
a. Cash Receipts	\$66,184,250.00
b. Cash Disbursements	\$66,952,528.90
c. Cash on Hand (line a minus b)	(\$768,278.90)

(Use lines d-o for single grant reporting)

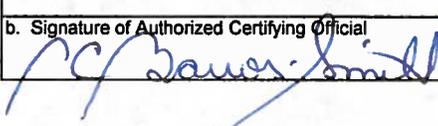
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	\$82,786,153.00
e. Federal share of expenditures	\$66,952,528.90
f. Federal share of unliquidated obligations	\$0.00
g. Total Federal share (sum of lines e and f)	\$66,952,528.90
h. Unobligated balance of Federal funds (line d minus g)	\$15,833,624.10
Recipient Share:	
i. Total recipient share required	\$4,193,013.88
j. Recipient share of expenditures	\$2,343,925.60
k. Remaining recipient share to be provided (line i minus j)	\$1,849,088.28

Program Income:	
l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
11a. Indirect Expense	Salaries	81%	04/01/2013	06/30/2013	211,762.98	171,528.01	100%
	Local Proff	40%	04/01/2013	06/30/2013	844,067.03	337,626.81	100%
	Consultants	40%	04/01/2013	06/30/2013	26,848.25	10,739.30	100%
g. Totals:					\$ 1,602,572.39		

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:

13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official Patricia Barros-Smith, Manager Corporate Accounting	c. Telephone (Area code, number and extension) 617-250-9214
b. Signature of Authorized Certifying Official 	d. Email address pbarrossmith@msh.org
	e. Date Report Submitted (Month, Day, Year) 7/25/2013
14. Agency use only.	

Standard Form 425
OMB Approval Number: 0348-0061
Expiration Date: 10/31/2011

Paperwork Burden Statement
 According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0061. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection.