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Cover photo: In a rural health facility, a doctor examines a child.

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ACRONYMS

AB	Advisory Board
ACT	Artemisinin-combination therapy
AMTSL	Active Management of Third Stage Labor
ANC	Antenatal Care
AOP	Annual Operational Plan
ARV	Antiretroviral
AS	*Aire de Santé* (health area)
BCC	Behavior Change Communication
BCZS	*Bureaux Centraux des Zones de Santé* (health zone central offices)
CBD	Community-based distribution or community-based distributor
CCSAS	Clinical Care for Sexual assault Survivors
CCM	Community Case Management
ICCM	Integrated Community Case Management
CHW	Community health worker
C-IMCI	Community Based Integrated Management of Childhood Illness
CODESA	Comité de Développement Sanitaire
CDR	Regional Distribution Center
CPA	Complementary Package of Activities
CPLT	Provincial coordination unit for leprosy and TB
CLTS	Community-Led Total Sanitation
CPR	Contraceptive Prevalence Rate
CUG	Closed User Group
DHMIS	District Health Management Information System
DOTS	Directly Observed Treatment Strategy (TB)
DRC	Democratic Republic of the Congo
DTP	Diphtheria, Tetanus, Pertussis (DTC in French acronym)
DPS	*Division Provinciale de la Santé* (provincial health division)
DQA	Data Quality Assessment
DQS	Data Quality Self-Assessment
DRC	Democratic Republic of the Congo
ECZ	*Equipe Cadre de Zone* (Zone Management Team)
EMMP	Environment Monitoring and Management Plan
ENA	Essential Nutrition Actions
EPI	Expanded Program on Immunization
ETL	Education through Listening
FFSDP	Fully Functional Service Delivery Point (see FOSACOF below)
FOSACOF	*Formation Sanitaire Complètement Fonctionnelle* (used more frequently in DRC)
FOSA	*Formation Sanitaire*
FP	Family Planning
GRH	General Referral Hospital
HBB	Helping Babies Breathe
HIV	Human Immunodeficiency Virus
IHP	Integrated Health Project
IMCI	Integrated Management of Childhood Illness
IPS	*Inspection provinciale de la santé*
IPTp	intermittent preventive treatment (of malaria) in pregnancy
IRC	International Rescue Committee
IT	*Infirmier Titulaire* (Head Nurse)
IYCF	Infant and young child feeding
KAPs	Knowledge, Attitudes, and Practices
KMC	Kangaroo Mother Care
LDP	Leadership Development Program
LLIN	Long-lasting Insecticide-treated Net
LMS	Leadership, Management, and Sustainability Program

MDR-TB	Multi-drug resistant TB
MEG	Generic and essential medicine
MEG	Medical Export Group
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MPT+	Smear-Positive Pulmonary Tuberculosis
MIP	Provincial Medical Inspector
MPA	Minimum Package of Activities
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
NTD	Neglected Tropical Diseases
OCC	Congolese Office of Control
ORS	Oral Rehydration Solution
OSC	Overseas Strategic Consulting, Ltd.
PBF	Performance-Based Financing
PEP kit	Post-exposure prophylaxis kit
PEPFAR	President's Emergency Plan for AIDS Relief
PEV	Enlarged Vaccination Program
PHAST	Participatory Hygiene and Sanitation Transformation
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-natal Consultation
PNCPS	*National Public Relations Program for the Promotion of Health*
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	National Malaria Control Program
PNLS	National AIDS Program
PNSR	National Reproductive Health Program
PPDS	Provincial Health Development Plan
PRONANUT	National Nutrition Program
PSPP	*Projet de Santé pour les Populations les plus Pauvres* (Health for Poorest Populations)
PY	Project Year
RBF	Results-Based Financing
RDT	Rapid diagnostic tests
RECO	*Relais Communautaires* (community health workers)
RH	Reproductive Health
RHC	Health Referral Center
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SNIS	National health information system
SMS	Short Message Service
SP	Sulfadoxine-pyrimethamine (malaria treatment)
SPS	Strengthening Pharmaceutical Systems Project
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water / Sanitation/Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

This report covers the fourth quarter reporting period (June through August 2013) of year three of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). This report also serves as the annual report for year three. 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 (Kasaï Occidental, Kasaï Oriental, Katanga and Sud Kivu).

The project's goal, purpose and objective is to improve the enabling environment for, and increase the 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 period, IHP reports the following key achievements:

<u>Support to health zone leadership</u>

- The project provided technical and financial support to the health zones to validate their annual operation plans (AOP), and advisory boards have approved 78 of 80 (99%) of the AOPs from the health zones.
- During PY3, among IHP's 80 health zones, 73 teams began their Leadership Development projects (LDP), and 45 health zones developed, carried out, and completed their LDP goals. Thirty-four of the 45 completed projects achieved at least 80% of their desired performance.

Maternal, newborn, and child health (MNCH)

- From project year two (PY2) to PY3, the percentage of children with pneumonia who were treated with antibiotics increased from 85% to 87%, due to the integration of new community care sites, the availability of drugs, regular supervisory visits, and motivated community health workers (CHW).
- An overall increase in the number of children under-five receiving correct care for malaria was reported from PY2 to PY3: compared to the annual target of 1,594,556 children under five treated for malaria in the health centers and in community care sites, the number of children increased from 477,399 children in PY2 seen in health facilities (476,475) and community care sites (924) to 653,417 children in PY3 seen in health facilities (639,137) and community care sites (14,279). The increase from PY2 to PY3 represents a percentage increase from 30% in PY2 (477,399/1,594,556) to 41% in PY3 (653,417/1,594,556).
- Following the DRC Ministry of Public Health's official launch of "A Promise Renewed," on May 31, 2013, 70 community care sites were established and 149 community health workers (CHWs) were trained in the health zones of Lodja, Djalo Ndjeka, Tshumbe, Vangakete, Bena Dibele, Kitenge, Songa and Kabongo. IHP also provided the community care sites with Rapid Diagnostic Tests (RDT) and artemisinin-combination therapy (ACT) supplies.
- During PY3, an estimated 33,458 lives among the children under five population were saved through prenatal care, other preventative interventions, vaccinations, antimalarials, antibiotics, and diarrhea treatments. Antimalarial treatments accounted for an estimated 13,162 lives saved; improved sanitation accounted for 5,207 lives saved; and oral rehydration solution account for 4,378 lives saved. IHP's impact on lives saved among children under five was estimated using the LiST tool.
- The percentage of pregnant women who attended at least four antenatal care (ANC) visits increased from 22% in PY2 to 71% in PY3.
- The percentage achievement rate of the PMP target for women whose deliveries were attended by skilled birth attendants was 101% in PY3, and the rate for women who received active management of the third stage of labor (AMTSL) was 105%.
- Overall, vaccination coverage was high: the average immunization coverage rate ranged from 95% to 107% for all vaccines.

Water, sanitation, and hygiene (WASH)

- The number of new people with access to safe drinking water increased from 138,136 in PY2 to 435,972 in PY3, a nearly three-fold increase. The PY3 results translate to an achievement rate of 130% over the PMP target number of 335,800.
- In PY3, the project rehabilitated 371 water sources, an increase from the 167 water sources rehabilitated in the previous year.
- In PY3, communities rehabilitated 40,351 latrines with support from IHP, compared to 6,116 latrines in PY2, contributing significantly to increased access to improved sanitation.
- In total, the number of people benefiting from improved sanitation increased from 43,980 in PY2 to 309,907 by the end of PY3, which represents a 604% increase in the number of beneficiaries between PY2 and PY3.

Family planning

- Between PY3 and PY2, the number of women who adopted a modern method of contraception increased from 502,914 to 556,230. These numbers represent achievement rates of 107% of the PMP target for PY2 and 115% for PY3, respectively.
- The number of family planning delivery service points increased from 1,379 in PY2 to 1,717 in PY3. The increase of 338 new delivery service points is due to the integration of family planning services into new and existing community care sites. IHP anticipates that with the integration of

family planning services into immunization activities, PY4 will see an even greater increase in the number of family planning delivery service points.

Malaria

- During PY3, 142,306 long-lasting insecticide-treated nets (LLIN) were distributed in the health zones supported by the project. Out of the total 95,824 LLIN were distributed during ANC visits and 46,482 during pre-school consultation visits.
- In PY3, 653,417 doses of ACT for children ages two to 11 months and from one to five years were distributed, compared to PY2 during which 477,399 doses were distributed in health facilities and community care sites.
- For all age ranges, 1,928,830 doses of ACT were distributed in PY3, compared to 993,613 doses in PY2. The improvement in performance for this indicator is due to improvements in reporting monthly anti-malaria supply consumption rates, the availability of ACT during the last three quarters of the PY3, and the payment of transportation costs ($15 per health facility) of antimalarial commodities from the health zones to health facilities[1].

Nutrition

- In PY3, during vitamin A campaigns, 3,012,950 children under five received vitamin A supplements, exceeding the PMP target of 2,250,000, for an achievement rate of 134%. In PY2, 2,885,610 children under five received vitamin A supplements.
- The PMP target for number of pregnant women who received iron and folic acid was also exceeded in PY3, with IHP reaching 450,213 compared to the target of 385,875. This number is more than double the number of pregnant women reached in PY2 (200,752).
- A total of 419,122 mothers of young children received nutritional consultations in PY3, compared to a target of 148,320. In PY2, 90,500 mothers received these services.

HIV and AIDS

- In PY3, 91,858 pregnant women attended ANC visits, compared to the PMP target of 87,500 women, an achievement rate of 105%. This strong performance was delivered despite the reduction in the number of prevention of mother-to-child transmission (PMTCT) sites from 212 to 52, per the PEPFAR strategic pivot limiting PMTCT services to Katanga.
- Among women who attended ANC visits (91,585), 95%, or 87,273, women received HIV counseling in PY3. Compared to the PMP target of 87,500, the project reported an achievement rate of 99.8%.
- The percentage of TB patients who were tested for HIV in PY3Q4 was 65.1%, which exceeded the PMP target of 58%, and represents an improvement from last quarter's rate of 56%.

Behavior change communication (BCC)

- During PY3, 26 Champion Communities were established, and all have developed and implemented an action plan.
- Of the 1,239 functional CODESAs, 905 of them (73%) have developed and implemented their action plans.
- In PY3, 208,130 Short Message Service (SMS) messages were sent, compared to the 105,000 SMS messages sent during PY2, which represents nearly a two-fold increase in messages sent between PY2 and PY3. New communications technologies such as SMS have been important in the implementation of BCC activities, and recipients have had a positive response.

[1] In PY3, for all age groups, the ratio of ACTs to RDTs is 1.8, or two ACTs for one RDT, as the ACT and RDT consumption is 1,928,830 and 1,044,750, respectively. Given that supplies are available in health facilities, it is necessary to promote the national protocol and to continue to raise awareness among care providers to encourage them to follow the recommended ratio: one ACT for every two RDTs.

I. PROJECT PERFORMANCE: ACHIEVEMENTS

I.1 COMPONENT 1: HEALTH SERVICES

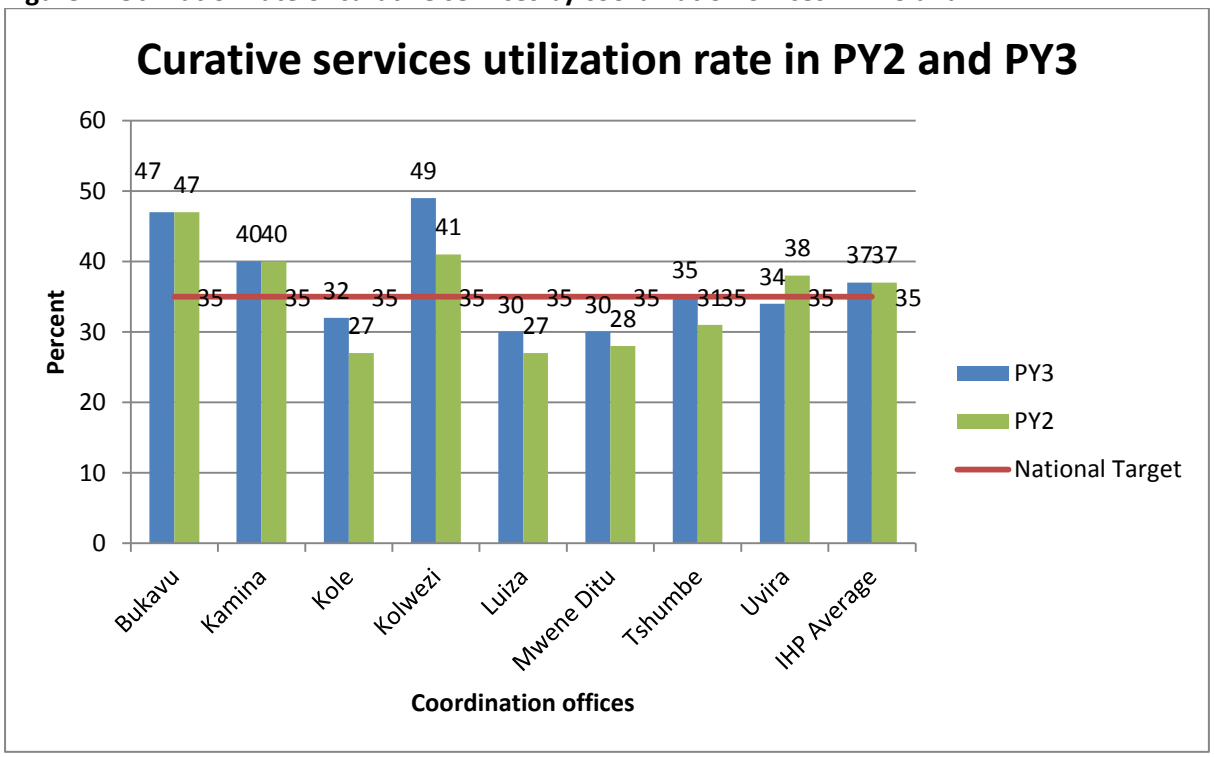
INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MINIMUM PACKAGE OF ACTIVITIES/ COMPLEMENTARY PACKAGE OF ACTIVITIES PLUS (MPA/CPA-PLUS) SERVICES IN TARGETED HEALTH ZONES INCREASED

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

1. <u>Cumulative utilization of health services</u>

As seen in Figure 1 and Table 1, Bukavu, Kamina, and Kolwezi reported rates of curative service utilization over the national average of 35%. Tshumbe fell within the national average, and Kole, Luiza, Mwene Ditu, and Uvira reported rates below the national average. Within higher performing coordination offices, health facilities offered higher quality of care (as noted by the adherence to national guidelines and policies, and the use of flow charts) and reported fewer stock outs of medications and other commodities.

Figure 1: Utilization rate of curative services by coordination offices in PY3 and PY2[2]



[2] The rates and percentages presented in this report have been rounded to the nearest whole number. For example, 40.5% is rounded to 41%, and 40.4% would be rounded to 40%.

Table 1: Curative services utilization by quarter and by coordination office

Coordination office	PY3Q1 (%)	PY3Q2 (%)	PY3Q3 (%)	PY3Q4 (%)	PY3 Average (%)	PY2 Average (%)
Bukavu	45	43	47	54	47	47
Kamina	37	42.	44	37	40	40
Kole	25	34	31	38	32	27
Kolwezi	50	48	55	43	49	41
Luiza	29	30	31	30	30	27
Mwene Ditu	28	28	31	34	30	28
Tshumbe	32	33	37	39	35	31
Uvira	33	34	34	34	33	38
IHP Average					37	35

All coordination offices, with the exception of Kamina and Uvira, demonstrated improvements in their service utilization rates in PY3 compared to PY2. The average rates of curative service use in PY2 increased to 37% in PY3. The PY3 average service utilization rate was calculated using an updated 2013 population estimate, compared to the PY3Q1 rate which was calculated using the 2012 population estimate.

Contributing factors to the improved results included: the availability of drugs, availability of medical supplies in facilities, the distribution of supplies from the PY2 pharmaceutical order and from the ASRAMES order, regular supervisory visits, post-training follow-up for care providers, the use of management tools, and the quality of care offered by health care providers.

In order to address the lower performing coordination offices, the project plans the following activities in PY4:

- Provide medications and other commodities to health facilities.
- Distribute long-lasting insecticide-treated nets (LLIN) and sulfadoxine-pyrimethamine (SP). When pregnant women return to their communities, they show the products that they have received to their friends and family, and they share their experience during the consultation in terms of advice, support, and hospitality received. These factors influence attendance and use of curative services starting first with these women's immediate families and eventually the entire community.
- Conduct supervisory visits as well as trainings and follow-up trainings for health care providers in quantification of monthly pharmaceutical consumption, data collection and management, family planning methods, and correct case management for childhood illnesses, among others.

2. <u>Support health zones Annual Operation Plans (AOP)</u>

Support in developing AOPs in PY3

IHP provided technical and financial support to the health zones to validate their AOPS. As a result, advisory boards in 78 out of 80 health zones, or 99% of the health zones, approved AOPs. Table 2 on the next page shows the list of coordination offices and the number of health zones with drafted and validated AOPs.

IHP provided funding for advisory board meetings, and project staff assisted health zones in identifying priorities and consolidating their workplans to align with the National Health Development Plan (PNSD in the French acronym) national health strategy.

Table 2: List of AOPs validated by coordination offices

Provinces	Coordination office	Health zone	AOP drafts 2013	AOPs validated 2013	(%) validated
Sud Kivu	Bukavu	22	22	20	91
	Uvira	5	5	5	100
Kasaï Occidental	Luiza	11	11	11	100
Kasaï Oriental	Kole	4	4	4	100
	Tshumbe	10	10	10	100
	Mwene Ditu	11	11	11	100
Katanga	Kolwezi	8	8	8	100
	Kamina	9	9	9	100
Total		80	80	78	99

The Bukavu coordination office was unable to validate the plans for Mulungu and Lulingu due to insecurity.

3. <u>Coverage plans for MPA/CPA-plus</u>

IHP contributed to the implementation and integration of the Complementary Package of Activities (CPA) in hospitals in collaboration with the Ministry of Health (MOH) and other organizations. Table 3 provides the number of general referral hospitals (GRH) that implement CPA by quarter and coordination office.

Table 3: Number of general referral hospitals (GRH) implementing a complementary package of activities

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3 Total
PY3Q1	21	6	4	6	11	8	5	4	65
PY3Q2	21	6	4	6	11	9	6	4	67
PY3Q3	21	6	4	6	11	9	6	4	67
PY3Q4	21	6	4	7	11	9	6	5	69
Target	23	9	4	8	11	11	9	5	80

An average of 67 GRH out of 80 GRHs supported by IHP provided the CPA, for an overall achievement of 84%. This high coverage is due to the availability of essential generic drugs, donated medical equipment and supplies, training of staff, and the renovation of maternity clinics. When compared to the PMP target of 48 GRHs, the rate of achievement is 144%. Compared to PY2, when 75 GRHs provided CPA, fewer GRHs in PY3 (67) offer CPA. The decrease in the number of GRHs that offer CPA is due to the fact that during PY3, there was a stock out of post-exposure prophylaxis (PEP) kits, nutrition commodities (vitamin A and PlumpyNut), LLIN, and SP.

During PY3Q4, it was found that the Fungurume general referral hospital no longer met the criteria required for a Complementary Package of Activities (CPA) as the hospital is under construction and is not able to offer full range of services. Also, after a supervision mission, the Tshumbe field team

found that the general referral hospitals of Minga, Ndjalo Ndjeka, and Omendjadi are not able to offer CPA due to outdated infrastructure and absence of a medical imaging service and gynecology-obstetrics services.

The number of GRHs with CPA-plus decreased to 13 GRHs in PY3Q4 from 24 in PY3Q1. See Table 4 below for a breakdown by coordination office for each quarter of PY3. The project provides GRHs with small and basic medical equipment, such as beds, mattresses, and trays. However, the GRHs require more advanced medical equipment, like ultrasound machines, biochemical materials for laboratories, and x-ray machines to be able to provide CPA-Plus services. IHP does not have the means to provide these materials to the health facilities.

Table 4: Number of GRH offering CPA-plus by coordination office

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3 Total	PY2 Total
PY3Q1	8	5	1	2	2	5	0	1	24	
PY3Q2	8	5	1	2	2	5	0	1	24	
PY3Q3	11	0	1	2	2	5	0	1	22	
PY3Q4	2	0	1	2	2	5	0	1	13	
Target	22	9	4	8	11	11	9	5	80	

The percentage of health centers which offer the minimum package of activities (MPA) increased from 78% in PY3Q1 to 95% in PY3Q4, for a PY3 average of 83% coverage. This result exceeds the PMP target of 60%. An average of 1,250 of 1,509 health centers offer MPA, including a full package of curative, preventive, promotional, and community activities. Table 5 provides the number of health centers with MPA services by coordination office and quarter. The availability of pharmaceutical products, the provision of equipment and medical supplies, and the delivery of quality care have helped contribute to the strong performance in PY3.

Table 5: The number of health centers offering MPA by coordination office and quarter

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3 Total
PY3Q1	208	201	55	105	177	191	156	83	1,176
PY3Q2	226	201	55	100	183	191	156	76	1,188
PY3Q3	253	202	55	105	177	191	156	83	1,222
PY3Q4	408	200	55	100	189	194	169	84	1,399
Target	408	207	55	105	197	191	156	104	1,509*

** The PMP target is based on 1,509 health centers*

The number of health centers offering MPA-plus remains low, as is the percent achievement of the PMP target (26%). Table 6, on the following page, shows the number of health centers that offer MPA-plus by coordination office and by quarter. The number of health centers offering MPA-Plus services decreased from 137 to 93 between PY3Q3 and PY3Q4 as the project experienced stock outs of PEP kits, nutritional commodities, LLINs, and vitamin A. IHP has placed orders for these commodities, which are expected to arrive in PY4.

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

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3
PY3Q1	36	8	0	N/A	4	20	7	0	75
PY3Q2	19	19	0	0	5	18	0	11	72
PY3Q3	48	20	0	29	5	23	0	12	137
PY3Q4	5	18	1	29	5	23	0	12	93
Target									1,509*

**1,509 is the number of health centers in the PMP*

In Tshumbe, the number of health centers offering MPA-plus fell from seven in PY3Q1 to 0 during the rest of PY3 as a result of stock outs of PEP kits, nutritional supplements, LLINs, and SP. Improving coverage rates for MPA-plus and CPA-plus remains a challenge for IHP, as a lack of necessary equipment prevented GRHs from providing certain health services. Nearly all health centers have integrated the basic curative, preventive, promotional, and community-based activities; however, the quality of care in many health centers is still low. Fully functional service delivery point (FOSACOF in its French acronym) assessments have provided recommendations to improve quality, but the means to implement these recommendations are not available. The recommendations resulting from the FOSCAOF assessments include reducing staff turnover and rehabilitating health facilities. However, IHP does not have the means to rehabilitate all health facilities or provide all of the necessary large equipment. In addition, the lack of funds for GRHs, the lack of financial support for management committees, and the lack of training in the Misgav Ladach technique for cesarean section have impeded the integration of MPA-plus and CPA-plus.

The project objective as stated in the award's program description is 80% by the end of project for both CPA-Plus and MPA-Plus. However, the recent external evaluation of IHP concluded that "none *of the 96 facilities surveyed currently provides a full range of MPA-plus service."* The reason for this finding is that " *there are more than 50 interventions in the IHP model of integrated services package (MPA-plus), including preventive, curative and community-based services focused on family planning (FP), mother and newborn health (MNCH), nutrition, malaria, neglected tropical diseases (NTDs), tuberculosis (TB), HIV/AIDS and water, sanitation, and hygiene (WASH)."* Nonetheless, the evaluation revealed that *"almost all facilities surveyed provided prenatal care and family planning, and 100% of the facilities offered clinic-based integrated management of childhood illnesses (IMCI.)*" The evaluation concluded that "*It is unrealistic to expect 80% of IHP's health facilities to achieve a full range of MPA-plus services by the end of the project because both the breadth of the target population and the depth of MPA-plus services are overly ambitious given the health system's existing status, logistical constraints, and implementation costs*. The recommendation was that "*USAID should convene with IHP and others to revisit project priorities and targets. The depth of the MPA-plus package should be reconsidered and tailored to fit the epidemiology and most pressing needs of the populations served*." Considering the potential contractual implications of this key recommendation, IHP and USAID are discussing how to address this recommendation with a modification to the project's program description with the following conclusions:

- The content of the MPA-plus and CPA-plus packages cannot be revisited.
- Rather, IHP needs to revise the target realistically and see how many health facilities that have integrated CPA and MPA are able to integrate CPA-plus and MPA-plus based on the situation of these health facilities before the start of the project.
- The IHP AOR will determine if the revision of the targets would require that the AO issue a corresponding revision of the Program Description as included in the project award.
- IHP will take into consideration the priority health zones targeted by the Ministry of Health (MOH) through the *Projet d'équipement des structures sanitaires* (PESS) program, which

supplies health facilities in DRC with basic equipment and medical supplies, to avoid duplication.

- IHP needs to propose a draft of realistic modified targets for MPA-plus and CPA-plus indicators and meet with USAID to resolve this issue.

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

Through PY3, the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) supported the project in the following activities:

1. Ensured the availability of medicines in health centers

SIAPS provided support to monitor the delivery of PY2 medicines from the Medical Export Group (MEG), and to monitor orders from the health zones, including conducting analysis of requisitions, developing distribution plans, and monitoring commodities, deliveries and the status of medicines and other commodities. Table 7 shows the overall delivery status from the PY2 pharmaceutical order as of October 2013. SIAPS also supported the process of obtaining import licenses for medicines to meet the needs of first quarter of PY3, and monitored the delivery of ASRAMES medicines. The status of the MEG and ASRAMES orders per site are highlighted in Table 7, below, and Table 8, on the next page.

Table 7. Status of ASRAMES orders: First quarter of 2013 (October 2013)

Province	Warehouse /CDR	Amount of the order in USD (Cfr Task order)	Delivered to date	(%) delivered	To be delivered	To be delivered in %
Sud Kivu	APAMESK	$446,363.18	$350,636.35	79	$95.726.83	21
Katanga	CEDIMEK	$343,309.48	$178,606.13	52.	$164,703.35	48
	KOLWEZI	$20, 075.67	$130,131.45	63	$76,944.22	37
Kasaï Occidental	CADIMEK	$302,484.32	$196,444.16	65	$106,040.16	35
Kasaï Oriental	CADMEKO	$235,525.12	$164,066.51	70	$71,458.61	30
	FODESA	$230,865.98	$132,230.43	57	$98 635,55	43
TOTAL order/delivery		**$1,765,623.74**	**$1,152,115.04**	**65**	**$613,508.71**	**35**

Having ASRAMES as a supplier helps avoid often cumbersome customs formalities and having products remain for long periods in customs storage, where they are susceptible to theft and embezzlement; however, IHP has noted that ASRAMES has had issues with performance, some due to factors beyond its control. The first delivery of ASRAMES, which consisted of 27.2% of the total order, arrived in the CDRs within 58 days, which is an acceptable delivery time, particularly compared to the delivery time of drug order no. 2 from supplier MEG. This delivery also helped cover serious stock outs reported from the last quarter of 2012. In addition, ASRAMES provides its orders through an annual supply line taking into account the respective needs of its clients. MSH was not on this list when this order was placed. The 80.3% of orders that arrived in March 2013 could have been delivered in December 2012 had it not been disrupted by the security situation in Nord Kivu, which suspended air transport from Goma for a month.

The project recommends developing a memorandum of understanding (MOU) with ASRAMES that outlines its commitment to meeting delivery dates and specifies penalty in case of default or noncompliance. The MOU could also mandate that ASRAMES acquire medicine from sources pre-

approved by USAID. ASRAMES should also register MSH in its supply lines along with its other clients. And, as noted in previous reports, ASRAMES does need capacity building.

Table 8. Status of MEG Orders: PY2 (October 2013)

Province	Warehouse/ CDR	Amount of the Order in USD (Cfr Task Order)	Delivered to date	(%) delivered	To be delivered	To be delivered in %
Sud Kivu	APAMESK	$727,872.22	$724,424.47	99	$3,447.75	1
Katanga	CEDIMEK	$349,096.97	$338,159.34	97	$10,937.63	3
	KOLWEZI	$229,766.61	$189,321.77	82	$40,444.84	18
Kasaï Occidental	CADIMEK	$383,139.15	$372,404.06	97	$10,735.09	3
Kasaï Oriental	CADMEKO	$197,241.99	$175,552.75	89	$21,689.24	11
	FODESA	$272,802.23	$243,639.20	89	$29,163.03	11
TOTAL order/delivery		**$2,159,919.17**	**$2,043,501.59**	**95**	**$116,417.58**	**5**

2. **Strengthened the management of medicines and other health commodities**

In PY3, SIAPS established an electronic data report sheet for the health zone and coordination office level. SIAPS also assisted the project through coaching sessions on the collection, analysis, and interpretation of pharmaceutical management data, and facilitated the redeployment of 4,028 RDT kits from Katanga and Lodja to Sud Kivu to avoid stock outs in Sud Kivu.

3. **Supported the quarterly supervision of drug management in health zones and health facilities**

SIAPS carried out supervisory visits for eight health zones in Kasaï Occidental, focusing on raising funds to create drug reserves, and collecting management reports to establish the pharmaceutical consumption tracking for the Presidential Malaria Initiative (PMI) and family planning commodities. SIAPS also provided coaching for health zone management teams (HZMT) on the development and transmission of drug orders to the regional distribution centers. SIAPS provided similar supervision for five health zones in Kasaï Oriental, and for the health zones of Dilala, Kanzenze, Bunkeya, and Fungurume in Katanga.

Along with IHP and the provincial health district team, SIAPS supervised five health zones in Sud Kivu for assistance with supply chain monitoring between warehouses and the GRHs, and between health zones and health centers. Table 9, on the following page, provides information on the redeployment of medicines in Sud Kivu and demonstrates how the project supports efforts by the MOH to build a sustainable system of drug procurement and recycling.

Table 9. Redeployment of medicines in Sud Kivu

Warehouse	Beneficiary Facility	Value of medicines (in USD)	30% value: redeployed	Funds saved (in USD)	Rate of savings (%)	Notes
APAMESK	Health zone	126,230	37,869	2,000	5	Only Nundu
	GRH	38,253	11,475.90	0	0	
BDOM	Health zone	142,132	42,639.20	13,940	33	Kadutu, Walungu, Kaniola, Nyzangezi, and Mubumbano
	GRH	39,559	11,867.70	6,940	59	Kadutu, Walungu, Mubumbano
CEPAC	Health zone	70,933	21,279.90	6,929	33	Katana, Bagira, and Minova
	GRH	23,548	7,064.40	836.05	12	Only Katana
Total		440,655	132,196.50	30,645.05	**23**	

4. Supported the tracking of credit lines and pharmaceutical stocks

SIAPS, IHP, and the provincial health division collaborated to monitor credit lines at the regional distribution centers and warehouse. SIAPS was also involved in readjusting credit lines in the CADIMEK, CADMEKO, CEDIMEK, Kolwezi, Lodja, and the three warehouses in Sud Kivu. SIAPS assisted in the tracking of requisitions from the health zones to the warehouses, conducting joint analysis and order validation with the provincial health division before medicines were delivered. SIAPS also assisted in monitoring PEPFAR commodities affected by the suspension of PMTCT activities in the provinces of Sud Kivu, Kasaï Oriental, and Kasaï Occidental, particularly given that most of these products were close to their expiration dates. As a result, IHP worked with SCMS in Kinshasa to redeploy these products to other implementation partners. In addition, IHP was able to borrow products for use in transfusion safety.

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

1. <u>i-CCM (Integrated management of childhood illnesses)</u>

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

For PY3Q4, 76 out of 80 health zones (or 1,445 health facilities out of 1,509) provided reports on pneumonia, diarrhea, and malaria case management for children under 5. The health zones of Kalehe, Minova, Kalonge, and Mpania Mutombo were unable to provide reports due to insecurity and poor road conditions in Sud Kivu.

In PY3, an additional 23,770 children under age 5 received pneumonia, diarrhea, and malaria treatment, as compared to PY2. Of this number, 3,343 children (19%) received that care in community care sites. From PY2 to PY3, the percentage of children who received proper case management for these illnesses increased from 85% to 87%, due to the integration of new community care sites, the availability of drugs, regular supervisory visits, and higher levels of motivation among CHWs due to the bicycles provided by the project to facilitate door-to-door visits.

Tables 10 and 11 below display the number of cases of pneumonia treated in health facilities and in community care sites in PY3Q4, and in PY3 and PY2, respectively.

During PY3Q4, 122,678 cases of pneumonia in children under age 5 were treated, representing 88% of the PMP target. Of these, 115,255 cases were treated in health facilities and 7,423 cases in community care sites. Appendix 2 provides a list of the number and location of community care sites operational as of PY3Q4.

In the coordination offices of Bukavu, Kamina, Kole, Kolwezi, and Tshumbe, the percentage of case management of childhood illnesses exceeded 70%, the target proposed by the MOH. In the coordination offices of Luiza and Mwene Ditu, some sites did not send their reports in a timely manner. The Uvira coordination office reported a low achievement rate of 40%, as care providers were on strike until October 2013.

The highest number of pneumonia cases (129,452) was reported during the second quarter of PY3, due to flooding in Malemba Nkulu and the increase in the population in Bukavu due to the conflict in Nord Kivu.

Table 10: Number of cases of childhood pneumonia treated with antibiotics in health facilities and i-CCM sites supported by the US Government in PY3Q4

Coordination office	Health facilities	i-CCM sites	Total	PMP Target	Achievement (%)
Bukavu	34,790	3217	38,007	39,712	96
Kamina	34,808	849	35,657	20,884	171
Kole	2,774	25	2,799	3,877	72
Kolwezi	5,357	1,100	6,457	9,045	71
Luiza	10,603	269	10,872	17,468	62
Mwene Ditu	14,831	1,202	16,033	26,549	60
Tshumbe	8,318	687	9,005	12,055	75
Uvira	3,774	74	3,848	9,544	40
PY3Q4	115,255	7,423	122,678	139,134	88

Table 11: Number of cases of childhood pneumonia treated with antibiotics in health facilities and i-CCM sites supported by the US Government in PY3 and PY2

Period	Health facilities	i-CCM sites	Achievement %
PY3Q1	98,700	6,757	
PY3Q2	125,814	3,638	
PY3Q3	119,286	3,438	
PY3Q4	115,255	7,412	
PY3 Total	460,055	**21,256**	**87%**
PY2 Total	439,639	**17,902**	**85%**

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

- Maintain the strong performances reported in Bukavu, Kamina, Kole, Kolwezi, and Tshumbe by ensuring that commodities and data management tools are regularly available, and support monthly supervisory visits to health centers and community care sites.

- Support health center care providers to use of care flow charts to correctly assess, classify, and treat pneumonia, focusing on Mwene Ditu, Luiza, and Uvira.
- Provide and monitor the distribution of cotrimoxazole in health facilities and care sites.
- Ensure completeness and quality of data, and provide post-training follow-up in data collection methods.

The total number of cases of diarrhea treated increased from 234,537 in PY2 to 243,986 in PY3. However, the number of cases managed in community care sites decreased from 21,988 in PY2 to 15,714 in PY3. This is due to a six-month stock out of oral rehydration solution (ORS) during PY3, resulting from a delay in the arrival of the pharmaceutical order by supplier MEG. The project placed an emergency order with ASRAMES; however, the ORS and zinc order did not arrive on time in the health zones due not only to the unavailability of these products in the ASRAMES warehouse, but also to a delayed delivery. The quantification of ORS and zinc sulfate is based on morbidity data (3 episodes of diarrhea per child per year). IHP provides for two ORS packets and 10 zinc tablets per episode in its quantifications.

In order for ORS and zinc to be available to the population free of cost, the project will have to remove them from the list of drugs included in the lines of credit in the CDRs. This decision will be implemented once IHP and SIAPS draft and sign an amendment to IHP's pharmaceutical management protocol, establishing ORS and zinc to be distributed without cost to treat diarrhea in children. This document will be provided to the CDRs.

Table 12, below, displays the breakdown by coordination office for PY3Q4.

Table 12: 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	Health facilities	i-CCM sites	Total	PMP Target	Achievement (%)
Bukavu	23,024	1,886	24,910	52,949	47
Kamina	13,550	1,333	14,883	24,438	61
Kole	1,582	128	1,710	5,169	33
Kolwezi	5,079	351	5,430	12,060	45
Luiza	6,889	258	7,147	23,291	31
Mwene Ditu	9,673	1,248	10,921	38,807	28
Tshumbe	5,119	827	5,946	16,074	37
Uvira	5,996	311	6,307	12,726	50
PY3Q4	70,912	6,342	77,254	185,514	42

In PY3Q4, 77,254 cases of diarrhea in children under 5 were treated with ORS and zinc, representing only 42% of the PMP target of 185,514 cases. Although this rate is low, it represents an increase of 8,759 cases compared to the previous quarter. In this quarter, 6,342 cases were treated in community care sites.

Kamina reported the highest rate of achievement, with nearly 61% of children with diarrhea having been treated with ORS or ORS and zinc. The stronger performance is due to the fact that between May and July 2013, health zones in Kamina were impacted by flooding. As a result of the extreme weather conditions, Kamina witnessed more diarrhea and pneumonia cases. In addition, Kamina reported some cases of cholera. Doctors Without Borders provided emergency care to the

population, and the project developed a communication plan to raise awareness in the community, and participated in the MOH's epidemiological unit meetings.

Mwene Ditu, however, reported the lowest rate of achievement for this indicator, with a percentage of 28. The poor performance in Mwene Ditu is strongly linked to reporting problems, specifically that diarrhea cases treated only with ORS were not reported. In response to this challenge, IHP staff will visit Mwene Ditu on a monthly basis to ensure that indicator definitions are correctly understood and that data is collected and analyzed correctly.

Although none of the coordination offices have attained the target of 70%, as recommended by the MOH, there has been a continued increase in the number of cases treated each quarter during PY3, as seen in Table 13, below. The numbers are improving due to the revitalization of community care sites, supervisory visits, the use of care flow charts, and the increased (although still not sufficient) availability of ORS and zinc.

Table 13: Number of children under 5 years old with diarrhea treated with oral rehydration solution (ORS) or ORS plus zinc supplements in USG-supported facilities in PY3 and PY2

Period	Health facilities	i-CCM sites	Achievement (%)
PY3Q1	52,413	3,265	
PY3Q2	57,545	2,422	
PY3Q3	64,777	3,718	
PY3Q4	70,912	6,342	
PY3 Total	245,647	15,747	**35**
PY2 Total	224,537	21,988	**34**

Despite community mobilization and awareness-raising efforts, seeking care for diarrhea in health facilities and community care sites is still not a common practice among the population. In "The Survey of Mothers of Children Under-five and Analysis of Bottlenecks in Health Facilities'' conducted by the School of Public Health at the University of Kinshasa (September 20, 2013) in 10 health zones covered by the Health for Poorest Populations (HPP) project (nine of which are supported by IHP), reported on the knowledge of danger signs for diarrhea among caregivers, noting that the most frequent responses provided by mothers when asked about dangers signs for diarrhea are the presence of loose stools, lethargy, inability to breastfeed or drink, and dryness of the tongue. These responses were similar across different health zones. The survey shows that the level of knowledge of mothers and /or caregivers on danger signs is acceptable.

IHP has planned the following activities for PY4:

- Continue to provide and distribute ORS in health facilities and community care sites.
- Finalize discussions with the MOH on the target for the diarrhea indicator, and distribute it to the health zones.
- Continue awareness-raising efforts within the community about the importance of treating diarrhea in a clinical setting.
- Organize small-scale awareness raising campaigns in the health zones of Kalomba, Luiza, and Mwene Ditu.
- Establish new community care sites.

1.2. Malaria case management in USG-supported health facilities

In PY3, 653,417 children under age 5 were treated for malaria, compared to 477,399 children in PY2, as shown in Table 15. An increase in the number of children treated in community care sites was also noted, from 924 in PY2 to 14,279 in PY3. Table 14 shows the number of children treated in facilities and community care sites in PY3Q4.

The number of cases of childhood illness treated in community care sites increased, overall, from PY2 to P3. The significant increase in malaria treatment in community care sites is due to the availability of RDTs and ACTs, which are provided by the President's Malaria Initiative (PMI).

Table 14: Number of children under five years old with malaria treated in facilities and i-CCM supported by the USG by PY3Q4

Coordination office	Health facilities	i-CCM sites	Total	PMP target	Achievement Rate (%)
Bukavu	75,362	324	75,686	124,706	61
Kamina	40,950	1298	42,248	65,582	64
Kole	10,330	324	10,654	12,174	88
Kolwezi	17,625	175	17,800	28,403	63
Luiza	15,190	608	15,798	49,793	32
Mwene Ditu	18,395	1,112	19,507	64,753	30
Tshumbe	17,182	513	17,695	23,257	76
Uvira	12,051	118	12,169	29,971	41
PY3Q4	**207,085**	**4,472**	**211,557**	**398,639**	**53**

In PY3Q4, Kole reported the highest performance of 88% treatment, and Tshumbe reported a care rate of 76%, which is linked to an unusually high number of severe fevers in Sankuru. IHP believes that the fevers in Sankuru are indicative of severe malaria; however, results from samples sent to the Kinshasa laboratory are not yet available to confirm this hypothesis. Again, Mwene Ditu reported the lowest achievement rate of 30%, which is due to reporting and data collection issues. IHP will conduct monthly supervisory visits to provide data management support.

Table 15 shows the number of new cases of malaria treated increasing by quarter, from 1,595 in PY3Q1, to 4,472 in PY3Q4. This increase is due to the integration of new community care sites, the availability of drugs, and supervisory visits.

Table 15: Number of children under five years old with malaria treated in facilities and i-CCM sites supported by the USG in PY3 and PY2

Period	Health facilities	i-CCM sites	Achievement (%)
PY3Q1	76,722	1,595	
PY3Q2	184,624	3,605	
PY3Q3	170,706	4,607	
PY3Q4	207,085	4,472	
PY3 Total	639,138	14,279	41
PY2 Total	476,475	924	31

During the next quarter, IHP will carry out the following activities:

- Regularly monitor the distribution of ACTs and RDTs to all service delivery points.
- Ensure the collection of quality data at health facilities, and help health zones record average monthly consumption levels.

1.3. A Promise Renewed

In the context of accelerating the reduction of maternal and infant mortality, IHP carried out the following activities:

- Contributed to the revision of the pneumonia treatment guidelines according to World Health Organization (WHO) recommendations, which includes the use of amoxicillin to treat pneumonia in children under 5 years.
- Established 70 community care sites and trained 149 CHWs following the MOH's official launch of "A Promise Renewed," on May 31, 2013. New sites are based in the health zones of Lodja (10), Djalo Ndjeka (9), Tshumbe (10), Vangakete (12), Bena Dibele (8), Kitenge (7), Songa (7) and Kabongo (7). IHP supplied the community care sites with ACTs and RDTs.
- Conducted post-training follow-up supervision for i-CCM activities in the community care sites, as well as in the health centers of the health zones of Uvira, Ruzizi, Idjwi, Mwana, Kaziba, and Bibanga.
- Briefed head nurses and health zone management teams in Uvira Ruzizi, Idjwi, Mwana, Kaziba and Bibanga on the framework for accelerating the reduction of mortality levels among mothers, newborns and children.
- Issued reminders on the correct management of diarrhea, pneumonia, and malaria to nurses in these health zones with the aim of improving health care quality and service.
- Contributed to the narrative report and the "Essential Medicines Initiative (EMI)," in relation to the 13 essential medicines, which were finalized and sent to the UN commission for funding.
- Supported the MOH to conduct an informational campaign among policy makers, health ministries and other organizations concerning the application of chlorhexidine digluconate (CHX 7.1%) for umbilical cord care.
- Conducted post-training follow-up on the Helping Babies Breathe (HBB) approach in 10 GRH in PY3Q3 and 31 GRH in PY3Q4.

It should be noted that pneumococcal conjugate vaccine (PCV13) was introduced much earlier in the province of Sud Kivu (2011) and the vaccination coverage rate is the same as the pentavalent 3 (DTP-HepB-Hib 3) coverage for the province of Sud Kivu. The provinces of Kasaï Occidental and Kasaï Oriental introduced PCV13 in July 2013, and Katanga introduced it in August 2013; the coverage will be assessed within the next 6 months.

During PY3, as indicated below in table 16, an estimated 33,458 lives among the children under five population were saved through prenatal care, other preventive interventions, vaccinations, antimalarials, antibiotics, and diarrhea treatments. Antimalarial treatments accounted for an estimated 13,162 lives saved; improved sanitation accounted for 5,207 lives saved; and oral rehydration solution account for 4,378 lives saved. IHP's impact on lives saved among children under five was estimated using the LiST tool.

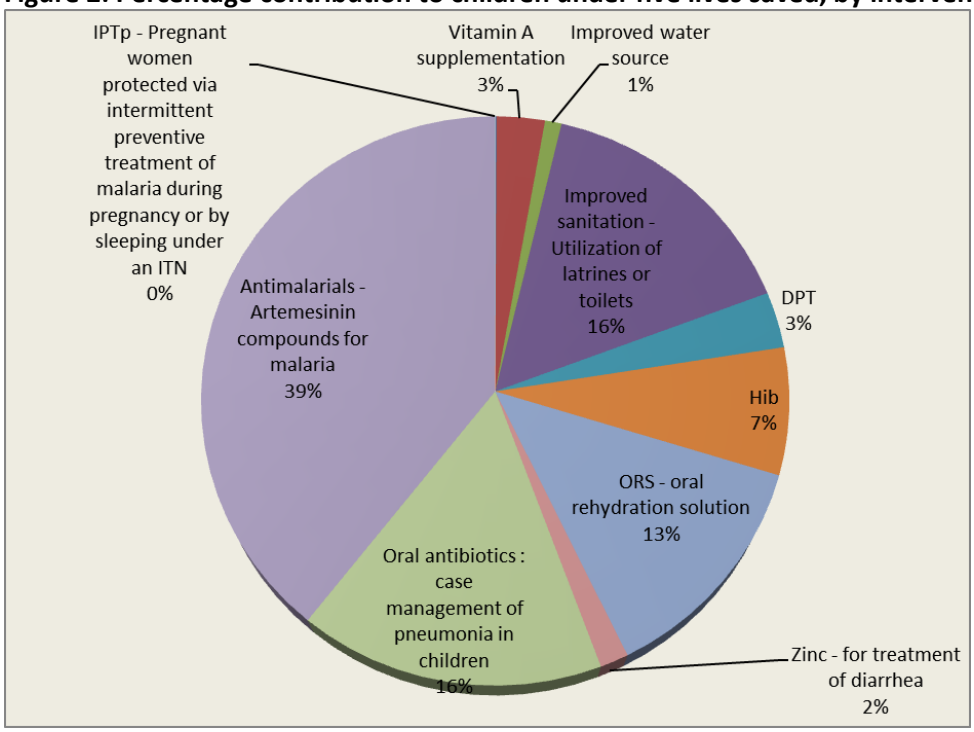
Improved sanitation, including the use of latrines or toilets, the availability of ORS, and the correct use of antimalarial drugs were the interventions which contributed to the greatest estimated number of lives saved among children under five. Please see Table 16 on the following page for more details on lives saved among children under five.

Table 16: Number of lives saved for children aged 1-59 months by intervention relative to impact

Number of lives saved for children aged 1-59 months by intervention relative to impact year	
	PY 3
Pregnancy	
IPTp – Pregnant women protected via intermittent preventive treatment of malaria during pregnancy or by sleeping under an ITN	26
Preventive	
Vitamin A supplementation	914
Improved water source	315
Improved sanitation – Utilization of latrines or toilets	5,207
Vaccines	
DPT	1,067
Hib	2,417
Curative after birth	
ORS – oral rehydration solution	4,378
Zinc – for treatment of diarrhea	509
Oral antibiotics : case management of pneumonia in children	5,463
Antimalarials – Artemesinin compounds for malaria	13,162
Total	**33,458**

Figure 2, on the following page, illustrates the percentage contribution to children under five lives saved by intervention type.

Figure 2: Percentage contribution to children under five lives saved, by intervention



Helping Babies Breathe

In PY3Q4, 31 out of 37 GRHs (84%) visited by project staff have care providers trained in HBB methods, compared to 10 out of 37 (or 27%) GHRs visited last quarter. Coordination office visits to Bukavu, Uvira, Mwene Ditu, Luiza, Kolwezi, and Kamina were carried out in order to provide post-training supervision on neonatal resuscitation. Care providers in GRHs in Tshumbe and Luiza have not yet received training on HBB methods. The project plans to support HBB trainings in these remaining coordination offices in PY4. As seen in Table 17 on the following page, overall, Bukavu, Kolwezi, and Mwene Ditu reported a rate of asphyxia below 10%, and Uvira reported an average rate close to the national average (3.5%). The table also shows the number of babies resuscitated with or without success in GRH maternity wards visited during PY3Q4.

Table 17: Number of babies with neonatal asphyxia reported during the period of PY3Q4

	GRH	No. of registered live births	No. of babies in intensive care in GRHs visited	No. of revived babies after neonatal intensive care	No. of babies not revived after neonatal intensive care	Percentage of babies revived per coordination office	Percentage of babies not revived per coordination office	Proportion of babies with neonatal asphyxia PY3Q4 (%)	Proportion of babies with neonatal asphyxia PY3Q3 (%)
Bukavu	Bagira	222	6	6	0	92%	8%	3	4
	Katana	379	17	16	1			5	Not reported
	Kavumu	874	92	82	10			10	2
	Minova	508	79	75	4			16	28
Uvira	Uvira	570	25	25	0	90%	10%	4	4
	Lemera	415	9	8	1			2	Not reported
	Ruzizi	152	14	11	3			9	Not reported
	Nundu	153	20	17	3			13	Not reported
Kolwezi	Mwangeji	74	14	12	2	80%	20%	19	Not reported
	Dilala	369	21	16	5			6	Not reported
	Kanzenze	96	10	7	3			10	Not reported
	Walemba	62	5	5	0			8	Not reported

Kamina	Kabongo	71	14	14	0	94%	6%	20	15
	Kayamba	26	2	2	0			8	Not reported
	Kinkondja	92	10	9	1			11	Not reported
	Malemba	84	22	22	0			26	Not reported
	Songa	18	5	3	2			28	Not reported
Luiza	Bilomba	18	3	3	0	71%	29%	17	Not reported
	Kalomba	56	12	8	4			21	Not reported
	Luambo	69	16	12	4			23	Not reported
	Luiza	53	6	5	1			11	6
	Yangala	27	3	1	2			11	Not reported
	Tshikaji	51	9	6	3			18	Not reported
Mwene Ditu	Bibanga	39	10	10	0	92%	8%	26	Not reported
	Dibindi	135	9	7	2			7	Not reported
	Luputa	314	12	11	1			4	12
	Tshamala/Mwene Ditu	71	8	8	0			11	5
Total		4,998	453	401	52				

Of the six coordination offices reporting the number of cases of resuscitated babies, four (Bukavu, Kamina, Mwene Ditu, and Uvira) showed an average rate of resuscitation greater than or equal to 90%; Kolwezi had a rate of 80% and Luiza reported a neonatal resuscitation success rate of 71%. Factors contributing to strong performance included the quality of the HBB training, which is also very practical; the provision of HBB neonatal resuscitation kits just after training; the post-training monitoring of service providers and the support by trained PNSR teams; and the involvement of project staff who had increased competency from technical briefings provided by IHP staff during field visits. Luiza's performance rate of 71% is the result of prematurity of some of the babies who were resuscitated (GRH Tshikaji) and late referrals of patients giving birth to babies with severe neonatal asphyxia (GRH Yangala and Kalomba).

The following activities will be a priority in the next quarter:

- Provide technical briefings, and if necessary, train the staff of the Kole and Tshumbe coordination offices in Sankuru to increase their competency in the HBB approach
- Strengthen monitoring in the underperforming GRHs (Yangala and Kalomba in Luiza; and Songa in Kamina)
- Improve the reporting system in certain GRHs by making data collection tools available, conducting supervisory visits to provide support for proper data collection methods, and ensuring that data is reported correctly in all records.
- Provide additional HBB kits for health facilities providing delivery services under IHP.

Health for the Poorest Populations (HPP)

During PY3Q4, the Health for the Poorest Populations (HPP) project, which will complement IHP activities in selected health zones, prepared for the start of the project. Although the arrival of pharmaceutical and other commodities for the family kits has been delayed, the HPP project carried out the following activities:

- **Project staff recruitment:** The project currently has four technical coordinators who will manage the implementation of activities in Katanga, Kasaï Occidental and Kasaï Oriental. The coordinators are collocated in IHP offices in Tshumbe, Mwene Ditu, Kolwezi, and Kamina.
- **Developing maps of community care sites:** As community care sites are a major component of the HPP project, preparatory activities included mapping the sites in the 27 health zones supported by HPP. The purpose of the mapping activity is to identify the community care sites that are functional and those that need to be rehabilitated, as well as to determine the care sites' needs in order to provide care. Out of the 27 HPP-supported zones, 14 health zones have completed the mapping exercise, which identified 64 functional sites, 10 sites needing rehabilitation, and the need for 173 more sites in these health zones in order to cover the population's needs.
- **Trainings on improved data monitoring:** Three HPP technical coordinators in Kamina, Tshumbe, and Mwene Ditu have been trained on data collection and analysis methods to identify bottlenecks and to assess the project.
- **Staff orientation on project implementation strategies:** In Kasai Oriental, staff in 12 HPP-supported health zones were oriented in two groups: six health zones in Mwene Ditu and six health zones in Lodja. In total, 38 staff from health zones, the provincial health districts, and other organizations were briefed on the HPP project and implementation strategies.
- **Population count:** Prior to implementing HPP, a population count was carried out before rolling out the family kit approach in the health zones. In PY3Q4, 24 staff in 12 health zones supported by HPP and three staff in Kasaï Oriental were briefed on the population count tool that was developed by the MOH. A census of the population has not yet taken place, but the process will follow the norms and standards required and will involve all stakeholders in the

health system, from the community to the provincial division of health, through nurses in health areas and health zone management teams. The data collected will follow the validation process implemented by the Ministry of Health.

In the next quarter, the HPP project expects to begin implementing activities, including improved data monitoring, staff orientations, population counts, the provision of family kits, and continued community care site mapping in the six health zones selected for the launch: Kanda Kanda, Vangakete, Dibaya, Ndekesha, Fungurume, and Kikondja. HPP plans to renovate and launch new community care sites in 2014, including the following: 91 community care sites to be renovated and 154 new sites to be launched (see table in Annex 4).

2. **Scale up evidence-based pilot WASH activities**

Regarding the number of people with access to safe drinking water, results have increased from 138,136 people in PY2 to 435,973 in PY3. In addition, the results reported in PY3 (435,973) greatly exceeded the PMP target (335,800), for an achievement rate of 116.5%. This strong performance demonstrates the success of the zonal approach, and is also due to IHP's support of the training of artisan-masons as well as the communities' engagement in improving sanitation in their villages.

The number of people who benefited from improved sanitation in PY2 (43,980) increased to 309,907 people by the end of PY3. The strong performance is due not only to the community-led total sanitation (CLTS) approach, but also strong community engagement, the involvement and ownership of community leaders, and the prioritization of improved sanitation among Champion Communities. The evolution of the WASH indicator results over the course of PY3 is illustrated in Table 18.

IHP also provided support for the development of a national WASH strategy, by assisting in the recruitment of two consultants, Professor Kiyombo Mbella and Dr. Yannick Pradelles, to provide technical support in the development of DRC's national WASH strategy.

Table 18: IHP WASH indicators results per IHP coordination for PY3 and PY2

Indicator	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	Target PY3	Total PY2
Number of people in target areas with first-time access to improved drinking water supply as a result of USG support	105,917	96,251	73,357	160,447	435,972	335,800	138,136
Number of people in target areas with first-time access to improved sanitation facilities as a result of USG support	74,599	68,044	97,886	69,378	309,907	335,800	43,980

The number of water sources rehabilitated in PY3 (371) nearly doubled from the number rehabilitated in PY2 (167). The number of latrines rehabilitated also greatly increased: 40,351 in PY3 versus 6,116 latrines in PY2. Table 19, on the following page, provides information on the number of water sources and latrines rehabilitated over PY3 and in PY2, overall.

Table 19: Number of water sources and latrines rehabilitated in collaboration with the community

Indicator	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	Total PY2
Number of rehabilitated water sources	88	109	83	91	371	167
Number of improved latrines built by the communities	10,375	9,677	14,091	6,208	40,351	6,116

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 PY3, 34 Leadership Development Program (LDP) teams completed their projects and achieved their desired performance, as compared to 22 teams in PY2. This improvement in LDP performance, as well as the increase in the number of teams implementing new projects, is linked to the strong involvement of community leaders, particularly during informational meetings and LDP planning. The project has also supported teams by providing coaching on management and the importance of team morale.

By the end of PY3, 73 health zone teams had developed new projects. Of these, 22 teams were from Bukavu, 8 from Kolwezi, 9 from Kamina, 3 from Tshumbe, 5 from Uvira, 4 from Kole, 11 from Luiza, and 11 from Mwene Ditu. Table 20 provides information on the LDP teams that have started and successfully completed their LDP projects over the course of PY3, and from PY2, overall.

Table 20: Number of health zone teams that carried out and finalized their LDP projects during PY3 and PY2

	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 Total
Total number of teams	80	80	80	80	**80**	**80**
Number of teams having conducted and completed their LDP projects	29	3	8	5	**45**	**37**
Number of teams having completed their projects and achieved their desired performance	22	3	6	3	**34**	**22**
Target number of teams with LDP projects	18	18	18	18	**72**	**72**
Number of teams with LDP projects during the period	11	22	20	20	**73**	**47**

In PY2, 47 health zone teams began their LDP projects, representing 65% of the PMP target of 72 teams. In PY3, 73 teams out of a PMP target of 72 teams began their projects, for an achievement rate of 101%. In addition, 45 teams out of 80 teams completed their LDP projects, for an achievement rate of 56%, and 34 out of the 45 teams reached their desired performance of at least 80%, for an achievement rate of 75.6%. Table 21, on page 31, shows the indicators selected by each team, and levels of achievement. The "realized performance" is expressed as a percentage.

Of these 73 teams, 53 teams are expected to complete their projects in early October 2013 (22 from Bukavu, 9 from Kamina, 11 from Luiza, and 11 in Mwene Ditu). Their project results will be presented in next quarter.

Table 21: Senior LDP Teams that achieved their desired performance in the six months after LDP, according to the indicators in their action plans

Field office	Health zone teams	Topics	Indicators per LDP project	Indicator trends after 6 months of LDP completion (% unless number indicated)		
				Baseline (%)	Expected performance (%)	Realized performance (%)
Bukavu	Bagira	MNCH: IPT	Coverage rate for ITP	21	46	46
	Ibanda	HIV: PMTCT	Testing rate among male partners	2	4	4
	Kadutu	MNCH: ANC	Utilization rate of ANC	28	40	71
	Kaniola	HIV: PMTCT	HIV testing among pregnant women	15	20	41
	Katana	FP	Contraceptive prevalence rate	9	14	24
	Walungu	TB	TB MPT+ detection rate	14	20	16
	Nyangezi	TB	TB MPT+ detection rate	12	18	61
	Kaziba	TB	TB MPT+ detection rate	6	12	15
	Mubumbano	PF	Contraceptive prevalence (LAM)	0.3	4	4
	Shabunda	PF	Contraceptive prevalence	12	20	35
	Kalonge	TB	TB MPT+ detection rate	8	11	15
Uvira	Uvira	HIV : PMTCT	Number of women counseled, tested, and provided with their results	1,825	4,262	33
	Ruzizi	MNCH: ANC	Rate of new ANC cases	40	80	113
		MNCH: EPI	% of VAT 2 coverage	51	72	71
	Haut Plateau	MNCH	% of assisted births	39	40	25
	Lemera	MNCH: EPI	Drop-out rate of pentavalent 1 and 3	13	10	75
		MNCH: ANC	% of health areas offering ANC	75	85	95
Kolwezi	Kanzenze	Renovation	Health facilities rehabilitated in Disombo	1	1	100
		Renovation	Health facilities rehabilitated in Mpala	1	1	70
	Bunkeya	MNCH: EPI	VAR immunization coverage	66	117	137

	Manika	Supervision	Level of supportive supervision	60	80	95
		Curative services	Utilization rate	7	13	87
	Lualaba	MNCH: EPI	% of children fully immunized	65	80	90
		MNCH	% of assisted births	32	60	99
	Dilala	MNCH: EPI	% of VAT 2 coverage	54	65	107
		MNCH: EPI	Drop-out rate of pentavalent 1 and 3	13	12	13
	Lubudi	Curative service	Utilization rate	23	35	33
		MNCH	% of assisted births	63	68	97
	Fungurume	MNCH: EPI	VAR immunization coverage	69	97	114
		SNIS	SNIS promptness	30	70	65
	Mutshatsha	MNCH: EPI	VAT2+ immunization coverage	61	79	93
Kole	Tshudi Loto	MNCH: AMTSL	% of assisted births	44	80	89
	Bena Dibele	MNCH: AMTSL	% of assisted births	77	95	100
Tshumbe	Lodja	MNCH: AMTSL	% of assisted births	92	100	100
	Ototo	MNCH: ANC	Utilization rate of ANC	25	30	85
	Vangakete	MNCH: EPI	Drop-out rate of pentavalent 1 and 3	15	9	96
	Katako Kombe	TB	TB MPT+ detection rate	30	40	60
	Wembonyama	TB	TB MPT+ detection rate	18	35	52
	Djalo	MNCH: ANC	Rate of achievement for CPN4	67	73	40
Luiza	Ndekesha	TB	TB MPT+ detection rate	60	80	93
	Luiza	MNCH: AMTSL	AMTSL coverage	70	100	100
	Kalomba	SNIS	Monitoring and evaluation rate of the data base	50	80	100
	Yangala	MNCH: EPI	Coverage rate for VPO3	47	90	90
Mwene Ditu	Mwene Ditu	TB	Rate of detection	27	50	39
		Renovation	Health facilities rehabilitated	2	2	100
	Kanda Kanda	PF	Contraceptive prevalence	15	25%	35

		MNCH	% of assisted births	72	85	90
		MNCH: ANC	Utilization rate of CPoN 2+	64	85	85
	Wikong	Renovation	Health facilities renovated	0	85	40
	Kamiji	WASH	Latrines constructed	0	84	83
	Bibanga	Renovation	Health facilities renovated	0	90	90
		Renovation	Health facilities renovated	0	100	100
	Luputa	Curative services	Utilization rate	23	40	30
Kamina	Kitenge	MNCH	% of assisted births	48	57	85
	Kabongo	WASH	VIP latrines constructed	5	10	100
	Kinkondja	HIV: PMTCT	Number of pregnant women tested for HIV	398	690	65
	Malemba	WASH	Latrines constructed	24	27	100
	Kayamba	TB	TB MPT+ detection rate	47	60	76
	Lwamba	Curative services	Utilization rate	1		75
	Mukanga	Curative services	Utilization rate	13	16	66
	Mulongo	TB/HIV	TB MPT+ detection rate	0	30	75
	Songa	Curative services	Utilization rate	2	8	80

Results from the teams were affected by a number of factors. For example, the health zone of Hauts Plateaux d'Uvira has long struggled with insecurity. Due to the persistent presence of armed groups, community members, including pregnant women, do not feel safe traveling to the health centers. In Lemera, the dropout rate in pentavalent vaccine decreased from 13% to 11%, which represented a gain of 75%. This is because the health zone does not have a strong system to recover patients who do not come in for routine vaccination. The EPI senior technical advisor carried out a mission in July 2013 to provide technical support to the zone supervisor to solve this issue.

The LDP team in Mwene Ditu was very ambitious when it set its target for TB rate of detection at 50% after 6 months. To achieve this target, the team would have to train providers and CHWs in DOTs and implement community-based activities; have enough commodities and laboratory equipment and material; and make available and use BCC materials. Health providers and CHWs were trained on DOTS only in the last quarter of PY3, and community activities began after this period. Moreover, the laboratories of these areas have received their commodities but the counseling cards were still being developed under the lead of the PNLT.

In the next quarter, to continue supporting the LDP projects, IHP will:

- Organize a bi-annual three-day meeting in support of the implementation of LDP projects.
- Support a monthly joint monitoring mission with health districts to supported LDP teams.
- Organize a bi-annual meeting to share success stories about LDP project results with health authorities.
- Prepare and share a success story for an LDP project that has completed the entire implementation and evaluation cycle (this will be done for every quarter moving forward).

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. <u>Family planning</u>

IHP reported an increase in the couple years of protection (CYP) from 477,584 in PY2 to 502,591 in PY3. The PMP target achievement rates for PY2 and PY3 are 111% for both years. Table 22 on the following page provides a breakdown by coordination office.

Over the course of PY3, IHP reported an overall increase in CYPs, with a slight dip between PY3Q2 and PY3Q3. Although the coordination offices of Bukavu, Kole, and Uvira did not achieve 100% of the PMP target, each demonstrated improvements in the indicator from quarter to quarter.

Table 22: Couple years of protection (CYP) in USG-supported programs

Field office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	PMP Target PY3	Total PY2	(%) PY3	(%) PY2
Bukavu	19,561	22,653	23,279	27,414	92,907	127,600	85,612	73	69
Kamina	25,680	23,952	23,700	29,055	102,387	66,000	101,724	155	158
Kole	2,527	2,587	3,158	3,282	11,554	13,200	11,298	88	88
Kolwezi	12,493	10,915	13,408	13,119	49,935	26,400	42,399	189	164
Luiza	15,249	19,717	19,269	17,622	71,857	52,800	68,115	136	132
Mwene Ditu	26,272	24,632	23,270	25,550	99,724	83,600	99,057	119	121
Tshumbe	13,286	13,093	12,963	12,210	51,552	39,600	54,513	130	141
Uvira	4,900	4,974	6,056	6,745	22,675	30,800	14,866	74	49
Total	119,968	122,523	125,103	134,997	502,591	440,000	477,584	114	111

Improvements over the project year can be attributed to the training of 144 care providers in long-term clinical methods; the training of 219 community-based distributors (CBDs) in basic family planning information; and the monitoring and rational use of family planning commodities. IHP carried out joint supervisory visits along with MOH staff, and provided intra-uterine devices (IUDs) to Bukavu (186 insertion kits for 23 GRH), Uvira (42 kits for 5 GRH), and Kole (28 kits for 4 GRH). The project also involved Champion Communities in family planning awareness-raising activities, provided CHWs with bicycles to carry out household visits, and integrated non-clinical family planning services in community care sites.

IHP has planned the following activities in PY4 to continue supporting the uptake of family planning methods:

- Organize CBD trainings in the Kaziba, Kaniola, and Mubumbano health zones.
- Support a mini-campaign to raise awareness of the importance of family planning in the health zone of Katana.
- Support the health zones of Wikong and Mwene Ditu to promote family planning methods through an awareness-raising campaign.
- Provide additional trainings for CBDs to distribute non-clinical methods and to support referrals for patients interested in clinical family planning methods to health facilities.
- Organize family planning trainings focusing on long-term methods, specifically implants, for care providers.
- Involve local health authorities and health zone management teams in Tshudi Loto and in Lomela in supervising family planning activities.

The project objective is to ensure all supported health zones can provide the same types of services. The approach is initiated based on each health zone's Annual Operation Plan. For the insertion of Implanon, six trainers from five coordination offices were trained in collaboration with PSI and Merck. The training of providers is planned to take place in PY4. In addition, Merck has agreed to provide free training kits including placebo tablets and Implanon NXT.

The number of people who adopted a modern method of contraception increased from PY2 to PY3, from 502,914 new acceptors to 556,320 new acceptors. The PMP target achievement rates in these years were 107% and 114%, respectively. In future reports, IHP will report CYP and number of new clients by type of methods, as well as the proportion of clinical versus non-clinical methods (such as cycle beads and condoms).

Table 23 displays the progression of new acceptors of modern methods throughout PY3, and the achievement in PY2, illustrating the fact that the number of people who chose a modern method of contraception increased steadily from quarter to quarter in PY3.

Table 23: Number of new acceptors of any modern contraceptive method in USG-supported family planning (FP) service delivery points

PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	PMP Target PY3	Total PY2	% PY3	% PY2
133,223	136,302	138,221	148,574	556,320	482,912	502,914	115	107

The strong performance for this indicator is due to the high quality of care offered by care providers, CBD trainings, the use of bicycles provided by the project to facilitate additional CBD visits, the availability of family planning commodities and data management tools, and the deployment of CBDs in all IHP-supported health zones. Higher quality of care was identified by the correct use of flow charts and adherence to national treatment protocols and standards. IHP staff also met with local authorities and care providers to ensure that they were not leveraging a fee for new acceptors choosing Jadelle. The project carried out an investigation in PY3 in the Uvira GRH, which determined that health care providers were not adhering to the Tiahrt Amendment in leveraging fees for Jadelle insertions. Please see the Family Planning and HIV and AIDS Statutory Requirements section of the report for more information.

In order to ensure that the project continues this strong performance, IHP has planned the following activities in PY4:

- Conduct capacity-building activities for CBDs in the health zones of Kaziba, Kaniola, and Mubumbano. CBDs in these health zones were trained in July 2013; the project will provide follow-up trainings.
- Support a mini-campaign to raise awareness of family planning in the Katana health zone.
- Conduct awareness-raising activities though CODESAs, community-based organizations and Champion Community efforts.
- Conduct trainings for family planning care providers in long-term family planning methods in all of the coordination offices.

The indicator “Number of family planning counseling visits” poses challenges, as has been discussed with USAID. The target for this indicator is underestimated, as counseling visits carried out by CBDs at the community level were not reported or recorded at health centers. IHP proposes increasing the target threshold, and disaggregating data for this indicator by community care sites and health facilities. In addition, the project must ensure that no family planning method is provided without first providing counseling services.

In PY3, 534,847 family planning counseling visits were carried out, for a PMP achievement of 206%. This rate for PY3 illustrates the need to revise the target. Table 24, on the following page, provides more detailed information by coordination office and quarter on the number of family planning counseling visits carried out and provides a comparison between achievement in PY3 and PY2. Table 25, also on the following page, compares results on this indicator between PY3 and PY2.

Table 24: Number of counseling visits for family planning by PY3Q4

Field office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target	Achievement %
Bukavu	15,020	31,101	29,273	30,354	105,748	75,400	140
Kamina	12,975	12,438	25,504	31,311	82,228	39,000	211
Kole	3,448	6,152	6,652	5,858	22,110	7,800	283
Kolwezi	11,137	10,688	12,834	15,356	50,015	15,600	321
Luiza	18,463	21,566	25,233	25,705	90,967	31,200	292
Mwene Ditu	9,217	23,259	25,907	30,551	88,934	49,400	180
Tshumbe	18,868	16,393	16,418	17,143	68,822	23,400	294
Uvira	5,696	5,713	6,943	7,671	26,023	18,200	143
IHP Total	**94,824**	**127,310**	**148,764**	**163,949**	534,847	**260,000**	206

Table 25: Number of counseling visits for family planning in PY3 and PY2

PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	Target PY3	Total PY2	% PY3	% PY2
94,824	127,310	148,764	163,949	534,847	260,000	263,519	206	105

The number of delivery points providing family planning services was 1,379 in PY2, which increased to 1,717 in PY3. The addition of the 338 new points of service is due to the establishment of new community care sites and the rehabilitation of existing community care sites. Appendix 2 provides information on which community care sites currently offer family planning services. The project anticipates that the integration of family planning services into immunization activities will increase the number of family planning service delivery points. The project is collaborating with the National Program on Reproductive Health and the Expanded Program on Immunization to implement this integration. Tables 26 and 27, on the following page, provide information on the number of health facilities and community care sites that offered family planning services in PY3 and PY2.

During this period, health workers in 130 sites distributed non-clinical methods, while 23 sites are capable of distributing both non-clinical and clinical methods. This effort will be scaled up during PY4 to cover more sites that can provide a range of FP methods. The site selection criteria for the introduction of clinical methods (e.g., combined pills and mini-pills) includes:

- Training of community health workers for i-CCM sites in counseling and distribution, including the use of the checklist
- Performance of the sites, and specifically the community health workers at the sites
- Incentives to the head nurses to ensure regular supervision
- Regular supply of commodities and supplies

Table 26: Number of USG-supported delivery points providing family planning counseling or services in health facilities / community care sites by PY3Q4

Type of service delivery point	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target PMP	Achievement %
Health facilities	1552	1401	1451	1586	1498	1600	94
Community care sites	144	149	364	220	219	350	63

Table 27: Number of USG-supported delivery points providing family planning counseling or services in health facilities and community care sites in PY3 and PY2

PY3Q1		PY3Q2		PY3Q3		PY3Q4		Total PY3	Total PY2	% PY3	% PY2
HF	i-CCM	HF	i-CCM	HF	i-CCM	HF	i-CCM				
1552	144	1401	149	1,451	364	1,586	220	1,717	1,950	1,379	88

**HF=health facility*

The number of health facilities that experienced a stock out of Depo-Provera decreased from PY2 to PY3, falling from 92 health facilities in PY2 to 39 reported stock outs in PY3. Appendix 3 provides information on family planning commodity distribution in PY3. Table 28 provides information on the number of stock outs by quarter and in PY2 and PY3.

Table 28: Number of USG-assisted health facilities experiencing stock outs of Depo-Provera in PY3 and PY2

PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 Total	PMP Target PY3	PMP Target PY2
84	44	18	10	39	92	160	220

Many of the stock outs reported were “false” stock outs as the health zones did not order sufficient supplies, despite the availability of commodities in the central offices. In order to prevent stock outs, false and actual, IHP will collaborate with SIAPS to provide trainings for care providers to manage the consumption of family planning commodities, and to strengthen the monitoring of these commodities at all levels--health zone, health facilities, and regional distribution centers.

Table 29, below, presents more information on the estimated impact of IHP's family planning interventions during PY3 as compared to PY2.

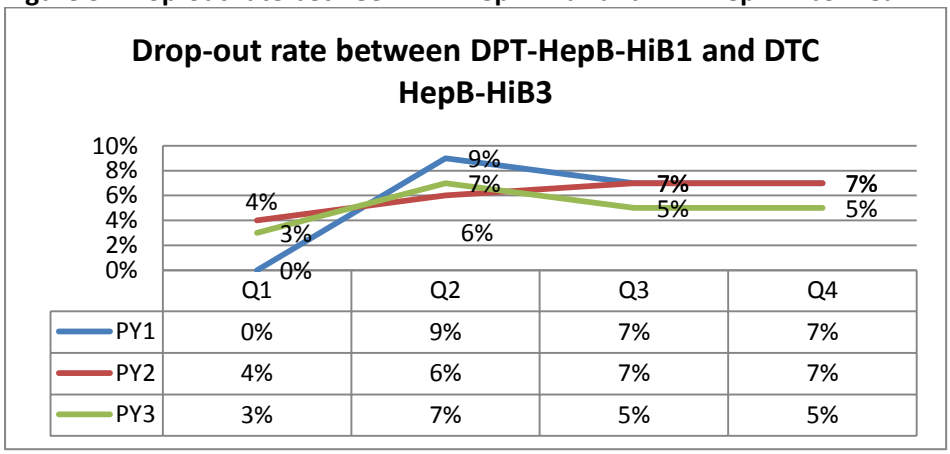
Table 29: Estimated impact of IHP family planning interventions by type for PY2 and PY3

Type of Impact	PY2	PY3	TOTALS	
Demographic impacts				
Unintended pregnancies averted	87,144	61,905	149,049	***149,000+***
Live births averted	61,071	43,383	104,454	***104,000+***
Abortions averted	10,874	7,725	18,599	***18,000+***
Health impacts				
Maternal deaths averted	257	182	439	***400+***
Unsafe abortions averted	10,890	7,743	18,633	***18,500+***
DALYs and economic impacts				
Maternal DALYs averted (mortality and morbidity)	15,591	11,077	26,668	***26,000+***

2. Expanded program on Immunization (EPI)

The drop-out rate between the DTP-HepB-Hib1 and DTP-HepB-Hib3 remained satisfactory during PY3, remaining between zero and 10%. The average drop-out rate in PY1 of 9% improved to 5% in PY3. Figure 3, below, provides information on the drop-out rates by quarter from PY1 through PY3.

Figure 3: Drop-out rate between DPT HepB-Hib1 and DPT HepB-Hib3: Year 1 - Year 3



Despite the variation of dropout rates between quarters, the rate remains within normal limits (<10%). Dropout rates can be attributed to the mass movement of populations (including mothers,

children, and pregnant women) to urban areas due to the ongoing armed conflict in Katanga and Sud Kivu. The influx of communities resulted in a large number of children enrolled to receive DTP-Hib-HepB1 during the second quarter, especially those living in health zones that do not receive support from other organizations.

Data for the second quarter corresponds to data from the first quarter of PY3. During this period, to celebrate the holidays, there is a mass movement of the rural population from places that are difficult to access to urban centers. Because of the influx of families, including children of vaccination age, and the access to vaccination services, IHP observed an increased coverage of DTP-Hib-HepB1. Moreover, it is also noted that the national EPI program workplanning workshop is conducted in the month of December. However, the program has often faced financial difficulties which in turn cause delays in the implementation of activities during the first quarter of the calendar year (second quarter for IHP).

The satisfactory results are due to joint follow-up missions to ensure that immunizations are correctly administered, the availability of commodities (gas, wicks, glass, etc.), correct management of the supply chain, and community awareness-raising activities carried out with Champion Community efforts and LDP projects. Overall, vaccination coverage has been satisfactory during the project's first three years, as seen in Table 30, which displays immunization coverage by project year and by immunization. In PY3, immunization coverage was reported to be between 95% to 107% for all immunizations.

In Mwene Ditu, coverage rates for PY3 are between 84% to 90%, below the project average; this is due to an over-estimated denominator, and the fact that the health zone of Mpania Mutombo was unable to report in September due to heavy rain which destroyed roads and rendered the health zone inaccessible. During the early stages of the project, IHP calculated the denominator for this indicator for Mwene Ditu using the population of the city of Mwene Ditu, which is comprised of two health zones, Mwene Ditu and Makota. However, IHP currently only operates in the Mwene Ditu health zone. IHP will work with local authorities to recalculate the denominator.

Table 30: Immunization coverage by coordination and vaccination type

Coordination office	Tetanus vaccine 2+	BCG (%)	DTP HepB-HIB 1 (%)	DTP HepB-HIB 3 (%)	TOPV3 (%)	Measles (%)
Bukavu	92	107	116	111	105	97
Kamina	102	109	111	106	103	104
Kole	95	92	102	95	97	92
Kolwezi	102	152	128	119	114	100
Luiza	101	108	106	103	100	100
Mwene Ditu	88	90	89	84	84	84
Tshumbe	101	113	105	101	101	99
Uvira	87	100	104	100	98	84
PY3 coverage (%)	95	107	107	103	100	95
PY2 coverage (%)	89	87	100	94	75	93
PY1 coverage (%)	89	74	102	96	[3]	90

[3] In PY1, the project did not collect data on TOPV3 coverage. This indicator was added to the PMP in PY2.

As shown in Table 31, below, coverage of DTPHepB-Hib3 during PY3 improved, with an average coverage of around 103%. Nearly all health areas improved their performance in relation to PY2: the DTP HepB-Hib 3 coverage rate went from 96% in PY2 to 111% in PY3.

Table 31: DTP HepB-HIB3 immunization coverage by coordination and by quarter for PY3

Period	Bukavu %	Kamina %	Kole %	Kolwezi %	Luiza %	Mwene Ditu %	Tshumbe %	Uvira %	Average %
PY3Q1	125	127	92	121	114	95	105	114	115
PY3Q2	104	83	100	108	99	78	96	88	94
PY3Q3	108	111	92	121	105	82	102	97	102
PY3Q4	106	102	97	123	95	83	101	103	100
PY3 average (%)	111	106	95	119	103	84	101	100	103
PY2 average (%)	96	82	92	115	98	94	95	82	94

This high level of performance can be attributed to joint missions to monitor the quality of immunization and implementation of activities; logistics support to ensure the cold chain; support of the Champion Communities; and teams from the LDP choosing to focus on immunizations.

Table 32: TOPV3 immunization coverage by coordination office and by quarter for PY3

Period	Bukavu (%)	Kamina (%)	Kole (%)	Kolwezi (%)	Luiza (%)	Mwene Ditu (%)	Tshumbe (%)	Uvira (%)	Average (%)
PY3Q1	116	113	96	114	103	98	104	110	107
PY3Q2	102	89	102	105	98	78	98	87	95
PY3Q3	106	108	89	119	104	81	101	94	100
PY3Q4	97	103	102	119	96	83	100	100	97
PY3 average (%)	105	103	97	114	100	84	101	98	100
PY2 average (%)	81	67	69	89	73	71	74	72	75

As illustrated in Table 32, above, improved TOPV3 coverage was noted during Year 3 with an average coverage of 100%. There has been a significant increase in the coverage rate from PY2 to PY3, with, for example, the Bukavu coordination office moving from 81% coverage in PY2 to 105% in PY3. The situation illustrated in Mwene Ditu, with an average of 84% coverage for PY3, is not linked to a performance problem but is mainly associated with the overestimation of its denominator (population) and incomplete data (with no report from Mpania Mutombo for September, for example). As previously noted, IHP is working with local health authorities to correct the denominator.

Table 33: Measles immunization coverage by coordination and by month

Period	Bukavu (%)	Kamina (%)	Kole (%)	Kolwezi (%)	Luiza (%)	Mwene Ditu (%)	Tshumbe (%)	Uvira (%)	Average (%)
PY3Q1	103	117	101	99	111	99	103	92	105
PY3Q2	92	92	87	96	97	77	93	77	89
PY3Q3	99	106	88	101	99	81	104	82	96
PY3Q4	94	99	94	103	94	81	95	85	92
PY3 average (%)	97	104	92	100	100	84	99	84	95
PY2 average (%)	88	98	92	96	99	91	96	87	93

For the measles vaccine, as seen in Table 33, above, the average coverage is 95% for PY3 in all coordination offices. The comparison with PY2 data showed that the rate has improved in the coordinations of Bukavu, Kamina, Kolwezi, and Tshumbe, respectively, as it changed on average from 88% to 104%; however, a slight decrease was observed in the coordination offices of Mwene Ditu and Uvira due mainly to a shortage of this antigen in their respective EPI sites.

Table 34: Health zone performance on immunization by coordination offices for PY3

		Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY3 Q1	Category 1	14	7	3	5	10	10	10	3	62
	Category 2	8	2	1	3	1	1	0	2	18
	Category 3	0	0	0	0	0	0	0	0	0
	Category 4	0	0	0	0	0	0	0	0	0
PY3 Q2	Category 1	19	7	3	3	11	10	8	4	65
	Category 2	3	2	1	5	0	1	2	0	14
	Category 3	0	0	0	0	0	0	0	1	1
	Category 4	0	0	0	0	0	0	0	0	0
PY3 Q3	Category 1	18	6	2	6	11	10	9	3	65
	Category 2	4	3	1	2	0	0	1	0	11
	Category 3	0	0	1	0	0	1	0	2	4
	Category 4	0	0	0	0	0	0	0	0	0
PY3 Q4	Category 1	15	7	3	6	10	9	10	4	64
	Category 2	7	1	0	2	0	2	0	0	12
	Category 3	0	1	1	0	1	0	0	1	4
	Category 4	0	0	0	0	0	0	0	0	0

Above, table 34 shows a continuous improvement and maintenance of the level of performance in relation to the accessibility and use of immunization services during PY3. In PY3Q1, more than 78% of health zones were in Category 1 and 22% were in Category 2. In other words, 100% of the health

zones have good access to vaccination. In PY3Q2, 99% of health zones had good access to vaccination, with 81% of health zones in Category 1 and 18% in Category 2. In PY3Q3, more than 81% of health zones were in Category 1 and 14% were in Category 2. In PY3Q4, more than 80% of health zones were in Category 1 and 15% were in Category 2.

These results are mainly due to the improvement of logistics, particularly the availability of commodities (auto-disabling syringes, oil, wick, glass, etc.); the organization of immunization clinics to recover children who were lost to follow up (primarily from communities being involved in identifying and locating those children who had not yet received all vaccinations); LDP teams identifying and addressing challenges related to vaccinations as part of their action plans; and joint monitoring missions and supervision with the Ministry of Health at all levels.

In order to ensure strong performance and continuous improvement in immunization coverage, the project plans the following activities:

- Carry out an audit of data quality (data quality sampling) in the Mwene Ditu and Kolwezi field offices.
- Provide technical support for data monitoring, analysis and validation meetings.
- Continue to provide support for the ongoing availability of vaccines and other commodities in storage sites.
- Provide support for maintenance of the cold chain, and the provision of immunization services in the health zones.
- Support for surveillance of preventable diseases by vaccination.

3. Maternal, Neonatal and Child Health (MNCH)

About 95% of project-targeted health zones submitted validated reports on maternal, neonatal, and child health (MNCH). The exceptions were the health zones of Minova, Muti Murhesa, and Kalehe from the Bukavu coordination office, and Mpania Mutombo in Mwene Ditu for reasons previously mentioned.

As in the other quarters of PY3, in PY3Q4 IHP exceeded the target for the number of pregnant women attending at least one antenatal care (ANC) visit in project-supported health zones. Table 35, on the following page, shows the number of women who attended at least one ANC visit in PY3 by coordination and quarter. In PY3Q4, 96% of pregnant women attended at least one ANC visit, surpassing the target percentage of 93%, for an achievement rate of 104%. Performance on this target has been steady over the last two years, with PY2 performance at 102%.

Table 35: Number and percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities

Coordination office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target	Achievement %
Bukavu	34,999	38,284	38,887	38,462	150,632	141,460	107
Kamina	18,652	15,363	19,776	19,189	72,980	73,169	100
Kole	3,906	4,089	3,781	2,765	14,541	14,634	99
Kolwezi	9,123	7,891	8,871	10,545	36,430	29,268	124
Luiza	15,303	18,692	15,929	14,556	64,480	58,535	105
Mwene Ditu	21,223	20,140	20,893	23,244	85,500	92,681	89
Tshumbe	12,166	12,103	11,928	11,998	48,195	43,901	110
Uvira	8,522	9,605	8,707	8,739	35,573	34,146	104
Total	123,894	126,167	128,772	129,498	508,331	487,794	104
PY3 Achievement (%)	94	94	98	97	96	93	104
PY2 Achievement (%)	(PY2Q1) 101	(PY2Q2) 102	(PY2Q3) 94	(PY2Q4) 95	(PY2) 98	92	102

Among all eight IHP coordination offices, only Mwene Ditu reported a performance level below 90%; nevertheless, this performance represents an improvement from the reported rate of 83% during PY2. Improvements reported in Mwene Ditu between PY2 and PY3 are credited to improved completeness and timeliness of reporting data from the health zones of Mpania Mutombo and Lusambo despite the challenges these health zones face due to geographic inaccessibility. The seven other coordination offices reported an average achievement rate of 99% of pregnant women having had at least one prenatal visit with qualified personnel in PY3. Kolwezi reported the highest achievement rate (124%), which can be explained by the influx of the population into Kolwezi due to the movement of miners and their families into the region. Given the increase in the population in Kolwezi, a revision of the denominator for this indicator may be necessary to more accurately assess Kolwezi's performance. In addition, the project supported behavior change communication (BCC) and awareness-raising activities carried out by CODESAs, Champion Communities, and mini-campaigns--including text messages and local radio broadcasts--on the importance of ANC.

To maintain this high level of performance in PY4, IHP will carry out the following activities:

- Continue support to the health zones to ensure completeness of data and timeliness of reporting.
- Investigate the performance of Kolwezi achieving a 124% achievement rate by cross-checking data related to reported prenatal visits to ensure that certain health zones did not include more than one consultation per pregnant woman and whether the increase in the population in some health zones was considered or not.
- Continue supporting the health zones in BCC activities.

The PY3 average rate of pregnant women who attended least four ANC visits was 71%, which is an increase from PY2's average of 21%. The achievement rates of the PMP target for this indicator are displayed in Table 36, on the following page. The improvement between PY2 and PY3 is due to the project's efforts to assist health care providers to understand the indicator, and ensure complete data collection and reporting. In addition, the BCC activities carried out by the project in the health

zones helped to raise awareness of the benefits of attending at least four ANC visits. Table 37 provides a comparison of the achievement rate across PY2 and PY3.

Table 36: Number of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

Coordination offices	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target	Achievement %
Bukavu	8,026	9,260	11,033	12,873	41,192	82,138	50
Kamina	6,767	5,880	4,620	3,077	20,344	42,485	48
Kole	1,918	2,549	2,121	1,695	8,283	8,497	97
Kolwezi	4,199	3,492	2,484	1,657	11,832	16,994	70
Luiza	7,395	8,220	8,320	7,123	31,058	33,988	91
Mwene Ditu	8,966	11,813	12,644	12,074	45,497	53,815	85
Tshumbe	7,411	7,973	7,978	8,329	31,691	25,491	124
Uvira	2,475	2,447	2,881	2,609	10,412	19,826	53
Total	47,157	51,634	52,081	49,437	200,309	283,234	71

Table 37: Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

	Q1 %	Q2 %	Q3 %	Q4 %	Total %	Target %	Achievement %
PY2	0	2	8	29	10	45	22
PY3	36	39	40	36	38	54	71

During PY3, the achievement rate of the number of deliveries with a skilled birth attendant exceeded 100% of the PMP target, maintaining the strong performance seen in PY2 (101%). See Table 38 on the following page for a breakdown by coordination office, and Table 39, also on the following page, for a comparison between PY2 and PY3 achievement rates.

The continued strong performance in PY3 was due to the implementation of BCC activities that involved community leaders, CODESAs, Champion Communities, and women's organizations. IHP, in collaboration with the World Health Organization (WHO), will continue to technically and financially support the MOH in testing a pilot checklist developed by WHO, the "Safe Childbirth Checklist." The checklist is intended to be used by health care providers to follow best practices, and ultimately improve maternal and perinatal outcomes. IHP will continue supporting the MOH in the adaptation, finalization, and adoption of this tool.

Table 38: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

Coordination office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target	Achievement %
Bukavu	28,761	27,668	31,810	32,180	120,419	121,686	99
Kamina	13,673	13,878	14,306	14,209	56,066	62,941	89
Kole	3,042	3,180	3,123	2,221	11,566	12,588	92
Kolwezi	7,844	7,137	9,833	9,137	33,951	25,176	135
Luiza	14,218	14,396	14,717	16,619	59,950	50,353	119
Mwene Ditu	17,857	17,935	18,965	18,318	73,075	79,725	92
Tshumbe	11,046	10,736	10,863	10,989	43,634	37,765	116
Uvira	6,509	6,100	7,166	6,887	26,662	29,372	91
Total	102,950	101,030	110,783	110,560	425,323	419,606	101

Table 39: Percent of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

	Q1	Q2	Q3	Q4	Total	Target	Achievement
PY2	83%	8%	80%	80%	81%	77%	105%
PY3	82%	78%	86%	86%	83%	80%	101

During PY3, the achievement rate of the number of women who received Active Management of the Third Stage of Labor (AMTSL) (see Table 40, below, and Table 41, on the following page) was 105%, which was similar to the achievement rate in PY2 (105%). Apart from Uvira, which obtained 88%, all of the coordination offices demonstrated a performance level of more than 94%, with the highest percentage at 140% for Kolwezi, which greatly improved its score since PY2, when it had only 65%. Kolwezi witnessed a population increase due to the movement of miners and their families, which may have contributed to Kolwezi's high achievement rate. Due to the geographic inaccessibility in the Haut Plateaux health zones, carrying out supervisory visits and ensuring that commodities were regularly available was difficult.

The continued strong performance in this indicator was due to the availability of oxytocin. In PY3, the project supplied the health zones with non-thermolabile oxytocin, which can be kept at room temperature and does not require cold chain equipment. Therefore, the availability of this type of oxytocin is not limited by typical constraints linked to cold supply chains. In addition, its shelf life is four years, which is double that of thermolabile oxytocin.

Table 40: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

Coordination offices	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3	Target	Achievement %
Bukavu	24,245	25,386	29,621	28,000	107,252	109,161	99
Kamina	13,560	13,828	13,908	13,819	55,115	56,463	98
Kole	2,838	2,982	2,617	2,221	10,658	11,293	94
Kolwezi	7,157	6,572	9,121	8,836	31,686	22,585	140
Luiza	17,990	14,213	14,026	17,029	63,258	45,170	135
Mwene Ditu	12,941	16,739	17,817	17,620	65,117	71,519	97
Tshumbe	10,685	10,120	9,732	8,855	39,392	33,878	116
Uvira	5,350	5,452	6,163	6,185	23,150	26,349	88
Total	94,766	95,292	103,005	102,565	395,628	376,418	105

Table 41: Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

	Q1 %	Q2 %	Q3 %	Q4 %	Total PY3 %	Target %	Achievement %
PY2	78	81	88	89	84	80	105
PY3	92	94	93	93	93	90	103

In PY3Q4, the project did not meet the target on the number of postpartum/newborn visits carried out by health providers within three day of birth, attaining only 77% of the target, as shown in Table 42 below. The Luiza and Kolwezi coordination offices were the only offices to reach more than 90% of the target. Overall, the number of women and newborns receiving visits within three days of birth increased from 97,840 in the first quarter to 106,524 during the fourth quarter of PY3. The Uvira coordination office reported the weakest performance in PY3, achieving 58%, as women who give birth at home do not visit health facilities for postpartum care. Overall, improved understanding of this indicator at the health zone level, the provision of maternity ward commodities, and joint support of the health zone management teams are factors that positively affected performance this project year.

Table 42: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs

Coordination offices	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	Target	Achievement %
Bukavu	28,323	24,689	29,537	31,213	113,762	152,108	75
Kamina	14,027	14,091	14,351	14,405	56,874	78,676	72
Kole	2,607	3,012	2,589	3,009	11,217	15,735	71
Kolwezi	6,563	6,792	9,420	9,273	32,048	31,471	102
Luiza	13,703	14,197	14,076	14,886	56,862	62,941	90
Mwene Ditu	17,105	17,215	18,292	17,640	70,252	99,657	71
Tshumbe	10,489	9,877	10,140	10,198	40,704	47,206	86
Uvira	5,023	4,556	5,976	5,900	21,454	36,716	58
Total	97,840	94,429	104,381	106,524	403,173	524,510	77

The project met the target of 100% coverage in the number of newborns receiving essential newborn care through USG-supported programs, as seen in Tables 43 and 44 on the following page. Only the health zones in the coordination of Kamina did not exceed the 90% coverage. In order to improve performance, the project will increase monitoring and supervision visits and use the checklist to strengthen skills in caring for the mother and the newborn child.

Table 43: Number of newborns receiving essential newborn care through USG-supported programs

Coordination offices	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	Target	Achievement %
Bukavu	28,045	24,068	28,848	29,706	110,667	114,650	**97**
Kamina	12,512	12,684	12,789	13,686	51,671	59,302	**87**
Kole	2,803	2,905	2,728	2,785	11,221	11,860	**95**
Kolwezi	7,053	6,792	9,420	9,089	32,354	23,721	**136**
Luiza	13,390	14,134	13,564	14,990	56,078	47,442	**118**
Mwene Ditu	16,506	16,918	17,799	17,389	68,612	75,116	**91**
Tshumbe	10,763	9,994	10,502	10,630	41,889	35,581	**118**
Uvira	6,466	6,070	6,891	6,243	25,670	27,674	**93**
Total	**97,538**	**93,565**	**102,541**	**104,518**	**398,162**	**395,346**	**101**

Table 44: Percent of newborns receiving essential newborn care through USG-supported programs

	Q1	Q2	Q3	Q4	Total	Target	Achievement %
PY2	75%	75%	70%	74%	74%	100%	74%
PY3	78%	73%	80%	81%	78%	100%	78%

In PY3, 87% of newborns who had infections received antibiotic treatment from appropriate health workers; that is, 27,440 out of 31,471 targeted. Health zones in the Kole coordination exceeded the target, reaching 1,579 newborns, 167% of the target number of 944. Similarly, Mwene Ditu achieved 151% of the target, reaching 9,028 newborns out of a target of 5,979. Table 45 below information on this indicator by quarter and by field office. The understanding of this indicator and how to collect the relevant data are factors to consider when interpreting the results. An average performance was observed in the Bukavu, Tshumbe, and Kolwezi health zones.

Table 45: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported program

Coordination offices	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	Target	Achievement %
Bukavu	1,329	1,316	1,255	1,672	5,572	9,127	61
Kamina	910	950	981	708	3,549	4,721	75
Kole	572	274	328	405	1,579	944	167
Kolwezi	2	643	528	141	1,314	1,888	69
Luiza	612	1,009	764	869	3,254	3,777	86
Mwene Ditu	2,692	2,037	2,278	2,021	9,028	5,979	151
Tshumbe	348	494	352	380	1,574	2,832	55
Uvira	391	347	358	474	1,570	2,203	74
Total	6,856	7,070	6,844	6,670	27,440	31,471	87

The project plans to carry out the following activities in PY4 to improve newborn health:

- Brief providers on the eligibility criteria for antibiotic administration.
- Increase supervision of care providers to ensure compliance to treatment protocols for newborns.

- Support the health zone management teams in disseminating the Performance Indicator Reference and Tracking Sheet (PIRTS) during monthly data reviews.

Fistula Care

During PY3, 615 women with fistulas benefited from IHP-supported fistula care activities. Among these women, 240 cases were treated at the Kaziba GRH where routine fistula repair activities were carried out. The project organized a fistula campaign in August 2013, during which 375 cases, or 61% of the total fistula cases seen in PY3, were treated.

As illustrated in Table 46, out of the 615 fistula cases, 513 cases were successfully treated (83%), while 102 surgical interventions were not successful (17%). In PY3, 174 more cases were treated as compared to PY2, during which 441 cases received care. An unsuccessful repair is recorded when urinary incontinence continues following the surgical treatment. This definition was adopted during the 4th Meeting of the Community of Fistula Practitioners, held in June 2013 in Kinshasa. In addition, a new approach in fistula case management emphasizes physiotherapy to help women with fistulas strengthen their pelvic floor, which will then aid in closing the bladder sphincter. This approach was introduced to doctors in DRC during a fistula symposium, and will be applied to the fistula cases treated in facilities supported by IHP.

Table 46: Outcome of fistula cases managed in PY2 and PY3

	Overall		Routine		Campaign	
	No. and % healed	No. and % unsuccessful	No. and % healed	No. and % unsuccessful	No. and % healed	No. and % unsuccessful
PY2	386 (88%)	55 (12%)	48 (77%)	14 (23%)	338 (89%)	41 (11%)
PY3	512 (83%)	103 (17%)	189 (79%)	51 (21%)	323 (86%)	52 (14%)

Among the fistula cases seen in hospitals in PY3, more than half of women with fistulas (54%) were younger than 35 years old. The primary causes of the fistulas seen during the routine and campaign activities were prolonged labor (29%) and obstructed labor and curettage (67%). Sexual violence was reported as a cause for five fistula cases.

The project recognizes that preventive measures must be strengthened to ensure that women do not experience fistulas. In PY4, IHP plans to promote important preventative activities, including:

- Promote the routine and correct use labor monitoring tools, such as the partogram, to help identify and manage obstetrical emergencies including obstructed labor, which contributed to 46% of the fistula cases managed in PY3.
- Conduct BCC activities in communities to encourage delivery in health facilities.
- Improve overall quality of services in maternities through trainings and supervision for care providers, and encourage the use of the WHO safe birth checklist.

Malaria prevention

Activity 11: Malaria prevention: Distribute Sulfadoxine Pyrimethamine (SP) for Intermittent Preventive Treatment (IPTp) for pregnant women and LLIN (to be integrated in the antenatal care package)

Activity 11.1: Distribution of 1,000,000 doses SP during antenatal care (ANC) in 70 health zones that are not covered by Global Fund

According to the current national policy in DRC, pregnant women should receive at least two doses of IPTp during pregnancy. The National Malaria Control Program (PNLP) has updated the policy to a minimum of three doses. Based on World Health Organization (WHO) guidelines, pregnant women should receive a dose of IPTp at each ANC visit. IHP has not yet applied this recommendation as the project does not have a sufficient quantity of SP. IHP will first coordinate with the PNLP and PMI as the application of this policy will have an impact on the quantification of SP needs for the project.

In PY3Q4, the percentage of pregnant women who received two doses of SP was 57%, compared to 63% in PQ3Y3. The decrease was due to the fact that while some health areas received SP supplies through other organizations, including People In Need (PIN) and Malteser in Sud Kivu, Médecins du Monde in Kalomba in Luiza, other health zones did not receive any supplies due to a project-wide stock out. Tables 47 and 48, below, provide the number and percentage of pregnant women who received SP this quarter, in PY3, and in PY2. Currently, the only health areas with SP supplies are those that are able to purchase SP on their own, and the Fungurume health zone, which was resupplied by the Tenke Fungurume Mining Company.

Table 47: Number and percentage of pregnant women who received two doses of SP in PY3Q4

	INDICATORS		
Coordination office	**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	20,362	36,784	55
Kamina	15,559	19,345	80
Kole	2,140	3,591	60
Kolwezi	4,128	8,378	49
Luiza	7,392	16,180	46
Mwene Ditu	13,670	24,592	56
Tshumbe	5,855	11,502	52
Uvira	3,834	8,841	64
PY3Q4	**72,940**	**129,213**	**57**

Table 48: Number and percentage of women who received 2 doses of SP in PY3 and PY2

PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 Total	% PY3	% PY2
75,989	79,387	82,223	72,940	310,539	293,717	74	59

In PY3Q4, 13 health zones exceeded the 80% target of pregnant women receiving two doses of SP, including three in Bukavu, six in Kamina, one in Kolwezi, one in Luiza, one in Mwene Ditu and one in

Sankuru. Twenty-six health zones reported a rate between 50% and 79% and 30 health zones reported coverage below 50%. The higher performing health zones received SP doses from other organizations, mentioned above, or used their own funds to purchase SP.

Not taking the correct dosage of SP can be associated with miscarriages, low birth weight, and premature births for women with malaria. Therefore, the project is prioritizing making available SP during PY4. The field offices of Bukavu and Kamina have received doses of SP from USAID, and Kole has received SP from IMA World Health. The project will ensure that the doses are distributed to the health facilities in these coordination offices.

Activity 11.2: Distribution of 455,000 LLIN during antenatal care (ANC) in 70 health zones that are not covered by Global Fund

Long-lasting insecticide-treated nets (LLINs) are routinely distributed to pregnant women and children under one year of age. Distribution takes place during the first ANC visit, pre-school consultation (PSC) visits, and immunization visits for children under one year receiving the measles vaccine. IHP had planned to provide regional distribution centers with 1 million LLINs during PY3; however, these nets did not arrive in time. The LLINs for PY3 and PY4 are not yet available in the regional distribution centers. As a result, health zones distributed the nets that were remaining from year two campaigns and routine distributions. Table 49, on the next page, shows the number of LLINs distributed by coordination office and by quarter and project year. A total of 142,306 LLINs were distributed in PY3 (compared to 113,864 in PY2): 95,824 through ANC visits and 46,482 at pre-school consultation. Given the small quantity of available LLINs, the distribution of nets was prioritized for pregnant women. The health zones distributed the remainder of the LLINs from PY2, and are nearly out of stock of the nets.

Table 49: Number of LLINs purchased with USG funds that were distributed routinely by coordination office from October 2012 to September 2013

	PY3Q1			PY3Q2			PY3Q3			PY3Q4			PY3		
	ANC	PSC*	Total	ANC	PSC	Total	ANC	PSC	Total	ANC	PSC	Total	ANC	PSC	Total
Bukavu	4,592	557	5,149	1,337	237	1,574	5,855	671	6,526	6,438	1,448	7,886	18,222	2,913	21,135
Kamina	7,892	700	8,592	8373	508	8,881	1,233	284	1,517	60	10	70	17,558	1,502	19,060
Kole	1,082	1,184	2,266	1,585	1,909	3,494	1,387	959	2,346	1,220	694	1,914	5,274	4,746	10,020
Kolwezi	792	21	813	830	147	977	545	11	556	102	7	109	2,269	186	2,455
Luiza	33	9	42	1,780	1,638	3,418	8,689	7,635	16,324	1,153	906	2,059	11,655	10,188	21,843
Mwene Ditu	3,152	2,824	5,976	6,358	6,525	12,883	10,854	7,318	18,172	7,070	5,327	12,397	27,434	21,994	49,428
Tshumbe	196	100	296	3,597	3,184	6,781	1,417	1,148	2,565	602	510	1,112	5,812	4,942	10,754
Uvira	0	0	0	3,554	9	3,563	1,408	0	1,408	2,638	2	2,640	7,600	11	7,611
TOTAL PY3	17,739	5,395	23,134	27,414	14,157	41,571	31,388	18,026	49,414	19,283	8,904	28,187	95,824	46,482	142,306
TOTAL PY2			50,400			34,757			18,640			10,067			113,864

**"PSC" indicates pre-school consultation*

Malaria case management

Activity 12: Correctly manage malaria cases in health facilities through training, distribution of medicine and commodities (ACTs, RDTs), and supervision

During PY3Q4, 211,557 doses of ACT for children under 5 years old (2 to 11 months and 1-5 years) were distributed, with 207,085 doses distributed in health facilities and 4,472 doses in community care sites. In PY3, as seen in Table 50, 653,417 doses of ACT were distributed, as compared to 477,399 doses in PY2.

Table 50: Number of ACT treatments for children under 5 purchased with USG funds and distributed to the health facilities and community health care sites, in PY3

	Quantity of ACT (2 – 11 months and 1 – 5 year) for children under 5 distributed through community care sites	Quantity of ACT (1 – 5 year) for children under 5 distributed to health facilities	Quantity of ACT (2 – 11 months) for children distributed to health facilities	Total quantity ACT distributed for children under 5
Bukavu	324	68,035	7,327	75,686
Kamina	1,298	30,188	10,762	42,248
Kole	324	6,667	3,663	10,654
Kolwezi	175	11,957	5,668	17,800
Luiza	608	14,369	821	15,798
Mwene Ditu	1,112	11,727	6,668	19,507
Tshumbe	513	10,679	6,503	17,695
Uvira	118	10,770	1,281	12,169
PY3Q4	4,472	164,392	42,693	211,557
PY3Q3	4,607	110,437	60,269	175,313
PY3Q2	3,605	131,880	52,745	188,230
PY3Q1	1,595	54,574	22,148	78,317
Total PY3	14,279	461,283	177,855	653,417
Total PY2	924	332,356	144,119	477,399

Community care sites in the health zones of Lodja, Bena Dibele, and Kanda Kanda experienced frequent ACT shortages for children under 5 years old during PY3. In response, IHP will supply these community care sites with ACT. A memorandum of understanding will be signed shortly with SANRU, the Global Fund, and the health zones that receive support from IHP and the Global Fund. The agreement outlines that the project will provide ACTs and RDTs to community care sites in health zones that typically receive support from the Global Fund while the Global Fund is in the process of implementing activities in the community care sites.

In PY3, the project distributed 1,928,830 doses of ACT for all age groups, as compared to 993,613 doses of ACT in PY2. Table 51, on the next page, provides information on the number of ACT treatments distributed by age group, coordination, and reporting period. The strong performance is due to strides made in improving the reporting of antimalarial commodity consumption, as well as consistent ACT availability in the last three quarters of PY3, and the reimbursement of the transport

of antimalarial commodities from the health zone central offices to health facilities ($15 per month per structure), as provided by the project to the health zones. Despite these successes, IHP still encounters difficulties in correctly quantifying monthly consumption of ACTs and RDTs, which thus impedes the calculation of the expected needs for heath zone. Table 52 shows the number of RDTs that were distributed in PY3.

Table 51: Number of ACT treatments for all age groups purchased with USG funds and distributed by quarter and project year

	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3	PY2
Infant (2-11 months)	22,148	52,745	60,269	47,787	182,949	316,779
Toddler (1-5 years)	56,169	135,485	115,044	168,864	475,562	353,792
Child (6-13 years)	141,088	199,847	129,404	160,356	630,695	243,339
Adolescent and Adult	142,084	170,333	184,053	143,154	639,624	79,703
Total	361,489	558,410	488,770	520,161	1,928,830	993,613

To address challenges in quantifying consumption, the project will make available in the health facilities a management tool for MEG for monthly consumption rates at health facilities. Along with SIAPS and the PNLP, the project will also provide trainings for quantifying antimalarial commodities for care providers.

Table 52: Number of USG-funded malaria-rapid diagnostic tests (RDTs) purchased and distributed in PY3

Period	Coordination office								
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3
PY3 Q1	36,516	38,530	5,179	7,875	11,104	60,655	11,450	86,153	257,462
PY3 Q2	26,322	109,630	3,310	56,250	4,324	47,420	21,133	61,525	329,914
PY3 Q3	20,092	98,066	3,344	62,060	24,400	47,831	30,929	6,352	293,074
PY3 Q4	17,631	42,071	1,796	10,125	6,960	45,855	34,695	5,167	164,300
PY3 Total	100,561	288,297	13,629	136,310	46,788	201,761	98,207	159,197	1,044,750

During PY3, as indicated in Table 52, 1,044,750 RDTs were distributed in health facilities and community care sites. The amount of RDT distributed in PY3Q4 (164,300) decreased significantly in relation to the previous quarters, due to the shortage at the CDR. In a report prepared by SIAPS, it was noted that the FODESA warehouse was overstocked with RDTs with expiration dates in January 2014, and that the health zones in the Bukavu coordination office were low on RDTs. IHP, in collaboration with SIAPS, redistributed 158,625 RDTs from the FODESA warehouse to the BDOM warehouse in Bukavu to cover the needs in Bukavu until October 2013. DELIVER has ordered 3.5 million RDTs that are expected to arrive in November 2013.

When comparing the amount of RDTs distributed (1,044,750) during PY3 in relation to the amount of ACTs for all ages (1,928,830) that were distributed during the same period, the project has observed that the amount of ACTs is always much greater than the amount of RDT distributed; therefore, all fever cases do not always benefit from a RDT as national policy recommends. Some health care providers believe that the thick film microscopy is more accurate than the RDT and say that RDT is less reliable.

Table 53: Number of USG-supported service delivery point stock outs of ACT intended for children 1- 5 years in PY3

PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3	PY2	Target PMP
541	256	188	111	274	290	**160**

As illustrated in Table 53, above, in PY3Q4, this indicator has significantly improved, as the number of stock outs decreased from 290 in PY2 to 274 in PY3. Improvements are due to the availability of ACTs during the last two quarters of the year. In PY3Q1, there was a stock out of ACT, which increased the overall average for this indicator.

During PY3, 82% of children under age 5 with malaria were treated at health facilities according to the national protocol, as seen in Table 54 on the following page. Compared to PY2, this indicator improved across all coordination offices; in Luiza, for instance, the percentage rose from 44% to 76%.

Table 54: Number and percentage of children under five with malaria treated correctly following the national protocol in PY3

Period		Coordination office								
		Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3
PY3	Children < 5 years admitted for malaria treatment	96,306	96,117	10,419	26,546	39,317	93,701	45,784	40,718	448,908
	Children < 5 years treated for malaria according to national protocol	87,565	88,050	8,340	24,977	30,043	60,815	34,432	32,563	366,785
	Percentage treated according to national protocol	91%	92%	80%	94%	76%	65%	75%	80%	82%
PY2	Children < 5 years admitted for malaria treatment	280,665	205,957	17,331	22,431	55,470	113,587	59,054	85,958	840,453
	Children < 5 years treated for malaria according to national protocol	227,189	184,453	11,411	21,462	24,139	95,958	55,441	60,062	680,115
	Percentage treated according to national protocol	81%	90%	66%	96%	44%	84%	94%	70%	80%

Table 55: Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female) in PY3

		Coordination offices								
	Sex	**Bukavu**	**Kamina**	**Kole**	**Kolwezi**	**Luiza**	**Mwene Ditu**	**Tshumbe**	**Uvira**	**PY3**
Number of health workers trained	Female	47	59	0	32	23	13	2	0	176
	Male	338	78	0	203	195	134	41	55	1,044
TOTAL PY3		**385**	**137**	**0**	**235**	**218**	**147**	**43**	**55**	**1,220**
Number of health workers trained	Female	12	0	8	0	0	1	181	42	244
	Male	66	18	31	0	0	14	815	109	1,053
TOTAL PY2		**78**	**18**	**39**	**0**	**0**	**15**	**996**	**151**	**1,297**

As seen in Table 55, above, during PY3, 1,220 service providers were trained in malaria prevention compared to 1,297 during PY2, of which 780 service providers (> 2/3) received training during PY3Q4. Since the annual target is 2,400, efforts must be made during PY4 to achieve the desired result.

During PY3, 111 community health care teams and 14 lab technicians were trained in malaria diagnosis, as indicated in Table 56, below. Additional efforts will be made in PY4 to increase the critical mass of trained lab technicians and organize training supervisions for those who were trained in previous years.

Table 56: Number of health workers trained in diagnosing malaria in the laboratory (RDT or microscopy) with funding from the USG

	Sex	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 total
Number of health staff trained in health facilities	Male	224	33	55	732	1,044	1,101
	Female	31	11	0	134	176	
Number of CHWs trained by sex	Male	16	0	70	16	102	652
	Female	6	0	3	0	9	
Number of lab technicians trained	Male	0	0	0	8	8	168
	Female	0	0	1	5	6	
Total		277	44	129	895	1,345	1,921

Malaria Monitoring and Assessment

- During PY3, the two malaria counselors conducted joint supervision and follow-up missions with the PNLP and/or the PMI team. Generally, work is still needed to improve data quality and management of commodities and antimalarial drugs at health facilities.
- Update on the outbreaks of fever/malaria: During PY3, the health zones of Sankuru and the province of Kasaï Occidental were subjected to outbreaks of fever/malaria. A joint PNLP, PMI, and IHP monitoring mission is scheduled for early November in the Sankuru health zones to explore these outbreaks.
- As part of operational research, IHP will conduct a study on the use of rectal artesunate in pre-reference among children less than 5 years at community care sites. The protocol is awaiting approval and the principal investigator of the study has been identified. However, the artesunate suppository is not yet available at the project level.
- During PY3, IHP provided financial and technical support to the performance review and development of the PNLP 2013-2015 strategic plan.

4. Support clinical care to survivors of sexual violence

Prior to this quarter, all coordination offices, with the exception of Kamina and Kolwezi, completed the Clinical Care of Sexual Assault Survivors trainings for health care providers. Kamina and Kolwezi will organize refresher courses for the Clinical Care of Sexual Assault Survivors once the Post-Exposure Prophylaxis (PEP) kits clear customs. In August 2013, the project carried out a public awareness campaign on preventing early marriage and sexual violence in Kole.

According to a report from Synergie, a Kole-based NGO, the campaign reached 3,121 people, including 1,212 women and 1,909 men across 11 churches in the area, with technical support from staff in the Kole coordination. Twenty-one community leaders reached by the campaign made a commitment to become involved in efforts to prevent gender-based violence. For example, the coordination of Kole identified a community network to raise awareness of sexual violence. To this effect, 21 community leaders have developed an action plan based on mass campaigns to be held during large religious and community events to raise awareness among the public on the negative impacts of early marriage (which has become a common practice in many communities) and domestic violence, and to advocate among local authorities to become involved in preventing and responding to rape cases. The action plan, in French, is found in Appendix 10. Table 57, on the following page, provides information on the number of medical professionals who received Clinical Care of Sexual Assault Survivors in PY3. No trainings were carried out in PY3Q4.

Table 57: 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 Dibele	0	12	12	0	1	4	1	6	14	22
TOTAL		**15**	**73**	**55**	**2**	**4**	**23**	**3**	**36**	**66**	**124**

In July 2013, another campaign was carried out in Kamina, in the health zone of Kabongo, on cultural practices that lead to gender discrimination. Next quarter, Synergie and other community-based organizations (CBOs) in Kamina will begin activities to strengthen public awareness of gender-based discrimination and encourage survivors of assault to seek referrals for care. In conjunction with these activities, IHP will hold trainings on clinical management of sexual assault for health care providers in Kamina. Table 58, on the following page, provides information on the number of people impacted by GBV services in PY3Q4.

In addition, the availability of PEP kits, expected to arrive in PY4, will allow for improved care for survivors of gender-based violence. IHP expects to make the PEP kits available in each coordination office over the course of the project. Due to the lack of availability of PEP kits in PY3Q4, survivors who were referred to health centers received antibiotics, when appropriate, but did not have access to antiretroviral treatment or emergency contraception.

Table 58: Number of people impacted by GBV services funded by the U.S. Government total Q4

Coordination Office	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 clinic given emergency contraceptive people reporting sexual violence in USG- supported clinic given emergency contraceptive
	Female	Male				
Bukavu	2,670	39	1,315	1,394	1,211	1,207
Uvira	175	0	127	49	108	123
Kole	9	0	9	0	0	0
Tshumbe	1	0	1	0	0	0
Luiza	104	8	82	0	0	0
Mwene Ditu	15	0	15	0	0	0
PY3Q4 Total	2,974	47	1,549	1,443	1,319	1,330

In Bukavu and Uvira, where GBV activities are concentrated, the number of people who have reported having experienced sexual violence has decreased from 5,445 people in 2012 to 2,884 people in 2013. These numbers are below the PMP target of 8,320 people. The project has not yet achieved more than 35% of the target. Numerous factors have contributed to this poor performance, including an insufficient quantity of PEP kits and the fact that there were identified cases of GBV that did not receive care or were not recorded, a lack of adherence to reporting systems among health centers, and a lack of coordination among the police, the justice division, and health centers to manage recorded cases so that survivors who report to the police are referred to health centers.

The other coordination offices were not regularly supplied with PEP kits or experienced a lack of adequate care despite having identified cases. A review of the reporting system should be established, including a clear definition of roles and responsibilities of all stakeholders, from the community level to the health center level, including the police and the justice department.

In addition, it is also necessary to ensure a consistent supply of PEP kits in all health centers so that there is adequate care. Finally, awareness-raising must be strengthened at the community level so that survivors of sexual assault will come forward to report their case and to receive care.

5. Nutritional rehabilitation

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

During PY3Q4, IHP supported the coordination of PRONAUT in Kasaï Oriental province by organizing a joint Infant and Young Child Feeding (IYCF) follow-up training in the health zones of Bibanga, Kamiji, and Mpokolo from August 3-17. The outcomes of this training were:

- Improved understanding of the IYCF support group functions among health zone management teams.
- Communities were assisted to organize cooking demos by IYCF groups to showcase local foods.
- Increased community ownership of the IYCF approach.

B. Nutrition Indicators Analysis

For PY3Q4, 76 out of the 80 project-supported health zones reported on nutrition indicators. The zones of Minova and Miti Murhesa within the coordination of Bukavu, as well as Mpania Mutombo in the coordination of Mwene Ditu, did not send reports in September. The health zone of Kalehe has not reported yet this quarter.

Table 59 on page 64 illustrates the nutrition indicator achievements from IHP-supported coordination offices over the course of PY3. On page 62, Table 61 provides information on nutrition indicators by quarter for PY3

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

The number of children under age five who received vitamin A supplements in PY3 surpassed the PMP target of 2,250,000, reaching 3,012,950, for an achievement rate of 134%. The results of PY3 have also shown a net improvement over those of PY2.

The MOH organized two vitamin A supplement campaigns for children six to 59 months of age during PY3, which greatly contributed to the actual numbers. The campaigns were organized in conjunction with the administration of the poliomyelitis vaccine, which was held from November to December 2012 and the other at the beginning of PY3Q4, in July 2013. Both reached a large population due to door-to-door visits and mobile phone outreach via SMS reminders. IHP supported the MOH in these campaigns through the following activities:

- Participated in different coordination meetings
- Supervised field work
- Provided data collection tools
- Assisted with transportation of supplies and provision of gasoline

Vitamin A supplies remaining after the campaign were distributed within project-supported health zones to 199,865 children six months and older. In order to ensure routine provision of vitamin A outside of campaign events, IHP is in the process of procuring a supply of vitamin A.

B.2. Number of pregnant women who received iron and folic acid supplements

IHP surpassed its target of pregnant women receiving iron and folic acid (385,874) in PY3, reaching 450,213 women with these vital supplements. This result is double the number of women reached in PY2 (200,752). The period with the greatest number of women reached was during PY3Q4, (122,665). The coordination offices of Uvira, Bukavu, Kolwezi, and Mwene Ditu reached more than 100% of their PMP targets.

The strong performance for this indicator can be attributed to the consistent availability and routine administration of folic acid to pregnant women. An overall high rate of utilization of ANC services in the health facilities supported the administration of iron and folic acid. In Bukavu, this availability

combined with the increased awareness-raising efforts carried out by IYCF groups among mothers encouraged pregnant women to use ANC services, during which they received supplements.

However, in Mwene Ditu, there were occasional iron and folic acid stock outs during the first three quarters of PY3. With the supplies received last quarter, Mwene Ditu attained a 114% achievement rate. IHP ordered iron and folic acid as part of the year three pharmaceutical order so that health facilities will be adequately equipped to provide routine supplements to pregnant women.

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

During PY3, 419,222 mothers received counseling compared to the target of 148,320 women. This was a four-fold increase over PY2, when 90,500 mothers who received counseling. The integration of IYCF groups in health zones in Bukavu, Uvira, Kolwezi, Tshumbe, Kole, and Mwene Ditu contributed significantly to the strong performance. Throughout PY3, 380 IYCF support groups were integrated into 28 health zones.

The following is a list of the number of IYCF support groups by coordination office and health zone:

- **Mwene Ditu:** 11 (Mpokolo, 3; Bibanga, 3; Kamiji, 5)
- **Kolwezi:** 79 (Dilala, 10; Fungurume, 28; Lualaba, 9; Manika, 5; Mutshatsha, 5; Kanzenze, 22)
- **Uvira:** 105 (Lemera, 11; Nundu, 16; Hauts Plateaux, 5; Uvira, 21; Ruzizi, 52)
- **Bukavu:** 106 (Katana, 30; Mwana, 29; Shabunda, 5; Miti Muresha, 15; Idjwi, 27)
- **Kole:** 22 (Kole, 4; Bena Dibele, 10; Tshudi Loto, 4; Lomela, 4)
- **Tshumbe:** 57 (Djalo, 11; Lodja, 12; Katako Kombe, 7; Ototo, 14; Tshumbe, 13).

In Kole, Mwene Ditu, and Kolwezi, IYCF groups frequently conduct cooking demonstrations using local and readily available foods to enhance the nutritional value of traditionally prepared meals, particularly those for infants over six months old and pregnant or nursing women. IYCF groups also provide counseling on breastfeeding and, more generally, healthy nursing practices, during ANC and post-natal care visits. PY3 data shows that for 393,128 of 425,491 live births, or 92%, mothers began breastfeeding with an hour after childbirth.

CHWs contribute to organizing IYCF group meetings and conduct home visits to providing counseling to new mothers. However, health zone management teams and head nurses do not track and record these activities as they do not have data collection tools to record IYCF activities.

In Kasaï Oriental province, anti-malnutrition efforts coordinated by several organizations (IHP, ALIMA, CRS and Save the Children) are in the planning stages.

MICS 2010 found that the province of Kasaï Occidental is among those with the highest burden of undernutrition among children 6-59 months in terms of stunting, wasting, global acute malnutrition, and underweight. To date, with its limited resources, IHP has not yet integrated IYCF support groups in this province. This was due primarily due to overlap of activities planned by the project and those planned by the MOH and/or the DPS. However, the Kasaï Occidental province and the health district of Kamina are categorized as priority areas for the integration of IYCF and the establishment of support groups for PY4.

In order to build upon the integration of IYCF into anti-malnutrition efforts, IHP has planned the following activities for PY4:

- Integrate IYCF in the health zones where it is not yet active by assisting CHWs in implementing IYCF support groups. Mobilize NGOs and CBOs through coordination meetings and by supporting their nutrition-related plans of action.
- Increase the quarterly indicator goal from 37,080 to 111,240.
- Supply the existing IYCF support groups with data collection tools as well as marketing materials (photos, informational booklets on nutrition, posters).
- Increase both adherence to good practices and public awareness in health care establishments and at home.
- Continue holding follow-up to the ENA (Essential Nutrition Actions) training with the PRONANUT teams.
- Increase the practice of Education through Listening (ETL) among mothers of children under 2 years of age to reinforce the nutritional counseling messages shared by the IYCF support groups.

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

In PY3, IHP did not reach the PMP target of 524,509 breastfeeding women receiving vitamin A supplements, reaching only 148,917 women, or 28%, of the target. This number is, however, an increase over PY2, when IHP reached 60,869 women.

The underperformance in this area is attributable to the fact that the only available vitamin A supplements available for distribution were those remaining from mass campaigns in December 2012 and July 2013. As stated earlier, IHP is in the process of procuring vitamin A supplements to ensure routine distribution during PY4.

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

The number of health facilities that experienced iron and folic acid stock outs in PY3 was 452, which exceeded the target of 160 facilities. This number also surpassed the PY2 number of 191 facilities. This situation is due primarily to the failure to monitor monthly consumption rates, care providers prescribing medicines to all patients suspected to have anemia without laboratory results to confirm the diagnosis, and forgetting to place orders during requisitions, resulting in a reduction in the quantity of stock available in health facilities and, eventually, a stock out. In response to this issue, IHP has ordered additional iron and folic acid supplements, and will provide support to the health zone management team to manage supply stocks.

Table 59: Nutrition indicators by coordination for PY3

Indicators	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY3 Total
Number of children under 5 years who received vitamin A supplements	776,365	292,115	82,599	412,337	574,357	332,736	388,187	354,119	3,212,815
Number of children under 5 years who received vitamin A supplements (*routine*)	105,978	5,054	3,643	42,374	2,875	33,406	660	5,875	199,865
Number of children under 5 years who received vitamin A supplements (*campaign*)	670,387	287,061	78,956	369,963	571,482	299,330	387,527	348,244	3,012,950
Number of pregnant women who received iron and folic acid supplements	146,969	52,624	8,916	43,444	40,736	86,406	31,571	39,548	450,213
Mothers of children 0 to 23 months who received counseling on child nutrition	100,898	56,572	10,887	15,597	48,288	106,308	53,159	27,413	419,122
Number of breastfeeding women who received vitamin A supplements	75,271	20,189	811	11,866	4,556	19,078	3,302	13,844	148,917
Number of newborn breastfed within one hour of birth	106,281	56,467	11,513	30,202	54,705	66,370	41,719	25,871	393,128
Number of breastfeeding women who received iron and folic acid supplements	69,512	21,679	4,929	29,385	14,091	48,588	13,308	11,706	213,198
Number of children 0-11 months admitted in PSC	194,308	97,154	15,449	99,009	85,507	122,317	65,828	34,075	713,647

Number of children 12-59 months admitted in PSC	146,729	148,077	21,764	21,927	120,117	174,022	105,547	5,440	743,623
Number of children < 5 years with malnutrition	44,613	1,929	4,487	3,304	5,469	19,411	9,810	6,363	95,386
Number of children < 5 treated for malnutrition who survived	15,886	304	1,691	756	2,355	5,799	5,534	1,726	34,051
Number of drop-out cases in malnutrition case management	965	59	255	39	59	787	227	61	2,452
Number of relapse cases in malnutrition case management	611	2	20	6	26	475	142	20	1,302
Number of cooking demonstration sessions	1,152	20	273	20	92	359	651	0	2,567
Number of health facilities with iron and folic acid stock out	80	74	20	1	77	73	108	19	452

Table 60: Nutrition PMP indicators, by quarter for PY3 and by year

Indicators	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 Total
Number of children under 5 years who received vitamin A supplements (campaign)	1,381,027	0	0	1,631,923	**3,012,950**	**2,885,610**
Number of pregnant women who received iron and folic acid supplements	106,736	105,787	110,026	127,665	**450,214**	**200,752**
Number of mothers of children 0 to 23 months who received counseling on child nutrition	83,367	99,388	120,774	115,593	**419,122**	**90,500**
Number of breastfeeding women who received vitamin A supplements	35,144	37,632	40,721	35,420	**148,917**	**60,869**
Number of health facilities with iron and folic acid stock out (average)	494	644	279	390	**452**	**191**

5. HIV – PMTCT

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

Throughout PY3, 91,858 pregnant women attended ANC visits, a 105% achievement rate compared to the PMP target of 87,500 women. This increase comes in spite of the decreased number of facilities (52 from 212) due to the PEPFAR strategic pivot, which led to IHP's withdrawal from Sud Kivu and the two Kasaïs in favor of a focus on Katanga. IHP recommends that the population count for the two zones in which the project operates (Kolwezi and Haut Lomami) should be reassessed in order to establish an accurate denominator for data analysis.

Number of pregnant women receiving HIV counseling

In PY3, 95% of pregnant women seen during ANC (87,273/91,858) received counseling during their pregnancy. However, IHP has an achievement rate of 99% (87,273/87,500) relative to the PMP. It remains to be determined why the remaining 5% (4,585) did not receive counseling yet received ANC. This may be due to a problem with reporting or data quality, as every woman who received ANC care should automatically receive counseling.

Number of pregnant women receiving HIV counseling and testing

In PY3, 64,031 (91%) out of the PMP target of 70,000 pregnant women were tested for HIV, but of the 87,272 women who received counseling, only 73% (63,031) were tested. The disparity between women counseled and tested needs to be investigated, particularly with a focus on the fear of receiving positive tests, quality of counseling, and stigma and discrimination within the community. These factors may present an obstacle toward getting tested and learning test results.

Number of pregnant women with known HIV status

Only 61,836 women know their serologic status, which represents 88% of the PMP target (70,000). However, when this number is compared to the number of women who received testing, the return rate is 97% rather than 100%. This means that there are 2,195 women who received testing (3%) but who did not receive their results. This disparity is due to the fact that results are given during appointments, and due to the time required for samples to be processed and received by the health facilities. Sites in Katanga currently deliver results on the same day as testing in order to ensure that women know their HIV status.

To guarantee that all women who receive testing also receive their results, sites must be instructed to have nurses collect and analyze blood samples using the Determine test. Nurses should then only send samples to the laboratory if the results are positive. Additionally, community workers should be encouraged to conduct house visits for women who have not returned to sites for their results, as well as to send them text message reminders. Finally, sites must be supplied with tests, efforts must be made to increase awareness of HIV positive stigma and discrimination, and the long-term availability of antiretroviral for pregnant women must be made known.

Number of pregnant women who tested positive for HIV

A total of 572 women tested positive for HIV out of 61,836 who were tested and received test results, for a seropositivity rate of 0.9%. However, relative to the PMP (1,400), the project had an achievement rate of 41%. Since April 2013, the project's HIV activities have focused on the province of Katanga. The selection of new sites will be based on elevated risk factors (such as the prevalence of sexually transmitted infections), the detection rate for tuberculosis in the health area or zone, and the presence of target populations.

Number of pregnant women who tested positive with known HIV status

Only 17 pregnant women already knew their serologic statuses out of the 572 pregnant women who tested positive for HIV. IHP acknowledges that this situation must be improved quickly and recommends the following actions:

- Ensure that HIV-positive women, as well as all women who are tested, are encouraged via SMS to return to health facilities for their test results.
- Increase community awareness through community liaisons
- Strengthen the capacity of local NGOs so that they are capable of promoting the use of condoms, to raise awareness among pregnant women and their partners of the importance of accessing ANC services in the PMTCT sites, and to accompany pregnant HIV positive women to accept, adhere to, and follow their treatment regime
- Accelerate the establishment of support groups in order to better assist those with HIV
- Spread awareness of anti-stigma and anti-discrimination activities through broadcast transmissions and through community leaders

Number of health facilities providing ANC services that provide both HIV testing and ART for PMTCT

The number of sites was expected to increase to 250 from 212 over the course of PY3, but due to the PEPFAR strategic pivot, IHP only has 52 sites in Katanga, 19 of which are new. The project is waiting for an agreement to be finalized between USAID and the Global Fund so that the Global Fund beneficiaries can take over IHP sites in Kasaï Oriental, Kasaï Occidental, and Sud Kivu.

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

A total of 233 HIV+ women received antiretroviral (ART) treatment compared to the PMP target of 980, representing an achievement rate of 23%. The 233 women who received ARV treatment account for 40% of the 572 pregnant women with HIV, which represents a reduced risk of virus transmission for their children.

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

A total of 133 out of 572 HIV positive women were treated with prophylaxis, which represents an achievement rate of 23%; this figure is only 19% of the PMP (133/688). This weak performance is due partly to supply stock out during the data collection period, as well as the refusal of some women to acknowledge their HIV positive status and take ARVs. The project will support efforts to raise awareness of preventing mother-to-child transmission, and to eliminate stigma and discrimination of people living with HIV. Additionally, IHP will support the creation of support groups for people living with HIV during PY4.

Number of newborns who received ARVs to reduce risk of mother-to-child transmission
The PMP target for newborns treated with ARVs was 1,688 newborns, but only 276 (16%) were recorded as having received treatment during this period. Pediatric care remains a challenge for IHP; however, the project plans a number of activities in PY4 to strengthen performance on this indicator.

- At the health care provider level, the project will
  - Train health care providers in the use of DBS kits, which are expected to arrive in PY4
  - Brief health care providers to monitor births and children exposed to HIV, and to emphasize the need to adhere to ARV or prophylaxis treatments
  - Identify HIV positive women and their children, particularly during ANC and post-natal consultation
- With local NGOs, IHP will
  - Collaborate to provide specific interventions, such as dispensing ARVs, providing cotrimoxazole to women from the 6th week of pregnancy onwards, drawing blood for Dried Blood Spot tests, monitoring infant growth for those exposed to HIV, in addition to a routine package of interventions normally provided for children
  - Collaborate to ensure that HIV positive mothers and children exposed to HIV can receive follow-up visits at home, with their consent, to improve adherence to treatment plans and for psycho-social support
  - Organize a quarterly meeting with members of local NGOs, care providers, health zone management teams, and the local IHP team to evaluate the effectiveness of this approach
- The project will start support groups, at the discretion of or as seen fit by care providers in targeted health zones.
- IHP will use BCC activities to strengthen awareness-raising activities through mass communication through community radios and SMS messages about mother-to-child transmission, the necessity for ARV prophylaxis for infants exposed to HIV, and the need to attend meetings as schedules
- IHP will promote partner involvement by implementing strategies to increase male partner participation so that they are supportive when women (who have given written consent) receive SMS messages that invite them to PMTCT sites and they ask their husbands or partners to accompany them

- The project will advocate at mining companies to have male workers accompany, at least one time, their female partners to ANC services
- To support high quality services, IHP will encourage health facilities to
  - Offer counseling and testing services during certain days and time-slots in sites that are capable of doing so
  - Prioritize care for women who are accompanied by male partners

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

3,934 men received HIV counseling and testing along with their wives, representing only 6% of the 61,836 pregnant women who have received counseling, testing, and test results. This low level of performance is attributed to the fact that the majority of these men work for mining companies and many of them are artisanal miners who are not always available to accompany their female partners to appointments.

The following steps will be taken to improve this situation:

- In conjunction with the health zone of Kolwezi, advocate that mining companies authorize their workers to accompany female partners to ANE/PMTCT appointments at least once a month.
- Ensure that each site is able to invite partners using written notes, as this is a common practice.
- Use radio to spread the message that it is important for men to participate in antenatal care with their partners.

Number of HIV+ pregnant women receiving cotrimoxazole (CTX) prophylaxis

Out of the target of 1,558 HIV-positive pregnant women, only 395 (24%) received cotrimoxazole prophylaxis. This situation is due to a stock out of cotrimoxazole in some PMTCT sites, as well as due to fact that health care providers ordered cotrimoxazole using lines of credit rather than obtaining them from the free products for people living with HIV. The stock out situation has been managed, and the health zone management teams and care providers have been informed in how to order free cotrimoxazole for people living with HIV. Recommendations were developed for the coordination offices so that the scope of work for joint supervisory visits contained pharmaceutical management: manage and verify tracer medicines and medicines for people living with HIV (ARVs and cotrimoxazole) and include a slot for the medicine and commodity stock level during monthly monitoring meetings.

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

This quarter, only 40% (72 out of 179) of infants born to HIV-positive mothers were given CTX prophylaxis within two months of birth. The low coverage is a result of stock outs of cotrimoxazole and mothers not making their appointments at the health facilities after giving birth for their children to receive the prophylaxis. In addition, training sessions for health providers on administering the CTX prophylaxis were delayed due to the unavailability of trainers, as other organizations, supported by PEPFAR, held their own trainings led by the same trainers in Lubumbashi.

To improve this situation, in PY4, IHP will:

- Ensure the availability of commodities by providing support to care providers to quantify commodity consumption and needs, ensuring the transport of commodities from regional distribution centers to health zones and health centers, and ordering commodities while taking into account potential delays in delivery time and commodity security issues.
- Strengthen supportive supervision by establishing support groups to encourage HIV-positive mothers to start their infants on the CTX prophylaxis within two months of birth.

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

This quarter, only 7.8% (14 of 179) of infants born to HIV-positive mothers were tested within 12 months of birth. It must be noted that early HIV diagnosis in DRC is only done in Kinshasa. All 14 infants, from the sites managed by the Tshumbe coordination office, tested negative. The samples from the infants in Tshumbe were sent to the laboratory in Kinshasa. The low coverage is a result of several factors, including non-availability of trainers who can train providers on early HIV detection and district health authorities' putting priorities elsewhere. Also, the project did not receive Dried Blood Spot (DBS) kits that were supposed to be donated by the Clinton Foundation and PNLS during the quarter. However, IHP has submitted an order for DBS kits to SCMS.

Number of HIV-positive pregnant women assessed for ART eligibility

During the current reporting period, 209 (37%) pregnant women were assessed for ART eligibility out of 572 HIV-positive pregnant women. This represents an increase in coverage due to the availability of PIMA kits in project sites. While PIMA kits are not available in all sites, the project transported blood samples from sites without CD4 kits to sites where they are available to ensure evaluation.

In PY3, the PMTCT cascade shows significant weaknesses in terms of lost to follow-up in each step: Pregnant women who attended ANC (91,858) →counseled and tested (64,031) → those who were tested and counseled and received their results (61,836) →those who tested positive (572) →HIV+ positive pregnant women on ART/prophylaxis (233+133 = 366) →exposed infants receiving névirapine→% of infants born to HIV-positive pregnant women who received an HIV test within 12 months of birth. In May 2013, based on those significant weaknesses and to improve the quality of service delivery, and upon USAID recommendation, IHP has hired an HIV expert in each of the two districts where IHP is implementing HIV/AIDS activities with the purpose of assisting the 16 health zones to better manage HIV interventions. However, IHP is well aware of the need to make additional adjustments to improve retention in the PMTCT cascade, keeping in mind that in Katanga province, PEPFAR DRC programming is switching to Option B+ (PMTCT) and treatment according to WHO guidelines. One of the most significant challenges is to decrease loss to follow up during implementation.

Assuming that commodity supply through SCMS will be successful in PY4, and budget permitting, IHP will adopt USAID recommendations to support the following steps:

- Ensure that HIV tests are performed during the ANC and result returned the same day, which may require revising the ANC flow in each clinic setting implementing PMTCT
- Introduce community based approaches, e.g., Mentor Mother, Support Self groups, to improve retention, cotrimoxazole dispensation, EID appointment, etc.
- Conduct regular supervision of sites
- Implement strong BCC activities where HIV activities are being implemented

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

IHP uses and interprets data validated by the National Tuberculosis Program, which are compiled in the project's database. As this report was being prepared, annual data was not yet available.

Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 populations in USG-supported areas

With only 77 out of 80 health zones reporting[4], the average TB detection rate across project sites this quarter is 61%, a slight decrease in coverage from the previous quarter (62%). Though the detection rate is an improvement from the second quarter of PY3 (50%), the project still did not meet the PMP target of 70%. Individually, only the sites managed by the coordination offices of Tshumbe (74%), Kolwezi (72%), and Kamina (120%) exceeded the target rate. High-performing coordination offices were characterized as having dynamic health district leadership and physicians who were proactive in identifying new TB cases. Table 61, on page 72, shows the TB detection rate by coordination office in PY3Q4, and Table 62, also on page 72, shows the notification rate in PY3Q4.

IHP will continue efforts to build capacity of providers and health zone management teams and revamp activities of the fight against TB. In addition, the project will continue to provide supplies to CHWs and BCC kits to health care providers. Additional bicycles will be provided for CHWs to extend TB screening to distant sites. Additionally, CHWs will roll out mini-campaigns on TB warning signs and symptoms, and CBOs will also be involved in awareness-raising activities.

[4] During the reporting period, three health zones did not report: Kalehe and Miti Murhesa in Bukavu, which are still affected by insecurity, and Santé de Pania Mutombo in Mwene Ditu, which is difficult to access due to the poor condition of the roads.

Table 61: TB detection rate by coordination office and by month for PY3Q4: July to September 2013

	July 2013			August 2013			September 2013			PY3Q4 Totals		
Coordination office	MPT+ new cases	Expected	Detection rate (%)	MPT+ New cases	Expected	Detection rate (%)	MPT+ new cases	Expected	Detection rate (%)	MPT+ new cases	Expected	Detection rate (%)
Bukavu	136	460	30	107	460	23	177	460	38	420	1,380	30
Uvira	0	111	0	0	111	0	171	111	154	171	333	51
Mwene Ditu	168	307	55	167	307	54	167	307	54	480	921	52
Luiza	105	202	52	129	202	64	99	202	49	333	606	55
Kole	21	45	47	36	45	80	25	45	56	82	135	61
Tshumbe	91	140	65	104	140	74	115	140	82	310	420	74
Kamina	314	242	130	325	242	134	306	242	126	945	726	120%
Kolwezi	0	105	0	0	105	0	226	105	0	226	315	72
Total	**835**	**1,612**	**52**	**868**	**1,612**	**54**	**1,286**	**1,612**	**80**	**2,763**	**4,836**	**61**

Table 62: Notification rate from July to September 2013

	July 2013			August 2013			September 2013			PY3Q4		
	Total population	MPT+ new cases	Notification rate (%)	Total population	MPT+ new cases	Notification rate (%)	Total Population	MPT+ new cases	Notification rate (%)	Total Population	MPT+ new cases	Notification rate (%)
Bukavu	306,536	136	44	306,536	107	35	306,536	177	58	919,608	420	46
Uvira	73,672	0	0	73,672	0	0	73,672	171	232	221,016	171	77
Mwene Ditu	204,936	168	82	204,936	167	81	204,936	145	71	614,808	480	78
Luiza	134,838	105	78	134,838	129	96	134,838	99	73	404,514	333	82
Kole	29,924	21	70	29,924	36	120	29,924	25	84	89,772	82	91
Tshumbe	93,056	91	98	93,056	104	112	93,056	115	124	279,168	310	111
Kamina	161,206	314	195	161,206	325	202	161,206	306	190	483,618	945	195
Kolwezi	69,816	0	0	69,816	0	0	69,816	226	324	209,448	226	108
Total	**1,073,984**	**835**	**78**	**1,073,984**	**868**	**81**	**1,073,984**	**1,264**	**118**	**3,221,952**	**2,967**	**92**

The non-availability of communication materials (e.g., cards with images, key TB messages, megaphones) discouraged CHWs from carrying out awareness-raising activities, therefore contributing to unimproved detection rates this quarter. IHP will ensure that these materials are available throughout PY4. Also, there are still sites managed by certain coordination offices that have not yet held awareness-raising sessions. In addition, the continued stock outs of collection and treatment supplies, and the irregular transportation of samples from local TB treatment centers (CST in its French acronym) to TB diagnosis and treatment centers (CSDT), have contributed to weak detection rates. IHP ensures the transport of sputum from the community to CST to CSDT in the framework of facilitating TB diagnostics via microscopy in order to improve TB case detection. The project's activities also aim to improve the CST-CSDT-health zone-CPLT conduit for suspected cases of MDR TB.

Communication materials, such as counseling cards, do not yet exist, and it is for this reason that the project, along with the NTP, plans to finance a workshop to develop counseling cards for TB awareness raising in PY4Q2. During the workshop, all relevant organizations will take part (C-Change, Ligue National Anti-tuberculeuse et anti-lépreuse au Congo (LNAC), Club des Amis de Damien (CAD), the World Health Organization (WHO), Action Damien (AD), The Leprosy Mission International (TLMI), World Food Program (WFP), Columbia University's International Center for AIDS Care and Treatment Programs (ICAP), MSH, USAID, Program for Appropriate Technology in Health (PATH), and others).

To improve TB detection rates, the project plans to procure additional laboratory supplies and TB commodities during the next quarter. The project also plans to organize a series of training workshops during the expansion of Directly Observed Treatment Strategy (DOTS) coverage. Communities will also be more engaged in educational sessions on TB detection.

IHP needs to systematically ensure the procurement of testing kits and other lab commodities and deliver them to health zones. In addition, the project must expand DOTS coverage by integrating 500 more CST around existing CSDT to facilitate access to TB care complemented by the engagement of the community to identify suspected cases. The availability of transportation for samples from the community and CST to CSDT, the treatment of TB patients living far from health facilities, and the launch of quality control activities at the CPLT during the first quarter of PY4 will contribute to better diagnosis and ensure sustainability of obtaining improved detection rates from project sites.

Percent of all registered TB patients who are tested for HIV through USG-supported programs

Under the project, 65% of TB patients were tested for HIV this quarter in the 39 TB and HIV sites implemented by IHP and those implemented by the Global Fund, FIH, and TB/CAP that receive technical and logistical technical assistance from IHP. This is an improvement from last quarter's 56% coverage, even despite the lack of reporting from three health zones (two in Bukavu, one in Mwene Ditu). This quarter's average coverage also surpassed the PMP target of 58%, as seen in Table 63, on the following page. Because of the availability of HIV tests, there was a 17% increase (from 964 patients counseled out of 2,036 tested to 1,746 counseled out of 2,741 tested) in coverage in PY3 in terms of patients being counseled and tested. Table 64, on page 75, provides a comparison for this indicator between PY3 and PY2.

This increase was due to a combination of strategies and activities implemented including the opening of new counseling and testing centers, as well as the revitalization of existing TB and HIV co-infection centers in the 80 targeted health zones.

Table 63: Number and percentage of TB patients tested for HIV in PY3Q4 by coordination and by month

	July 2013		August 2013		September 2013		Total PY3Q4		
	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	%
Bukavu	136	61	107	66	177	142	420	269	64
Uvira	0	0	0	0	171	124	171	124	73
Mwene Ditu	168	124	167	67	145	111	480	302	63
Luiza	105	51	129	52	99	43	333	146	44
Kole	21	14	36	24	25	21	82	59	72
Tshumbe	91	53	104	54	115	51	310	158	51
Kamina	314	197	325	239	306	252	945	688	73
Kolwezi	0	0	0	0	226	186	226	186	82
Total	**835**	**500**	**868**	**502**	**1,264**	**930**	**2,967**	**1,932**	**65**

Table 64: Number of TB patients tested for HIV from PY2Q1 to PY3Q4 by coordination and by quarter in PY2 and PY3

	PY2Q1		PY2Q2		PY2Q3		PY2Q4		PY3Q1		PY3Q2		PY3Q3		PY3Q4	
	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested	Tested	Counseled and tested
Bukavu	360	483	259	175	317	251	409	332	221	98	275	271	438	194	420	269
Uvira	25	15	21	13	26	15	23	29	222	51	143	91	146	88	171	124
Mwene Ditu	263	3	395	12	444	167	424	12	421	74	451	232	474	303	480	302
Luiza	359	61	431	76	387	131	429	108	457	343	456	221	414	281	333	146
Kole	54	11	71	9	91	12	72	52	100	47	102	34	102	46	82	59
Tshumbe	364	6	316	55	261	48	320	14	315	112	278	133	325	139	310	158
Kamina	611	385	795	274	725	143	632	70	606	83	482	264	869	534	945	688
Kolwezi	0	0	10	10	39	16	0	0	250	74	216	166	123	99	226	186
Total	**2,036**	**964**	**2,298**	**624**	**2,290**	**783**	**2,309**	**617**	**2,592**	**882**	**2,403**	**1,412**	**2,891**	**1,684**	**2,967**	**1,932**

In addition, the previous trainings on co-infection conducted in Mwene Ditu, Kamina, and Kolwezi have been effective since the percentage of TB patients tested for HIV in the sites managed by these three coordination offices has increased considerably since PY2. For example, the percentage of TB patients tested for HIV increased from 17% (PY2Q4) to 63% (PY3Q4) in Mwene Ditu, 13% to 73% in Kamina, and 4% to 82% in Kolwezi. In addition to the workshops conducted on co-infection, this improved performance is also essentially due to the availability of HIV tests in the health zones.

The recent integration of new co-infection sites in Luiza will help increase the number of people with TB who are tested for HIV. The project also plans to integrate new co-infection centers into health facilities that provide TB care in the Bukavu, Uvira, Kole, and Tshumbe field offices, as well as to help disseminate guides on TB and HIV co-infection management to health facilities in the 80 health zones supported by the project.

Number of multi-drug resistant (MDR) TB cases detected

The number MDR-TB cases detected increased from zero last quarter to 11 during the current reporting period since the PNLT National Mycobacteria Reference Lab re-opened (internal conflict among senior PNLT staff halted services last quarter). Meanwhile, IHP has expanded activities involving the collection and transport of samples by training providers from 38 CSDT under the coordination offices of Mwene Ditu on MDR. Table 65 illustrates in which coordination offices MDR-TB cases were identified in PY3Q4.

Table 65: Number of MDR-TB cases in PY3Q4 by coordination and by month

	July 2013	August 2013	September 2013	TOTAL PY3Q4
Bukavu	0	0	8	8
Uvira	0	0	1	1
Mwene Ditu	0	0	0	0
Luiza	0	0	0	0
Kole	0	0	0	0
Tshumbe	0	0	1	1
Kamina	0	0	1	1
Kolwezi	0	0	0	0
Total	**0**	**0**	**11**	**11**

In PY3, the project strengthened activities related to correct care for MDR-TB in Kolwezi, Kamina, and Mwene Ditu by:

- Training all CSDT care providers to diagnose potential cases of MDR-TB and to take and transport samples correctly and securely.
- Implementing a sample collection circuit and expediting sputum samples
- Identifying roles and responsibilities for all actors involved (CST, CSDT, health zones, health districts, and the CPLT)

The following next steps will be undertaken by the project to increase the number of MDR-TB cases detected:

- Extend the use of GenExpert, a diagnostic tool used to identify MDR-TB cases, to Kamina, Kolwezi, Lodja, Mbuji Mayi, and Kananga.
- Support the transport of potential MDR-TB samples from the field to the National Mycobacteria Reference Laboratory in Kinshasa by tracking the sample from the community until it reaches the lab.

- Complete a series of trainings on MDR-TB in all TB diagnostic and treatment centers (CSDT in the French acronym) In Luiza, Bukavu, Kole, Tshumbe, and Uvira throughout PY4.

During PY3Q4, the number of health facilities that experienced stock outs of RH (rifampicin/ isoniazid) combination decreased from the previous quarter. A few facilities that had stock outs include those managed by the coordination offices of Bukavu, Kamina, Uvira, Tshumbe, and Kole, as transport of commodities from the CPLT to the health zones remain an issue. Table 66, below, shows the number of RH stock outs by coordination office in PY3Q4.

Table 66: Number of USG-assisted service delivery points experiencing stock out of RH (rifampicin/isoniazid) combination during PY3Q4

	July 2013	August 2013	September 2013
Bukavu	3	7	15
Uvira	0	1	5
Mwene Ditu	0	2	0
Luiza	0	0	0
Kole	2	0	0
Tshumbe	0	3	2
Kamina	7	4	4
Kolwezi	0	0	0
Total	12	17	26

The following steps will be undertaken by IHP in PY4:

- Ensure that commodities can be transported to project health zones and all health facilities as needed, upon request from the CPLTs.
- Use SMS messaging, among CSDT with mobile coverage, to collect data on TB medicine supplies and to transmit messages about urgent TB medicine needs to the CPLT.

IR2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted

1. <u>Percentage of health centers meeting all nine FOSACOF minimum standards</u>

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

As indicated in Table 67, on the following page, during PY3, 75 health facilities integrated the FOSACOF approach out of 104 targeted in the PMP (72% achievement). To date, the project has registered 504 health centers that integrated FOSACOF out of the 939 targeted in the PMP (54% achievement). The overlapping of IHP's scheduled activities with those of the MOH contributed to the fact that MOH staff and trainers were unable to extend the integration of the FOSACOF approach as expected. To improve this situation, IHP will continue to support the health zones during the development of their AOPs to improve the coordination of activities at the health zone level, as well as those planned at the central level.

Table 67: Integration of the FOSACOF approach in health facilities by coordination office in PY2 and PY3

Coordination office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3 Total	PY2 Total
Bukavu	33	48	48	67	67	33
Uvira	21	21	36	36	36	21
Kolwezi	14	40	40	40	40	14
Kamina	29	29	29	29	29	29
Kole	49	49	49	49	49	49
Tshumbe	93	93	93	93	93	93
Luiza	93	93	93	93	93	93
Mwene Ditu	97	97	97	97	97	97
Total health facilities	429	470	485	504	504	429

During PY3, IHP focused more effort on performing periodic assessments of the health facilities that had introduced the FOSACOF approach, supported by IHP, from October 2010 onwards, as well as in facilities from the previous LMS Program in 2009, rather than on introducing the approach to new health facilities. The project also used this time to focus on strengthening the quality of services provided. This is the reason why some of the coordination offices had no new health facilities that integrated the approach. The coordination offices of Bukavu, Uvira, and Kolwezi, however, which had initially been slow to adopt the FOSACOF approach, moved forward during 2013 to integrate the approach. The number of facilities in Bukavu increased from 33 to 67, in Uvira from 21 to 36, and in Kolwezi from 14 to 40.

The introduction of the FOSACOF approach in the health facilities has had a positive impact on service quality in health facilities in the following areas:

- Biomedical waste management
- Improvements in updating inventories
- Improvements in managing medicines and other medical supplies
- Reductions in the number of health facilities reporting a stock out of medicines.

For the next quarter, the following activities have been prioritized:

- 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 coordination offices; a summary table of results will be presented in the next quarter.

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

Summary of activities under the RBF program: During the current reporting period, the project carried out the final part of the preparatory phase of the RBF program by signing performance contracts with 15 health centers, one general referral hospital, and one health zone management team. The project developed a workplan for the first three months of implementation. Achievements of the RBF program this quarter are presented in Table 68, on the following page.

Table 68: Summary of RBF activities during PY3Q4

Activities	No. planned	No. completed	Achievement %
At the coordination office level, determine performance indicators for health centers for contract negotiation	160	118	73.8
Organize a workshop in each of the eight[5] RBF-targeted health zones for the negotiation and signing of performance contracts and development of implementation workplans	8	1	12.5
Work with the RBF unit of the MOH to develop the electronic database	1	1	100
Cooperate with the external evaluator hired by USAID to develop the baseline	1	1	100
Develop a performance contract template for community-based organizations (CBO)	1	1	100

Details of the activities completed (or partially completed) are given below.

Work with the RBF unit of the MOH to develop the electronic database. The consultant engaged by IHP arrived in September and delivered a presentation and demonstration of the RBF web-based database for the RBF unit of the MOH and SNIS staff. The participants were able to practice working with the application. A test on database management was also given to local computer technicians; three out of 10 participants passed. Opportunities for in-country hosting of the server was analyzed but proved inconclusive because the main servers, such as with the National Post Office and Telecommunications, are hosted abroad.

The RBF unit of the MOH has expressed interest in reviewing the baseline data for IHP's RBF activities, with a country-wide program in mind. IHP's RBF activities have been developed with a view toward country-wide scale-up. The World Bank is also engaged in supporting the RBF process in DRC. Under the leadership of the MOH RBF unit and starting in the first quarter of PY4, the project will implement a working group for all of the RBF actors to manage the baseline data. The web portal is an MOH portal and can be consulted and used by all organizations involved in RBF in DRC.

Collaborate with external firm IBTCI on project evaluation. Select IHP staff responded as key informants to questions posed by investigators from the external evaluation firm hired by USAID to conduct the baseline survey for RBF, International Business & Technical Consultants, Inc. (IBTCI). IHP staff also helped organize logistics and offer information on accessibility and security of the project-targeted health zones to IBTCI.

Develop a performance contract template for CBOs. The template for a fixed-price obligation grant contract was submitted to home office in August for the Senior Contracts Officer to seek USAID approval for its use.

At the coordination office level, set performance indicators for health centers for contract negotiation. In preparation of the delivery of performance contracts to health centers involved,

[5] For PY4, RBF activities will be carried out in seven health zones. The health zone of Walungu will no longer be included in project-supported RBF activities.

performance targets were set at the coordination offices. Out of the 160 selected health centers, 118 have set targets. Out of the eight general referral hospitals, seven have set targets. And out of the eight health zone management teams, seven fixed performance targets. About 74% of the health facilities involved have therefore set performance targets. Since the health zone of Walungu was turned over to the support of RBF implementer CordAid, time and financial constraints did not make it possible to undertake the preparation and selection process for another health zone to replace Walungu. IBTCI confirmed that this change would not influence the statistical analysis in their baseline evaluation of RBF.

In addition, at the request of the provincial medical inspector (MIP in the French acronym) in Katanga, the health zone of Songa, with 29 health areas, was replaced by Kayamba, which covers 13 health areas. Also, at the request of the MIP of Kasaï Oriental, the health zone of Minga, which had 17 health areas, was replaced by Wembonyama, which also has 17 health areas.

Organize a workshop in each of eight RBF-targeted health zones for the negotiation and signing of performance contracts and development of implementation workplans. Of the eight contracting workshops planned, only one was carried out, in the health zone of Bibanga, due to funding constraints. During the workshop, IHP worked with health providers to set annual performance targets for 17 health centers, one general referral hospital, and one health zone management team. A workplan was developed for the first quarter of implementation for the 19 health facilities.

Across the project, contract negotiation workshops are still to be planned for 101 health centers, six general referral hospitals, and six health zone management teams. This activity is scheduled to be carried out in October 2013 in order to begin the actual implementation of RBF, which has a start date of November 1, 2013. On this day, IHP will pay an advance of 30% of premiums scheduled for the first quarter to allow health facilities to better prepare for implementation, particularly to support the implementation of plans for reorganization based on the baseline assessment.

Table 69, on the following page, demonstrates that out of 19 planned RBF activities, eight were carried out, two were partially completed, and nine were not carried out. The activities that were achieved were related to the RBF implementation, and the activities that were not achieved were related to the implementation of counter-verification and verification cycles as related to payment, as well as the enforcement of the rules. Activities that are underway are linked to the final preparatory phase of the implementation.

1. **RBF achievements during PY3**

Table 69: Status of RBF activities planned during PY3

Activity Status	No.	% of total activities	Comments
Activities planned for PY3	19		
Activities completed	8	42%	**Linked to the preparation phase :** • Developed four RBF contract models for health centers, GRH, health zone management teams, and CBOs • Trained 147 care providers: health centers (90), GRH (22), health zone management teams (22), and health districts (5) in the health zones of Bibanga, Minga, Lomela, and Luiza • Conducted awareness raising and advocacy efforts directed toward the local health authorities in Kananga, Lodja, Lubumbashi, Mbuji Mayi, and Uvira • Carried out baseline FOSACOF evaluations in 32 health zones, including 485 health centers and 32 GRH. The evaluation covers eight RBF health zones and in 24 "control" health zones • Collected quantitative data from 485 health centers and 32 health zone management teams in 32 health zones • Collaborated with IBTCI during their baseline RBF evaluation • Carried out a FOSACOF evaluation in three health zones Walungu, Nundu, and Kanzenze • Supported follow-up and supervision for RBF activities in the coordination offices
Activities not completed	9	48%	**Linked to the implementation phase :** • Carry out RBF activities • Conduct verification activities • Conduct counter-verification activities • Pay performance-based bonuses • Strengthen regulation of RBF activities through supervisory visits at the operational and intermediary level • Follow up on data base trainings and activity review • Conduct travel study trips and experience exchanges. • Conduct operational research
Activities underway	2	10%	**Linked to the final preparations for the RBF implementation** • Develop the RBF work plans for the first quarter of project year four, and finalize contracts • Set up an RBF web portal that will also be used as a RBF database nationwide

As IBTCI did not complete the baseline evaluation until September 2013, certain activities were put on hold during the fourth quarter. Also, it was not possible to extend the contractualization process begun in Bibanga in August 2013 to the remaining health zones due to budgetary constraints at the project level. These activities will be carried out during PY4.

The project's RBF activities and planned activities have had a positive impact on other aspects of the project:

- RBF has also contributed to approaches to evaluate quality using the FOSACOF tool at the central level in DRC.
- IHP has become a key actor in DRC's overall RBF program development.
- IHP's innovative model for evaluating the quality of health centers and quality care "purchasing" option is appreciated at the national level in DRC, and is becoming known in the international RBF arena.
- The process developed by IHP is that from which the MOH RBF unit has drawn inspiration for WHO, World Bank, and PROVIC's program.
- The baseline evaluation from the RBF unit, the District Health Management Information System (DHMIS), and the Division of Care Strategy and Operational Research (DSS-RO in the French acronym) allow collected baseline data, which reflects the actual situation among the health structures, to aid in decision-making and operational research.
- Mining companies, such as Tenke Fungurume Mining, are interested in the IHP RBF model, and may provide collaborative opportunities.

Priority activities for next quarter include:

- Complete the contractualization process while organizing pre-workshops at the health district level, and organizing contractualization workshops for the six health zones remaining after Bibanga.
- Disseminate the management tools to RBF health zones.
- Conduct the official RBF implementation on November 1, 2013.
- Develop an organizational structure for the RBF program within IHP so that the RBF activities are aligned with IBTCI's evaluations and the structure of the DRC MOH RBF unit.
- With the external evaluator and with USAID, define the framework for tracking the RBF program performance.
- Pay 30% of the RBF-related bonuses for the first quarter following the start of the RBF program in November 2013.

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

As seen in Table 70, on the following page, the results reported in Kole, Tshumbe, and Uvira for the number of health centers with accurate and up-to-date inventory records were satisfactory in PY3, reaching 85%, 71%, and 65% of the PMP targets, respectively. In addition, Mwene Ditu improved from having 33 health centers with up-to-date records in PY3Q1 to 101 in PY3Q4. IHP carried out supervisory visits to Mwene Ditu, Kole, and Tshumbe to provide support for the use of management tools, and ensured that the management tools were available. Table 71, also on the following page, provides information on hospitals with up-to-date records and inventory.

Unfortunately, the achievement rates for the remaining IHP offices did not surpass 50%. Special attention will be paid the low-performing coordination offices in order to improve their performance, including increasing the number of support supervisory visits, ensuring that management tools are available, and providing a financial incentive of $10 to the health center, as part of the sub-grant to the health zone, for care providers to provide reports on pharmaceutical management.

Table 70: Number of health centers with accurate and up-to-date inventory records

Coordination office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3	Target PY3	Achievement (%)
Bukavu	60	94	109	100	91	408	22
Kamina	84	93	84	131	98	207	47
Kole	42	48	48	53	48	55	87
Kolwezi	8	11	18	18	14	105	13
Luiza	22	65	98	107	73	197	37
Mwene Ditu	33	102	134	135	101	194	52
Tshumbe	49	120	154	146	117	156	75
Uvira	N/A	71	77	61	52	104	50
Total	298	604	722	751	594	1,426	42

Table 71: Number of hospitals with accurate and up-to-date inventory records

Coordination office	PY3Q1	PY3Q2	PY3Q3	PY3Q4	Total PY3	PMP Target	Achievement (%)
Bukavu	10	7	14	13	11	23	48
Kamina	6	4	4	6	5	9	56
Kole	3	4	4	4	4	4	94
Kolwezi	2	3	6	5	4	8	50
Luiza	10	4	7	6	7	11	61
Mwene Ditu	8	7	8	6	7	11	82
Tshumbe	3	7	9	7	7	9	72
Uvira	N/A	4	4	3	3	5	55
Total	42	40	56	50	48	80	60

Overall, the achievement rate for all coordination offices was over 50%, and Kole achieved 94% of its targeted number of hospitals with accurate and up-to-date inventory records. Tshumbe also achieved 78% of its targeted number of hospitals. The high achievements in Kole and Tshumbe are due to their health district initiative through which district-level pharmacists conduct field visits to ensure correct drug management and availability of management tools, including inventory sheets and *Registre d'Utilisation de Medicaments et des Recettes* (RUMER) forms. Special efforts must be placed on poorer performing coordination offices, including advocating at the health district level to ensure that regular supervisory visits to the field occur, additional trainings for care providers on drug management are carried out, and that drug management tools are consistently available.

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

As seen in Table 72, on the following page, the achievement rate for the percentage of patients referred to GRHs is very low. Many families do not have the financial means to travel to a GRH to seek care, and are unable to do so. Also, there are no forms for the health care providers and CHWs to use to record referrals from health centers to GRHs. IHP has duplicated referral and counter-referral forms in the community care sites, but each health facility uses a notebook which allows them to ensure the regular monitoring of referred and counter-referred clients. This tool will be included on the list of items to duplicate during the next order.

Table 72: Percentage of patients referred to GRHs in PY3, by quarter and by coordination office

Field Office	PY3Q1		PY3Q2		PY3Q3		PY3Q4		Total PY3		Achievement Rate (%)
	Patients referred to GHR	Patient seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	
Bukavu	1,187	399,145	13,570	396,179	12,490	419,902	10,030	498,514	37,277	1,713,740	2
Kamina	0	174,930	3,543	206,848	4,111	219,811	3,678	178,895	11,332	780,484	1
Kole	0	23,653	1,191	31,534	1,167	28,810	1,505	33,837	3,863	117,834	3
Kolwezi	1,804	97,601	1,589	100,254	3,155	114,920	1,847	89,151	8,395	401,926	2
Luiza	1,891	103,050	1,699	117,446	2,619	124,714	2,170	116,211	8,379	461,421	2
Mwene Ditu	0	169,717	14,033	173,407	9,928	189,945	10,439	208,827	34,400	741,896	5
Tshumbe	0	87,493	6,357	92,066	7,777	103,650	7,890	108,949	22,024	392,158	6
Uvira	0	71,101	3,209	75,032	2,572	67,490	2,925	74,406	8,706	288,029	3

The project has provided referral tokens to CHWs to improve tracking of patients from health centers for GRHs. CHWs do not directly refer clients to hospitals, as the clients should first visit health centers before receiving a referral to the GRH. Once a referred patient reaches the GRH, the patient will give the health care provider the token to indicate that a referral should be recorded. IHP plans to provide referral forms for the health care providers to fill out and will provide training on the importance of the forms and how to fill them out. Table 73, on the next page, illustrates the percentage of patients referred to health centers by quarter in PY3.

Table 73: Percent of patients referred to health centers, by quarter and by coordination office

	PY3Q1		PY3Q2		PY3Q3		PY3Q4		Total PY3		Achievement Rate (%)
	Patient referred to HC by CHW	Total patient seen by a CHW	Patient referred to HC by CHW	Total patient seen by a CHW	Patient referred to HC by CHW	Total patient seen by a CHW	Patient referred to HC by CHW	Total patient seen by a CHW	Patient referred to HC by CHW	Total patient seen by a CHW	
Bukavu	133	1,200	392	1,631	605	1,327	232	1,167	**1,362**	**5,325**	**26**
Kamina	19	3,512	914	3,123	388	9,511	319	2,166	**1,640**	**18,312**	**9**
Kole	0	2,263	816	1,211	352	602	94	419	**1,262**	**4,495**	**28**
Kolwezi	N/A	2,398	61	520	142	1,014	74	744	**277**	**4,676**	**6**
Luiza	29	654	874	1,150	394	1,330	319	1,460	**1,616**	**4,594**	**35**
Mwene Ditu	52	2,333	20	1,743	325	2,504	0	2,914	**397**	**9,494**	**4**
Tshumbe	65	1,069	76	1,166	60	1,531	0	1,161	**201**	**4,927**	**4**
Uvira	14	288	188	409	100	839	232	1,167	**1,362**	**5,325**	**26**

Health zones monitor counter-referrals for patients from GRHs to health centers, and from health centers to community care sites through their respective reports. IHP estimates that the difference in the proportion of patients transferred from community care sites to health centers: Bukavu, Kole, Uvira and Luiza (26%, 28%, 35%, 26%) vs. Kamina, Kolwezi, Mwene Ditu, Tshumbe (9%, 6%, 4%, 4%) is linked to the following factors:

- The level of involvement of local NGOs and of community health workers in social mobilization and psycho-social support from the family
- Socio-economic status of the family
- Distance between health centers (the further away a health facility, the less likely a family is to accept the referral)
- The attitude/welcome and care from the providers at the health centers
- The availability of medicines and other medical supplies
- The quality of the facility infrastructure and the presence of equipment in health centers
- The proximity of community care sites and/or a health center to a referral health center, i.e., patients can go directly to referral health centers without first visiting community care sites and health centers.

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

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

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

IHP continues to provide support to the revitalization of CODESAs. Table 74, below, shows the number of revitalized and functional CODESAs. Highlights from this quarter, PY3, and progress to-date include:

- Nine CODESAs were revitalized during the fourth quarter.
- The slowdown in field activities due to project budgetary constraints during the fourth quarter impacted the overall number of CODESAs that were revitalized, as there were fewer field visits during which project staff could provide technical assistance and support to CODESAs. In many cases, there were also fewer CODESA monitoring visits from health zone officials, as these officials would generally time their trips to coincide with project staff so that they could share their transportation.
- The total number of CODESAs revitalized during PY3 is 1,239, which represents 88% of the annual PMP target of 1,415. During PY2, a total of 1,143 CODESAs were revitalized.
- Out of the 1,239 CODESAs that have been successfully revitalized, 905 (73%) have developed and put in place action plans. The overall increase in the number of CODESAs with action plans is due in part to the health zone management teams maintaining their supervisory roles in nearly all coordination offices.
- In Mwene Ditu, the slight decline in the number of revitalized CODESAs is due to the fact that five CODESAs that had reached the end of their authorized mandates did not hold new elections for officers, choosing instead to temporarily shut down operations. Elections are planned for this upcoming quarter.
- In Bukavu, new CODESAs were not supported in drafting and implementing their action plans, an activity which has been planned for PY4.
- In Kole and Kamina, the security situations and the IHP office move from Kole to Lodja was not favorable for maintaining ongoing CODESA supervision.

Table 74: Number of revitalized and functional CODESAs

Field office	Number of CODESAS identified	Number of CODESAs revitalized and functional	Functional CODESAs (%)	Number of revitalized and functional CODESAs with an action plan	Functional CODESAs with an action plan (%)
Kole	55	43	78	32	74
Mwene Ditu	191	186	97	185	99
Tshumbe	156	131	84	89	68
Luiza	189	169	89	157	93
Kamina	207	176	85	129	73
Kolwezi	105	87	83	87	100
Uvira	104	82	79	82	100
Bukavu	408	365	89	132	36
TOTAL	**1,415**	**1,239**	**88**	**893**	**72**

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

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 fourth 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:

- Five additional youth associations were identified during the fourth quarter. All five of these organizations were in Uvira: Association des Jeunes Mulangaliro, Association des Jeunes de la Sucrecrie de Kiliba, Association des Jeunes Musaka, Association des Jeunes Udomja, and Association des Jeunes Kusaidjana. Table 75, on the following page, shows the number of youth organizations participating in the youth awareness-raising activities throughout PY3.
- In total, 150 organizations have been identified. Although five new organizations were identified this quarter, two previously identified organizations are no longer functional, leading to an absolute increase of three organizations relative to last quarter. Appendix 4 provides a list of NGOs and CBOs by coordination office, identified by the project.
- Among the 150 organizations, 125 (83%) collaborate with IHP. All of the newly-identified organizations have begun collaborating with IHP.
- Despite small declines in the number of active youth organizations in Luiza and Bukavu due to instability in those areas, the overall number of active associations increased from 119 in the third quarter to 125 in the fourth quarter.
- These 125 active youth associations conduct awareness-raising activities about community development and the project's key health themes with local youth with support from IHP and the health zone management teams.
- The number of active youth organizations increased from 105 at the end of PY2 to 125 at the end of PY3. This increase can be explained in part by IHP's concerted effort to ensure that local youth are engaged and feel that they can work to shape their own futures. IHP staff provided, among other things, support for small-scale business management (for example, running an individual motorcycle taxi business), assistance in implementing instruction manuals (such as for setting up a market garden), and assisting youth leaders in raising awareness about disease prevention (HIV and AIDS, TB, WASH, etc.).
- In Uvira, the Association des Jeunes de la Sucrerie de Kiliba recruited 25 group members to work together to harvest sugar cane on the larger farms in the area. The money they earned was put into a communal pot of funds used to pay the school fees for each group member. The association has also been begun small-scale chicken and duck raising projects. Some of the animals are sold and some are distributed among members for consumption. The association meets once a week to review its progress. The health zone management team members and IHP have been invited to provide advice during these meetings. IHP's work to date with this association has largely been limited to providing advice, but plans have been discussed to provide technical assistance tailored to the group's progression and needs.

Table 75: Number of youth organizations participating in the youth awareness-raising activities

Field office	Number of associations Identified (PY3Q4 & YTD)	Number of active associations (PY3Q1)	Number of active associations (PY3Q2)	Number of active associations (PY3Q3)	Number of active associations (PY3Q4)
Bukavu	21	9	9	9	8
Uvira	19	4	10	10	14
Mwene Ditu	76	65	65	65	71
Kole	4	2	2	4	4
Tshumbe	5	4	2	5	5
Luiza	17	17	17	18	15
Kamina	3	3	3	3	3
Kolwezi	5	5	5	5	5
Total	**150**	**109**	**113**	**119**	**125**

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:

- During the fourth quarter, the number of identified NGOs across all eight coordination offices increased from 172 to 179. Of these, 89 (50%) are participating in CODESA coordination meetings.
- Of these seven new organizations, five were youth groups (the youth organizations in Uvira listed above) and two were women's organizations: Réseau des Femmes pour la Défense des Droits de la Femme et de l'Enfant (REFEDEF) in Luiza and l'Association des Femmes pour le Développement des personnes en Détresse (AFeDeT) in Kamina.
- The major issue discussed during these coordination meetings was mobilizing the community and raising awareness about pneumonia, diarrhea, exclusive breastfeeding, and vaccination (specifically, a campaign against polio).
- During the fourth quarter, IHP encouraged the health zone management teams to increase the number of community-based youth and women's organizations involved in community mobilization, particularly in mobilization meetings in rural areas. IHP also encouraged the health zone management teams to clearly define the collaboration between the different community partners and the health zone's community mobilization work.
- IHP also continued to provide technical assistance for coordination meetings for community-based organizations led by different groups (the health zone, the district, CARITAS, village council, etc.).

Community mobilization and organization has occurred to varying degrees across IHP's target health zones. In general, youth NGOs exist and meet independently following their pre-established schedules or as needed. During coordination meetings, IHP staff is sometimes invited to provide technical support on certain issues. Among other things, IHP staff briefs members on community-based diagnosis techniques, different methods of malaria prevention, communication techniques (group discussions, panel discussions, etc.), small and easy ways to raise awareness among their peers, and the ETL principles of OARS (open-ended questions, affirmations, reflective listening, and summary of key points) and APTE (autonomy, partnership, transformation, and empathy) in order to

help group members engage in awareness-raising with their peers. In conjunction with the health zone management team, IHP staff also help youth NGOs draft their annual action plans, which they are implementing.

At the request of the health zone management team, IHP also continues to support communities' efforts to develop communications strategies. In particular, the health zone management team asks IHP staff for help with providing technical assistance to different community-based organizations on properly following the principles in their strategies and responding appropriately to community needs. Among the most important of these principles is that of democracy, thus ensuring that NGO leaders are elected and that all members have a voice.

In Mwene Ditu, the health zone management team noticed that some NGO and CBO leaders were making unilateral decisions and not being accountable to their members. To address this situation, the health zone collaborated with IHP staff to organize dialogue and reconciliation meetings with youth NGOs in order for group leaders and members to effectively work out their differences. Those NGOs whose leadership was determined to be functioning well (such as Forum SIDA, UCOP+, RACOJ, and certain women's groups) were advised to work together and coordinate their activities so that they were aligned with the health zone objectives.

Overall, IHP's technical assistance has enabled different community-based associations to improve their organizational structure and learn important information that subsequently enabled them to have a positive impact on their community.

At this stage, there are more youth organizations than women's organizations. The Champion Man initiative, however, has provided the health zone management teams with a means of introducing gender equality ideas and norms at the household level by discussing certain themes and issues during meetings with the community. The introduction of these ideas will hopefully reduce the constraints women face when trying to organize and thus lead to creation of more women's groups over time.

Notably in Luiza, IHP has introduced certain gender equality concepts through the piloting of the Champion Man initiative with the Champion Community in Dibaya (in the Tshmayi and Mupoyi health areas). The main topics introduced to local men included: encouraging men to accompany their sick spouses and children to the health center for treatment, and encouraging men to give women freedom of choice to join an action group (of her choosing), to attend meetings, and to co-manage the household budget.

The health zone is responsible for supervising and monitoring the progress of local men in adopting these practices. The health zone collaborated with local organizations in putting together a team (six women) that accompanied health zone staff in monitoring the 10 households chosen as pilot households.

During project year three, IHP and health zones also provided support to youth associations (students and non-students) which generated interested in 15 schools in Mwene Ditu and led to 20 other schools conducting awareness-raising activities about the fight against HIV. The health zone provides support to these youth associations in developing a communications plan and in organizing ETL sessions with their peers.

Additionally, health zones have conducted the following activities with community organizations to reinforce collaboration and partnership with them:

- Participate in each others' administrative counsel/management committee meetings (once per quarter)
- Support local organizations in organizing health awareness-raising activities
- Support local organizations in drafting action plans
- Collaborate with local organizations in conducting large-scale community activities, and
- Participate in each others' reviews

As part of their routine work independent of IHP support, the health zones accompany and provide technical support to community organizations. But we are aware that the community mobilizers who are in charge of this work face many challenges, including a dearth of community organization, the remoteness of, and distance between, certain health areas, among other factors. To help address these realities, the project continues to provide technical support to the health zone management teams to help them carry out their responsibilities, including familiarizing themselves with existing local groups and assets, integrating local group activities in the health zone's action plan, etc.

IHP assistance enabled the majority of selected local NGOs within the Champion Community structures to interact with other local groups and persuade them to integrate key IHP health messages into the respective action plans. As a result, the number of community agents working towards the same health zone goal was increased, inter-group relations were improved, and the link between the health zone and local zones was reinforced.

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. The goal of mini-campaigns is to direct the target audience towards health facilities for treatment and care, reach target audience members who may have fallen off the radar, and foster a mini-call to action around a particular health issue among community members. Mini-campaigns are concentrated on an area that can be easily covered (such as a health area), and they are beneficial because they can be organized with little lead time (1-3 days), few resources, and strong local participation. Mini-campaign activities can be easily supervised and monitored, leading to solid results with little lag time.

If two or three health areas are involved, as was the case with a mini-TB communications campaign in the Luputa health zone (Mwene Ditu), mini-campaigns allow for easier supervision of activities in neighboring health areas and reduce the need for staff to travel long distances. Mini-campaigns are also advantageous as they allow target audience members to be identified and, in some cases, accompanied all the way to the point of service or treatment. Thus it is preferable to implement mini-campaigns in a continuous manner (health area to health area) and to progressively cover a health zone based on identified health problems.

To organize a mini-BCC campaign at the IHP field office level, project staff first analyses available data to identify problem health indicators (per target health zone/health area). At the end of this analysis, which involves the community, the health zone management team, and IHP staff, an implementation plan with very clear intervention strategies is developed. At this stage, SMS messages have been included among these strategies as the preferred method of information dissemination; other strategies used include community media and other mechanisms for local-level information dissemination such public criers, etc. SMS messages are preferable for a variety of

reasons: the same message can be read many times by targeted individuals, they facilitate group and community discussions, and SMS messages are often considered by recipients to be a sign of the project's respect for the population. As SMS messages are a relatively new and innovative means of communication, they attract more public attention relative to traditional methods of information dissemination. SMS messages also save the community health workers and other community agents from having to take many trips to the field.

Together with the CUG system and other communications channels employed by IHP, SMS campaigns allow for an increase in the populations' knowledge and help promote and support local populations' ability to adopt positive behaviors. It is important to note that this approach also allows for easier monitoring and evaluation of results relative to community media (the target is clearly documented by project staff, as well as the number of messages sent, the content of the sent messages, etc.).

By contrast, conducting large communications campaigns generally requires developing a larger-scale communications plan and associated health activities and programs. Larger campaigns require more lead time, more resources, and centralized planning and supervision. As a result, mini campaigns can often provide similar positive behavior change results as those associated with larger campaigns (albeit on a smaller scale).

Advantages of a mini campaign include the following:

- Organized in the target site at the grassroots level of the community (health zone, village, or neighborhood)
- Costs very little, if anything
- Increases community mobilization and the community's empowerment
- Encourages information exchanges between community members and helps trigger individual and collective behavior change, and
- Champion Community members and CODESA members are key supporters and contributors to the implementation of mini-campaign activities.

Highlights from this quarter include:

- Eighteen campaigns were organized across IHP's eight coordination offices on fistulas, family planning, WASH, breastfeeding, and post-natal consultations (see breakdown by coordination office and health topic in Table 76 on the following page).
- There was a 28% increase in the number of campaigns organized this quarter relative to the third quarter. This increase is due in part to the fact that grassroots-level activities were organized by the Champion Communities and CODESAs as part of their community awareness-raising efforts. In particular, the fistula repair campaigns garnered a lot of community participation, including from the Champion Communities, CODESAs, and community health workers.
- In Luiza, a multi-faceted fistula repair campaign was organized which included the following:
    - Dissemination of 2,000 SMS messages in the Tshikaji and Luiza health zones (1,000 SMS messages urging women to come forward for treatment for fistulas and 1,000 SMS messages urging women to use pre-natal services and learn more about the dangers of fistulas in order to encourage women to give birth in a health facility with a birth attendant);
    - Organization of 46 sessions of interpersonal communication by 32 community health workers who had previously been briefed on fistula prevention (22 sessions in Luiza and 24 sessions in Tshikaji);

- Distribution of 5,000 flyers and 1,000 copies of health authority communiqués about available fistula treatment services to clergy to be distributed in churches, prayer groups, etc.; and
- As a result of this campaign, about 310 people in Luiza (247 women and 63 men) were exposed to IHP messaging about fistula prevention, 70 women went to the hospital for treatment, and 50 women received treatment.

- In general, BCC campaigns on fistula prevention were conducted across all of IHP's coordination offices during the fourth quarter. These campaigns included the dissemination of SMS messages, the organization of ETL sessions, household visits, the distribution of leaflets with treatment information, and, in certain coordination offices, radio programming.
- IHP coordination offices also organized BCC campaigns about WASH, family planning, exclusive breastfeeding, and post-natal care. All campaigns involved SMS message dissemination; household visits, ETL sessions with community members, radio programs, community demonstrations, and leaflet distribution were incorporated as appropriate and possible.

Table 76: BCC campaigns implemented during PY3Q4 by health issue and coordination office

Health topic	Field office								TOTAL
	Bukavu	Kamina	Mwene Ditu	Kole	Tshumbe	Luiza	Uvira	Kolwezi	
Fistulas	1	1	1	1	1	1	1	1	**8**
Family planning	-	-	1	-	-	-	-	-	**1**
WASH	-	-	1	1	-	1	-	-	**3**
Breastfeeding	1	1	-	-	1	1	1	-	**5**
Post-natal consultations	-	-	-	-	1	-	-	-	**1**
TOTAL	**2**	**2**	**3**	**2**	**3**	**3**	**2**	**1**	**18**

As indicated in Table 77, below, over the course of project year three, 61 BCC campaigns were organized across IHP's eight coordination offices out of annual target of 80 (76%). The number of BCC campaigns this project year represents a notable increase from the total number of campaigns organized PY2 (14). This increase was due to the project's focus on mini-BCC campaigns, as opposed to larger multi-media communications that require greater time and resources, throughout the project year in order to improve lagging health indicators.

Table 77: BCC campaigns implemented during PY3 by coordination office

Field office	Number of BCC campaigns (PY3Q1)	Number of BCC campaigns (PY3Q2)	Number of BCC campaigns (PY3Q3)	Number of BCC campaigns (PY3Q4)	Total PY3
Bukavu	2	2	2	2	8
Kamina	2	2	1	2	7
Kole	1	2	2	2	7
Kolwezi	3	1	5	1	10
Luiza	2	2	1	3	8
Mwene Ditu	2	1	1	3	6
Tshumbe	1	2	1	3	7
Uvira	3	2	1	2	8
Total	**16**	**14**	**14**	**18**	**61**

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

IHP continues to implement its mHealth initiatives. During the fourth quarter, project staff continued to successfully transmit SMS messages on, among other health topics, fistula prevention, family planning, WASH, breastfeeding, and post-natal consultations. Table 78 on the following page illustrates the number of SMS messages that were sent by each coordination office in PY3. Highlights from this quarter include:

- Over the course of the fourth quarter, 51,227 SMS messages were transmitted out of a quarterly target of 105,000 (48%). This completion rate is noticeably higher than last quarter (26%) and reflects the incorporation of the revised PMP target.
- During the fourth quarter, the PMP target was officially revised to 60,000 SMS messages per coordination office (excluding Kole due to its historical lack of network coverage) per year (420,000 annually or 105,000 per quarter). This change is a better reflection of the reality on the ground, as 46 of IHP's health zones have full cell phone network coverage, 15 have partial coverage, and 19 do not have coverage at all. Previously, the quarterly PMP target was 250,000 (1,000,000 annually).
- A total of 236,144 SMS messages were sent over the course of PY3. The number of SMS messages more than doubled relative to PY2, when IHP disseminated a total of 105,000 SMS messages.
- With respect to closed user groups (CUGs), IHP plans to add more groups to its existing six functional CUGs. The first new CUGs to be established will be in Champion Communities in Kamina (two) and in Tshumbe (two).
- In Uvira, Champion Community members have purchased 10 cell phones with their own funds to be added to the existing CUG system. IHP has begun looking into connecting these phones to the existing system.

SMS campaign interventions, which were in an initial pilot phase during project year two, were rolled out in the seven field offices that had mobile network coverage during year two (one field office did not have mobile network coverage during that period). During this period, SMS messages were disseminated in about 20 health zones; most of these messages were in support of the malaria communications campaign (3+1, Tuendeni Kumpala). These messages generated a great deal of interest among the population.

In light of recipients' responses, the field offices, in collaboration with the health zone management teams, updated IHP's phone lists, which became more extensive over the course of year three. Additionally, four health zones sent SMS messages independent of IHP, which also contributed to the number of target SMS messages disseminated. Health SMS messages continued to be well-received by target populations. To this end, it is important to emphasize that new communications technologies have been of paramount importance in the implementation of IHP's BCC activities, particularly in year three. They have been used by the field offices to conduct mini-BCC campaigns to boost lagging health indicators across different health topics, proving over the course of year three to be an effective means to improve health indicators. As a result, there was a doubling in the number of SMS messages disseminated in PY3 as compared to PY2, which can be considered an experimental, or pilot, year with respect to IHP's mobile-phone based activities.

Given recipients' positive response to awareness-raising SMS messages across a variety of health issues, it is possible that the number of SMS messages disseminated will rise yet again in PY4, provided that sufficient cell phone credit is made available to IHP staff at the field office level.

Table 78: Number of SMS messages sent by health area and by coordination office during PY3*

Field office	Number of SMS messages sent (PY3Q1)	Number of SMS messages sent (PY3Q2)	Number of SMS messages sent (PY3Q3)	Number of SMS messages sent (PY3Q4)	Number of SMS messages sent (Total PY3)
Bukavu	5,783	2,014	6,611	3,843	18,251
Kamina	648	539	4,447	3,978	9,612
Kolwezi	600	1,887	5,500	2,250	10,237
Luiza	4,150	6,100	3,068	7,743	21,061
Mwene Ditu	7,400	4,400	3,000	4,500	19,300
Tshumbe	9,752	975	6,004	15,120	31,851
Uvira	9,450	29,795	36,294	12,793	88,332
Kinshasa/mobile operators	19,000	16,000	1,500	1,000	37,500
Total	**56,783**	**61,710**	**66,424**	**51,227**	**236,144**

** Kole was unable to send SMS messages during PY3 due to lack of network coverage*

Project years two and three marked a decisive turning point in IHP's BCC methodology, with the introduction of mobile technology at the community level (leading to a subsequent increase in the use of medical services at the local health center level). The overall challenge was to effectively use this technology based on sending target SMS messages and fostering community exchange through the Closed User Groups (CUGs). IHP's BCC component continues to successfully apply these technologies to, among other things, support mini-campaigns and raise awareness throughout the community on different health issues.

Based on the results achieved, and at the request of USAID/DRC, IHP attended conferences in Dar es Salam, Tanzania (November 2012) and Addis Ababa, Ethiopia (September 2013), as one of the key partners in the DRC providing services and implementing BCC campaigns to promote family planning and fight malaria, in particular through mHealth. The conference's themes were "the use of mobile technology to improve family planning" and "promoting the use of malaria services and products through behavior change communication at the country level for PMI-supported countries." IHP was also invited to participate in the President's Malaria Initiative (PMI) Behavior Change Communications (BCC) partners meeting in Kinshasa along with members of the USAID Mission, the PNLP, C-Change, and PMI Extension Project. During the meeting (which took place September 16–20), the DRC team shared its experience using mHealth in support of malaria prevention and treatment, specifically via SMS campaigns and the establishment of Closed User Groups (CUGs).

At the end of these conferences, IHP had built upon its experiences and learned from the experiences of implementers in other countries. The project's principle takeaways were the following:

- The use of targeted SMS messages is advantageous and facilitates the establishment of a comprehensive and reliable database of community data. It also allows for a project to reach clearly identified targets and not waste resources. Additionally, this system allows for research or evaluations (qualitative or quantitative) to be conducted in order to evaluate the impact of this approach.
- SMS message technology can also help with online data collection with the use of basic feature phones to reinforce reporting systems, reduce data collection times (notably in remote health zones), and assure the monitoring of field activities for better decision

making. With the use of a server, this data can be shared broadly and accessed via the Internet.

- IHP should increase levels of coordination with, and involvement of, potential private sector partners and civil society actors to ensure sustainability of project's mHealth initiatives.
- The project will continue dialogue with the Ministry of Health and other stakeholders necessary to align BCC mHealth interventions with national priorities.
- IHP can facilitate information and lesson sharing among and between BCC mHealth implementers at the country level, potentially through the dissemination of white papers or articles about implementation and results. IHP plans to contribute by documenting and disseminating information about its own mHealth intervention design, implementation experience, and results. This information would initially be shared electronically, via partner websites, and potentially published at a later stage. The target audience for these articles would be mHealth practitioners in other countries, global public health specialists, and international development researchers and academics.

Challenges: Since beginning to implement mobile technology-based intervention, many challenges have been encountered, notably network connectivity in health zones not covered by mobile operators and the monitoring of calls made using CUG phones.

To deal with these challenges, IHP has put in place close supervision and has reinforced the phone communication capacity of community actors. Table 79, below, presents the advantages and disadvantages of IHP's mHealth approaches.

Table 79: Advantages and disadvantages of mHealth approaches used by IHP

Approach	Advantages	Disadvantages
SMS messages	• Make messages accessible to target audience • Send targeted messages rapidly in real time • Generate enthusiasm • Possibility of sending group messages with the help of Frontline software • Easy to evaluate	• Illiteracy • Difficult to respond to the message
CUG system	• Flexible • Hands-free listening with the possibility of a group discussion • Confidentiality • Freedom of expression • No-cost phone calls for community members • Possibility of personal interaction • Easy to evaluate	• Limited battery life • Insufficient number of phones • Need to teach users how to use phones (particularly in rural settings)

Perspectives for PY4: Taking into account the different advantages of using mobile technology and the lessons learned at the international conferences, IHP plans to:

- pilot a hotline to make its community interventions more efficient
- increase the number of target SMS messages disseminated

- increase the number of CUG phones available at the community level, and
- buy SIM cards for CUG phones purchased by community members (with their own funds).

Activity 4: Implement media campaigns through agreements with community radio, monitoring and evaluating the terms of these agreements, and the provision of solar radios to community listening clubs

During the fourth quarter, IHP finalized renewable contracts with 12 community radio stations in six of eight coordination offices (two radio stations per coordination office), specifically in Bukavu, Kamina, Kolwezi, Kole, Mwene Ditu, and Tshumbe. These radio stations will air health programming that will be developed by local and provincial health authorities and IHP based on community needs (for example, if an emergent epidemic has been detected, to commemorate an international day, etc.). Programming will promote key IHP health messages and use multiple formats (Q&A sessions with local health experts, community member testimony about personal experiences, and call-in shows).

In Luiza, local radio stations initially requested to be paid cash up front for radio health programs to be aired in the future. IHP has restarted negotiations to set up a contract for services for one quarter in which payment will be made once services have been provided. In Uvira, a formal contract was precluded by late payment of a bill for services already provided. One local radio station nonetheless produced and aired four sessions of a program called "Let's Talk Health" in which local health authorities and community members participated. IHP is currently talking to the radio stations to formalize contracts.

After each quarter of programming, these radio stations will submit activity reports providing an overview of programming, as well as detailing the different health messages they have promoted, the interviews they aired with community members, health care professionals, and community leaders. Based on these reports, IHP will make programming recommendations and decide whether the contracts should be adjusted or renewed, as well as report on the results of these radio-based BCC interventions.

A survey led by the Kinshasa School of Public Health and published in September 2013 was carried out in nine health zones supported by IHP. The survey demonstrated that, due to the radio station work, there were positive impacts on improvement of knowledge, attitudes and practices linked to diarrhea danger signs among children under 5 years of age.

IHP plans to monitor the impact of community media through listening groups (each community media outlet with which IHP works has its own organized listening groups). As budgetary constraints will not allow for weekly supervision, monitoring by project staff will be conducted each month in health zones nearest to the field offices and every three months in the farther health zones. Mobile phones will be used to facilitate communication between the listening group organizers.

The IHP team in Kinshasa has discussed several possibilities for measuring the impact of its work through community stations. One of the possibilities being considered is to conduct community opinion polls, which can be useful tools for measuring the impact of community-based interventions. These polls could be conducted through a variety of channels, such as:

- During live broadcasts, note takers can be assigned to accompany selected community members as they listen and respond verbally to the questions posed during the broadcast
- Listening group members can be interviewed in order to gather their options about programming or message content and the effectiveness of this method of health awareness-raising

Given that the majority of the rural population in IHP's target health zones is illiterate to some degree, verbal Q&A is a well-suited polling method. A community opinion poll can thus be conducted by a local journalist, and respondent answers will be used as the basis for impact analysis.

Activity 5: Selecting and training Champion Communities

IHP continues to select, train, and establish Champion Communities throughout the project's target health zones. The number of Champion Communities selected and pre-trained is displayed in Table 80, below. Highlights from this quarter include:

- Out of a quarterly target of two, one Champion Community was established during the fourth quarter in Luiza (Kalomba health zone).
- Over the course of PY3, IHP has established 16 Champion Communities out of an annual PMP target of 18 (89%). See Table 80 below for a breakdown by coordination office. IHP increased the number of Champion Communities established this year relative to PY2 (10 Champion Communities).
- The total number of Champion Communities established and supported by IHP is currently 26. Of these 26 Champion Communities, 2 have been certified and celebrated as Champion Communities (in Uvira and Bukavu), 15 are ready to be evaluated during the first half of PY4, 1 has been evaluated and is preparing for its certification festival (Mwene Ditu), and 8 are still working towards their objectives. All three of the Champion Community evaluations that have been completed to date were finalized earlier in the project year (during the first and third quarters), and the two Champion Community celebrations that were held also occurred prior to the fourth quarter.
- The PMP target for the life of the project is 40 Champion Communities. The remaining Champion Communities (14) will be established during PY4, and both the fourth and fifth project years will be focused on ensuring their long-term viability and sustainability beyond the life of IHP.

Table 80: Number of Champion Communities selected and trained (pre-certified)

Coordination office	Number of Champion Communities (PY3Q1)	Number of Champion Communities (PY3Q2)	Number of Champion Communities (PY3Q3)	Number of Champion Communities (PY3Q4)
Bukavu	0	0	0	0
Kamina	3	0	0	0
Kole	1	1	0	0
Kolwezi	0	2	0	0
Luiza	1	0	2	1
Mwene Ditu	0	0	0	0
Tshumbe	0	3	0	0
Uvira	1	1	0	0
Total	**6**	**7**	**2**	**1**

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

- All 26 established Champion Communities have developed and implemented an action plan. These action plans help communities map out how they will achieve the objectives they have set for themselves as part of the certification process. Appendix 5 provides an example

of an action plan from the Champion Community in Muangaza. Examples of the types of goals that IHP-supported Champion Communities have set for themselves include the following:

- Increase community-wide referrals to local health centers for treatment
- Increase the number of households that understand and apply water treatment practices
- Increase the number of pregnant women sleeping under LLINs every night to 100% of pregnant women in the community
- Increase the number of households with latrines
- Increase the number of women of reproductive age who are aware of modern methods of contraception
- Increase the number of women that exclusively breastfeed their children during the first six months.

The two certified Champion Communities (Uvira and Bukavu) and the one that has been evaluated and is preparing for its certification celebration (Mwene Ditu) have all already begun planning for their operations over the next six months, and their membership remains active and engaged in Champion Community activities. The Afya Kwa Wote Champion Community in Uvira is in the process of preparing to become a non-profit, and its organizational statute and procedure documents could be ready to be signed by the territorial administrator during the upcoming quarter. IHP has supported the Champion Community in this process by supervising the drafting and finalizing of the procedural documents, as well as advocating on behalf of the Champion Community with the territorial authorities in order to facilitate the signing of the documents.

Champion Communities operate at different levels depending on the different socio-cultural environments in which they function. For those that have been very successful, they are adequately informed and educated about their goals, i.e., to become autonomous organizations capable of entering into contracts and creating efficient partnerships with other organizations to ensure the sustainability of the Champion Community. To achieve NGO status is effectively the end goal for all of IHP's Champion Communities. This element of sustainability is what is different than the current configuration of the CODESAs.

The impetus to become an autonomous organization and foster grassroots development is an important source of motivation. It is important to recall that Champion Communities set their own goals to be achieved on a set schedule, they participate in the evaluations of their efforts, and their efforts are subject to external evaluation. Obtaining recognized NGO status would be an asset for them. In order to help them achieve this status, IHP works with health zones and Champion Community pilot committees to advocate for territorial authorities to provide the necessary legal recognition of Champion Communities as local NGOs. Reinforced by this legal status, the Champion Communities would be in a position to develop beneficial partnerships, including one with Vodacom to maintain the CUG systems.

Vodacom is willing to collaborate with Champion Communities directly and provide service for CUG systems at a price negotiated by IHP, allowing for the community to take complete ownership of the CUG system and prolonging its existence beyond the life of IHP. The only condition is that the Champion Communities be entities recognized by the state by achieving NGO status. The project is able to help the communities with this step. IHP has already identified examples of communities beginning to take ownership of their CUG systems. In the Dekesha health zone, the health zone management team and IHP encourage the Champion Community to continue to purchase their own cell phones (with community funds) to increase the number of available CUG phones. To date, they have purchased 27 mobile phones. The Dibaya health zone followed suit and purchased 6 mobile phones.

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. **Percentage of health zones with an annual operational plan based on National Development Plan ("PNDS")**

Along with other organizations, IHP provided technical and financial support for the development of 80 AOPs in 80 health zones in project year three. IHP's support includes technical and financial support for Advisory Board meetings during which AOPs were validated at the health zone level in 78 out of the 80 health zones supported by the project (see Table 81). IHP staff assisted the health zones in identifying priorities and consolidating workplans to align with PNDS as required by the national DRC policy. The project also provided support at the provincial level to organize the Advisory Board meetings. IHP's support was greatly appreciated by its partners at the provincial level.

IHP provided support to the central level by accompanying the four IHP-supported provinces in the planning process at the health zone, health district, and provincial levels. The Directorate of Studies and Planning (Directions d'etudes et de plannification, or DEP in the French acronym) helped to ensure that that the project's support would not interfere with the MOH's priorities and requirements. In PY4, IHP's plan to ensure that the 80 project-supported health zones will validate their AOPs before January 2014 includes:

- Support for the action plan evaluation process.
- Provide technical and financial support for the development of action plans for 2014.
- Provide technical and financial support for the organization of Advisory Board meetings at the health zone level.
- Build the capacity of health zone management teams to implement a monitoring and evaluation framework for the 2014 AOP

Table 81: Number of AOPs validated by coordination office

Provinces	Coordination office	Health zones	Plan drafts 2013	AOPs validated 2013	Achievement %
Sud Kivu	Bukavu	22	22	20	91
	Uvira	5	5	5	100
Kasaï Occidental	Luiza	11	11	11	100
Kasaï Oriental	Kole	4	4	4	100
	Tshumbe	10	10	10	100
	Mwene Ditu	11	11	11	100
Katanga	Kolwezi	8	8	8	100
	Kamina	9	9	9	100
Total		80	80	78	99

The Bukavu coordination office was unable to validate Mulungu and Lulingu's plans due to insecurity issues. Kamina and Kolwezi made strong effort, as compared to PY2, to ensure that all of the plans in their health zones were validated, with technical and financial support from IHP.

II. PROJECT MANAGEMENT

1. Success stories:

Overall, the number of success stories developed in PY3 (37) was more than double the 15 success stories developed in PY2 and the eight developed in PY1. In addition, many coordination offices sent success stories for multiple health domains in PY3, while in PY2 and PY1, the submitted success stories had less diversity in terms of health topics covered. This quarter the project areas of MNCH, i-CCM, nutrition, WASH, immunizations, LDP, and BCC were well represented. In PY4, IHP will focus on developing success stories in other domains, including HIV, TB, malaria, family planning, immunizations, and gender-based violence. IHP will continue to provide support to staff to build their capacity to develop success stories and to take high quality photos that illustrate the work USAID is doing in country.

2. Cost share:

During IHP's Year 3, cost share activity consisted of medical equipment donations and volunteer labor from Robert Metcalf, a WASH consultant, as well as donated labor from OSC. In the second quarter of Year 3, Project Cure shipped two containers of medical equipment. The containers will be distributed among four hospitals in the health zones of Dibindi, Kalenda, Mwene Ditu, and Kitenge. Another pair of containers of medical equipment was shipped in PY3Q4, to be distributed among health facilities in Dibaya, Luiza, and Kayamba. To date, the project has booked $2,343,925.60 of cost share value.

3. Pharmaceutical procurement

Status of the PY2 pharmaceutical order:

There are currently four pending deliveries from the PY2 pharmaceutical order placed with Medical Export Group (MEG). Two of the products are pending customs clearance, while two shipments have been delayed due to earlier setbacks in the supply chain process with the manufacturer. The shipment is now on track and will be dispatched shortly. All shipments continue to be closely monitored by MEG, our team in DRC, and the home office.

Status of the PY3 pharmaceutical order:

After harmonizing the Child Survival Call to Action (CSC2A) intervention needs with USAID and determining our PY3 needs, IHP issued Task Order to IDA Foundation on August 16, 2013. Delivery of the pharmaceuticals to IDA's warehouses in Amsterdam and Singapore will take place in early to late February 2014. Once the products arrive at the warehouses they will be consolidated per destination and shipped out with our global shipping and logistics experts, Kuehne & Nagel. Deliveries are expected to arrive in DRC March-June 2014, depending on the location. There is no indication that the current procurement will be delayed.

Status of the non-pharmaceutical procurements:

This year's non-pharmaceutical procurements saw a significant amount of movement on items that were previously pending exoneration. All 12 motor vehicles have cleared customs and have been delivered to the project locations. All 112 motorcycles have been delivered from Johannesburg, South Africa, to DRC, and the handover to the Ministry of Heath took place on September 30, 2013. Ten solar refrigerators cleared customs and were delivered. A new procurement of 10 additional refrigerators has been purchased and they are currently in customs and will clear shortly. The home

office is also currently working on a large procurement of medical equipment, half of which is slotted for delivery in early December and half of which should arrive late January.

As seen below in Table 82, ASRAMES has delivered 65% of the PY3 order. IHP had anticipated complete delivery by February 28, 2013. The most recent deliveries to APAMESK, CADIMEK, and CADMEKO occurred in July 2013, which raised the delivery rate from 63% to 65%, eight months after the order was placed.

Table 82: Status of IHP Year 3 ASRAMES Pharmaceutical Order by October 2013

Province	Warehouse/ CDR	Cost of the order (in USD)	Delivery value	Delivery (in %)	Remaining balance (in USD)	Percentage (%) of balance
Sud Kivu	APAMESK	$446,363.18	$350,636.35	79	$95,726.83	21
Katanga	CEDIMEK	$343m309.48	$178,606.13	52	$164,703.35	48
	KOLWEZI	$207,075.67	$130,131.45	63	$76,944.22	37
Kasaï Occidental	CADIMEK	$302,484.32	$196,444.16	65	$106,040.16	35
Kasaï Oriental	CADMEKO	$235,525.12	$164,066.51	70	$71,458.61	30
	FODESA	$230,865.98	$132,230.43	57	$98,635.55	43
TOTAL order/delivery		**$1,765,623.74**	**$1,152,115.03**	**65**	**$613,508.71**	**35**

III. FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

1. **Family planning**

During the first quarter of PY3, several coordinations, including Luiza, Mwene Ditu, Kamina, and Tshumbe, held trainings on the Tiahrt amendment. These trainings reached 80 community health workers from 40 community care sites, as well as 439 health care providers from 29 health zones supported by IHP. Moreover, IHP aims to integrate family planning services into all project-supported PMTCT sites in PY4, as it ensures that sites are regularly supplied with contraceptives.

From January to March 2013, family planning services were integrated in 132 community care sites in the health zones of Kanda Kanda, Songa, Kanzenze, Uvira, Lualaba, Mutshatsha, Tshikaji, Idjwi, Mwenga, and Mubumbano. As part of this integration, 264 community care workers (two for each site) were trained in modern contraceptive methods, with a special focus on the Tiahrt amendment.

Adherence to the Tiahrt amendment is a requirement for the project. During PY3Q3, the National Reproductive Health Program (NRHP), health district staff, and local project team in Uvira led an investigation of the GRH in Uvira and the Kiliba health center in Ruzizi, as both facilities were suspected of violating the established guidelines for family planning services provision. The investigation revealed that two health workers charged patients for the insertion of IUDs and other contraceptive implants. It was also found that patients did not receive adequate counseling before choosing their method of contraception.

In response to these findings, NRHP staff held a refresher training on the consequences of not following the Tiahrt amendment for all staff at the GRH in Uvira and the Kiliba health center. Additionally, the head doctor of the Uvira health zone published a letter reminding the Uvira health

care workers of the importance of following both national policy and the Tiahrt amendment. A warning was issued to health care center workers against buying contraceptives with personal funds and then billing patients. They were reminded to use the supply provided by the project, which covers the needs of all of the health facilities in the Uvira health district.

The project, in collaboration with the provincial NRHP and health district, continues to monitor the situation in order to ensure that all policies are respected.

2. HIV: PEPFAR strategic pivot

Challenges linked to the implementation of the new PEPFAR strategic pivot

During the annual meeting of PEPFAR stakeholders held in Washington, DC, in May 2013, PEPFAR redefined the DRC strategy, making a new distinction between priority (Katanga, the Orientale Province, and the town of Kinshasa) and non-priority provinces (Sud Kivu, Kasaï Occidental and Kasaï Oriental). Priority was given to provinces where the rate of HIV infection is the highest.

1. Priority provinces

Activities in the three provinces will continue, and efforts should be focused on improving the quality of care and increasing the number of sites that offer PMTCT services. Services should also be expanded by ensuring the diagnosis and treatment of seropositive patients. The project's HIV activities also concern preventing opportunistic infections among people living with HIV, as well as HIV super infection, in which a person living with HIV is infected with another, different HIV strain. Additionally, health care workers should be trained appropriately in the areas of HIV and provider-initiated HIV testing and counseling.

2. Non-priority provinces

An analysis of sites and health centers was recommended, as well as an evaluation of the current total population and total number of seropositive people, so that the Office of the U.S. Global AIDS Coordinator (OGAC) could identify the PMTCT priority provinces.

USAID instructed IHP to stop all activities, including the testing of new cases and the provision of supplies, but to continue supporting patients receiving preventive treatment and focus on transferring patients to sites supported by the Global Fund. A memorandum of understanding between USAID and the Global Fund will outline guidelines for providing services to people on ARV treatments.

USAID has directed IHP to focus on improving health care and support activities in the province of Katanga, as well as to support and promote community-based approaches in order to increase staff capacity and client adherence to treatment.

IV. ENVIRONMENTAL MONITORING AND MITIGATION PLAN

Hospital hygiene and management of biomedical waste remains an important issue in improving the quality of care and overall hospital management. IHP has taken efforts to ensure this improvement by providing consistent briefings to staff on waste regulations and developing the Environmental Mitigation and Monitoring Plan (EMMP), including the waste management checklist and the environmental impact evaluation.

During PY3, IHP coordination office indicated an overall improvement in health facilities supported by the project. Health facilities have taken great efforts to improve their hygiene conditions,

including the availability of incinerators and placenta pits. IHP has assisted the health facilities in executing their respective plans to improve facility hygiene, protection of the environment, and reducing the impact on the environment. Table 83 provides EMMP results from PY3 by coordination office.

Table 83: EMMP-related results by coordination office in PY3

	Luiza	Mwene Ditu	Kole	Tshumbe	Kamina	Kolwezi	Bukavu	Uvira	PY3
VIP latrines	5	1	4	5	0	4	15	26	60
Hand washing stations	22	0	210	5	0	0	0	0	237
Incinerators	10	3	4	6	0	5	10	8	46
Placenta pits	11	0	3	4	0	3	7	13	41
Indoor waste disposal	480	12	44	100	15,865	73,000	30	0	89,531
Outdoor waste disposal	0	0	13	0	0	0	30	0	43
Hospital hygiene training	1	0	0	0	0	0	8	1	10

Biomedical waste management experienced major constraints due to limited or no means to implement hygiene plans and plans to reduce the environmental impact, as well as failing to apply the correct procedures for managing waste.

IHP has briefed care providers and hospital management staff on the correct methods of storing and disposing of biomedical waste. Biomedical waste is collected each day, and is generally disposed of properly. Some health facilities covered waste pits to prevent access to toxic and dangerous waste and to prevent access to contaminated waste by flies.

The most visible improvements in the FOSACOF structures are due to regular evaluations, and including waste management in recovery plans. In the Tshamala GRH in Mwene Ditu, the hospital committee was trained on hospital hygiene and follow-up trainings for care providers made a difference in reducing the rate of iatrogenic infection. Also important to note is that the majority of FOSAs faced difficulties in obtaining the necessary kits or equipment to be able to improve performance in terms of managing waste.

V. CHALLENGES ENCOUNTERED

- **Data quality**: Data quality at the health zone level remains a challenge, as does data interpretation and analysis, which is often done hastily and without attention to detail to the different health intervention areas. The project will continue to provide data collection tools in all health facilities, and will continue to provide technical support during data monitoring and evaluation meetings.
- **Achieving target of 70% of children under 5 with diarrhea receiving care**: No coordination offices have achieved the target of 70% of children under 5 with diarrhea receiving care as

set by the MOH for the acceleration of the reduction of maternal and child mortality, despite the improvements in community care sites, mobilization of the community, and awareness-raising among community health workers regarding diarrhea. The analysis IHP has carried out at the community level revealed that the population does not believe that diarrhea constitutes a significant public health concern. The population tends to treat cases of diarrhea with local and traditional products, or with oral rehydration solution made at home with salt and sugar. The population tends not to bring children to community care sites or to health centers except in cases of severe diarrhea with danger signs. In general, children always receive treatment for diarrhea, even if they are treated at home (with oral rehydration solution), but cases treated at home are not reported in community care sites and in health centers. Various local NGOs and community health workers should continue efforts to raise awareness to encourage care givers to immediately bring their children to community care sites or health centers at the first signs of diarrhea. IHP plans to integrate additional community care sites, and, through awareness-raising activities, to encourage parents to seek care in community care sites or health facilities for children under 5 with diarrhea.

- **Women delivering in health facilities**: Encouraging women to give birth in facilities rather than at home remains a major challenge for the rural health zones. Often, women do not begin attending ANC visits until the last trimester of their pregnancy. In the Bukavu and Uvira areas, this delay in seeking ANC is linked to cultural norms. In order to encourage more women to attend ANC visits earlier in their pregnancies, the project plans to work more closely with politico-administrative authorities, community leaders, and community health workers in all health areas supported by the project to raise awareness among women and their families to follow ANC visit cycles and to give birth in health centers. However, raising awareness is not a sufficient solution to the problem. Necessary measures to encourage women to give birth in health facilities include making maternity wards and clinics more inviting and attractive to mothers, improving the overall quality of care, and constructing waiting rooms and houses for expectant mothers and their families.
- **Provision of vitamin A**: The project does not routinely provide a sufficient quantity of vitamin A and folic acid to pregnant women, and uses leftover commodities from vitamin A and folic acid campaigns. In order to ensure regular and consistent access, IHP is in the process of acquiring vitamin A through the next order of pharmaceutical commodities.
- **ACTs and RDTs**: Not all health facilities carefully manage their average monthly use of ACTs and RDTs, and as a result, they do not properly quantify their needs. The inadequate quantification of needs constitutes a major challenge as the project is unable to evaluate if the health zones' needs were covered.
- **SP stock out**: The project reported a stock out of SP for multiple months in project year three, as the last delivery of SP occurred in June 2012. Some supplies of SP were distributed sporadically, but the majority of health facilities used their own means to purchase SP or borrowed SP from other organizations, such as Malteser, PIN, Médecins du monde.

Since 2011, IHP has integrated the use of RDTs into community care sites; however, the actual use of the tests remains low. Insecurity in the Malemba Nkulu territory has negatively impacted the rate of curative health services in the health facilities in the health zones of Malemba Nkulu, Mulongo, Mukanga, and Luamba. The security situation in Sud Kivu has become a challenge in the health zones of Kalehe, Miti Muresha, and Minova.

IHP does work with other USAID mechanisms and partners on commodity-related changes. For example, regarding SP, ACT, and RDT, IHP participated with SIAPS in a PMI-organized training-of-trainers in Kinshasa in October 2013 on the correct quantification of commodity needs. PMI also organized on-the-job trainings on quantification and the control of average monthly consumption

during supervisory visits that were carried out by SIAPS in the health zones. Vitamin A and folic acid were added to the list of products that the project ordered from suppliers. The project will continue to support the management of the transport of medicines from the health zones to the health centers, and payment for monitoring and production of monthly reports reporting medicine management. To ensure regular supplies of SP, it is necessary to improve communication with JSI/DELIVER in order to share, in real time, the challenges and problems encountered, as well as to jointly search for appropriate solutions (JSI/DELIVER already has an office in Kinshasa).

VI. PLANNED ACTIVITIES FOR NEXT QUARTER

Due to budgetary restrictions, the project has prioritized the following activities:

- ✓ Manage and distribute pharmaceutical commodities to the health zones
- ✓ Continue subgrants to the health zones, health districts, and health provinces, including RBF grants and contracts.
- ✓ Maintain the functionality of the IHP Kinshasa office.
- ✓ Ensure the distribution and use of rehabilitation materials for WASH activities in Kamina

VII. LIST OF APPENDICES

Appendix 1: DRC-IHP Performance Monitoring Plan
Appendix 2: List of community care sites with and without family planning services
Appendix 3: PY3Q4 Distribution Plan for family planning commodities*
Appendix 4: NGO inventory list
Appendix 5: Sample Champion Community action plan
Appendix6: DRC-IHP International Travel/STTA Plan*
Appendix 7: DRC-IHP: Organization Chart
Appendix 8: DRC-IHP SF425 April to June 2013
Appendix 9: DRC-IHP Accruals Report April to June 2013

*Appendices 3 and 6 are attached separately as Excel files.

VIII. SUCCESS STORIES

The DRC-IHP Success Stories appear on the following page

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SUCCESS STORY

Encouraging Mothers to Practice Exclusive Breastfeeding in Kole

Poor nutritional practices meant that babies were suffering and dying from severe malnutrition in Kole.

Photo: Management Sciences for Health

Thérèse Ashingo with Ataadji, her son, after several months of exclusive breastfeeding.

"My child was going to die, but since I have been practicing exclusive breastfeeding, Ataadji gained weight and is healthy..."

- Thérèse Ashingo

In the Kole health zone in Kasaï Oriental province, 23 children were diagnosed with severe malnutrition between February and April 2013, with two infants under six months old dying from the condition. Poor nutritional practices are behind these grim statistics, and an analysis by the local health team showed that of 272 mothers of infants under six months visited in April, only 12 were exclusively breastfeeding.

Thérèse Ashingo, who lives in the village of Tonkete in the Kole health zone, recently became a mother for the first time. After the birth of her son, Ataadji Shomba, she followed the village custom, and did not practice exclusive breastfeeding. By the time he was three months old, her son was visibly underweight and failing to thrive.

Then Thérèse was visited by a woman who invited her to join a young mothers' nutritional support group in her village. The women there discussed the benefits of exclusive breastfeeding with Thérèse. This group was formed in 2012, and educated through the assistance of a community health worker trained by the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP). Members of the group conduct home visits four times per year to check on new mothers. Thérèse pledged to begin practicing exclusive breastfeeding, and Ataadji began gaining weight, growing from just under 5 pounds at three months to more than 15 pounds at five months.

"My child was going to die, but since I have been practicing exclusive breastfeeding, Ataadji gained weight and is healthy," Thérèse said. "I thank the support group, and I plan to breastfeed him until he is two years old."

Encouraging exclusive breastfeeding is one example of how DRC-IHP 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 by 2015.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to promote essential nutrition activities in 80 health zones in four provinces.

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SUCCESS STORY

A Return to Dignity after Fistula Repair in Dikungu

Fifty women suffering with fistula came to the Dikungu General Reference Hospital in despair but left with hope.

Photo: Management Sciences for Health

Enongo Kimpanga has returned home to her husband and children after her fistula was successfully repaired.

"My dignity as a woman has been restored. I can go back to work to support my children."

- Enongo Kimpanga, treated through a fistula repair campaign supported by DRC-IHP

Women who suffer complications while giving birth in resource-poor countries may be left with a fistula, a tear between the birth canal and the bladder or lower intestine, resulting in chronic leaking of urine or feces. At Dikungu General Reference Hospital (GRH) in Kasaï Oriental province, 50 women suffering with fistula arrived in despair but left with hope after a month-long fistula treatment campaign in August 2013. Enongo Kimpanga, aged 27 and mother of four, was one of them.

"I developed a fistula six years ago, during childbirth with my youngest daughter," Enongo said. "Since the ordeal began, it has created a great distance between me and my community. People avoided me and whenever I saw two or more people talking, I always thought they were talking about me. I had to go several times a day to wash and change my clothes, and my husband finally kicked me out. I found myself alone."

In August, Enongo was reached by a trained community health worker, who told her that treatment was available at the Dikungu GRH. She was sure at first that she could not be helped because she had no money, and because Dikungu was 67 kilometers from her village—a vast distance which would be an expensive journey. The community health worker advised her that the Democratic Republic of Congo-Integrated Health Project (DRC-IHP) was supporting a fistula repair campaign that included roundtrip transportation to and free surgical treatment at the GRH as well as post-surgical support.

''I received free transportation and care, and my dignity as a woman has been restored. I can go back to work to support my children," Enongo said. She has also been reunited with her husband, who learned of his wife's surgery and journeyed to the hospital to see her.

''I apologized to my wife because I acted out of ignorance," said Daniel Kimpanga, Enongo's husband. "I thought her illness was caused by a curse. I now understand the cause and I will do my part to ensure that she can fully heal." DRC-IHP has provided the couple with family planning counseling, explaining the need for Enongo to avoid pregnancy and childbirth for at least two years post-surgery.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is advancing maternal health efforts in 80 health zones in four provinces.

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SUCCESS STORY

Recovering Smiles in Kolwezi after Fistula Repair Campaign

Forty-three women suffering with fistula came to the Mwangeji General Hospital in shame but left with a new sense of joy.

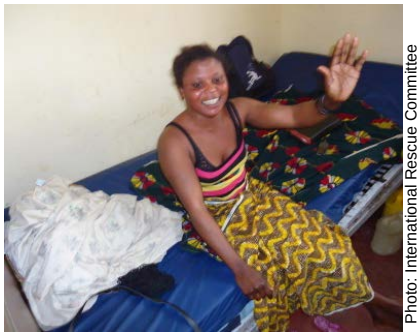

Photo: International Rescue Committee

Christine Kabaya smiling after her fistula repair.

"I am delighted to rediscover my smile and joy... My wish is that IHP continues to save many women who suffer terribly from this issue."

- Christine Kabaya, treated through a fistula repair campaign supported by DRC-IHP

In the Democratic Republic of the Congo, obstetric fistulas, or tears between the birth canal and bladder or lower intestine, are caused primarily by obstructed and prolonged labor. Fistulas can result in chronic incontinence, and women living with fistulas are often ostracized by their communities, families, and husbands. Due to stigma, shame, and a lack of accessible treatment options, fistula cases generally go underreported and untreated.

To help restore the health and well-being of women living with fistulas, the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) organized a mass campaign on fistula repair in September at Mwangeji General Hospital in the Manika health zone, Kolwezi district. As part of the campaign efforts, community health workers were sent out to canvass the surrounding communities, some of them many miles from the hospital, to locate women who were suffering from the condition. In many cases, the women were unaware that treatment existed or were afraid that due to the cost, they could not be helped. The community health workers assured the women that they could be helped and at no cost to themselves. As a result of the campaign, 43 women were referred to the hospital for surgical fistula repair in Kolwezi district, with costs for the program covered by DRC-IHP.

On leaving the hospital, most the women voiced their satisfaction, including Madame Christine Kabaya of Kayembe village in the Mutshatsha health zone (her name has been changed for privacy reasons). She said, "I am delighted to rediscover my smile and joy... I have new hope for my marriage as my husband returned to me after this intervention. Thanks to IHP, I was able to receive this service—including being transported from my village to the hospital, fed, operated on, and housed—for free. In addition, a small amount of money was provided to me to start a commercial activity. There are still many fistula cases in our villages. My wish is that IHP continues to save many women who suffer terribly from this issue."

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SUCCESS STORY

Cold Chain Guarantees Children's Vaccines in Sankuru

Difficulties in storing vaccines properly put children at greater risk of diseases such as diphtheria, tetanus, and whooping cough.

Photo: Management Sciences for Health

Refrigerators like this one are key to ensuring viable supplies of vaccines.

"Before DRC-IHP began subsidizing our vaccine program, we were only able to turn on our refrigerators two days before the campaign..."

- District Medical Officer Dr. John Martin Malaba

In the Sankuru health district in Kasaï Oriental province, nearly 65,000 children are vaccinated each year. One immunization, the pentavalent vaccine, is known as the "five-in-one" vaccine because it protects children against five illnesses: diphtheria, tetanus, whooping cough, hepatitis B, and haemophilus influenza type B. This vaccine must be kept cold to ensure its efficacy. In prior years, the "cold chain" transport and storage of this vaccine was challenging in the Democratic Republic of Congo (DRC), where temperatures are high and reliable sources of electricity are few, especially in rural areas like Sankuru. Children who are not unimmunized are at great risk for all five illnesses and even death.

In 2012, the USAID-funded DRC-Integrated Health Project (DRC-IHP) stepped in to remedy the cold chain issue and support the Congolese Ministry of Health in its "expanded program on immunization" (EPI) which aims to deliver life-saving vaccines to all children. Every three months, DRC-IHP provides 13,530 liters of oil that will power 98 refrigerators and two vaccine storage sites. The project also provides spare parts for refrigerator maintenance, including the wicks, glassware, and burners that are indispensable to maintain the cold chain. These supplies ensure that the refrigerators can run constantly and maintain the temperature required to guarantee that the vaccines are handled according to international health standards.

''Before DRC-IHP began subsidizing our vaccine program, we were only able to turn on our refrigerators two days before the campaign and we had to turn them off immediately after the two-day campaign, because we didn't have enough gas," said Dr. John Martin Malaba, the District Medical Officer in Sankuru. "This affected our coverage rate—the number of children who could receive the vaccine—so we were only reaching 80 to 85 percent of the children. We were also not always sure that the quality of the vaccines was maintained. Since we have been receiving support from DRC-IHP, our coverage rate for the pentavalent vaccine is between 90 and 96 percent."

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

Immunizing Children in Challenging Circumstances in Haut Plateaux

Ensuring full vaccination coverage in the DRC is difficult in some areas, particularly the volatile Sud Kivu province.

Photo: International Rescue Committee

A nurse in Kitoga health center immunizes a child.

Due to the EPI support strategy in Haut Plateaux, the vaccine availability rate increased from 75% in 2010 to 100% in 2013.

The Expanded Program of Immunization (EPI) was adopted by the World Health Organization (WHO) to improve child survival by reducing morbidity and mortality due to preventable diseases through immunization. The Congolese Ministry of Health defines a child as being fully immunized when the child has received vaccines against tuberculosis, polio, diphtheria, tetanus, pertussis, and measles before reaching the age of twelve months.

The 2007 Demographic and Health Survey in the Democratic Republic of Congo (DRC) found that nationally, only 31% of children 12-23 months of age were fully immunized, and 18% had not received any vaccines. Full immunization coverage varies across provinces. In Sud Kivu, the coverage rate was 67%. The USAID-funded DRC-Integrated Health Project (DRC-IHP), through its Uvira field office, has been supporting EPI implementation in five health zones in Sud Kivu, including the Haut Plateaux of Uvira (HPU), since 2011.

The HPU health zone covers 22 health areas with a total of 108,613 inhabitants. While in other circumstances the zone's mountains might have been the biggest obstacle health workers encountered, today the HPU is also home to multiple armed groups, making the security context volatile. Health workers are therefore faced with multiple challenges: difficult access to and transportation of medical supplies, insufficient supervision by the health zone management team of health centers and immunization sites, and difficulty in maintaining support for the cold chain (to ensure vaccine efficacy), as well as the presence of armed groups.

To overcome these challenges and ensure full immunization coverage in HPU, IHP developed an EPI support strategy in July 2011. The strategy includes ongoing provision of fuel as well as the transport of vaccines and supplies from Bukavu, the provincial capital, to the HPU health zone, resulting in an increase of vaccine availability rate from 75% in 2010 to 100% in 2013. It also includes maintaining the cold chain, improving management of the immunization database, and motivating healthcare workers and community members to better monitor immunization activities.

Through the implementation of this strategy, health care providers are now able to vaccinate nearly all children from 0 to 11 months in the HPU, protecting them from preventable diseases.

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SUCCESS STORY

Improving Immunization Coverage through Leadership Development

Easily preventable, maternal and neonatal tetanus remains a problem in the DRC, despite an effective vaccine.

Photo: Management Sciences for Health

A pregnant women receives her vaccination.

"This LDP helped us."

- Nurse Supervisor Dieudonné Fumbu in Rusizi, explaining how the team increased coverage rates for the TT2+ vaccine.

Although easily preventable, maternal and neonatal tetanus remains a problem in the Democratic Republic of Congo (DRC), putting mothers and babies at risk of death. A highly effective tetanus vaccine exists—known as the TT2+ vaccine—but few women receive it.

This was the case in the Rusizi health zone in Uvira, Sud Kivu province. There were 5,441 pregnant women in 2012, but the coverage of the TT2+ vaccine was low and had been for two years. In November 2012, Rusizi's Chief Medical Officer, Dr. Delphin Byamungu, participated in a Leadership Development Program (LDP) offered under the USAID-funded DRC-Integrated Health Project (DRC-IHP). The LDP teaches health managers and their teams to identify service delivery challenges, increase their capacity to mobilize local resources, and improve health services. Dr. Byamungu and his colleagues decided to focus on increasing TT2+ coverage from its then-rate of 51% to 70% coverage by the end of June 2013.

"This LDP helped us," said Nurse Supervisor Dieudonné Fumbu, citing the use of two particular tools—the fishbone diagram and the 'five whys technique'—as instrumental in helping the team diagnose the root causes of the problem. After analyzing the situation, the team realized that among the root causes for the low vaccine rate were community ignorance of the importance of tetanus vaccination, little support for immunizations from the husbands of pregnant women, and low levels of involvement by local leaders in health activities.

The LDP team enlisted the local women's associations as a key stakeholder in an awareness campaign, with messages focusing on the importance of the TT2+ vaccine as well as entreating husbands to encourage their wives to be immunized. In addition, the health team also refreshed health care providers on the vaccine's importance, and developed the use of the timetable to track the immunizations, which must be given in a series of three different doses. The campaign had the intended effect, said Dr. Byamungu, reporting that TT2+coverage rose to 68.7% by the end of June, 2013.

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

Improving Treatment for Pregnant Women Infected with HIV in Manika

Without CD4 immunological assessments, pregnant women in Manika could not receive proper care to prevent HIV transmission to their unborn babies.

Photo: Management Sciences for Health

A lab technician uses the new FACSCount equipment at the GRH Mwangeji.

"This gift of laboratory equipment has contributed to improving the quality of decision-making regarding prophylaxis and/or treatment of HIV infected patients."

- Dr. Thierry Mwande, Medical Director, GRH Mwangeji

In the Manika health zone in Katanga province of the Democratic Republic of Congo, the current HIV infection rate for pregnant women is 3.1% of 894 pregnant women tested. Until a few months ago, the General Reference Hospital of Mwangeji, serving these women, was woefully equipped to address their health needs.

Among the main problems in the GRH Mwangeji was an inability to monitor CD4 counts; this blood cell count indicates a patients' ability to fight infections. This changed in September 2013, with the intervention of the DRC-Integrated Health Project (DRC-IHP), funded by USAID and PEPFAR. Through a comprehensive prevention of mother-to-child transmission (PMTCT) approach—encompassing expectant women, their male partners and children—DRC-IHP is contributing to the Congolese Ministry of Public Health's efforts to reduce HIV infections and improve the treatment for HIV and AIDS in Katanga.

First, DRC-IHP trained 22 laboratory technicians in how to use two low-cost tools, the PIMA diagnostic test and monitoring kit and the FACSCount system, which help guide doctors in making treatment decisions for HIV-infected persons. Upon completion of the training DRC-IHP provided both PIMA Kits and FACSCount systems to the GRH Mwangeji and supplied the facility with anti-retroviral treatments. These donations had an immediate effect on the delivery of prevention services at the hospital, said Dr. Thierry Mwande, the facility's medical director.

"GRH Mwangeji was missing many materials in several different departments," Dr. Mwande said. "This gift of laboratory equipment has contributed to improving the quality of decision making regarding prophylaxis and / or treatment of HIV infected patients. It has helped us reduce the number of patients lost to follow-up—those who were sent elsewhere for this test due to our lack of equipment—and thus we have increased the cohort of patients on prophylaxis and treatment. As a result, we have been able to put 39 patients on anti-retrovirals in September 2013—and monitor their CD4 counts correctly. The month prior to that we were not able to give any patients ARVs."

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

Increasing TB Detection via Community Outreach and Mobilization

A week of intensive outreach and activities commemorating World Tuberculosis Day leads to major gains in TB detection and treatment.

Photo: Overseas Strategic Consulting

A community outreach event in the Luputa health zone.

"We have decided to no longer ignore [an untreated] cold for more than two weeks. We will go to the health center as soon as possible to see a nurse."

-Luputa resident

The Democratic Republic of Congo (DRC) ranks eleventh among the world's 22 high-burden tuberculosis countries. TB is a leading cause of death in the DRC, and represents a major health problem in the communities where the USAID-funded Integrated Health Project (DRC-IHP) operates.

Low levels of TB detection are one of the biggest obstacles in preventing treatment and reducing the number of people affected by this deadly illness. In Mwene Ditu, DRC-IHP staff noticed low levels of TB detection in the Luputa health zone. In March 2013, project staff commemorated World Tuberculosis Day by ramping up outreach and awareness-raising in Luputa and organizing a week of community mobilization activities and events. This concerted effort led to notable increases in tuberculosis detection and treatment rates over the following month.

Throughout the week, DRC-IHP staff organized a variety of outreach activities with community members and local health workers. Some of the activities were geared towards disseminating information and increasing awareness about TB broadly throughout the community, including placing four banners about TB in the center of Luputa and presenting a community theater piece about TB. Other activities were intended to mobilize specific members of the community, such as a briefing for 60 community health workers, religious leaders, and members of community-based organizations (CBOs). Community health workers and CBO members conducted nearly 500 home visits to households with individuals being treated for TB or believed to have undiagnosed TB.

As a result of these activities, the monthly TB detection rate increased from 38% in February to 90% in April. The number of identified and treated new Smear Positive Pulmonary Tuberculosis (PMP+) cases increased from 13 in February to 31 in April, and the monthly TB case notification rate more than doubled. DRC-IHP plans to continue its community level outreach and behavior change interventions in order to promote effective management and treatment of TB.

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SUCCESS STORY

Increasing Access to Health Services in Kaponda

Frequent stock-outs of medicines were the norm in Kaponda before DRC-IHP worked to revitalize the community care site.

Photo: Management Sciences for Health

Health worker Melanie Kayinda is providing better services to her patients with the help of this bike donated by DRC-IHP.

"Since we got the bikes, it has made it easier to transport patients to the health center and also to transport medicines."

- Community Health Worker Melanie Kayinda

The small community care site in Kaponda, in Kanzenze health zone, was established in 2009 and serves four villages of approximately 1,200 people, including 240 children under age five. Health workers in Kaponda often face shortages of medicines and supplies, since restocking them regularly has been difficult due to the distance of the larger health center in Musokanda—six hours by foot. Due to these frequent stock outs, community members had lost confidence in the care site's ability to address their basic health needs.

The USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) is working with the Congolese Ministry of Public Health to revitalize community care sites, which are designed to ensure the treatment of young children in remote areas where long travel times to health facilities are severely impacting child health. As malaria is a common health problem in Kaponda, DRC-IHP offered health workers there a refresher training on malaria testing and treatment, and donated rapid diagnostic tests for malaria. In addition, DRC-IHP began providing essential medicines to the site and donated bicycles to give health workers more mobility to better respond to client needs.

Within three months, there was a marked increase in residents accessing services at the community care site. Patient visits rose from an average of 10 per month to 30 per month, once community residents saw that medicines were regularly available to treat their illnesses. In May 2013, three children arrived at the care site with high fevers, and were rapidly diagnosed with malaria by the newly-trained health workers. These children were quickly transported by bike to the health center in Musokanda for treatment.

"In the past, we were receiving only about 10 patient visits a month, and community residents often preferred traditional medicine to our services. Since we got the bikes, it has made it easier to transport patients to the health center and also to transport medicines. We are providing much better service to the community and are grateful for the support of DRC-IHP," said community health worker Melanie Kayinda.

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SUCCESS STORY

Developing a Champion Community in Walungu, Sud Kivu Province

After embarking on a Champion Communities program in 2012, Walungu was certified as a Champion Community this year.

Photo: International Rescue Committee

Nadia Kabale shows a certificate she received during her participation in the Champion Community process.

"We are delighted to be the first champion community."

- Nadia Kabale

The Champion Communities Approach is an initiative which supports communities to achieve their social and economic development objectives. This method engages communities to come together to take specific actions that will lead to concrete benefits, such as building latrines to improve sanitation. The USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) is using the approach as part of its national communication strategy for behavior change in family ealth.

In Walungu health zone in Sud Kivu province, chosen as a pilot site, residents set three specific objectives to improve community health: increase tuberculosis detection; reduce malaria cases by 30%; and sensitize 1,000 households in building latrines. DRC-IHP conducted advocacy campaigns at different levels of the community about these health challenges, and organized a series of trainings for 25 members of the Champion Community Steering Committee in areas related to achieving these goals.

Fifty-four year old Nadia Kabale (whose name has been changed here for privacy reasons) is a local resident who took part in the Champion Community campaign. She noted that, "With the support of IHP at each step of the process, we are now able to address some of the health issues in our area such as building latrines with local materials, sleeping under a bed net every night, and consulting a health center in case of persistent cough."

In the first phase of implementation, from July to December 2012, TB detection services increased, with 32 clients seeking care for a chronic cough during that period, versus 0 clients seeking care in the prior six months. Malaria cases recorded in the health zone decreased by 33.8% (falling from 1,721 cases recorded between January and June 2012, to 1,139 between July and December 2012); and 3,056 latrines were built. These results were possible due to the community's strong commitment to improve its health situation. The pilot process concluded in Walungu earlier this year with the certification of the first Champion Community in the Bukavu region.

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SUCCESS STORY

Meeting Family Planning Needs in the Democratic Republic of Congo

Women who have too many poorly spaced pregnancies are at a greater risk of serious health outcomes—including death.

Photo: Management Sciences for Health

Anifa at home with three of her children.

"Now that we have access to family planning, my husband and I can determine how many children we want to have..."

- Anifa, seen here with three of her children

At 34 years old, Anifa has already given birth 14 times. Women like Anifa, with too many poorly spaced pregnancies, are at a dramatically higher risk of serious health outcomes—including death. While Anifa lived, six of her children died before age five.

Unfortunately, situations like this are common in Sud Kivu province in the Democratic Republic of Congo (DRC), where Anifa lives. Information about contraceptive methods is hard to come by in her rural community of Minova, and large families are the cultural norm. In 2012, the number of people choosing a family planning method was just 83 people.

In April 2012, family planning education arrived in Minova through the USAID-Funded DRC-Integrated Health Project (DRC-IHP). DRC-IHP trained 30 health care providers, including members of the health management team, on family planning methods. Family planning services in Minova are supported by community-based distribution (CBD) agents, and as part of the training, the CBD agents were trained on the wide range of methods available, including long-term injectable contraceptives such as Depo-Provera. Women in rural areas are increasingly choosing Depo-Provera because it is effective, can be used confidentially, and requires less frequent re-supply.

For Anifa, the visit from a CBD agent was life-changing. In consultation with her husband, she chose to use Depo-Provera and said, "Now that we have access to family planning, my husband and I can determine how many children we want to have. I am healthy, and my youngest child, who is now two, is healthy, too."

Since April 2012, the number of people choosing a family planning method in Anifa's community has grown from 83 to 866. Anifa now regularly accompanies the CBD agent on his rounds, telling other women how counseling in family planning has helped change her life.

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Appendix 1: DRC IHP Performance Monitoring Plan PY3

	Indicator	Definition	PY3Q1	PY3Q2	PY3Q3	PY3Q4	PY3		PY3 Achievement (%)
							Achievement	Target	
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	119,968	122,523	125,103	134,997	502,591	440,000	114
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	46,952	48,041	48,542	52,377	195,912	160,000	122
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	133,223	136,302	138,221	148,574	556,320	482,912	115
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	94,824	127,310	148,764	163,949	534,847	260,000	206
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	1,696	1,550	1,815	1,806	1,717	1,950	88
	Disaggregated by type of service delivery:	*(a) Health facility based*	1,552	1,401	1,451	1,586	1,498	1,600	94
		(b) Community-level based	144	149	364	220	219	350	63
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	84	44	18	10	39	160	24
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	123,894	126,167	128,772	129,498	508,331	487,794	104
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total	125,124	128,878	128,878	128,878	511,758	524,509	

		Numerator/ Denominator (in percentage)	99%	98%	100%	100%	99%	93%	
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	47,157	51,634	52,081	49,437	200,309	283,235	71
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	125,124	128,878	128,878	128,878	511,758	524,509	
		Numerator/Denominator (in percentage)	37.7%	40.1%	40.4%	38.4%	39.1%	54%	
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	102,950	101,030	110,783	110,560	425,322	419,607	101
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	125,124	128,878	128,878	128,878	511,758	524,509	
		Numerator/ Denominator (in percentage)	82.3%	78.4%	86.0%	85.8%	83.1%	80%	
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	94,766	95,292	103,005	102,565	395,628	376,418	105
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	102,950	101,030	110,783	110,560	425,322	419,607	
		Numerator/ Denominator (in percentage)	92.1%	94.3%	93.0%	92.8%	93.0%	90%	
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)	97,840	94,429	104,381	106,524	403,174	524,509	77
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,	97,538	93,565	102,541	104,518	398,162	395,346	101
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	125,124	128,878	128,878	128,878	511,758	395,346	
		Numerator/ Denominator (in percentage)	78.0%	72.6%	79.6%	81.1%	77.8%	100%	

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)	6,856	7,070	6,915	6,670	27,511	31,471	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)	106,457	129,452	122,724	122,678	481,311	556,536	86
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)	55,678	59,967	68,495	77,254	261,394	742,056	35
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	122,219	104,687	114,283	111,815	453,004	408,000	111
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref	109,171	112,446	112,446	112,446	446,509	457,634	
		Numerator/ Denominator (in percentage)	112.0%	93.1%	101.6%	99.4%	101.5%	89%	
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	3,963	7,447	5,581	5,882	22,872	20,400	112
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	126,182	112,133	119,864	117,697	475,876	408,000	
		Numerator/ Denominator (in percentage)	3%	7%	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	108,491	99,597	107,093	103,405	418,585	408,000	103
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref	109,171	112,446	112,446	112,446	446,509	457,634	
		Numerator/ Denominator (in percentage)	99%	89%	95%	92%	94%	89%	
18	**MNCH:** Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	279	119	87	156	160	160	100
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	1,191,811	0	29,442	1,791,697	3,012,950	2,250,000	134
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	106,736	105,787	110,026	127,665	450,213	385,875	117
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	125,124	128,878	128,878	128,878	511,758	524,509	
		Numerator/ Denominator (in percentage)	85%	82%	85%	99%	88%	74%	
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)	83,367	99,388	120,774	115,593	419,122	148,320	
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	35,144	37,632	40,721	35,420	148,917	524,509	28
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	494	644	279	390	452	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)	2,609	2,403	2,811	2,741	10,564	25,963	41

		Denominator: Total population in the specified geographical area	3,128,106	3,221,949	3,221,949	3,221,949	12,793,953	13,112,724	
		Numerator/ Denominator (per 100,000 population)	83.4	74.6	87.2	85.1	82.6	198	
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	882	1,412	1,614	1,932	5,840	15,059	39
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering	2,592	2,403	2,896	2,967	10,858	25,963	
		Numerator/ Denominator (in percentage)	34	59	56	65	54	58	
26	**TB:** Case detection rate	Numerator: Number of new smear positive TB cases detected	2,609	2,403	2,811	2,741	10,564	13,768	77
		Denominator: Estimated number of TB cases expected	4,641	4,692	4,692	4,692	18,717	19,669	
		Numerator/ Denominator (in percentage)	56.2%	51.2%	59.9%	58.4%	56.4%	70%	
27	**TB:** Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	14	7	1	11	33	40	83
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	32	70	10	18	33	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	33,089	40,618	8,889	9,262	91,858	87,500	105
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)	28,559	45,130	7,075	6,509	87,273	87,500	100
31	***HIV/PMCT:** Number of pregnant women receiving HIV counseling and testing	Number of pregnant women who received counseling and testing services for HIV	21,240	31,567	5,462	5,762	64,031	70,000	91
32	***HIV/PMTCT:** 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	20,575	30,506	5,462	5,293	61,836	70,000	88
33	***HIV/PMTCT:** Number of pregnant women who tested positive for HIV	Number of pregnant women who tested HIV positive	162	315	41	54	572	1,400	41

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	194	40	41	8	283	1,400	20
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,	212	212	47	52	52	250	21
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	79	115	19	20	233	980	24
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	0	45	0	88	133	686	19
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	0	100	35	141	276	1,666	17
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	674	2,411	0	849	3,934	7,000	56
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+)	129	151	9	106	395	1,666	24
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	0	29	2	41	72	1,000	7
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including	0	69	0	110	179	1,400	
		Numerator/ Denominator (in percentage)	0.0%	42.0%	0.0%	0.0%	40.2%	71%	

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	0	14	0	0	14	100	14
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including	0	69	0	110	179	1,400	
		Numerator/ Denominator (in percentage)	#DIV/0!	20.3%	#DIV/0!	0.0%	7.8%	7%	
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	0	154	22	33	209	49	427
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	0	0	0	0	0	30	0
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	0	0	0	0	0	30	0
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	23,193	39,001	7,021	18,618	87,833	91,050	96
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	2,076	5,453	863	3,093	11,485	12,620	91
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	21,117	33,548	6,158	15,641	76,464	78,430	97
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	9	0	16	63	88	50	176
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	23,184	39,001	7,005	17,606	86,796	91,000	95
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	363	404	234	123	1,124	1,820	62

45.6	***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 <15 who received T&C services for HIV and received their test results during the reporting period	9	0	16	412	437	89,180	0.5
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	674	2,411	454	1,441	4,980	9,100	55
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	1,969	37,795	888	3,489	44,141	72,800	61
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	65	67	67	69	69	48	144
		Denominator: Total # of GRHs	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	81%	84%	84%	86%	86%	60%	
47	***L+M+G:** % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	24	19	22	13	13	16	81
		Denominator: Total # of GRHs	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	30.1%	23.8%	27.5%	16.3%	16.3%	20%	
48	***L+M+G:** % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	1,176	1,188	1,222	1,399	1,399	905	155
		Denominator: Total # of health centers	1,509	1,509	1,509	1,509	1,509	1,509	
		Numerator/ Denominator (in percentage)	77.9%	78.7%	81.0%	92.7%	92.7%	60%	
49	***L+M+G:** % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	75	72	137	93	93	302	31
		Denominator: Total # of health centers	1,509	1,509	1,509	1,509	1,509	1,509	
		Numerator/ Denominator (in percentage)	5.0%	4.8%	9.1%	6.2%	6.2%	20%	

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/	75,989	79,387	82,223	72,940	310,539	419,607	74
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12	125,124	128,878	128,878	128,878	511,758	524,509	
		Numerator/ Denominator (in percentage)	61%	62%	64%	57%	61%	80%	
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	541	256	187	111	274	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	9,287	10,100	30,566	15,006	64,959	N/A	
53	**MALARIA:** Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	0	0	0	0	0	N/A	
54	**MALARIA:** Number of ITNs purchased with USG f	Number of ITNs purchased with USG funds that were distributed	50,400	34,757	18,640	10,067	113,864	N/A	
54.1		*(a) through campaigns*	0	0	0	0	0	N/A	
54.2		*(b) through health facilities*	23,134	41,571	49,414	28,187	142,306	N/A	
54.3		*(c) through the private/commercial sector*	0	0	0	0	0	N/A	
54.4		*(d) through other distribution channels*	0	0	0	0	0	N/A	
54.5		*(e) through voucher schemes*	0	0	0	0	0	N/A	
55	**MALARIA:** Number of health workers trained in IP	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	255	44	55	866	1,220	N/A	
		Male	224	33	55	732	1,044	N/A	

		Female	31	11	0	134	176	N/A	
56	**MALARIA:** Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	344,503	496,581	298,227	256,496	1,395,807	N/A	
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	0	0	0	0	0	N/A	
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)	214,570	218,232	239,518	167,600	839,920	N/A	
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	255	44	55	866	1,220	N/A	
60	**MALARIA:** Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	0	0	0	0	0	N/A	
61	**MALARIA:** Number of ACT treatments purchased	Number of ACT treatments purchased with USG funds that were distributed	361,489	558,410	488,770	520,161	1,928,830	N/A	
61.1	Disaggregated in 3 sub-categories:	*(a) to health facilities*	337,746	502,060	423,894	650,851	1,914,551	N/A	
61.2		*(b) to community health workers (HBMF, CCM)*	1,595	3,605	4,607	4,472	14,279	N/A	
61.3		*(c) to the private/commercial sector*	0	0	0	0	0	N/A	
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	277	44	129	895	1,345	N/A	
	(a) Number of health facility workers trained (ma	*Male*	224	33	55	732	1,044	N/A	
		Female	31	11	0	134	176	N/A	

	(b) Number of community members trained. Disaggregated by sex	*Male*	16	0	70	16	102	N/A	
		Female	6	0	3	0	9	N/A	
	c) Number of lab technicians trained. Disaggregated by sex	*Male*	0	0	0	8	8	N/A	
		Female	0	0	1	5	6	N/A	
63	**MALARIA:** Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	149,046	209,006	203,598	149,748	711,398	N/A	
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	257,462	329,914	293,074	164,300	1,044,750	N/A	
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	3,187	3,219	3,260	3,193	12,859	682,910	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/	1,028	1,218	1,230	1,239	1,179		
		Denominator: Total # of communities in IHP target area	1,415	1,509	1,509	1,509	1,509	1,509	
		Numerator/Denominator (in percentage)	72.7%	80.7%	81.5%	82.1%	78.1%	0%	
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)	105,917	96,251	73,357	160,447	435,972	335,800	130

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)	74,599	68,044	97,886	69,378	309,907	335,800	92
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	29	3	8	5	45	70	64
		Denominator: Total number of IHP health zones	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	36%	4%	10%	6%	56%	88%	
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	58	71	76	78	78	80	97
		Denominator: Total # HZs in IHP target area	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	73%	89%	95%	97%	97%	100%	
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)	298	604	722	751	594	1,207	49
		Denominator: Total number of health centers in IHP areas	1,509	1,509	1,509	1,509	1,509	1,509	
		Numerator/ Denominator (in percentage)	19.7%	40.0%	47.8%	49.8%	39.3%	80%	

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	42	39	56	50	47	64	73
		Denominator: Total number of hospitals in IHP areas	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	52.5%	48.8%	70.0%	62.5%	58.4%	80%	
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	40	98	190	0	328	500	66
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	970	1,097	1,745	1,302	1,279	8,320	15
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,	16	14	14	18	62	N/A	
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	429	41	15	19	504	1,042	48
		Denominator: Total # of facilities	1,509	1,509	1,509	1,509	1,509	1,509	
		Numerator/ Denominator (in percentage)	28%	3%	1%	1%	33%	69%	
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	312	3,341	1,978	1,270	6,901	37,870	18
		Denominator: Total # of patients seen by a CHW	13,717	10,953	18,658	11,192	54,520	N/A	
		Numerator/ Denominator (in percentage)	2%	31%	11%	11%	13%	N/A	
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	4,882	45,191	43,819	40,484	134,376	42150	

		Denominator: Total number of patients seen by a CHW or health care provider	1,126,690	1,192,766	1,269,242	1,308,790	4,897,488	3,250,512	
		Numerator/ Denominator (in percentage)	0%	4%	3%	3%	3%	1.3%	
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	62	82	84	89	79	N/A	
		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	172	172	172	179	174	N/A	
		Numerator/ Denominator (in percentage)	36%	48%	49%	50%	46%	10%	
78	***L+M+G:** # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	5	7	2	1	15	N/A	
79	***L+M+G:** # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	5	7	2	1	15	970	2
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	109	113	119	125	125	N/A	
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	959	816	887	893	889	970	92
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.,	56,783	61,710	66,424	51,227	236,144	1,000,000	24
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")	52	69	80	80	80	80	100

		Denominator: Total # of health zones	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	65%	86%	100%	100%	100%	100%	
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 organigrams, 2) work plans (including supervision plan and guide), and 3) performance review reports	26	42	52	52	43	60	72
		Denominator: Total # of health zones	80	80	80	80	80	80	
		Numerator/ Denominator (in percentage)	33%	53%	65%	65%	54%	75%	
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.)	10	9	7	11	37	30	124

Appendix 2: List of rehabilitated community care sites

No	Provinces	Health Zone	Health Area	Community Care Site	FP integrated
1	Sud Kivu	Idjwi	Mugote	Lubuye	Yes
2	Sud Kivu	Idjwi	Nyakalengwa	Kinyaba Langa	Yes
3	Sud Kivu	Idjwi	Kihumba	Bozi	Yes
4	Sud Kivu	Idjwi	Mafula	Cibanda	Yes
5	Sud Kivu	Idjwi	Bunyakiri	De Muganzo	Yes
6	Sud Kivu	Idjwi	Nyamizi	Nyamizi	Yes
7	Sud Kivu	Idjwi	Bwando	Bwando	Yes
8	Sud Kivu	Idjwi	Ntalenga	Ntalenga	Yes
9	Sud Kivu	Uvira	Kalonge	Kalonge	No
10	Sud Kivu	Uvira	Wembogo	Wembogo	No
11	Sud Kivu	Uvira	Site Kifuta	Site Kifuta	No
12	Sud Kivu	Uvira	Katonyera	Katonyera	No
13	Sud Kivu	Uvira	Kagosi	Kagosi	No
14	Sud Kivu	Uvira	Site Kakuba	Site Kakuba	No
15	Sud Kivu	Uvira	Kagomba	Kagomba	No
16	Sud Kivu	Lemera	Ndolera	Namuziba	No
17	Sud Kivu	Lemera	Munanira	Bwigala	No
18	Sud Kivu	Lemera	Bulaga	Kigarama	No
19	Sud Kivu	Lemera	Mulenge	Kihinga	No
20	Sud Kivu	Lemera	Busulira	Kyonga	No
21	Sud Kivu	Ruzizi	Kigoma,	Rugeje	No
22	Sud Kivu	Ruzizi	Hongero,	Kisanga-Kazimwe	No
23	Sud Kivu	Ruzizi	Mangwa,	Kishaje	No
24	Sud Kivu	Ruzizi	Luhito,	Katembo	No
25	Sud Kivu	Ruzizi	Ndunda,	Kimuka	No
26	Sud Kivu	Ruzizi	Mutarure,	Ngendo	No
27	Sud Kivu	Ruzizi	Mugaja,	Kitija	No
28	Sud Kivu	Nundu	Asisa	Asisa	No
29	Sud Kivu	Nundu	Tubondo	Tubondo	No
30	Sud Kivu	Nundu	Lusenda	Mkyamba	No
31	Sud Kivu	Nundu	Kaginga	Kaginga	No
32	Sud Kivu	Nundu	Kabumbe	Kigoma	No
33	Sud Kivu	Nundu	Bitobolo	Katenga	No
34	Sud Kivu	Nundu	Bitaliro	Bitaliro	No
35	Sud Kivu	Kamituga	Mboza	Wanyenga	No
36	Sud Kivu	Kamituga	Isopo	Itabi	No
37	Sud Kivu	Kamituga	Kankanga	Nyaba Lume	No
38	Sud Kivu	Kamituga	Bungalama	Ilambo	No
39	Sud Kivu	Kamituga	Kigalama	Kiligi	No
40	Sud Kivu	Kitutu	Mukemenge	Kansinini	No
41	Sud Kivu	Kitutu	Mapale	Mabondo	No

42	Sud Kivu	Kitutu	Byonga	Kalamba	No
43	Sud Kivu	Kitutu	Cs Bakongo	Kambulumbulu	No
44	Sud Kivu	Kitutu	Kakemenge	Kalokalo	No
45	Sud Kivu	Mwenga	Mulombozi	Bumba	Yes
46	Sud Kivu	Mwenga	Ngondo	Kalungenge	Yes
47	Sud Kivu	Mwenga	Irangi	Iuro	Yes
48	Sud Kivu	Mwenga	Bisembe	Lusenge	Yes
49	Sud Kivu	Mwenga	Kilimbwe	Kashindaba	Yes
50	Sud Kivu	Buniakiri	Lwana	Bihuha	No
51	Sud Kivu	Buniakiri	Bitale	Mikonzi.	No
52	Sud Kivu	Buniakiri	Cs Mingazi	Rumondo	No
53	Sud Kivu	Kalonge	Kashesha	Sati	No
54	Sud Kivu	Kalonge	Chaminunu	Bigizi	No
55	Sud Kivu	Kalonge	Fendula	Nshumo	No
56	Sud Kivu	Kalonge	Kakunda	Lugasha	No
57	Sud Kivu	Kalonge	Cholobera	Cibumbuji	No
58	Sud Kivu	Kalonge	Ntulu	Lugereso	No
59	Sud Kivu	Mubumbamu	Mukungwe	Nkonda	Yes
60	Sud Kivu	Mubumbamu	Cinda	Nshesha	Yes
61	Sud Kivu	Mubumbamu	Lubona	Birherema	Yes
62	Kasai Occidenta	Bilomba	Nzuji Kalamba	Dinanga	Yes
63	Kasai Occidenta	Bilomba	Bikuta	Mukadi	Yes
64	Kasai Occidenta	Bilomba	Bilomba	Mbumba	Yes
65	Kasai Occidenta	Bilomba	Luabala	Kaputa	Yes
66	Kasai Occidenta	Bilomba	Ntumbu Kambulu	Lubemba	Yes
67	Kasai Occidenta	Bilomba	Bikuta	Mabue Malunga	Yes
68	Kasai Occidenta	Bilomba	Mutefu	Beya Kakumba	Yes
69	Kasai Occidenta	Bilomba	Majiba	Tshikolo	Yes
70	Kasai Occidenta	Bulape	Yoolo	Nganda	Yes
71	Kasai Occidenta	Bulape	Maluku	Shambo	Yes
72	Kasai Occidenta	Bulape	Misumba	Buedi.	Yes
73	Kasai Occidenta	Bulape	Misumba	Mboloko	Yes
74	Kasai Occidenta	Bulape	Bambalate	Tshiputu	Yes
75	Kasai Occidenta	Bulape	Bupole	Nganda Mbongo	Yes
76	Kasai Occidenta	Bulape	Bangombe	Mbetu	Yes
77	Kasai Occidenta	Bulape	Bungongo	Bungongo	Yes
78	Kasai Occidenta	Bulape	Bangombe	Shamana	Yes
79	Kasai Occidenta	Bulape	Luayi Bushongo	Masangu	Yes
80	Kasai Occidenta	Bulape	Ingongo	Matungu	Yes
81	Kasai Occidenta	Lubondaie	Kamponde	Mfuamba	Yes
82	Kasai Occidenta	Lubondaie	Dibue Dietu	Bishika	Yes
83	Kasai Occidenta	Lubondaie	Tshinkenke	Kanyiyi	Yes

84	Kasai Occidenta	Lubondaie	Malowa	Nsangaie	Yes
85	Kasai Occidenta	Lubondaie	Tshidimba	Kangandu	Yes
86	Kasai Occidenta	Lubondaie	Tshimakaka	Katende.	Yes
87	Kasai Occidenta	Lubondaie	Mikulumbu	Nsamba Tshibala	Yes
88	Kasai Occidenta	Lubondaie	Kateba	Mayaya	Yes
89	Kasai Occidenta	Lubondaie	Tshilolo	Kasamba..	Yes
90	Kasai Occidenta	Lubondaie	Tshibambula.	Gbadolite	Yes
91	Kasai Occidenta	Lubondaie	Kateba	Lupandu	Yes
92	Kasai Occidenta	Lubondaie	Kambuji	Kayi Nkolo	Yes
93	Kasai Occidenta	Tshikaji	Nkonko2	Beya Mpasu	Yes
94	Kasai Occidenta	Tshikaji	Katomba	Kabasubabu Mpemba	Yes
95	Kasai Occidenta	Tshikaji	Mbumba	Tshidiadia	Yes
96	Kasai Occidenta	Tshikaji	Kazole	Kazole	Yes
97	Kasai Occidenta	Tshikaji	Mbumba	Tshikapa	Yes
98	Kasai Occidenta	Tshikaji	Ntambue St B	Katambayi	Yes
99	Kasai Occidenta	Tshikaji	Nkonko 1	Tshiabambumba	Yes
100	Kasai Oriental	Kanda Kanda	Kabuela	Tshiela	Yes
101	Kasai Oriental	Kanda Kanda	Tshiamu	Tshisuakudi	Yes
102	Kasai Oriental	Kanda Kanda	Mukola	Tshikoka	Yes
103	Kasai Oriental	Kanda Kanda	Mukola	Muanza Ngudi	Yes
104	Kasai Oriental	Kanda Kanda	Kamanda K.	Tusana	Yes
105	Kasai Oriental	Kanda Kanda	Kabila	Dinga	Yes
106	Kasai Oriental	Kanda Kanda	Kayembe	Kaheha	Yes
107	Kasai Oriental	Kanda Kanda	Katobo	Lubuwa	Yes
108	Kasai Oriental	Kanda Kanda	Lulamba	Lulamba2	Yes
109	Kasai Oriental	Kanda Kanda	Lulamba	Kanangila1	Yes
110	Kasai Oriental	Kanda Kanda	Kanda Kanda	Tshifumba	Yes
111	Kasai Oriental	Kanda Kanda	Matamba	Kashilu	Yes
112	Kasai Oriental	Kanda Kanda	Mutembue	Mushala	Yes
113	Kasai Oriental	Kanda Kanda	Kapangu	Bakuanda	Yes
114	Kasai Oriental	Kanda Kanda	Kambaye	Dilenga	Yes
115	Kasai Oriental	Kanda Kanda	Tshiavi	Mwazangudi	Yes
116	Katanga	Dilala	Dilende	Mupenda	Yes
117	Katanga	Dilala	Kanina	Hewabora	Yes
118	Katanga	Fungurume	Kilusonsa	Kwatebala Gare	Yes
119	Katanga	Fungurume	Kilusonsa	Mutaka	Yes
120	Katanga	Fungurume	Kuvumbi	Kitimba	Yes
121	Katanga	Fungurume	Lukotola	Cite Nguba	Yes
122	Katanga	Fungurume	Mukabe	Mukabe.	Yes
123	Katanga	Fungurume	Kasonga	Kasonga Mubamba	Yes
124	Katanga	Fungurume	Tenke	Salabwe	Yes
125	Katanga	Fungurume	Tenke	Kabwe Kakese	Yes
126	Katanga	Fungurume	C.S.Baraka	Mutaka Wadilomba	Yes
127	Katanga	Fungurume	Lukotola	Cite Kyango	Yes

128	Katanga	Fungurume	Nguba	ShoNogo	Yes
129	Katanga	Kanzenze	Musowatanda	Kaponda	Yes
130	Katanga	Kanzenze	Nzilo	Mpumbwe	Yes
131	Katanga	Kanzenze	Mulomba	Nkonda	Yes
132	Katanga	Kanzenze	Kantala	Kamoa	Yes
133	Katanga	Kanzenze	Kamimbi	Tshisanyama	Yes
134	Katanga	Kanzenze	Nseke	Ferme Nzeya	Yes
135	Katanga	Kanzenze	Mpala	Lulua - Dippe - Nord	Yes
136	Katanga	Lualaba	Kalutenge	Kahongo	Yes
137	Katanga	Lualaba	Kalupi	Kalupi	Yes
138	Katanga	Lualaba	Mupanja	Kipepe	Yes
139	Katanga	Lualaba	Musompo	Misamba	Yes
140	Katanga	Lualaba	Manga Manga	Tshikopo	Yes
141	Katanga	Lualaba	Mwanfwe	Tshileji	Yes
142	Katanga	Mutshatsha	Kazovu	Kampesat	Yes
143	Katanga	Mutshatsha	Yanva	Kanema	Yes
144	Katanga	Mutshatsha	Namwana	Kanale	Yes
145	Katanga	Mutshatsha	Mutshatsha Ii	Kangama	Yes
146	Katanga	Mutshatsha	Kayembe	Kazenge	Yes
147	Katanga	Mutshatsha	Yanva	Nyamwana	Yes
148	Katanga	Mutshatsha	Kaleji	Mukata	Yes
149	Katanga	Kitenge	Kaloko	Ngoy mwabi	No
150	Katanga	Kitenge	Kisenge	Sengwa	No
151	Katanga	Kitenge	Kamunza	Masengo	No
152	Katanga	Kitenge	Amani	Mateshi	No
153	Katanga	Kitenge	Kitenge	Kashukulu	No
154	Katanga	Kitenge	Anuarite	Kina	No
155	Katanga	Kitenge	Kashukulu	Numbi	No
156	Katanga	Kabongo	Nyembo	Konyi	No
157	Katanga	Kabongo	Lubiay	Ndayakabo	No
158	Katanga	Kabongo	Kamwenze	Kako	No
159	Katanga	Kabongo	Kina	Mulenda	No
160	Katanga	Kabongo	Kime	Kisanga	No
161	Katanga	Kabongo	Nseke	Kabwila	No
162	Katanga	Kabongo	Bushimbi	Bushimbi	No
163	Katanga	Songa	Songa	Mwilambwe	Yes
164	Katanga	Songa	Kipukwe	Mwibu	Yes
165	Katanga	Songa	Samba	Kidiangala	Yes
166	Katanga	Songa	Lukanvwe	Ntala	Yes
167	Katanga	Songa	Kafumbe	Kafumbe	Yes
168	Katanga	Songa	Kafungo	Kafungo- kazadi	Yes
169	Katanga	Songa	Dikuluyi	Mato	Yes
170	Kole	Bena dibele	Yenga	Epombo	No
171	Kole	Bena dibele	Nkavu	Mbomba Ringa	No

172	Kole	Bena dibele	Kabondozi	Bandja	No
173	Kole	Bena dibele	Epombo	Kabondo	No
174	Kole	Bena dibele	Ototo	Esembe	No
175	Kole	Bena dibele	Mb ambaringa	Nkamba	No
176	Kole	Bena dibele	Mpelo	Mpelo	No
177	Kole	Bena dibele	Mpelo	Nkamba	No
178	Tshumbe	Djalo ndjeka	Ndeka losele	Bikungu	No
179	Tshumbe	Djalo ndjeka	Djalo catholique	Ona wenge	No
180	Tshumbe	Djalo ndjeka	Ekanga	Dina delembe	No
181	Tshumbe	Djalo ndjeka	Longonya	Okito tshudi	No
182	Tshumbe	Djalo ndjeka	Lonya	Diata	No
183	Tshumbe	Djalo ndjeka	Ekanga	Omana	No
184	Tshumbe	Djalo ndjeka	Lando	Kandja	No
185	Tshumbe	Djalo ndjeka	Lando	Ogangamba	No
186	Tshumbe	Djalo ndjeka	Mudimbi	Elenge	No
187	Kasai Oriental	Lodja	Dikombe	Nkoy nkoy	Yes
188	Kasai Oriental	Lodja	Dikombe	Ehalala	Yes
189	Kasai Oriental	Lodja	Onema piete	Ngombe	Yes
190	Kasai Oriental	Lodja	Onema piete	Wosha	Yes
191	Kasai Oriental	Lodja	Fin de terme	Oshiwo	Yes
192	Kasai Oriental	Lodja	Fin de terme	Nyenge	Yes
193	Kasai Oriental	Lodja	Diengenga	Omekenge	Yes
194	Kasai Oriental	Lodja	Diengenga	Dihokamanga	Yes
195	Kasai Oriental	Lodja	Cs lunda	Otomba	Yes
196	Kasai Oriental	Lodja	Cs lunda	Dibongo	Yes
197	Tshumbe	Tshumbe	Dikinadjondo	Mbodja	No
198	Tshumbe	Tshumbe	Oshingoto	Djonganumbe	No
199	Tshumbe	Tshumbe	Oshingoto	Numbe	No
200	Tshumbe	Tshumbe	Dima	KIBIDI	No
201	Tshumbe	Tshumbe	Majeka senga	Diu otoy	No
202	Tshumbe	Tshumbe	Ndjoo	Wunge	No
203	Tshumbe	Tshumbe	Ndjoo	OWANDJI	No
204	Tshumbe	Tshumbe	Woma	Tshinga	No
205	Tshumbe	Tshumbe	Dima	Matonge	No
206	Tshumbe	Tshumbe	Djondu cité	Djondu	No
207	Tshumbe	Tshumbe	Wete	Wete	No
208	Kasai Oriental	Vangakete	Lukuke	Vole	Yes
209	Kasai Oriental	Vangakete	Otshudi	Yimbo	Yes
210	Kasai Oriental	Vangakete	Otshudi	Kond’osue	Yes
211	Kasai Oriental	Vangakete	Osomba	Ongela	Yes
212	Kasai Oriental	Vangakete	Osomba	Ongele	Yes
213	Kasai Oriental	Vangakete	Ongondo	Akona	Yes
214	Kasai Oriental	Vangakete	Mouge loteta	Pongo	Yes
215	Kasai Oriental	Vangakete	Monge lokeke	Lokombo	Yes

216	Kasai Oriental	Vangakete	Dikonda	Diwungi	Yes
217	Kasai Oriental	Vangakete	Onyumbe	Ngando	Yes
218	Kasai Oriental	Vangakete	Lukuke	Djombe	Yes
219	Kasai Oriental	Vangakete	Onyumbe	Eloma	Yes

Appendix 3: PY3Q4 Distribution Plan for Family Planning commodities

IHP FAMILY PLANNING COMMODITIES SITUATION (JULY -SEPTEMBER 2013, PY3Q4)

	Coordination	Health Zone	Total Pop 2012	Total FP Target	Monthly Target	Depo Provera				Jadelle + Trocard				IUD				Cycle Beads				Female Condom				Microgynon				Combinaison 3 /COC Lo-femenal				Male Condom				Ovrette				Microlut			
						Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4	Balance Q3	Qty received Q4	Qty distributed Q4	Balance End of Q4
1	TSHUMBE	Dikungu	127,959	26,871	2,239	993	659	387	1,265	0	0	0	0	0	0	0	0	425	228	67	586	763	0	47	716	395	0	78	317	662	0	196	466	3,574	29656	13208	20,022	671	237	145	763	0	0	0	0
2		Djalo	73,238	15,380	1,282	338	403	452	289	0	0	0	0	0	0	0	0	176	37	52	161	38	4	0	42	118	692	114	696	465	163	362	266	5,160	19,819	20,042	4,937	0	107	17	90	0	0	0	0
3		Katako Kombe	123,076	25,846	2,154	507	384	436	455	0	0	0	0	0	0	0	0	306	116	105	317	400	43	8	435	433	366	310	489	37	169	136	70	14,123	13020	11,926	15,217	611	254	304	561	0	0	0	0
4		Lodja	172,998	36,330	3,027	228	2010	389	1,849	0	0	0	0	41	0	0	41	1,040	1,620	391	2,269	1,248	661	123	1,786	0	22	22	0	51	991	165	877	45,091	37,162	46,318	35,935	54	804	238	620	0	0	0	0
5		Minga	143,379	30,110	2,509	1,473	0	294	1,179	50	0	0	50	0	0	0	0	134	46	72	108	648	234	228	654	235	253	85	403	104	87	63	128	6,926	1,554	7,110	1,370	1161	0	96	1,065	0	0	0	0
6		Omendjadi	122,060	25,633	2,136	696	90	181	605	0	0	0	0	0	0	0	0	814	172	142	844	0	405	132	273	215	849	94	970	276	26	37	265	8,603	4,956	8,119	5,440	67	338	76	329	0	0	0	0
7		Ototo	121,162	25,444	2,120	297	325	128	494	0	0	0	0	0	0	0	0	734	0	118	616	282	0	50	232	1,057	0	124	933	0	0	0	0	4,389	4,839	6,575	2,653	438	157	107	488	0	0	0	0
8		Tshumbe	91,119	19,135	1,595	1,772	0	97	1,675	0	0	0	0	0	0	0	0	1,330	0	80	1,250	867	26	212	681	0	0	0	0	1,662	134	185	1,611	11,449	8,170	12,667	6,952	1241	0	38	1,203	0	0	0	0
9		Vangakete	116,118	24,385	2,032	432	216	252	396	0	0	0	0	0	0	0	0	293	62	113	242	427	0	12	415	135	191	322	4	0	12	12	0	9,572	21,474	16,147	14,899	740	358	262	836	0	0	0	0
10		Wembonyama	77,093	16,190	1,349	2,867	0	305	2,562	0	0	0	0	0	0	0	0	396	47	76	367	1,921	0	4	1,917	734	65	25	774	2,321	0	157	2,164	45,347	20,012	13,087	52,272	1775	0	167	1,608	0	0	0	0
	s/total1		1,168,202	245,322	20,444	9,603	4,087	2,921	10,769	50	0	0	50	41	0	0	41	5,648	2,328	1,216	6,760	6,594	1,373	816	7,151	3,322	2,438	1,174	4,586	5,578	1,582	1,313	5,847	154,234	160,662	155,199	159,697	6,758	2,255	1,450	7,563	0	0	0	0
11	KOLE	Kole	88,639	18,614	1,551	5,400	0	368	5,032	50	0	0	50	165	0	0	165	30	500	155	375	0	5,000	2,002	2,998	1,000	0	1,000	0	17,500	0	0	17,500	43,200	0	30,000	13,200	0	0	0	0	110	0	0	110
12		Dibele	97,520	20,479	1,707	0	1000	500	500	50	0	0	50	0	0	0	0	320	0	140	180	0	0	0	0	0	1,000	1,000	0	0	1,000	400	600	3,127	20000	20,000	3,127	0	0	0	0	0	0	0	0
13		Tshudiloto	68,050	14,291	1,191	1,350	0	350	1,000	50	0	0	50	0	0	0	0	0	500	145	355	130	1,000	1,000	130	4,630	0	10,050	-5,420	250	750	1,000	0	0	0	0	0	0	0	0	0	0	0	0	0
14		Lomela	103,971	21,834	1,819	8,975	0	8000	975	50	0	0	50	54	0	0	54	531	0	219	312	5,070	0	3,000	2,070	13,550	0	450	13,100	15,900	0	6,500	9,400	24,100	0	20,000	4,100	0	0	0	0	0	0	0	0
	s/total 2		358,180	75,218	6,268	15,725	1,000	9,218	7,507	200	0	0	200	219	0	0	219	881	1,000	659	1,222	5,200	6,000	6,002	5,198	19,180	1,000	12,500	7,680	33,650	1,750	7,900	27,500	70,427	20,000	70,000	20,427	0	0	0	0	110	0	0	110
15	MWENE DITU	Bibanga	143,570	30,150	2,512	2,876	0	452	2,424	20	0	0	20	141	0	0	141	1,911	0	126	1,785	1,853	0	885	968	2,669	0	271	2,398	3,770	0	172	3,598	33,156	0	14,296	18,860	1,946	0	320	1,626	242	0	97	145
16		Wikong	112,127	23,547	1,962	4,345	0	241	4,104	16	0	0	16	12	0	0	12	412	0	176	236	249	0	174	75	2,179	0	271	1,908	264	0	40	224	19,203	0	9,842	9,361	147	0	90	57	293	0	10	283
17		Dibindi	253,296	53,192	4,433	960	0	478	482	2	0	2	0	29	0	6	23	846	0	142	704	845	0	694	151	120	0	120	0	518	0	326	192	48,267	0	16,839	31,428	676	0	627	49	3	0	3	0
18		Kalenda	201,326	42,278	3,523	1,778	0	302	1,476	28	0	0	28	0	0	0	0	185	0	40	145	207	0	71	136	5,581	0	666	4,915	1,778	0	125	1,653	8,482	0	4,630	3,852	1087	0	125	962	140	0	21	119
19		Kamiji	94,948	19,939	1,662	1,265	0	124	1,141	13	0	0	13	71	0	0	71	392	0	48	344	336	0	128	208	1,485	0	169	1,316	3,905	0	12	3,893	20,488	0	8,212	12,276	336	0	29	307	510	0	190	320
20		Kanda Kanda	222,776	46,783	3,899	3,374	0	364	3,010	30	0	0	30	72	0	0	72	670	0	259	411	139	0	89	50	2,643	0	349	2,294	3,233	0	289	2,944	43,115	0	27,184	15,931	3,450	0	194	3,256	0	0	0	0
21		Luputa	276,110	57,983	4,832	1,998	0	635	1,363	38	0	0	38	8	0	0	8	2,525	0	138	2,387	2,298	0	312	1,986	1,612	0	409	1,203	80	0	48	32	38,341	0	24,343	13,998	136	0	24	112	4,534	0	104	4,430
22		Lusambo	92,571	19,440	1,620	2,913	0	148	2,765	12	0	0	12	108	0	0	108	2,339	0	145	2,194	3,452	0	378	3,074	2,962	0	222	2,740	4,232	0	16	4,216	50,741	0	5,861	44,880	424	0	109	315	183	0	73	110

23		Mpokolo	292,680	61,463	5,122	3,784	0	555	3,229	41	0	0	41	170	0	0	170	2,088	0	321	1,767	601	0	375	226	6,903	0	802	6,101	4,569	0	15	4,554	42,299	0	22,724	19,575	4,157	0	215	3,942	3,400	0	52	3,348
24		Mwene Ditu	404,014	84,843	7,070	4,164	0	467	3,697	57	0	0	57	122	0	0	122	2,124	0	163	1,961	799	0	254	545	1,996	0	449	1,547	2,795	0	254	2,541	43,084	0	12,444	30,640	1,019	0	79	940	62	0	0	62
25		Pania Mutombo	75,313	15,816	1,318	2,038	0	184	1,854	10	0	0	10	42	0	0	42	-12	0	261	-273	842	0	210	632	1,874	0	238	1,636	5	0	5	0	8,647	0	7,132	1,515	194	0	48	146	159	0	49	110
	s/total 3		**2,168,730**	**455,433**	**37,953**	**29,495**	**0**	**3,950**	**25,545**	**267**	**0**	**2**	**265**	**775**	**0**	**6**	**769**	**13,480**	**0**	**1,819**	**11,661**	**11,621**	**0**	**3570**	**8,051**	**30,024**	**0**	**3966**	**26,058**	**25,149**	**0**	**1,302**	**23,847**	**355,823**	**0**	**153,507**	**202,316**	**13,572**	**0**	**1,860**	**11,712**	**9,526**	**0**	**599**	**8,927**
26		Luiza	154,689	32,485	2,707	8,851	0	474	8,377	10	30	1	39	77	0	2	75	721	0	101	620	9,622	0	1,511	8,111	11,635	0	110	11,525	3,958	0	153	3,805	51,986	0	34,136	17,850	3,552	0	132	3,420	2,225	0	14	2,211
27		Yangala	144,271	30,297	2,525	15,626	0	567	15,059	42	30	0	72	185	0	4	181	4,988	0	206	4,782	6,080	0	1,303	4,777	12,987	0	335	12,652	9,285	0	0	9,285	53,875	0	6225	47,650	0	0	0	0	683	0	285	398
28		Dekese	131,507	27,616	2,301	5,510	0	711	4,799	0	23	0	23	97	0	0	97	274	0	140	134	6,224	0	284	5,940	9,058	0	454	8,604	528	0	110	418	22,871	0	3,032	19,839	0	0	0	0	0	0	0	0
29		Bulape	148,522	31,190	2,599	8,215	0	372	7,843	0	20	0	20	71	0	0	71	1,530	0	55	1,475	7,212	0	1,560	5,652	8,778	0	72	8,706	9,278	0	133	9,145	16,303	0	3,345	12,958	374	0	0	374	0	0	0	0
30		Bilomba	81,313	17,076	1,423	6,201	0	281	5,920	0	20	0	20	65	0	0	65	378	0	104	274	8,728	0	1,130	7,598	7,362	0	97	7,265	6,688	0	110	6,578	71,823	0	11,988	59,835	1,139	0	0	1,139	707	0	40	667
31	**LUIZA**	Luambo	252,700	53,067	4,423	11,772	0	339	11,433	0	30	0	30	46	0	0	46	274	0	105	169	9,512	0	3,987	5,525	7,001	0	859	6,142	550	0	206	344	23,806	0	7,646	16,160	1,046	0	39	1,007	34	0	0	34
32		Kalomba	135,701	28,497	2,375	8,261	0	437	7,824	10	23	2	31	108	0	2	106	399	0	217	182	5,607	0	3,362	2,245	10,221	0	190	10,031	2,859	0	97	2,762	19,668	0	15,539	4,129	1,657	0	428	1,229	64	0	2	62
33		Dibaya	128,451	26,975	2,248	9,125	0	995	8,130	0	20	0	20	83	0	0	83	773	0	71	702	8,411	0	2,520	5,891	10,586	0	1,111	9,475	801	0	73	728	43,955	0	10,199	33,756	934	0	163	771	481	0	131	350
34		Lubondaie	144,495	30,344	2,529	8,540	0	765	7,775	0	20	0	20	78	0	0	78	916	0	141	775	8,608	0	2,104	6,504	9,654	0	516	9,138	271	0	10	261	32,227	0	16,009	16,218	85	0	383	-298	728	0	0	728
35		Ndekesha	143,979	30,236	2,520	8,544	0	542	8,002	0	20	0	20	77	0	0	77	898	0	37	861	6,683	0	2,397	4,286	10,918	0	0	10,918	3,642	0	441	3,201	38,393	0	15,703	22,690	1,969	0	300	1,669	0	0	0	0
36		Tshikaji	105,303	22,114	1,843	8,457	0	415	8,042	0	20	0	20	120	0	0	120	640	0	69	571	75,664	0	1,273	74,391	11,917	0	407	11,510	183	0	259	-76	36,597	0	28130	8,467	479	0	106	373	278	0	162	116
	s/total 4		***1,570,931***	***329,897***	***27,493***	***99,102***	***0***	***5,898***	93,204	***62***	***256***	***3***	315	***1,007***	***0***	***8***	999	***11,791***	***0***	***1,246***	10,545	***152,351***	***0***	***21,431***	130,920	***110,117***	***0***	***4,151***	105,966	***38,043***	***0***	***1,592***	36,451	***381,504***	***0***	***151,952***	229,552	***11,235***	***0***	***1,551***	9,684	***5,200***	***0***	***634***	4,566
37		Bagira-Kasha	91,902	19,299	1,608	1,414	7148	5,190	3,372	45	1002	60	987	20	1462	109	1,373	-32	3187	212	2,943	3,275	9270	4,770	7,775	2,000	3455	625	4,830	-41	5482	610	4,831	-13,125	33892	48,990	-28,223	-81	1300	480	739	0	603	603	0
38		Bunyakiri	142,525	29,930	2,494	474	1413	114	1,773	23	48	21	50	9	65	0	74	36	132	58	110	2,000	150	15	2,135	2,673	7353	822	9,204	-156	1431	149	1,126	-1,464	3657	270	1,923	-105	199	121	-27	0	0	0	0
39		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	0	0	-1,158	-140	0	0	-140	0	0	0	0
40		Idjwi	228,817	48,052	4,004	-715	1293	3064	-2,486	16	86	72	30	20	3089	0	3,109	38	124552	47,305	77,285	1,970	31814	6	33,778	0	16195	2,006	14,189	0	0	0	0	-280	58736	4228	54,228	-950	445	1017	-1,522	0	3155	0	3,155
41		Kadutu	187,608	39,398	3,283	1,964	7325	4206	5,083	-5	34	26	3	19	42	13	48	-249	470	970	-749	4,000	2827	1275	5,552	3,992	3239	3161	4,070	-18	0	0	-18	-4,400	118085	12739	100,946	-19	0	0	-19	0	7651	0	7,651
42		Kalole	97,542	20,484	1,707	205	583	89	699	5	152	11	146	9	111	0	120	-67	719	14	638	1,405	18630	230	19,805	1,934	4215	182	5,967	-168	468	282	18	-9,592	40766	3,436	27,738	-348	1368	426	594	0	1962	114	1,848
43	**BUKAVU**	Kalonge	171,878	36,094	3,008	319	643	300	662	-17	60	16	27	10	0	0	10	34	14	3,014	-2,966	1,960	1	730	1,231	0	243	6	237	0	236	3	233	0	28291	4,678	23,613	0	2086	61	2,025	0	23	0	23
44		Kamituga	148,073	31,095	2,591	756	1077	104	1,729	15	10	2	7	15	7	0	22	-56	3440	38	3,346	1,995	4221	102,102	-95,886	3,833	4009	84	7,758	-113	0	16	-129	-4,195	25608	4,945	16,468	-3	129	0	126	0	0	0	0
45		Kaniola	164,497	34,544	2,879	162	3961	455	3,668	5	0	0	5	10	35	11	34	-60	230	250	-80	929	3490	750	3,669	1,965	1064	400	2,629	-14	0	0	-14	-4,025	69020	4,880	60,115	-57	0	0	-57	0	5000	0	5,000
46		Katana	188,523	39,590	3,299	1,270	3100	2839	1,531	26	40	24	42	20	46	4	62	-119	808	136	553	2,000	2619	0	4,619	5,836	1719	0	7,555	-712	38200	3,672	33,816	-2,388	189142	2,338	184,416	-626	0	0	-626	0	0	0	0
47		Kaziba	111,461	23,407	1,951	259	1164	287	1,136	2	11	4	9	8	313	8	313	10	1393	306	1,097	1,965	2054	691	3,328	1,916	584	241	2,259	-8	322	6	308	-1,219	8285	3,548	3,518	-140	863	171	552	0	36	6	30
48		Kitutu	123,479	25,931	2,161	940	2780	67	3,653	10	135	14	131	15	250	0	265	-12	1202	18	1,172	1,841	1845	6	3,680	0	2637	365	2,272	0	0	0	0	-9,419	21638	3,429	8,790	0	3551	0	3,551	0	3300	19	3,281
49		Lulingu	149,035	31,297	2,608	655	79	496	238	15	0	0	15	20	0	0	20	44	0	2	42	2,000	0	40	1,960	3,808	1710	213	5,305	-60	100	87	-47	-560	6048	860	4,628	-195	0	162	-357	0	0	0	0
50		Minova	184,500	38,745	3,229	1,134	448	242	1,340	24	12	10	26	13	0	0	13	43	87	8	122	3,995	500	0	4,495	3,847	0	0	3,847	-231	516	368	-83	-5,047	36812	8992	22,773	-82	1093	94	917	0	0	0	0
51		Miti-Murhesa	192,853	40,499	3,375	385	1135	516	1,004	2	141	0	143	14	123	11	126	-28	477	50	399	2,996	3319	30	6,285	5,140	418	0	5,558	-1,079	1116	1,320	-1,283	-4,003	4300	0	297	-661	1718	802	255	0	0	0	0

52		Mubumbano	160,327	33,669	2,806	343	0	0	343	9	0	0	9	10	0	0	10	22	0	0	22	2,000	0	0	2,000	2,956	0	0	2,956	-41	0	0	-41	0	0	0	0	-53	0	0	-53	0	0	0	0
53		Mulungu	130,520	27,409	2,284	500	0	0	500	5	0	0	5	10	0	0	10	40	0	0	40	2,000	0	0	2,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
54		Mwana	124,448	26,134	2,178	414	6544	202	6,756	17	48	3	62	8	0	0	8	-38	26670	84	26,548	1,991	18804	88	20,707	2,492	2200	0	4,692	0	50	3	47	-1,985	8637	5,046	1,606	-28	3355	11	3,316	0	3000	0	3,000
55		Mwenga	118,275	24,838	2,070	673	2563	124	3,112	20	33	10	43	8	35	5	38	-85	1540	96	1,359	2,000	6994	297	8,697	3,914	2539	144	6,309	-66	980	0	914	-1,502	18478	5,322	11,654	-12	72	25	35	0	1146	25	1,121
56		Nyangezi	129,311	27,155	2,263	864	1006	108	1,762	10	9	0	19	10	8	807	-789	-63	39	2,952	-2,976	1,986	76	961	1,101	2,942	47	0	2,989	-3	17680	2,035	15,642	-797	372	0	-425	-20	72	0	52	0	0	0	0
57		Shabunda Centre	134,654	28,277	2,356	-220	3774	282	3,272	2	20	879	-857	5	1284	32	1,257	24	233778	512	233,290	3,670	5321	1,303	7,688	3,388	0	0	3,388	0	7114	3,126	3,988	-4,269	1473	207	-3,003	-390	309	261	-342	0	0	0	0
58		Walungu	236,249	49,612	4,134	421	4918	3	5,336	13	19	30	2	14	44	0	58	-106	3500	3,927	-533	3,274	3427	3	6,698	4,871	78	0	4,949	-321	20000	400	19,279	-5,085	21412	0	16,327	-160	0	0	-160	0	0	0	0
	s/total 5		***3,514,503***	***738,046***	***61,504***	***13,429***	***50,954***	***18,688***	45,695	***117***	***1,860***	***1,182***	795	***276***	***6,914***	***1,000***	6,190	***-710***	***402,238***	***0***	401,528	***53,112***	***115,362***	***113,297***	55,177	***61,454***	***51,705***	***8,249***	104,910	***-3,069***	***93,695***	***12,077***	78,549	***-74,513***	***694,652***	***113,908***	506,231	***-4,070***	***16,560***	***3,631***	8,859	***0***	***25,876***	***767***	25,109
59	KOLWEZI	Bunkeya	48,861	10,261	855	30	4200	54	4,176	10	0	0	10	0	50	0	50	150	350	14	486	1,000	0	0	1,000	0	300	100	200	0	0	0	0	1,000	39600	838	39,762	100	1200	55	1,245	80	200	100	180
60		Dilala	111,673	23,451	1,954	1,250	200	210	1,240	25	10	10	25	20	10	2	28	200	150	12	338	0	500	0	500	0	0	0	0	0	0	0	0	4,640	12,000	14,588	2,052	1,000	2,000	75	2,925	0	0	0	0
61		Fungurume	104,029	21,846	1,821	2,052	2000	321	3,731	50	0	11	39	0	0	0	0	56	2,000	170	1,886	500	500	91	909	0	1,000	3	997	0	0	0	0	27,000	10,000	13,102	23,898	3,700	1,800	114	5,386	0	0	0	0
62		Kanzenze	87,566	18,389	1,532	1,420	1500	1302	1,618	10	20	6	24	0	60	0	60	0	1,000	26	974	0	0	0	0	0	4,000	0	4,000	0	0	0	0	3,500	2,000	2,106	3,394	100	0	66	34	17	100	6	111
63		Lualaba	93,478	19,630	1,636	0	2000	181	1,819	0	20	0	20	3	100	0	103	1,060	0	96	964	600	0	10	590	0	200	108	92	0	0	0	0	2,500	6,000	4,788	3,712	36	1,000	116	920	80	200	0	280
64		Lubudi	114,128	23,967	1,997	100	1200	154	1,146	0	200	0	200	0	50	0	50	0	450	218	232	0	1,000	0	1,000	500	1,600	3	2,097	0	0	0	0	570	17,000	7,789	9,781	500	500	259	741	0	0	0	0
65		Manika	211,634	44,443	3,704	700	1200	151	1,749	50	0	13	37	0	50	3	47	20	500	36	484	100	1,000	100	1,000	0	300	8	292	0	0	0	0	7,500	5,000	5,288	7,212	180	500	169	511	0	0	0	0
66		Mutsatsa	66,421	13,948	1,162	100	100	158	42	0	50	4	46	0	0	0	0	100	500	221	379	200	1,000	404	796	0	500	0	500	0	0	0	0	0	20000	7813	12,187	0	500	212	288	0	0	0	0
	s/total 6		837,790	175,936	14661.325	5,652	12400	2531	15,521	145	300	44	401	23	320	5	338	1,586	4,950	793	5,743	2,400	4,000	605	5,795	500	7,900	222	8,178	0	0	0	0	46,710	111,600	56,312	101,998	5,616	7,500	1,066	12,050	***177***	500	106	571
67	UVIRA	Lemera	143,065	30,044	2,504	5,411	5,200	194	10,417	23	0	12	11	182	10	0	***192***	1,514	102	151	1,465	4,018	6,000	874	9,144	0	0	98	-98	11,816	10,800	199	22,417	78,605	28,800	9,185	98,220	0	0	0	0	0	0	0	0
68		Nundu	223,455	46,926	3,910	4,891	7,200	529	11,562	31	0	8	23	195	30	1	***224***	479	108	520	68	2,400	7,000	2,601	6,799	0	0	150	-150	8,691	14,400	1,540	21,552	10,860	36,000	21,375	25,485	0	0	0	0	0	0	0	0
69		Hautsplateaux	105,449	22,144	1,845	4,402	3,200	202	7,400	31	0	0	31	68	10	0	***78***	559	38	13	584	5,124	2,000	61	7,063	0	0	47	-47	7,412	5,040	60	12,392	13,386	7,200	1,077	19,509	0	0	0	0	0	0	0	0
70		Uvira	261,907	55,001	4,583	7,342	15,200	199	22,343	36	0	21	15	236	60	0	***296***	327	150	299	178	6,754	11,000	244	17,510	0	0	128	-128	8,034	36,000	17	44,017	103,153	57,600	4,072	156,681	0	0	0	0	0	0	0	0
71		Ruzizi	132,061	27,733	2,311	8,146	9,200	774	16,572	62	0	3	59	208	40	0	***248***	491	102	34	559	6,597	6,000	175	12,422	0	0	159	-159	5,498	14,400	138	19,760	89,241	19,200	15,908	92,533	0	0	0	0	0	0	0	0
	s/total 7		***865,939***	***181,847***	***15,154***	30,192	***40,000***	***1,899***	68,293	378	***0***	***44***	334	***889***	***150***	***1***	1,038	***3,670***	***500***	***1,017***	3,153	27,593	***32,000***	***3,954***	55,639	***79,994***	***0***	582	79,412	***43,610***	***80,640***	***1,953***	122,297	***344,583***	***148,800***	***51,617***	441,766	0	0	0	0	***274***	0	0	274
72	KAMINA	Kabongo	336,839	70,736	5,895	444	0	535	-91	70	0	0	70	62	0	0	62	11803	0	159	11,644	7000	0	1,740	5,260	7303	0	840	6,463	3335	0	837	2,498	93950	0	23,856	70,094	1194	0	123	1,071	1,531	0	51	1,480
73		Kinkondja	234,077	49,156	4,096	939	0	789	150	120	0	2	118	137	0	0	137	1692	0	423	1,269	6301	0	2,976	3,325	2768	0	2,145	623	2789	0	0	2,789	20796	0	8,698	12,098	0	0	63	-63	0	0	0	0
74		Songa	168,783	35,444	2,954	827	0	708	119	53	0	0	53	60	0	0	60	936	0	168	768	4480	0	36	4,444	2300	0	29	2,271	1353	0	358	995	3033	0	7,394	-4,361	214	0	450	-236	0	0	0	0
75		Kayamba	98,517	20,689	1,724	124	0	128	-4	39	0	9	30	60	0	0	60	1021	0	849	172	4142	0	617	3,525	1927	0	2,001	-74	1835	0	179	1,656	4048	0	11,517	-7,469	482	0	40	442	54	0	24	30
76		Kitenge	260,809	54,770	4,564	247	0	234	13	87	0	0	87	12	0	0	12	1000	0	180	820	7203	0	7,919	-716	29825	0	2,979	26,846	1654	0	0	1,654	48199	0	30,110	18,089	0	0	0	0	0	0		0
77		Lwamba	125,233	26,299	2,192	152	0	145	7	30	0	0	30	50	0	0	50	0	0	47	-47	3129	0	610	2,519	1072	0	31	1,041	0	0	19	-19	6566	0	5,144	1,422	0	0	0	0	1,156	0	0	1,156
78		Malemba	244,392	51,322	4,277	577	0	583	-6	133	0	0	133	13	0	0	13	0	0	93	-93	5134	0	2,529	2,605	8104	0	1,020	7,084	0	0	0	0	102714	0	12,738	89,976	0	0	0	0	0	0	0	0
79		Mukanga	202,043	42,429	3,536	390	0	431	-41	70	0	0	70	20	0	0	20	1822	0	156	1,666	4943	0	999	3,944	3726	0	283	3,443	4979	0	57	4,922	155905	0	16,671	139,234	2375	0	384	1,991	0	0	5	-5
80		Mulongo	268,800	56,448	4,704	1,013	0	1,137	-124	100	0	9	91	61	0	0	61	976	0	753	223	6178	0	508	5,670	4000	0	0	4,000	3000	0	0	3,000	194	0	18,006	-17,812	165	0	372	-207	0	0	0	0
	s/total 8		***1,939,493***	***407,294***	***33,941***	***4,713***	***0***	***4,690***	23	***702***	***0***	***20***	682	***475***	***0***	***0***	475	***19,250***	***0***	***2,828***	16,422	***48,510***	***0***	***17,934***	30,576	***61,025***	***0***	***9,328***	51,697	***0***	***0***	***1,450***	-1,450	***435,405***	***0***	***134,134***	301,271	***4,430***	***0***	***1,432***	2,998	***2,741***	***0***	***80***	2,661

	TOTAL GENERAL		12,423,768	2,608,993	217,418	207,911	108,441	49,795	266,557	1,921	2,416	1,295	3,042	3,705	7,384	1,020	10,069	55,596	411,016	9,578	457,034	307,381	158,735	167,609	298,507	365,616	63,043	40,172	388,487	142,961	177,667	27,587	293,041	1,714,173	1,135,714	886,629	1,963,258	37,541	26,315	10,990	52,866	18,028	26,376	2,186	42,218

Appendix 4 : NGO Inventory List

Coordination de Tshumbe

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	Association MAMANS CATHOLIQUE	Agriculture	Femmes	Vanga Kete
02	Association MAMANS BONGISA	Agricole	Femmes	Vanga Kete
03	Association SOLIDARITE POTOHA	Lutte contre le VIH/SIDA	Jeunes	Ototo
04	GRESA	Agriculture et Education de la jeunesse	Jeunes	Ototo
05	OJWSP	Santé	Jeunes	Omendjadi
06	Espoir pour le Développement du Sankuru (EDS)	Sécurité alimentaire	Jeunes	Tshumbe
07	JEUNESSE POUR CHRIST (JPC)	Encadrement de la jeunesse	Jeunes	Wembonyama
08	Groupe de femmes unies pour le développement du Sankuru, GFUDS en sigle	lutte contre le VIH, TBC, Malaria et la pauvreté	Femmes vulnérables	Lodja
09	UFELFA	Encadrement de filles mères et prevention du VIH/SIDA	Jeunes mères	Lodja
10	Association de Mamans Methodistes	Planification familiale et Malnutrition	Femmes	Minga
11	Association pour le Developpement de Lubefu (ADELU)	Agriculture, Elevage et Planification Familiale	Femmes	Minga

Coordination de Mwene Ditu

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	Club des Jeunes Scolarisés Moyo Mupeluka wa Maria (cycle court))	Développement et Santé	OAC des jeunes filles	Mwene Ditu
02	Complexe Scolaire Professionnel	Développement et santé	OAC des jeunes	Mwene Ditu

03	Complexe Scolaire SEFAMU	Enseignement	OAC des jeunes	Mwene Ditu
04	Club des Jeunes Scolarisés Les Elites	Développement et santé	OAC des jeunes	Mwene Ditu
05	Club des Jeunes Scolarisés de BONDOYI	Développement et santé	OAC des jeunes	Mwene Ditu
06	Club des Jeunes Scolarisés Mgr MUKENG	Développement et santé	OAC des jeunes	Mwene Ditu
07	Club des Jeunes Scolarisés MAWEJA Mushindame	Développement et santé	OAC des jeunes	Mwene Ditu
08	Club des Jeunes Scolarisés Charles LWANGA	Développement et santé	OAC des jeunes	Mwene Ditu
09	Club des Jeunes Scolarisés MUAN A MAWEJ	Développement et santé	OAC des jeunes	Mwene Ditu
10	Club des Jeun es Scolarisés BONSO TUTANTE	Développement et santé	OAC des jeunes	Mwene Ditu
11	Club des Jeunes Scolarisés DE MWENE DITU	Développement et santé	OAC des jeunes	Mwene Ditu
12	Institut Supérieur de Techniques Médicales VICTOIRE	Santé et Développement	OAC des jeunes	Mwene Ditu
13	Club des Jeunes Scolarisés MUNVUYI	Santé et Développement	OAC des jeunes	Mwene Ditu
14	Institut Technique Médical MUAKA	Santé et Développement	OAC des jeunes	Mwene Ditu
15	Institut Supérieur Médical Rehobot	Santé et Développement	OAC des jeunes	Mwene Ditu
16	Club des Jeunes Scolarisés Christ Roi de KANDAY	Santé et Développement	OAC des jeunes	Mwene Ditu
17	Club des Jeunes Scolarisés Lycée Notre Dame de la Jeunesse	Santé et Développement	OAC des jeunes	Mwene Ditu
18	Club des Jeunes Scolarisés Notre Dame de Fatima	Santé et Développement	OAC des jeunes	Mwene Ditu
19	Club des Jeunes Scolarisés Lycée Cœur Immaculé de Marie	Santé et Développement	OAC des jeunes	Mwene Ditu
20	Club des Jeunes Scolarisés Lycée Moyo Mupeluka wa Maria (Cycle long)	Santé et Développement	OAC des jeunes	Mwene Ditu
21	Club des Jeunes Scolarisés MUSAMPI BONDOYI	Santé et Développement	OAC des jeunes	Mwene Ditu
22	Club des Jeunes Scolarisés LUANYO	Santé et Développement	OAC des jeunes	Mwene Ditu
23	Club des Jeunes Scolarisés Christ Roi 2	Santé et Développement	OAC des jeunes	Mwene Ditu
24	Club des Jeunes Scolarisés Collège Père MARC	Santé et Développement	OAC des jeunes	Mwene Ditu
25	Club des Jeunes Scolarisés Collège Vital Maurice	Santé et Développement	OAC des jeunes	Mwene Ditu
26	Club des Jeunes Scolarisés TUDJENGE MUNARA	Santé et Développement	OAC des jeunes	Mwene Ditu

27	Club des Jeunes Scolarisés Lycée Mater Dei	Santé et Développement	OAC des jeunes	Mwene Ditu
28	Club des Jeunes Scolarisés Lycée MUSADIDI	Santé et Développement	OAC des jeunes	Mwene Ditu

Structures des Jeunes Non-Scolarises (Mwene Ditu)

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
29	Action Chrétienne pour l'Abolition de la Torture des Jeunes	VIH/SIDA et PF	OAC des jeunes	Mwene Ditu
30	Association des Chargeurs du Kasaï Oriental	Transport et Santé	OAC des jeunes	Mwene Ditu
31	Association des Colporteurs Pédaleurs de Mwene Ditu	Transport et Santé	OAC des jeunes	Mwene Ditu
32	Association pour le Développement Communautaire	Développement et Santé	OAC des jeunes femmes	Mwene Ditu
33	Association des Jeunes pour le Développement Fraternel	Développement et Santé	OAC des jeunes	Mwene Ditu
34	Association des Jeunes pour le Développement intégral	Développement et Santé	OAC des jeunes	Mwene Ditu
35	Association des Jeunes Manutentionnaires du Kasaï	Transport et Santé	OAC des jeunes	Mwene Ditu
36	Action Sociale Kasaï Développement	A Développement et Santé JDI	OAC des jeunes	Mwene Ditu
37	Action Communautaire pour le Développement Intégral du Kasaï	Développement et Santé	OAC des jeunes	Mwene Ditu
38	Groupe Social d'Entraide Mutuelle	Développement et Santé	OAC des jeunes	Mwene Ditu
39	Assemblée Chrétienne de Kinshasa/Jeunesse Pour Christ	Développement et Santé	OAC des jeunes	Mwene Ditu
40	Club des Jeunes Volontaires pour la Lutte contre le Sida	VIH/SIDA	OAC des jeunes	Mwene Ditu
41	Club des Auditeurs des Radios Okapi et Tutante	Information et Santé	OAC des jeunes	Mwene Ditu
42	Entente Urbaine de Football Féminin)	Sport et Santé	OAC des jeunes femmes	Mwene Ditu
43	Club Karaté CHENOURS KYU	Sport et Santé	OAC des jeunes	Mwene Ditu
44	Jeunesse pour le Développement du Territoire de Ngandajika	Développement et Santé	OAC des jeunes	Mwene Ditu
45	Comité des Etudiants de la Victoire	Développement et Santé	OAC des jeunes	Mwene Ditu
46	Jeunesse en Mission pour Christ (JMC/Communauté Evangélique au Congo)	Développement et Santé	OAC des jeunes	Mwene Ditu
47	KIRO CATHOLIQUE	Développement de la jeunesse	OAC des jeunes	Mwene Ditu

48	Mouvement de Développement pour la Relance des Bonnes Mœurs des Jeunes	Développement et Santé	OAC des jeunes	Mwene Ditu
49	ORPHELINAT BENA DIANYI	Nutrition et Réinsertion sociale	OAC des jeunes	Mwene Ditu
50	SCOUT/Société Nationale de Chemin de Fer du Congo	Développement et Santé	OAC des jeunes	Mwene Ditu
51	TROUPE THEATRALE LA VICTOIRE	Culture et Santé	OAC des jeunes	Mwene Ditu
52	CLUB ESPOIR	Santé	OAC des jeunes	Mwene Ditu
53	Club des Jeunes Chrétiens pour la Lutte contre le Sida	Santé/VIH SIDA	OAC des jeunes	Mwene Ditu
54	Association des Chauffeurs de Taxi Moto	Transport et Santé	OAC des jeunes	Mwene Ditu
55	Association des Chauffeurs du Congo	Transport et Santé	OAC des jeunes	Mwene Ditu
56	Association des Coiffeurs pour le Développement du Kasaï Oriental	Coiffure et Lutte contre le VIH	OAC des jeunes	Mwene Ditu
57	Ligue de la Zone Afrique pour la Défense des Droits des Enfants, Elèves, Etudiants et de la Femme	Droits de l'Homme et VIH	OAC des jeunes	Mwene Ditu
58	Centre d'Ecoute et d'Information Conviviale aux Adolescents	Communication sur la santé	OAC des jeunes	Mwene Ditu
59	Radio Mont Carmel et Télévision	Média et communication	OAC des jeunes	Mwene Ditu
60	Synergie pour le Développement du Kasaï	Développement et santé	OAC des jeunes	Mwene Ditu
61	Institut Technique Médical Notre Dame de Grâce	Santé	OAC des jeunes	Mwene Ditu
63	Centre Universitaire de Mwene Ditu	Développement et santé	OAC des jeunes	Mwene Ditu
64	Action des Etudiants pour le Développement de la Jeunesse	Développement et santé	OAC des jeunes	Mwene Ditu
65	Club des Adolescents pour le Développement	Développement et santé	OAC des jeunes	Mwene Ditu
66	Association des Filles pour le Développement de de Wikong	Développement et Santé	OAC des jeunes filles	Wikong
67	Club des Adolescents de Wikong	Développement et Santé	OAC des jeunes garçons	Wikong
68	Assistance pour Enfants Sans Protection	Protection des enfants	ONG Mixte	Mwene Ditu
69	Action Chrétienne pour le Développement Intégral	Santé, Agriculture et Scolarisation	ONG Mixte	Mwene Ditu
70	Femmes Unies pour le Développement	Santé et Agriculture	ONG des femmes	Kamiji
71	Action pour le Développement Intégral de Kamiji	Développement Rural	ONG Mixte	Kamiji
72	Associations des Mamans de l'Eglise	Développement	OAC des femmes	Kanda Kanda

	EELDA	Rural		
73	Association des Mamans de CPCO	Développement Rural	OAC des femmes	Kanda Kanda
74	ONG ESPOIR	Encadrement des jeunes	ONG des jeunes	Kanda Kanda
75	Mouvement KIRO/SCOUT	Encadrement des jeunes	OAC des jeunes	Kanda Kanda
76	Association Femmes Debout de Kayind	Développement	OAC des femmes	Wikong
77	Femmes Unies pour le Progrès	Développement	OAC des femmes	Wikong
78	Association Bon Berger de Muadi	Développement	OAC des femmes	Wikong

Coordination de Bukavu

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	Promotion et Appui aux Initiatives Féminine	Droit de l'homme, Violence sexuelles, Développement durable	ONG des femmes	ZS Katana
02	Réseau du Mouvement Paysan de Katana	Développement rural	Mixte	ZS Katana
03	Groupe d'Encadrement des Eleveurs de Katana	Agriculture et Développement rural	ONG des jeunes	ZS Katana
04	Association des Femmes pour la Sécurité Alimentaire dans le Ménage	Agriculture, Sécurité alimentaire et Développement rural	ONG des femmes	ZS Katana
05	Maman Bulezi de Katana		ONG des femmes	ZS Katana
06	Programme d'Initiative Agricole et Développement	Agriculture et Développement rural	Mixte	ZS Walungu
07	Association des Femmes pour la Planification Familiale et DBC	Planning familial	ONG des femmes	ZS Walungu
08	Solidarité pour le Développement de Kaniola	Développement durable	Mixte	ZS Walungu
09	Union des Familles pour le Développement Rural	Développement Communautaire	Mixte	ZS Walungu
10	Association de Développement pour le Progrès Social	Encadrement des Filles	Association locale	ZS Miti-Murhesa
11	Organisation Villageoise pour le Progrès	Développement Communautaire	Association locale	ZS Miti-Murhesa
12	MAMAN RHUDOSANE	Encadrement des Jeunes filles	Association locale	ZS Miti-Murhesa

13	BDOM	Sante et Développement	Mixte	ZS Kadutu
14	PLD	Sante et Développement	Jeunes	ZS Kadutu
15	FONDATION MPANZI/PROJET UNSHINDI	Développement Communautaire	Mixte	ZS Ibanda
16	FONDATION MPANZI/MAISON DORCAS	Santé et développement	Jeunes	ZS Ibanda

Coordination de Kole

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	ASSOCIATION DES FEMMES INTEGREES POUR LE DEVELOPPEMENT DU SANKURU	PF , SGBV	Femmes	Kole
02	ASSOCIATION DES FEMMES PAYSANNES ET PROFESSIONNELLES DE SEXE	PF, SGBV,VIH/Sisa	Femmes	Lomela
03	ASSOCIATION POUR LA DEFENSE DE DROIT DE LA FEMME ET DE L'ENFANT	PF, SGBV, VIH/Sida	Femmes	Benadibele
04	ASSOCIATION DES JEUNES POUR LE DEVELOPPEMENT RURAL	SDBV, VIH/Sida	Jeunes	Kole et Benadibele
05	ASSOCIATION POUR L'ALPHABETISATION DES FEMMES ET FILLES-MERES RURALES DE KOLE	PF, SDBV	Jeunes/Filles	Kole
06	CENTRE DE FORMATION POUR UNE FEMME CAPABLE	Nutrition, SMNE, PF	Femmes	Kole

Coordination de Luiza

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	PROFA (projet des femmes et familles	Sensibilisation sur les droits de la femme, accompagnement psychosocial des victimes des violences sexuelles	Femme	Luiza
02	Centre MUKUNDA	Secutrans, secualimentaire,	Mixte	Luiza

03	RAF(réseau actions femmes)	Encadrement femmes en nutrition et technologie appropriée	Femmes	Luiza
04	AMKOLD	Nutrition, violence sexuelle	Femmes	Luiza
05	REFEDEF	Droit et Développement	Femmes	Ndekesha
06	AJDB (assoc. Des donneurs bénévoles du sang)	Don du sang, Assistance	Mixte	Dibaya
07	PROFER (projet des femmes rurales	Agriculture et conservation des semences	Femmes	Dibaya
08	Association des églises de réveil pour l'unité(AERU)	Vulgarisation des messages évangélique et la promotion de la santé, éducation chrétienne pour le changement de comportement et prévoir l'avenir, lutte contre la violence, tracasserie et banditisme)	-	Kalomba
09	Comité de DVPT de Tshitadi (CODET)	Élevage agropastorale, aménagement des routes, sources d'eaux et portes	Mixte	Kalomba
10	Organisation des jeunes de Tshitadi pour le DVPT (OJTD)	CCC, Aide mutuel	Mixte	Kalomba
11	Fratérnité des jeunes charismatiques de Kalomba (FJCK)	Education des jeunes pour la vie missionnaire et laïc Aide mutuel	Mixte	Kalomba
12	Association pour le DVPT Intégré de Kalomba	Aménagement des sources d'eaux, routes, aide mutuel	Mixte	Kalomba
13	Association de jeunes debout (AJD)	-	Jeunes	Bilomba
14	Couture Ndeja	Encadrement des jeunes filles	Mixte	Tshikaji
15	FERMAK (Fille mère de tshikaji - Ferme Mampanga Kabuanga)	Encadrement Filles mères	Femmes/Filles	Tshikaji
16	DIAMUAMUA	Agriculture et élevage parcellaire	Mixte	Tshikaji
17	ASS TUYE KUMPALA	Agriculture et élevage	Mixte	Tshikaji
18	CLUB DE JEUNES LA COLOMBE	Prévention de VIH, planification familial, mariage précoce	Mixte	Tshikaji

19	ASS TUYE LUMUE			
20	CEPO (centre d'encadrement des personnes opprimées)	Promotion, protection de la femme et de l'enfant, violence sexuelle, PF, VIH, PEC enfants orphelins	Mixte	Luiza
21	UJIKI (Union des jeunes Kimbanguiste)	Sante et développement	Jeunes	Tshikaji
22	Association des jeunes pour le developpement de Mutefu (AJDM)	Agro-pastoral et entretien des routes	Mixte	Bilomba

Coordination d'Uvira

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	UGEAFI	Agriculture	Mixte	Uvira-Fizi
02	Centre d'Encadrement des jeunes pour le développement intégré	Construction et sécurité alimentaire	Jeunes	Uvira-Fizi
03	Debout Femmes de Lweba	Agriculture, défense droits des femmes	ONG des Femmes	Sud Kivu
04	SOS JEUNESSE ET ENFANCE	Lutte contre les viols et violence sexuelle, santé mentale	Jeunes	Uvira-Fizi
05	SCODAP	Agriculture, elevage, pèche, promotion de la femme	Mixte	Uvira
06	MONSO-MATUMAINI	Microcrédit	Mixte	Uvira
07	GAPHU	Sensibilisation, renforcement des capacités	Mixte	Uvira-Fizi
08	Femmes en Action pour le développement Intégré	Agri culture et élevage	Femmes	Uvira-Fizi
09	Promotion et Développement des Artisans et Paysan (PRODAP)	Agriculture et malnutrition	Mixte	Uvira
10	UWAKI	Agriculture et élevage	Femmes	Uvira-Fizi
11	Mutualité NYINDU FULIRU	Aide interfamiliale	Mixte	Uvira-Fizi
12	Ensemble pour la Promotion de la femme (EPF)	Elevage et microcredit	Femmes	Uvira
13	ADHB	Agri culture, élevage, et microcrédit	Mixte	Uvira
14	Femmes Soyons en Action (FESA)	Hygiène, assainissement, genre, VIH	femmes	Uvira-Fizi
15	Association des Jeunes Mulangaliro	Agriculture, élevage et entraide	Jeunes	Uvira
16	Association des Jeunes de la Sucrerie de Kiliba	Entraide, élevage	Jeunes	Ruzizi
17	Association des Jeunes Musaka	Education	Jeunes	Ruzizi

18	Association des Jeunes Umodja	Entraide et agriculture	Jeunes	Ruzizi
19	Association des Jeunes Kusaidjana	Entraide	Jeunes	Ruzizi

Coordination de Kolwezi

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	AFIMADE ASSOCIATIONS DES FILLES MERES DEMUNIES	-Occupation des filles et mères démunies -Enseignement coupe et couture -Sensibilisation sur le VIH SIDA	Filles	Lubudi
02	ASSOCIATION FEMININE POUR LE DEVELOPPEMENT - AFEDEV	-Education aux filles et garçons sur les IST -Agriculture	Femmes	Lubudi
03	SOCIETE AFRCAINE DES FEMMES CONTRE LE SIDA (SWAA en Anglais)	-Sensibilisation VIH SIDA -Occupation des filles et mères illettrées	Mixte	Lubudi
04	WORLD VISION AREA DEVELOPMENT PROGRAM	-VIH (sensibilisation) -watsan (forage) -Revitalisation	Mixte	Fungurume
05	BANA TSHAD	-Sensibilisation VIH/SIDA et planification familiale -Agropastoral -Sensibilisation de la population sur les problèmes de santé	Mixte	Kanzenze
06	BUREAU DIOCESAIN DES ŒUVRES MEDICALES	-Sensibilisation dans le cadre de la lutte contre le VIH SIDA -Prise en charge des malades mentaux	Mixte	Dilala
07	RACOJE (réseau des associations congolaises des jeunes)	-Sensibilisation dans le cadre de la lutte contre le VIH SIDA	Jeunes	Dilala
08	SISTER TO SISTER	- Sensibilisation dans le cadre de la lutte contre le VIH SIDA	Femmes	Dilala
09	CMT ONG , COOPERATIVE des mamans	- Culture maraichère	Femmes	Dilala

	Tujenge (100 membres)			
10	Plate forme des mamans de Luilu (200 membres)	- Culture maraichère	Femmes	Dilala
11	ONG LA GRACE (62 membres)	- Encadrement des filles-mères à DIUR (coupe et couture, tricotage et alphabétisation)	Femmes et filles	Dilala
12	CENTRE NURU (10 membres)	- Encadrement des femmes et filles handicapées (coupe et couture, tricotage)	Femmes et filles meres	Dilala
13	ASSOCIATION DES MAMANS PLEUREUSES (500 membres)	- Encadrement de femmes veuves	Femmes	Manika
14	ASSOCIATION DES MAMANS DE L EGLISE DES NOIRS EN AFRIQUE ENAF	- Encadrement des filles-mères et des veuves (préparation de munkoyo, coupe et couture, autres AGR)	Femmes	Manika
15	RESEAU DES ASSOCIATIONS CONGOLAISES DES JEUNES	-	Jeunes	Dilala
16	CLUB ADO DEV ADOLESCENT POUR LE DEVELOPPEMENT	Développement des écoliers	Jeunes	Dilala

Coordination de Kamina

No.	Nom de l'ONG/OAC	Domaine d'intervention	Type de ONG/OAC	ZS d'intervention
01	Action des Femmes pour le Développement et la Protection des Enfants	Leadership féminin, Santé, Education, Enjeux électoraux, Violence sexuelle, Paix et réconciliation, Infrastructure, Agriculture et élevage, Economie	Femmes	Kamina, Kinda, Kabondo, Bukama, Malemba, Songa, Kaniama, Kabongo, Kitenge
02	Amis des Personnes en Détresse	Education enfants sortis des groupes de forces armées, Santé	Mixte	Kinshasa, Katanga, Kasaï orientale
03	Mamans Maraichères	Agriculture, Elevage, Santé	Femmes	Kamina
04	Centre BWIMWA Département genre	Education, Santé	Femmes	Kamina

05	Promotion des Personnes vivant avec Handicap et Amis	Agriculture, Elevage, Education, Santé, Coupe couture, Cordonnerie	Mixte	Kamina, Songa (Kipukwe)
06	Association des femmes pour le developpement des personnes en detresse	Agriculture, Elevage, Social, Entraide, Santé, Education	Femmes	Songa, Kayamba
07	Action pour Promotion des Initiatives et le Développement de la Femme	Agriculture, Education, Infrastructure, Santé	Femmes et filles	Kamina, Songa, Bukama
08	Mouvement des Mamans Catholiques de Kamina	Agriculture, Elevage, Santé, Education, Enjeux électoraux, Economie	Femmes	Kamina (11 paroisse), Kaniama, Kinda, Kabongo, Kitenge, Kayamba, Kabondo, Bukama
09	Union des Femmes Musulmanes du Congo	Agriculture, Elevage, Santé, Education, Economie	Femmes	Kamina
10	Associations des Femmes Nouvelle Eglises Méthodiste.	Elevage, Education, Santé	Femmes	Kamina
11	Batwa Bemba	Santé, Elevage et Agriculture, Alphabétisation	Mixte	Kayamba, Kabongo, Malemba, Bukama, Kamima

Appendix 5: Sample Champion Community action plan (Muangaza)

Projet de Sante Integre

USAID

OSC msh

TERRITOIRE D'UVIRA
CPCC MUANGAZA
Sange Etat,CEPAC et Nazareno

Plan d'action CC MUANGAZA 1èPhase Juin 2013

N°	Objectifs	Activités	Responsables								Résultats Attendus	Période/ 2013					
			CPCC	APA	Partenaires	Reco	AC	Associations des jeunes et Femmes	Eglieses	Ecoles		J	J	A	S	O	N
1	D'ici fin Nov 2013, récupérés 280 Enf de 0-11mois pour la vaccination des 3AS couverte par l'approche CC	Identifier les parents avec enfants cibles (0-11 mois) en retard avec antigène sur le CV				*	*	*	*		les ménages avec MILD sont identifiés	*	*	*	*	*	*
		sensibiliser les parents à amener leurs enfants au CS lors des séances de vaccination pour récuperer le vaccin rater.				*	*	*	*	*	Tous les membres des ménages dorment chaque nuit sous le les latrines MILD.	*	*	*	*	*	*
		Tenir les réunions mensuelles de monitoring sur les nombre des enfants récupérés lors des séances de vaccination.	*								Les activités de sensibilisations sont suivis et évaluées mensuellement.	*	*	*	*	*	*
2	D'ici fin nov , Orienter 450 femmes enceintes pour beneficier d'un accouchement assité au CS	Identifier les femmes enceintes cibles				*	*	*	*		les femmes enceintes cibles sont Identifiées.	*	*	*	*	*	*
		Sensibiliser ces femmes enceintes à utiliser le service de la CPN dans les CS avec maternité des 3 AS couverte par l'approche CC				*	*	*	*		Les femmes enceintes sont récuperées et orientées au service de la CPN dans les CS avec maternité des 3 AS couverte par l'approche CC	*	*	*	*	*	*
		Evaluer les accouchement mensuelles dans la CC.	*								Les accouchement des femmes orientées sont suivi et évaluer mensuellement.	*	*	*	*	*	*
3	D'ici fin nov 2013,orienter 1000 couples à adhérer et pratiquer les différentes méthodes de PF de leur choix.	Identifier les couples				*	*	*	*		Les couples cibles de la PF sont identifiées	*	*	*	*	*	*
		Etablir les listes et jetons d'orientations.	*								les listes,jetons d'orientations sont établits et rendus disponibles aux AC.	*					
		Sensibiliser les couples sur l'importance de la PF.				*	*	*	*		Les couples sont sensibilsées sur l'importance d'utiliser une des méthodes contraceptives pour les biens être de leur famille.	*	*	*	*	*	*
		Faire le suivi ds activités menées par des DBC dans les AS.				*	*	*			Les couples sensibilisées sont suivis au service de PF pour se rassurer sur leurs orietations.		*			*	
		Evaluer mensuellement l'utilisation des services PF.	*								Les couples sensibilisées utilisent les services de la PF pour les biens être de leur famille.	*	*	*	*	*	*

4	D'ici fin nov , Sensibiliser les populations des 3AS sur 3+1/ les pratiques d'utilisation des MIILD,Reference précoce de tout cas defièvre,Terminer la dose préscrite par l'agent de santé) +1 (Orienter chaque femme enceinte au CS pour beneficier les 2 doses SP)assainissement peri et intra domiciliaire pouvant amener à la reduction des cas de décès lié au paludisme.	Identifier les ménages ayant bénéficiés les MILD.				*	*	*	*	*	les ménages avec MILD sont identifiés	*	*	*	*	*	*
		Sensibiliser les responsables des ménages sur utilisation correcte des MILD, et le respect des autres pratiques				*	*	*	*	*	les populations des 3AS sont sensibilisées sur 3+1/ et les pratiques	*	*	*	*	*	*
		Tenir les réunions mensuelles de monitoring sur les séances des sensibilisations réalisées.	*								Les activités de sensibilisations sont suivis et évaluées mensuellement.	*	*	*	*	*	*
5	**D'ici fin Novembre 2013, amener 660. ménages des 3 AS à amenager et utiliser correctement les latrines hygièniques**	Identifier les ménages avec latrine en mauvais etat ou sans latrine (à construire)				*	*	*	*	*	les ménages avec où sans latrines/hygièniques sont identifiés	*	*				
		Sensibiliser les responsables des ménages à amenager/ construire leurs latrines				*	*	*	*	*	Les responsables des ménages amenagent/ construire leurs latrines	*	*	*	*	*	*
		Sensibiliser les autres membres à utiliser le latrines aménagées				*	*	*	*	*	Tous les membres des ménages utilisent les latrines hygièniques.	*	*	*	*	*	*
		Evaluer les latrines hygièniques amenagées et utilisées dans les AS.	*								Les activités de sensibilisations réaliséessont suivis et évaluées mensuellement.	*	*	*	*	*	*

Visa du MCZ où Son Représentant

Fait à UVIRA le 01/ 06/2013

Pour le CPCC MUANGAZA

Président où vice-président

COMITE DE PILOTAGE COMMUNAUTE CHAMPIONNE
AIRES DE SANTE KASENGA
C.P.C.C.
CEPAC . ETAT . NAAA
MWANGAZA

BISHEKO BIRIKANI

Appendix 6

12	BCC	Vololoniania Razaka	OSC	July 15 - 30,2014	Assess the progress made by IHP's certified Champion Communities in becoming self-sufficient.Training modules will be adjusted and developed as needed in order to adapt the sustainability plan.	Antananarivo/Kinshasa	15	Planned
13	Workplanning	Andrea Spakaukas	OSC	September 1-15, 2014	Andrea will travel to Kinshasa to provide technical and management support during the workplanning workshop for PY5 and continued assistance with finalizing the work plan post-workshop.	Philadelphia/Kinshasa	15	Planned
14	Workplanning	Elena Chopyak	MSH	September 1-15, 2014	Provide technical and management support during workplanning workshop for PY5.	Boston/Kinshasa	16	Planned
15	Workplanning	Kristin Cooney	MSH	September 1-15, 2014	Provide technical and management support during workplanning workshop for PY5.	Boston/Kinshasa	15	Planned
16	Workplanning	Joan Marshall-Missiye	MSH	September 15-30, 2014	Provide technical and management support during workplanning workshop for PY5.	Boston/Kinshasa	15	Planned
17	Workplanning	Aboubakar Mama Sambo	MSH	September 15-30,2014	Provide technical and financial support during workplanning workshop for PY5.	Boston/Kinshasa	15	Planned
18	RBF	Alfred Antoine	Consultant	September 15-30, 2014	Provide technical support for RBF activities.	Kigali/Kinshasa	15	Planned
19	Workplanning	Jean Kagubare	MSH	September 1-15, 2014	Provide technical support for RBF activities and during workplanning workshop for PY5.	Boston/Kinshasa	15	Planned
		New trips requiring approval are indicated in olive green (these trips have been added or more precise details provided since the version of the STTA plan submitted on (date).						

Integrated Health Project (IHP) Year 4 International Travel and STTA Plan Oct 2013 - Sept 2014								
#	TECHNICAL AREA	SUGGESTED PERSON	ORG	TRAVEL DATES	INDICATIVE SCOPE OF WORK	ORIGIN/DESTINATION	LENGTH OF TRIP (DAYS)	STATUS
INTERNATIONAL TRAVEL IHP LOCAL STAFF AND PARTNERS								
Quarter 1 Oct-Dec 2013								

1	i-CCM	Narcisse Embeke	MSH	October 4-12, 2013	Participate in and present during Diarrhea and Pneumonia Working group, and to present IHP i-CCM work to the Cambridge office	Kinshasa/Washington DC, USA	8	Completed
2	Family Planning	Ousmane Faye	MSH	November 12-15, 2013	Present IHP abstract on community based distributors at the 2013 International Family Planning Conference	Kinshasa/Addis Ababa	5	Cancelled
3	RBF	TBD	MSH	November	Study trip to exhange RBF lessons learned and experience.	Kinshasa/Burundi		Postponed
Quarter 2 Jan-March 2014								
4	Malaria	Local Staff IHP/ TBD	MSH	March 2014	Conference participation if an abstract is accepted	Kinshasa/TBD	7	Planned
5	RBF	TBD	MSH	March 2014	To share RBF experiences and lessons learned.	Kinshasa/Haiti	10	Planned
Quarter 3 April-June 2014								
6	MNCH	TBD	MSH	TBD	Conference participation if an abstract is accepted.	Kinshasa/TBD	7	Planned
7	i-CCM	TBD	MSH	TBD	Conference participation if an abstract is accepted.	Kinshasa/Nairobi	7	Planned
8	RBF	TBD	MSH	TBD	To share RBF experiences and lessons learned.	Kinshasa/Europe	10	Planned
Quarter 4 Jul-Sep 2014								
9	Nutrition	TBD	MSH	TBD	Conference participation if an abstract is accepted	Kinshasa/	7	Planned
		New trips requiring approval are indicated in olive green (these trips have been added or more precise details provided since the version of the STTA plan submitted on (date).						

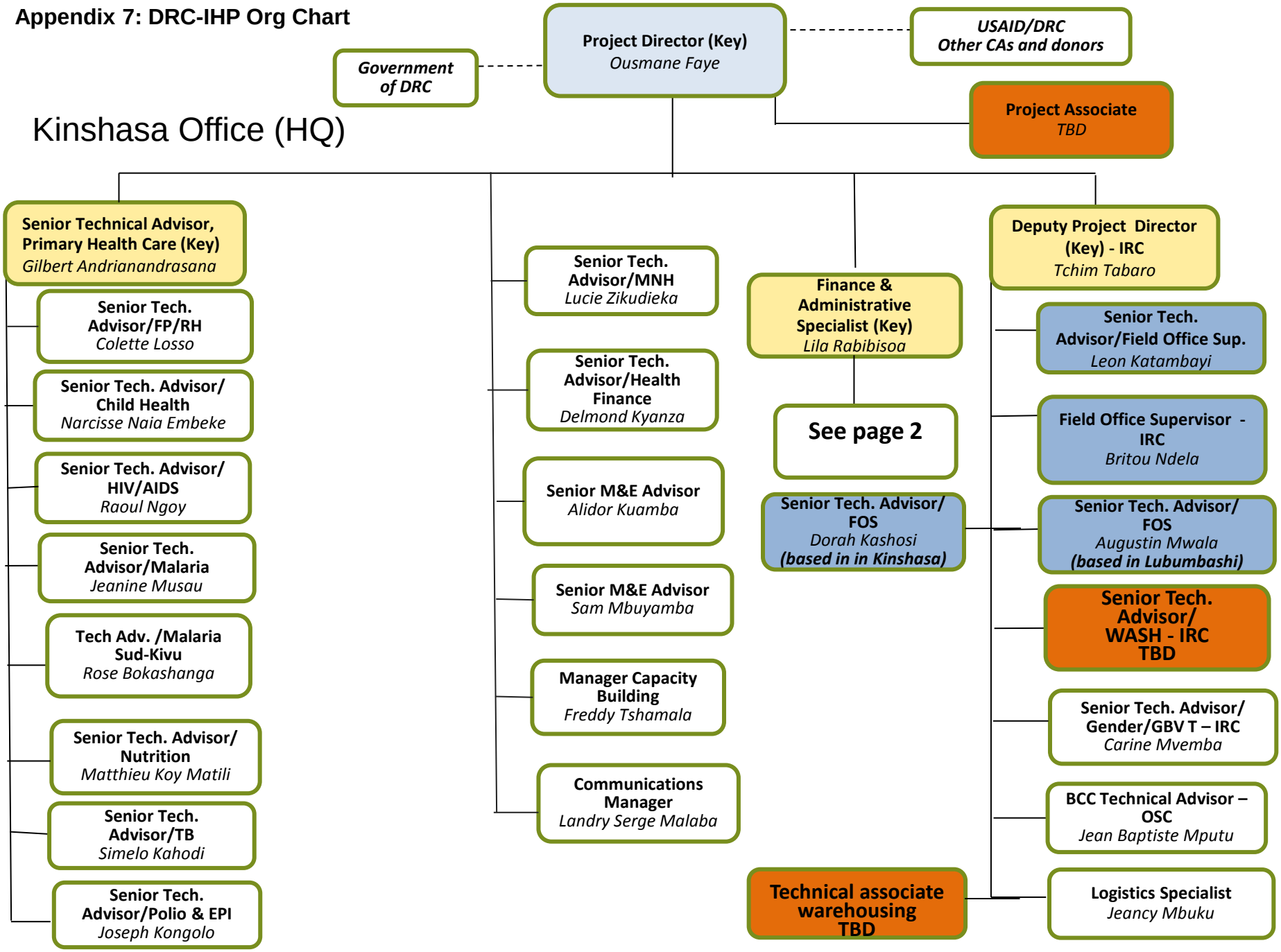
Integrated Health Project (IHP) Year 4 International Travel Oct 2013 - Sept 2014

#	TECHNICAL AREA	SUGGESTED PERSON	ORG	TRAVEL DATES	INDICATIVE SCOPE OF WORK	ORIGIN/DESTINATION	LENGTH OF TRIP (DAYS)	STATUS
ALLOWANCES TRAVEL								
Quarter 1 Oct-Dec 2013								
Quarter 2 Jan-March 2014								
Quarter 3 April-June 2014								
1	Program Management (COP)	Ousmane Faye dependent	MSH	June 2014	Education travel	DC/Kinshasa		Planned
2	Program Management (COP)	Ousmane Faye dependent	MSH	June 2014	Education travel	DC/Kinshasa		Planned
Quarter 4 Jul-Sep 2014								

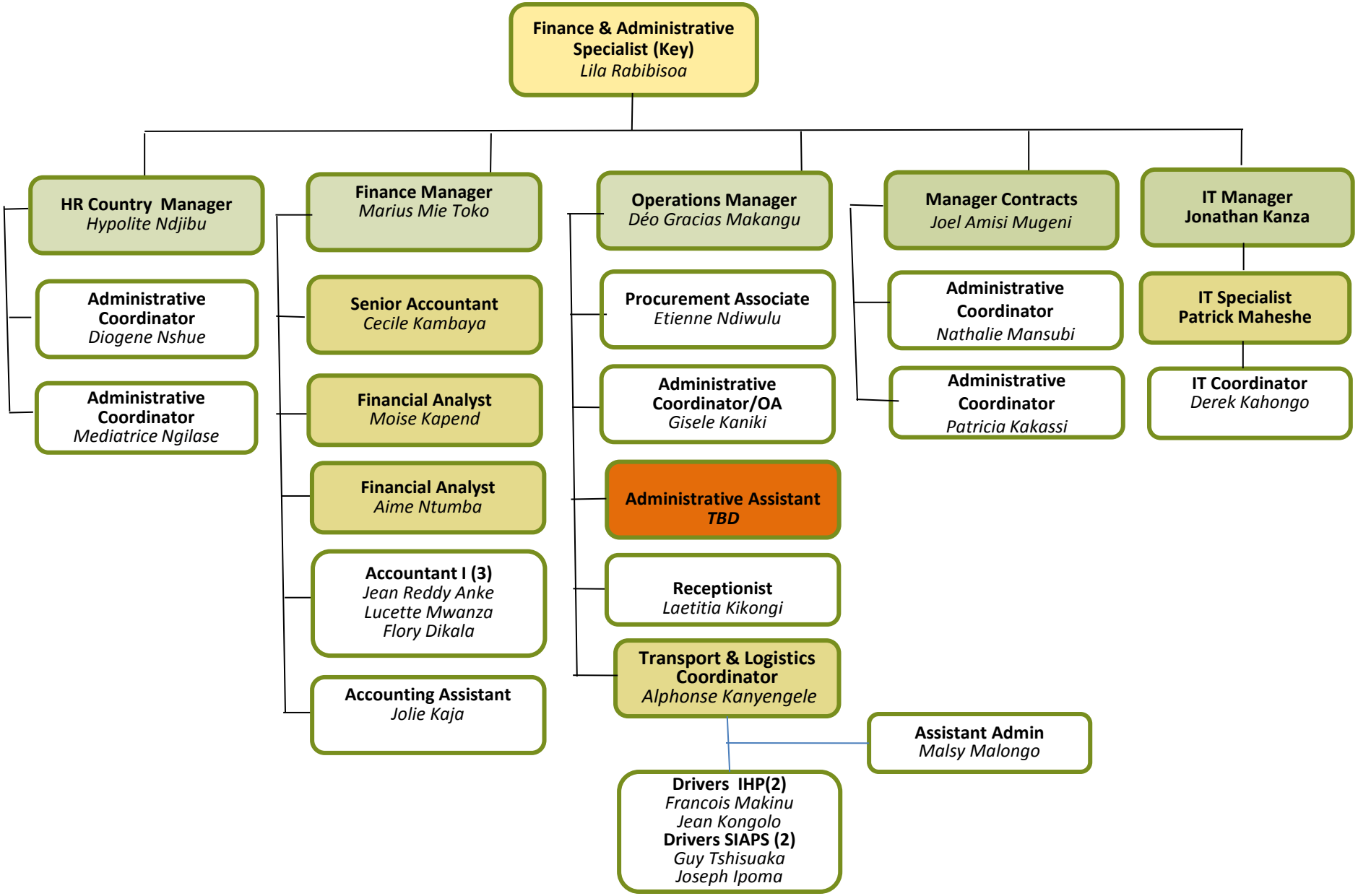
3	Program Management (F&A Specialist)	Lila Rabibisoa	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
4	Program Management (F&A Specialist)	Lila Rabibisoa dependent	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
5	Program Management (F&A Specialist)	Lila Rabibisoa dependent	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
6	Program Management (Principal Technical Advisor)	Gilbert Andrianandrasana	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
7	PTA	Gilbert Andrianandrasana dependent	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
8	PTA	Gilbert Andrianandrasana dependent	MSH	July 2014	R&R	Kinshasa/Antananarivo	23	Planned
9	Program Management (COP)	Ousmane Faye	MSH	August 2014	R&R	Kinshasa/Dakar	23	Planned
10	Program Management (COP)	Ousmane Faye dependent	MSH	August 2014	R&R	Kinshasa/Dakar	23	Planned

	New trips requiring approval are indicated in olive green (these trips have been added or more precise details provided since the version of the STTA plan submitted on (date).

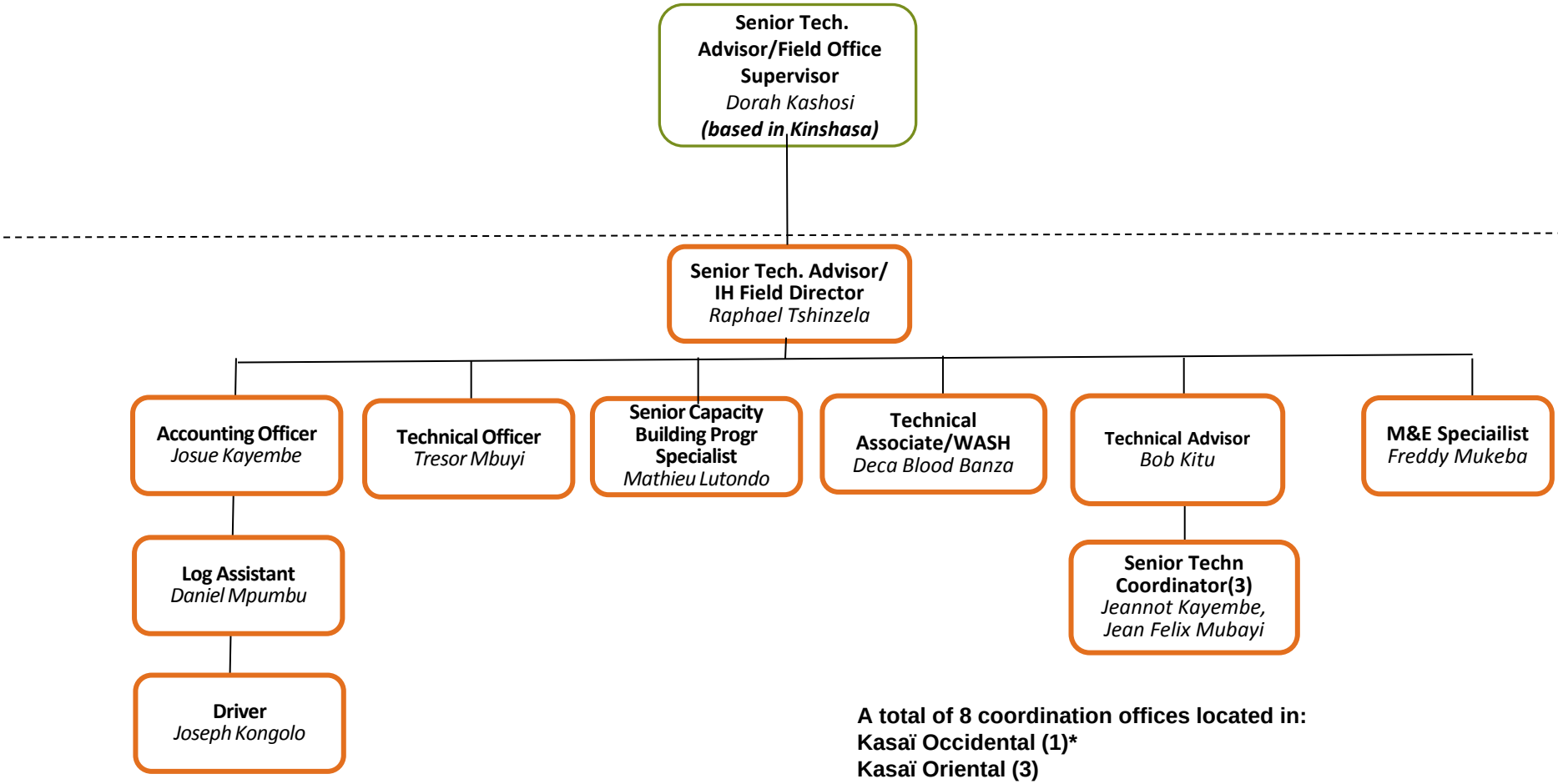
Appendix 7: DRC-IHP Org Chart



Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasaï Occidental

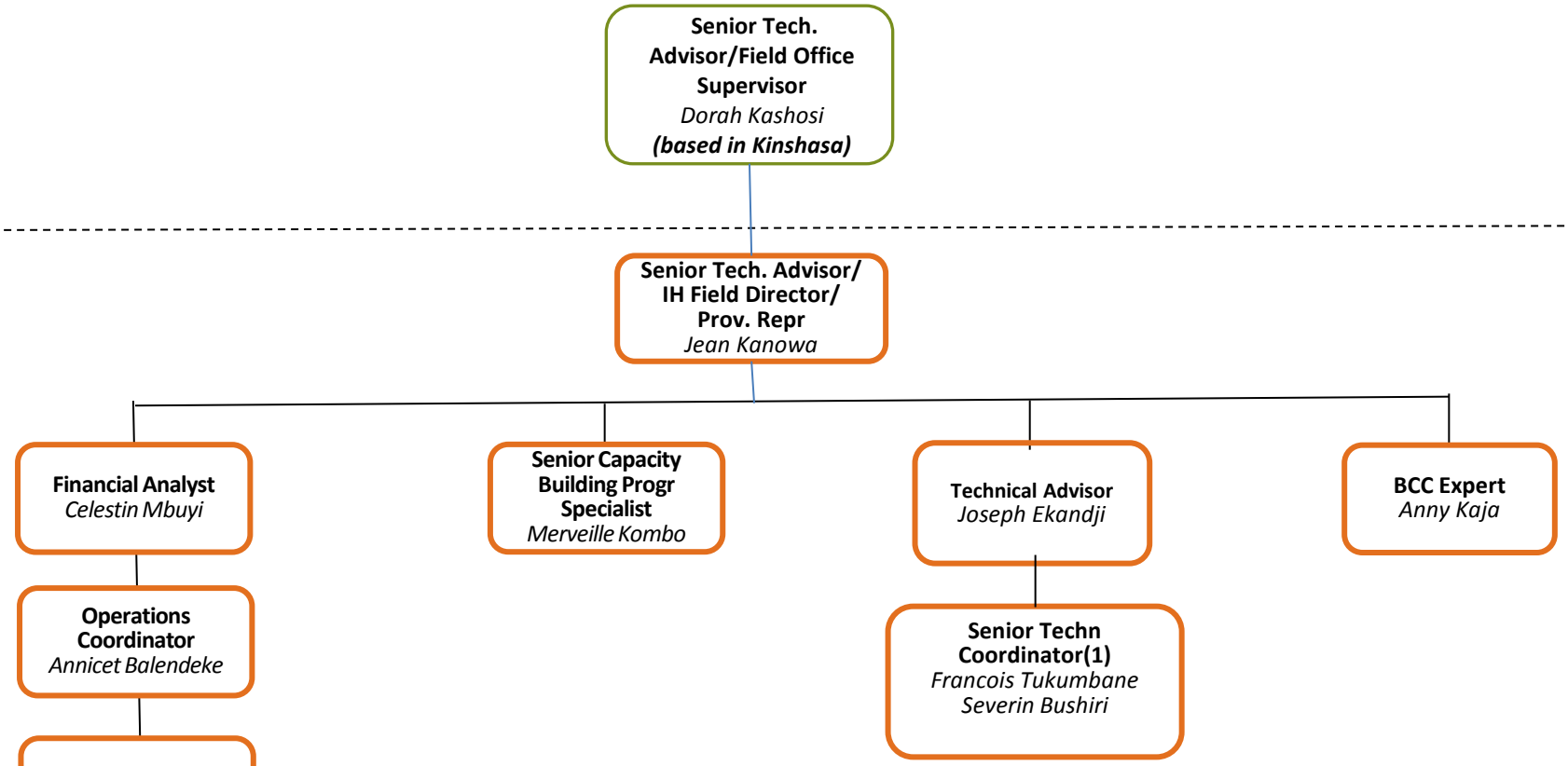


A total of 8 coordination offices located in:
Kasaï Occidental (1)*
Kasaï Oriental (3)
Katanga (2)
Sud Kivu (2)

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

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

IHP Field Office: Kananga, Kasaï Occidental

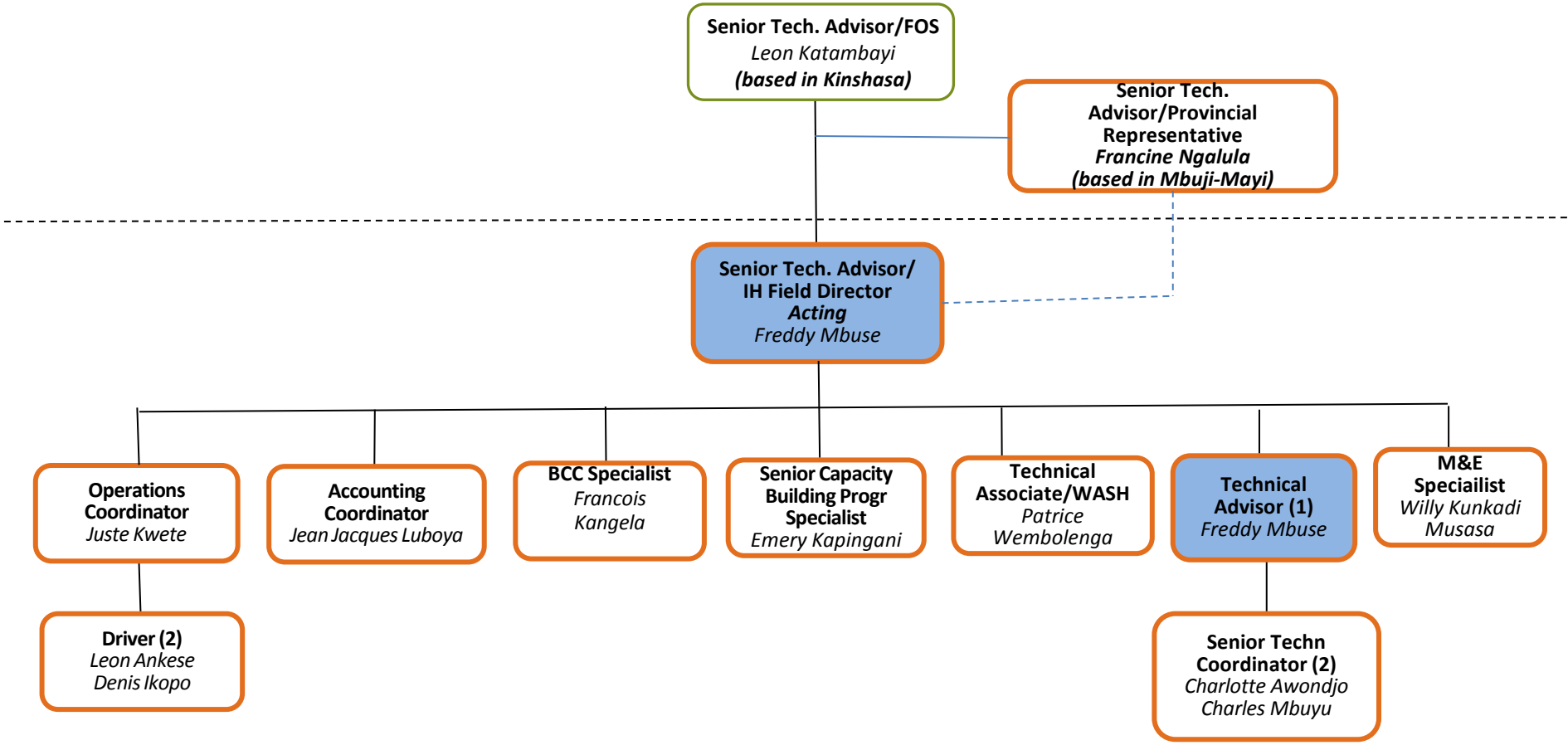


A total of 8 coordination offices located in:
Kasaï Occidental (1)*
Kasaï Oriental (3)
Katanga (2)
Sud Kivu (2)

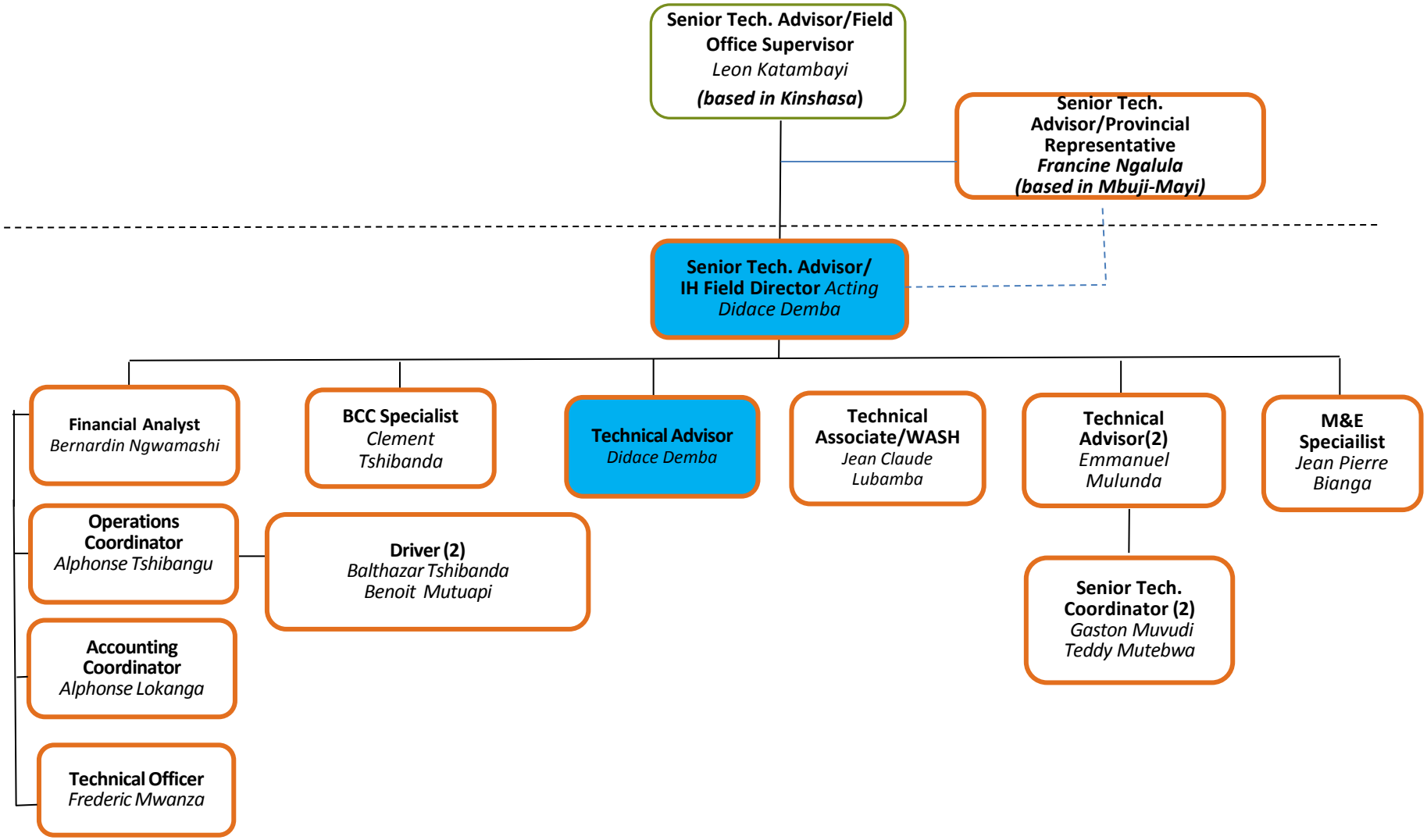
Two satellite offices are located in Kananga and Lubumbashi.

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

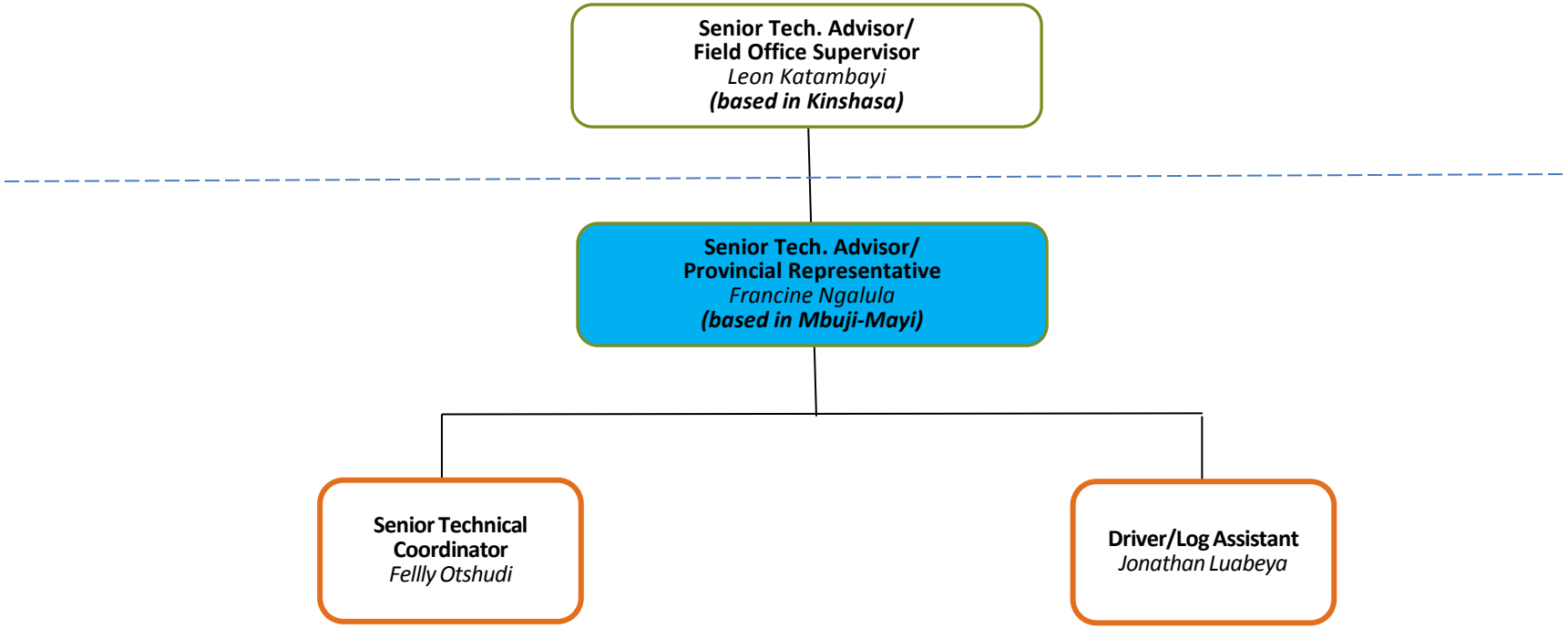
IHP Field Office: Kole, Kasaï Oriental



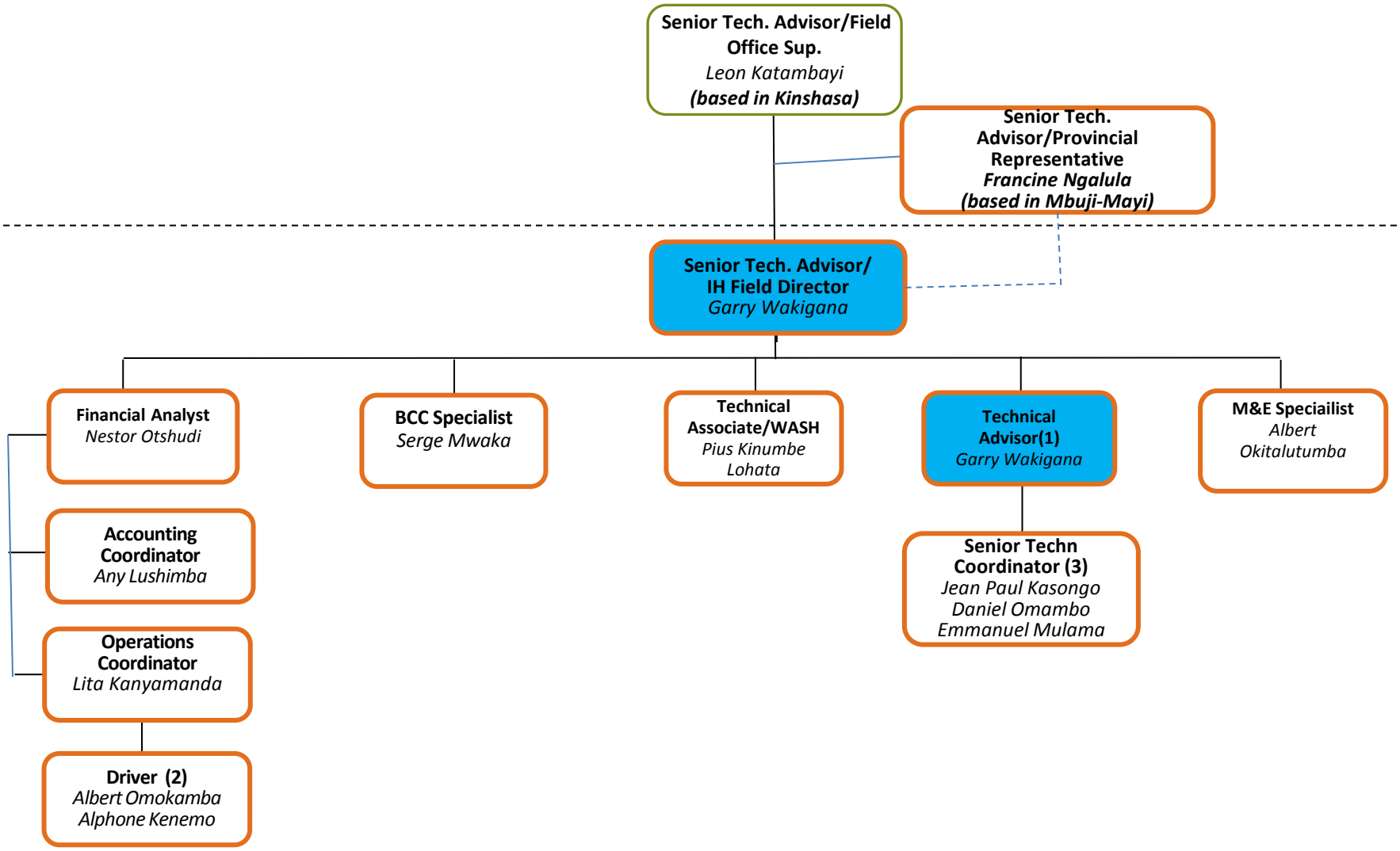
IHP Field Office: Mwene-Ditu, Kasaï Oriental



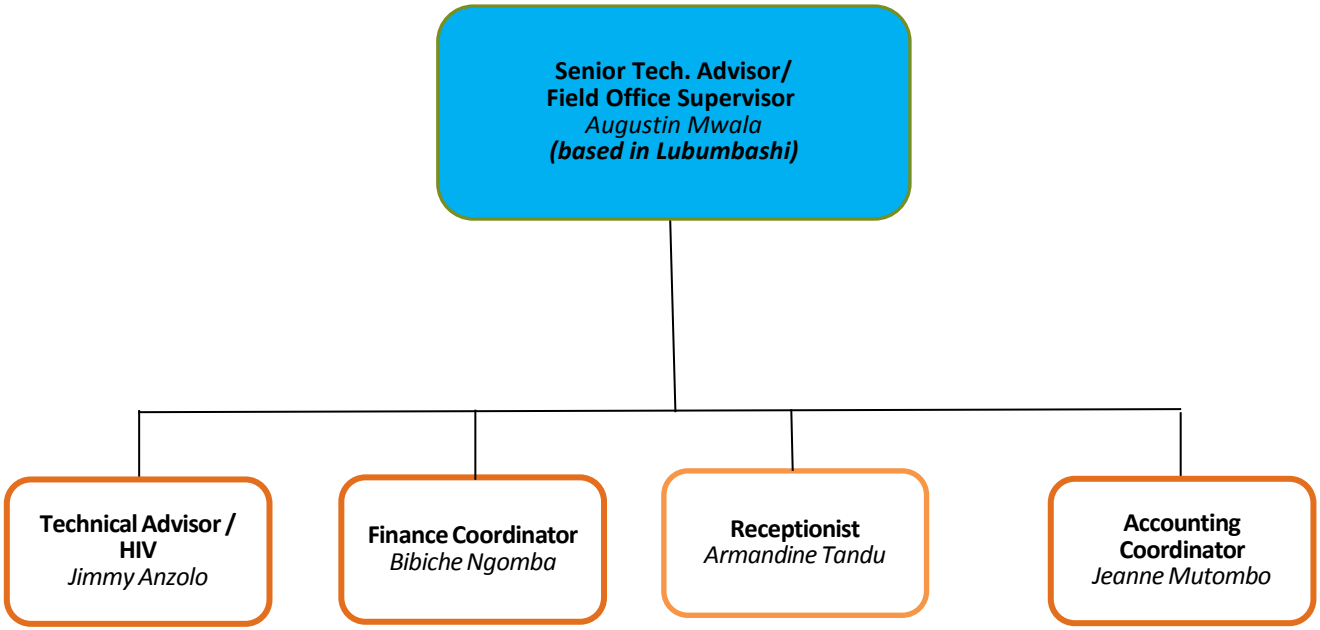
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



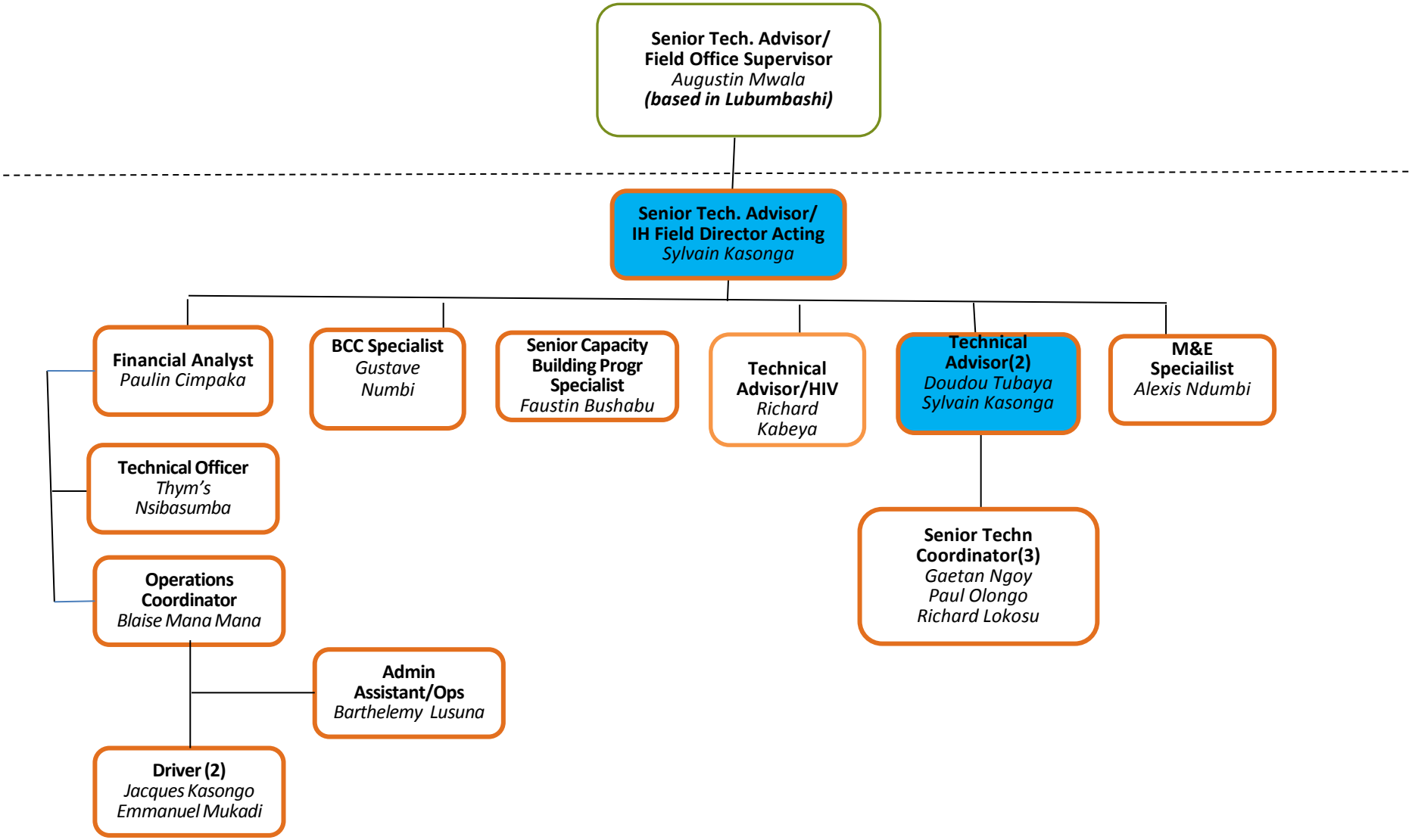
IHP Field Office: Tshumbe, Kasaï Oriental



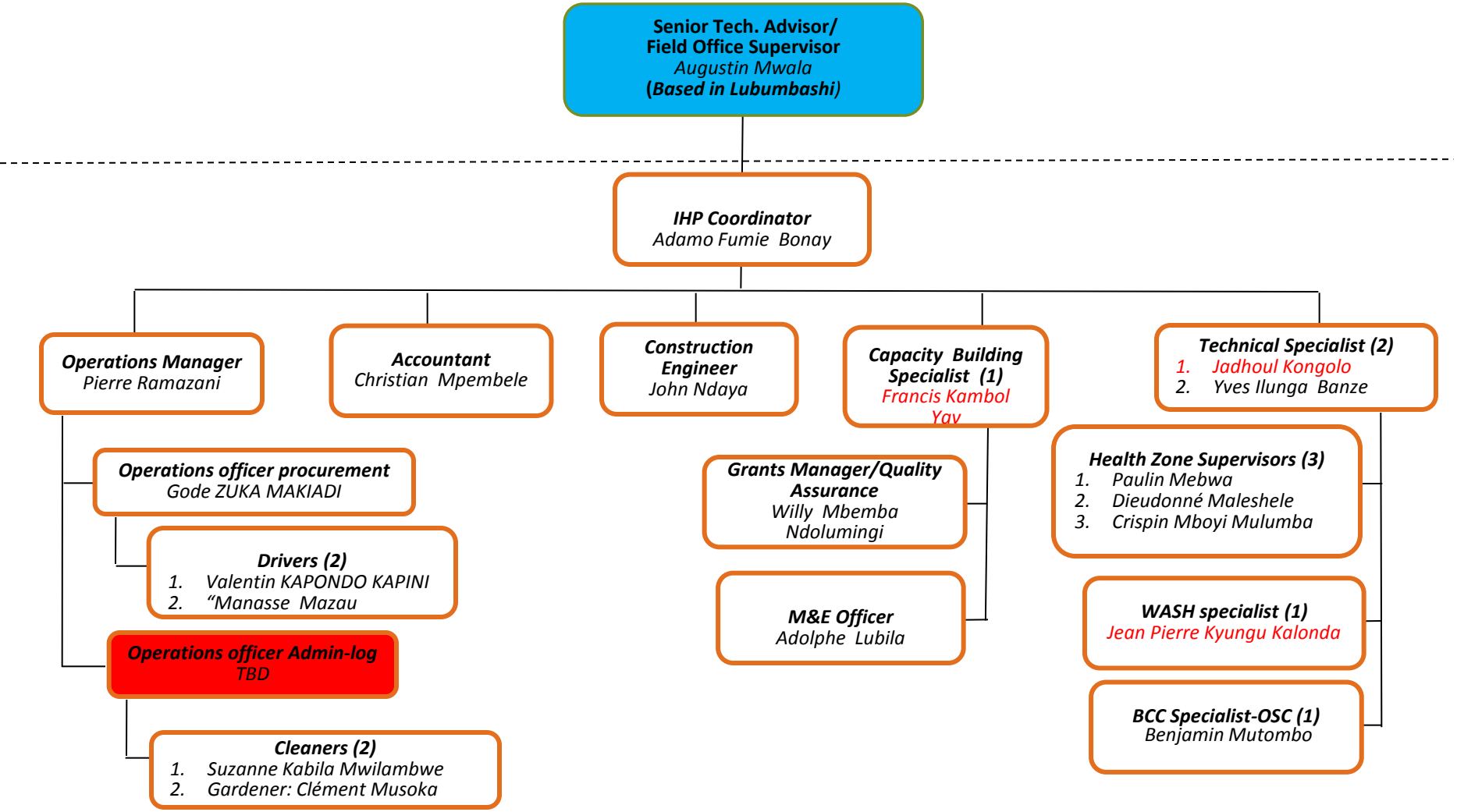
IHP Field Satellite Office: Lubumbashi, Katanga



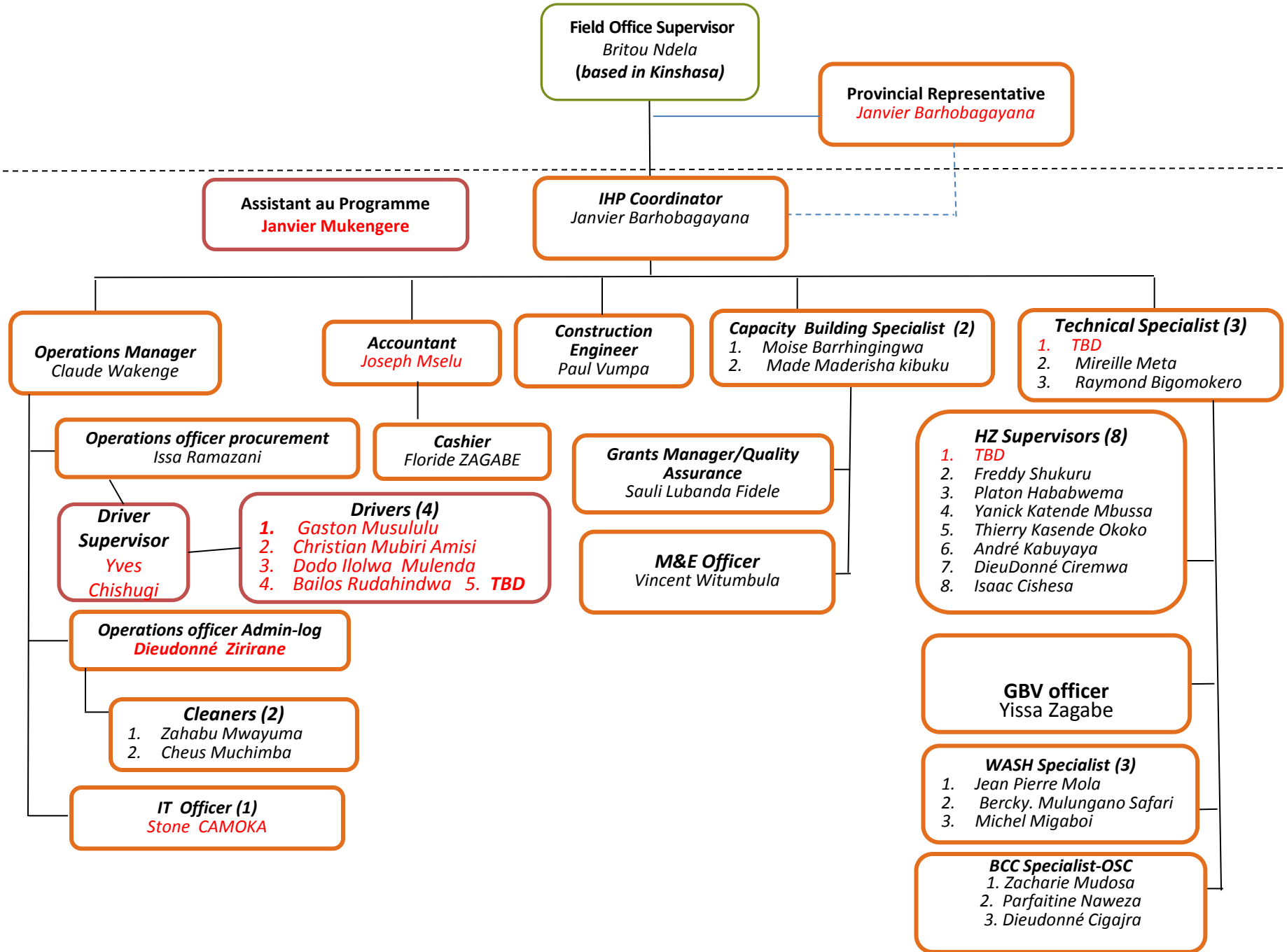
IHP Field Office: Kamina, Katanga



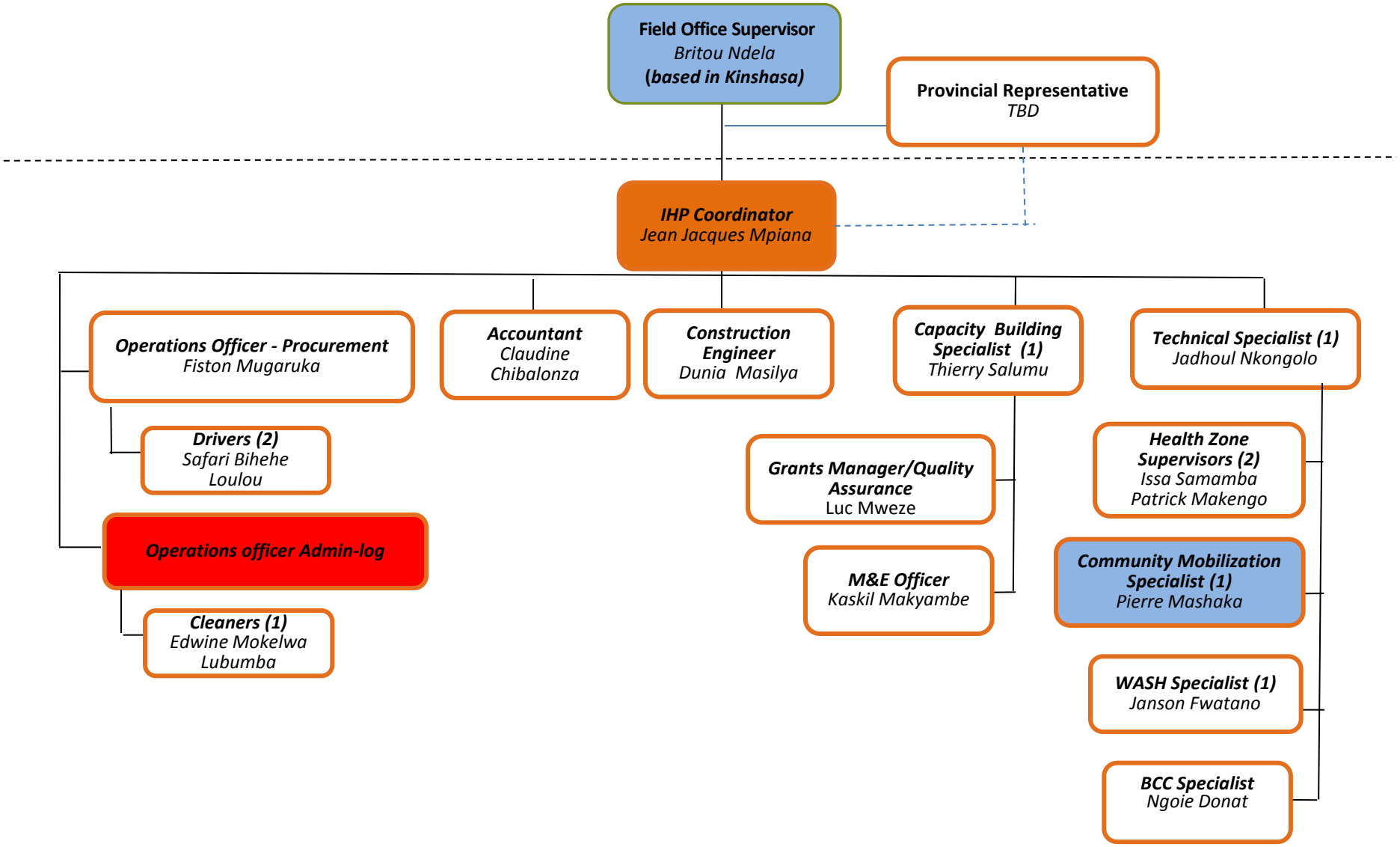
IHP Field Office: Kolwezi, Katanga



IHP Field Office: Bukavu, Sud Kivu



IHP Field Office: Uvira, Sud Kivu



Appendix 8: DRC IHP SF425 July to September 2013

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
3. Recipient Organization (Name and complete address including Zip code) Management Sciences for Health, Inc. 784 Memorial Drive, Cambridge, MA 02139		

4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type	7. Basis of Accounting
071713085	04-2482188	FRLC 72 00 1329	X Quarterly □ Semi-Annual	X Cash □ Accrual

8. Project/Grant Period From: (Month, Day, Year)	To: (Month, Day, Year)	9. Reporting Period End Date (Month, Day, Year)
09/30/2010	09/29/2015	09/30/2013

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	$75,283,250.00
b. Cash Disbursements	$75,960,415.70
c. Cash on Hand (line a minus b)	($677,165.70)
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$84,336,153.00
e. Federal share of expenditures	$75,960,415.70
f. Federal share of unliquidated obligations	$0.00
g. Total Federal share (sum of lines e and f)	$75,960,415.70
h. Unobligated balance of Federal funds (line d minus g)	$8,375,737.30
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%	07/01/2013	09/30/2013	167,926.04	136,020.09	100%
	Local Proff	40%	07/01/2013	09/30/2013	931,347.20	372,538.88	100%
	Consultants	40%	07/01/2013	09/30/2013	15,205.50	6,082.20	100%
				g. Totals:	$ 1,629,119.91		

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 penalities. (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
	d. Email address pbarrossmith@msh.org
b. Signature of Authorized Certifying Official P Barros-Smith	e. Date Report Submitted (Month, Day, Year) 10/23/2013
	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

Appendix 9: DRC IHP Accruals Report July-September 2013

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

Document #: AID-OAA-A-10-00054
Vendor: MANAGEMENT SCIENCES FOR HEALTH, INC
RFA OAA-10-000006

Program Area	Program Element	BFY Fund	Estimated LOP Budget	Obligations	Disbursements (Oct 2010 - June 2013)	Quarter 4 - Disbursement (July-Sept 2013)	Quarter 4 Accruals (Sept 2013)	Project Total to Date (including accrual)	Obligations remaining (Pipeline)	Estimated Balance
A11	A047- HIV/AIDS	GH-AIDS/2010/201	$ 14,743,405.00	$ 6,919,613.00	$ 6,187,110.81	$ 387,031.58	$ 322,420.22	$ 6,896,562.61	$ 23,050.39	$ 7,846,842.39
A11	A048 - TB	GH-C/2010/2011	$ 17,286,763.00	$ 10,280,000.00	$ 8,184,282.28	$ 645,302.20	$ 910,106.42	$ 9,739,690.90	$ 540,309.10	$ 7,547,072.10
A11	A049 - Malaria	GH-C/20102011	$ 20,245,000.00	$ 13,580,762.00	$ 10,315,143.41	$ 1,023,756.38	$ 2,099,881.61	$ 13,438,781.40	$ 141,980.60	$ 6,806,218.60
A11	A052- MCH	GH-C/20102011	$ 45,731,306.00	$ 29,226,385.00	$ 24,837,713.09	$ 2,440,744.29	$ 289,786.29	$ 27,568,243.67	$ 1,658,141.33	$ 18,163,062.33
A11	A053 - FP/RH	GH-C-POP/2010/201	$ 20,625,615.00	$ 12,725,615.00	$ 10,449,796.51	$ 755,213.71	$ 852,799.27	$ 12,057,809.48	$ 667,805.52	$ 8,567,805.52
A11	A054 - WASH	ES/2010/2011	$ 12,610,800.00	$ 7,279,538.00	$ 6,586,689.69	$ 545,424.25	$ 688,907.88	$ 7,821,021.82	$ (541,483.82)	$ 4,789,778.18
A11	A142- Nutrition	GH-C-GFSI/2010/201	$ 8,524,240.00	$ 4,324,240.00	$ 3,331,801.48	$ 270,405.99	$ 487,833.76	$ 4,090,041.23	$ 234,198.77	$ 4,434,198.77
Grand Total			$ 139,767,129.00	$ 84,336,153.00	$ 69,892,537.27	$ 6,067,878.41	$ 5,651,735.44	$ 81,612,151.12	$ 2,724,001.88	$ 58,154,977.88

Noted IHP DRC project received additional funding in the amount of $2,903,630.45, on October 30, 2013 that is not reflected in the obligated amount as of September 30, 2013

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal.