DRC-IHP Quarterly/Annual Report: Year 4 (October 2013 to September 2014)

DRC-IHP staff

March, 11th 2015

Create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 78 health zones in four provinces in the DRC

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

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

Integrated Health Project in the Democratic Republic of Congo Management Sciences for Health
200 Rivers Edge Drive
Medford, MA 02155
Telephone: (617) 250-9500
http://www.msh.org

Integrated Health Project

in the Democratic Republic of Congo

DRC-IHP Quarterly/Annual Report: Year 4 (October 2013 to September 2014)
USAID Cooperative Agreement Number: AID-OAA-A-10-00054
Submitted to USAID/DRC on November 17, 2014
Final version March 11, 2015

Cover photo: Children in Mwene Ditu.

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

Contact information in DRC:
Avenue des Citronniers, No. 4, Commune Gombe, Kinshasa
Chief of Party: Dr. Ousmane Faye, +243 0992006180

Contact information in the U.S:
200 Rivers Edge Drive Medford, MA 02155
Director, Country Portfolio: Kristin Cooney, Tel: +1 617-250-9168

TABLE OF CONTENTS

TABLE OF CONTENTS 3
ACRONYMS 4
EXECUTIVE SUMMARY 6
PROJECT PERFORMANCE 10
Component 1: Health Services 10
INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MPA-PLUS AND CPA-PLUS SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED 10
INTERMEDIATE RESULT 2: QUALITY OF KEY FAMILY HEALTH CARE SERVICES IN TARGET HEALTH ZONES INCREASED 23
INTERMEDIATE RESULT 3: KNOWLEDGE, ATTITUDES, AND PRACTICES TO SUPPORT HEALTH-SEEKING BEHAVIORS 53
Component 2: Health Systems Strengthening 61
INTERMEDIATE RESULT 4: HEALTH SECTOR LEADERSHIP AND GOVERNANCE IN TARGET PROVINCES IMPROVED 61
PROJECT MANAGEMENT 63
FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS 64
ENVIRONMENTAL MONITORING AND MITIGATION PLAN 65
CHALLENGES ENCOUNTERED 66
PLANNED ACTIVITIES FOR NEXT QUARTER 68
LIST OF APPENDICES 69
SUCCESS STORIES 70

ACRONYMS

AB	Advisory Board
ACT	Artemisinin-based Combination Therapy
AMTSL	Active Management of Third Stage Labor
AOP	Annual Operational Plan
ARV	Antiretroviral
BCC	Behavior Change Communication
CBD	Community-based distribution or community-based distributor
CCM	Community Case Management
i-CCM	Integrated Community Case Management
CHW	Community Health Worker
C-IMCI	Community Based Integrated Management of Childhood Illness
CODESA	*Comité de Développement Sanitaire* (health development committee)
CDR	*Centrale de Distribution Régionale* (regional distribution center)
CPA	Complementary Package of Activities
CPLT	Provincial coordination unit for leprosy and TB
CLTS	Community-Led Total Sanitation
CST	*Centre de Santé de Traitement*
CSDT	*Centre de Santé de Diagnostic et Traitement*
CUG	Closed User Group
DTP	Diphtheria, Tetanus, Pertussis
DPS	*Division Provinciale de la Santé*
DQS	Data Quality Self-Assessment
DRC	Democratic Republic of the Congo
EONC	Emergency Obstetric and Newborn Care
ENA	Essential Nutrition Actions
EPI	Expanded Programme on Immunization (see PEV)
ETL	Education through Listening
FEFOL	Iron/Folic Acid
FFSDP	Fully Functional Service Delivery Point (see FOSACOF)
FOSACOF	*Formation Sanitaire Complètement Fonctionnelle* (Fully Functional Service Delivery Point)
FOSA	*Formation Sanitaire* (health facility)
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GRH	General Referral Hospital
HBB	Helping Babies Breathe
HPP	Health for Poorest Populations Project
HIV	Human Immunodeficiency Virus
HZ	Health Zone
HZMT	Health Zone Management Team
IDA	International Dispensary Association
IHP	Integrated Health Project
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent preventive treatment (of malaria) in pregnancy
IRC	International Rescue Committee
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	Multidrug-Resistant Tuberculosis
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child Health
MIP	Provincial Medical Inspector
MPA	Minimum Package of Activities
MPT+	Microscopy Positive Pulmonary TB
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OSC	Overseas Strategic Consulting, Ltd.
PBF	Performance-Based Financing (see RBF)
PEPFAR	President's Emergency Plan for AIDS Relief
PEV	*Programme élargi de vaccination* (see EPI)
PIP	Provincial Pharmaceutical Inspector
PIRTS	Performance Indicator Reference and Tracking Sheets
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan

PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-natal Consultation
PNCPS	National Health Communication Program
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	National Malaria Control Program
PNLS	National AIDS Program
PNLT	National TB Program
PNPCS	National Health Communication Program
PNSR	National Reproductive Health Program
PPMR	Procurement Planning and Monitoring Report
PRONANUT	National Nutrition Program
RBF	Results-Based Financing
RDT	Rapid diagnostic tests
SANRU	*Santé Rural* (the medical office of the Congolese Church of Christ)
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SNIS	National health information system
SP	Sulfadoxine-Pyrimethamine
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
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

This report covers the fourth quarter reporting period (July to September 2014) of year four of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). This report also serves as the project's year four annual report.

Implemented by Management Sciences for Health, the International Rescue Committee, and Overseas Strategic Consulting, Ltd (hereafter referred to respectively as MSH, IRC, and OSC), the five-year project (October 2010-September 2015) supports the DRC National Health Development Program. IHP has two components – "Services" and "Other Health Systems" – that are designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 78 (formerly 80)[1] target health zones in 4 of the DRC's 11 provinces: Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu.

The project currently provides varying levels of support to 1,476 facilities (1,715 health centers and 78 general referral hospitals) in 78 health zones. Road conditions in the country are poor, and the majority of these zones are located in hard-to-reach geographical areas. Thus, in addition to establishing a project office in Kinshasa to facilitate communication with the DRC Ministry of Health, other host government authorities and USAID, IHP set up 8 provincial-level coordination offices to facilitate activity implementation at the field level. The offices are located in Bukavu (covers 22 health zones), Kamina (9), Kole (8), Kolwezi (8), Luiza (9), Mwene Ditu (9), Tshumbe (8), and Uvira (5).

The project's strategic 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; human immunodeficiency virus (HIV); and water/sanitation/hygiene in the target health zones. There are four intermediate results (see Table 1).

In October 2014, IHP submitted a proposed modification to USAID to adjust its targets under IR 1 related to "Access to and availability of Minimum Package of Activities/ Complementary Package of Activities plus (MPA/CPA-plus) services in targeted health zones Increased." The modification also included formalizing the reduction in the number of health zones from 80 to 78, due to negotiations with other donors (for example, to have DfID take over Tshikaji) and security preventing access to certain health zones. Finally, due to the changes in the number of health zones as well as other technical considerations, IHP worked with the USAID/DRC Health Team to modify its Performance Management Plan (PMP), which was submitted for approval and inclusion in the modification.

[1] Of the initial 80 health zones, IHP dropped the Kalehe health zone (Bukavu) due to insecurity; transferred the Bulape and Tshikaji health zones (Kasaï Occidental) to IMA World Health to be covered under the DFID-funded *Accès au Soins de Santé Primaires* (ASSP) project, at USAID's request; and split the Dikungu-Tshumbe health zone into two separate zones (Dikungu and Tshumbe). This will be reflected in a pending modification with USAID.

Table 1: DRC-IHP Results Framework

DRC-IHP Results Framework	
Component 1: Services	
Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	**IR 1.1:** Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased
	IR 1.2: Community-based health care services and products in target health zones increased
	IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery
Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased	**IR 2.1:** Clinical and managerial capacity of health care providers increased
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
	IR 2.3: Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized
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
	IR 3.2: Health advocacy and community mobilization organizations strengthened
	IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched
Component 2: Other Health Systems	
Intermediate Result 4: Health sector leadership and governance in target provinces improved	**IR 4.1:** Provincial health sector policies and national level policies aligned
	IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted
	IR 4.3: Community involvement in health policy and service delivery institutionalized

Project Performance: Reporting Key Achievements

Summary of PY4 Results: The project tracks results for 12 groups of technical area indicators: family planning; maternal, newborn and child health (MNCH); nutrition; tuberculosis; HIV and AIDS; leadership, management and governance (L+M+G); malaria; WASH; gender; referral systems; behavior change communications (BCC); and project management. Similar to last quarter's results, IHP exceeded or met targets for more than half (37/70) of the indicators for these technical areas, with strong results in family planning, HIV, and MNCH. Also similar to last quarter, the weakest performance was noted for TB and WASH. Of the 32 indicators for which targets were not met in PY4, 14 of them achieved at least 75% of target, which means that IHP met, exceeded, or in the case of some indicators, was close to meeting 73% of project targets.

The number of malaria indicators was reduced from 20 to 14 in PY4Q4 to coincide with the recently revised Performance Monitoring Plan (PMP), which includes revised targets for most of these indicators. None of the targets were met in PY4Q4. The majority of these indicators are affected by procurement issues over which IHP has limited control. They will be discussed in greater detail in the malaria section of the report. The project's full PMP is in Appendix 1.

Table 2: Indicator Achievements for PY4

Result area	PY4 targets met or exceeded	PY4 targets not met	New target or data not collected	Total indicators
Family planning	5	0		5
MNCH	7	6		13
Nutrition	3	2		5
Tuberculosis	0	5		5
HIV (PEPFAR DSD)	10	3	1	14
L+M+G	5	9		14
WASH	0	2		2
Gender	2	1		3
Referral system	1	1		2
Behavior change	3	3		6
Project Management	1	0		1
Total (w/o malaria):	37	32	1	70
Malaria	*0*	*14*	*0*	*0*

IHP Service Delivery Results at a Glance[2]

Family planning: IHP exceeded 5 family planning targets.
Exceeded targets:

- 562,982 Couple Years of Protection (CYP) (125% of 450,000 target)
- 606,320 new acceptors of any modern contraceptive method (122% of 497,399 target)
- 747,573 counseling visits for family planning/reproductive health (117% of 640,349 target)
- 2,025 USG-supported delivery points providing family planning counseling or services (101% of 2,000 target)[3]
- Stock outs of Depo-Provera at IHP sites were minimized (59 sites had stock outs; threshold is 100)

Maternal, neonatal and child health (MNCH): IHP met or exceeded 7 of 13 targets for MNCH indicators, and fell short of targets for 6 indicators.
Met or exceeded target:

- 546,162 women received at least one antenatal care (ANC) visit by a skilled provider (107% of 510,830 targeted)
- 460,227 deliveries took place with a skilled birth attendant (102% of 449,208 target)
- 424,835 women benefitted from Active Management of the Third Stage of Labor (AMTSL) (99% of 425,518 target)
- 439,793 newborns received essential newborn care (102% of 430,006 target)
- 34,820 newborns were treated for infection with antibiotics (107% of 32,415 target)
- 457,056 children <12 months received DPT-HepB-Hib3 (108% of 425,017 target)
- 431,855 children <12 months received measles vaccine (102% of 25,017 target)

[2] In PY4, we have presented this section to function as a "results at a glance." For those areas needing improvement, in the subsequent sections of the report, we outline steps to take to improve these results.
[3] Service delivery points = 1,398 health centers, 78 GRHs, and 549 community care sites and CBDs (IHP and HPP)

Below target:

- 73% of pregnant women had 4 antenatal care visits by skilled providers (246,154 of 334,951 target)
- 440,147 newborns benefitted from postpartum visits within 3 days of birth (81% of 540,244 target)
- 86% of child pneumonia cases were treated with antibiotics by a trained facility or community health worker (495,392 cases of 573,232 target)
- 522,511 of child diarrhea cases were treated using oral rehydration solution (ORS) or ORT plus zinc (68% of 764,318 target)
- 24,473 children less than 12 months did not complete full regimen of DPT-HepB-Hib1-3 (dropout rate was 15% over threshold of 21,251)
- 216 facilities out of 1,793 (12%) IHP-supported facilities (1,715 health centers and 78 general referral hospitals) reported ORS stock outs (threshold is 100 facilities)

Nutrition: IHP exceeded 3 of its PY4 nutrition targets and encountered challenges with 2 others.
Exceeded target:

- 3,378,133 children under 5 years received vitamin A (134% of 2,520,338 target)
- 504,282 pregnant women received iron folate to prevent anemia (124% of 405,169 target)
- 547,577 mothers of children under 2 years received nutritional counseling for their children (140% of 409,823 target)

Below target:

- 138,003 breastfeeding mothers received vitamin A (38% of 361,051 target)
- 489 facilities reported stock outs of iron folate each month during PY4 (threshold was 100 facilities)

HIV and AIDS: IHP uses PEPFAR direct service delivery indicators to track results for the project. For 10 of 14 HIV indicators, IHP met or exceeded PY4 annual targets and is on track to meet or exceed PEPFAR FY14 targets. Targets were not met for three indicators, and 1 indicator is only applicable beginning with PEPFAR COP 15.
Met or exceeded target:

- 69 sites (100% of PEPFAR-supported sites) in Kolwezi and Kamina achieved 90% ARV or ART coverage for HIV+ pregnant women
- 18,778 of pregnant women with known HIV status (includes women who were tested for HIV and received their results (106% of 17,222 target)
- 254/165 HIV+ pregnant women received antiretroviral therapy (ART) to reduce risk of mother-to- child transmission (total PY4 achievement is 167% of annual PEPFAR target of 165 women)
- 39,211 individuals received testing and counseling (T&C) services for HIV and received their test results (129% of annual PEPFAR target of 30,330 people)
- 989 HIV-positive adults and children receiving a minimum of one clinical service (142% of 696 target)
- 100% (69) of laboratories and Point of Care testing sites perform HIV diagnostic testing that participate and successfully pass an analyte-specific proficiency testing (PT) program
- 100% (1) PEPFAR-supported testing facility (laboratory) with capacity to perform clinical laboratory tests that are recognized by national, regional, or international standards for accreditation
- Family planning and HIV integration: 100% (69) of HIV service delivery points supported by PEPFAR are directly providing integrated voluntary family planning services
- 1,369 HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) or CD4 count or viral load

- 1,382 (199% of 696 target) of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (DSD)

Below target:
- 57% (106 of 185 target) of registered TB cases who are HIV-positive who are on ART
- 36% of adults and children receiving ART (63 of 175 PEPFAR COP 14 target)
- 58% of HIV+ patients were screened for TB in HIV care or treatment setting (362 of 623 PEPFAR COP14 target)

Non applicable HIV indicator for current reporting:
Percentage of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (no data, activities to begin next quarter)

Tuberculosis: IHP did not meet PY4 targets for any of the 5 TB indicators, but it did attain 74% and 84% of targets for 2 of the indicators. There are some promising developments with TB as well as ongoing challenges. These will be discussed in the TB section of the report.

Other Indicators: Indicators and results for WASH, gender, malaria, and L+M+G will be presented and discussed in the appropriate sections of this report.

PROJECT PERFORMANCE

COMPONENT 1: HEALTH SERVICES

INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MPA-PLUS AND CPA-PLUS SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED

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

1. Utilization of health care services

During PY4, the health services utilization rate of six of the eight IHP coordination offices exceeded the 35% national average utilization rate. Bukavu and Kolwezi had the highest rates, with an average of 52% and 50% by the end of the year, while Luiza and Uvira were slightly below the national average with rates of 32% and 34%, respectively. The other four offices exceeded the national rate by 3 to 6 percentage points (see Figure 1 and Table 3 below).

The lower rate in Luiza was due to the transfer of oversight of two health areas (Tshikaji and Bulape) from IHP to IMA World Health under the DFID-funded *Accès aux Soins de Santé Primaires* (ASSP) project, at USAID's request[4]. Data from these areas were therefore no longer included in the Luiza database. In the Uvira coordination office, recurring unrest prevented the local population from using health services in some health zones, such as Lemera and Ruzizi.

[4] The figures for the Tshikaji and Bulape health zones are included in the PY4Q1 and PY4Q2 service utilization rates because IHP transferred the zones to ASSP in May 2014; the figures are not included for PY4Q3 and PY4Q4.

The utilization rate varied between coordination offices as a result of health centers being closed during immunization campaigns and immunization days, the fact that private facilities do not report to the central offices, and the unaffordable fees that certain health facilities impose for services.

On average, the health utilization rate for curative services in IHP-supported health zones was around 40%.

Figure 1: Health service utilization rate by quarter and coordination office

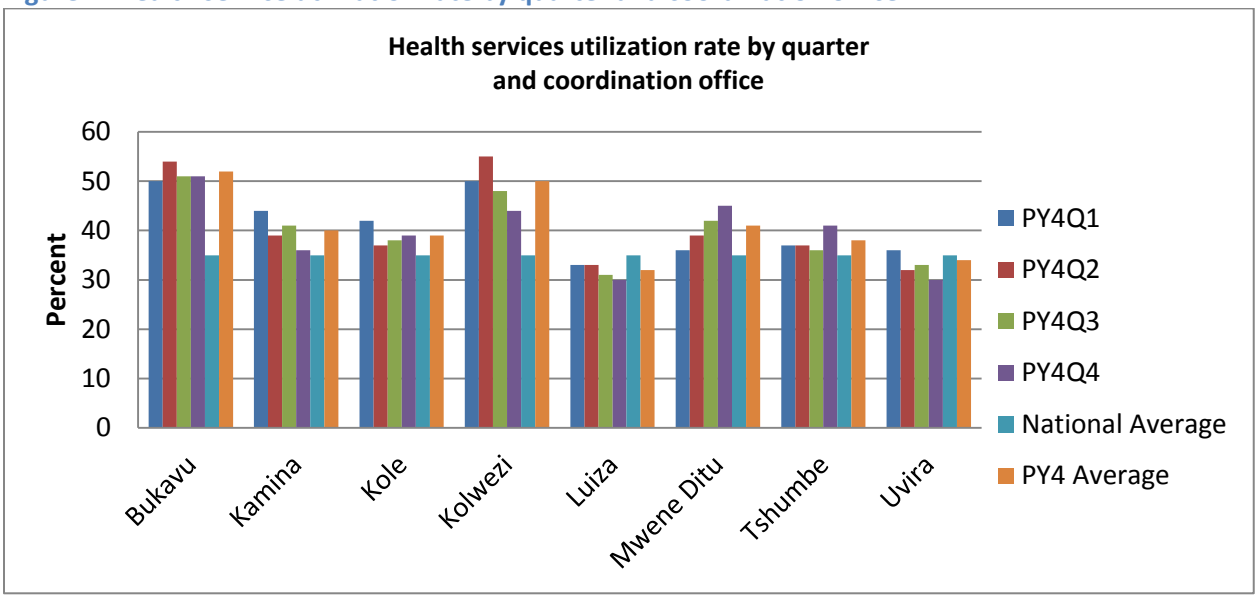


Table 3: Curative services utilization by quarter and by coordination office

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira
PY4Q1	50	44	42	50	33	36	37	36
PY4Q2	54	39	37	55	33	39	37	32
PY4Q3	51	41	38	48	31	42	36	33
PY4Q4	51	36	39	44	30	45	41	30
National Average	35	35	35	35	35	35	35	35
PY4 Average (%)	52	40	39	50	32	41	38	34

2. Facility-based Minimum Package of Activities (MPA)/Complementary Package of Activities (CPA)

CPA and CPA-Plus: IHP surpassed its yearly target for number of GRHs implementing CPA. During PY4, 71 of the 78 (91%) IHP-supported GRHs provided the CPA during PY4. These include 23 of 25 GRHs in Kasaï Oriental, 26 of 27 GRHs in Sud Kivu, 13 of 17 in Katanga, and 9 of 9 in Kasaï Occidental.

CPA-Plus was provided by a total of 21 GRHs during the year (12 in Bukavu, 5 in Mwene Ditu, 1 each in Uvira and Kole, and 2 in Kolwezi, see Table 4). However, none of the current IHP-supported GRHs in the coordination offices of Kamina (Katanga Province), Tshumbe (Kasaï Oriental), and Luiza (Kasaï Occidental) provided CPA-Plus. The two GRHs in Tshikaji and Bulape (Kasaï Occidental) did apply CPA-Plus, but their data are now included in the DFID ASSP project since oversight for this work was transferred from IHP to IMA World Health. At the end of

PY3Q4, 86% of target GRHs were providing CPA and 16% were providing CPA-Plus. One year later, at the end of PY4Q4, these percentages were 127% and 88% respectively.

Table 4: Number of GRHs implementing a complementary package of activities (CPA), by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	21	7	7	6	11	8	5	4	**69**
PY4Q2	21	7	7	6	11	8	8	4	**72**
PY4Q3	21	7	7	6	9	8	8	5	**71**
PY4Q4	21	7	7	6	9	8	8	5	**71**
Target PY4Q4	16	6	6	6	8	6	5	3	**56**
% of target achieved in PY4Q4	**131**	**117**	**117**	**100**	**113**	**133**	**160**	**167**	**127**
% of target achieved in PY3Q4	**91**	**67**	**100**	**88**	**100**	**82**	**67**	**100**	**86**

Table 5: Number of GRHs offering CPA-Plus by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	9	0	2	2	2	5	0	1	**21**
PY4Q2	12	0	1	2	0	5	0	1	**21**
PY4Q3	12	0	1	2	0	5	0	1	**21**
PY4Q4	12	0	1	2	0	5	0	1	**21**
Target PY4Q4	**7**	**3**	**2**	**2**	**3**	**3**	**2**	**2**	**24**
% of target achieved in PY4Q4	**171**	**0**	**50**	**100**	**0**	**167**	**0**	**50**	**88**
% of target achieved in PY3Q4	**9**	**0**	**25**	**25**	**18**	**45**	**0**	**20**	**16**

MPA and MPA-Plus: During PY4Q4, in all coordination offices, MPA and MPA-Plus were provided at the same health centers as in PY4Q3, except for the Kolwezi coordination office, where 4 new health areas integrated MPA (1 center in the Dilala health area and 3 in Fungurume). Compared to the annual target, the achievement rate increased from 93% at the end of PY3Q4 to 137% a year later in PY4Q4 for health centers offering MPA, and from 6.5% during PY3Q4 to 28% during PY4Q4 for health centers offering MPA-Plus.

As described in previous reports, to increase the percentage of health centers offering MPA-Plus, additional efforts will be necessary, including integrating new health services (such as PMTCT, nutrition, and TB activities), presenting and explaining indicators in ways that everyone can understand, and providing education and advocacy on MPA-Plus.

Table 6: Number of health centers offering MPA by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	361	201	129	100	189	168	104	92	**1,344**
PY4Q2	395	201	129	101	197	168	104	92	**1,387**
PY4Q3	395	201	129	**101**	170	168	104	**92**	**1,360**
PY4Q4	395	201	129	**105**	170	168	104	**92**	**1,364**
Target PY4Q4	**279**	**142**	**90**	**74**	**138**	**120**	**83**	**72**	**998**
% of target achieved in PY4Q4	**142**	**142**	**143**	**136**	**123**	**140**	**125**	**128**	**137**
% of target achieved in PY4Q3	**100**	**97**	**100**	**95**	**96**	**102**	**108**	**81**	**93**

Table 7: Number of health centers offering MPA-Plus by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	19	18	1	29	5	21	1	12	**96**
PY4Q2	29	20	1	29	5	21	1	13	**119**
PY4Q3	29	20	1	**29**	4	21	1	**13**	**118**
PY4Q4	29	20	1	**29**	4	21	1	**13**	**118**
Target PY4Q4	**120**	**61**	**39**	**32**	**59**	**51**	**36**	**30**	**428**
% of target achieved in PY4Q4	**24**	**33**	**3**	**91**	**7**	**41**	**3**	**43**	**28**

3. Availability of medicines, commodities, and equipment

The USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project aims to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Working in close collaboration with IHP, SIAPS ensures the availability of generic and essential medicines (MEG) at all IHP-supported sites. SIAPS' support to IHP includes:

Ensuring the availability of medicine in health facilities: SIAPS continued to follow up on IHP deliveries from the supplier, International Dispensary Association (IDA), and on the status of health zone lines of credit at their respective regional distribution centers (CDR). It took about one year to receive supplies that were ordered in August 2013. By August 2014, CDRs received about 96% of the total deliveries expected from IDA.

Table 8: Expected supplies from the second half of IHP Year 3 (from supplier IDA)

Province	Warehouse/ CDR	Cost of Order (in USD)	Cost of delivery (as of August 31, 2014)	Delivered (%)	Remaining balance	Balance to be delivered (%)
Sud Kivu	**APAMESK**	$435,721.00	$427,936.00	98	$7,785.00	2
Katanga	**CEDIMEK**	$242,189.00	$229,286.65	95	$12,902.35	5
	Kolwezi	$163,155.75	$151,389.75	93	$11,766.00	7
Kasaï Occidental	**CADIMEK**	$256,361.00	$245,787.00	96	$10,574.00	4
Kasaï Oriental	**CADMEKO**	$249,789.00	$242,890.76	97	$6,898.24	3
	FODESA	$222,680.00	$222,229.45	100	$450.55	0
Total order/delivery		**$1,569,895.75**	**$1,519,519.61**	**97**	**$50,376.14**	**4**

****Please note that on percentages here and elsewhere in the report, numbers may not match exactly due to rounding.**

In PY4Q4 SIAPS continued to support distribution of medicines to the health zones and reviewed quarterly procurement plans for malaria (PMI), family planning commodities, and other products to prevent stock outs. Distribution plans for PMI and family planning commodities are found in Appendices 2 and 3. In cooperation with the IHP staff in Kananga, SIAPS organized the re-distribution of an overstock of blood transfusion supplies with an imminent expiration date from Kananga to Lodja. A surplus of Artemisinin-based Combination Therapy (ACT) will be similarly distributed from Lubumbashi to Bukavu during PY5Q1. SIAPS worked with IHP staff to calculate the shortage of rapid diagnostic tests (RDTs) in Kamina and secured a loan from the faith-based organization SANRU to procure the needed test kits (the memorandum of understanding with SANRU and PMI is found in Appendix 4). SIAPS coordinated the distribution of 720,000 long lasting insecticide-treated nets (LLIN) in the Sud Kivu province for IHP and PMI Extension projects. Deliveries are ongoing in other provinces. SIAPS also ensured follow-up, distribution, and costing of family kits provided by UNICEF for IHP.

Strengthening management of specific medicines, commodities, and medical supplies: During the quarter, SIAPS continued to provide assistance to IHP-supported CDRs in supply planning, adjusting lines of credit, and adherence to stock management protocols. In September 2014, SIAPS assisted the CDR in Kasaï Occidental, CADIMEK, with installation of equipment and supplies (e.g., dehumidifiers, digital thermo-hygrometric devices, red tape for quarantined areas, and alkaline batteries). To improve stock rooms, SIAPS distributed IHP-financed non-digital thermo-hygrometric devices to all health facilities. SIAPS continued to centralize all medication management data from the health zones. Medicine consumption data are available in electronic format and will be analyzed for the upcoming quantification exercise. Average monthly consumption data will be updated in December 2014, jointly with the provincial health team (DPS) and IHP.

Supporting monthly supervision of medicine management in the IHP-supported health zones and facilities: In cooperation with IHP and DPS staff, SIAPS conducted supervision visits to 12 health facilities located in three health zones (Luputa, Mwene Ditu, and Dibindi) in Kasaï Oriental (Mwene Ditu), September 1-15, 2014; to 17 health facilities located in 6 health zones in Kasaï Oriental (Sankuru), August 11-30, 2014; and to 20 health facilities in 4 health zones in Sud Kivu, August 27-September 1, 2014. All supervision visits focused on correct use of data management tools, evidence-based medicine deliveries at the health facility level, active data collection for medicine management indicators, and active reporting tools to ensure accurate consumption history. As

indicated above, consumption data are available and will be aggregated and analyzed in several coordination offices during the next quarter, in collaboration with the MOH.

Other SIAPS activities during PY4Q4: SIAPS conducted a stock inventory at the MSH warehouse in Kinshasa, finalized a report on missing Depo-Provera stocks, developed an addendum to MSH/Kinshasa warehouse management procedures for the management of commodities with impending expiration dates, and followed up on import certificates with the DPM. In cooperation with IHP staff, SIAPS developed a medical supply distribution plan for IHP commodities and will follow up to ensure that CDRs confirm receipt of all IHP-funded goods. SIAPS also followed the evolution of rehabilitation work at the CADMEKO warehouse buildings, and prepared a Procurement Planning and Monitoring Report (PPMR) that compiled and summarized all data on family planning commodities managed by IHP, UNFPA, and Population Services International (PSI). SIAPS staff participated in IHP weekly technical meetings in all coordination offices. SIAPS continues to routinely review all invoices submitted by the warehouses to the IHP procurement unit for payment. IHP plans to work with SIAPS in the future on assessing and documenting the root causes of stock outs as well as expirations.

IR 1.2: Community-based health care services and products in target health zones increased

1. **Integrated Community Case Management (i-CCM)**

During PY4, 382 community health sites in 38 IHP-supported health zones were established and became operational to better address the three main threats to child health and mortality in the DRC: malaria, pneumonia, and diarrhea. The number of diarrhea episodes treated doubled in PY4 compared to PY3 (522,511 cases treated in PY4, and 261,758 cases treated in PY3). The number of malaria episodes treated at the community level also doubled compared to the previous year, increasing from 14,279 in PY3 to 30,028 in PY4.

Pneumonia: During PY4, 495,392 pneumonia episodes were treated with antibiotics in the IHP-supported health facilities and health sites. This figure represents 86% of the expected episodes among children under 5, according to the PMP target (see Table 9). Compared to PY3 results, this represents an increase of 14,081 new episodes treated; nearly half of these additional episodes (6,918) were treated in community health sites. The improvement of this indicator is due to an increase in community health site activities, including training providers on the utilization of flow charts, provision of antibiotics to health facilities, distribution of job aids for pneumonia management, and data quality audits (DQA) performed in the health zones.

Five coordination offices achieved at least 80% of their targets: Kamina (125%), Bukavu (91%), Mwene Ditu (86%), Tshumbe (83%), and Kole (80%). Results reported by Uvira (40%), Kolwezi (62%) and Luiza (73%) had lower target achievements. The project speculates that results may be under-reported in Kolwezi and Uvira, but the extent of under reporting is unknown. Delays in the delivery of antibiotics in the health zones managed by the Uvira coordination office due to recurring unrest may also have contributed to lower results.

Table 9: Number of children under 5 with pneumonia treated by antibiotics in facilities and i-CCM sites in PY4

Coordination office	PMP target PY4	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4			% of target achieved
		Total	Total	Total	Total	Health facilities	i-CCM sites	Total	
Bukavu	163,371	34,639	44,133	38,980	31,343	144,709	4,386	**149,095**	91
Kamina	85,985	33,748	28,523	25,381	19,464	94,805	12,311	**107,116**	125
Kole	40,126	8,963	8,343	8,207	6,684	28,377	3,820	**32,197**	80
Kolwezi	37,260	7,866	6,813	4,602	3,993	22,886	388	**23,274**	62
Luiza	72,227	12,199	18,220	12,990	9,604	51,583	1,430	**53,013**	73
Mwene Ditu	102,035	19,793	22,450	22,041	23,345	83,920	3,709	**87,629**	86
Tshumbe	32,674	6,799	8,632	6,255	5,539	25,725	1,500	**27,225**	83
Uvira	39,553	4,082	4,365	4,027	3,369	15,213	630	**15,843**	40
Total PY4	**573,232**	**128,089**	**141,479**	**122,483**	**103,341**	**467,218**	**28,174**	**495,392**	**86**
Total PY3		106,457	129,452	122,724	122,678	460,055	21,256	481,311	87

Diarrhea: IHP-supported health facilities and community health sites treated 522,511 new cases of diarrhea with ORS and zinc sulfate, achieving 68% of the PMP target (see Table 10). Additional new cases were treated and reported, with numbers increasing steadily from Q1 through Q4 (114,660 cases in Q1; 129,442 cases in Q2; 136,164 cases in Q3; and 142,245 cases in Q4).

Three coordination offices out-performed the others on number of children under 5 treated for diarrhea by ORS or ORS plus zinc sulfate: Uvira achieved 93% of its target, Kamina achieved 91%, and Bukavu achieved 83%. These results were obtained through joint IHP-MOH supervision visits to service sites, and to IHP-sponsored provider training on treatment flow charts, correct diagnosis of diarrhea, and appropriate case management. The availability of ORS and zinc sulfate in the health zones and increased diarrhea case management at community health sites also contributed to an overall 13 percentage point increase between PY4Q3 and Q4 on this indicator, albeit with significant variation in achievements among the different coordination offices.

Table 10: Number of children under 5 with diarrhea treated by ORS or ORS plus zinc in PY4

Coordination office	PMP Target PY4	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4			% of target achieved
						Health facilities	i-CCM sites	Total	
Bukavu	217,831	37,924	47,914	46,294	49,037	176,106	5,063	**181,169**	**83**
Kamina	114,648	22,512	27,053	28,337	26,590	90,796	13,696	**104,492**	**91**
Kole	53,502	9,609	6,350	7,726	10,075	26,907	6,853	**33,760**	**63**
Kolwezi	49,681	5,930	5,491	6,110	5,201	22,050	682	**22,732**	**46**
Luiza	96,304	7,755	9,918	15,394	12,347	40,918	4,496	**45,414**	**47**
Mwene Ditu	136,049	13,081	15,322	14,718	18,304	56,939	4,486	**61,425**	**45**
Tshumbe	43,566	5,335	5,570	5,940	7,421	22,023	2,243	**24,266**	**56**
Uvira	52,738	12,514	11,824	11,645	13,270	47,754	1,499	**49,253**	**93**
Total PY4	**764,318**	**114,660**	**129,442**	**136,164**	**142,245**	483,493	39,018	**522,511**	**68**
Total PY3		55,678	60,331	68,495	77,254	246,011	15,747	261,758	35

Malaria: During PY4Q4, 9,963 ACT doses for children under 5 were distributed at the community health site level. This is 1,640 more doses compared to results from the previous quarter. The number of ACT doses distributed doubled compared to the previous year, from 14,279 during PY3 to 30,028 doses distributed in PY4. All of the i-CCM sites supported by MSH (382 IHP and 278 HPP) follow the NMCP directives regarding malaria case management; the RDT is conducted routinely before providing any treatment.

Table 11: Number of children under 5 with malaria treated in i-CCM sites in PY4

Coordination office	PY4Q1	PY4Q2	PY4Q3	PY4Q4	Total PY4
	i-CCM sites	i-CCM sites	i-CCM sites	i-CCM sites	i-CCM sites
Bukavu	397	812	373	443	2,025
Kamina	2,142	1,336	2,049	3,568	9,095
Kole	137	37	218	142	534
Kolwezi	369	459	587	875	2,290
Luiza	275	336	966	293	1,870
Mwene Ditu	300	4,383	2,600	1,595	8,878
Tshumbe	277	317	569	2,163	3,326
Uvira	552	303	611	544	2,010
Total PY4	**4,449**	**7,983**	**7,973**	**9,623**	**30,028**
Total PY3	1,595	3,605	4,607	4,472	14,279

The most important challenges confronting child health interventions include:

- Under-reporting the actual number of cases of pneumonia and/or diarrhea that may go undiagnosed by untrained or inexperienced providers (e.g., some providers do not systematically measure respiratory rates for children with coughs, or they do not always provide a diagnosis of diarrhea for children with over three bowel movements a day);
- Data collection is difficult at the health facility level, especially if indicators are not included in the MOH HMIS (e.g., the MOH HMIS captures *number of cases* of diseases but not the number of cases *treated correctly*);
- The long lead time required for the timely delivery of medicine and supplies that is not always taken into account by the health zone management team responsible for ordering;
- For the Uvira coordination office, insecurity in the region.

To address these challenges during PY5 fiscal year, IHP plans to:

- Continue with the dissemination of job aids, closely monitor data collection for treatment of pneumonia and diarrhea at the health zone level, and address low performance issues in the coordination offices of Kolwezi, Luiza, and Mwene Ditu during supervision visits;
- Within the framework of IHP's results-based financing (RBF) initiative, propose the inclusion of indicators for treatment of diarrhea and pneumonia in RBF contracts;
- Monitor the availability of medicines for diarrhea and pneumonia (e.g., ORS, zinc, amoxicillin, and cotrimoxazole) at 5 selected health centers per coordination office twice a month.

A Promise Renewed: In June 2012, the DRC participated in the Global Child Survival Call to Action meeting held in Ethiopia from which the "A Promised Renewed" (APR) initiative ensued. In DRC, this initiative is led by an integrated committee comprised of all key health sector partners and donors. With support from UNICEF, USAID, and other actors, the DRC government developed an action framework with detailed strategies and the

potential to address bottlenecks and barriers in the health system that impedes access to health services. The Action Framework aims to reduce, by the year 2035, under-five mortality by 48% and maternal mortality by 31%, saving the lives of 430,000 children and 7,900 mothers.

IHP provides support for the Ministry's APR objectives and 6 maternal and child health strategies in 52 priority health zones. In 27 of these zones IHP provides support through a joint effort with UNICEF (via the Health for Poorest Populations project or HPP[5]). In 25 zones, IHP is the primary provider of support. In the 25 health zones, the i-CCM sites were expanded from 100 to 152 new sites. In the 27 health zones, the i-CCM sites were expanded from 94 to 173 new sites. The present report presents IHP's contribution to APR objectives during the quarter (PY4Q4).

Strategy 1: Universal coverage for vulnerable populations (pregnant women and children under five) family kits/voucher approach: IHP assisted with the distribution of HPP-funded family kits in the 4 health zones of Dibaya, Ndekesha, Kanda Kanda, and Vangakete. Jointly with the MOH, IHP organized post-training sessions at community health sites established last quarter in the health zones of Kole, Minga, Kayamba, and Wikong.

Strategy 2: Support for health services at the peripheral level including reference facilities: To strengthen the technical capabilities of health facilities, IHP provided medical supplies and small equipment to health facilities in 11 health zones where health personnel had benefited from competency-based maternal and child health training. Supplies typically included boxes of dressings, surgical gloves, fetoscopes, stethoscopes, blood pressure (BP) monitors, scrubs, salter scales, emesis basins, pressure sterilizer, digital thermometers, neonatal kits, and infant scales.

Strategy 3: Improve health zone governance and management: IHP provided technical and financial support to the health zones for the development of operational plans, for supervision visits and data monitoring meetings, and for the reinforcement of performance-based management that includes three essential elements: job descriptions and organograms; work plans, monitoring plans, and guides; and performance evaluations. During PY5, IHP aims to further strengthen health zone management team capacity for informed decision-making and activity planning based on bottleneck analyses.

Strategy 4: Strengthen human resources (health facility service providers: staff motivation, quality training): In PY4Q3, IHP provided financial and technical support to train 35 MNCH trainers in family planning, post-abortion care, care for victims of sexual violence, essential and emergency obstetrical care, and essential and emergency newborn care. During PY4Q4, these trainers trained 238 providers, including 31 physicians, 137 nurses, and 70 midwives in 11 health zones (Uvira, Nundu, Lemera, Kabongo, Bibanga, Kanda Kanda, Lodja, Vangakete, Dibaya, Lubondaie, and Ndekesha).

Strategy 5: Communication for Development: During the quarter, IHP provided support for three family planning mini campaigns in three health zones (Mwene Ditu, Dibaya, and Ndekesha). In total, 1,987 people (1,827 women and 160 men), were sensitized by the campaigns, which also resulted in 460 new acceptors of a modern method of family planning.

Strategy 6: Community Mobilization: During the quarter, 1,322 CODESAs were revitalized, and 1,265 of them developed an action plan to address community health matters. CODESAs held meetings with community members and/or conducted household visits to discuss and promote essential family health practices (CODESAs are discussed in greater detail below).

[5] HPP is financed by UNICEF and implemented by MSH.

2. CODESA integration: Health advocacy and community mobilization

CODESA members are responsible for disseminating health information to the local populations. They interact with community members, listen to their views and concerns, and educate them about health problems, causes, and solutions. CODESAs carry out awareness-raising and community mobilization activities to promote behavior change for disease prevention and treatment. Community mobilization and accountability for health are central to the long-term behavior change process. To support the process, IHP has implemented several innovative behavior change communications (BCC) approaches, including Champion Communities, Education Through Listening (ETL), and mHealth. IHP also utilizes more traditional capacity-building BCC interventions to strengthen local partners' capacity, such as CODESAs, to design and carry out their own communication action plans and actively engage with local populations.

During PY4Q4, IHP revitalized 1,322 CODESAs, reaching 94.6% of the annual goal of 1,398 (See Table 12). Of these revitalized CODESAs, 1,265 developed a communications action plan to be implemented with the assistance of IHP and community mobilizers. IHP supported many CODESAs in implementing their BCC interventions. In the Kasaï Occidental province, for example, the project facilitated the mobilization of all CODESAs in the province's 9 health zones to support a MOH mass polio vaccination campaign. CODESA members led community mobilization interventions in churches, schools, and households. After extensive preparatory meetings and briefings to organize the BCC campaign, the CODESA members counted households with children under the age of five, and worked with MOH vaccination teams to ensure that children received the required vaccinations. They also helped dispel misinformation and rumors about vaccination in the community. Similar interventions were conducted by CODESAs in all health zones.

CODESAs were also actively involved in addressing a dangerous outbreak of diarrhea in the Luiza health zone in July 2014. CODESA members conducted outreach initiatives to raise awareness about the importance of washing hands at critical moments, using hygienic latrines, only consuming clean water, properly conserving clean water, and thoroughly cooking and preserving food. The Luiza CODESAs BCC campaign included 14 group community mobilization sessions in churches and 634 outreach visits to households. CODESAs also distributed 100 informational announcements to local churches to be read by pastors to their congregations regarding prevention of diarrhea. A WASH committee was also formed to maintain potable water sources.

Table 12: Number of revitalized and functional CODESAs during PY4Q4

Coordination	Total CODESAs identified	Total CODESAs revitalized PY4Q1	Total CODESAs revitalized PY4Q2	Total CODESAs revitalized PY4Q3	Total CODESA revitalized PY4Q4	Total CODESAs with an action plan
Bukavu	399	352	393	399	399	367
Kamina	202	176	192	182	201	198
Kole	129	113	113	125	129	129
Kolwezi	106	87	81	89	92	92
Luiza	160	174	174	156	147	137
Mwene Ditu	171	168	168	168	168	168
Tshumbe	119	88	88	88	92	92
Uvira	102	94	90	98	94	82
Total	1,396	1,252	1,299	1,305	1,322	1,265

Challenges: While the number of functional CODESAs with communication action plans continues to increase, this growth is challenged by a lack of financial and other resources. Some health zones are unable to properly supervise their community volunteers due to a lack of training and resources. Many CODESAs lack office facilities that would allow them to archive valuable documents. There is an insufficient level of coordination between CODESAs and other community stakeholders, including religious groups, teachers, local authorities, community-based organizations (CBOs), and other private sector community leaders.

Next steps: IHP has two primary strategies planned for next quarter to ensure that CODESAs continue to grow in support and influence. The project will continue to provide CODESAs with management tools (such as reporting templates, documents, and meeting guides) and will guide health zone teams in supervising community activities. IHP will also organize, together with the National Health Communication Program (PNCPS), the MOH Primary Health care Development Office (B5), and health district authorities, joint supervision missions to support the revitalization of CODESAs. Finally, IHP will continue to facilitate the interactions between CODESAs and other stakeholders in project health areas.

3. WASH Activities

Although the WASH portfolio has not yet fully rebounded from the effects of the budget restrictions and subsequent slowdown in activities experienced from October 2013 to April 2014, sanitation and clean drinking water interventions were undertaken during the quarter to get WASH results back on track.

Provision of clean water: PY4Q4 results related to clean water supply (see Table 13) fell short of targets and were not as strong as results achieved last quarter. Tshumbe was the high performer this quarter, providing potable water for the first time to 53,253 people. Three of the coordination offices provided clean water for the first time to an additional 23,072 people, while another three coordination offices did not report on this indicator. Several different factors contributed to these low results.

Last quarter, IHP indicated that new water sources were limited in Kanzenze in Kolwezi due to poor soil conditions. During the current quarter, WASH experts noted that the situation is similar in Songa (Kamina). Compounding the situation in Kamina is the absence of a WASH advisor in this coordination office. WASH activities are labor intensive and require frequent, if not constant, oversight in the field. The contract of the project-funded WASH advisor for Kamina expired at the end of June 2014 and has not been replaced.

Challenges notwithstanding, the Kolwezi coordination office began to reassess the entire Kanzenze health zone to identify new potential water sources. To date, seven possible sources have been identified in hard-to-reach places and exploratory work is in progress. IHP improved the hygiene in some of Kolwezi's new health structures by resolving waste management issues (e.g., building placenta pits, providing incinerators). The project also devoted time and attention to promotion of community-led total sanitation (CLTS), including more family latrines in Kolwezi.

Planned initiatives to improve drinking water sources in Kole and Luiza were delayed due to the late arrival of WASH construction materials. Construction of new water sources started late in PY4Q4, and will be completed and reported in the next quarter. The Uvira coordination office carried out community outreach activities and training to increase awareness about CLTS and family latrines, and improved hygiene and sanitation in four newly-renovated health structures.

Given the current planning and work in progress in several coordination offices, IHP expects to report improved results during the next quarter. A number of corrective measures have been put in place starting in PY5 to improve results:

- Ensure that materials are available in a timely manner to cap water sources and construct (Lodja);
- Hire WASH consultants as needed in order to increase IHP support to target health zones;
- Strengthen CLTS by conducting additional awareness activities and building more family latrines;
- Reassess and identify health zones with potential water sources to be capped this year to serve a significant number of the population and continue rehabilitation of community wells (e.g., Kanzenze in Kolwezi) in order to provide water to more new people;
- Organize more joint IHP-MOH supervision visits.

Sanitation: The number of people in target areas with first-time access to improved sanitation nearly doubled from the third to fourth quarter (60,260 vs. 107,830). The strongest results were achieved in Kanzenze, Katana, and Walungu, which benefited from Champion Community awareness-raising efforts and community support for the CLTS approach for informed behavior change and construction of latrines with local materials to eliminate the practice of open defecation. Lessons learned by these coordination offices can be used to improve performance in areas that have had less success with CLTS, for example in Mwene Ditu and Kole.

WASH experts from the coordination offices focused attention on supervising WASH committees and strengthening community awareness-raising activities for the CLTS approach in order to accelerate water source repairs and latrine construction for PY5.

IHP will maintain current and expanding CLTS activities into new areas during PY5. PY5Q1 plans include:

- Conduct supportive supervision and post-training follow up in WASH health zones;
- Work more closely with WASH committees in villages and health sites identified as weak in terms of family latrines;
- Organize sensitization visits to enlist the support of village chiefs for family latrines, and continue mini campaigns and BCC-WASH interventions as was done in PY3.

Table 13: IHP WASH indicators results per IHP coordination office for PY4Q4

	Target number of people in target areas	No. of people in target areas with first-time access to improved drinking water supply	No. of people in target areas with first-time access to improved sanitation facilities	Achievement rate for water sources	Achievement rate for latrines
Bukavu	87,503	1,437	24,229	2	28
Kamina	33,454	0	19,145	0	57
Kole	37,472	659	3,533	2	9
Kolwezi	18,039	0	40,350	0	224
Luiza	50,075	0	7,350	0	15
Mwene Ditu	80,670	7,020	987	9	1
Tshumbe	27,367	53,253	7,231	195	26
Uvira	28,021	5,355	5,005	19	18
PY4Q4 Total	**362,600**	**67,724**	**107,830**	**21**	**30**

Overall performance in WASH has been affected by the following challenges:

- Buy-in from the community for the Community Led Total Sanitation (CLTS) approach (community involvement) takes time, particularly in terms of mobilizing local resources for the construction of family latrines
- Extended period of time is needed for the procurement of construction materials and transportation services due to the more stringent management procedures implemented by the project management to tighten control over the procurement processes and protect the project resources from fraudulent practices the project identified, reported, and sanctioned
- There may be insufficient new water sources that are accessible and which can cover enough of the population who in turn commit to providing a contribution (e.g., local resources and family latrines) on top of the project subsidy in order to maximize the impact in IHP targets and results achievement
- There is a stock out of water quality tests but the project has placed an order that has not yet been delivered.

The project has learned the following lessons:

- For the CLTS approach to succeed, ongoing sensitization of the community is needed
- Implementing the Champion Community approach can add value to the success of CLTS as it provides the opportunity to secure a significant contribution to the community commitment and ownership
- The zonal approach needs to be flexible to allow for enrolling a new health zone that has the potential to significantly contribute to the project results, even if the target of 80% coverage of the first selected health zones is not achieved due to factors such as lack of community commitment, longer or much more time needed for changes to occur, hard to reach and land locked areas, weak flow of available water sources, and small number of people being served
- Prior to selecting health zones to implement this approach, it is necessary to prospect and conduct a situational analysis of potential water sources.

IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery

1. Leadership Development Program

IHP's Leadership Development Program (LDP) was designed specifically for health sector personnel, NGOs, community groups, and associations that have major roles in health zone strengthening. The LDP program facilitates the transfer of skills and knowledge to help health actors face and address challenges, creates an environment that motivates staff, and reinforces teamwork. The teams involved in the LDPs carry out leadership projects for a period of 4-6 months while they work in collaboration with stakeholders at all levels to address real organizational challenges to improve services and the work environment.

During PY4, a total of 189 LDP projects were implemented. Most projects focused on improving TB services or maternal and child health indicators. In all, 177 teams implemented projects and achieved expected results (see Table 14). This is more than twice the number of participating teams in 2013 (N=73). By the end of PY4, 94% of the projects (177/189) had attained their expected measurable results. Community leaders were typically very involved in all projects.

Table 14: LDP projects per technical area during PY4

Areas	Number of projects implemented	Number of projects achieving expected results	Achievement rate (in %)
MNCH (EPI,PMTCT, HBB, ANC, pre-school consultation visits, ITP)	114	104	91
Family planning	19	19	100
TB	26	26	100
L+M+G (FOSACOF, curative services, MPA, CPA)	30	28	93
Total	189	177	94

While it is commendable and understandable that most teams to date have focused on challenges related to maternal and child health, family planning, and tuberculosis, there are other important health care challenges which also require attention (e.g., nutrition, malaria, and safe water, hygiene, and sanitation). IHP will encourage health zone teams to design and implement projects that address these other areas in PY5, as appropriate.

INTERMEDIATE RESULT 2: QUALITY OF KEY FAMILY HEALTH CARE SERVICES IN TARGET HEALTH ZONES INCREASED

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

1. **Maternal, Newborn, and Child Health (MNCH)**

During PY4, 546,162 pregnant women made their first antenatal care (ANC) visit in IHP-supported health facilities that had qualified personnel (see Table 15). The number of women surpassed last quarter's results and exceeded the quarterly target (510,831) for a 107% achievement rate. Six of IHP's eight coordination offices exceeded their respective targets. It should be noted that ANC data from private health facilities in three Kolwezi health zones (Lubondaie, Luambo, and Yangala) were not collected.

Mwene Ditu did not meet targets due to stock outs of commodities such as LLINs, Sulfadoxine-Pyrimethamine (SP), and iron/folic acid in the health zones of Kalenda, Kamiji, and Wikong. In Luiza, poor planning and tardiness of health staff responsible for ANC sessions (Lubondaie), and difficult geographic access to some health centers (Yangala) were reasons given that discouraged women from attending ANC.

IHP will continue to advise head nurses to empower health providers responsible for ANC to improve service delivery and punctuality to increase utilization of services. IHP will also support the head nurses of Lubondaie and Luambo to plan ANC during community outreach events to address issues related to access, and to ensure the availability of ANC commodities. IHP will brief head nurses on MNCH guidelines during supervision missions, and encourage health zone management teams in Lubondaie, Luambo, and Yangala to actively collect data from private health facilities.

Table 15: Number of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	150,632	39,271	44,517	51,290	42,010	177,088	145,587	**122**	141,460	**106**
Kamina	76,354	20,417	19,847	19,469	19,213	78,946	76,625	**103**	73,169	**104**
Kole	15,829	9,944	9,933	9,834	10,059	39,770	35,758	**111**	14,634	**108**
Kolwezi	36,430	8,784	9,079	9,553	10,926	38,342	33,204	**115**	29,268	**124**
Luiza	62,760	16,058	16,541	14,679	14,155	61,433	64,365	**95**	58,535	**107**
Mwene Ditu	82,558	19,606	20,863	20,750	21,028	82,247	90,928	**90**	92,681	**89**
Tshumbe	48,195	7,627	8,099	7,948	8,242	31,916	29,117	**110**	43,901	**110**
Uvira	35,573	8,696	9,163	9,312	9,249	36,420	35,247	**103**	34,146	**104**
Total	**508,331**	**130,403**	**138,042**	**142,835**	**134,882**	**546,162**	**510,831**	**107**	**487,794**	**104**

Table 16: Number of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	39,372	12,160	14,856	16,095	17,171	60,282	95,461	**63**	82,138	**48**
Kamina	20,365	5,764	6,045	7,719	6,897	26,425	50,243	**53**	42,485	**48**
Kole	9,157	6,710	6,363	6,768	7,002	26,843	23,447	**114**	8,497	**108**
Kolwezi	11,832	2,411	2,221	2,745	3,652	11,029	21,772	**51**	16,994	**70**
Luiza	31,973	7,840	8,673	8,265	9,108	33,886	42,204	**80**	33,988	**94**
Mwene Ditu	45,507	11,520	13,931	13,965	14,048	53,464	59,621	**90**	53,815	**85**
Tshumbe	31,691	5,142	5,033	4,500	5,076	19,751	19,092	**103**	25,491	**124**
Uvira	10,412	3,308	3,217	3,539	4,410	14,474	23,112	**63**	19,826	**53**
Total	**200,309**	**54,855**	**60,339**	**63,596**	**67,364**	**246,154**	**334,952**	**73**	**283,234**	**71**

As seen in Table 16, the number of pregnant women who completed at least four ANC visits increased by about 23% between PY3 and PY4 (i.e., 45,845 more women in Y4 than Y3). Two of the eight IHP coordination offices exceeded their targets, two achieved 80% and 90% of respective targets, and the remaining four had results ranging from 51% to 73%. There was an increase of 2% in reporting completion rates between PY3 and PY4. The improvement in the reporting completion rate is due to monitoring missions, strengthened supportive

supervision, and competency-based MNCH training of providers and CHWs in July, August, and September 2014. There was also improvement in the collection and reporting of data by health providers. Late ANC4 consultations in certain health zones (e.g., Lubondaie) and missed follow-up appointments explain the lower coverage observed in the coordination offices that did not meet targets.

To improve the performance of the health zones, IHP will continue to support community outreach efforts to promote ANC. As for private health facilities that did not submit reports, the project plans to obtain data through joint supervision missions with health authorities. The project will also continue to ensure the availability of commodities related to ANC (i.e., LLINs, Mebendazole, iron) to motivate health providers responsible for ANC. IHP will continue to use and improve SMS to remind pregnant women of their ANC appointments in health zones that have cell phone reception.

Table 17: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	120,419	32,199	34,781	35,618	35,886	138,484	128,024	**108**	121,686	**99**
Kamina	56,366	14,932	15,352	15,880	14,953	61,117	67,381	**91**	62,941	**90**
Kole	12,717	8,586	8,421	8,409	8,787	34,203	31,445	**109**	12,588	**101**
Kolwezi	33,951	8,751	8,152	8,663	9,555	35,121	29,199	**120**	25,176	**135**
Luiza	58,487	15,049	15,807	13,755	12,907	57,518	56,600	**102**	50,353	**116**
Mwene Ditu	73,075	17,762	19,274	19,550	19,847	76,433	79,959	**96**	79,725	**92**
Tshumbe	43,634	6,945	7,010	6,951	7,206	28,112	25,605	**110**	37,765	**116**
Uvira	26,674	7,229	6,867	7,798	7,345	29,239	30,995	**94**	29,372	**91**
Total	**425,322**	**111,453**	**115,664**	**116,624**	**116,486**	**460,227**	**449,208**	**102**	**419,606**	**101**

Compared to PY3 (425,322), the number of deliveries with a skilled birth attendant rose by 8% during PY4 (460,227) with an average achievement rate of 102% vis-à-vis targets. Moreover, the coordination offices of Bukavu, Kole, Kolwezi, Luiza, and Tshumbe exceeded the annual target due to structural improvements and better hygiene in the maternity clinics (e.g., installation of solar panels and equipment). In addition, the reduction of delivery fees motivated more women to give birth in a health center assisted by skilled providers.

In PY5, IHP will continue to assist head nurses through supportive supervision and monitoring visits. IHP will encourage greater involvement of community leaders in outreach activities to discourage home births, promote improved services and infrastructure of health facilities (e.g., better equipment, steady supply of medicines), and encourage community monitoring of women in the last month of pregnancy.

During PY4, the project increased coverage of AMTSL from last year by 7 percentage points (424,835/395,628) and had an average achievement rate of 100% (see Table 18). Kole (88%) and Uvira (90%) were not able to reach their respective targets (95%) due to stock outs of oxytocin at maternity clinics. The product was available at the CDRs, but stock outs were experienced at the clinic level because clinic staff did not submit orders on time.

In the upcoming quarter, during supportive supervision visits with SIAPS, IHP will continue to advocate for the centralization of health facility orders by the health zone management teams who would review, consolidate, and submit orders on a quarterly basis to the district health team for validation. IHP will also continue provide technical support to health care providers and will ensure that each maternity clinic has the revised AMTSL standards clearly posted.

Table 18: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	108,152	27,501	31,148	32,620	33,699	124,968	121,273	**103**	109,161	**99**
Kamina	55,420	14,728	15,343	15,705	14,572	60,348	63,828	**95**	56,463	**98**
Kole	11,545	6,085	5,946	6,134	8,035	26,200	29,786	**88**	11,293	**102**
Kolwezi	31,686	8,303	7,868	8,141	7,985	32,297	27,659	**117**	22,585	**140**
Luiza	56,578	14,860	15,693	13,424	12,488	56,465	53,615	**105**	45,170	**125**
Mwene Ditu	69,605	17,435	18,718	19,007	19,470	74,630	75,742	**99**	71,519	**97**
Tshumbe	39,492	5,947	5,660	5,630	6,192	23,429	24,255	**97**	33,878	**117**
Uvira	23,150	6,579	6,207	6,965	6,747	26,498	29,361	**90**	26,349	**88**
Total	**395,628**	**101,438**	**106,583**	**107,626**	**109,188**	**424,835**	**425,519**	**100**	**376,418**	**105**

By the end of PY4, IHP had achieved 81% of the yearly target for the number of postpartum/newborn visits within three days of birth (440,147 visits vs. target of 540,245), and the number of visits this year increased by nine percentage points compared to PY3 results (403,174 visits). The strongest performance was reported by Kolwezi (achieved 99% of target) and the weakest was Uvira (attained 68% of target), as seen in Table 19.

To improve future performance, IHP and health zone management teams will use supervision visits to health service sites to overcome identified factors that discourage postnatal visits. In some health facilities, postnatal consultations are not routinely scheduled. In other places, provider understanding or appreciation of the process and purpose of the consultation need to be reinforced (e.g., systematic examination of the newborn, counseling about newborn and maternal care issues, provision of iron folate and vitamin A). In facilities that have not been well maintained and that lack basic amenities (e.g., no toilets, no running water, no beds or mattresses), new mothers will understandably go home two to six hours after delivery and will not return to the facility for a postnatal consultation. Discussion is underway with MOH national- and provincial-level authorities on ways to improve the quality of postnatal services and increase providers' and women's understanding of the value of these services for both newborns and mothers.

Table 19: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	113,762	30,629	34,087	34,879	35,048	134,643	153,970	**87**	152,108	**75**
Kamina	56,874	14,997	15,250	15,625	14,255	60,127	81,037	**74**	78,676	**72**
Kole	11,217	6,452	6,320	6,662	7,243	26,677	37,817	**71**	15,735	**71**
Kolwezi	32,048	8,605	8,285	8,466	9,428	34,784	35,116	**99**	31,471	**102**
Luiza	56,862	14,778	15,698	13,490	12,886	56,852	68,071	**84**	62,941	**90**
Mwene Ditu	70,252	17,420	18,431	18,781	19,162	73,794	96,163	**77**	99,657	**70**
Tshumbe	40,704	6,960	6,862	6,987	7,151	27,960	30,794	**91**	47,206	**86**
Uvira	21,455	6,058	6,040	6,902	6,310	25,310	37,277	**68**	36,716	**58**
Total	**403,174**	**105,899**	**110,973**	**111,792**	**111,483**	**440,147**	**540,245**	**81**	**524,510**	**77**

During PY4, 439,793 newborns received essential care. This number reflects a 9% increase over PY3 results and 102% of the total PY4 target for this indicator. Five coordination offices exceeded their targets, while three (Kamina, Mwene Ditu, and Uvira) were slightly under target. Factors that impact negatively on results for this indicator include frequent turnover of qualified staff, and refusal of some providers to implement recommendations made during supervision visits. IHP will continue to monitor essential newborn care and provide coaching and refresher training to health care providers as needed during supervision visits.

Table 20: Number of newborns receiving essential newborn care through USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	110,667	29,373	34,114	34,850	35,196	133,533	122,552	**109**	114,650	**97**
Kamina	51,671	13,187	13,084	15,136	13,599	55,006	64,501	**85**	59,302	**87**
Kole	11,221	7,630	7,646	7,627	8,149	31,052	30,100	**103**	11,860	**95**
Kolwezi	32,354	8,601	8,314	8,466	8,416	33,797	27,950	**121**	23,721	**136**
Luiza	56,078	14,541	15,581	13,217	12,727	56,066	54,181	**103**	47,442	**118**
Mwene Ditu	68,612	17,265	18,857	19,003	19,578	74,703	76,541	**98**	75,116	**91**
Tshumbe	41,889	6,725	6,722	6,922	6,989	27,358	24,510	**112**	35,581	**118**
Uvira	25,670	7,098	6,816	7,388	6,976	28,278	29,670	**95**	27,674	**93**
Total	**398,162**	**104,420**	**111,134**	**112,609**	**111,630**	**439,793**	**430,005**	**102**	**395,346**	**101**

During PY4, 34,820 newborns received antibiotic treatment for infection, exceeding the annual target of 32,415, for a 107% achievement rate. This represents a 21% increase over PY3 results (25,511 newborns treated). Nevertheless, as seen in the following table, results are uneven across the coordination offices. The Bukavu coordination office attained 64% of its target, Tshumbe was lower at 46%, while Kolwezi and Luiza greatly surpassed their respective targets (257% and 164% achievement). Ongoing challenges with this indicator include poorly-trained providers (inability to recognize infections and/or weak use of tools, such as respiratory timer, designed to aid in diagnoses) and uneducated population (lack of knowledge about danger signs, and delays in seeking care due to traditional beliefs).

Table 21: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs

Coordination office	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Results	Target PY4	Achievement % PY4	Target PY3	PY3 Results	Achievement % PY3
Bukavu	1,523	1,388	1,733	1,257	5,901	**9,238**	64	9,127	5,584	**61**
Kamina	1,917	698	439	2,095	5,149	**4,862**	106	4,721	3,549	**75**
Kole	730	602	626	555	2,513	**2,269**	111	944	1,579	**167**
Kolwezi	203	598	1,353	3,259	5,413	**2,107**	257	1,888	1,314	**70**
Luiza	596	1,404	2,480	2,206	6,686	**4,084**	164	3,777	3,254	**86**
Mwene Ditu	2,027	1,418	864	1,142	5,451	**5,770**	94	5,979	9,028	**151**
Tshumbe	190	118	366	168	842	**1,848**	46	2,832	1,574	**56**
Uvira	872	593	747	653	2,865	**2,237**	128	2,203	1,629	**74**
Total	**8,058**	**6,819**	**8,608**	**11,335**	**34,820**	**32,415**	107	**31,471**	**27,511**	**87**

2. Family Planning

Couple Years of Protection: All coordination offices, with the exception of Uvira, exceeded their family planning targets for PY4. The total CYP obtained this year (562,982), not only exceeded the target (450,000) by 25%, but also showed a significant increase compared to PY3 (502,592) (see Table 22). IHP believes that Uvira (with 80% target attained in PY4Q4) will be able to report stronger performance next quarter. In this regard, Uvira experienced a stock out of family planning commodities in July 2014, which has since been resolved. Uvira's newly-trained CBD workers should be fully operational and family planning should be integrated into some, if not all, of Uvira's community health sites by the end of next quarter.

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

Coordination office	PY3 CYP	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 CYP	Target PY4	Achievement (%)
Bukavu	92,908	32,969	33,246	32,026	39,096	137,337	128,250	107
Kamina	102,387	26,175	23,410	26,446	25,953	101,985	67,500	151
Kole	11,554	9,677	9,910	9,498	10,183	38,548	31,500	122
Kolwezi	49,935	9,336	10,730	11,116	15,691	46,874	29,250	160
Luiza	71,857	19,300	19,536	16,428	16,923	72,185	56,700	127
Mwene Ditu	99,724	22,216	23,608	24,620	25,947	96, 391	80,100	120
Tshumbe	51,552	11,621	11,327	11,000	10,909	44,857	25,650	175
Uvira	22,676	5,446	5,272	6,164	7,923	24,805	31,050	80
Total	**502,592**	**136,740**	**136,318**	**137,298**	**152, 626**	**562, 982**	**450,000**	**125**

These impressive results are due in large part to family planning awareness activities carried out in the IHP Champion Communities. Activities include the training of 111 community-based distribution (CBD) workers in 5 health zones (Bagira, Ibanda, Kadutu, Lemera, and Ruzizi); training of 372 providers in long-term family planning methods (Implanon and IUD); integration of non-clinical family planning services into community health care sites; integration of FP counseling into maternity clinics; increasing community awareness about FP via mini campaigns; and 6 training sessions based on the skills approach in 11 health zones (Kabongo, Bibanga, Kanda Kanda, Lodja, Vangakete, Dibaya, Lubondaie, Ndekesha, Uvira, Nundu, and Lemera). IHP and health zone teams also paid careful attention to the management of family planning commodities to avoid stock outs, and successfully integrated FP at 51 PMTCT sites.

Modern Methods of Contraception: The number of people using modern methods of contraception increased from 556,320 to 606,320 between PY3 and PY4. During PY44, the achievement rate exceeded the PMP target (497,400) by 22%. During PY4, 1,751 health facilities and 506 community health sites provided FP services with respective achievement rates of 109% and 127%, compared to PMP targets (1,600 and 400).

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

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement (%)
Bukavu	103,042	30,424	33,270	38,003	33, 048	134,745	141,759	95
Kamina	113,436	31,415	24,373	24,956	23,121	103,865	74,610	139
Kole	24,460	15,195	17,092	14,354	14,686	61,327	34,818	176
Kolwezi	49,960	10,199	14,590	12,985	12,131	49,905	32,331	154
Luiza	77,162	21,662	5,737	17,745	13,678	130		125
Mwene Ditu	98,186	20,073	22,883	25,276	21,139	95,957	88,537	108
Tshumbe	66,827	16,369	13,993	12,289	11,974	54,625	28,352	193
Uvira	23,247	5,998	5,801	7,367	8,391	27,557	34,321	80
Total	**556,320**	**151,335**	**152,332**	**152, 975**	**149,678**	**606,320**	**497,400**	**122**

This strong performance would not have been possible without the availability of a wide range of contraceptive products, well-trained providers to dispense quality family planning services, hard-working and motivated CBD workers who travel long distances by bicycle to reach remote villages, and the involvement and support for family planning by political and administrative authorities.

Noting that about 40% of overall CYP is due to modern methods, IHP will continue to assist health zones to expand family planning services and ensure the availability of a wide range of contraceptive methods. IHP will also work with MOH, other donor counterparts, civil society leaders, and other stakeholders to address national policy issues (e.g., the promulgation of the new reproductive health law and repeal of the anti-contraception legislation that dates back to 1933 and the integration of family planning curricula into schools of medicine and nursing). IHP will continue to expand access to family planning by supporting and strengthening CBD activities and the integration of FP into other health services (PMTCT, HIV, ANC, and postpartum care), community health care sites, and private sector facilities. Additional health providers, including CHWs and CBD workers, will be trained in family planning and will benefit from supportive supervision visits in PY5.

Table 24: Number of USG-assisted health facilities experiencing stock outs of Depo-Provera

	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4
Number of USG-assisted health facilities experiencing stock outs of Depo-Provera	38	31	35	67	**67**	100

A total of 59 facilities experienced stock outs for at least three days during a month in the quarter. In most cases, the product was available at the CDRs and central distribution offices, but due to untimely ordering, lack of data on monthly consumption rates, and insufficient quantification skills at the health facility level, stock outs occurred at some facilities. Although 59 is higher than the number of stock outs reported in PY4Q2 and Q3 (45 and 39, respectively), this result is well under the established threshold (100) for PY4. Overall PY4 results indicate that IHP is likely to continue to keep stock outs to a minimum and not exceed the new threshold (50) for this indicator beginning next quarter.

3. Malaria

Distribution of 1,000,000 doses of Sulfadoxine Pyrimethamine (SP) during antenatal care (ANC) in 69[6] health zones that are not covered by Global Fund: Intermittent preventive treatment of malaria in pregnancy (IPTp) is a full therapeutic course of antimalarial medicine given to pregnant women at routine prenatal visits, regardless of infection status. IPTp reduces maternal malaria episodes, maternal and fetal anemia, placental parasitemia, low birth weight, and neonatal mortality. The WHO recommends IPTp -SP in all areas with moderate to high malaria transmission in Africa.

During IHP PY4, 317,588 pregnant women received two doses of SP (IPTp2), reaching 63% of target women, for an increase of 4% compared to PY3 results. The coordination offices of Mwene Ditu, Bukavu, and Kole surpassed PY3 results by 20, 7, and 6 percentage points respectively. In these coordination offices, SP supplies were readily available, and community outreach activities helped to boost SP coverage. Mwene Ditu also met the annual target (2 doses of SP for 80% of expected pregnant women) set by the national malaria control program (PNLP).

However, due to stock outs of SP in Uvira, Tshumbe, and Luiza, SP coverage dropped between PY3 and PY4. In PY4, Uvira's coverage dropped by 15 percentage points, Tshumbe by 6 points, and Luiza by 5 points (see Table 25). The results from these coordination offices pulled down overall results for this indicator. In terms of IPTp2 coverage, 42 out of 69 IHP-supported health zones achieved at least 50% of target for IPTp2 SP coverage.

Table 25: Percentage of pregnant women that received two doses of SP from October 2013 to September 2014 in 69 IHP-supported health zones

	Indicators					
Coordination office	No. of pregnant women who received at least two doses of SP during ANC visits (PY4)	No. of expected pregnant women at ANC visits (PY4)	Percentage of pregnant women who received at least two doses of SP	No. of pregnant women who received at least two doses of SP during ANC visits (PY3)	No. of expected pregnant women at ANC visits (PY3)	% of pregnant women who received at least two doses of SP (PY3)
Bukavu	96,780	147,071	66	90,337	150,448	60
Kamina	54,269	79,120	69	53,975	79,120	68
Kole	24,652	37,112	66	8,878	14,687	60
Kolwezi	16,755	34,266	49	16,713	34,266	49
Luiza	30,301	60,793	50	37,853	64,251	59
Mwene Ditu	66,052	84,844	78	60,039	100,583	60
Tshumbe	17,431	32,120	54	25,928	45,672	57
Uvira	11,347	36,158	31	16,716	36,158	46
PY4 Total	**317,588**	**505,636**	**62**			
PY3 Total				**310,439**	**525,185**	**59**

Distribution of 455,000 LLINs during antenatal care (ANC) in 69 health zones that are not covered by Global Fund: Due to a chronic stock out of bed nets in the targeted health zones during the majority of the year, the

[6] Starting in July 2014, the health zones of Tshikaji and Bulape (Kasaï Occidental) were transferred to IMA World Health to be covered under the DFID-funded *Accès au Soins de Santé.* Data collected prior to July 2014 were considered in this report.

project could not meet the distribution target of 455,000 LLINs. Only 26,087 nets were distributed during PY4 -- 16,404 during ANC sessions and 9,683 during preschool consultations.

As of PY5Q1, LLINs are available at the CDRs in Kamina, Kolwezi, Bukavu, and Mwene Ditu. Deliveries for Luiza and the Sankuru are imminent. In total, 545,375 LLINs have been received in the different CDRs: 355,325 for Sud Kivu, 94,800 for Kolwezi, 44,800 for Kamina, and 50,450 for Mwene Ditu. The coordination offices, in collaboration with SIAPS and the National Malaria Program (PNLP), have already developed distribution plans and will work with the CDRs to transport the nets to the health zones. These measures were put in place by provincial health authorities to ensure that the LLINs reach the intended beneficiaries.

Correctly managing malaria cases in health facilities through training, distribution of medicine and commodities (ACTs, RDTs, and supervision): During PY4, 979,560 doses of ACT (for children 2-11 months and 1-5 years) were distributed -- 949,532 doses at health facilities and 30,028 doses at community care sites. Compared to PY3 (653,417 doses distributed), there has been an increase in ACT use due to the availability of ACT throughout the year, project-supported transportation of commodities from the health zone central offices to health facilities, and sound management of the supply chain of ACTs in collaboration with SIAPS.

The preceding notwithstanding, there were stock outs of ACT for 2-11 months old in the health zones supported by the coordination offices of Bukavu, Kamina, and Luiza, mainly due to underestimation of needs during quantification. In the health zones in Sankuru district there were stock outs of ACT (2-11 months) and other challenges as well (e.g., noncompliance of some providers with MOH malaria treatment protocols). To address these issues, IHP has started to redistribute commodities among CDRs to avoid stock outs. To address imminent ACT stock outs in Bukavu health zones, IHP developed a redistribution plan transferred surplus ACT stocks from the CDR in Lubumbashi to Bukavu.

Table 26: Number of ACT treatments for children under 5 purchased with USG funds and distributed to health facilities and community care sites PY4

Coordination Office	Total ACT 1-5 years and 2 – 11 months (health facilities and sites)			
	Quantity of ACT for children under 5 distributed through community care sites	Quantity of ACT for children 1 – 5 years distributed to health facilities	Quantity of ACT for children 2-11 months distributed to health facilities	Total quantity ACT distributed for children under 5
Bukavu	2,025	179,378	43,386	224,789
Kamina	9,095	166,333	40,168	215,596
Kole	534	31,035	26,791	58,360
Kolwezi	2,290	42,394	21,251	65,935
Luiza	1,870	94,895	47,048	143,813
Mwene Ditu	8,878	85,610	56,627	151,115
Tshumbe	3,326	45,063	19,862	68,251
Uvira	2,010	37,649	12,042	51,701
PY4 Total	**30,028**	**682,357**	**267,175**	**979,560**
PY3 Total	**14,279**	**461,283**	**177,855**	**653,417**

Table 27: Number of ACT treatments for all age groups purchased with USG funds and distributed PY4

Coordination office	ACT infant (2- 11 months)	ACT toddler (1 - 5 years)	ACT child (6 - 13 years)	ACT adolescent and adult > 13 years)	PY4 Total
Bukavu	44,248	180,541	162,731	149,891	537,411
Kamina	43,818	171,778	104,124	85,809	405,529
Kole	26,815	31,545	13,235	48,450	120,045
Kolwezi	21,274	44,661	29,222	46,323	141,480
Luiza	47,248	96,565	67,673	89,414	300,900
Mwene Ditu	57,400	93,715	100,273	138,923	390,311
Tshumbe	20,389	47,862	36,933	35,786	140,970
Uvira	12,632	39,069	27,629	23,065	102,395
PY4 Total	**273,824**	**705,736**	**541,820**	**617,661**	2,139,041
PY3 Total	**182,949**	**475,562**	**630,695**	**639,624**	1,928,830

During PY4, 2,166,145 doses of ACT for all ages were administered, which represents 87% of IHP's annual target (2,500,000 doses) and an increase of 12% since PY3 (1,928,830). The 87% coverage also surpasses the PNLP's target of 80%. The availability of commodities, trainings, and refresher trainings of providers, as well as monthly monitoring of commodities, all contributed to this achievement. Joint supervision missions with health zone and district management teams reinforced compliance with national policies regarding case management of malaria.

Table 28: Number of USG-funded malaria-rapid diagnostic tests (malaria-RDTs) purchased and distributed in PY4

Period	Coordination office								
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	**Total**
PY4Q1	91,354	51,800	8,809	5,174	4,428	59,609	31,754	22,604	**275,532**
PY4Q2	67,541	26,817	4,546	8,887	17,871	92,678	21,949	12,211	**252,500**
PY4Q3	56,627	79,632	7,263	13,917	21,033	34,984	18,029	24,890	**256,375**
PY4Q4	98,165	70,404	12,468	25,059	18,634	116,757	24,283	15,384	**381,154**
PY4 Total	**313,687**	**228,653**	**33,086**	**53,037**	**61,966**	**304,028**	**96,015**	**75,089**	**1,165,561**
PY3 Total	**100,561**	**288,297**	**13,629**	**136,310**	**46,788**	**201,761**	**98,207**	**159,197**	**1,044,750**

During PY4, 1,165,561 malaria RDTs were distributed (31,865 to community care sites). Although this reflects a 12% increase over PY3 results, it falls short of meeting the annual target for RDTs distributed (2,500,000). On a positive note, coordination offices with weak results for this indicator in PY4Q1 had significantly increased distribution of RDTs by the end of the year: Kole (from 8,809 to 12,468), Kolwezi (from 5,174 to 25,059), Luiza (from 4,428 to 18,634) and Mwene Ditu (from 59,609 to 116,757).

The ratio of ACT/RDT at health centers went from 2 ACT to 1 RDT (PY3) to 1.8 ACT to 1 RDT (PY4), while the ratio at community care sites is 1 ACT/0.9 RDT. The MOH norm is 1 ACT/2 RDT, so more work needs to be done in this area. IHP notes that CHWs are more likely than health center providers to follow MOH norms. However, IHP

also notes that management of patients who test negative for malaria remains problematic as many CHWs and health center providers continue to see patients presenting with fever and a negative RDT as uncomplicated malaria. Further efforts are required to reverse the ratio of 1 ACT per 2 RDT through supportive supervision that focuses on compliance with the national protocol for the management of cases and management of malaria commodities.

As part of the collaboration between partners in the fight against malaria, RDTs at risk of expiring from SANRU were redistributed to IHP towards health zones that were in need via a memorandum of understanding between SANRU, IHP, and PMI Extension.

Table 29: Number of USG-supported service delivery points with ACT (1- 5 years) stock out PY4

Indicator	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Results	PY3 Results
Number of USG-supported SDPs experiencing stock out of ACT for 1–5 year olds	301	561	506	260	260	243
Target (threshold)					**100**	**160**

In PY4, stock outs of ACT (1-5 years) occurred at 260 service delivery sites that provide ACT. By the end of PY4, the stock out situation at all coordination offices was improved. For example, Kolwezi, Uvira, Bukavu, and Mwene Ditu each reported less than 5 structures with stock outs in PY4Q4. Although the number of stock outs declined between PY4Q3 and Q4 in other coordination offices (Luiza: from 45 in Q3 to 36 in Q4, Kamina: from 57 to -26; and Tshumbe: from 48 to 14), there is room for improvement and an ongoing need to strengthen monthly inventory monitoring and improved management of orders from health zones.

Table 30: Health staff trained on malaria diagnosis (RDT)

	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Total
Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests [RDTs] or microscopy) with USG funds	46	124	653	554	1,377
Male	40	112	585	455	1,192
Female	6	12	68	99	185
Number of health facility workers trained	46	124	469	537	1,176
Number of community-level workers trained	0	0	140	17	157
Number of lab technicians trained	0	0	44	0	44

In total, 1,429 providers were trained, reaching 60% of the 2,400 target number. All coordination offices trained health care providers in malaria prevention and treatment. In PY4, focus was placed on training health center providers and CHWs in the management of uncomplicated malaria, which is the most frequent reason for consultation visits. Given overall budgetary constraints, the planned training of health care providers on the management of severe malaria in hospitals and training of technicians in referral laboratories in microscopy did not take place. In PY5, a focus will be placed on training during supportive supervision visits for these groups of health care professionals to ensure quality of care for patients.

Monitoring and Evaluation

- IHP drafted the PPRM report with SIAPS and USAID|DELIVER to record health zone drug consumption.
- The data collection phase of the study on the pre-referral use of rectal artesunate to be given to children under five at community care sites was completed. The implementation phase should begin in November 2014, subject to obtaining the artesunate suppository at the end of October, at the latest. The PMI team in Kinshasa initiated a loan for this product with DFID through the ASSP project as it appears that delivery of commodities by USAID|DELIVER will be delayed.
- The preliminary report of the performance evaluation of health care providers in the implementation of RDTs is being finalized, and results will be shared in November 2014. Further assessment of providers in other provinces is needed to enable us to generalize the results.

4. Expanded Program on Immunization (EPI)

EPI data presented in this section were validated by all 78 health zone management teams. Overall, immunization coverage for tetanus, BCG, DTP HepB-HiB1, DTP HepB-HiB3, TOPV3, and measles has improved every year from PY1 to PY4 (see Table 31). Vaccine PCV13-3 is relatively new in the DRC. It was introduced in the country in 2011 and rolled out gradually to all service sites during the next two years (rollout was complete by the end of October 2013). There is weak coverage of PCV13-3 across the coordination offices due to frequent stock outs of the antigen for the following reasons:

- The quantity ordered is often different from the quantity delivered by the MOH (EPI), which has full responsibility for supplying vaccines from the central level down to the health zone level
- Delivery does not occur according to the agreed terms on frequency and intervals between deliveries according to the context and the needs
- As a result, the Extended Program on Immunization (EPI) supplied the branches late and in quantities below the minimum level of stocks required
- There was a delay in the availability of the government's contribution

Other vaccines are provided by the Global Alliance for Vaccines and Immunization (GAVI), with no government co-share requirement. For the most part, fewer stock outs of these antigens are reported compared to PCV13.

Table 31: Immunization coverage by coordination and vaccination type

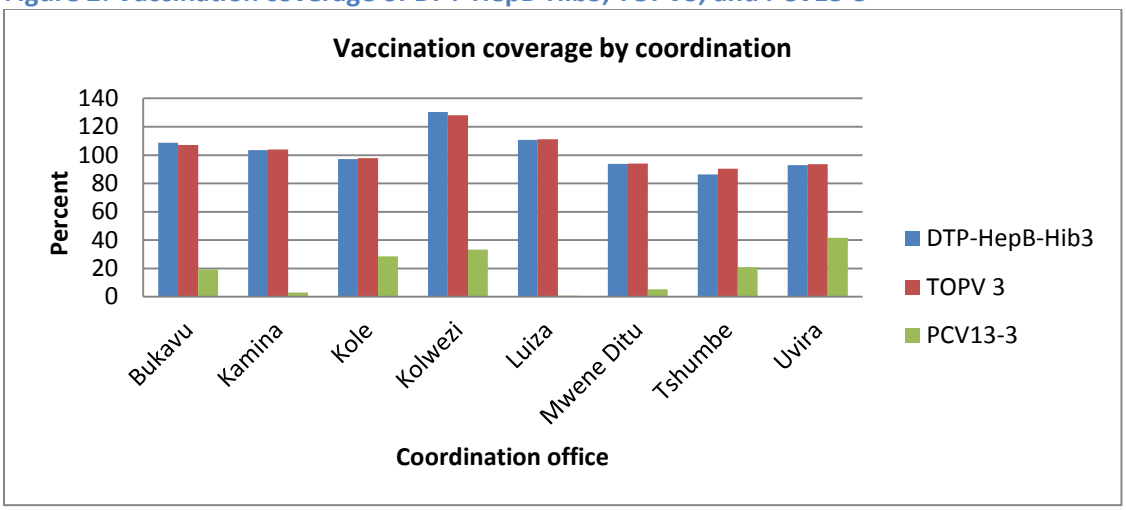
Coordination office	Tetanus vaccine 2+ (%)	BCG (%)	DTP HepB-Hib1 (%)	DTP HepB-Hib3 (%)	TOPV 3 (%)	Measles (%)	PCV13-3 (%)
Bukavu	93	91	114	109	107	98	19
Kamina	102	99	110	104	104	104	3
Kole	92	78	101	97	98	97	28
Kolwezi	109	148	139	130	128	106	33
Luiza	114	108	116	111	111	111	1
Mwene Ditu	100	89	99	94	94	94	5
Tshumbe	84	73	91	86	90	87	21
Uvira	82	68	99	93	94	78	42
PY4 coverage (%)	97	94	109	104	104	98	16
PY3 coverage (%)	95	107	107	103	100	95	-
PY2 coverage (%)	89	87	100	94	75	93	-

PY1 coverage (%)	89	74	102	96	-	90	-

Over the first four years of the project, the drop-out rate between DPT-HepB-HiB1 and DPT-HepB-Hib3 has been fairly low, from zero to 10% at its highest, due mainly to the consistent availability of commodities, successful implementation of the *atteindre chaque zone de santé* ("reach every health zone") approach, community outreach via the work of Champion Communities and community-based organizations, and donations of supply chain materials and commodities.

The vaccination coverage for DPT-Hepb-Hib3 and for Trivalent Oral Polio Vaccine (TOPV3) during PY4 was consistent across project sites. The only significant difference is with the PCV13-3 coverage: even though PCV13-1 is normally administered with the DPT-HepB-Hib3 and OPV3 at the same time, the low coverage is mainly due to stock outs not only in project sites but across the country in general.

Figure 2: Vaccination coverage of DPT-HepB-Hib3, TOPV3, and PCV13-3



Health zones' performance on coverage of DPT-HepB-Hib3 by coordination office: Overall, DPT-HepB-Hib3 coverage has been satisfactory. Seventy-three of 78 health zones have achieved at least 80% of coverage in 96% of project-supported health zones (20 out of 22 health zones in Bukavu, all 9 health zones in Kamina, 7 out of 8 in Kole/Lodja, all 8 in Kolwezi, all 9 in Luiza, all 9 in Mwene Ditu, 7 out of 8 in Tshumbe, and 4 out of 5 health zones in Uvira).

Five health zones achieved vaccination coverage between 50% and 79% (72% in Kalole, 73% in Mulungu, 72% in Nundu, 74% in Minga, and 62% in Tshudi Loto). Late delivery of vaccines in these zones resulted in some children missing vaccinations. For the next project year, IHP will continue to use the *atteindre chaque zone de santé* (ACZ) approach to maintain vaccination support gains, but will also focus on the *atteindre chaque enfant* (ACE) approach to raise performance where needed, and to strengthen data quality audits in health zones and health areas. While both approaches have similar components, i.e., planning and resource management, reaching out to targeted populations, linking the service and the population, supportive supervision, and monitoring for action, ACE may help reach those children who are the hardest to reach with our efforts.

Polio eradication: In March 2013, DRC was taken off the WHO list of polio endemic countries. The last detected case was in April 2013 in the health zone of Kabondo Dianda (Kamina district). In connection with the active surveillance for cases of acute flaccid paralysis (AFP), 66 of 78 project-supported health zones reported at least

one case of AFP from January to September 2014, which represents an overall notification rate of 85% at the project level. The remaining 12 health zones did not report (Ndekesha, Dekese, Bena Dibele, Djalo Ndjeka, Katako Kombe, Minga, Lusambo, Luamba, Bunkeya, Bagira, Miti Murhesa, and Nyangezi). The project will address this issue by strengthening surveillance at health facilities and communities.

5. HIV and AIDS

Since last quarter the HIV indicators presented in IHP quarterly reports coincide with the direct service delivery (DSD) indicators that are reported semi-annually for IHP PEPFAR COP activities, as discussed with USAID in June 2014.

By the end of last quarter (PY4Q3), IHP was supporting PMTCT activities in 52 sites across 13 health zones, including 7 Kolwezi health zones and 6 health zones in Kamina. PMTCT activities continued at these sites during PY4Q4. In terms of reporting this quarter, however, only 47 sites were able to regularly submit reports. The internal conflict within the health zone management team of Songa (Kamina coordination), as documented in previous reports, continued to have a negative impact on the roll-out of activities and reporting in this health zone in PY4Q4. IHP provided assistance during the quarter to settle the conflict and helped to direct the discussion towards a meaningful solution by the beginning of PY5. Finally, 17 new PMTCT sites (9 in Kolwezi, 8 in Kamina,) were established towards the end of PY4, for a total of 41 PMTCT sites in Kolwezi and 28 in Kamina by the end of PY4. The project will start reporting on activities at these new sites during the first quarter of PY5.

Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women: At the end of PY4, all PMTCT sites in Kolwezi (n=41) and in Kamina (n=28) had at least 90% of HIV+ pregnant women on ARV.

Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results): By the end of PY4, 18,778 women (of a target of 17,722) knew their HIV status. This includes women at ANC visits that were tested for HIV and received their results. The coverage exceeds the COP 2014 target by 6 percentage points. IHP plans to further strengthen awareness-raising activities at the community level and increase involvement of local leaders in such activities.

Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery: During PY4, 254 pregnant women (237 in Kolwezi and 17 in Kamina) were put on ARVs to reduce the risk of transmitting the virus to their infants during pregnancy, labor, or while breastfeeding. The number of women reached greatly exceeded the COP 2014 target of 152 (167% of target). Among the 254 pregnant women put on ARVs, 163 were put on treatment for their own survival while 91 were put on prophylaxis with zidovudine (AZT) from the 14th week of pregnancy. The successful coverage was a result of the availability of tests, ARVs, Pima and FACS Count as well as to the supportive supervision visits made by health zone management teams to health care providers at PMTCT sites. A data quality audit will be conducted in PY5 to ascertain if there are any overlaps and/or double-counting of beneficiaries by IHP and the Global Fund, which also supports PMTCT activities in some of the same health zones as IHP.

Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required: Results for this indicator are not yet available, but planning for HIV prevention activities and related procurements is underway. IHP will provide appropriate training in HIV prevention and use of awareness-raising kits that have been ordered but not yet delivered. The kits are due to arrive during the first quarter of PY5 and training in their use will be scheduled shortly thereafter.

Number of individuals who received testing and counseling (T&C) services for HIV and received their test results: In total, 39,211 individuals were counseled and tested for HIV, and received their test results, exceeding the COP 2014 target of 30,330 by about 30%. This is due to awareness-raising activities in the communities, availability of rapid screening tests, technical oversight by health zone management teams, and joint supportive supervision visits by the MOH and IHP.

Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load: In the two districts supported by IHP, 1,382 individuals received at least one clinical assessment on the advancement of their infection following WHO standards or had CD4 counted to determine their eligibility to go on treatment. The result greatly exceeds the COP 2014 target of 696, which represents an achievement rate of 197% (1,382 over 696). The coverage is due mainly to the availability of HIV commodities, CD4 tests and Pima cartridges, technical oversight by the health zone management teams, and joint supportive supervision visits from the MOH and IHP.

Number of HIV-positive adults and children receiving a minimum of one clinical service: A total of 989 HIV-positive adults and children received at least one clinical service in the PMTCT sites supported by the project, surpassing the target of 696 per the COP 2014 for an achievement of 142%. This result is due to the availability of cotrimoxazole and other HIV commodities such as the Pima cartridge to count CD4 cells, technical oversight by the health zone management teams, and supportive supervision.

As mentioned elsewhere in this report, given the possibility that patients from sites supported by other donors, such as the Global Fund, may have been counted for this indicator, a data quality audit will be conducted in PY5 to clarify data and avoid double counting of beneficiaries.

TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting: During PY4, 362 people living with HIV out of the 632 (58%) expected in COP 2014 were screened for TB. This fairly low coverage is linked to the qualification of health care providers, notably those in new HIV sites, who were not yet trained on HIV/TB co-infection. Training will be held in PY5 for providers.

Number of adults and children receiving antiretroviral therapy (ART) (current): During PY4, 786 people living with HIV received ARV treatment; this is well above the target of 175 set in the COP 2014. This achievement may be related to health zone management teams also counting patients on ARV that were supported by Global Fund programming. IHP and the Global Fund share coverage in four health zones (Manika, Dilala, Lubudi, and Lualaba) where the Pima CD4 cartridges were also distributed. Monthly meetings between partners are organized by the health zone head physician to discuss results and potential problems related to the fight against HIV, share experiences to avoid duplication, and promote complementary strategies and activities.

Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging), or CD4 count or viral load: During PY4, the number of HIV-infected adults and children was 1,369 (292 in Q4).

Proportion of registered TB cases that are HIV-positive who are on ART: During PY4, 106 registered TB patients (2 from Kamina, 104 from Kolwezi) started or continued ART. The total number of registered TB cases with documented HIV-positive status during the reporting period was 185. Training and refresher training sessions of health care providers will take place in PY5 in order to improve results for this indicator.

Percentage of laboratories and Point of Care (POC) testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program: Sixty-nine laboratories supported by the project are capable of performing HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing program. The project will support health teams at the provincial and health zone levels in follow-up and quality control under the direction of the provincial referral laboratory.

Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation: IHP met the target of 1 laboratory.

Family planning and HIV integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services: Sixty-nine functional PMTCT sites, with the support of IHP, systematically integrated family planning and safe motherhood services. The project also ensured family planning commodities were available at all sites. Health providers were trained in long-term family planning methods. Post-training supervision by health zone management teams followed. Awareness-raising campaigns, including SMS messaging, were launched to inform the public about the availability of integrated HIV and family planning services at these sites.

6. Tuberculosis

A total of 12,163 new sputum positive pulmonary tuberculosis cases (MPT+) patients were diagnosed during the year, and 60% of them were tested for HIV. In the field of multi-drug resistant tuberculosis management, there were 46 confirmed cases as compared to the PMP target of 60 expected, for an achievement rate of 77%. For TB/HIV coinfection, the number of patients counseled and tested increased from 7,528 to 7,703, for a rate of 63%, surpassing the target of 60% in the PMP.

Table 32: Case notification rate in new sputum smear positive pulmonary TB (MPT+) cases per 100,000 populations in USG-supported areas[7]

Coordination	Total PY4 population	PY4Q1		PY4Q2		PY4Q3		PY4Q4		PY4			
		MPT+ new cases	Notification rate (%)	MPT+ new cases	Notification rate (%) (‰)	MPT+ new cases	Notification rate (%)	MPT+ new cases	Notification rate (%)	MPT+ new cases total	Notification rate (%)	Target (%)	Achievement (‰)
Bukavu	3,619,941	477	53	533	59	515	57	434	52	1,959	54	150	37
Kamina	1,992,502	841	169	866	174	905	182	916	184	3,528	177	150	119
Kole	934,614	303	130	292	125	266	114	299	128	1,160	124	150	83
Kolwezi	862,924	276	128	241	112	205	95	248	115	970	112	150	56
Luiza	1,397,312	356	102	322	92	335	96	226	65	1,239	89	150	54
Mwene Ditu	2,064,337	488	95	517	100	530	103	493	96	2,028	98	150	64
Tshumbe	858,699	173	81	151	70	165	77	203	95	692	81	150	57
Uvira	910,582	132	58	143	63	161	71	151	66	587	64	150	43
Total	**12,640,912**	3,046	**96**	3,065	**97**	3,082	**98**	2,970	94	12,163	96	150	63

*Note that numbers may not be exact due to rounding.

[7] The case notification rate is the number of new TB cases (positive or all forms) that can be found in a group of 100,000 people. For the DRC, a high prevalence country, it is around 150/100,000 inhabitants. IHP calculates this indicator annually as stated in its PMP and Performance Indicator Reference and Tracking Sheet (PIRTS). The formula is as follows:

$$\frac{\text{Number of new sputum smear positive pulmonary TB cases reported in the past year X 100,000}}{\text{Total population in the specified geographical area of the same year}}$$

Data source: tuberculosis treatment registry; place of collection: health center for diagnosis and treatment of TB and health center for treatment

Overall results for number of new MPT+ cases notified per 100,000 population in USG-supported areas are encouraging, with 11,915 new MPT+ cases notified in PY4 compared to 10,953 new MPT+ cases in PY3. The number of notified cases for PY4 will no doubt be higher when the Kolwezi data is added. This is equivalent to the notification of 94/100,000 positive cases (cf. 83/100,000 in the previous year). In addition, although the result is less than the PMP target of 214 MPT+ cases notified per 100,000 inhabitants, the result is close to 97/100,000 which is the annual national average achieved by the National Treatment Program (NTP) in 2013. During IHP PY4, the quarterly notification rate (per 100,000 population) fluctuated slightly (Q1: 95, Q2: 94, Q3: 100, Q4 : 88), with the best results achieved in PY4Q3 (April and June 2014), during which health workers implemented an active door-to-door screening strategy in Uvira, Bukavu, Luiza , Mwene Ditu, and Kamina.

To date, the project achieved an average rate of 63% for the notification of smear-positive cases (using the rate of 150 cases for 100,000 as recommended by WHO and the International Union Against Tuberculosis and Lung Disease). The lackluster performance in Uvira, Tshumbe, and Luiza is due to the delayed allocation of mini-lab kits and DOT kits for sputum sample collection and shipment to the diagnostic and treatment centers (CSDT), to recurrent stock outs (Luiza, Tshumbe) and to security problems (Uvira).

To accelerate the achievement of objectives during PY5, the project will focus on reinforcing the capacity of trained CHWs and health providers to detect TB (provision of awareness kits, bicycles, etc.). Mini awareness campaigns will be organized to inform the public about TB, care and treatment, especially in areas where CHWs have been trained.

Percent of all registered TB patients who are tested for HIV through USG-supported programs: PY4 surpassed its PMP target (60%) with 63% of MPT+ patients tested for HIV across all 78 health zones (cf. 32% and 55% for PY2 and PY3, respectively). In the province of Katanga alone, the rate of achievement for tuberculosis patients with access to HIV diagnosis and comprehensive care is nearly 150%.

Table 33: Number and percentage of TB patients tested for HIV in PY4 by coordination

Coordination	MPT+ new cases	TB cases counseled and tested for HIV	%
Bukavu	1,959	1,363	70
Kamina	3,528	3,052	87
Kole	1,160	509	44
Kolwezi	970	790	81
Luiza	1,239	554	45
Mwene Ditu	2,028	975	48
Tshumbe	692	151	22
Uvira	587	216	37
PY4 Total	**12,163**	**7,610**	63

During PY4, IHP worked with Global Fund partners IMA/SANRU and World Vision to consolidate interventions against TB/HIV co-infection in HIV care sites in provinces where IHP no longer has a presence and in Katanga where HIV activities are being scaled up. The availability of rapid tests and other HIV supplies improved overall in these two districts in Katanga (Kolwezi and Haut Lomami) largely due to the increased supervision of sites by two newly-hired HIV technical staff.

Table 34: Number of TB patients tested for HIV in PY4 by quarter

	PY4Q1		PY4Q2		PY4Q3		PY4Q4		PY4	
	Counseled	Tested	Counseled	Tested	Counseled	Tested	Counseled	Tested	Counseled	Tested
Bukavu	477	315	533	332	515	390	434	326	1,959	1,363
Kamina	841	813	866	735	905	812	916	692	3,528	3,052
Kole	303	172	292	123	266	84	299	130	1,160	509
Kolwezi	276	380	241	186	205	142	248	82	970	790
Luiza	356	156	322	146	335	137	226	115	1,239	554
Mwene Ditu	488	301	517	231	530	161	493	282	2,028	975
Tshumbe	173	31	151	42	165	33	203	45	692	151
Uvira	132	86	143	31	161	65	151	34	587	216
PY4 Total	**3046**	**2254**	**3065**	**1826**	**3082**	**1824**	**2970**	**1706**	**12163**	**7610**

Table 35: Number of multi-drug tuberculosis (MDR-TB) cases detected in PY4 by coordination

Coordination	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PMP	Achievement %
	MDR-TB confirmed	MD-TB confirmed	MDR-TB confirmed	MDR-TB confirmed	MDR-TB confirmed	MDR-TB confirmed		
Bukavu	**6**	3	7	8	9	27	16	169
Kamina	**2**	0	0	4	0	4	10	40
Kole	**2**	0	0	0	0	0	5	0
Kolwezi	**0**	1	0	1	2	4	4	100
Luiza	**1**	0	1	1	0	2	7	29
Mwene Ditu	**2**	0	0	0	4	4	10	40
Tshumbe	**1**	0	0	0	0	0	4	0
Uvira	**3**	1	2	2	0	5	4	125
Total	**17**	5	10	16	15	**46**	**60**	**77**

The fight against multi-drug resistant tuberculosis: The total number of MDR cases detected in PY4 was 46, or 77% of the target (60), and nearly 3 times the number of MDR cases confirmed in PY3. These good results can be attributed to a combination of factors: the availability of IHP-procured GenExpert at the CSDTs and provincial laboratories; a transportation plan to take MDR samples between facilities; and caregiver training for MDR-TB patients for health zone management teams, nurses and lab technicians in Uvira, Bukavu, and Luiza. The fight against multidrug-resistant tuberculosis (MDR-TB) is a new initiative that the National TB Program is currently implementing in the DRC. IHP supported the program by arranging related trainings, organizing the supply chain, and transporting sputum samples from the health facilities to the National Reference Laboratory via the central health zone offices and the provincial coordination unit for leprosy and TB (CPLT). Additionally, the installation of GeneXpert should strengthen the decentralization of MDR-TB among the seven CPLTs in the provinces supported by the project. The Kole and Tshumbe coordination offices began this initiative last in relation to other coordination offices and still require close supervision of service providers and close monitoring of the MDR-TB activities package.

To further improve the management of MDR-TB, the project has planned to:

- Assist with transportation of NTP-provided MDR-TB supplies from the provincial level to health zone facilities;
- Support the installation of USAID-donated GenExpert equipment in Kamina, Kolwezi, Tshikapa, and Kananga;
- Fund the collection and transportation of sputum samples from MDR sites to GenExpert sites in Bukavu, Uvira, Mbuji Mayi, Kananga, Kolwezi, Kamina and Tshikapa, as well as to the culture laboratories in Kinshasa and Lubumbashi.

Number of USG-assisted service delivery points experiencing stock out of RH (rifampicin/isoniazid) combination: The number of facilities that experienced stock outs of RH decreased from 34 health facilities on average in PY3 to 17 health facilities in PY4. The Kamina coordination reported the largest number of stock outs.

Table 36: Number of USG-assisted service delivery points experiencing stock out of RH (rifampicin/isoniazid) combination

Coordination	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Average
Bukavu	4	4	2	2	2
Kamina	1	9	5	15	15
Kole	1	4	2	1	1
Kolwezi	0	0	0	0	0
Luiza	1	5	5	1	1
Mwene Ditu	0	0	0	0	0
Tshumbe	2	1	5	0	0
Uvira	0	0	0	0	0
Total	**10**	**23**	**19**	**19**	**19**

Stock outs are commonly due to the delays in receiving transportation funding tied to lengthy CAG/Global Fund procedures. To remedy this situation, the project will pre-position the TB supplies (medications and lab equipment) in the health zones in order to prevent stock outs.

The main reasons for the current situation are :

- Stock out of commodities, especially anti-TB drugs, in the supported health zones which are under the direct responsibility of the National TB Control Program (PNLT) (the PNLT occasionally requests IHP to assist with transport of these commodities)
- Frequent movement of qualified staff and lack of appropriate training of new staff in TB diagnosis and care
- Insufficient implementation of successful community-based strategies that involve community-based organizations (CBO), health development committees (CODESA), TB support group Club d'Amis Damien (CAD), and active TB screening through a door-to-door strategy in low performing health zones

The project has learned the following lessons to improve the situation going forward:

- Strengthen proven community-based strategies and combine them with CBO, CODESA, and CAD involvement as well as active TB screening for more successful programs
- Ensure that a full integrated package of TB activities (including clinical and community activities; lab quality control and accreditation process; co-infection and multi-drug resistant TB (TB-MR) related

activities; and reliable supply chain management of TB drugs) is planned and implemented in target priority weak performing health zones.

7. **Nutrition**

Activities on the integration of Infant Young Child Feeding (IYCF): From July 11 to August 2, 2014, the project facilitated the training of 18 members of health zone management teams, two from the district health team, four IHP staff, community health workers, and health care providers from two health zones (Kabongo and Kitenge) on the integration of IYCF in the Haut Lomami district.

From September 25 to October 13, 2014, IHP participated in a joint post-training supervision mission with staff from the national nutrition program (PRONANUT) at the national and provincial levels and health zone management teams to the health zones of Dibaya, Luiza, and Kalomba to oversee activities promoting IYCF rolled out by trained health care providers and CHWs and confirm that communities are starting to apply best feeding practices. Data presented in this section for PY4 were validated by all 78 health zones, indicating a completion rate of 100%.

Number of children under 5 years of age who received vitamin A: During PY4, the project exceeded the annual target (2,520,338) by distributing vitamin A to 3,378,133 children under five years of age (134% achievement). The project distributed 1,743,109 during PY4Q3 and 1,635,024 during PY4Q1 as scheduled.

Number of pregnant women who have received iron-folate tablets to prevent anemia during the last five months of pregnancy: During PY4, 504,282 pregnant women received iron-folate, exceeding the annual target of 405,168 for an achievement rate of 124% and increasing by 11% since PY3 (450,214).

This high coverage is due mainly to the availability of commodities in health centers and the sound management of essential generic drugs, including close monitoring of inventory. IHP will maintain this performance by closely monitoring commodity management and regularly supplying health zones with products.

Number of mothers of children 2 years of age or less who have received nutritional counseling for their children: During PY4, 574,577 women received nutritional counseling for their children, exceeding the annual target of 409,824 for an achievement rate of 140%. The coverage increased by 27% from the previous year (419,122), due in part to the promotion of IYCF in the targeted health facilities and in the communities.

Despite the increase, reports from CHWs, who are key in providing nutritional counseling to mothers and caregivers through home visits and support group meetings, frequently are not counted by the health zones. Often, reports that are sent to the health centers do not get forwarded to the health zone central office. The majority of health zone central offices are not monitoring data collection and submission closely enough. In some instances, CHWs do not even have data collection tools to use. The project plans to continue to emphasize close monitoring by health zones and will continue to ensure that collection and management tools are available to CHWs working to promote nutrition counseling. The project also will focus on health zones with low levels of post-training monitoring plan achievement and supportive supervision.

Number of breastfeeding mothers receiving vitamin A: During PY4, only 138,003 (38%) breastfeeding mothers received vitamin A, falling short of the annual target of 361,052. The project did not meet the target due to insufficient quantity of vitamin A in the health centers. The project will emphasize close monitoring of vitamin A supply in health facilities and to encourage distribution when they are available. This supplement is provided to breastfeeding women during routine postnatal visits. The vitamin A ordered by IHP only arrived at the end of

PY4Q3; distribution via the CDRs began only over the course of the last quarter of the year (PY4Q4). On the other hand, data on the supplementation of children under five months of age was reported during a mass campaign, accomplished by a door-to-door strategy; as a result, the target was reached and even exceeded.

Number of USG-supported health facilities experiencing stock outs of iron-folate: During PY4, the number of health facilities (489) experiencing stock outs of iron-folate exceeded the annual target (400) and last project year's (452) result. The high stock outs result from ordering insufficient amount of iron-folate on the part of health facilities. In addition, monitoring the supply chain of iron-folate by the health zone management teams needs to be further strengthened. During its first two years, IHP experienced iron-folate supply challenges. After PY3, all health zones were provided with supplies and should not have experienced further stock outs. However, certain health zones continued to experience stock outs for the following reasons:

- Poor prescription practices by health providers who do not adhere to the flow charts, resulting in a waste of products;
- Lack of information on product availability and some providers do not know when to place an order or when to restock;
- Emphasis on drugs used for more profitable curative care services at the expense of drugs used for free consultations such as prenatal and pre-school consultations.

8. Sexual and Gender-based Violence

During PY4, IHP was not able to train health care providers in Kolwezi on the management of sexual assault cases as planned: there was a lack of time and limited availability of trainers after the period when the spending of the project was limited. The Bukavu and Uvira coordination offices distributed post-exposure prophylaxis (PEP) kits in the health facilities that receive and treat victims of sexual violence. It should be noted that throughout the life of the project, only four coordination offices received PEP kits: Bukavu and Uvira (which received their PEP kits in April 2014) and Kolwezi and Kamina (where PEP kits were delivered and distributed in August 2014). As of this report, Bukavu had received 550 kits and used 164, for a balance of 386 available; Uvira received 300 and used 29, for a balance of 271 available kits; Kamina received 100 and has not used any of them; and Kolwezi received 100 and used 92, for a balance of 8 available kits.

There were 3,886 reported cases of sexual violence during this project year, which was slightly lower compared to that of PY3 (4,144). About 99% of victims were women or girls. The decrease in the numbers of cases is due in part to the project's efforts to raise awareness via community outreach by Champion Communities and SMS messaging by CHWs. About 61% of the victims were received, examined, and treated at health facilities within 72 hours; 39% were examined and treated between 72 and 120 hours after the attack. It should be noted that the location of the crime is not necessarily near a health center or its surroundings, so delays can be related to distance, accessibility to a health center that treats these cases, hesitation on the part of the victim, feelings of shame, and victims taking time to discuss their situation; however, care begins as soon as the victim arrives at the center. Most of the attacks reported were perpetrated by armed men or members of the family, including partners and spouses.

In Luiza, cases have not been reported since February 2014 when Doctors of the World, a U.S.-based humanitarian organization, ended its involvement in the region. To ensure proper care of victims, IHP will continue to supply PEP kits to health zones, conduct awareness-raising activities in the communities, and provide supportive supervision to health care staff.

The table below shows the number of reported sexual violence victims treated at health facilities.

Table 37: Number of people impacted by GBV services funded by the U.S. Government, disaggregated by sex and period of arrival at a health facility						
Health zone	**Number of people reporting sexual violence in USG-supported health clinic**		**Number of people reporting sexual violence in USG-supported clinic within 72 hours**	**Number of people reporting sexual violence in USG-supported clinic between 72 and 120 hours**	**Number of people reporting sexual violence in USG-supported clinic given ARVs**	**Number of people reporting sexual violence in USG-supported clinic given emergency contraceptive**
	Females	Males				
Bukavu	2,826	12	1,749	1,091	1,494	1,542
Kamina	52	24	29	25	4	2
Kole	104	19	69	37	26	27
Kolwezi	1,511	1,526	0	1,511	0	0
Luiza	332	15	132	200	65	92
Mwene Ditu	0	15	0	0	0	0
Tshumbe	14	14	8	6	5	2
Uvira	498	21	375	138	337	337
PY4 Total	**5,337**	**1,646**	**2,362**	**3,008**	**1,931**	**2,002**

Fistula: During PY4, a total of 240 women suffering from urogenital fistula benefitted from care under the project. Women between the ages of 20 and 45 years old were the most affected. The Kaziba GRH in Bukavu, the only hospital with the capability to do this work, carried out the surgeries under an IHP sub-grant. About 20 fistula repairs were done per month over the course of the year. There were 128 cases of vesico-vaginal fistula, 34 vesico-utero-vaginal cases, and 41 victims have been incontinent (see Appendix 5).

Most fistula cases are caused by prolonged, unrelieved obstructed labor, especially for women who give birth at home without medical assistance. The repair success rate is 80% (194 cases) and 19% failure (46 cases). Proper monitoring of a woman in labor using the partograph could help reduce fistula cases but this important tool is not yet used or available in all maternity clinics. If the repair fails, the woman is asked to recuperate from the intervention and then consult again with a surgeon. There are cases that require plastic surgery, but this option is neither available nor feasible in the context of this project.

Next quarter actions to be taken: During joint supervision visits, health care providers at Kaziba hospital will be trained in the correct use of the partograph, provided by IHP. In addition, the project will support community mobilization activities to promote use of services at maternity clinics where pregnant women can await delivery thus avoiding the need to seek transportation and travel long distances to give birth when labor starts.

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

1. **Continued integration of the FOSACOF approach**

IHP's *fully functional service delivery point* (FOSACOF) approach is used in target health facilities as a standards-based tool centered around nine criteria reflecting the national norms established by the MOH in order to improve the quality and availability of services offered to the population.

During PY4Q4, 82 new health facilities integrated FOSACOF, which is almost double the number seen in PY4Q3 (44). This makes 227 total structures in PY4 2014, as Bukavu, Kolwezi, and Kamina were able to integrate the approach in 86, 50 and 48 sites, respectively. This result was achieved through the involvement of local health authorities, the motivation of care providers, and the ownership of the approach by the community. Finally, it should be noted that the result of PY4 (227) is lower than that of PY3 (504) due to budgetary constraints during the first three quarters of the year.

Table 38: Health facilities integrating the FOSACOF approach by coordination offices in PY4

Coordination office	Cumulative PY1-PY3	PY4 Q1	PY4 Q2	PY4 Q3	PY4 Q4	Total PY4	Cumulative PY1- PY4	# of structures (health centers and hospitals)	Integration rate (%)
Bukavu	67	27	0	44	15	86	**153**	421	36
Kamina	29	48	0	0	0	48	**77**	211	36
Kole	49	26	0	0	1	27	**76**	137	55
Kolwezi	40	0	0	0	50	50	**90**	114	79
Luiza	93	0	0	0	0	0	**93**	179	52
Mwene Ditu	97	0	0	0	0	0	**97**	180	54
Tshumbe	93	0	0	0	0	0	**93**	127	73
Uvira	36	0	0	0	16	16	**52**	107	49
PY4 Total	**504**	**101**	**0**	**44**	**82**	**227**	**731**	**1,476**	**50**

During this same period, the project evaluated 288 of 1,476 health facilities, and the results show that 63.8% of the evaluated structures (i.e., 184 out of 288) exceeded 50% of the quality threshold and 7.6% (22 out of 288) were below 25%, as they had just recently integrated the approach.

Table 39: Evaluation of the evolution of qualitative data in health facilities that have integrated the Fully Functional Service Delivery Point approach (FOSACOF) by coordination office

Coordination office	# of health facilities evaluated	Class D <25%	Class C 25< 50%	Class B 50<79%	Class A ≥80%
Bukavu	38	3	19	10	6
Kamina	15	2	6	5	2
Kole	18	0	6	8	4
Kolwezi	66	9	14	38	5
Luiza	19	0	1	17	1
Mwene Ditu	71	0	21	46	4
Tshumbe	24	0	4	19	1
Uvira	37	8	11	14	4
Total IHP	**288**	**22**	**82**	**157**	**27**

The remaining challenge is the application of FOSACOF in the Kamina and Uvira coordination offices, which have not yet achieved a 50% FOSACOF integration rate. The next steps are:

1. Work with the MOH so that they are able to full adopt the approach, to ensure continuity and sustainability;
2. Support the other coordination offices (Kole, Luiza, Mwene Ditu, and Tshumbe) to focus on implementing FOSACOF evaluations in the health facilities to follow the evolution of service quality in the health structures through recovery plans.

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

RBF implementation began on November 1, 2013, at which time contracts were signed with 135 RBF participating entities (118 health centers, 7 health zone management teams, 7 general referral hospitals). IHP also signed contracts with 14 community-based organizations (2 per health zone) assigned to undertake verification of health center data. Given that RBF activities began in November 2013, the quarterly periods are as follows:

- First quarter: November 2013-January 2014
- Second quarter: February-April 2014
- Third quarter: May-July 2014
- Fourth quarter: August-September 2014 (this "quarter" was shortened to just two months to return to and respect the normal fiscal year calendar that began October 1, 2014)

The cycle of RBF activities is six months and includes service delivery for three months, verification and counter-verification, and the payment process. During the third quarter (May-July 2014), all activities in the six-month cycle were implemented, but given that the data had not yet been validated at the time of the annual report, we made the decision that we would not yet present them. The process of verification and counter-verification is a prerequisite to validating the data. For IHP PY5Q1, RBF data collection and reporting will be aligned with the overall IHP quarterly reporting cycle.

RBF is a strategy to improve performance and outcomes of health services by linking incentives with results. RBF contractors receive payment from IHP according to contractual performance-based criteria and a sliding pay

scale that is linked to the level of attainment of agreed-upon targets. This report presents the achievements of the first three quarters of implementation of the approach for the services during two quarters and checks-against-verification and payment.

The results related to maternal and child health indicators show that ANC 1 was covered at 86% in the first quarter and 80% in the second quarter; VAT 2+ at 75% in the first quarter and 80% the second quarter; and ANC 4 at 46% in the first quarter and 62% in the second quarter. High-risk pregnancies were referred at a rate of 65% in the first quarter and 81% in the second quarter, deliveries at 73% in the first quarter and 70% in the second, and at least two postnatal visits at 70% in the first quarter and 80% in the second. DTP HepB-Hib3 vaccination was 84% in the first quarter and 87% in the second quarter.

These figures are close to the results of the 2013 DRC Demographic and Health Survey (DHS), but exceed DHS figures for VAT 2+. The IHP RBF health zones achieved 84% in the first quarter and 87% in the second quarter, while the 2013-2014 DRC DHS result was 66%. The IHP RBF results are also close to the results of the International Business & Technical Consultants, Inc. (IBTCI) baseline assessment, which is comparable to the 2013-2014 DRC DHS results. In the course of data verification, some RBF data were refuted due to errors made in filling out the required management forms. Thus, there is reason to believe that in reality the RBF numbers in the health zones might be higher than those reported.

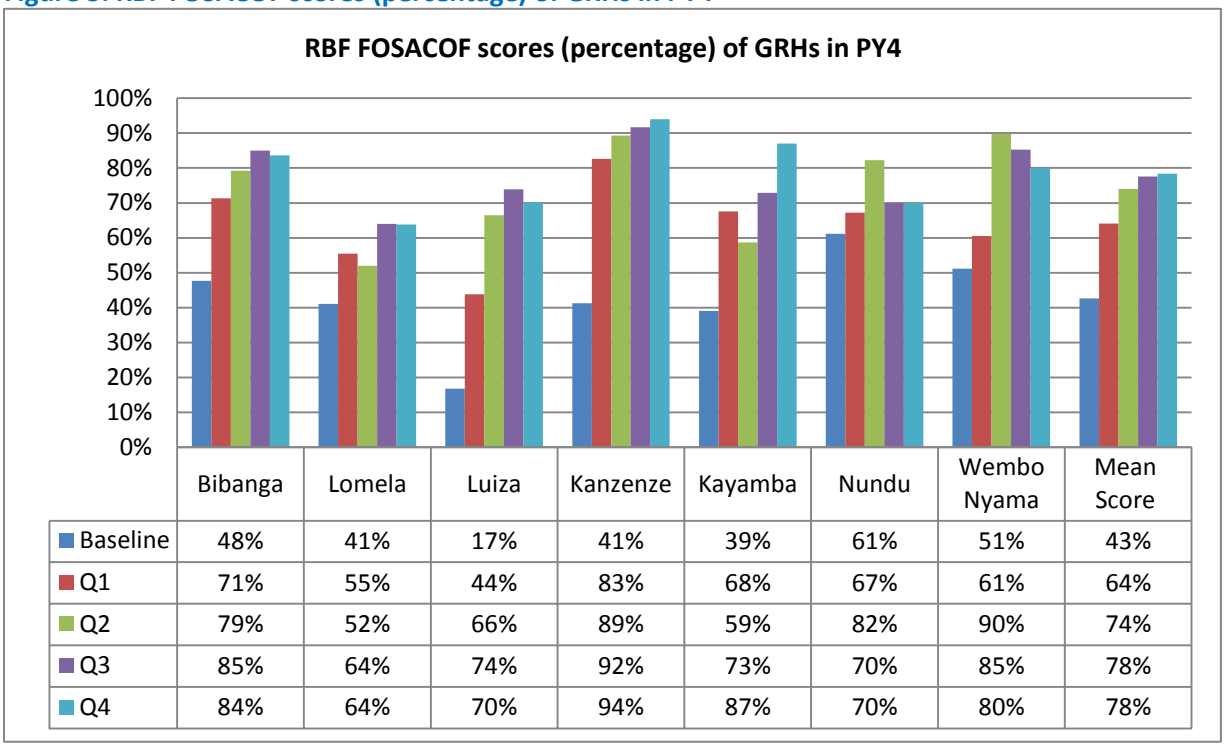
Table 40 summarizes the progress of verified and validated FOSACOF scores for health centers and GRHs from the baseline to the fourth quarter of the first year of RBF activities.

Table 40: Verified and validated FOSACOF scores for health centers and GRHs

	GRH (%)	Health centers (%)
Baseline	43	32
Q1	64	44
Q2	74	54
Q3	78	60
Q4	78	61

The GRHs have made significant efforts to improve quality and have become functional, with an overall FOSACOF score of 74% after 6 months of implementation. However, they had an overall score of 39% for PY4, all quality criteria considered. The health centers improved their overall score of 33% in the baseline assessment to 43% in the first quarter and reached 45% in the second quarter.

Figure 3: RBF FOSACOF scores (percentage) of GRHs in PY4



	Bibanga	Lomela	Luiza	Kanzenze	Kayamba	Nundu	Wembo Nyama	Mean Score
Baseline	48%	41%	17%	41%	39%	61%	51%	43%
Q1	71%	55%	44%	83%	68%	67%	61%	64%
Q2	79%	52%	66%	89%	59%	82%	90%	74%
Q3	85%	64%	74%	92%	73%	70%	85%	78%
Q4	84%	64%	70%	94%	87%	70%	80%	78%

Table 41, below, summarizes the progress of verified and validated FOSACOF scores for health centers and GRHs from the baseline to the fourth quarter of the first year of RBF activities. The table illustrates that during the third quarter, more than two-thirds of the health facilities, or 67%, are moderately functional, while 2 percent are still not functional; and 8% are fully functional. Numbers may not match exactly due to rounding.

Table 41: RBF results by health zone and performance category

RBF health zone	Health center with performance below 50%	Health center with performance 50-80%	Health centers with performance > 80%	Total health facility
Bibanga	4	11	2	17
Kanzenze	3	6	6	15
Kayamba	4	9	0	13
Lomela	15	4	0	19
Luiza	1	16	1	18
Nundu	3	18	0	21
Wembo Nyama	0	15	0	15
Total	**30**	**79**	**9**	**118**
%	**25**	**67**	**8**	**100**

Health zone management team indicators related to the supervisory functions of health facilities and medication management need improvement: the results attained against the overall annual targets are only 45% for the supervision of health facilities, 39% for support to community mobilization, 34% for support to WASH activities, 12% for the validation of drug orders by the quantification committee, and 13% for stock outs.

With respect to payment, GRHs received $ 72,453 in the first quarter, a 74% achievement of the target, and $75,358 for an achievement of 87.6% in the second quarter. Health centers were awarded $ 72,129 in the first quarter for a completion rate of 67.2% and $91,435 for an achievement rate of 76.2% in the second quarter. The health zone management teams received $ 10,725 with a completion rate of 64% in the first quarter and $13,969 in the second quarter for an achievement of 83%. However, the high achievements of the health zone management teams in the second quarter related to setting easily achievable targets.

At this stage, it was found that the health zone central offices are the weak link in the system at the operational level. There are extenuating circumstances related to the problems of understanding indicators or availability of scarce drugs; however, improving the management of health zone management teams is an important challenge to maintain and improve the performance achieved.

There is room for improvement in several areas: maintenance of management tools, health information, community involvement, effective medication management, supervision of secondary structures, provider support, CBO outreach, organization of IHP coordination offices to perform more of the *Agence d'Achat de Performance* (AAP) RBF duties[8], and the management of the RBF program at the MOH central level. During the second year of implementation of the IHP RBF model, IHP will work with the MOH RBF unit to address any improvements in the RBF model and tools, particularly based on the findings and recommendations of the mid-term assessment conducted recently by IBTCI. It will be critical to consider the needed improvements as IHP revises the contracts to all involved parties for the second year of implementation.

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

In PY4, the number of patients referred by health centers to the GRH was 213,788 and represents 4% of the number of patients seen and consulted in health centers.

[8] AAP is the fiduciary body in charge of overseeing the IHP-contracted entities and ensuring that they are fulfilling their responsibilities, working in compliance with the contractual regulations, and ensuring transparency of all of their RBF activities and operations.

Table 42: Number and percentage of patients referred to GRHs

Coordination Office	PY4Q1		PY4Q2		PY4Q3		PY4Q4			PY4	
	Patients referred to GRH	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Rate (%)**
Bukavu	19,460	455,368	18,687	512,145	16 315	478,616	20,318	480,786	74,780	1,926,915	4
Kamina	4,337	211,394	3,698	194,864	3 860	202,746	2,930	179,379	14,825	788,383	2
Kole	4,941	96,005	5,398	87,556	5 591	89,302	5,663	90,583	21,593	363,446	6
Kolwezi	3,187	105,171	2,571	118,490	1 521	103,261	1,474	94,631	8,753	421,553	2
Luiza	2,314	134,481	1,618	137,930	1 444	129,500	1,912	123,407	7,288	525,318	1
Mwene Ditu	11,488	204,457	12,331	199,963	13 687	217,327	14,437	232,385	51,943	854,132	6
Tshumbe	5,030	68,051	4,760	70,738	5 490	67,956	5,792	77,599	21,072	284,344	7
Uvira	3,416	79,019	3,556	73,022	3,298	74,583	3,264	67,283	13,534	293,907	5
PY4 Total	**54,173**	**1,353,946**	**52,619**	**1,394, 708**	**51,206**	**1,363,291**	**55,790**	**1,346,053**	**213,788**	**5,457,998**	**4**

This represents an increase over the number of referrals recorded during PY3 (134,376). This is due to head nurses properly using flow charts and to health centers not replacing the GRHs in trying to apply CPA. Some health areas (e.g., Bilomba and Kalomba) in Luiza performed well because they used health center bicycles as a means of transportation to refer patients, improving the quality of care for patients, and improving hygiene conditions in the GRHs. CHWs referred 28% of patients seen (around 20,000 cases) to health centers and managed the remaining cases (72%) at their level. These figures provide evidence for continuing to support and strengthen the community-level health system, particularly i-CCM.

Table 43: Number and percentage of patients referred to health centers

	PY4Q1		PY4Q2		PY4Q3		PY4Q4		Total PY4		Rate (%)
	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center	Patients seen by a CHW	
Bukavu	379	1,374	901	1,508	307	1,454	1,115	5,421	2,702	9,757	28
Kamina	946	6,555	736	5,451	648	3,625	1,172	3,558	3,502	19,189	18
Kole	827	2,186	288	843	295	2,070	343	3, 956	1,753	9,055	19
Kolwezi	66	872	112	671	188	1,124	156	1,300	522	3,967	13
Luiza	171	1,696	98	1,781	220	2,666	373	2,908	862	9,051	10
Mwene Ditu	813	2,240	709	2,442	918	3,465	3,511	4,657	5,951	12,804	47
Tshumbe	293	515	1,514	2,517	1,123	1,246	1,178	1,784	4108	6,062	68
Uvira	181	795	167	428	84	592	143	802	575	2,617	22
PY4 Total	3,676	16,233	4,525	15,641	3,783	16,242	**7,991**	**24,386**	**19,975**	**72,502**	**28**

INTERMEDIATE RESULT 3: KNOWLEDGE, ATTITUDES, AND PRACTICES TO SUPPORT HEALTH-SEEKING BEHAVIORS

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

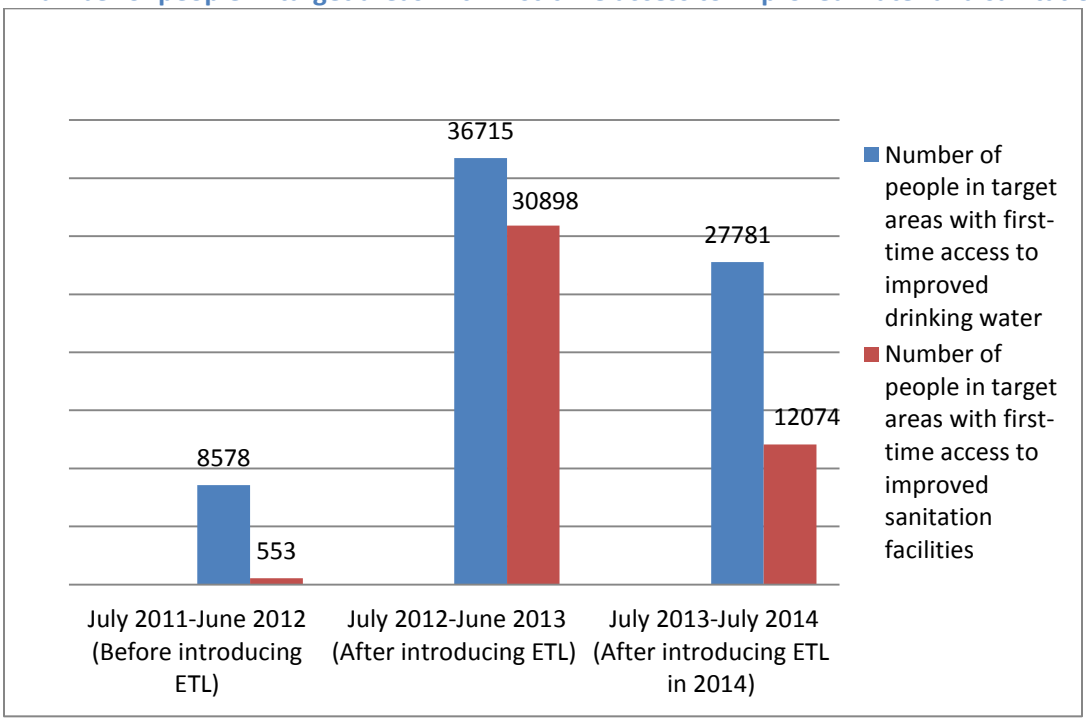
1. Education Through Listening

Education Through Listening (ETL) has been adopted by IHP as a BCC approach that enables community health workers and volunteers to encourage positive and community-driven health-seeking behavior change. Designed as a participatory teaching method, ETL promotes behavior change through participant-focused discussions in which community members identify local health challenges and discuss potential solutions. ETL has been incorporated into a wide variety of project initiatives across the target health zones, including CODESAs, Champion Communities, Champion Men, and youth associations.

During PY4Q4, ETL was a key BCC intervention. In Mwene Ditu, the Network of Congolese Associations of Youth Against AIDS (RACOJ) brought together youth associations to conduct 83 youth-led ETL sessions with their peers on HIV/AIDS prevention, reproductive health, and community involvement. Also this quarter, Champion Communities and Champion Men groups in Dibaya, Ndekesha, and Bilomba used ETL to support a mass polio vaccination campaign facilitated by the project across the Kasaï Occidental province.

In August 2014, BCC consultant and ETL expert Amélie Sow-Dia traveled to Mwene Ditu to evaluate the implementation and effects of the ETL approach. As part of her evaluation, she found that ETL has contributed significantly to the WASH component of IHP. Prior to the introduction of ETL and Champion Communities in the Wikong health zone, much of the population did not have access to potable water or sanitation facilities. Since the introduction of ETL in 2013, the number of people in the Wikong health zone with access to potable water and sanitation facilities has dramatically increased, which can be seen in the graph below. Based on interviews with M&E staff from the Mwene Ditu coordination office, the consultant reported that 68 improved water sources have been built in Wikong health zone since the introduction of ETL. This development contributes to 72 percent of the health zone's population access potable water and places it within reach of the IHP end-of-project target of 80 percent.

Figure 4: Number of people in target areas with first-time access to improved water and sanitation facilities



Challenges: Despite the positive outcomes ETL has contributed to the project, there is room for improvement. As the project begins its final year, a key challenge is ensuring the sustainability of ETL. While the integration of ETL in other project initiatives is promising, it is important that master ETL facilitators are trained in as many CODESAs, Champion Communities, youth organizations, and other community groups as possible.

Although budget constraints have also limited the number of formal five-day ETL training sessions, BCC experts have conducted informal half-day briefings which they supplement with support from the field during ETL campaigns.

Next steps: BCC experts in the coordination offices will continue to provide supervisory support to community groups conducting ETL outreach sessions. The project will also continue to promote the integration of ETL in other project initiatives

2. Youth Associations

Youth associations play a vital role in the promotion of healthy practices and behaviors. They facilitate active participation of young people in their communities, and create a voice for young people on issues related to health and development.

Of the current 257 NGOs identified by IHP, more than half (55%) are active (N=143). Working with and through the youth NGOs and associations has proven to be an effective means of conveying vital health and hygiene information to young people and to support their community development initiatives. A few highlights of this quarter's youth activities follow, and the number of youth organizations carrying out awareness-raising activities by coordination office is found in Table 41.

In the Dilala health zone, two youth associations participated in two training sessions. Topics included sexual and gender based violence and STIs. After the training, the youth associations held 13 group sessions on the same themes for 132 young people in their communities. As a result of these group sessions, 14 cases of STIs were referred to health centers and three cases of sexual violence were reported to local authorities.

In Lodja, 12 youth associations educated 422 people on the advantages of contraceptive methods, and condoms were also distributed during these outreach meetings. The number of awareness-raising activities completed by youth associations this quarter can be seen in Table 44 below.

Table 44: Number of youth organization completing youth awareness raising activities*

Coordination Office	PY4Q1	PY4Q2	PY4Q3	PY4Q4
Bukavu	8 (21)	5 (10)	55 (8)	10 (55)
Kamina	5 (12)	5 (12)	3 (7)	8 (8)
Kole	8 (8)	8 (8)	6 (6)	15 (23)
Kolwezi	5 (5)	5 (5)	52 (9)	13 (9)
Luiza	10 (10)	15 (15)	12 (8)	12 (8)
Mwene Ditu	74 (76)	74 (76)	59 (60)	76 (78)
Tshumbe	5 (5)	5 (5)	1 (0)	7 (2)
Uvira	15 (20)	15 (20)	13 (75)	15 (34)
Total	130 (157)	132 (151)	106 (268)	143 (257)

**The second number, in parentheses, represents the number of youth associations identified by the project this year. The first number, not in parentheses, represents the number of active youth associations.*

Challenges: During this quarter, the number of youth associations that were identified in project health zones decreased from 268 to 257 due to poor reporting by project health zones; several health areas did not fully complete supervision of youth organizations prior to the end of the reporting period, and were unable to provide information to their respective health zones on the youth organizations in their territories. The health zones, after receiving the reports, are responsible for compiling a list of approved youth associations and sending to the project coordination office.

IR 3.2: Health advocacy and community mobilization organizations strengthened

1. **CODESA: Health advocacy and community mobilization**

CODESA members are responsible for disseminating health information to the local populations. They interact with community members, listening to their views and concerns and educating them on identifying health problems and causes, as well seeking solutions. CODESA members promote behavior change to ensure prevention and treatment of disease through awareness-raising activities and community mobilization. Community mobilization, which encourages local responsibility for community health, is central to the long-term behavior change process. To support this process, IHP has implemented several innovative BCC approaches, including Champion Communities, ETL, and mHealth. IHP also utilizes more traditional BCC interventions, such as building the capacity of local partners such as CODESAs to carry out their own communication action plans, enabling them to actively engage with local populations.

During PY4Q4, IHP revitalized 1,322 CODESAs, reaching 94.6% of the annual goal of 1,398. Of these revitalized CODESAs, 1,265 have developed a communication action plan, to be implemented with the assistance of IHP and community mobilizers. For example, of the 129 CODESAs identified by the coordination office in Kole, by the end of project year 4, 100% have been revitalized and have a corresponding communication action plan. See Table 12, presented on page 19, for data on revitalized CODESAs.

IHP has supported many CODESAs in implementing BCC interventions this quarter. In the Kasaï Occidental province, for example, the project facilitated the mobilization of all CODESAs in the province's 9 health zones to support a Ministry of Health mass polio vaccination campaign. CODESA members led community mobilization interventions in churches, schools, and households. After extensive preparatory meetings and briefings to organize the BCC campaign, the CODESA members counted households with children under the age of five, and worked with Ministry of Health vaccination teams to ensure the children received the required vaccinations. They also helped dispel rumors current in the community regarding vaccination. These same types of actions were made by CODESAs in all health zones.

CODESAs were also actively involved in handling a dangerous outbreak of diarrhea in the Luiza health zone in July 2014. CODESA members conducted outreach initiatives to raise awareness about the importance of washing hands at critical moments, using hygienic latrines, only drinking water collected from improved water sources and properly conserving potable water, and thoroughly cooking and preserving food. The Luiza CODESA BCC campaign included 14 group community mobilization sessions in churches and 634 outreach visits to households. CODESAs also distributed 100 informational announcements to local churches to be read by pastors to their congregations regarding prevention of diarrhea. A WASH committee was also formed to maintain potable water sources.

Challenges: While the number of functional CODESAs with communication action plans continues to increase, this growth is challenged by a lack of financial resources. Some health zones are unable to properly supervise their community volunteers due to a lack of training and resources. Many CODESAs lack office facilities that would allow them to archive valuable documents. There remains an insufficient level of coordination between CODESAs and other community stakeholders, including religious groups, teachers, local authorities, CBOs, and other private leaders.

Next steps: IHP has two primary goals for next quarter to ensure that CODESAs continue to grow in support and influence. With the assistance of the health districts, the project will continue to provide CODESAs with

management tools (such as reporting documents and meeting facilitation guidelines) and will guide health zones in supervising community activities.

IHP will also organize, together with the PNCPS, the MOH primary health office (B5), health districts, and the IHP team, joint supervisory missions to support the revitalization of CODESAs. Finally, the project will continue to facilitate the relationship between CODESAs and other stakeholders in each health area.

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

1. **Behavior Change Communication (BCC)**

Targeted SMS messages were particularly effective during the course of the year. For example, in Bunkeya (Kolwezi health district), 472 women received counseling on CPN, vaccination, and the use of LLINs through a targeted SMS campaign. Prior to PY4, women were rarely the targeted recipients of SMS messages, and this campaign increased their feelings of empowerment related to their families' health. Men are now also encouraged to share SMS messages with women. In the Bibanga, Dibaya, and Dilala health zones, approximately 68 teachers received SMS messages that they then disseminated to their students, who shared these messages with their peers. The SMS themes focused on responsible sexual behaviors, early marriage, sexually transmitted disease, and hygiene.

- In the Bunkeya health area, 10 male heads of household who received SMS messages on the benefits of exclusive breastfeeding report encouraging their wives to practice exclusive breastfeeding correctly;
- In the Kabongo health zone, 41 couples stated that they have an open dialogue in the household about the SMS health messages they receive;
- The chief of Bayeke Bunkeya launched a week of awareness-raising about the benefits of breastfeeding, using the IHP SMS messages he received. The chief invited his people to read the messages, to share the information, and to act according to the recommendations.

The CUGs continue to facilitate communication between community members engaged in mobilization efforts via the Champion Community approach, both within health areas and across health areas. They allow community members to confidentially receive and exchange information. During this quarter, there were six educational interactive discussions (*causeries)* were held on vaccination through the aid of CUGs, involving 87 women with children under 11 months old in for residents of the Kamina and Kolwezi health areas. Using the speakerphone, the phone allowed the nurses in the health center to respond to women's questions. Following this *causerie,* 56 of the participants brought their children for vaccinations before they began school.

Challenges: There is a lack of electricity to recharge batteries in rural areas. Beyond this technical issue, women and youth frequently lack access to CUG phones, as CUG holders are frequently men.

Next steps: In the next quarter, the project will seek to encourage the Champion Communities to purchase their own telephones, which should enable broader access to these CUGs by women and youth. IHP will pay special attention to increasing individuals' access to CUG phones, particularly among women and youth. Further guidance will also be given to the health zone management teams on how to educate local populations and stakeholders about the importance and benefits of CUGs.

2. Champion Communities and Champion Men Initiatives

Champion Communities: During this quarter, the project supported the establishment of three new champion communities, one in the health zone of Mwana in Bukavu, and two in the health zone of Lodja in Kole. This brings the total number of champion communities supported by IHP to 33. During this quarter, IHP provided financial assistance to 26 champion communities for income-generating activities.

This year, IHP assessed participating IHP Champion Communities using questionnaires that focused on the community's progress with the communication action plans, except for the newly-formed champion communities this quarter, and Fungurume (Kolwezi), where the Champion Communities, established under another USAID activity (ProVIC, the Integrated HIV and AIDS project), have not yet fully transitioned to the IHP Champion Community model.

To address sustainability and in support of making the champion communities autonomous, IHP has made it possible for four champion communities in Kolwezi and Luiza to finalize their status as independent NGOs. Their statutes, which have been developed with guidance from IHP staff, have been sent to political and judicial authorities for approval. The finalized and signed documents will appear in next quarterly report (October – December 2014).

Results from preliminary evaluations of the champion communities have been encouraging. From June 16-19, 2014, Lulua Health District evaluated action plans in Tuibake, Sanga, and Bante.

Table 45: Champion Community - Tuibake

Period	Second half of 2012				First half of 2013				Second half of 2013				First half of 2014			
Indicator	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**
Baseline[9]	45	156	140	0	6219	967	861	1,178	7,339	862	711	770	7,339	862	711	770
Fixed targets	7,206	990	876	400	7,362	1,014	900	400	7,362	1,014	900	400	8,862	1,212	1074	400
Targets obtained	6,219	967	861	1,178	7,339	862	711	770	7, 028	758	538	382	7458	857	377	493
Percentage of target reached	90	98	98	29	110	85	79	19	95	75	60	10	84	71	4	12

[9]These are the descriptions of the indicators used for Tables 45 and 46:

- Baseline: Baseline data for the eight health centers prior to the Champion Community intervention
- Fixed targets: Indicator target set by the Champion Communities
- Targets obtained: Level reached by Champion Communities after six months of activities
- Percentage of target reached: Achievement rate (%) compared to the target

Table 46: Champion Community - Nsanga Bantu

Period	2nd half of 2013				1st half of 2014			
Indicator	**Curative care**	**Family planning**	**ANC4**	**TB**	**Curative care**	**Family planning**	**ANC4**	**TB**
Baseline	1,013	107	39	44	6,985	771	411	314
Fixed target	8,688	1,194	504	408	10,950	1,470	624	450
Targets obtained	6,985	771	411	314	6,332	811	518	347
Percentage of target reached	80	65	60	80	62	55	85	77

The tables above indicate:

- A more than 25% increase in curative care visits in eight health areas in two of the communities. These results are due in large part to the efforts of the champion communities. Through constant exchanges and involvement of religious leaders, champion community members were able to effectively promote messages on self-medication, beliefs, and orientation of illnesses.
- A 30% increase in the utilization rate of modern family planning methods (e.g., pills, condoms, Depo-Provera, cycle beads) from the campaign IHP conducted through the Closed User Group (CUG) phone messaging system (not from the use of modern methods). The indicator is: Number of new acceptors for any modern contraceptive method in USG-supported family planning service delivery points.
- There was a 75% increase in the detection rate of tuberculosis (confirmed new smear positive TB cases detected by microscopy) after an SMS campaign to raise awareness on TB was launched. "Screening" (*dépistage* in French) will be corrected to report a 75% increase in the number of new smear positive TB cases detected. The indicator is: Number of new smear positive TB cases detected.

The involvement of the champion communities and their steering committees has been remarkable. There has been increased participation and involvement in activities from community leaders and supervisors of the health areas in addition to increased awareness in healthy practices and participation by community members, and 20 men involved in the Champion Man initiative have distributed kits to households, and dispelled rumors surrounding these kits. Kits are designed for both literate and illiterate households, with printed images and practice guides on prenatal and maternal and child health to encourage men's participation in their wives' and family's health.

Interventions in Tshikisha and Mfuamba health zones have also contributed to the improvement of indicators of the champion communities. Marked increases in discussions about health amongst couples may be related to CUGs and SMS campaigns about CPN4.

Similar activities were reported by the Mwene Ditu and Kole coordination offices. Champion communities organized ETL meetings about early education interventions and family planning. The champion communities conducted a mini campaign on family planning and community-based distribution of contraceptives in the health zone in July 2014. The IHP coordination offices collected and verified the following results of the mini campaign:

- 1,543 messages sent about family planning
- 1,393 individuals were reached including 1315 women and 78 men
- 307 individuals were counseled on modern family planning methods
- 214 new practitioners

Challenges: Although members of the champion communities have been approached by other organizations requesting assistance in awareness-raising activities, they do not have the financial capacity or materials to take on these initiatives.

Next Steps: The project will organize supervisory trainings for champion communities to reinforce their capacity in the implementation and management of income-generating activities, continue to work with champion communities to develop and elaborate their statutes and internal policies to obtain legal status as NGOs, seek out and support partnerships between the communities and health facilities through the establishment of respectful and collaborative initiatives to long lasting relationships and help the champion communities liaise with cellular companies to establish relationships and ensure continuity of the CUG and *ligne verte* activities.

Champion Man Initiative: The champion man Initiative continues to be implemented throughout all target project health zones. The initiative allows men to become positive role models in their communities and motivates them to engage others in discussions about healthy practices and behaviors.

In the Kanda Kanda health zone, 29 men have informed project staff that they have been conducting outreach to members of their communities and parishes to encourage men to help women with household chores, sexual responsibility, early childhood development, and hygiene, as well as referring families with members suffering from illnesses. In Luiza, health centers verified that 131 champion men contributed the improvement of indicators in family planning and CPN4 through exchanges with 64 households in the community.

Challenges: The project has noted fatigue with the champion man initiative from participants due to insufficient support and/or other commitments, as well as the expected obstacle of entrenched cultural and religious norms surrounding masculinity and traditional gender roles such as the desire for large families and the fact that it is not "manly" for men to be implicated in family health matters. The champion men are members of their respective champion communities. As such, the motivation of the champion men would include moral support and encouragement from the members of the community they serve and would also benefit from grants to the champion community. Upon successful implementation of the first six-month action plan of the champion community, IHP provides a $1,000 grant to each champion community (disbursed in two $500 payments) to support the implementation of the next champion community action plan (which integrates champion man activities) and income-generating activities (IGA). IGA would ensure the sustainability of champion community activities and would also help them in obtaining official status as a non-governmental organization, which would allow them to sign contracts with other partners. In addition, IHP will continue the champion man initiative through field visit for monitoring as well as supportive supervision. IHP will further document the lessons learned from the champion man and the champion community efforts.

Next steps: IHP will continue to collaborate with target health zones to implement the champion man initiative in other health areas and will collaborate with religious leaders to introduce the initiative in action groups.

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

During the four years of IHP, the operational planning processes of the supported provinces have evolved at different speeds due to several reasons, including overlap in areas such as health vaccination campaigns, the lack of funds allocated to activities (IHP had allocated funding for the planning process but this fell short of what was needed on the ground), the low level of stakeholder involvement in supporting the operations of the health zones, and the weak leadership of some DPS.

Katanga and part of Kasaï Oriental (the new Sankuru DPS) are the last provinces to engage in this process, while Sud Kivu has already finalized it at the beginning of the year. IHP has been involved in this process by supporting provinces and health zones in taking ownership of the planning process for better management of the activities of primary health care. There is no other document that health zones use pending the approval of the AOP. The AOP is the only reference document. During the development of the 2014 AOPs, health zones used the 2013 AOPs.

The following table shows the status of validation for the AOPs.

Table 47: Status of Annual Operational Plans

N°	Provinces	DPS	# of health zones per DPS	# health zones supported by IHP	# of health zones with validated AOPs	# of health zones with AOPs adopted by advisory boards	% of IHP health zones with AOPs approved by advisory boards
1	**Katanga**	Lualaba	14	8	8	0	0
		Haut Lomami	16	9	9	8	89
2	**Sud Kivu**	Sud Kivu	34	27	27	27	100
3	**Kasaï Oriental**	Kasaï Oriental	19	3	3	3	100
		Sankuru	16	16	16	6	38
		Lomami	16	6	6	6	100
4	**Kasaï Occidental**	Kasaï	25	1	1	1	100
		Kasaï Central	18	8	8	8	100
Total			**158**	**78**	**78**	**59**	**76**

All 78 IHP health zones benefitted from technical and financial support in finalizing the Annual Operational Plans (AOPs). Fifty-nine health zones validated their AOPs under the guidance of the PNDS, the board of directors. In Katanga, all 17 IHP-supported health zones defended their AOPs at the DPS, but the eight supported health zones in Kolwezi, as well as the Kinkondja health zone in Kamina, have validated their AOPs at the level of their respective administrative boards. In Sankuru, six health zones out of 16 in the district of Sankuru (new Sankuru DPS) validated their AOPs with their respective administrative boards. The unavailability of the provincial medical inspector (MIP) or his delegates prevented some health zones from organizing and holding administrative boards.

Particular attention will be paid to Katanga and Sankuru during the planning process, which will start soon. Moreover, IHP helped the D5 (the officer in charge of primary health care) in the writing and approval of a guide

to conducting and arranging periodic reviews at the health zone and the DPS; this document will allow for a good analysis of the situation on the ground and lead to effective and efficient decision-making.

PROJECT MANAGEMENT

1. **Success stories:** During this quarter, the project produced 11 success stories for a total of 35 for PY4 (as compared to 24 from PY1-PY3), exceeding the target of 30 stories per project year.

2. **Cost share:** As of September 30, 2014, IHP has booked $3,213,548.15 of cost share. At full obligation, the project is required to book a total of $4,193,013.87, which means the project needs to book $979,465.72 to meet its cost share requirement.

The following activities are yet to be booked as cost share:

- Once all backing documents are received for the four remaining Project CURE containers of donated medical supplies, the project will book the fair market value of $1,091,392.36. Once the MSH Contract Officer approves and this value is booked, the project would meet its cost share requirement.
- The project has submitted for booking $19,267 for the Implanon insertion training kits donated by Merck.
- The project also anticipates booking as cost share about $200,000 from the HPP project for technical support in 27 health zones shared with IHP.
- U.S.-based Brothers' Brother Foundation shipped a 20-foot container of donated beds, mattresses, bikes and other medical equipment with a market value quoted at $8,000. The project will book this value as cost share once proof of delivery documents are received.

3. **Procurement Updates**
   - **Status of the PY3 pharmaceutical order:** The final shipment for the PY3 pharmaceutical order arrived in early August 2014. Amoxicillin was the only outstanding product; all CDRs received two types of Amoxicillin (250 mg/5 ml powder for oral suspension and 500 mg capsules) in September 2014.
   - **Status of the PY4 pharmaceutical order:** The PY4 pharmaceutical order was placed with Amsterdam-based vendor IDA in July 2014 and will be shipped to final destination by global shipping and logistics experts Kuehne & Nagel. Fresh products and cold chain supply will be airlifted from Amsterdam.
   - **Arrival dates**: The import permits for the PY4 order have not been received yet; estimated date of arrival in DRC is between December and April 2015. All products scheduled to depart in the first shipment from Shanghai are being prepared for departure at end of October 2014 once all permits are received and inspections conducted. The following shipments departing from Amsterdam, Singapore, Mumbai, and Chennai are still planned to arrive at the six final destinations starting from December 2014 through April 2015.
   - **Status of the medical equipment procurements:** The final shipment for the medical equipment order arrived to the final destination and cleared as of September 2014.

FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

1. Family planning

During the first two quarters of PY4 (PY4Q1 and PY4Q2), when the project was operating under the interim plan and budget restrictions, only the management teams of the health zones and health districts were able to go into the field to make supervision visits. The main activities carried out in terms of family planning compliance include: ensuring contraceptive supplies so that clients can make an educated selection from a range of methods; planning and organization post-training providers and community-based distributors, including monitoring of contraceptive management; and the distribution of management tools.

Two people were also supported by IHP to attend a refresher training on Implanon NXT organized by Merck on October 31, 2013; they attended a second training in November 2013, when Merck held an additional training on classic Implanon NXT, including the Tiahrt Amendment, management of side effects, and advantages and disadvantages of the method. There were two sets of workshop on the insertion of Implanon NXT sponsored by the Merck pharmaceutical company. Five officials from the National Reproductive Health Program (PNSR) and provincial representatives (from Katanga, Kasaï Occidental and Oriental, and Sud Kivu) participated during the first phase. Almost all national trainers and two provincial trainers attended the second workshop because it was held during the period when IHP's spending was restricted. IHP plans to support on-the-job training for the central and provincial trainers during the competency-based integrated MNH/FP post-training follow up and supportive supervision visits. In January 2014, IHP received 30 training kits from Merck, 200 Implanon PARSS placebos, 200 conventional placebos, and 300 NXT placebos from CARE-Goma, as well as 200 conventional placebos and 300 NXT placebos from IMA/SANRU. These products were donated by Merck via ASSP/IMA and have already been booked as cost share. IHP covered the shipping costs from Kinshasa to the health facilities.

In PY4Q3, 134 staff reported having completed the training on USG family planning legislative policies. Of those staff members, 120 are from IHP coordination offices and 14 from provincial health services in Mbuji Mayi and Kananga. Only 58 certificates of course completion have been collected so far. Most of the staff reported not being able to retrieve their certificates from the site. Eventually we were able to download 98 out of 120 certificates. The rest (22 staff) were not able to get their certificates due to problematic internet connections in the coordination offices. IHP IT staff members are providing technical support to overcome the specific challenges individual staff members are facing.

IHP provided technical support to the development of the National Strategic Plan for family planning, which was adopted on January 10, 2014, by the Multi-sectoral Technical Committee on Family Planning (CTMP), and published and distributed to all levels of the health system. This plan covers the period 2014-2020, reflects the recommendations of the 2009 National Conference on Repositioning Family Planning, and provides a framework for all family planning activities in the DRC. The National Program for Reproductive Health, with the support of partners and stakeholders, continues to push for uniform application of the existing legislation on reproductive health issues and the adoption of a comprehensive law. The law was resubmitted to the National Assembly, which sent it to the Supreme Court of Justice to examine its constitutional basis before continuing the debate.

For PY4 , IHP trained 372 people in long-term methods (IUD , Implanon), including those who have been trained in the skills-based approach developed by the MOH, in which the people selected to participate already have some family planning experience (the competency-based approach includes modules on maternal, newborn and child health along with family planning).

2. HIV and AIDS

All IHP activities related to HIV and AIDS were in compliance with the PEPFAR team's orientation and guidance and relevant USG legislation and requirements. Staff have attended relevant training offered in the context of PEPAR (e.g., OGAC New Generation Indicators-NGI); all COP 2014 planning and relevant documentation was completed; and all PEPFAR reporting requirements were met (e.g., semiannual and annual reporting, 2014 PEPFAR Expenditures Analysis and input to the PEPFAR Record and Organization Management Information System (PROMIS).

ENVIRONMENTAL MONITORING AND MITIGATION PLAN

IHP supported the following activities, including active involvement of the population in awareness sessions to master approaches and appropriate knowledge and ownership of the projects:

- **Ventilated Improved Pit (VIP) Latrines:** During PY4, IHP supported the construction of 526 VIP latrines (503 of which were in the Kole health zone) during community outreach events in the Ishenga health area. Community leaders and WASH supervisors from the project and health zone management teams presented different models and their usage to community members. The ventilation aspect of these latrines is constructed from large bamboo. Nine VIP latrines were built in Bukavu, seven in Uvira, four in Kolwezi, and three in Luiza.
- **Handwashing stations**: IHP supported the construction of 338 handwashing stations, alongside newly-built household latrines, in Kole (246), Luiza (69), and Kolwezi (23).
- **Incinerators:** In the coordination offices of Luiza, Mbuji Mayi and Kamina, the construction of incinerators was planned for PY3 but the project was not able to provide this support until PY4 when the necessary materials and tools arrived. Twenty-three incinerators were constructed in total, including three in Luiza, six in Kolwezi, 12 in Bukavu, and two in Uvira.
- **Placenta disposal pits:** The project supported the construction of 23 placentas pits were constructed during PY4, one of which was built exclusively by the Ishenga health center in the coordination of Kole.
- **External Trash Bins:** IHP supported the digging of a total of 186 garbage holes, including 178 in the households of four villages (Ikfutu, Okonga, Topeko, and Tshendjo) in the Ishenga health area in the Kole health zone, five in Kolwezi, and three in Bukavu. In Luiza, 260 external bins are being built in the health areas of Bilomba, Luambo, and Ndekesha in collaboration with their respective health committees.
- **Internal Trash Bins:** The project provided 1,150 internal trash bins in Luiza, 39 in Kamina and 7 in Kolwezi, for a total of 1,196 in PY4. Moreover, the Tshumbe coordination office trained water, hygiene and sanitation community leaders and supervisors in Dikungu, Tshumbe, and Wembonyama in the regular maintenance of waste management devices in their health facilities.
- **Training in hospital hygiene:** IHP provided CLTS training in PY4Q4 in Uvira, as well as refresher trainings on hospital hygiene as needed. In Tshumbe, there was no formal training on this topic, but the WASH and BCC technical assistants helped community leaders and WASH technicians from the health zones of Dikungu, Tshumbe, and Wembonyama hold briefings in PY4Q1 and PY4Q2 on the management of biomedical waste for 46 GRH providers and the donation of 35 hospital hygiene data sheets. In addition, 6 Ishenga health center providers were briefed on the importance of hospital hygiene.

During the implementation of these activities, IHP experienced no issues regarding environmental compliance. Health care providers have been briefed on how to use and complete a checklist concerning medical waste management and to have a related action plan.

CHALLENGES ENCOUNTERED

The main challenges that the project experienced during PY4 included the following:

Technical constraints: The 70% target set by the MOH for accelerating the reduction of maternal and infant mortality was not attained by the majority of the health zones. IHP will intensify efforts to revitalize the community care sites, strengthen community mobilization, and train additional community care site workers in the management of three priority illnesses (diarrhea, pneumonia, and malaria). The MOH target to treat at least 70% of all cases is difficult to achieve for most health zones as only patients with complicated diarrhea (e.g., severe dehydration) are regularly consulted in the health facilities. The other diarrhea cases are treated by parents or caretakers at home.

Convincing women to give birth in health facilities with assistance by skilled providers remains a major challenge in rural health areas, as many pregnant women continue to begin ANC consultations only in the last trimester of pregnancy, particularly in the coordination areas of Bukavu and Uvira. The project will continue to encourage the participation of local authorities and community leaders in raising awareness about the importance of prenatal care and childbirth in the health structures. The challenge is particularly evident in Shabunda, Kalole, and Lulingu health zones in the coordination of Bukavu, as well as in Hauts Plateaux d'Uvira and Nundu in the Uvira coordination (where women begin ANC only during the last trimester of pregnancy). The data presented and reported are cumulative and reflect a summary of data from the different health zones. However, if data were to be broken down by health zone, we would see that the results of the health zones mentioned above are much lower than other urban or semi-urban health zones of Bukavu and Uvira.

The rate of deliveries in health facilities attended by skilled providers in the coordination of Kamina is also low, but for different reasons than those cited for Sud Kivu; this is essentially related to the difficult accessibility of health facilities from villages and communities (50 to 100 kilometers in distance in the territory of Malemba Nkulu, for example). As a result, actions to improve the situation differ.

<u>Kamina:</u>

- Schedule ANC sessions during community outreach campaigns to overcome the geographical access issue
- Ensure the availability of ANC supplies and MNCH standards and guidelines, and brief head nurses on the new MNCH guidelines during monthly monitoring reviews and supervision missions

<u>Bukavu and Uvira:</u>

- In collaboration with community leaders and community health workers, strengthen the awareness-raising campaign for pregnant women and their families to attend at least three ANC visits before birth

The number of pregnant women who complete four ANC visits remains low, since many women only begin ANC visits when they feel the baby move. Awareness sessions in the community and through the CHWs are planned, in conjunction with sending SMS messages about the benefits of ANC.

Compliance with the national protocol on the use of RDTs (ratio of 1 RDT for 2 ACT) is not yet fully achieved in health facilities, despite the recommendation of the National Malaria Program. IHP will strengthen training on prevention and treatment of malaria cases through post-training follow-up visits and joint supervision missions with MOH and health zone management teams.

Budgetary Restrictions: The project was required to operate on an interim spending plan in the first quarter of PY4 due to a delay in funds obligation. The delay had negative consequences for the implementation of the IHP action plan, including support for the development of AOPs in the health zones and prioritization of activities since the project was able to focus exclusively on only four principal activities: the supply of medicines and medical commodities; technical and financial support to health zones; provision of medical equipment in rehabilitated facilities; and staffing activities related to RBF. The restriction was finally lifted, but it took longer than anticipated for the project to re-establish full operational capacity.

Logistics: 112 motorcycles were ordered and have arrived; however, the official records of 17 of the motorcycles do not match the identification numbers on their frames. The team continues to work to resolve this issue.

Security: There is recurring insecurity in certain health zones, such as Lemera, Ruzizi, Minova, Miti Murhesa, and in the territory of Malemba Nkulu. This has led to a migration of the population, mostly women and children, and has had a negative impact on project activities (e.g., stopping activities, inaccessibility of health facilities, late reporting, and inability to carry out planned supervision visits). IHP continues to work closely with the health zones and health authorities in the affected districts to provide technical and financial support to the activities within this uncertain environment.

Supply Chain System: Frequent vaccine stock outs are due to the delay in co-funding from the DRC government to purchase the vaccines. The lack of vaccines affects the project's ability to implement planned activities and attain the objectives of the project. IHP requested USAID support to identify and implement short (immediate), medium, and long-term solutions to the chronic vaccine shortages.

The last delivery of bed nets and SP dates back to June 2012. This has had a negative impact for malaria prevention efforts. The absence of kits for severe malaria still persists. Women are more likely to go to a facility that distributes mosquito nets and provides malaria treatment. Within this context, IHP encouraged health zones to use their money to purchase drugs for the treatment of severe malaria. Drugs are purchased but are sold at prices that are not affordable for the population, including pregnant women.

Some institutions have not yet mastered the calculation of their average monthly consumption of most commodities (e.g., ACTs and RDTs, iron/folic acid and ORS, etc.) to produce reliable quantifications. It is therefore very difficult to calculate the annual needs for health zones for a year of full coverage. In collaboration with SIAPS, during supervision visits IHP organized training and information sessions for service providers on the quantification and management of drugs.

Data Quality: Data quality remains a major challenge in the project due to hastily performed collection and interpretation without a careful analysis of all the data, despite the availability of tools for data collection. The project continues to provide tools to all health facilities, support monitoring meetings to ensure quality data, and perform data quality assessments. The project plans to continue the DQA exercises in other field offices during the next quarters.

PLANNED ACTIVITIES FOR NEXT QUARTER

IR 1

- ✓ Assist the health zone management team's capacity to develop the AOPs for 2015 as well as other plans (health coverage plan, communication plans, training, supervision plans) in the health zones supported by the coordination offices
- ✓ Provide basic equipment in health facilities, based on need, in the health zones supported by the eight coordination offices
- ✓ Provide medical supplies to renovated maternity wards as well as comprehensive MNCH kits in the health zones supported by the coordination offices
- ✓ Provide essential medicines and other specific commodities for family planning, HIV, TB, and malaria in health facilities supported by the coordination offices and establish an efficient management system of drugs and commodities
- ✓ Reinforce logistics and management of essential medicines and other specific commodities for family planning, HIV, TB, and malaria in the health zones supported by the eight coordination offices
- ✓ Improve the capacity of human resources to deliver MPA/CPA-plus services through supportive supervision on the use of health care flow charts (ordinograms) in the intervention zones in the coordination offices
- ✓ Strengthen activities at community care sites implementing integrated case management of childhood illnesses (i-CCM) through supportive supervision of community health workers (CHWs) and the provision of essential drugs and supplies, and management tools; including dissemination of communication materials on integration of ORS-Zinc
- ✓ Consolidate the WASH zonal approach in order to achieve the expected result: at least 80% of population in the selected health zones have access to improved drinking water and sanitation facilities by the end of the project
- ✓ Strengthen and mobilize IYCF support groups at the community level in supported health zones

IR 2

- ✓ Strengthen family planning activities through supportive supervision of service providers on clinical family planning methods, integration of CBD activities, integration of FP strategies at community care sites, and the distribution of monitoring and management tools and other necessary supplies, and ensure close collaborate and coordination with E2A project
- ✓ Strengthen routine immunizations in project-supported health zones by assisting the EPI with funding for transport for commodities, provision of tools to collect data, fuel, and other supplies for the maintenance of the cold chain, the supervision of workers from storage sites on the maintenance of the cold chain, and emphasizing supportive supervision to CHWs
- ✓ Strengthen the technical skills of maternal care service providers to ensure the quality of care for MNCH in project-supported the health zones through supportive supervision of a package covering family planning, Helping Babies Breathe (HBB), Kangaroo Mother Care (KMC), complicated birth management, AMTSL
- ✓ Distribute SP for intermittent preventive treatment of malaria for pregnant women (IPTp) and LLINs to prevent malaria
- ✓ Support health care providers to correctly manage cases of malaria in the health facilities through supportive supervision and provision of medicines and other commodities--for example, ACTs and RDTs
- ✓ Ensure transition to B+ of all 69 existing sites and transportation of DBS

- ✓ Strengthen the fight against TB, TB and HIV co-infection, and MDR-TB through supportive supervision of health providers, provision of reliable transportation of TB samples, and joint follow-up visits to supported health zones
- ✓ Implement and evaluate the RBF program, improving the capacity of CBOs to conduct counter-verification, organizing quarterly reviews of RBF data and health promotion activities, and providing management tools to CBOs to implement the RBF program
- ✓ Monitor, observe, and evaluate the RBF program through monthly updates of the database, organization of joint visits for follow-up and supervision with the health district teams and the health zone management teams, and the presentation of certificates for the health facilities that demonstrate the best performance

IR 3

- ✓ Implement and evaluate the ETL approach by training members of the community (including CODESAs), organizing ETL sessions on different themes (FP, CPN, malaria, TB, WASH, GBV, nutrition, HIV, MNCH, EPI, danger signs, key practices, i-CCM), and organizing post-training follow-up visits
- ✓ Conduct phone-based information campaigns and finance the quarterly dissemination of awareness-raising SMS messages on priority intervention areas in communities within IHP-supported health zones
- ✓ Select Champion Communities and follow up Champion Communities with the provision of technical and financial assistance in developing action plans post training

IR 4

- ✓ Provide technical and financial support to the various coordination organizations at the provincial level, including advisory boards, task forces, interagency coordination units, and other working groups
- ✓ Strengthen capacity of health zone management teams in the development of AOPs for 2015 and other plans (coverage plan for health facilities, communication plan, training plan, supervision plan) in supported health zones (Same as IR1.1, Activity 1)
- ✓ Provide financial and technical support for monitoring and evaluation systems
- ✓ Provide technical and financial support for provincial, district, and zonal health operations, in conformity with the sub grants provided by the project

LIST OF APPENDICES

Appendix 1: DRC-IHP Performance Monitoring Plan, PY4
Appendix 2: Distribution plan for family planning commodities PY4Q4*
Appendix 3: Distribution plan for PMI commodities PY4Q4*
Appendix 4: Summary of all training workshops conducted during PY4*
Appendix 5: Memorandum of Understanding between SANRU, PMI, and IHP
Appendix 6: Fistula Care Data PY4Q4
Appendix 7: DRC-IHP Accruals Report July to September 2014
Appendix 8: DRC-IHP Organizational Chart
Appendix 9: DRC-IHP SF425 July to September 2014
Appendix 10: DRC-IHP International Travel/STTA Plan, PY4*

*Appendices 2, 3, 4, and 10 are attached separately as Excel files

SUCCESS STORIES

The success stories are attached on the following pages.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Fighting Malnutrition in Kolwezi by Promoting Exclusive Breastfeeding

Exclusive breastfeeding and child feeding support groups helped decrease cases of malnutrition and diarrhea in Kolwezi.

Photo: International Rescue Committee

Members of the exclusive breastfeeding support group in Bunkeya meet.

"We are now fully aware of the benefits of exclusive breastfeeding for both our children and ourselves, as opposed to misleading and false information we used to receive from our grandmothers, aunts, or friends."

- ***Clementine Kalonda, breastfeeding support group member, Bunkeya, Kolwezi***

Breastmilk provides all nutrients an infant needs and contains antibodies that help protect them from common childhood illnesses.[1] Yet, in the Democratic Republic of Congo (DRC), an average of only 49% of infants aged 0 to six months are exclusively breastfed.[2] In Bunkeya health zone in Kolwezi, this rate-- at 15% in 2013[3]-- was well below the average. Low exclusive breastfeeding is linked to increased diarrhea and malnutrition: in Bunkeya, 52% of infants 0 to six months suffered from chronic diarrhea and 30% were malnourished.[4] According to the 2013-2014 Demographic and Health Survey, misinformation and rumors also contribute to a low rate of exclusive breastfeeding.

To address these challenges, the USAID-funded Integrated Health Project (DRC-IHP) trained the Bunkeya health zone management team, health providers, and community health workers on Essential Nutrition Actions (ENA) and Infant and Young Child Feeding (IYCF) strategies. DRC-IHP supported the creation of IYCF support groups and a one-week awareness-raising campaign on ENA and exclusive breastfeeding, including door-to-door home visits. The project also helped establish discussion forums in communities to encourage breastfeeding and expectant mothers to share experiences and best practices. More than 1,500 women from Bunkeya have participated in these activities to date.

As a result of these initiatives, from March to August 2014, exclusive breastfeeding of infants 0 to six months increased to 50%, while cases of chronic diarrhea dropped from 52% to 28%, and severe acute malnutrition cases dropped from 30% to 19%[5].

"I exclusively breastfed my daughter, and she is healthier than my other children were," said Clementine Kalonda,[6] a breastfeeding support group member. "The discussion forum is a unique opportunity to freely share my experience with, and learn from, other mothers."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] "Ten Facts on Breastfeeding," World Health Organization
[2] DRC Demographic and Health Survey, 2013-2014
[3] Bunkeya Health Zone Report, 2013
[4] Bunkeya Health Zone Report, 2013
[5] Bunkeya Health Zone Report, 2013, PRONANUT data
[6] Name changed for privacy

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Community Leaders Work to Combat Diarrhea Outbreak in Luiza

CODESA members implement a BCC campaign in the Bambaie health area, reducing the incidence of diarrhea by 65%.

Photo: Overseas Strategic Consulting, Ltd.

A young girl uses a new handwashing station in Luiza.

"We were shaken by the diarrhea outbreak during the last three months, but the CODESA members really helped us with the advice they provided...We salute their bravery, dedication, and the sacrifices they made on our behalf."

- Mme Mbombo, age 36, resident of Bambaie

In the Democratic Republic of Congo (DRC), diarrhea is among the most deadly illnesses for children under the age of five, especially if victims do not receive early treatment. At the same time, diarrhea is also a largely preventable illness if key protective measures are followed, including washing hands with soap at "critical moments" (such as after using the toilet, while washing a child, and before handling food), using hygienic toilets, conserving and consuming pure water, properly cooking food, and de-worming children. However, communities often do not associate the absence of these behaviors with diarrhea, making it difficult for community health volunteers and officials to change harmful behaviors and combat the disease.

In July 2014, an epidemic of diarrhea broke out in the Luiza health zone, with 904 recorded cases. In the Bambaie health area of Luiza, one of the areas hardest hit by the epidemic, there were 31 cases recorded in July alone. In response, the USAID-funded DRC-Integrated Health Project (DRC-IHP), along with the Luiza health zone management team, the World Health Organization, UNICEF, local non-governmental organization partners, and community-based health development committee (CODESA) members, formed a crisis committee to solve the problem at the community level.

CODESA members, supported by DRC-IHP, developed a behavior change communications (BCC) plan to raise awareness of the causes of diarrhea. This plan included the distribution of 25 educational announcements read by church leaders during services, 100 SMS messages sent to community members, 56 household visits, 32 sessions focused on Education through Listening (ETL), and the creation of a water, sanitation, and hygiene (WASH) committee.

As a result, 20 households (out of a total of 1,476 in the Bambaie health area) constructed latrines (five of which have handwashing posts), and the WASH committee maintained two sources of potable water in the community. The number of reported diarrhea cases fell from 31 in July to 11 by August 2014, and to 8 cases in September 2014.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Results-based Financing Improves Service Utilization in Osomba Health Center

Results-based financing program pushes health center to improve quality of services, staff attendance, and infrastructure to increase patient visits.

Photo: Management Sciences for Health

Head nurse Marie Jeanne Osomba at the Osomba health center in Wembonyama

"The way we evaluate the quality of our services has changed. We work with the community, and we have established a community suggestion box to help us identify ways to strengthen ties with the community. The community has increased confidence in us, resulting in improved service utilization rates."

- ***Head nurse Marie Jeanne Osomba***

During the first half of 2013, the Osomba health center in the Wembonyama health zone in the Kasaï Oriental province of Democratic Republic of Congo (DRC) reached just under 9% of expected curative service utilization. People still became ill in Osomba, but the health center's poor infrastructure and poor service quality--combined with stock outs of essential medicines and low staff availability--discouraged attendance of those needing care.

To support under-performing health facilities like the Osomba health center, the USAID-funded Integrated Health Project in the DRC (DRC-IHP) launched an innovative results-based financing (RBF) program in October 2013 in seven health zones, including Wembonyama, where the Osomba health center is located. DRC-IHP's RBF program provides financial incentives for health facilities that achieve pre-determined and mutually-agreed upon goals linked to improved access to care, quality of services, resource management, and community engagement. The project also provided health structures with essential medicines and management tools, followed by coaching of health care providers during follow-up visits and work plan development.

The health center reinvested the $778 incentive received in the first quarter to repaint the walls and to purchase a registry book and other office supplies. The center also strengthened community outreach by working with community leaders. Data accuracy has also improved from almost 37% to nearly 85% from the first to the second quarter of 2014, according to quarterly verifications conducted by the health zone management team and counter-verifications conducted by a selected local non-governmental organization.

After the launch of the RBF program, from February to July 2014, the service utilization rate climbed to 27%, compared to slightly less than 9% during the same period a year earlier. Head nurse Marie Jeanne Osamba asserts, "The community has increased confidence in us, resulting in improved service utilization rates."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Spacing Births to Reduce Health Risks for Families in Lodja

A couple in Lodja became community-based distributors of family planning methods after experiencing birth spacing success in their family.

Photo: Management Sciences for Health

Family planning method acceptors Opanga and Akao with one of their children in Lodja.

"I can attest that Depo-Provera has been an effective method for our family in order to better space the births of our children."

- Opanga, Lodja, DRC

Opanga and his wife, Akao, have four children who were born so close to each other that neighbors in their community of Lodja in the district of Sankuru in the Democratic Republic of Congo often teased the couple. Teasing aside, multiple closely-spaced pregnancies are no joking matter, as they come with a dramatically higher risk of maternal, infant, neonatal, and perinatal mortality.

But in 2011, Opanga attended a family planning awareness-raising event put on by members of *Ebenezer Global Multisectoriel*, a local organization trained and supported by the USAID-funded DRC-Integrated Health Project (DRC-IHP) to educate communities about the importance of family planning and the methods available at their health centers. Opanga shared this information with Akao, and together they decided to visit the Edinga Health Center in Lodja to speak to the nurse about their options. They chose to use Depo-Provera for longer birth spacing.

Akao did not get pregnant for three years, which prompted curious neighbors to wonder why. Opanga and Akao spoke to 24 couples about family planning and convinced four couples to accept modern family planning methods. In February 2014, Opanga and Akao were chosen by the Lodja health zone management team, supported by DRC-IHP, to be trained as community-based distributors (CBD) of family planning products. They joined 82 other CBDs in Lodja to help improve contraceptive use. From February to August 2014, 538 couples received counseling and accepted a family planning method thanks to the efforts of Opanga, Akao, and fellow CBDs.

"I can attest that Depo-Provera has been an effective method for us to space the birth of our children," said Opanga. In addition, the couple's friends appreciate their efforts to save lives. One such friend, Henriette Omoyi, who now uses Depo-Provera thanks to the couple's advocacy efforts, notes that her husband now is in favor of family planning because she had previously given birth twice in close succession and had suffered from anemia during her pregnancies.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Improving Care of Sexual Violence Victims in Kole: Alice's Story

Thanks to technical and financial support from the DRC-Integrated Health Project, referral of sexual violence victims to health care has improved in Kole.

Photo: Management Sciences for Health

GBV survivors and their families stand in front of the Synergie Kole center.

"…despite the attack, I am in good health again and I can continue my studies."

- Alice Kabena, 14, sexual violence survivor referred for medical care in Kole

After 14-year-old Alice Kabena[1] was sexually assaulted in March 2014, she received medical and psychosocial care at the Kole General Referral Hospital. She was referred there by the rape support group *Synergie Kole*. In the Kole health zone of the Democratic Republic of Congo, about 4.36% of an estimated population of 46,562 women and girls like Alice reported being sexually assaulted in 2013. However, only about half of those reported cases were referred to health facilities for proper medical care, despite health risks such as unwanted pregnancy and sexually transmitted infections.

To address this issue, the USAID-funded DRC-Integrated Health Project (DRC-IHP) has been working with local health units and *Synergie Kole* to advocate for medical attention for rape victims. In May 2013, DRC-IHP trained members of the Sankuru district health management team, including eight health care providers from the general referral hospital in Kole, on the medical care and treatment of sexual violence victims. DRC-IHP also provides technical and financial support to *Synergie Kole* to mobilize the community on raising awareness of sexual violence, work with community leaders and the police on advocating for and implementing laws that punish perpetrators of sexual violence, and provide psychosocial support to victims.

Because of DRC-IHP's involvement in improving care of sexual violence victims, and providing Post-Exposure Prophylaxis (PEP) kits, referrals rose to 143 in Kole in 2013 (compared to zero referrals in 2011 and 72 in 2012), 48 of which were referred within 72 hours. Most of those referred were under 18 years old (68 girls were 10 years old or younger, 62 girls were 10 to 17 years old, and 13 women were 18 or older).

"Thanks to *Synergie* and IHP, despite the attack, I am in good health again and can continue my studies," Alice said. Her attacker was eventually arrested by local authorities and prosecuted for rape.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] Name has been changed for privacy

USAID FROM THE AMERICAN PEOPLE | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

The Golden Minute: Saving Newborns' Lives in the DRC through the "Helping Babies Breathe" Method

When a baby struggled to breathe upon delivery, a birth attendant in Luiza used the "Helping Babies Breathe" technique she learned to resuscitate the child within the first minute of life.

Photo: Management Sciences for Health

Marie Miambokila Mumba and her three-month-old twins at home in Luiza, November 2014.

"I thank God and Judith and her team at the maternity unit for saving my child's life. If it had been a few years ago, my baby would have died."

- Marie Miambokila Mumba, 38, Luiza, DRC

Marie Miambokila Mumba, 38, had a smooth pregnancy and attended all of her scheduled prenatal consultations at the Tutante health center in Luiza, located in the province of Kasaï Oriental in the Democratic Republic of Congo (DRC). When she gave birth at the Luiza General Referral Hospital (GRH) in August 2014, the baby was delivered safely by skilled birth attendant Judith Kambuyi.

However, within moments, Judith realized that there was a second baby. Despite the prenatal consultations, the Tutante health center staff had not detected that Marie was carrying twins. But the second baby was struggling to breathe upon delivery. Judith, trained in the Helping Babies Breathe® (HBB) technique, acted quickly to assess and resuscitate the child during the first critical minute after delivery, called "The Golden Minute."

The HBB training that Judith attended in August 2012 was organized by the USAID-funded DRC-Integrated Health Project (DRC-IHP) as a response to high neonatal mortality rates in the DRC--approximately 104 deaths for every 1,000 live births. HBB is an evidence-based neonatal resuscitation approach for resource-limited settings that promotes attendance of skilled attendants at birth, assessment of every baby, temperature support, stimulation to breathe, and assisted ventilation as needed, all within "The Golden Minute" after birth.

Prior to the HBB training, the hospital in Luiza struggled with a high infant mortality rate. Thanks to the HBB training and other capacity building, such as training on Active Management of the Third Stage of Labor (AMTSL), as well as the provision of caesarian kits and neonatal resuscitation kits, the hospital has been able to save 22 babies who were delivered in distress from January to September 2014.

"It's a source of pride to save lives," said Judith, who was trained with 11 other nursing staff from Luiza GRH. "I have been a birth attendant for 24 years, but it was IHP that made me more effective as a result of the HBB training."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID FROM THE AMERICAN PEOPLE | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Reducing Maternal and Neonatal Mortality through Reliable Blood Banks

Donated blood saves the life of a young mother in Uvira following childbirth complications.

Photo: International Rescue Committee

Donors give blood in Uvira.

"Our daughter would have died if it was not for the blood drive. We would like to recommend to DRC-IHP to organize blood drives across the country to save women and children's lives."

- Mother of Christine, blood donor recipient in Uvira

When twenty-year-old Christine[1] gave birth at the health center of Kabinda in Uvira in eastern Democratic Republic of Congo (DRC), she suffered from a ruptured uterus during delivery. The nurse referred her to the Uvira General Referral Hospital (GRH), where health workers confirmed that her life was in danger due to blood loss.

Every day, approximately 800[2] women die due to complications from pregnancy or childbirth, including postpartum hemorrhaging, infection, hypertension during pregnancy (preeclampsia and eclampsia), and unsafe or untreated abortions. Nearly 99% of these deaths happen in developing countries, and half of those in Sub-Saharan African. In the DRC, the maternal and neonatal mortality rates remain high, with 846 maternal deaths for every 100,000 live births and 28 neonatal deaths (0-28 days) per 1,000 births.[3]

To help prevent maternal mortality, the USAID-funded DRC-Integrated Health Project (IHP), in collaboration with the Congolese Ministry of Health at the local level, identified a reliable blood bank and source of donors to treat hemorrhage cases. In August 2014, DRC-IHP supported the organization of a three-day blood drive campaign in the health zone of Uvira. Due to the campaign's success, the Uvira GRH blood bank was able to add to the stock 69 bags of safe blood.[4] During the few weeks that followed the campaign, the number of screened blood bags stocked at Uvira GRH rose from 290 to 1,993.

Christine's mother affirmed, "Our daughter would have died if it was not for the blood drive." After two surgeries and the transfusion of six bags of blood, Christine was safely out of danger and on her way to recovery.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

---

[1] Name has been changed for confidentiality
[2] World Health Organization, May 2014
[3] DRC Demographic and Health Survey, 2013-2014
[4] According to DRC Ministry of Health standards, blood is deemed safe when tested and cleared for Hepatitis B and C, HIV, and Syphilis.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Rapid and Accurate: Improving Malaria Case Management for Children in Tshumbe using Rapid Diagnostic Tests

The use of RDTs to quickly and accurately diagnose malaria cases leads to proper treatment of sick children in Tshumbe.

Photo: Management Sciences for Health

A mother holds her child while a nurse administers an RDT in a Tshumbe health facility.

"The RDT provides more accurate results in a short amount of time and allows us to treat the patient quickly and properly. The old system was painstaking, and we had to wait 24 hours for the results."

- Head nurse Albert Kasongo of Tshumbe

Malaria is the leading cause of death for children under five living in Tshumbe, Democratic Republic of Congo (DRC). In May 2014, about 60% of children (119 out of 197) who were brought in for consultations had fevers and were suspected to have malaria. They were immediately put on Artemisinin-Based Combination Therapy (ACT) without being tested to confirm malaria. Even though there were Rapid Diagnostic Tests (RDTs) at the health facilities, health providers were not yet trained on how to use them properly.

In response, the USAID-funded DRC-Integrated Health Project (DRC-IHP), with the national malaria control program (PNLP), trained 20 health providers in June 2014 on the utilization of RDTs and health flow charts which are part of the new national directives governing malaria prevention and treatment at the health center level. After the one-week training, the head nurse from Tshumbe trained 14 other health providers working within the health area covered by the health center.

At the end of July 2014, 104 of 130 (80%) children under five seen for high fever were properly diagnosed with malaria using RDTs (the other 20% did not have malaria). Using RDTs not only ensures proper diagnosis and treatment of malaria, but also prompts further investigation to find out the real cause of high fever in the case of a negative RDT. Based on this data, if 80% of an estimated 1,560 yearly cases of high fever seen in the Tshumbe health area are confirmed by RDT to be malaria, the project will be able to save 312 unnecessary doses of ACT per year.

Albert Kasongo, the head nurse of Tshumbe, said he is very happy to see that that data obtained at the end of July show the advantages of using RDT to diagnose malaria.

"The RDT provides results in a short amount of time and allows us to treat the patient quickly and properly. The old system (microscopy) was painstaking, and we had to wait 24 hours for the results. I thank DRC-IHP for this opportunity to better manage high fever cases at the health center level," Mr. Kasongo said.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Fighting Diarrhea by Improving Water, Hygiene, and Sanitation Conditions in Kasaï Oriental

After the rehabilitation of two water sources and the construction of 173 latrines in July 2013, the number of diarrhea cases per month has decreased from three to one for every 10 children in Okako.

Photo: Management Sciences for Health

Women fetch water from the Opemba water source, which was rehabilitated by the Okako community with the support of DRC-IHP.

"Because of the project's help to repair our water sources, the community now has access to safe drinking water. We are thankful."

-Kahodi, Okako village chief

In February 2012, in the village of Okako in the Dikungu health zone, Kasaï Oriental, Democratic Republic of Congo (DRC), three out of 10 children under five years of age had diarrhea. Only 40% of households had latrines, about 80% of households defecated in the open air, and all households accessed drinking water from unsafe water sources.[1]

In May 2013, to improve water, sanitation, and hygiene (WASH) conditions in targeted communities, including Okako, the USAID-funded DRC-Integrated Health Project (DRC-IHP) launched community awareness campaigns on the risks of unsafe drinking water and poor hygiene and sanitation infrastructure. Working with local Ministry of Health staff, the project supported the establishment of a community-elected WASH committee and trained members on the health benefits of drinking from improved water sources, hand washing, taking out household trash, and the use of latrines.

To rehabilitate two water sources and construct household latrines, IHP trained a local mason and provided cement and steel, while the community contributed materials that were sourced locally (e.g., gravel, sand, and sticks). The WASH committee led awareness-raising sessions to guide community members on how to properly use and maintain latrines and to promote drinking water from rehabilitated sources only.

Today, 1,684 people in Okako have access to safe drinking water; 88% of households (1,384 people) now have latrines; and the number of households practicing open defecation fell to 20%. A survey in 20 households in June 2014 documented that monthly diarrhea cases for children under age five had decreased to one child out of 10.[2]

The village chief of Okako confirms, "Because of the project's help to repair our water sources, the community now has access to safe drinking water. We are thankful."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] Dikungu health zone Knowledge, Attitude, and Practice (KAP) survey in Okako, February 2012

[2] Dikungu health zone KAP survey in Okako, June 2014

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Happier and Healthier: A Family in Tshumbe Enjoy the Benefits of Family Planning

A couple in Tshumbe accepted a family planning method after losing two children to poor health caused by poorly-spaced births.

Photo: Management Sciences for Health

Family planning acceptors and CBDs Thérèse Ewango and Jules Okende with their child at home in Tshumbe.

"We are happier and healthier. Since using family planning, we have decided to have one more child. Our children are in better health, and we have better control of our finances since we do not have to spend as much on health care anymore."

- ***Jules Okende, family planning acceptor in Tshumbe***

In 2011, Thérèse Ewango lost two of her three children to malnutrition. Thérèse, who lives in Tshumbe in the Kasaï Oriental province of the Democratic Republic of Congo (DRC), became pregnant within six months after the birth of each of her children; she thought their deaths could have been the result of poor birth spacing. She herself was often sick. Unable to financially support several children and uninformed about family planning options that promote optimal birth spacing, many families in Tshumbe have malnourished children. In July 2011, eight children out of 231 suffering from malnutrition died (3.46%).

In January 2012, Thérèse was visited by community-based distributors (CBD) who spoke to her and her husband about various contraceptive methods. They explained the importance of family planning, especially its role in child spacing and child survival. After the visit, Thérèse and her husband decided to use Depo-Provera.

The CBDs in Tshumbe were trained in September 2011 by the USAID-funded DRC-funded Integrated Health Project (DRC-IHP) and the Ministry of Health. With the goal of increasing family planning acceptors in the Tshumbe area, the curriculum focused on training caregivers to provide family planning methods and carry out door-to-door outreach to inform couples of various contraceptive options. The project also provided family planning commodities for the Tshumbe health zone.

Door-to-door outreach efforts and the availability of family planning supplies resulted in 3,793 new family planning acceptors between January and July 2014.

More than two years after deciding to use family planning, Thérèse and her husband, Jules Okende, say they are happier and healthier. "Since using family planning, we decided to have one more child," Jules said. "Our children are in better health, and we have better control of our finances since we do not have to spend as much on health care anymore."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Improving Health Services in a Remote Congolese Village through Results-based Financing

Under the Results-based Financing program, the Lufwishi health center was able to increase utilization of services by improving quality of care and infrastructure.

Photo: Management Sciences for Health

Health zone officials cross one of the rivers that surround the community of Lufwishi.

"Now we are motivated to more than ever to monitor and evaluate performance of health centers, including Lufwishi."

- ***Dr. Amide Ngongo, health zone medical chief***

Lufwishi is a remote community isolated by rivers in the Katanga province of the Democratic Republic of Congo (DRC). As health officials rarely came to supervise the health center, the quality of services and the physical state of the building deteriorated. The curative care utilization rate was only 14% in 2013 compared to the national average of 35%.

To support under-performing health facilities like the Lufwishi health center, the USAID-funded Integrated Health Project in the DRC (DRC-IHP) launched an innovative results-based financing (RBF) program in October 2013 in seven health zones, including Kayamba where the Lufwishi health center is located. DRC-IHP's RBF program provides financial incentives for health facilities that achieve pre-determined and mutually-agreed upon goals linked to improved access to care, quality of services, resource management, and community engagement. The project also provided health facilities with essential medicines and management tools, followed by the coaching of caregivers during supervision visits and workplan development. IHP also provides supervisors from the health zone central office with incentives when the health centers they supervise perform well.

During the RBF pilot year, the Lufwishi health center was awarded $1,262 for the first two quarters of the RBF pilot year after health center data quality was audited by the health zone management team and DRC-IHP staff. With the funds, the Lufwishi health center installed a fence around the facility, painted and plastered the walls, and set up waste bins. The center also built shelves to organize drugs and other supplies. Newly-motivated health center staff began to strengthen community outreach to promote health services and announce the availability of commodities at the health center. Because of these efforts, the service utilization rate increased from 14% prior to the intervention to 81% by May 2014. Examples of improved health services in Lufwishi include an increase in referrals of high-risk pregnancy (from zero at the end of 2013 to 33% in May 2014) and an increase in the percentage of infants receiving the third dose of the DTP vaccine from 71% to 83% in the same period.

"Before we received bonuses under the RBF program, we only visited clinics during the dry season (when the rivers are low). Now, we are motivated more than ever to monitor and evaluate performance of health centers, including Lufwishi," said health zone medical chief Dr. Amide Ngongo.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

Annex 1: DRC-IHP Performance Management Plan, PY4			PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4		PY4 Achievement (%)
Indicateur		Définition					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	136,740	136,318	137,298	152,626	**562,982**	**450,000**	**125**
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	57,830	53,708	52,626	61,366	**225,530**	**165,000**	**137**
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	151,335	152,332	152,975	149,678	**606,320**	**497,399**	**122**
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	201,111	179,496	178,610	188,356	**747,573**	**640,349**	**117**
4	**FP:** Number of USG-supported delivery points providing family planning (FP) counseling or services	Number of USG-supported service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service	2,115	2,115	2,115	2,025	**2,025**	**2,000**	**101**
	Disaggregated by type of service delivery:	*(a) Health facility based*	1,751	1,751	1,751	1,542	**1,542**	**1,600**	**96**
		(b) Community-level based	364	364	364	483	**483**	**400**	**121**
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	47	42	38	56	**56**	**100**	**56**

6	**MNCH:** Percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	130,403	138,042	142,835	134,882	**546,162**	**510,830**	**107**
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**101%**	**106%**	**113%**	**107%**	**107%**	**95%**	
7	**MNCH:** Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	54,855	60,339	63,596	67,364	**246,154**	**334,951**	**73**
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/Denominator (in percentage)	**42.6%**	**46.5%**	**50.3%**	**53.3%**	**0**	**62%**	**78**
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	111,453	115,664	116,624	116,486	**460,227**	**449,208**	**102**
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**86%**	**89%**	**92%**	**92%**	**1**	**83%**	**108**
9	**MNCH:** Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	Numerator: Number of women giving birth who received AMSTL through USG-supported programs in IHP target area	101,438	106,583	107,626	109,188	**424,835**	**425,518**	**100**
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	111,453	115,664	116,624	116,486	**460,227**	**449,208**	

		Numerator/ Denominator (in percentage)	**91%**	**92%**	**92%**	**94%**	**92%**	**95%**	**97**
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)	105,899	110,973	111,792	111,483	**440,147**	**540,244**	**81**
11	**MNCH:** Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area	104,420	111,134	112,609	111,630	**439,793**	**430,006**	**102**
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**430,006**	
		Numerator/ Denominator (in percentage)	**81%**	**86%**	**89%**	**88%**	**86%**	**100%**	**86**
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)	8,058	6,819	8,608	11,335	**34,820**	**32,415**	**107**
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)	128,089	141,479	122,483	103,341	**495,392**	**573,232**	**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)	67,850	70,548	72,131	78,374	**288,903**	**764,318**	**68**
		Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	46,810	58,894	64,033	63,871	**233,608**		
15	**MNCH:** Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs =	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	111,071	111,390	116,587	118,008	**457,056**	**425,017**	**108**
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	112,446	113,239	110,292	110,292	**446,269**	**471,363**	
		Numerator/ Denominator (in percentage)	**99%**	**98%**	**106%**	**107%**	**102%**	**90%**	**114**
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	4,696	6,652	6,833	6,292	**24,473**	**21,251**	**115**
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	115,767	118,042	123,420	124,300	**481,529**	**425,017**	
		Numerator/ Denominator (in percentage)	**4%**	**6%**	**6%**	**5%**	**5%**	**5%**	**102**
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	103,842	104,924	112,889	110,200	**431,855**	**425,017**	**102**

		target area							
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	112,446	113,239	110,292	110,292	**446,269**	**471,363**	
		Numerator/ Denominator (in percentage)	**92%**	**93%**	**102%**	**100%**	**1**	**90%**	**107**
18	**MNCH:** Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	154	215	197	216	**216**	**100**	**216**
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	1,635,024	0	1,743,109	0	**3,378,133**	**2,520,338**	**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 during the last five months of pregnancy	121,019	118,742	136,753	127,768	**504,282**	**405,169**	**124**
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**94%**	**91%**	**108%**	**101%**	**99%**	**75%**	**131**
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)	120,628	126,664	161,462	165,823	**574,577**	**409,823**	**140**
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	34,693	32,907	34,109	36,294	**138,003**	**361,051**	**38**

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	399	488	436	489	**489**	**100**	**489**
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)	3,046	3,065	3,082	2,970	**12,163**	**28,903**	**42**
		Denominator: Total population in the specified geographical area	3,160,228	3,160,228	3,160,228	3,160,228	**12,640,912**	**13,506,106**	
		Numerator/ Denominator (per 100,000 population)	**96**	**97**	**98**	**94**	**96**	**214**	**45**
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	2,254	1,826	1,824	1,706	**7,610**	**17,342**	**44**
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	3,046	3,065	3,082	2,970	**12,163**	**28,903**	
		Numerator/ Denominator (in percentage)	**74**	**60**	**59**	**57**	**63**	**60**	**105**
26	**TB:** Case detection rate	Numerator: Number of new smear positive TB cases detected	3,046	3,065	3,082	2,970	**12,163**	**14,181**	**86**
		Denominator: Estimated number of TB cases expected	4,833	4,867	4,867	4,867	**19,434**	**20,259**	
		Numerator/ Denominator (in percentage)	**63%**	**63%**	**63%**	**61%**	**63%**	**70%**	**89**
27	**TB:** Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	5	10	16	15	**46**	**60**	**77**
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	10	23	19	19	**19**	**0**	
29	**Percentage of PEPFAR-supported**	***Percent =(Num/Den)x100***	85%	98%	100%	100%	**100%**		

	sites achieving 90% ARV or ART coverage for HIV+ pregnant women	***Numerator:*** Number of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	44	51	52	69	69		
		Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	52	52	52	69	69		
30	**Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results) (DSD)**	Percent =(Num/Den)x100	79%	74%	81%	77%	80%	86%	**93**
		Numerator: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	4,617	4,649	4,735	4,777	18,778	17,722	**106**
		Denominator: Number of new ANC and L&D clients	5,812	6,022	5,787	5,904	23,525	20605	
31	**Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)**	***Percent =(Num/Den)x100***	241%	100%	132%	128%	147%	84	**174**
		Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	89	59	64	42	254	152	**167**
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	37	46	35	55	173	180	
32	**Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (DSD)**	Number of female sex workers (FSW) reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	0	0	0	0	0	60	
33	**Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (DSD)**	Number of individuals who received T&C services for HIV and received their test results during the reporting period	8,019	11,636	9,676	9,880	39,211	30,330	**129**

34	**"Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)**	Number of HIV positive adults and children (aggregated by age/sex : female, male , <15 and <15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	245	358	483	296	1,382	696	**199**
35	**Number of HIV-positive adults and children receiving a minimum of one clinical service (DSD)**	Number of HIV-positive adults and children –aggregated by age/sex , female, male , <15 and > 15) in the reporting period receiving a minimum of one clinical service (DSD)	282	299	206	202	989	696	**142**
36	**TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting**	***Percent =(Num/Den)x100***	23%	2%	14%	12%	19%	90%	**142**
		Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	86	44	80	152	362	623	**58**
		Denominator: Number of patient HIV-positive	371	375	611	505	1,862	696	
37	**Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD)**	Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD) (aggregated by age/sex , female, male , <15 and >15) in the reporting period	5	13	19	26	63	175	**36**
38	**Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load**	Number of HIV-infected adults and children newly enrolled in clinical care (aggregated by age/sex , female, male , <15 and >15) during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	240	356	481	292	1,369		
39	**Proportion of registered TB cases who are HIV-positive who are on ART**	***Percent =(Num/Den)x100***	67%	100%	71%	78%	57%		
		Numerator: The number of registered TB cases with documented HIV-positive status who start or continue ART during the reporting period	2	7	46	51	106		

		Denominator: The number of registered TB cases with documented HIV-positive status during the reporting period	3	9	55	118	185		
40	**Percentage of laboratories and POC testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program**	***Percent =(Num/Den)x100***	100%	100%	100%	100%	100%	61%	
		Number of PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing on HIV serologic/diagnostic testing , CD4, EID and TB diagnostic	52	52	52	69	69	38	182
		Denominator : Total number of laboratories and testing sites	52	52	52	69	69	62	
41	**Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation**	Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation aggregated by site support type (DSD and TA)	1	1	1	1	1	1	100
42	**Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services**	***Percent =(Num/Den)x100***	100%	100%	100%	100%	100%	61%	
		Numerator: Number of service delivery points supported by PEPFAR for HIV services that are directly providing integrated voluntary family planning services	52	52	52	69	69	38	182
		Denominator: Total number of PEPFAR-supported HIV service delivery points	52	52	52	69	69	62	
IR 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									
43	***L+M+G:** % of general reference hospitals GRHs implementing complementary package of activities	Numerator: # of GRHs implementing CPA	69	72	71	71	71	55	129

	CPA	Denominator: Total # of GRHs	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**86%**	**90%**	**91%**	**91%**	91%	71%	**129**
44	***L+M+G:** % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	21	23	21	21	21	23	**91**
		Denominator: Total # of GRHs	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**26%**	**29%**	**27%**	**27%**	27%	29%	**90**
45	***L+M+G:** % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	1,346	1,388	1,360	1,382	1,382	979	**141**
		Denominator: Total # of health centers	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**95%**	**97%**	**95%**	**99%**	99%	70%	**141**
46	***L+M+G:** % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	106	119	118	120	120	419	**29**
		Denominator: Total # of health centers	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**7%**	**8%**	**8%**	**9%**	9%	30%	**28**
47	**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/	71,668	71,379	82,875	91,665	317,588	459,208	**69**
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	128,878	129,787	126,409	126,409	511,483	540,244	
		Numerator/ Denominator (in percentage)	**56%**	**55%**	**66%**	**73%**	62%	85%	**73**

48	**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	301	561	506	260	260	100	**260**
49	**MALARIA:** Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	0	0	0	0	0	455,000	
50	**MALARIA:** Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	18,210	3,008	1,340	3,600	26,158	455,000	**6**
50.1		*(a) through campaigns*	0	0	0	0	0		
50.2		*(b) through health facilities*	18,210	3,008	1,340	3,600	26,158	455,000	**6**
50.3		*(c) through the private/commercial sector*	0	0	0	0	0		
50.4		*(d) through other distribution channels*	0	0	0	0	0		
50.5		*(e) through voucher schemes*	0	0	0	0	0		
51	**MALARIA:** Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female)	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	46	124	653	537	1,360	1,750	**78**
		Male	40	112	585	455	1,192	1,167	**102**
		Female	6	12	68	82	168	583	**29**

52	**MALARIA:** Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	0	153,257	0	313,247	466,504	3,000,000	**16**
53	**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		
54	**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)	130,121	104,251	198,535	247,806	680,713	3,000,000	**23**
55	**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	46	124	653	537	1,360	2,350	**58**
56	**MALARIA:** Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	0	0	0	0	0	3,500,000	**0**
57	**MALARIA:** Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	543,180	567,418	569,525	458,918	2,139,041	2,500,000	**86**
57.1	Disaggregated in 3 sub-categories:	*(a) to health facilities*	546,506	564,601	566,818	458,192	2,136,117	2,440,204	**88**
57.2		*(b) to community health workers (HBMF, CCM)*	4,449	7,983	7,973	9,623	30,028	59,796	**50**
57.3		*(c) to the private/commercial sector*	0	0	0	0	0	0	
58	**MALARIA:** Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds Disaggregate in 3 sub-categories:	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	46	124	653	554	1,377	2,400	**57**

	(a) Number of health facility workers trained (male/female)	*Male*	40	112	410	455	1,017	1,167	**87**
		Female	6	12	59	82	159	583	**27**
	(b) Nombre d'agents communautaires formés (sexe masculin/sexe féminin)	*Male*	0	0	124	0	124	400	**31**
		Female	0	0	16	17	33	200	**17**
	(c) Nombre de techniciens de laboratoire formés (sexe masculin/sexe féminin)	*Male*	0	0	40	0	40	40	**100**
		Female	0	0	4	0	4	10	**40**
59	**MALARIA:** Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	0	0	0	0	0	4,000,000	**0**
60	**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	275,532	252,500	256,375	381,154	1,165,561	2,500,000	**47**
IR 1.2: Community-based health care services and products in target health zones increased									
61	***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/	1,252	1,299	1,305	1,295	1,288	1,398	**93**
		Denominator: Total # of communities in IHP target area	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/Denominator (in percentage)	**88%**	**91%**	**92%**	**93%**	92%	100%	**92**

62	**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)	21,244	8,032	135,631	67,724	**232,631**	**1,450,402**	**16**
63	**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)	24,296	41,500	60,610	107,830	**234,236**	**1,450,402**	**16**
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased									
64	***L+M+G:** % of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	Leadership Development Program (LDP) team made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas. Numerator: Number of HZ with leadership that has undergone LDP training	31	39	56	55	**55**	**78**	**71**
		Denominator: Total number of IHP health zones	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**39%**	**49%**	**72%**	**71%**	**71%**	**100%**	
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									
65	***L+M+G:** Percent of health zones (HZs) with validated action plans	Numerator: # HZ with validated actions plans	77	42	58	59	**59**	**78**	**76**
		Denominator: Total # HZs in IHP target area	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**96%**	**53%**	**74%**	**76%**	**76%**	**100%**	**76**

65.1	***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)	791	1,009	968	1,050	**954**	**1,258**	**76**
		Denominator: Total number of health centers in IHP areas	1,419	1,425	1,425	1,398	**1,398**	**1,398**	
		Numerator/ Denominator (in percentage)	**56%**	**71%**	**68%**	**75%**	**68%**	**90%**	**76**
65.2	***L+M+G:** Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies (Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	60	64	71	68	**66**	**70**	**94**
		Denominator: Total number of hospitals in IHP areas	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**75%**	**80%**	**91%**	**88%**	**84%**	**90%**	**94**
66	**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	0	0	0	93	**93**	**200**	**47**
67	**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	1,253	912	905	2,300	**5,370**	**4,000**	**134**

68	**GENDER:** # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	0	12	0	199	211	16	**1,319**
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted									
69	***L+M+G:** % of health centers meeting all nine FOSACOF minimum standards, disaggregated by type of health facility (Please create another row for hospitals with same indicator)	Numerator: # of health centers meeting all nine FOSACOF minimum standards	605	605	649	716	716	690	**104**
		Denominator: Total # of facilities	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**43%**	**42%**	**46%**	**51%**	51%	49%	**104**
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized									
70	% 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	3,676	4,525	3,783	7,991	19,975	42,257	**47**
		Denominator: Total # of patients seen by a CHW	16,233	15,641	16,242	24,386	72,502		
		Numerator/ Denominator (in percentage)	**23%**	**29%**	**23%**	**33%**	28%		
71	% 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	54,173	52,619	51,206	55,790	213,788	44,069	**485**
		Denominator: Total number of patients seen by a CHW or health care provider	1,353,946	1,394,708	1,363,291	1,346,053	5,457,998	3,348,028	
		Numerator/ Denominator (in percentage)	**4.0%**	**3.8%**	**3.8%**	**4.1%**	4%	1.3%	**298**
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									
72	***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	130	109	106	79	79	N/A	

		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	144	206	268	309	309	N/A	
		Numerator/ Denominator (in percentage)	**90%**	**53%**	**40%**	**26%**	26%	**20**	**128**
73	***L+M+G:** # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	0	0	2	7	9	**16**	
74	***L+M+G:** # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	0	0	2	4	6	**26**	**23**
75	***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	130	132	106	143	143	**120**	
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched									
76	**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	841	1,080	1,113	1,265	1,075	**1,038**	**104**
77	**BCC:** # of educational SMS messages during BCC campaigns or mini campaigns on malaria, nutrition and/or family planning	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	59,244	96,524	110,700	102,812	369,280	**480,000**	**77**
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									
78	***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")	79	49	51	62	62	**78**	**79**
		Denominator: Total # of health zones	80	80	78	78	78	**78**	
		Numerator/ Denominator (in percentage)	**99%**	**61%**	**65%**	**79%**	79%	**100%**	

79	***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	60	65	43	48	48	78	**62**
		Denominator: Total # of health zones	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**75%**	**81%**	**55%**	**62%**	1	100%	**62**
Project Management									
80	**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.)	6	10	8	8	32	30	**107**

SANRU

MEMORANDUM D'ENTENTE POUR LE PRET DES TDR (test de diagnostic rapide) DE LUTTE CONTRE LE PALUDISME DANS LES ZONES DE SANTE DU KATANGA et DE LA PROVINCE ORIENTALE

SIGNE ENTRE SANRU asbl, LE PROJET DE SANTE INTEGRE (PROSANI) et le PROJET PMI-EXPANSION.

AOUT 2014

nak

ENTRE:

1. D'une part l'ASBL SOINS DE SANTE PRIMAIRE EN MILIEU RURAL, en sigle "SANRU asbl", agissant dans le cadre du projet Fonds Mondial de lutte contre le SIDA et le paludisme, dont les bureaux sont établis à KINSHASA, 76 avenue de la justice, dans la commune de la GOMBE, ici représenté par Dr. GOMA MIEZI KINTAUDI, Directeur Exécutif, ci-après dénommée "SANRUasbl" :

ET d'autre part:

2. Le projet de sante intégré (PROSANI), mis en œuvre par Management science for Heath(MSH) finance par l'USAID, dont la représentation en RDC est établie au 8-avenue des citronniers, à KINSHASA-GOMBE, représenté par Dr OUSMANE FAYE, chef de projet, ci-après dénommé "PROJET PROSANI/USAID".

3. Et le projet PMI-Expansion, dont la représentation en RDC est établie au 4630, avenue de la science, à KINSHASA-GOMBE, représenté par Dr. Louis AKULAYI, chef de projet.

SANRU asbl , PROSANI et PMI-expansion étant collectivement appelées « parties ».

Considérant :

La nécessité urgente de faire face au cas de rupture de stock en test de diagnostic rapide (TDR) dans les les zones de santé de la province de KATANGA et de la province orientale.

La requête des prêts de TDR formulée par l'USAID/PMI pour le compte de son projet de sante intégré en date du 28 juin 2014 et appuyée par le programme national de lutte contre le paludisme et dont la désignation et les quantités sont contenues dans ladite requête.

AINSI, IL A ETE CONVENU ET ARRETE CE QUI SUIT :

Article 1 :

Sur demande et recommandation du PNLP, SANRU asbl prête au projet PROSANI /USAID une quantité de 11600 kits de 25 TDR (test de dépistage rapide) dont la répartition est reprise dans le tableau que voici :

Kalemie	Kamina	Kolwezi	Kisangani	TOTAL
1 400	3 600	1 600	5 000	11 600

MK

Article 2 :

Les intrants CIF dédouanés par USAID/PMI seront livres dans le dépôt SANRU asbl de KINSHASA au plus tard au dernier trimestre de l'an 2014.

FAIT A KINSHASA, le

Pour et au nom de PROSANI OUSMANE FAYE COP PROSANI	Pour et au nom de SANRU asbl NGOMA MIEZI KINTAUDI Directeur Exécutif	Pour et au nom de PMI-Exp Louis AKULAYI COP
DATE : 20/10/2014	DATE : 21/10/2014	DATE : 20/10/14

Appendix 6: Fistula Care Data PY4Q4

Hospital	Period	Age				Etiology							Diagnostic																				Results		
		Under 20 years	20 - 35 years	35 - 45 years	Over 45 years	Others	Home Birth	Curettage	Difficult labor at health center	C-section	Post-operation	Other trauma	FVV	FVV Récidive + Incontinence	FUVV	FRV	FVVR1	FVVR2	FVVR3	FUVVR3	FVVR4	FVVR5	FCV	FUVR1	FUVR2	FRVR2	FRVR3	Incontinence	Incontinence Récidive	Incontinence Urinaire Résiduelle	Rupture Uréthrale	Unsuccessful reparation	Successful reparation	Death
KAZIBA	PY4Q1	3	35	13	9	10	22	0	27	0	0	0	27	1	6	4	1	1	3	0	1	1	0	0	0	1	1	9	1	3	0	14	46	0
	PY4Q2	4	31	11	14	11	21	0	36	0	0	0	36	0	10	3	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	11	49	0
	PY4Q3	1	36	11	12	11	16	0	31	0	0	0	31	0	12	5	0	0	1	0	0	0	0	0	0	0	0	10	0	0	0	12	48	0
	PY4Q4	2	34	14	10	13	21	0	34	0	0	0	34	4	6	5	0	1	0	0	0	0	0	0	0	0	0	11	0	0	0	9	51	**0**
	PY4 Total	10	136	49	45	45	80	0	128	0	0	0	128	5	34	17	1	2	4	0	1	1	0	0	0	1	1	41	1	3	0	46	194	**0**

APPENDIX 7: Accruals Report, July to September 2014

USAID/DRC
Financial Management Office
Accruals Worksheet for the period
July 1, 2014 - September 30, 2014

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

Vendor: MANAGEMENT SCIENCES FOR HEALTH, INC

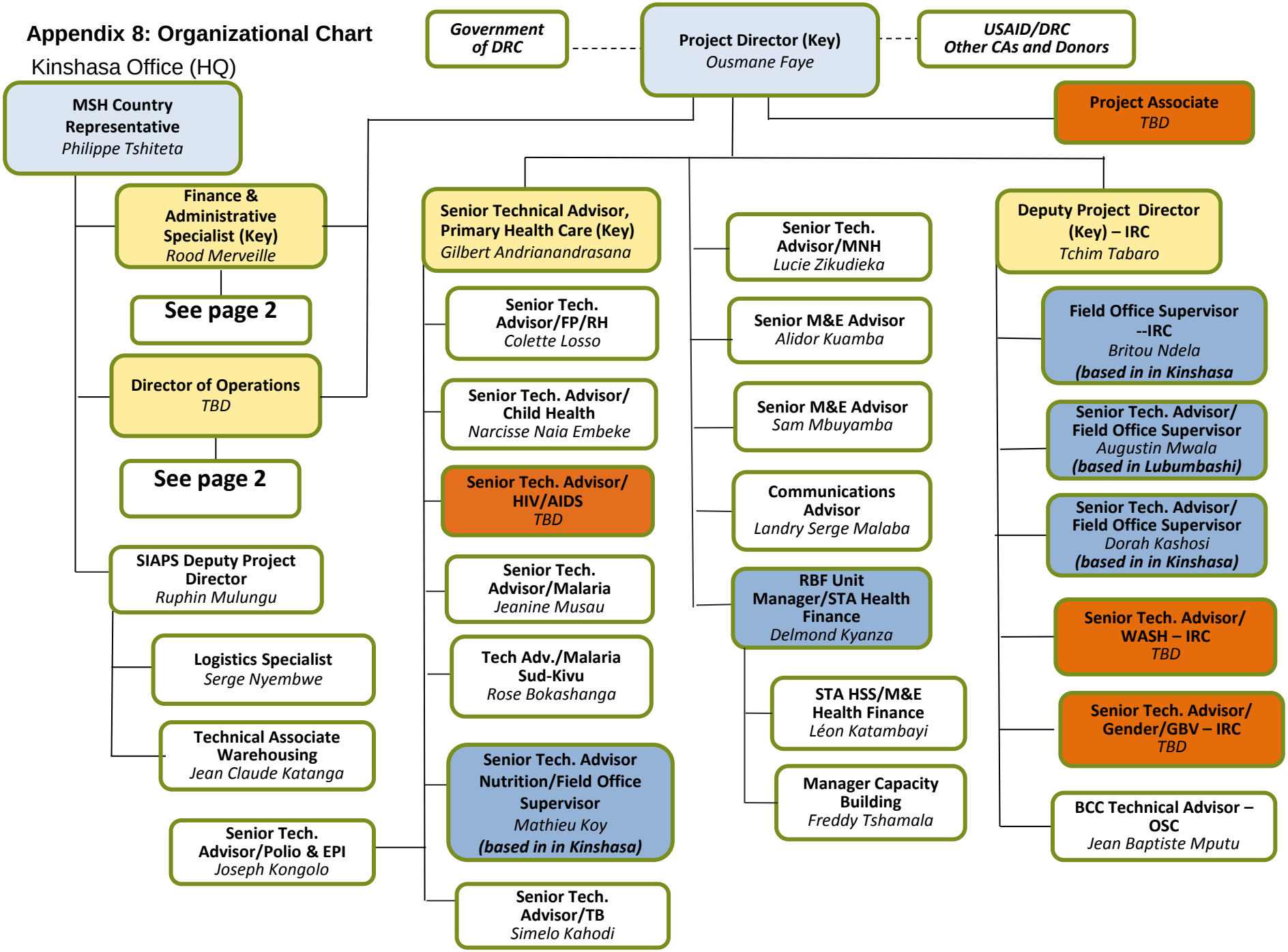
RFA OAA-10-000006

			A	B	C	D	E	F= (C + D+ E)	G = B - F	H=A-F
Program Area	**Program Element**	**BFY Fund**	**Estimated LOP Budget**	**Obligations**	**Disbursements (Oct 2010 - June 2014)**	**Quarter 3 - Disbursement (July-September 2014)**	**Quarter 3 Accruals (September 2014)**	**Project Total to Date (including accrual)**	**Obligations remaining (Pipeline)**	**Estimated Balance**
A11	A047- HIV/AIDS	GH-AIDS/2010/201	$ 14,743,405.00	$ 7,669,613.00	$ 7,263,332.05	$ 135,342.31	$ 202,180.73	$ 7,600,855.10	$68,757.90	$ 7,142,549.90
A11	A048 - TB	GH-C/2010/2011	$ 17,286,763.00	$ 12,866,667.00	$ 10,958,366.89	$ 432,020.84	$ 1,150,734.83	$ 12,541,122.56	$325,544.44	$ 4,745,640.44
A11	A049 - Malaria	GH-C/20102011	$ 20,245,000.00	$ 17,344,982.33	$ 14,503,355.57	$ 640,662.66	$ 1,513,122.20	$ 16,657,140.43	$687,841.90	$ 3,587,859.57
A11	A052- MCH	GH-C/20102011	$ 45,731,306.00	$ 52,458,614.83	$ 36,988,492.10	$ 2,425,741.08	$ 4,707,077.17	$ 44,121,310.35	$8,337,304.48	$ 1,609,995.65
A11	A053 - FP/RH	GH-C-POP/2010/201	$ 20,625,615.00	$ 15,958,948.00	$ 14,050,276.80	$ 599,126.10	$ 1,302,188.74	$ 15,951,591.63	$7,356.37	$ 4,674,023.37
A11	A054 - WASH	ES/2010/2011	$ 12,610,800.00	$ 11,725,018.67	$ 8,912,513.77	$ 407,147.65	$ 956,716.40	$ 10,276,377.82	$1,448,640.85	$ 2,334,422.18
A11	A142- Nutrition	GH-C-GFSI/2010/201	$ 8,524,240.00	$ 5,590,229.80	$ 4,947,465.77	$ 260,557.44	$ 254,412.58	$ 5,462,435.79	$127,794.01	$ 3,061,804.21
Grand Total			$ 139,767,129.00	$ 123,614,073.63	$ 97,623,802.95	$ 4,900,598.08	$ 10,086,432.66	$ 112,610,833.69	$11,003,239.94	$ 27,156,295.31

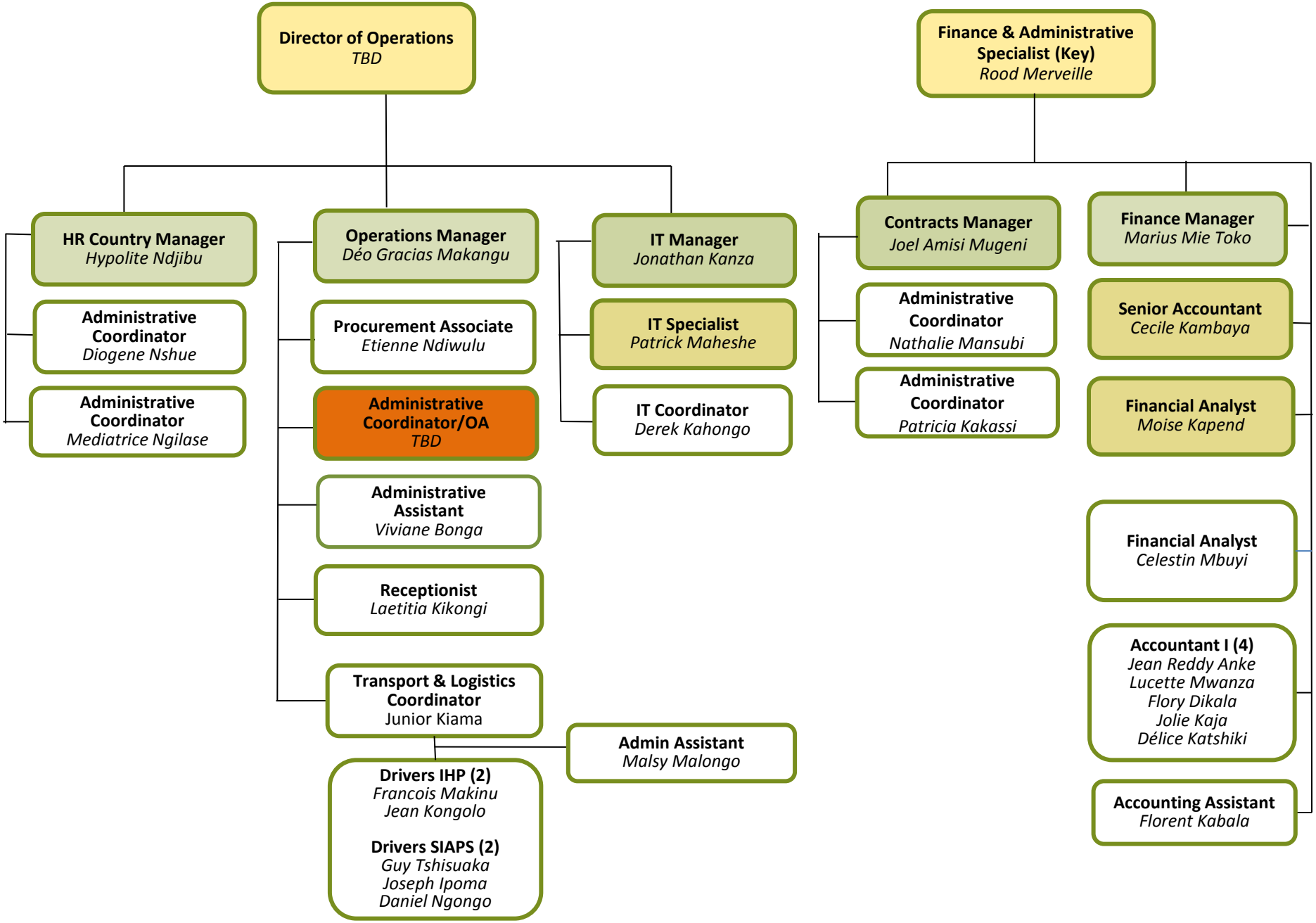
Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal.

Appendix 8: Organizational Chart

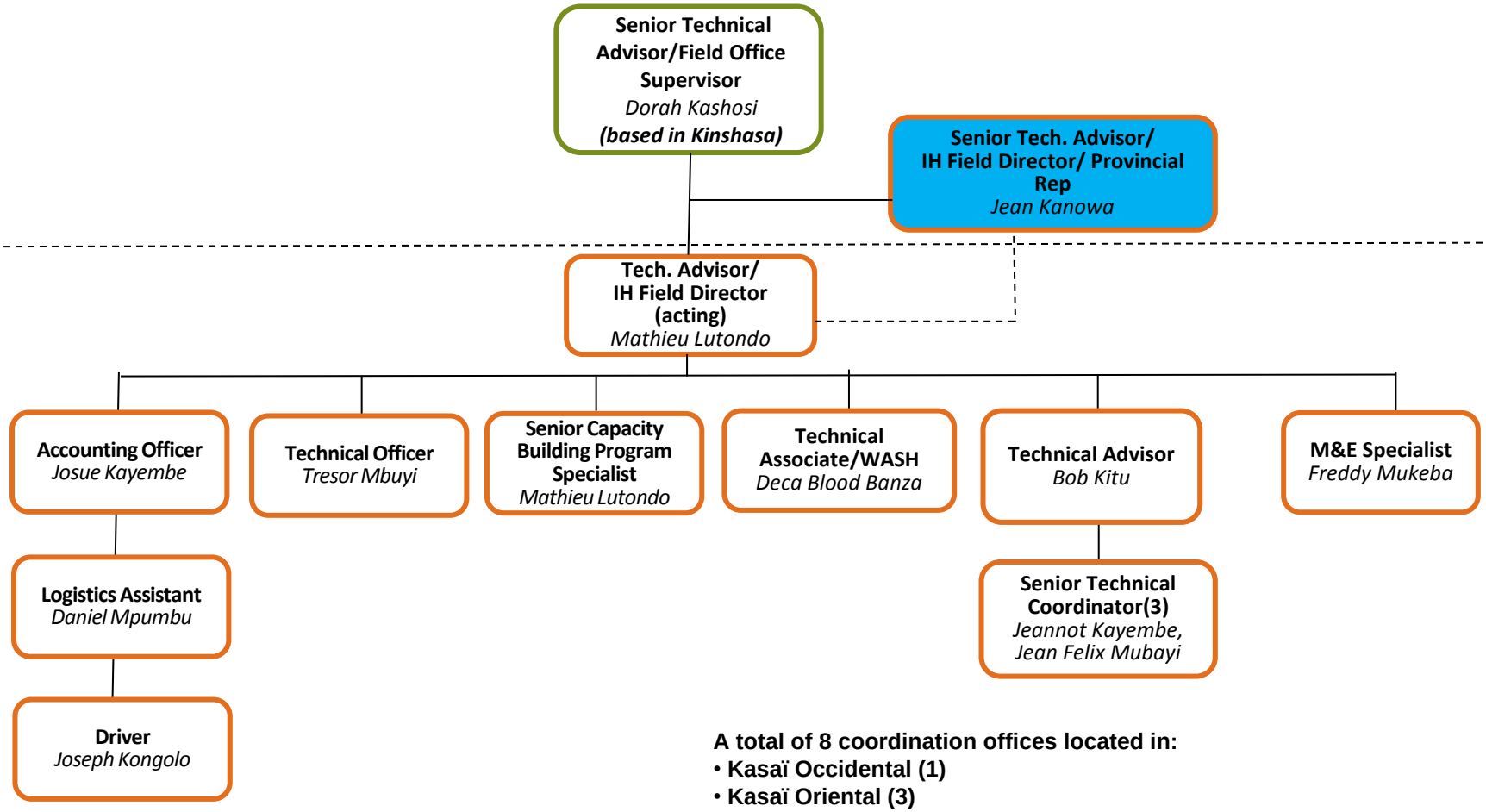
Kinshasa Office (HQ)



Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasaï Occidental

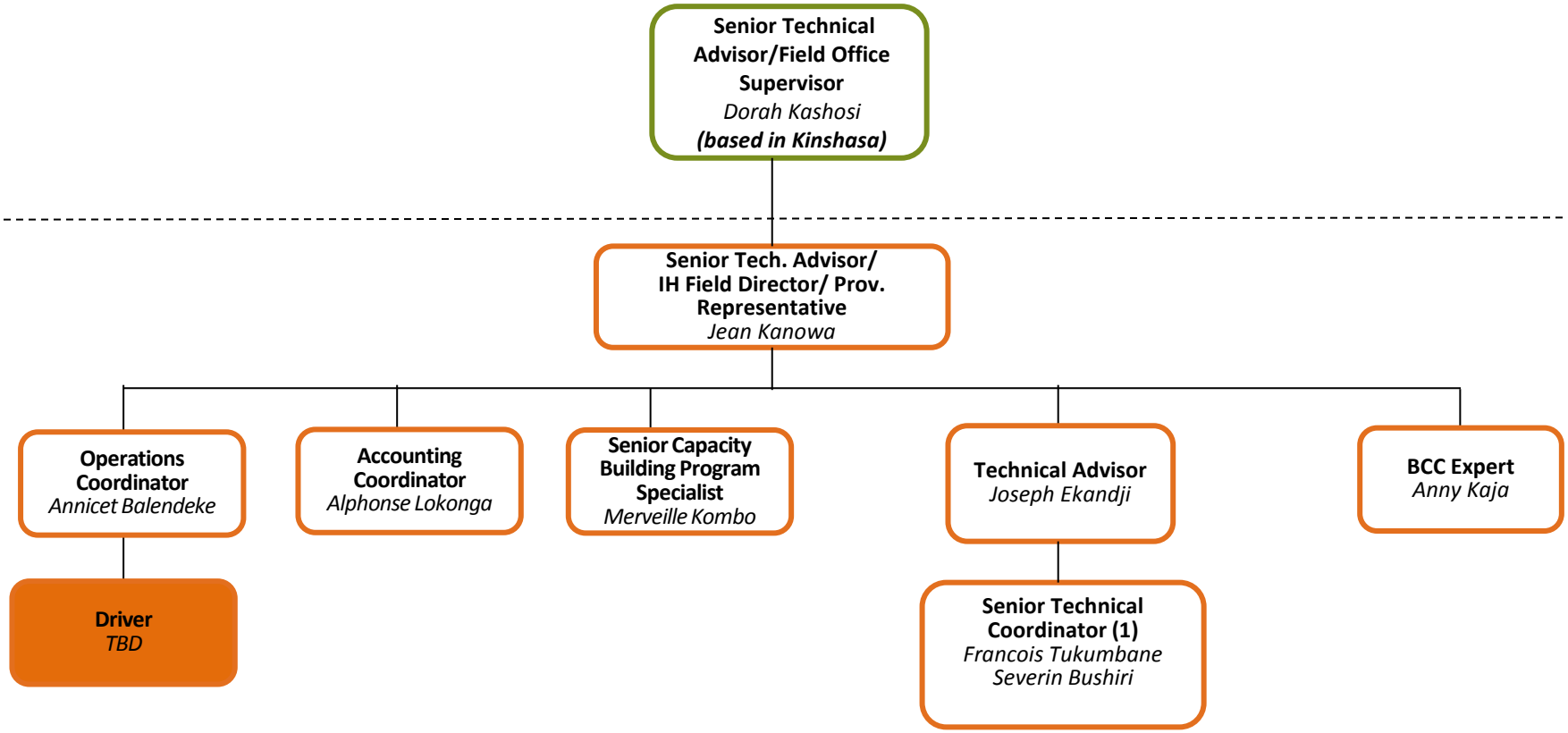


A total of 8 coordination offices located in:

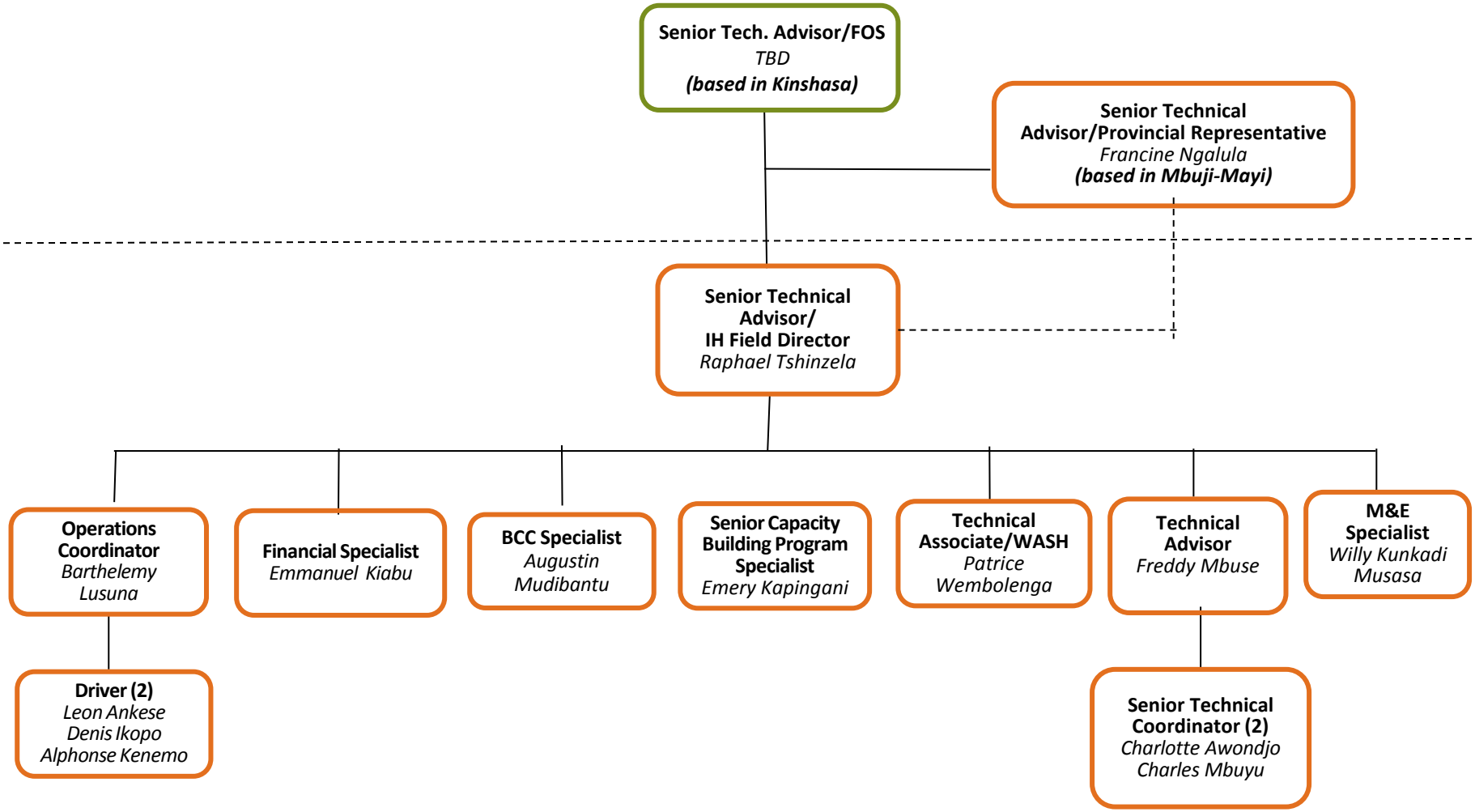
- **Kasaï Occidental (1)**
- **Kasaï Oriental (3)**
- **Katanga (2)**
- **Sud Kivu (2)**

Three satellite offices are located in Mbuji Mayi, Kananga and Lubumbashi, mainly for provincial representation purposes. The Bukavu field office also hosts the provincial representation for Sud Kivu.

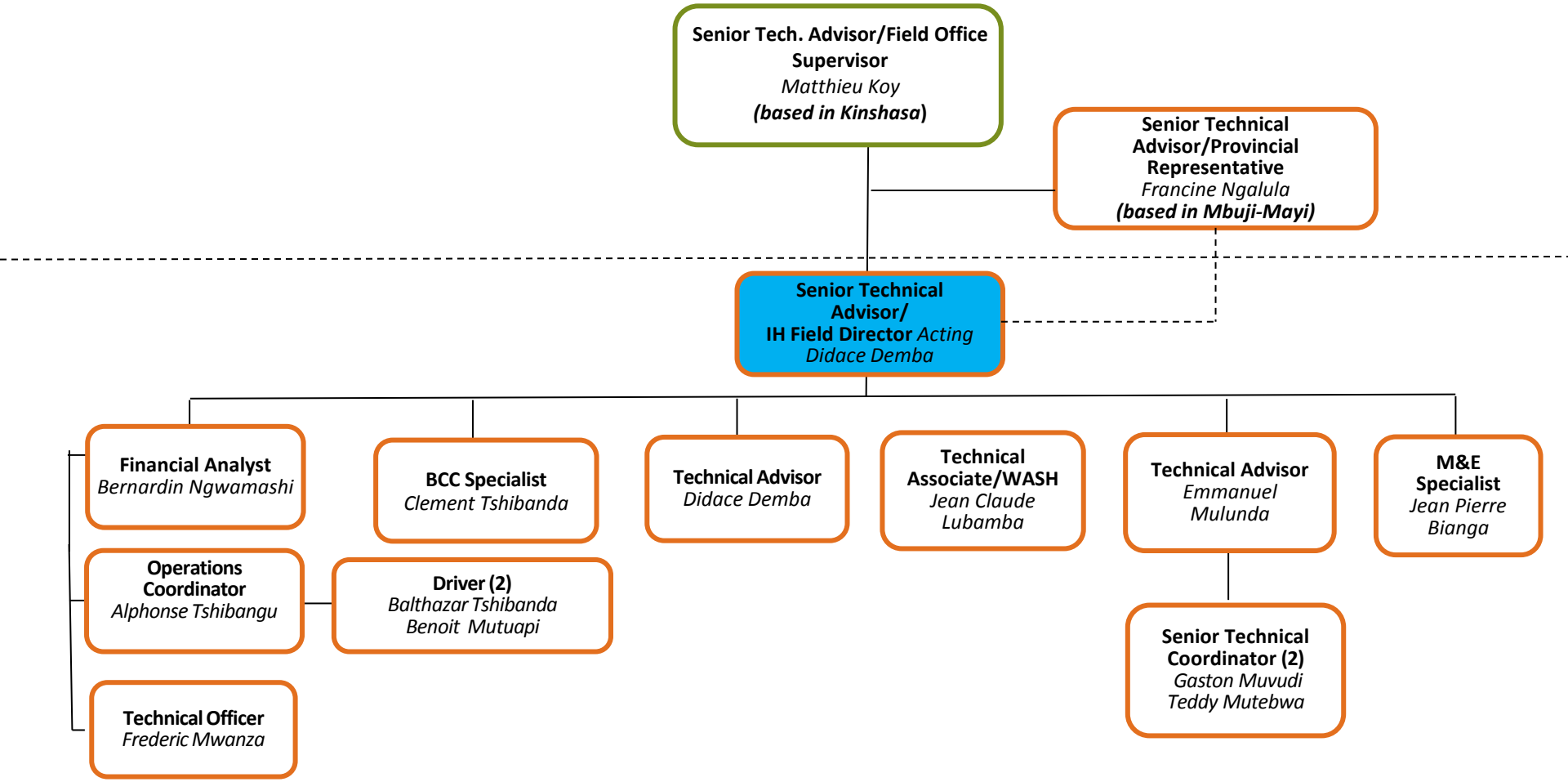
IHP Field Office: Kananga, Kasaï Occidental



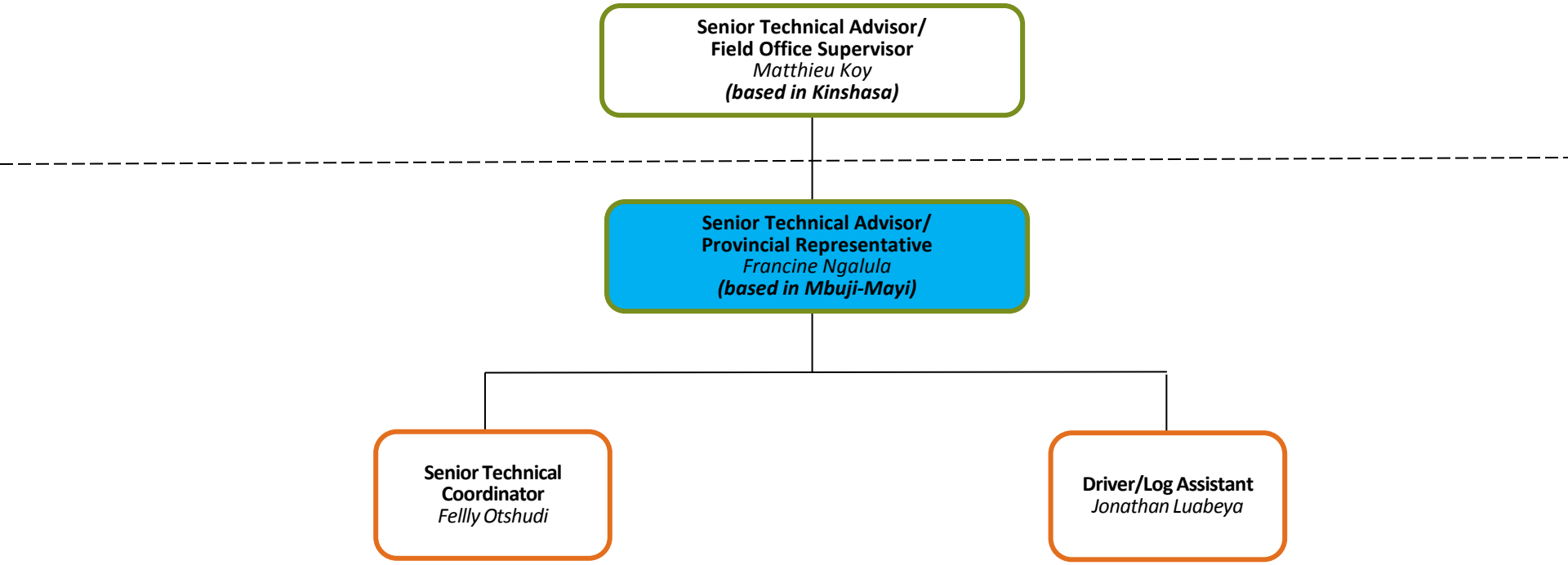
IHP Field Office: Kole (Lodja), Kasaï Oriental



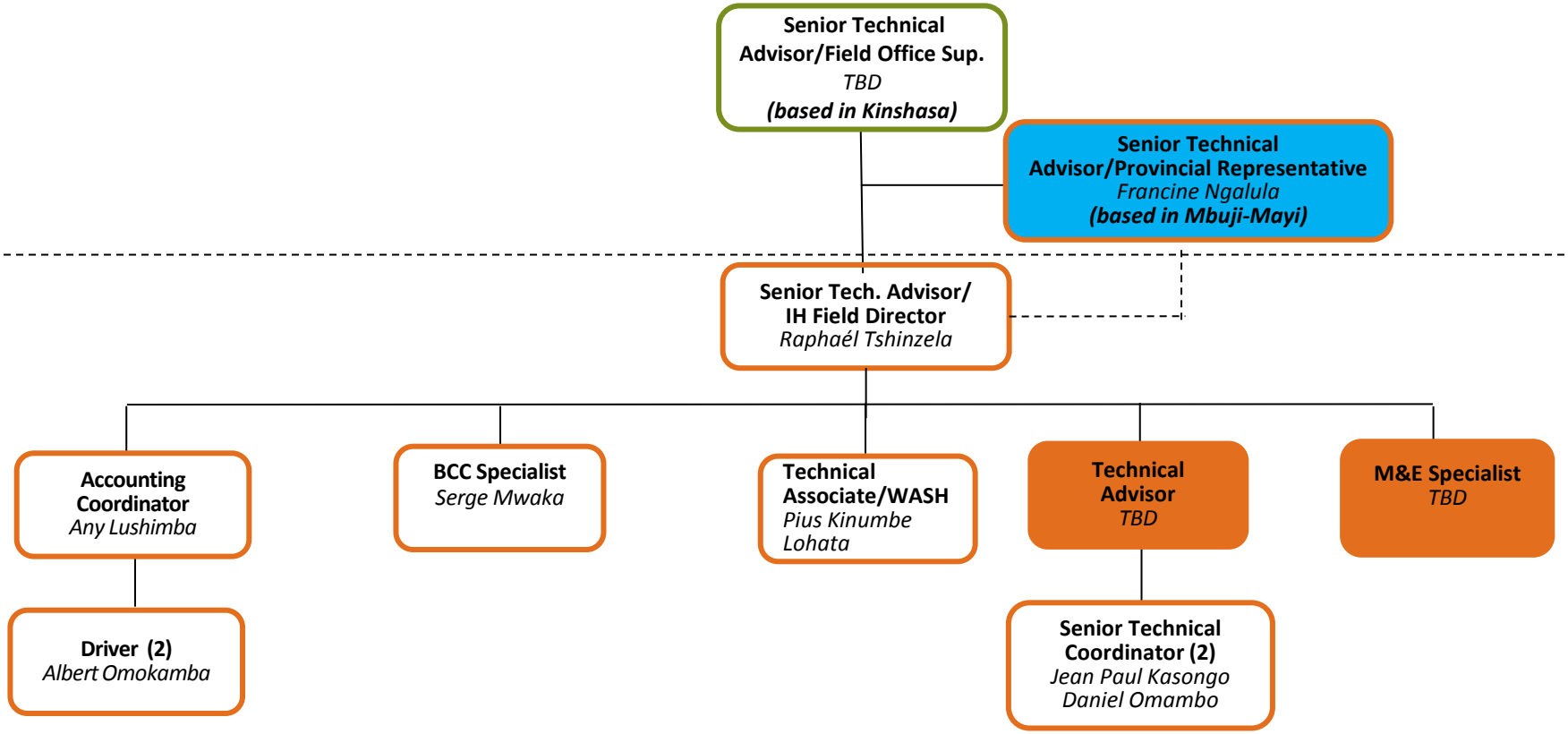
IHP Field Office: Mwene-Ditu, Kasaï Oriental



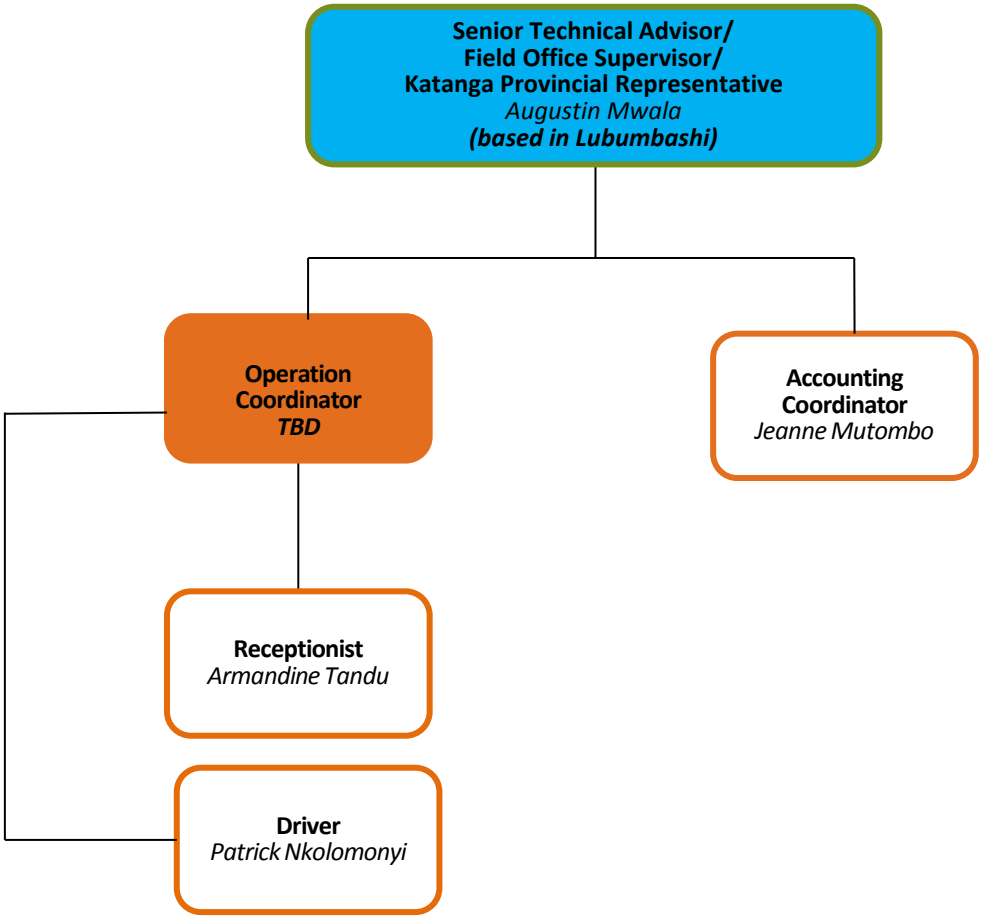
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



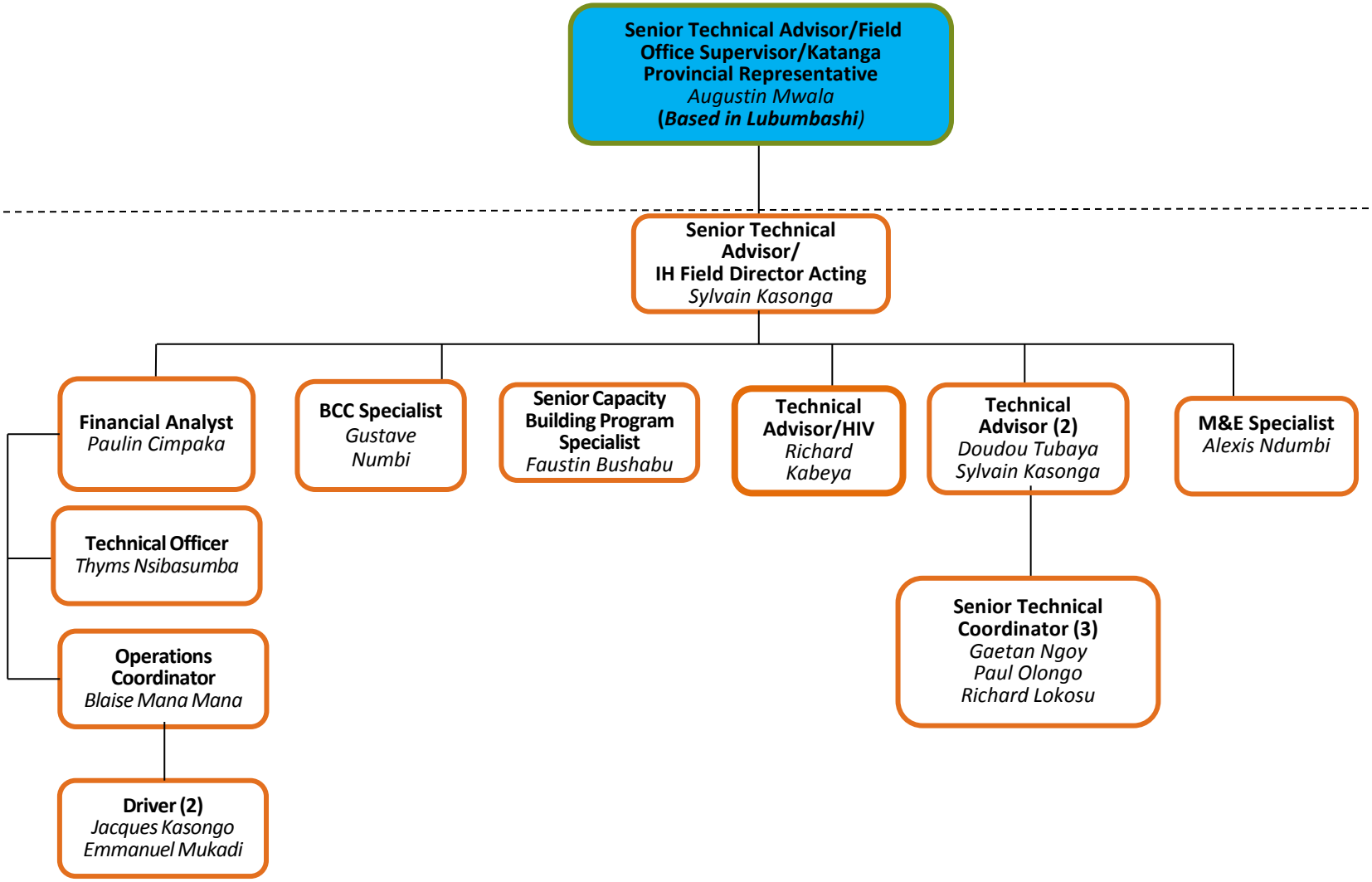
IHP Field Office: Tshumbe, Kasaï Oriental



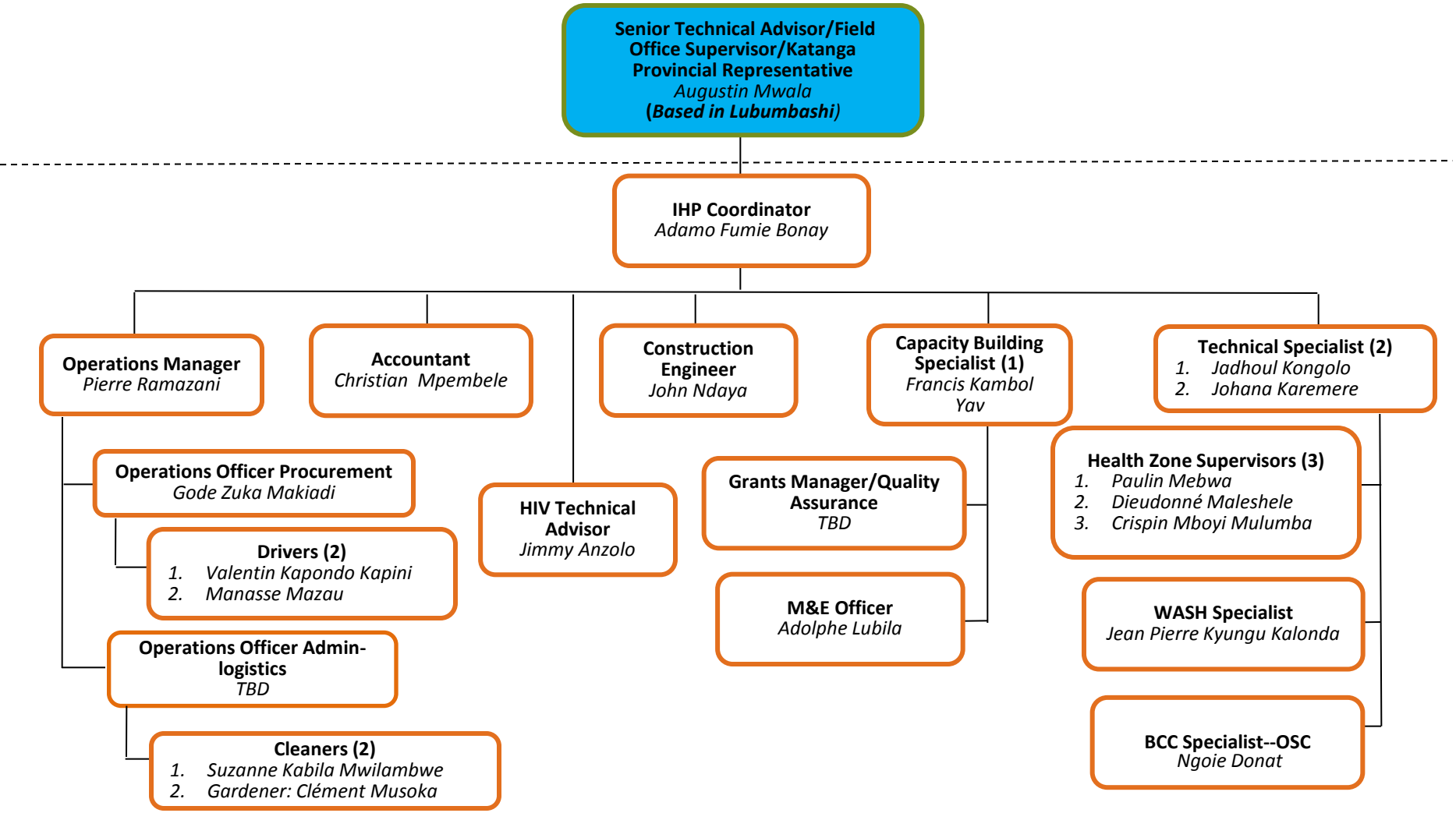
IHP Field Satellite Office: Lubumbashi, Katanga



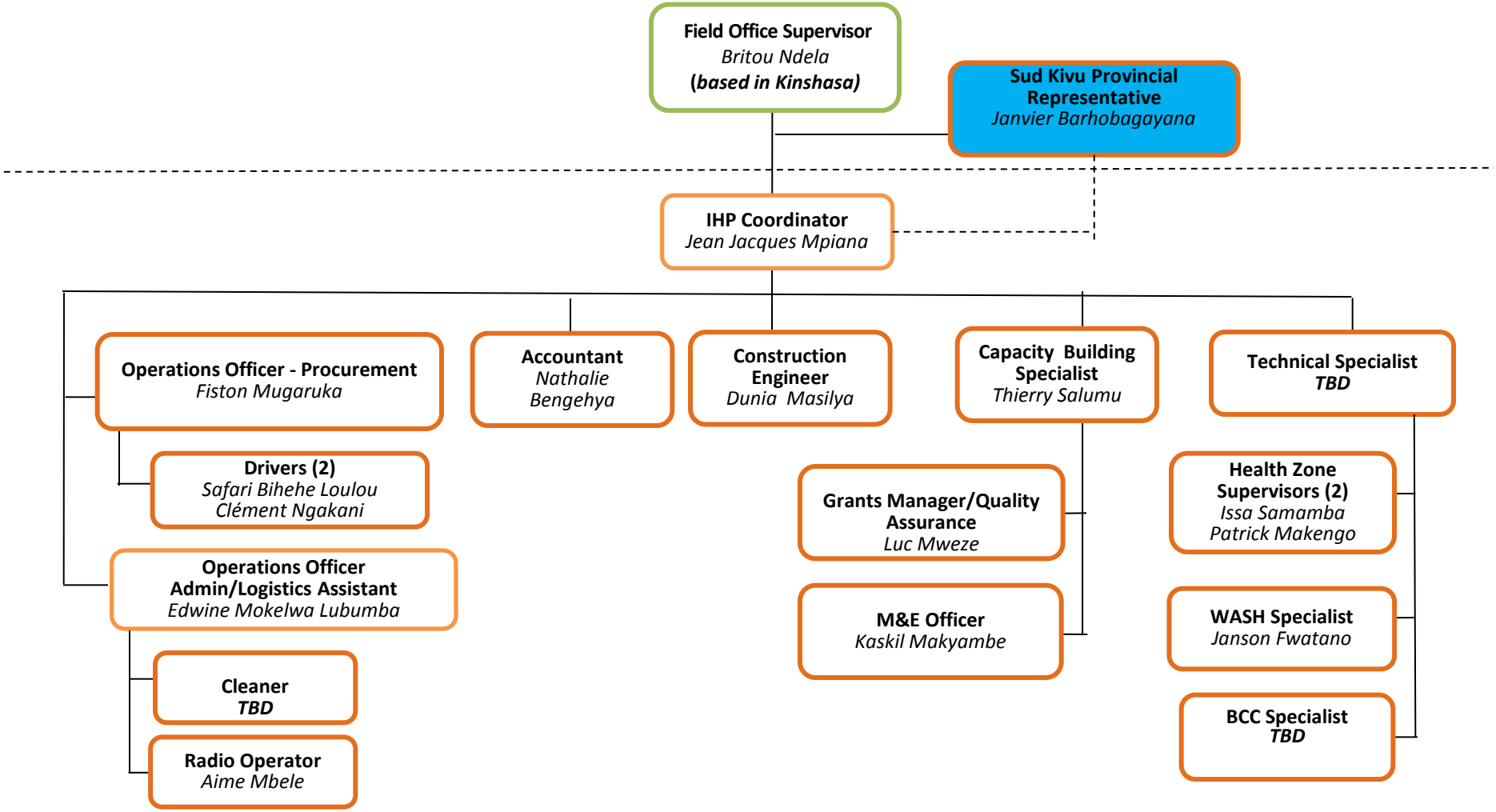
IHP Field Office: Kamina, Katanga



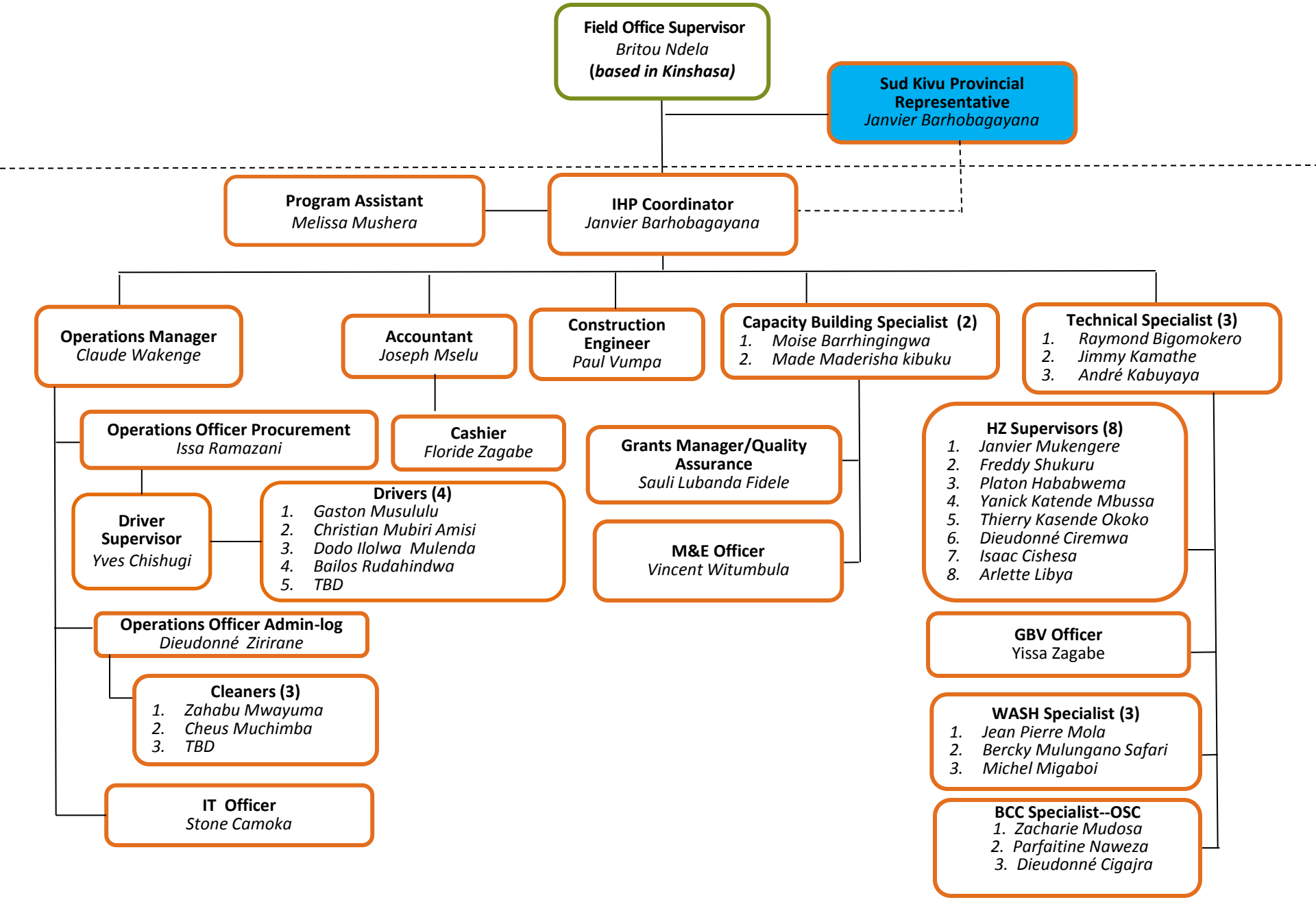
IHP Field Office: Kolwezi, Katanga



IHP Field Office: Uvira, Sud Kivu



IHP Field Office: Bukavu, Sud Kivu



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.
200 Rivers Edge Drive, Medford, MA 02155
United States

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	09/30/2014

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	$102,893,689.00
b. Cash Disbursements	$102,524,457.45
c. Cash on Hand (line a minus b)	$369,231.55
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$123,614,073.63
e. Federal share of expenditures	$102,524,457.45
f. Federal share of unliquidated obligations	$0.00
g. Total Federal share (sum of lines e and f)	$102,524,457.45
h. Unobligated balance of Federal funds (line d minus g)	$21,089,616.18
Recipient Share:	
i. Total recipient share required	$4,193,013.88
j. Recipient share of expenditures	$3,213,548.15
k. Remaining recipient share to be provided (line i minus j)	$979,465.73
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%	07/01/2014	09/30/2014	166,980.74	135,254.40	100%
	Local Proff	40%	07/01/2014	09/30/2014	839,252.25	335,700.90	100%
	Consultants	40%	07/01/2014	09/30/2014	26,750.00	10,700.00	100%
				g. Totals:	$ 1,514,638.29		

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, Sr Treasury Mgr	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) 10/30/2014
	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

Integrated Health Project

in the Democratic Republic of Congo

DRC-IHP Quarterly/Annual Report: Year 4 (October 2013 to September 2014)
USAID Cooperative Agreement Number: AID-OAA-A-10-00054
Submitted to USAID/DRC on November 17, 2014
Final version March 11, 2015

Cover photo: Children in Mwene Ditu.

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

Contact information in DRC:
Avenue des Citronniers, No. 4, Commune Gombe, Kinshasa
Chief of Party: Dr. Ousmane Faye, +243 0992006180

Contact information in the U.S:
200 Rivers Edge Drive Medford, MA 02155
Director, Country Portfolio: Kristin Cooney, Tel: +1 617-250-9168

TABLE OF CONTENTS

TABLE OF CONTENTS 3
ACRONYMS 4
EXECUTIVE SUMMARY 6
PROJECT PERFORMANCE 10
Component 1: Health Services 10
INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MPA-PLUS AND CPA-PLUS SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED 10
INTERMEDIATE RESULT 2: QUALITY OF KEY FAMILY HEALTH CARE SERVICES IN TARGET HEALTH ZONES INCREASED 23
INTERMEDIATE RESULT 3: KNOWLEDGE, ATTITUDES, AND PRACTICES TO SUPPORT HEALTH-SEEKING BEHAVIORS 53
Component 2: Health Systems Strengthening 61
INTERMEDIATE RESULT 4: HEALTH SECTOR LEADERSHIP AND GOVERNANCE IN TARGET PROVINCES IMPROVED 61
PROJECT MANAGEMENT 63
FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS 64
ENVIRONMENTAL MONITORING AND MITIGATION PLAN 65
CHALLENGES ENCOUNTERED 66
PLANNED ACTIVITIES FOR NEXT QUARTER 68
LIST OF APPENDICES 69
SUCCESS STORIES 70

ACRONYMS

AB	Advisory Board
ACT	Artemisinin-based Combination Therapy
AMTSL	Active Management of Third Stage Labor
AOP	Annual Operational Plan
ARV	Antiretroviral
BCC	Behavior Change Communication
CBD	Community-based distribution or community-based distributor
CCM	Community Case Management
i-CCM	Integrated Community Case Management
CHW	Community Health Worker
C-IMCI	Community Based Integrated Management of Childhood Illness
CODESA	*Comité de Développement Sanitaire* (health development committee)
CDR	*Centrale de Distribution Régionale* (regional distribution center)
CPA	Complementary Package of Activities
CPLT	Provincial coordination unit for leprosy and TB
CLTS	Community-Led Total Sanitation
CST	*Centre de Santé de Traitement*
CSDT	*Centre de Santé de Diagnostic et Traitement*
CUG	Closed User Group
DTP	Diphtheria, Tetanus, Pertussis
DPS	*Division Provinciale de la Santé*
DQS	Data Quality Self-Assessment
DRC	Democratic Republic of the Congo
EONC	Emergency Obstetric and Newborn Care
ENA	Essential Nutrition Actions
EPI	Expanded Programme on Immunization (see PEV)
ETL	Education through Listening
FEFOL	Iron/Folic Acid
FFSDP	Fully Functional Service Delivery Point (see FOSACOF)
FOSACOF	*Formation Sanitaire Complètement Fonctionnelle* (Fully Functional Service Delivery Point)
FOSA	*Formation Sanitaire* (health facility)
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GRH	General Referral Hospital
HBB	Helping Babies Breathe
HPP	Health for Poorest Populations Project
HIV	Human Immunodeficiency Virus
HZ	Health Zone
HZMT	Health Zone Management Team
IDA	International Dispensary Association
IHP	Integrated Health Project
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent preventive treatment (of malaria) in pregnancy
IRC	International Rescue Committee
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	Multidrug-Resistant Tuberculosis
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child Health
MIP	Provincial Medical Inspector
MPA	Minimum Package of Activities
MPT+	Microscopy Positive Pulmonary TB
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OSC	Overseas Strategic Consulting, Ltd.
PBF	Performance-Based Financing (see RBF)
PEPFAR	President's Emergency Plan for AIDS Relief
PEV	*Programme élargi de vaccination* (see EPI)
PIP	Provincial Pharmaceutical Inspector
PIRTS	Performance Indicator Reference and Tracking Sheets
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan

PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-natal Consultation
PNCPS	National Health Communication Program
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	National Malaria Control Program
PNLS	National AIDS Program
PNLT	National TB Program
PNPCS	National Health Communication Program
PNSR	National Reproductive Health Program
PPMR	Procurement Planning and Monitoring Report
PRONANUT	National Nutrition Program
RBF	Results-Based Financing
RDT	Rapid diagnostic tests
SANRU	*Santé Rural* (the medical office of the Congolese Church of Christ)
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SNIS	National health information system
SP	Sulfadoxine-Pyrimethamine
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
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

This report covers the fourth quarter reporting period (July to September 2014) of year four of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). This report also serves as the project's year four annual report.

Implemented by Management Sciences for Health, the International Rescue Committee, and Overseas Strategic Consulting, Ltd (hereafter referred to respectively as MSH, IRC, and OSC), the five-year project (October 2010-September 2015) supports the DRC National Health Development Program. IHP has two components – "Services" and "Other Health Systems" – that are designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 78 (formerly 80)[1] target health zones in 4 of the DRC's 11 provinces: Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu.

The project currently provides varying levels of support to 1,476 facilities (1,715 health centers and 78 general referral hospitals) in 78 health zones. Road conditions in the country are poor, and the majority of these zones are located in hard-to-reach geographical areas. Thus, in addition to establishing a project office in Kinshasa to facilitate communication with the DRC Ministry of Health, other host government authorities and USAID, IHP set up 8 provincial-level coordination offices to facilitate activity implementation at the field level. The offices are located in Bukavu (covers 22 health zones), Kamina (9), Kole (8), Kolwezi (8), Luiza (9), Mwene Ditu (9), Tshumbe (8), and Uvira (5).

The project's strategic 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; human immunodeficiency virus (HIV); and water/sanitation/hygiene in the target health zones. There are four intermediate results (see Table 1).

In October 2014, IHP submitted a proposed modification to USAID to adjust its targets under IR 1 related to "Access to and availability of Minimum Package of Activities/ Complementary Package of Activities plus (MPA/CPA-plus) services in targeted health zones Increased." The modification also included formalizing the reduction in the number of health zones from 80 to 78, due to negotiations with other donors (for example, to have DfID take over Tshikaji) and security preventing access to certain health zones. Finally, due to the changes in the number of health zones as well as other technical considerations, IHP worked with the USAID/DRC Health Team to modify its Performance Management Plan (PMP), which was submitted for approval and inclusion in the modification.

[1] Of the initial 80 health zones, IHP dropped the Kalehe health zone (Bukavu) due to insecurity; transferred the Bulape and Tshikaji health zones (Kasaï Occidental) to IMA World Health to be covered under the DFID-funded *Accès au Soins de Santé Primaires* (ASSP) project, at USAID's request; and split the Dikungu-Tshumbe health zone into two separate zones (Dikungu and Tshumbe). This will be reflected in a pending modification with USAID.

Table 1: DRC-IHP Results Framework

DRC-IHP Results Framework	
Component 1: Services	
Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	**IR 1.1:** Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased
	IR 1.2: Community-based health care services and products in target health zones increased
	IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery
Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased	**IR 2.1:** Clinical and managerial capacity of health care providers increased
	IR 2.2: Minimum quality standards for health facilities (referral hospitals and health zone health centers) and services developed and adopted
	IR 2.3: Referral system for primary health care prevention, care and treatment between community and health facilities (district and provincial levels) institutionalized
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
	IR 3.2: Health advocacy and community mobilization organizations strengthened
	IR 3.3 Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched
Component 2: Other Health Systems	
Intermediate Result 4: Health sector leadership and governance in target provinces improved	**IR 4.1:** Provincial health sector policies and national level policies aligned
	IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted
	IR 4.3: Community involvement in health policy and service delivery institutionalized

Project Performance: Reporting Key Achievements

Summary of PY4 Results: The project tracks results for 12 groups of technical area indicators: family planning; maternal, newborn and child health (MNCH); nutrition; tuberculosis; HIV and AIDS; leadership, management and governance (L+M+G); malaria; WASH; gender; referral systems; behavior change communications (BCC); and project management. Similar to last quarter's results, IHP exceeded or met targets for more than half (37/70) of the indicators for these technical areas, with strong results in family planning, HIV, and MNCH. Also similar to last quarter, the weakest performance was noted for TB and WASH. Of the 32 indicators for which targets were not met in PY4, 14 of them achieved at least 75% of target, which means that IHP met, exceeded, or in the case of some indicators, was close to meeting 73% of project targets.

The number of malaria indicators was reduced from 20 to 14 in PY4Q4 to coincide with the recently revised Performance Monitoring Plan (PMP), which includes revised targets for most of these indicators. None of the targets were met in PY4Q4. The majority of these indicators are affected by procurement issues over which IHP has limited control. They will be discussed in greater detail in the malaria section of the report. The project's full PMP is in Appendix 1.

Table 2: Indicator Achievements for PY4

Result area	PY4 targets met or exceeded	PY4 targets not met	New target or data not collected	Total indicators
Family planning	5	0		5
MNCH	7	6		13
Nutrition	3	2		5
Tuberculosis	0	5		5
HIV (PEPFAR DSD)	10	3	1	14
L+M+G	5	9		14
WASH	0	2		2
Gender	2	1		3
Referral system	1	1		2
Behavior change	3	3		6
Project Management	1	0		1
Total (w/o malaria):	37	32	1	70
Malaria	*0*	*14*	*0*	*0*

IHP Service Delivery Results at a Glance[2]

Family planning: IHP exceeded 5 family planning targets.
Exceeded targets:

- 562,982 Couple Years of Protection (CYP) (125% of 450,000 target)
- 606,320 new acceptors of any modern contraceptive method (122% of 497,399 target)
- 747,573 counseling visits for family planning/reproductive health (117% of 640,349 target)
- 2,025 USG-supported delivery points providing family planning counseling or services (101% of 2,000 target)[3]
- Stock outs of Depo-Provera at IHP sites were minimized (59 sites had stock outs; threshold is 100)

Maternal, neonatal and child health (MNCH): IHP met or exceeded 7 of 13 targets for MNCH indicators, and fell short of targets for 6 indicators.
Met or exceeded target:

- 546,162 women received at least one antenatal care (ANC) visit by a skilled provider (107% of 510,830 targeted)
- 460,227 deliveries took place with a skilled birth attendant (102% of 449,208 target)
- 424,835 women benefitted from Active Management of the Third Stage of Labor (AMTSL) (99% of 425,518 target)
- 439,793 newborns received essential newborn care (102% of 430,006 target)
- 34,820 newborns were treated for infection with antibiotics (107% of 32,415 target)
- 457,056 children <12 months received DPT-HepB-Hib3 (108% of 425,017 target)
- 431,855 children <12 months received measles vaccine (102% of 25,017 target)

[2] In PY4, we have presented this section to function as a "results at a glance." For those areas needing improvement, in the subsequent sections of the report, we outline steps to take to improve these results.
[3] Service delivery points = 1,398 health centers, 78 GRHs, and 549 community care sites and CBDs (IHP and HPP)

Below target:

- 73% of pregnant women had 4 antenatal care visits by skilled providers (246,154 of 334,951 target)
- 440,147 newborns benefitted from postpartum visits within 3 days of birth (81% of 540,244 target)
- 86% of child pneumonia cases were treated with antibiotics by a trained facility or community health worker (495,392 cases of 573,232 target)
- 522,511 of child diarrhea cases were treated using oral rehydration solution (ORS) or ORT plus zinc (68% of 764,318 target)
- 24,473 children less than 12 months did not complete full regimen of DPT-HepB-Hib1-3 (dropout rate was 15% over threshold of 21,251)
- 216 facilities out of 1,793 (12%) IHP-supported facilities (1,715 health centers and 78 general referral hospitals) reported ORS stock outs (threshold is 100 facilities)

Nutrition: IHP exceeded 3 of its PY4 nutrition targets and encountered challenges with 2 others.
Exceeded target:

- 3,378,133 children under 5 years received vitamin A (134% of 2,520,338 target)
- 504,282 pregnant women received iron folate to prevent anemia (124% of 405,169 target)
- 547,577 mothers of children under 2 years received nutritional counseling for their children (140% of 409,823 target)

Below target:

- 138,003 breastfeeding mothers received vitamin A (38% of 361,051 target)
- 489 facilities reported stock outs of iron folate each month during PY4 (threshold was 100 facilities)

HIV and AIDS: IHP uses PEPFAR direct service delivery indicators to track results for the project. For 10 of 14 HIV indicators, IHP met or exceeded PY4 annual targets and is on track to meet or exceed PEPFAR FY14 targets. Targets were not met for three indicators, and 1 indicator is only applicable beginning with PEPFAR COP 15.
Met or exceeded target:

- 69 sites (100% of PEPFAR-supported sites) in Kolwezi and Kamina achieved 90% ARV or ART coverage for HIV+ pregnant women
- 18,778 of pregnant women with known HIV status (includes women who were tested for HIV and received their results (106% of 17,222 target)
- 254/165 HIV+ pregnant women received antiretroviral therapy (ART) to reduce risk of mother-to- child transmission (total PY4 achievement is 167% of annual PEPFAR target of 165 women)
- 39,211 individuals received testing and counseling (T&C) services for HIV and received their test results (129% of annual PEPFAR target of 30,330 people)
- 989 HIV-positive adults and children receiving a minimum of one clinical service (142% of 696 target)
- 100% (69) of laboratories and Point of Care testing sites perform HIV diagnostic testing that participate and successfully pass an analyte-specific proficiency testing (PT) program
- 100% (1) PEPFAR-supported testing facility (laboratory) with capacity to perform clinical laboratory tests that are recognized by national, regional, or international standards for accreditation
- Family planning and HIV integration: 100% (69) of HIV service delivery points supported by PEPFAR are directly providing integrated voluntary family planning services
- 1,369 HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) or CD4 count or viral load

- 1,382 (199% of 696 target) of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (DSD)

Below target:
- 57% (106 of 185 target) of registered TB cases who are HIV-positive who are on ART
- 36% of adults and children receiving ART (63 of 175 PEPFAR COP 14 target)
- 58% of HIV+ patients were screened for TB in HIV care or treatment setting (362 of 623 PEPFAR COP14 target)

Non applicable HIV indicator for current reporting:
Percentage of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (no data, activities to begin next quarter)

Tuberculosis: IHP did not meet PY4 targets for any of the 5 TB indicators, but it did attain 74% and 84% of targets for 2 of the indicators. There are some promising developments with TB as well as ongoing challenges. These will be discussed in the TB section of the report.

Other Indicators: Indicators and results for WASH, gender, malaria, and L+M+G will be presented and discussed in the appropriate sections of this report.

PROJECT PERFORMANCE

COMPONENT 1: HEALTH SERVICES

INTERMEDIATE RESULT 1: ACCESS TO AND AVAILABILITY OF MPA-PLUS AND CPA-PLUS SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED

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

1. Utilization of health care services

During PY4, the health services utilization rate of six of the eight IHP coordination offices exceeded the 35% national average utilization rate. Bukavu and Kolwezi had the highest rates, with an average of 52% and 50% by the end of the year, while Luiza and Uvira were slightly below the national average with rates of 32% and 34%, respectively. The other four offices exceeded the national rate by 3 to 6 percentage points (see Figure 1 and Table 3 below).

The lower rate in Luiza was due to the transfer of oversight of two health areas (Tshikaji and Bulape) from IHP to IMA World Health under the DFID-funded *Accès aux Soins de Santé Primaires* (ASSP) project, at USAID's request[4]. Data from these areas were therefore no longer included in the Luiza database. In the Uvira coordination office, recurring unrest prevented the local population from using health services in some health zones, such as Lemera and Ruzizi.

[4] The figures for the Tshikaji and Bulape health zones are included in the PY4Q1 and PY4Q2 service utilization rates because IHP transferred the zones to ASSP in May 2014; the figures are not included for PY4Q3 and PY4Q4.

The utilization rate varied between coordination offices as a result of health centers being closed during immunization campaigns and immunization days, the fact that private facilities do not report to the central offices, and the unaffordable fees that certain health facilities impose for services.

On average, the health utilization rate for curative services in IHP-supported health zones was around 40%.

Figure 1: Health service utilization rate by quarter and coordination office

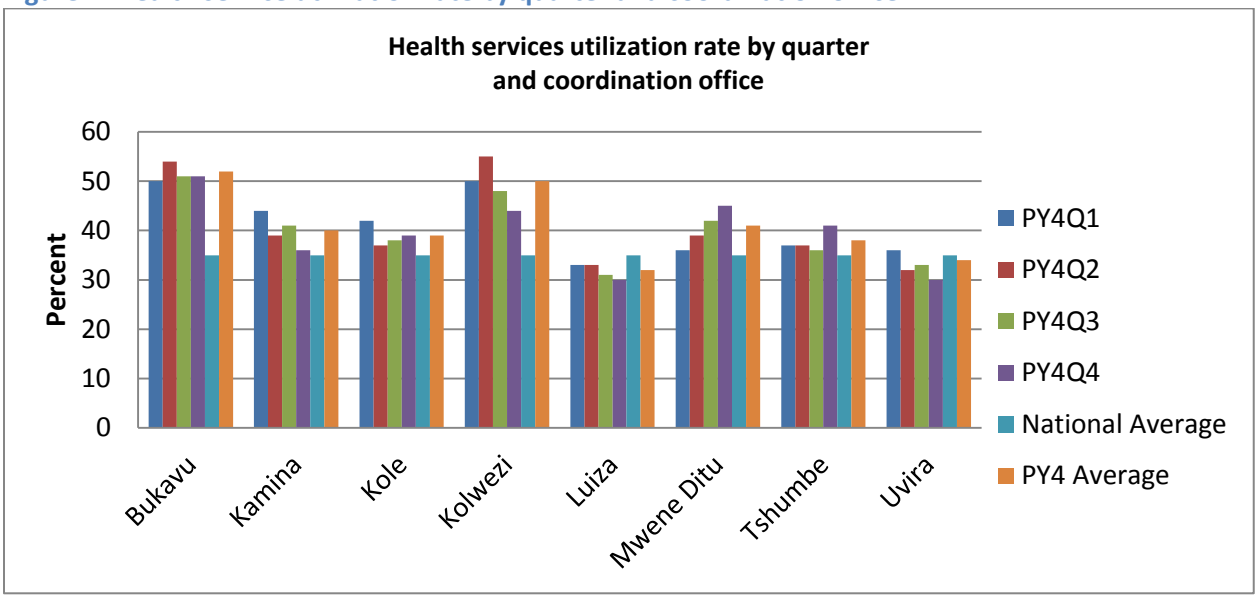


Table 3: Curative services utilization by quarter and by coordination office

Period	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira
PY4Q1	50	44	42	50	33	36	37	36
PY4Q2	54	39	37	55	33	39	37	32
PY4Q3	51	41	38	48	31	42	36	33
PY4Q4	51	36	39	44	30	45	41	30
National Average	35	35	35	35	35	35	35	35
PY4 Average (%)	52	40	39	50	32	41	38	34

2. Facility-based Minimum Package of Activities (MPA)/Complementary Package of Activities (CPA)

CPA and CPA-Plus: IHP surpassed its yearly target for number of GRHs implementing CPA. During PY4, 71 of the 78 (91%) IHP-supported GRHs provided the CPA during PY4. These include 23 of 25 GRHs in Kasaï Oriental, 26 of 27 GRHs in Sud Kivu, 13 of 17 in Katanga, and 9 of 9 in Kasaï Occidental.

CPA-Plus was provided by a total of 21 GRHs during the year (12 in Bukavu, 5 in Mwene Ditu, 1 each in Uvira and Kole, and 2 in Kolwezi, see Table 4). However, none of the current IHP-supported GRHs in the coordination offices of Kamina (Katanga Province), Tshumbe (Kasaï Oriental), and Luiza (Kasaï Occidental) provided CPA-Plus. The two GRHs in Tshikaji and Bulape (Kasaï Occidental) did apply CPA-Plus, but their data are now included in the DFID ASSP project since oversight for this work was transferred from IHP to IMA World Health. At the end of

PY3Q4, 86% of target GRHs were providing CPA and 16% were providing CPA-Plus. One year later, at the end of PY4Q4, these percentages were 127% and 88% respectively.

Table 4: Number of GRHs implementing a complementary package of activities (CPA), by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	21	7	7	6	11	8	5	4	**69**
PY4Q2	21	7	7	6	11	8	8	4	**72**
PY4Q3	21	7	7	6	9	8	8	5	**71**
PY4Q4	21	7	7	6	9	8	8	5	**71**
Target PY4Q4	16	6	6	6	8	6	5	3	**56**
% of target achieved in PY4Q4	**131**	**117**	**117**	**100**	**113**	**133**	**160**	**167**	**127**
% of target achieved in PY3Q4	**91**	**67**	**100**	**88**	**100**	**82**	**67**	**100**	**86**

Table 5: Number of GRHs offering CPA-Plus by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	9	0	2	2	2	5	0	1	**21**
PY4Q2	12	0	1	2	0	5	0	1	**21**
PY4Q3	12	0	1	2	0	5	0	1	**21**
PY4Q4	12	0	1	2	0	5	0	1	**21**
Target PY4Q4	**7**	**3**	**2**	**2**	**3**	**3**	**2**	**2**	**24**
% of target achieved in PY4Q4	**171**	**0**	**50**	**100**	**0**	**167**	**0**	**50**	**88**
% of target achieved in PY3Q4	**9**	**0**	**25**	**25**	**18**	**45**	**0**	**20**	**16**

MPA and MPA-Plus: During PY4Q4, in all coordination offices, MPA and MPA-Plus were provided at the same health centers as in PY4Q3, except for the Kolwezi coordination office, where 4 new health areas integrated MPA (1 center in the Dilala health area and 3 in Fungurume). Compared to the annual target, the achievement rate increased from 93% at the end of PY3Q4 to 137% a year later in PY4Q4 for health centers offering MPA, and from 6.5% during PY3Q4 to 28% during PY4Q4 for health centers offering MPA-Plus.

As described in previous reports, to increase the percentage of health centers offering MPA-Plus, additional efforts will be necessary, including integrating new health services (such as PMTCT, nutrition, and TB activities), presenting and explaining indicators in ways that everyone can understand, and providing education and advocacy on MPA-Plus.

Table 6: Number of health centers offering MPA by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	361	201	129	100	189	168	104	92	**1,344**
PY4Q2	395	201	129	101	197	168	104	92	**1,387**
PY4Q3	395	201	129	**101**	170	168	104	**92**	**1,360**
PY4Q4	395	201	129	**105**	170	168	104	**92**	**1,364**
Target PY4Q4	**279**	**142**	**90**	**74**	**138**	**120**	**83**	**72**	**998**
% of target achieved in PY4Q4	**142**	**142**	**143**	**136**	**123**	**140**	**125**	**128**	**137**
% of target achieved in PY4Q3	**100**	**97**	**100**	**95**	**96**	**102**	**108**	**81**	**93**

Table 7: Number of health centers offering MPA-Plus by coordination office

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
PY4Q1	19	18	1	29	5	21	1	12	**96**
PY4Q2	29	20	1	29	5	21	1	13	**119**
PY4Q3	29	20	1	**29**	4	21	1	**13**	**118**
PY4Q4	29	20	1	**29**	4	21	1	**13**	**118**
Target PY4Q4	**120**	**61**	**39**	**32**	**59**	**51**	**36**	**30**	**428**
% of target achieved in PY4Q4	**24**	**33**	**3**	**91**	**7**	**41**	**3**	**43**	**28**

3. Availability of medicines, commodities, and equipment

The USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project aims to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Working in close collaboration with IHP, SIAPS ensures the availability of generic and essential medicines (MEG) at all IHP-supported sites. SIAPS' support to IHP includes:

Ensuring the availability of medicine in health facilities: SIAPS continued to follow up on IHP deliveries from the supplier, International Dispensary Association (IDA), and on the status of health zone lines of credit at their respective regional distribution centers (CDR). It took about one year to receive supplies that were ordered in August 2013. By August 2014, CDRs received about 96% of the total deliveries expected from IDA.

Table 8: Expected supplies from the second half of IHP Year 3 (from supplier IDA)

Province	Warehouse/ CDR	Cost of Order (in USD)	Cost of delivery (as of August 31, 2014)	Delivered (%)	Remaining balance	Balance to be delivered (%)
Sud Kivu	**APAMESK**	$435,721.00	$427,936.00	98	$7,785.00	2
Katanga	**CEDIMEK**	$242,189.00	$229,286.65	95	$12,902.35	5
	Kolwezi	$163,155.75	$151,389.75	93	$11,766.00	7
Kasaï Occidental	**CADIMEK**	$256,361.00	$245,787.00	96	$10,574.00	4
Kasaï Oriental	**CADMEKO**	$249,789.00	$242,890.76	97	$6,898.24	3
	FODESA	$222,680.00	$222,229.45	100	$450.55	0
Total order/delivery		**$1,569,895.75**	**$1,519,519.61**	**97**	**$50,376.14**	**4**

****Please note that on percentages here and elsewhere in the report, numbers may not match exactly due to rounding.**

In PY4Q4 SIAPS continued to support distribution of medicines to the health zones and reviewed quarterly procurement plans for malaria (PMI), family planning commodities, and other products to prevent stock outs. Distribution plans for PMI and family planning commodities are found in Appendices 2 and 3. In cooperation with the IHP staff in Kananga, SIAPS organized the re-distribution of an overstock of blood transfusion supplies with an imminent expiration date from Kananga to Lodja. A surplus of Artemisinin-based Combination Therapy (ACT) will be similarly distributed from Lubumbashi to Bukavu during PY5Q1. SIAPS worked with IHP staff to calculate the shortage of rapid diagnostic tests (RDTs) in Kamina and secured a loan from the faith-based organization SANRU to procure the needed test kits (the memorandum of understanding with SANRU and PMI is found in Appendix 4). SIAPS coordinated the distribution of 720,000 long lasting insecticide-treated nets (LLIN) in the Sud Kivu province for IHP and PMI Extension projects. Deliveries are ongoing in other provinces. SIAPS also ensured follow-up, distribution, and costing of family kits provided by UNICEF for IHP.

Strengthening management of specific medicines, commodities, and medical supplies: During the quarter, SIAPS continued to provide assistance to IHP-supported CDRs in supply planning, adjusting lines of credit, and adherence to stock management protocols. In September 2014, SIAPS assisted the CDR in Kasaï Occidental, CADIMEK, with installation of equipment and supplies (e.g., dehumidifiers, digital thermo-hygrometric devices, red tape for quarantined areas, and alkaline batteries). To improve stock rooms, SIAPS distributed IHP-financed non-digital thermo-hygrometric devices to all health facilities. SIAPS continued to centralize all medication management data from the health zones. Medicine consumption data are available in electronic format and will be analyzed for the upcoming quantification exercise. Average monthly consumption data will be updated in December 2014, jointly with the provincial health team (DPS) and IHP.

Supporting monthly supervision of medicine management in the IHP-supported health zones and facilities: In cooperation with IHP and DPS staff, SIAPS conducted supervision visits to 12 health facilities located in three health zones (Luputa, Mwene Ditu, and Dibindi) in Kasaï Oriental (Mwene Ditu), September 1-15, 2014; to 17 health facilities located in 6 health zones in Kasaï Oriental (Sankuru), August 11-30, 2014; and to 20 health facilities in 4 health zones in Sud Kivu, August 27-September 1, 2014. All supervision visits focused on correct use of data management tools, evidence-based medicine deliveries at the health facility level, active data collection for medicine management indicators, and active reporting tools to ensure accurate consumption history. As

indicated above, consumption data are available and will be aggregated and analyzed in several coordination offices during the next quarter, in collaboration with the MOH.

Other SIAPS activities during PY4Q4: SIAPS conducted a stock inventory at the MSH warehouse in Kinshasa, finalized a report on missing Depo-Provera stocks, developed an addendum to MSH/Kinshasa warehouse management procedures for the management of commodities with impending expiration dates, and followed up on import certificates with the DPM. In cooperation with IHP staff, SIAPS developed a medical supply distribution plan for IHP commodities and will follow up to ensure that CDRs confirm receipt of all IHP-funded goods. SIAPS also followed the evolution of rehabilitation work at the CADMEKO warehouse buildings, and prepared a Procurement Planning and Monitoring Report (PPMR) that compiled and summarized all data on family planning commodities managed by IHP, UNFPA, and Population Services International (PSI). SIAPS staff participated in IHP weekly technical meetings in all coordination offices. SIAPS continues to routinely review all invoices submitted by the warehouses to the IHP procurement unit for payment. IHP plans to work with SIAPS in the future on assessing and documenting the root causes of stock outs as well as expirations.

IR 1.2: Community-based health care services and products in target health zones increased

1. **Integrated Community Case Management (i-CCM)**

During PY4, 382 community health sites in 38 IHP-supported health zones were established and became operational to better address the three main threats to child health and mortality in the DRC: malaria, pneumonia, and diarrhea. The number of diarrhea episodes treated doubled in PY4 compared to PY3 (522,511 cases treated in PY4, and 261,758 cases treated in PY3). The number of malaria episodes treated at the community level also doubled compared to the previous year, increasing from 14,279 in PY3 to 30,028 in PY4.

Pneumonia: During PY4, 495,392 pneumonia episodes were treated with antibiotics in the IHP-supported health facilities and health sites. This figure represents 86% of the expected episodes among children under 5, according to the PMP target (see Table 9). Compared to PY3 results, this represents an increase of 14,081 new episodes treated; nearly half of these additional episodes (6,918) were treated in community health sites. The improvement of this indicator is due to an increase in community health site activities, including training providers on the utilization of flow charts, provision of antibiotics to health facilities, distribution of job aids for pneumonia management, and data quality audits (DQA) performed in the health zones.

Five coordination offices achieved at least 80% of their targets: Kamina (125%), Bukavu (91%), Mwene Ditu (86%), Tshumbe (83%), and Kole (80%). Results reported by Uvira (40%), Kolwezi (62%) and Luiza (73%) had lower target achievements. The project speculates that results may be under-reported in Kolwezi and Uvira, but the extent of under reporting is unknown. Delays in the delivery of antibiotics in the health zones managed by the Uvira coordination office due to recurring unrest may also have contributed to lower results.

Table 9: Number of children under 5 with pneumonia treated by antibiotics in facilities and i-CCM sites in PY4

Coordination office	PMP target PY4	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4			% of target achieved
		Total	Total	Total	Total	Health facilities	i-CCM sites	Total	
Bukavu	163,371	34,639	44,133	38,980	31,343	144,709	4,386	**149,095**	91
Kamina	85,985	33,748	28,523	25,381	19,464	94,805	12,311	**107,116**	125
Kole	40,126	8,963	8,343	8,207	6,684	28,377	3,820	**32,197**	80
Kolwezi	37,260	7,866	6,813	4,602	3,993	22,886	388	**23,274**	62
Luiza	72,227	12,199	18,220	12,990	9,604	51,583	1,430	**53,013**	73
Mwene Ditu	102,035	19,793	22,450	22,041	23,345	83,920	3,709	**87,629**	86
Tshumbe	32,674	6,799	8,632	6,255	5,539	25,725	1,500	**27,225**	83
Uvira	39,553	4,082	4,365	4,027	3,369	15,213	630	**15,843**	40
Total PY4	**573,232**	**128,089**	**141,479**	**122,483**	**103,341**	**467,218**	**28,174**	**495,392**	**86**
Total PY3		106,457	129,452	122,724	122,678	460,055	21,256	481,311	87

Diarrhea: IHP-supported health facilities and community health sites treated 522,511 new cases of diarrhea with ORS and zinc sulfate, achieving 68% of the PMP target (see Table 10). Additional new cases were treated and reported, with numbers increasing steadily from Q1 through Q4 (114,660 cases in Q1; 129,442 cases in Q2; 136,164 cases in Q3; and 142,245 cases in Q4).

Three coordination offices out-performed the others on number of children under 5 treated for diarrhea by ORS or ORS plus zinc sulfate: Uvira achieved 93% of its target, Kamina achieved 91%, and Bukavu achieved 83%. These results were obtained through joint IHP-MOH supervision visits to service sites, and to IHP-sponsored provider training on treatment flow charts, correct diagnosis of diarrhea, and appropriate case management. The availability of ORS and zinc sulfate in the health zones and increased diarrhea case management at community health sites also contributed to an overall 13 percentage point increase between PY4Q3 and Q4 on this indicator, albeit with significant variation in achievements among the different coordination offices.

Table 10: Number of children under 5 with diarrhea treated by ORS or ORS plus zinc in PY4

Coordination office	PMP Target PY4	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4			% of target achieved
						Health facilities	i-CCM sites	Total	
Bukavu	217,831	37,924	47,914	46,294	49,037	176,106	5,063	**181,169**	**83**
Kamina	114,648	22,512	27,053	28,337	26,590	90,796	13,696	**104,492**	**91**
Kole	53,502	9,609	6,350	7,726	10,075	26,907	6,853	**33,760**	**63**
Kolwezi	49,681	5,930	5,491	6,110	5,201	22,050	682	**22,732**	**46**
Luiza	96,304	7,755	9,918	15,394	12,347	40,918	4,496	**45,414**	**47**
Mwene Ditu	136,049	13,081	15,322	14,718	18,304	56,939	4,486	**61,425**	**45**
Tshumbe	43,566	5,335	5,570	5,940	7,421	22,023	2,243	**24,266**	**56**
Uvira	52,738	12,514	11,824	11,645	13,270	47,754	1,499	**49,253**	**93**
Total PY4	**764,318**	**114,660**	**129,442**	**136,164**	**142,245**	483,493	39,018	**522,511**	**68**
Total PY3		55,678	60,331	68,495	77,254	246,011	15,747	261,758	35

Malaria: During PY4Q4, 9,963 ACT doses for children under 5 were distributed at the community health site level. This is 1,640 more doses compared to results from the previous quarter. The number of ACT doses distributed doubled compared to the previous year, from 14,279 during PY3 to 30,028 doses distributed in PY4. All of the i-CCM sites supported by MSH (382 IHP and 278 HPP) follow the NMCP directives regarding malaria case management; the RDT is conducted routinely before providing any treatment.

Table 11: Number of children under 5 with malaria treated in i-CCM sites in PY4

Coordination office	PY4Q1	PY4Q2	PY4Q3	PY4Q4	Total PY4
	i-CCM sites	i-CCM sites	i-CCM sites	i-CCM sites	i-CCM sites
Bukavu	397	812	373	443	2,025
Kamina	2,142	1,336	2,049	3,568	9,095
Kole	137	37	218	142	534
Kolwezi	369	459	587	875	2,290
Luiza	275	336	966	293	1,870
Mwene Ditu	300	4,383	2,600	1,595	8,878
Tshumbe	277	317	569	2,163	3,326
Uvira	552	303	611	544	2,010
Total PY4	**4,449**	**7,983**	**7,973**	**9,623**	**30,028**
Total PY3	1,595	3,605	4,607	4,472	14,279

The most important challenges confronting child health interventions include:

- Under-reporting the actual number of cases of pneumonia and/or diarrhea that may go undiagnosed by untrained or inexperienced providers (e.g., some providers do not systematically measure respiratory rates for children with coughs, or they do not always provide a diagnosis of diarrhea for children with over three bowel movements a day);
- Data collection is difficult at the health facility level, especially if indicators are not included in the MOH HMIS (e.g., the MOH HMIS captures *number of cases* of diseases but not the number of cases *treated correctly*);
- The long lead time required for the timely delivery of medicine and supplies that is not always taken into account by the health zone management team responsible for ordering;
- For the Uvira coordination office, insecurity in the region.

To address these challenges during PY5 fiscal year, IHP plans to:

- Continue with the dissemination of job aids, closely monitor data collection for treatment of pneumonia and diarrhea at the health zone level, and address low performance issues in the coordination offices of Kolwezi, Luiza, and Mwene Ditu during supervision visits;
- Within the framework of IHP's results-based financing (RBF) initiative, propose the inclusion of indicators for treatment of diarrhea and pneumonia in RBF contracts;
- Monitor the availability of medicines for diarrhea and pneumonia (e.g., ORS, zinc, amoxicillin, and cotrimoxazole) at 5 selected health centers per coordination office twice a month.

A Promise Renewed: In June 2012, the DRC participated in the Global Child Survival Call to Action meeting held in Ethiopia from which the "A Promised Renewed" (APR) initiative ensued. In DRC, this initiative is led by an integrated committee comprised of all key health sector partners and donors. With support from UNICEF, USAID, and other actors, the DRC government developed an action framework with detailed strategies and the

potential to address bottlenecks and barriers in the health system that impedes access to health services. The Action Framework aims to reduce, by the year 2035, under-five mortality by 48% and maternal mortality by 31%, saving the lives of 430,000 children and 7,900 mothers.

IHP provides support for the Ministry's APR objectives and 6 maternal and child health strategies in 52 priority health zones. In 27 of these zones IHP provides support through a joint effort with UNICEF (via the Health for Poorest Populations project or HPP[5]). In 25 zones, IHP is the primary provider of support. In the 25 health zones, the i-CCM sites were expanded from 100 to 152 new sites. In the 27 health zones, the i-CCM sites were expanded from 94 to 173 new sites. The present report presents IHP's contribution to APR objectives during the quarter (PY4Q4).

Strategy 1: Universal coverage for vulnerable populations (pregnant women and children under five) family kits/voucher approach: IHP assisted with the distribution of HPP-funded family kits in the 4 health zones of Dibaya, Ndekesha, Kanda Kanda, and Vangakete. Jointly with the MOH, IHP organized post-training sessions at community health sites established last quarter in the health zones of Kole, Minga, Kayamba, and Wikong.

Strategy 2: Support for health services at the peripheral level including reference facilities: To strengthen the technical capabilities of health facilities, IHP provided medical supplies and small equipment to health facilities in 11 health zones where health personnel had benefited from competency-based maternal and child health training. Supplies typically included boxes of dressings, surgical gloves, fetoscopes, stethoscopes, blood pressure (BP) monitors, scrubs, salter scales, emesis basins, pressure sterilizer, digital thermometers, neonatal kits, and infant scales.

Strategy 3: Improve health zone governance and management: IHP provided technical and financial support to the health zones for the development of operational plans, for supervision visits and data monitoring meetings, and for the reinforcement of performance-based management that includes three essential elements: job descriptions and organograms; work plans, monitoring plans, and guides; and performance evaluations. During PY5, IHP aims to further strengthen health zone management team capacity for informed decision-making and activity planning based on bottleneck analyses.

Strategy 4: Strengthen human resources (health facility service providers: staff motivation, quality training): In PY4Q3, IHP provided financial and technical support to train 35 MNCH trainers in family planning, post-abortion care, care for victims of sexual violence, essential and emergency obstetrical care, and essential and emergency newborn care. During PY4Q4, these trainers trained 238 providers, including 31 physicians, 137 nurses, and 70 midwives in 11 health zones (Uvira, Nundu, Lemera, Kabongo, Bibanga, Kanda Kanda, Lodja, Vangakete, Dibaya, Lubondaie, and Ndekesha).

Strategy 5: Communication for Development: During the quarter, IHP provided support for three family planning mini campaigns in three health zones (Mwene Ditu, Dibaya, and Ndekesha). In total, 1,987 people (1,827 women and 160 men), were sensitized by the campaigns, which also resulted in 460 new acceptors of a modern method of family planning.

Strategy 6: Community Mobilization: During the quarter, 1,322 CODESAs were revitalized, and 1,265 of them developed an action plan to address community health matters. CODESAs held meetings with community members and/or conducted household visits to discuss and promote essential family health practices (CODESAs are discussed in greater detail below).

[5] HPP is financed by UNICEF and implemented by MSH.

2. CODESA integration: Health advocacy and community mobilization

CODESA members are responsible for disseminating health information to the local populations. They interact with community members, listen to their views and concerns, and educate them about health problems, causes, and solutions. CODESAs carry out awareness-raising and community mobilization activities to promote behavior change for disease prevention and treatment. Community mobilization and accountability for health are central to the long-term behavior change process. To support the process, IHP has implemented several innovative behavior change communications (BCC) approaches, including Champion Communities, Education Through Listening (ETL), and mHealth. IHP also utilizes more traditional capacity-building BCC interventions to strengthen local partners' capacity, such as CODESAs, to design and carry out their own communication action plans and actively engage with local populations.

During PY4Q4, IHP revitalized 1,322 CODESAs, reaching 94.6% of the annual goal of 1,398 (See Table 12). Of these revitalized CODESAs, 1,265 developed a communications action plan to be implemented with the assistance of IHP and community mobilizers. IHP supported many CODESAs in implementing their BCC interventions. In the Kasaï Occidental province, for example, the project facilitated the mobilization of all CODESAs in the province's 9 health zones to support a MOH mass polio vaccination campaign. CODESA members led community mobilization interventions in churches, schools, and households. After extensive preparatory meetings and briefings to organize the BCC campaign, the CODESA members counted households with children under the age of five, and worked with MOH vaccination teams to ensure that children received the required vaccinations. They also helped dispel misinformation and rumors about vaccination in the community. Similar interventions were conducted by CODESAs in all health zones.

CODESAs were also actively involved in addressing a dangerous outbreak of diarrhea in the Luiza health zone in July 2014. CODESA members conducted outreach initiatives to raise awareness about the importance of washing hands at critical moments, using hygienic latrines, only consuming clean water, properly conserving clean water, and thoroughly cooking and preserving food. The Luiza CODESAs BCC campaign included 14 group community mobilization sessions in churches and 634 outreach visits to households. CODESAs also distributed 100 informational announcements to local churches to be read by pastors to their congregations regarding prevention of diarrhea. A WASH committee was also formed to maintain potable water sources.

Table 12: Number of revitalized and functional CODESAs during PY4Q4

Coordination	Total CODESAs identified	Total CODESAs revitalized PY4Q1	Total CODESAs revitalized PY4Q2	Total CODESAs revitalized PY4Q3	Total CODESA revitalized PY4Q4	Total CODESAs with an action plan
Bukavu	399	352	393	399	399	367
Kamina	202	176	192	182	201	198
Kole	129	113	113	125	129	129
Kolwezi	106	87	81	89	92	92
Luiza	160	174	174	156	147	137
Mwene Ditu	171	168	168	168	168	168
Tshumbe	119	88	88	88	92	92
Uvira	102	94	90	98	94	82
Total	1,396	1,252	1,299	1,305	1,322	1,265

Challenges: While the number of functional CODESAs with communication action plans continues to increase, this growth is challenged by a lack of financial and other resources. Some health zones are unable to properly supervise their community volunteers due to a lack of training and resources. Many CODESAs lack office facilities that would allow them to archive valuable documents. There is an insufficient level of coordination between CODESAs and other community stakeholders, including religious groups, teachers, local authorities, community-based organizations (CBOs), and other private sector community leaders.

Next steps: IHP has two primary strategies planned for next quarter to ensure that CODESAs continue to grow in support and influence. The project will continue to provide CODESAs with management tools (such as reporting templates, documents, and meeting guides) and will guide health zone teams in supervising community activities. IHP will also organize, together with the National Health Communication Program (PNCPS), the MOH Primary Health care Development Office (B5), and health district authorities, joint supervision missions to support the revitalization of CODESAs. Finally, IHP will continue to facilitate the interactions between CODESAs and other stakeholders in project health areas.

3. WASH Activities

Although the WASH portfolio has not yet fully rebounded from the effects of the budget restrictions and subsequent slowdown in activities experienced from October 2013 to April 2014, sanitation and clean drinking water interventions were undertaken during the quarter to get WASH results back on track.

Provision of clean water: PY4Q4 results related to clean water supply (see Table 13) fell short of targets and were not as strong as results achieved last quarter. Tshumbe was the high performer this quarter, providing potable water for the first time to 53,253 people. Three of the coordination offices provided clean water for the first time to an additional 23,072 people, while another three coordination offices did not report on this indicator. Several different factors contributed to these low results.

Last quarter, IHP indicated that new water sources were limited in Kanzenze in Kolwezi due to poor soil conditions. During the current quarter, WASH experts noted that the situation is similar in Songa (Kamina). Compounding the situation in Kamina is the absence of a WASH advisor in this coordination office. WASH activities are labor intensive and require frequent, if not constant, oversight in the field. The contract of the project-funded WASH advisor for Kamina expired at the end of June 2014 and has not been replaced.

Challenges notwithstanding, the Kolwezi coordination office began to reassess the entire Kanzenze health zone to identify new potential water sources. To date, seven possible sources have been identified in hard-to-reach places and exploratory work is in progress. IHP improved the hygiene in some of Kolwezi's new health structures by resolving waste management issues (e.g., building placenta pits, providing incinerators). The project also devoted time and attention to promotion of community-led total sanitation (CLTS), including more family latrines in Kolwezi.

Planned initiatives to improve drinking water sources in Kole and Luiza were delayed due to the late arrival of WASH construction materials. Construction of new water sources started late in PY4Q4, and will be completed and reported in the next quarter. The Uvira coordination office carried out community outreach activities and training to increase awareness about CLTS and family latrines, and improved hygiene and sanitation in four newly-renovated health structures.

Given the current planning and work in progress in several coordination offices, IHP expects to report improved results during the next quarter. A number of corrective measures have been put in place starting in PY5 to improve results:

- Ensure that materials are available in a timely manner to cap water sources and construct (Lodja);
- Hire WASH consultants as needed in order to increase IHP support to target health zones;
- Strengthen CLTS by conducting additional awareness activities and building more family latrines;
- Reassess and identify health zones with potential water sources to be capped this year to serve a significant number of the population and continue rehabilitation of community wells (e.g., Kanzenze in Kolwezi) in order to provide water to more new people;
- Organize more joint IHP-MOH supervision visits.

Sanitation: The number of people in target areas with first-time access to improved sanitation nearly doubled from the third to fourth quarter (60,260 vs. 107,830). The strongest results were achieved in Kanzenze, Katana, and Walungu, which benefited from Champion Community awareness-raising efforts and community support for the CLTS approach for informed behavior change and construction of latrines with local materials to eliminate the practice of open defecation. Lessons learned by these coordination offices can be used to improve performance in areas that have had less success with CLTS, for example in Mwene Ditu and Kole.

WASH experts from the coordination offices focused attention on supervising WASH committees and strengthening community awareness-raising activities for the CLTS approach in order to accelerate water source repairs and latrine construction for PY5.

IHP will maintain current and expanding CLTS activities into new areas during PY5. PY5Q1 plans include:

- Conduct supportive supervision and post-training follow up in WASH health zones;
- Work more closely with WASH committees in villages and health sites identified as weak in terms of family latrines;
- Organize sensitization visits to enlist the support of village chiefs for family latrines, and continue mini campaigns and BCC-WASH interventions as was done in PY3.

Table 13: IHP WASH indicators results per IHP coordination office for PY4Q4

	Target number of people in target areas	No. of people in target areas with first-time access to improved drinking water supply	No. of people in target areas with first-time access to improved sanitation facilities	Achievement rate for water sources	Achievement rate for latrines
Bukavu	87,503	1,437	24,229	2	28
Kamina	33,454	0	19,145	0	57
Kole	37,472	659	3,533	2	9
Kolwezi	18,039	0	40,350	0	224
Luiza	50,075	0	7,350	0	15
Mwene Ditu	80,670	7,020	987	9	1
Tshumbe	27,367	53,253	7,231	195	26
Uvira	28,021	5,355	5,005	19	18
PY4Q4 Total	**362,600**	**67,724**	**107,830**	**21**	**30**

Overall performance in WASH has been affected by the following challenges:

- Buy-in from the community for the Community Led Total Sanitation (CLTS) approach (community involvement) takes time, particularly in terms of mobilizing local resources for the construction of family latrines
- Extended period of time is needed for the procurement of construction materials and transportation services due to the more stringent management procedures implemented by the project management to tighten control over the procurement processes and protect the project resources from fraudulent practices the project identified, reported, and sanctioned
- There may be insufficient new water sources that are accessible and which can cover enough of the population who in turn commit to providing a contribution (e.g., local resources and family latrines) on top of the project subsidy in order to maximize the impact in IHP targets and results achievement
- There is a stock out of water quality tests but the project has placed an order that has not yet been delivered.

The project has learned the following lessons:

- For the CLTS approach to succeed, ongoing sensitization of the community is needed
- Implementing the Champion Community approach can add value to the success of CLTS as it provides the opportunity to secure a significant contribution to the community commitment and ownership
- The zonal approach needs to be flexible to allow for enrolling a new health zone that has the potential to significantly contribute to the project results, even if the target of 80% coverage of the first selected health zones is not achieved due to factors such as lack of community commitment, longer or much more time needed for changes to occur, hard to reach and land locked areas, weak flow of available water sources, and small number of people being served
- Prior to selecting health zones to implement this approach, it is necessary to prospect and conduct a situational analysis of potential water sources.

IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery

1. Leadership Development Program

IHP's Leadership Development Program (LDP) was designed specifically for health sector personnel, NGOs, community groups, and associations that have major roles in health zone strengthening. The LDP program facilitates the transfer of skills and knowledge to help health actors face and address challenges, creates an environment that motivates staff, and reinforces teamwork. The teams involved in the LDPs carry out leadership projects for a period of 4-6 months while they work in collaboration with stakeholders at all levels to address real organizational challenges to improve services and the work environment.

During PY4, a total of 189 LDP projects were implemented. Most projects focused on improving TB services or maternal and child health indicators. In all, 177 teams implemented projects and achieved expected results (see Table 14). This is more than twice the number of participating teams in 2013 (N=73). By the end of PY4, 94% of the projects (177/189) had attained their expected measurable results. Community leaders were typically very involved in all projects.

Table 14: LDP projects per technical area during PY4

Areas	Number of projects implemented	Number of projects achieving expected results	Achievement rate (in %)
MNCH (EPI,PMTCT, HBB, ANC, pre-school consultation visits, ITP)	114	104	91
Family planning	19	19	100
TB	26	26	100
L+M+G (FOSACOF, curative services, MPA, CPA)	30	28	93
Total	189	177	94

While it is commendable and understandable that most teams to date have focused on challenges related to maternal and child health, family planning, and tuberculosis, there are other important health care challenges which also require attention (e.g., nutrition, malaria, and safe water, hygiene, and sanitation). IHP will encourage health zone teams to design and implement projects that address these other areas in PY5, as appropriate.

INTERMEDIATE RESULT 2: QUALITY OF KEY FAMILY HEALTH CARE SERVICES IN TARGET HEALTH ZONES INCREASED

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

1. **Maternal, Newborn, and Child Health (MNCH)**

During PY4, 546,162 pregnant women made their first antenatal care (ANC) visit in IHP-supported health facilities that had qualified personnel (see Table 15). The number of women surpassed last quarter's results and exceeded the quarterly target (510,831) for a 107% achievement rate. Six of IHP's eight coordination offices exceeded their respective targets. It should be noted that ANC data from private health facilities in three Kolwezi health zones (Lubondaie, Luambo, and Yangala) were not collected.

Mwene Ditu did not meet targets due to stock outs of commodities such as LLINs, Sulfadoxine-Pyrimethamine (SP), and iron/folic acid in the health zones of Kalenda, Kamiji, and Wikong. In Luiza, poor planning and tardiness of health staff responsible for ANC sessions (Lubondaie), and difficult geographic access to some health centers (Yangala) were reasons given that discouraged women from attending ANC.

IHP will continue to advise head nurses to empower health providers responsible for ANC to improve service delivery and punctuality to increase utilization of services. IHP will also support the head nurses of Lubondaie and Luambo to plan ANC during community outreach events to address issues related to access, and to ensure the availability of ANC commodities. IHP will brief head nurses on MNCH guidelines during supervision missions, and encourage health zone management teams in Lubondaie, Luambo, and Yangala to actively collect data from private health facilities.

Table 15: Number of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	150,632	39,271	44,517	51,290	42,010	177,088	145,587	**122**	141,460	**106**
Kamina	76,354	20,417	19,847	19,469	19,213	78,946	76,625	**103**	73,169	**104**
Kole	15,829	9,944	9,933	9,834	10,059	39,770	35,758	**111**	14,634	**108**
Kolwezi	36,430	8,784	9,079	9,553	10,926	38,342	33,204	**115**	29,268	**124**
Luiza	62,760	16,058	16,541	14,679	14,155	61,433	64,365	**95**	58,535	**107**
Mwene Ditu	82,558	19,606	20,863	20,750	21,028	82,247	90,928	**90**	92,681	**89**
Tshumbe	48,195	7,627	8,099	7,948	8,242	31,916	29,117	**110**	43,901	**110**
Uvira	35,573	8,696	9,163	9,312	9,249	36,420	35,247	**103**	34,146	**104**
Total	**508,331**	**130,403**	**138,042**	**142,835**	**134,882**	**546,162**	**510,831**	**107**	**487,794**	**104**

Table 16: Number of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	39,372	12,160	14,856	16,095	17,171	60,282	95,461	**63**	82,138	**48**
Kamina	20,365	5,764	6,045	7,719	6,897	26,425	50,243	**53**	42,485	**48**
Kole	9,157	6,710	6,363	6,768	7,002	26,843	23,447	**114**	8,497	**108**
Kolwezi	11,832	2,411	2,221	2,745	3,652	11,029	21,772	**51**	16,994	**70**
Luiza	31,973	7,840	8,673	8,265	9,108	33,886	42,204	**80**	33,988	**94**
Mwene Ditu	45,507	11,520	13,931	13,965	14,048	53,464	59,621	**90**	53,815	**85**
Tshumbe	31,691	5,142	5,033	4,500	5,076	19,751	19,092	**103**	25,491	**124**
Uvira	10,412	3,308	3,217	3,539	4,410	14,474	23,112	**63**	19,826	**53**
Total	**200,309**	**54,855**	**60,339**	**63,596**	**67,364**	**246,154**	**334,952**	**73**	**283,234**	**71**

As seen in Table 16, the number of pregnant women who completed at least four ANC visits increased by about 23% between PY3 and PY4 (i.e., 45,845 more women in Y4 than Y3). Two of the eight IHP coordination offices exceeded their targets, two achieved 80% and 90% of respective targets, and the remaining four had results ranging from 51% to 73%. There was an increase of 2% in reporting completion rates between PY3 and PY4. The improvement in the reporting completion rate is due to monitoring missions, strengthened supportive

supervision, and competency-based MNCH training of providers and CHWs in July, August, and September 2014. There was also improvement in the collection and reporting of data by health providers. Late ANC4 consultations in certain health zones (e.g., Lubondaie) and missed follow-up appointments explain the lower coverage observed in the coordination offices that did not meet targets.

To improve the performance of the health zones, IHP will continue to support community outreach efforts to promote ANC. As for private health facilities that did not submit reports, the project plans to obtain data through joint supervision missions with health authorities. The project will also continue to ensure the availability of commodities related to ANC (i.e., LLINs, Mebendazole, iron) to motivate health providers responsible for ANC. IHP will continue to use and improve SMS to remind pregnant women of their ANC appointments in health zones that have cell phone reception.

Table 17: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	120,419	32,199	34,781	35,618	35,886	138,484	128,024	**108**	121,686	**99**
Kamina	56,366	14,932	15,352	15,880	14,953	61,117	67,381	**91**	62,941	**90**
Kole	12,717	8,586	8,421	8,409	8,787	34,203	31,445	**109**	12,588	**101**
Kolwezi	33,951	8,751	8,152	8,663	9,555	35,121	29,199	**120**	25,176	**135**
Luiza	58,487	15,049	15,807	13,755	12,907	57,518	56,600	**102**	50,353	**116**
Mwene Ditu	73,075	17,762	19,274	19,550	19,847	76,433	79,959	**96**	79,725	**92**
Tshumbe	43,634	6,945	7,010	6,951	7,206	28,112	25,605	**110**	37,765	**116**
Uvira	26,674	7,229	6,867	7,798	7,345	29,239	30,995	**94**	29,372	**91**
Total	**425,322**	**111,453**	**115,664**	**116,624**	**116,486**	**460,227**	**449,208**	**102**	**419,606**	**101**

Compared to PY3 (425,322), the number of deliveries with a skilled birth attendant rose by 8% during PY4 (460,227) with an average achievement rate of 102% vis-à-vis targets. Moreover, the coordination offices of Bukavu, Kole, Kolwezi, Luiza, and Tshumbe exceeded the annual target due to structural improvements and better hygiene in the maternity clinics (e.g., installation of solar panels and equipment). In addition, the reduction of delivery fees motivated more women to give birth in a health center assisted by skilled providers.

In PY5, IHP will continue to assist head nurses through supportive supervision and monitoring visits. IHP will encourage greater involvement of community leaders in outreach activities to discourage home births, promote improved services and infrastructure of health facilities (e.g., better equipment, steady supply of medicines), and encourage community monitoring of women in the last month of pregnancy.

During PY4, the project increased coverage of AMTSL from last year by 7 percentage points (424,835/395,628) and had an average achievement rate of 100% (see Table 18). Kole (88%) and Uvira (90%) were not able to reach their respective targets (95%) due to stock outs of oxytocin at maternity clinics. The product was available at the CDRs, but stock outs were experienced at the clinic level because clinic staff did not submit orders on time.

In the upcoming quarter, during supportive supervision visits with SIAPS, IHP will continue to advocate for the centralization of health facility orders by the health zone management teams who would review, consolidate, and submit orders on a quarterly basis to the district health team for validation. IHP will also continue provide technical support to health care providers and will ensure that each maternity clinic has the revised AMTSL standards clearly posted.

Table 18: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	108,152	27,501	31,148	32,620	33,699	124,968	121,273	**103**	109,161	**99**
Kamina	55,420	14,728	15,343	15,705	14,572	60,348	63,828	**95**	56,463	**98**
Kole	11,545	6,085	5,946	6,134	8,035	26,200	29,786	**88**	11,293	**102**
Kolwezi	31,686	8,303	7,868	8,141	7,985	32,297	27,659	**117**	22,585	**140**
Luiza	56,578	14,860	15,693	13,424	12,488	56,465	53,615	**105**	45,170	**125**
Mwene Ditu	69,605	17,435	18,718	19,007	19,470	74,630	75,742	**99**	71,519	**97**
Tshumbe	39,492	5,947	5,660	5,630	6,192	23,429	24,255	**97**	33,878	**117**
Uvira	23,150	6,579	6,207	6,965	6,747	26,498	29,361	**90**	26,349	**88**
Total	**395,628**	**101,438**	**106,583**	**107,626**	**109,188**	**424,835**	**425,519**	**100**	**376,418**	**105**

By the end of PY4, IHP had achieved 81% of the yearly target for the number of postpartum/newborn visits within three days of birth (440,147 visits vs. target of 540,245), and the number of visits this year increased by nine percentage points compared to PY3 results (403,174 visits). The strongest performance was reported by Kolwezi (achieved 99% of target) and the weakest was Uvira (attained 68% of target), as seen in Table 19.

To improve future performance, IHP and health zone management teams will use supervision visits to health service sites to overcome identified factors that discourage postnatal visits. In some health facilities, postnatal consultations are not routinely scheduled. In other places, provider understanding or appreciation of the process and purpose of the consultation need to be reinforced (e.g., systematic examination of the newborn, counseling about newborn and maternal care issues, provision of iron folate and vitamin A). In facilities that have not been well maintained and that lack basic amenities (e.g., no toilets, no running water, no beds or mattresses), new mothers will understandably go home two to six hours after delivery and will not return to the facility for a postnatal consultation. Discussion is underway with MOH national- and provincial-level authorities on ways to improve the quality of postnatal services and increase providers' and women's understanding of the value of these services for both newborns and mothers.

Table 19: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	113,762	30,629	34,087	34,879	35,048	134,643	153,970	**87**	152,108	**75**
Kamina	56,874	14,997	15,250	15,625	14,255	60,127	81,037	**74**	78,676	**72**
Kole	11,217	6,452	6,320	6,662	7,243	26,677	37,817	**71**	15,735	**71**
Kolwezi	32,048	8,605	8,285	8,466	9,428	34,784	35,116	**99**	31,471	**102**
Luiza	56,862	14,778	15,698	13,490	12,886	56,852	68,071	**84**	62,941	**90**
Mwene Ditu	70,252	17,420	18,431	18,781	19,162	73,794	96,163	**77**	99,657	**70**
Tshumbe	40,704	6,960	6,862	6,987	7,151	27,960	30,794	**91**	47,206	**86**
Uvira	21,455	6,058	6,040	6,902	6,310	25,310	37,277	**68**	36,716	**58**
Total	**403,174**	**105,899**	**110,973**	**111,792**	**111,483**	**440,147**	**540,245**	**81**	**524,510**	**77**

During PY4, 439,793 newborns received essential care. This number reflects a 9% increase over PY3 results and 102% of the total PY4 target for this indicator. Five coordination offices exceeded their targets, while three (Kamina, Mwene Ditu, and Uvira) were slightly under target. Factors that impact negatively on results for this indicator include frequent turnover of qualified staff, and refusal of some providers to implement recommendations made during supervision visits. IHP will continue to monitor essential newborn care and provide coaching and refresher training to health care providers as needed during supervision visits.

Table 20: Number of newborns receiving essential newborn care through USG-supported programs

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement %	Target PY3	Achievement % PY3
Bukavu	110,667	29,373	34,114	34,850	35,196	133,533	122,552	**109**	114,650	**97**
Kamina	51,671	13,187	13,084	15,136	13,599	55,006	64,501	**85**	59,302	**87**
Kole	11,221	7,630	7,646	7,627	8,149	31,052	30,100	**103**	11,860	**95**
Kolwezi	32,354	8,601	8,314	8,466	8,416	33,797	27,950	**121**	23,721	**136**
Luiza	56,078	14,541	15,581	13,217	12,727	56,066	54,181	**103**	47,442	**118**
Mwene Ditu	68,612	17,265	18,857	19,003	19,578	74,703	76,541	**98**	75,116	**91**
Tshumbe	41,889	6,725	6,722	6,922	6,989	27,358	24,510	**112**	35,581	**118**
Uvira	25,670	7,098	6,816	7,388	6,976	28,278	29,670	**95**	27,674	**93**
Total	**398,162**	**104,420**	**111,134**	**112,609**	**111,630**	**439,793**	**430,005**	**102**	**395,346**	**101**

During PY4, 34,820 newborns received antibiotic treatment for infection, exceeding the annual target of 32,415, for a 107% achievement rate. This represents a 21% increase over PY3 results (25,511 newborns treated). Nevertheless, as seen in the following table, results are uneven across the coordination offices. The Bukavu coordination office attained 64% of its target, Tshumbe was lower at 46%, while Kolwezi and Luiza greatly surpassed their respective targets (257% and 164% achievement). Ongoing challenges with this indicator include poorly-trained providers (inability to recognize infections and/or weak use of tools, such as respiratory timer, designed to aid in diagnoses) and uneducated population (lack of knowledge about danger signs, and delays in seeking care due to traditional beliefs).

Table 21: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs

Coordination office	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Results	Target PY4	Achievement % PY4	Target PY3	PY3 Results	Achievement % PY3
Bukavu	1,523	1,388	1,733	1,257	5,901	**9,238**	64	9,127	5,584	**61**
Kamina	1,917	698	439	2,095	5,149	**4,862**	106	4,721	3,549	**75**
Kole	730	602	626	555	2,513	**2,269**	111	944	1,579	**167**
Kolwezi	203	598	1,353	3,259	5,413	**2,107**	257	1,888	1,314	**70**
Luiza	596	1,404	2,480	2,206	6,686	**4,084**	164	3,777	3,254	**86**
Mwene Ditu	2,027	1,418	864	1,142	5,451	**5,770**	94	5,979	9,028	**151**
Tshumbe	190	118	366	168	842	**1,848**	46	2,832	1,574	**56**
Uvira	872	593	747	653	2,865	**2,237**	128	2,203	1,629	**74**
Total	**8,058**	**6,819**	**8,608**	**11,335**	**34,820**	**32,415**	107	**31,471**	**27,511**	**87**

2. Family Planning

Couple Years of Protection: All coordination offices, with the exception of Uvira, exceeded their family planning targets for PY4. The total CYP obtained this year (562,982), not only exceeded the target (450,000) by 25%, but also showed a significant increase compared to PY3 (502,592) (see Table 22). IHP believes that Uvira (with 80% target attained in PY4Q4) will be able to report stronger performance next quarter. In this regard, Uvira experienced a stock out of family planning commodities in July 2014, which has since been resolved. Uvira's newly-trained CBD workers should be fully operational and family planning should be integrated into some, if not all, of Uvira's community health sites by the end of next quarter.

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

Coordination office	PY3 CYP	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 CYP	Target PY4	Achievement (%)
Bukavu	92,908	32,969	33,246	32,026	39,096	137,337	128,250	107
Kamina	102,387	26,175	23,410	26,446	25,953	101,985	67,500	151
Kole	11,554	9,677	9,910	9,498	10,183	38,548	31,500	122
Kolwezi	49,935	9,336	10,730	11,116	15,691	46,874	29,250	160
Luiza	71,857	19,300	19,536	16,428	16,923	72,185	56,700	127
Mwene Ditu	99,724	22,216	23,608	24,620	25,947	96, 391	80,100	120
Tshumbe	51,552	11,621	11,327	11,000	10,909	44,857	25,650	175
Uvira	22,676	5,446	5,272	6,164	7,923	24,805	31,050	80
Total	**502,592**	**136,740**	**136,318**	**137,298**	**152, 626**	**562, 982**	**450,000**	**125**

These impressive results are due in large part to family planning awareness activities carried out in the IHP Champion Communities. Activities include the training of 111 community-based distribution (CBD) workers in 5 health zones (Bagira, Ibanda, Kadutu, Lemera, and Ruzizi); training of 372 providers in long-term family planning methods (Implanon and IUD); integration of non-clinical family planning services into community health care sites; integration of FP counseling into maternity clinics; increasing community awareness about FP via mini campaigns; and 6 training sessions based on the skills approach in 11 health zones (Kabongo, Bibanga, Kanda Kanda, Lodja, Vangakete, Dibaya, Lubondaie, Ndekesha, Uvira, Nundu, and Lemera). IHP and health zone teams also paid careful attention to the management of family planning commodities to avoid stock outs, and successfully integrated FP at 51 PMTCT sites.

Modern Methods of Contraception: The number of people using modern methods of contraception increased from 556,320 to 606,320 between PY3 and PY4. During PY44, the achievement rate exceeded the PMP target (497,400) by 22%. During PY4, 1,751 health facilities and 506 community health sites provided FP services with respective achievement rates of 109% and 127%, compared to PMP targets (1,600 and 400).

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

Coordination office	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4	Achievement (%)
Bukavu	103,042	30,424	33,270	38,003	33, 048	134,745	141,759	95
Kamina	113,436	31,415	24,373	24,956	23,121	103,865	74,610	139
Kole	24,460	15,195	17,092	14,354	14,686	61,327	34,818	176
Kolwezi	49,960	10,199	14,590	12,985	12,131	49,905	32,331	154
Luiza	77,162	21,662	5,737	17,745	13,678	130		125
Mwene Ditu	98,186	20,073	22,883	25,276	21,139	95,957	88,537	108
Tshumbe	66,827	16,369	13,993	12,289	11,974	54,625	28,352	193
Uvira	23,247	5,998	5,801	7,367	8,391	27,557	34,321	80
Total	**556,320**	**151,335**	**152,332**	**152, 975**	**149,678**	**606,320**	**497,400**	**122**

This strong performance would not have been possible without the availability of a wide range of contraceptive products, well-trained providers to dispense quality family planning services, hard-working and motivated CBD workers who travel long distances by bicycle to reach remote villages, and the involvement and support for family planning by political and administrative authorities.

Noting that about 40% of overall CYP is due to modern methods, IHP will continue to assist health zones to expand family planning services and ensure the availability of a wide range of contraceptive methods. IHP will also work with MOH, other donor counterparts, civil society leaders, and other stakeholders to address national policy issues (e.g., the promulgation of the new reproductive health law and repeal of the anti-contraception legislation that dates back to 1933 and the integration of family planning curricula into schools of medicine and nursing). IHP will continue to expand access to family planning by supporting and strengthening CBD activities and the integration of FP into other health services (PMTCT, HIV, ANC, and postpartum care), community health care sites, and private sector facilities. Additional health providers, including CHWs and CBD workers, will be trained in family planning and will benefit from supportive supervision visits in PY5.

Table 24: Number of USG-assisted health facilities experiencing stock outs of Depo-Provera

	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PY4
Number of USG-assisted health facilities experiencing stock outs of Depo-Provera	38	31	35	67	**67**	100

A total of 59 facilities experienced stock outs for at least three days during a month in the quarter. In most cases, the product was available at the CDRs and central distribution offices, but due to untimely ordering, lack of data on monthly consumption rates, and insufficient quantification skills at the health facility level, stock outs occurred at some facilities. Although 59 is higher than the number of stock outs reported in PY4Q2 and Q3 (45 and 39, respectively), this result is well under the established threshold (100) for PY4. Overall PY4 results indicate that IHP is likely to continue to keep stock outs to a minimum and not exceed the new threshold (50) for this indicator beginning next quarter.

3. Malaria

Distribution of 1,000,000 doses of Sulfadoxine Pyrimethamine (SP) during antenatal care (ANC) in 69[6] health zones that are not covered by Global Fund: Intermittent preventive treatment of malaria in pregnancy (IPTp) is a full therapeutic course of antimalarial medicine given to pregnant women at routine prenatal visits, regardless of infection status. IPTp reduces maternal malaria episodes, maternal and fetal anemia, placental parasitemia, low birth weight, and neonatal mortality. The WHO recommends IPTp -SP in all areas with moderate to high malaria transmission in Africa.

During IHP PY4, 317,588 pregnant women received two doses of SP (IPTp2), reaching 63% of target women, for an increase of 4% compared to PY3 results. The coordination offices of Mwene Ditu, Bukavu, and Kole surpassed PY3 results by 20, 7, and 6 percentage points respectively. In these coordination offices, SP supplies were readily available, and community outreach activities helped to boost SP coverage. Mwene Ditu also met the annual target (2 doses of SP for 80% of expected pregnant women) set by the national malaria control program (PNLP).

However, due to stock outs of SP in Uvira, Tshumbe, and Luiza, SP coverage dropped between PY3 and PY4. In PY4, Uvira's coverage dropped by 15 percentage points, Tshumbe by 6 points, and Luiza by 5 points (see Table 25). The results from these coordination offices pulled down overall results for this indicator. In terms of IPTp2 coverage, 42 out of 69 IHP-supported health zones achieved at least 50% of target for IPTp2 SP coverage.

Table 25: Percentage of pregnant women that received two doses of SP from October 2013 to September 2014 in 69 IHP-supported health zones

	Indicators					
Coordination office	No. of pregnant women who received at least two doses of SP during ANC visits (PY4)	No. of expected pregnant women at ANC visits (PY4)	Percentage of pregnant women who received at least two doses of SP	No. of pregnant women who received at least two doses of SP during ANC visits (PY3)	No. of expected pregnant women at ANC visits (PY3)	% of pregnant women who received at least two doses of SP (PY3)
Bukavu	96,780	147,071	66	90,337	150,448	60
Kamina	54,269	79,120	69	53,975	79,120	68
Kole	24,652	37,112	66	8,878	14,687	60
Kolwezi	16,755	34,266	49	16,713	34,266	49
Luiza	30,301	60,793	50	37,853	64,251	59
Mwene Ditu	66,052	84,844	78	60,039	100,583	60
Tshumbe	17,431	32,120	54	25,928	45,672	57
Uvira	11,347	36,158	31	16,716	36,158	46
PY4 Total	**317,588**	**505,636**	**62**			
PY3 Total				**310,439**	**525,185**	**59**

Distribution of 455,000 LLINs during antenatal care (ANC) in 69 health zones that are not covered by Global Fund: Due to a chronic stock out of bed nets in the targeted health zones during the majority of the year, the

[6] Starting in July 2014, the health zones of Tshikaji and Bulape (Kasaï Occidental) were transferred to IMA World Health to be covered under the DFID-funded *Accès au Soins de Santé.* Data collected prior to July 2014 were considered in this report.

project could not meet the distribution target of 455,000 LLINs. Only 26,087 nets were distributed during PY4 -- 16,404 during ANC sessions and 9,683 during preschool consultations.

As of PY5Q1, LLINs are available at the CDRs in Kamina, Kolwezi, Bukavu, and Mwene Ditu. Deliveries for Luiza and the Sankuru are imminent. In total, 545,375 LLINs have been received in the different CDRs: 355,325 for Sud Kivu, 94,800 for Kolwezi, 44,800 for Kamina, and 50,450 for Mwene Ditu. The coordination offices, in collaboration with SIAPS and the National Malaria Program (PNLP), have already developed distribution plans and will work with the CDRs to transport the nets to the health zones. These measures were put in place by provincial health authorities to ensure that the LLINs reach the intended beneficiaries.

Correctly managing malaria cases in health facilities through training, distribution of medicine and commodities (ACTs, RDTs, and supervision): During PY4, 979,560 doses of ACT (for children 2-11 months and 1-5 years) were distributed -- 949,532 doses at health facilities and 30,028 doses at community care sites. Compared to PY3 (653,417 doses distributed), there has been an increase in ACT use due to the availability of ACT throughout the year, project-supported transportation of commodities from the health zone central offices to health facilities, and sound management of the supply chain of ACTs in collaboration with SIAPS.

The preceding notwithstanding, there were stock outs of ACT for 2-11 months old in the health zones supported by the coordination offices of Bukavu, Kamina, and Luiza, mainly due to underestimation of needs during quantification. In the health zones in Sankuru district there were stock outs of ACT (2-11 months) and other challenges as well (e.g., noncompliance of some providers with MOH malaria treatment protocols). To address these issues, IHP has started to redistribute commodities among CDRs to avoid stock outs. To address imminent ACT stock outs in Bukavu health zones, IHP developed a redistribution plan transferred surplus ACT stocks from the CDR in Lubumbashi to Bukavu.

Table 26: Number of ACT treatments for children under 5 purchased with USG funds and distributed to health facilities and community care sites PY4

Coordination Office	Total ACT 1-5 years and 2 – 11 months (health facilities and sites)			
	Quantity of ACT for children under 5 distributed through community care sites	Quantity of ACT for children 1 – 5 years distributed to health facilities	Quantity of ACT for children 2-11 months distributed to health facilities	Total quantity ACT distributed for children under 5
Bukavu	2,025	179,378	43,386	224,789
Kamina	9,095	166,333	40,168	215,596
Kole	534	31,035	26,791	58,360
Kolwezi	2,290	42,394	21,251	65,935
Luiza	1,870	94,895	47,048	143,813
Mwene Ditu	8,878	85,610	56,627	151,115
Tshumbe	3,326	45,063	19,862	68,251
Uvira	2,010	37,649	12,042	51,701
PY4 Total	**30,028**	**682,357**	**267,175**	**979,560**
PY3 Total	**14,279**	**461,283**	**177,855**	**653,417**

Table 27: Number of ACT treatments for all age groups purchased with USG funds and distributed PY4

Coordination office	ACT infant (2- 11 months)	ACT toddler (1 - 5 years)	ACT child (6 - 13 years)	ACT adolescent and adult > 13 years)	PY4 Total
Bukavu	44,248	180,541	162,731	149,891	537,411
Kamina	43,818	171,778	104,124	85,809	405,529
Kole	26,815	31,545	13,235	48,450	120,045
Kolwezi	21,274	44,661	29,222	46,323	141,480
Luiza	47,248	96,565	67,673	89,414	300,900
Mwene Ditu	57,400	93,715	100,273	138,923	390,311
Tshumbe	20,389	47,862	36,933	35,786	140,970
Uvira	12,632	39,069	27,629	23,065	102,395
PY4 Total	**273,824**	**705,736**	**541,820**	**617,661**	2,139,041
PY3 Total	**182,949**	**475,562**	**630,695**	**639,624**	1,928,830

During PY4, 2,166,145 doses of ACT for all ages were administered, which represents 87% of IHP's annual target (2,500,000 doses) and an increase of 12% since PY3 (1,928,830). The 87% coverage also surpasses the PNLP's target of 80%. The availability of commodities, trainings, and refresher trainings of providers, as well as monthly monitoring of commodities, all contributed to this achievement. Joint supervision missions with health zone and district management teams reinforced compliance with national policies regarding case management of malaria.

Table 28: Number of USG-funded malaria-rapid diagnostic tests (malaria-RDTs) purchased and distributed in PY4

Period	Coordination office								
	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	**Total**
PY4Q1	91,354	51,800	8,809	5,174	4,428	59,609	31,754	22,604	**275,532**
PY4Q2	67,541	26,817	4,546	8,887	17,871	92,678	21,949	12,211	**252,500**
PY4Q3	56,627	79,632	7,263	13,917	21,033	34,984	18,029	24,890	**256,375**
PY4Q4	98,165	70,404	12,468	25,059	18,634	116,757	24,283	15,384	**381,154**
PY4 Total	**313,687**	**228,653**	**33,086**	**53,037**	**61,966**	**304,028**	**96,015**	**75,089**	**1,165,561**
PY3 Total	**100,561**	**288,297**	**13,629**	**136,310**	**46,788**	**201,761**	**98,207**	**159,197**	**1,044,750**

During PY4, 1,165,561 malaria RDTs were distributed (31,865 to community care sites). Although this reflects a 12% increase over PY3 results, it falls short of meeting the annual target for RDTs distributed (2,500,000). On a positive note, coordination offices with weak results for this indicator in PY4Q1 had significantly increased distribution of RDTs by the end of the year: Kole (from 8,809 to 12,468), Kolwezi (from 5,174 to 25,059), Luiza (from 4,428 to 18,634) and Mwene Ditu (from 59,609 to 116,757).

The ratio of ACT/RDT at health centers went from 2 ACT to 1 RDT (PY3) to 1.8 ACT to 1 RDT (PY4), while the ratio at community care sites is 1 ACT/0.9 RDT. The MOH norm is 1 ACT/2 RDT, so more work needs to be done in this area. IHP notes that CHWs are more likely than health center providers to follow MOH norms. However, IHP

also notes that management of patients who test negative for malaria remains problematic as many CHWs and health center providers continue to see patients presenting with fever and a negative RDT as uncomplicated malaria. Further efforts are required to reverse the ratio of 1 ACT per 2 RDT through supportive supervision that focuses on compliance with the national protocol for the management of cases and management of malaria commodities.

As part of the collaboration between partners in the fight against malaria, RDTs at risk of expiring from SANRU were redistributed to IHP towards health zones that were in need via a memorandum of understanding between SANRU, IHP, and PMI Extension.

Table 29: Number of USG-supported service delivery points with ACT (1- 5 years) stock out PY4

Indicator	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Results	PY3 Results
Number of USG-supported SDPs experiencing stock out of ACT for 1–5 year olds	301	561	506	260	260	243
Target (threshold)					**100**	**160**

In PY4, stock outs of ACT (1-5 years) occurred at 260 service delivery sites that provide ACT. By the end of PY4, the stock out situation at all coordination offices was improved. For example, Kolwezi, Uvira, Bukavu, and Mwene Ditu each reported less than 5 structures with stock outs in PY4Q4. Although the number of stock outs declined between PY4Q3 and Q4 in other coordination offices (Luiza: from 45 in Q3 to 36 in Q4, Kamina: from 57 to -26; and Tshumbe: from 48 to 14), there is room for improvement and an ongoing need to strengthen monthly inventory monitoring and improved management of orders from health zones.

Table 30: Health staff trained on malaria diagnosis (RDT)

	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Total
Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests [RDTs] or microscopy) with USG funds	46	124	653	554	1,377
Male	40	112	585	455	1,192
Female	6	12	68	99	185
Number of health facility workers trained	46	124	469	537	1,176
Number of community-level workers trained	0	0	140	17	157
Number of lab technicians trained	0	0	44	0	44

In total, 1,429 providers were trained, reaching 60% of the 2,400 target number. All coordination offices trained health care providers in malaria prevention and treatment. In PY4, focus was placed on training health center providers and CHWs in the management of uncomplicated malaria, which is the most frequent reason for consultation visits. Given overall budgetary constraints, the planned training of health care providers on the management of severe malaria in hospitals and training of technicians in referral laboratories in microscopy did not take place. In PY5, a focus will be placed on training during supportive supervision visits for these groups of health care professionals to ensure quality of care for patients.

Monitoring and Evaluation

- IHP drafted the PPRM report with SIAPS and USAID|DELIVER to record health zone drug consumption.
- The data collection phase of the study on the pre-referral use of rectal artesunate to be given to children under five at community care sites was completed. The implementation phase should begin in November 2014, subject to obtaining the artesunate suppository at the end of October, at the latest. The PMI team in Kinshasa initiated a loan for this product with DFID through the ASSP project as it appears that delivery of commodities by USAID|DELIVER will be delayed.
- The preliminary report of the performance evaluation of health care providers in the implementation of RDTs is being finalized, and results will be shared in November 2014. Further assessment of providers in other provinces is needed to enable us to generalize the results.

4. Expanded Program on Immunization (EPI)

EPI data presented in this section were validated by all 78 health zone management teams. Overall, immunization coverage for tetanus, BCG, DTP HepB-HiB1, DTP HepB-HiB3, TOPV3, and measles has improved every year from PY1 to PY4 (see Table 31). Vaccine PCV13-3 is relatively new in the DRC. It was introduced in the country in 2011 and rolled out gradually to all service sites during the next two years (rollout was complete by the end of October 2013). There is weak coverage of PCV13-3 across the coordination offices due to frequent stock outs of the antigen for the following reasons:

- The quantity ordered is often different from the quantity delivered by the MOH (EPI), which has full responsibility for supplying vaccines from the central level down to the health zone level
- Delivery does not occur according to the agreed terms on frequency and intervals between deliveries according to the context and the needs
- As a result, the Extended Program on Immunization (EPI) supplied the branches late and in quantities below the minimum level of stocks required
- There was a delay in the availability of the government's contribution

Other vaccines are provided by the Global Alliance for Vaccines and Immunization (GAVI), with no government co-share requirement. For the most part, fewer stock outs of these antigens are reported compared to PCV13.

Table 31: Immunization coverage by coordination and vaccination type

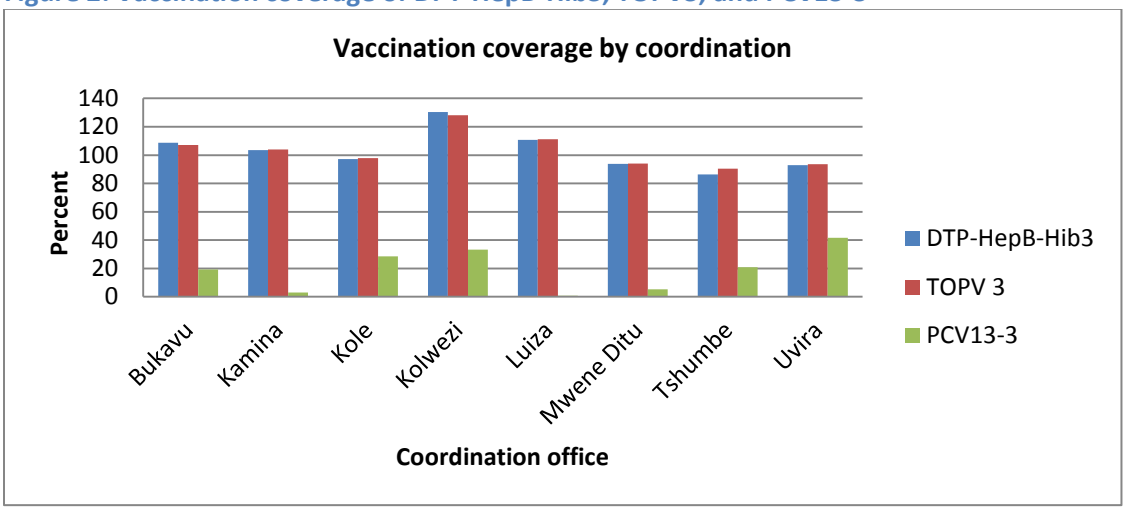
Coordination office	Tetanus vaccine 2+ (%)	BCG (%)	DTP HepB-Hib1 (%)	DTP HepB-Hib3 (%)	TOPV 3 (%)	Measles (%)	PCV13-3 (%)
Bukavu	93	91	114	109	107	98	19
Kamina	102	99	110	104	104	104	3
Kole	92	78	101	97	98	97	28
Kolwezi	109	148	139	130	128	106	33
Luiza	114	108	116	111	111	111	1
Mwene Ditu	100	89	99	94	94	94	5
Tshumbe	84	73	91	86	90	87	21
Uvira	82	68	99	93	94	78	42
PY4 coverage (%)	97	94	109	104	104	98	16
PY3 coverage (%)	95	107	107	103	100	95	-
PY2 coverage (%)	89	87	100	94	75	93	-

PY1 coverage (%)	89	74	102	96	-	90	-

Over the first four years of the project, the drop-out rate between DPT-HepB-HiB1 and DPT-HepB-Hib3 has been fairly low, from zero to 10% at its highest, due mainly to the consistent availability of commodities, successful implementation of the *atteindre chaque zone de santé* ("reach every health zone") approach, community outreach via the work of Champion Communities and community-based organizations, and donations of supply chain materials and commodities.

The vaccination coverage for DPT-Hepb-Hib3 and for Trivalent Oral Polio Vaccine (TOPV3) during PY4 was consistent across project sites. The only significant difference is with the PCV13-3 coverage: even though PCV13-1 is normally administered with the DPT-HepB-Hib3 and OPV3 at the same time, the low coverage is mainly due to stock outs not only in project sites but across the country in general.

Figure 2: Vaccination coverage of DPT-HepB-Hib3, TOPV3, and PCV13-3



Health zones' performance on coverage of DPT-HepB-Hib3 by coordination office: Overall, DPT-HepB-Hib3 coverage has been satisfactory. Seventy-three of 78 health zones have achieved at least 80% of coverage in 96% of project-supported health zones (20 out of 22 health zones in Bukavu, all 9 health zones in Kamina, 7 out of 8 in Kole/Lodja, all 8 in Kolwezi, all 9 in Luiza, all 9 in Mwene Ditu, 7 out of 8 in Tshumbe, and 4 out of 5 health zones in Uvira).

Five health zones achieved vaccination coverage between 50% and 79% (72% in Kalole, 73% in Mulungu, 72% in Nundu, 74% in Minga, and 62% in Tshudi Loto). Late delivery of vaccines in these zones resulted in some children missing vaccinations. For the next project year, IHP will continue to use the *atteindre chaque zone de santé* (ACZ) approach to maintain vaccination support gains, but will also focus on the *atteindre chaque enfant* (ACE) approach to raise performance where needed, and to strengthen data quality audits in health zones and health areas. While both approaches have similar components, i.e., planning and resource management, reaching out to targeted populations, linking the service and the population, supportive supervision, and monitoring for action, ACE may help reach those children who are the hardest to reach with our efforts.

Polio eradication: In March 2013, DRC was taken off the WHO list of polio endemic countries. The last detected case was in April 2013 in the health zone of Kabondo Dianda (Kamina district). In connection with the active surveillance for cases of acute flaccid paralysis (AFP), 66 of 78 project-supported health zones reported at least

one case of AFP from January to September 2014, which represents an overall notification rate of 85% at the project level. The remaining 12 health zones did not report (Ndekesha, Dekese, Bena Dibele, Djalo Ndjeka, Katako Kombe, Minga, Lusambo, Luamba, Bunkeya, Bagira, Miti Murhesa, and Nyangezi). The project will address this issue by strengthening surveillance at health facilities and communities.

5. HIV and AIDS

Since last quarter the HIV indicators presented in IHP quarterly reports coincide with the direct service delivery (DSD) indicators that are reported semi-annually for IHP PEPFAR COP activities, as discussed with USAID in June 2014.

By the end of last quarter (PY4Q3), IHP was supporting PMTCT activities in 52 sites across 13 health zones, including 7 Kolwezi health zones and 6 health zones in Kamina. PMTCT activities continued at these sites during PY4Q4. In terms of reporting this quarter, however, only 47 sites were able to regularly submit reports. The internal conflict within the health zone management team of Songa (Kamina coordination), as documented in previous reports, continued to have a negative impact on the roll-out of activities and reporting in this health zone in PY4Q4. IHP provided assistance during the quarter to settle the conflict and helped to direct the discussion towards a meaningful solution by the beginning of PY5. Finally, 17 new PMTCT sites (9 in Kolwezi, 8 in Kamina,) were established towards the end of PY4, for a total of 41 PMTCT sites in Kolwezi and 28 in Kamina by the end of PY4. The project will start reporting on activities at these new sites during the first quarter of PY5.

Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women: At the end of PY4, all PMTCT sites in Kolwezi (n=41) and in Kamina (n=28) had at least 90% of HIV+ pregnant women on ARV.

Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results): By the end of PY4, 18,778 women (of a target of 17,722) knew their HIV status. This includes women at ANC visits that were tested for HIV and received their results. The coverage exceeds the COP 2014 target by 6 percentage points. IHP plans to further strengthen awareness-raising activities at the community level and increase involvement of local leaders in such activities.

Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery: During PY4, 254 pregnant women (237 in Kolwezi and 17 in Kamina) were put on ARVs to reduce the risk of transmitting the virus to their infants during pregnancy, labor, or while breastfeeding. The number of women reached greatly exceeded the COP 2014 target of 152 (167% of target). Among the 254 pregnant women put on ARVs, 163 were put on treatment for their own survival while 91 were put on prophylaxis with zidovudine (AZT) from the 14th week of pregnancy. The successful coverage was a result of the availability of tests, ARVs, Pima and FACS Count as well as to the supportive supervision visits made by health zone management teams to health care providers at PMTCT sites. A data quality audit will be conducted in PY5 to ascertain if there are any overlaps and/or double-counting of beneficiaries by IHP and the Global Fund, which also supports PMTCT activities in some of the same health zones as IHP.

Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required: Results for this indicator are not yet available, but planning for HIV prevention activities and related procurements is underway. IHP will provide appropriate training in HIV prevention and use of awareness-raising kits that have been ordered but not yet delivered. The kits are due to arrive during the first quarter of PY5 and training in their use will be scheduled shortly thereafter.

Number of individuals who received testing and counseling (T&C) services for HIV and received their test results: In total, 39,211 individuals were counseled and tested for HIV, and received their test results, exceeding the COP 2014 target of 30,330 by about 30%. This is due to awareness-raising activities in the communities, availability of rapid screening tests, technical oversight by health zone management teams, and joint supportive supervision visits by the MOH and IHP.

Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load: In the two districts supported by IHP, 1,382 individuals received at least one clinical assessment on the advancement of their infection following WHO standards or had CD4 counted to determine their eligibility to go on treatment. The result greatly exceeds the COP 2014 target of 696, which represents an achievement rate of 197% (1,382 over 696). The coverage is due mainly to the availability of HIV commodities, CD4 tests and Pima cartridges, technical oversight by the health zone management teams, and joint supportive supervision visits from the MOH and IHP.

Number of HIV-positive adults and children receiving a minimum of one clinical service: A total of 989 HIV-positive adults and children received at least one clinical service in the PMTCT sites supported by the project, surpassing the target of 696 per the COP 2014 for an achievement of 142%. This result is due to the availability of cotrimoxazole and other HIV commodities such as the Pima cartridge to count CD4 cells, technical oversight by the health zone management teams, and supportive supervision.

As mentioned elsewhere in this report, given the possibility that patients from sites supported by other donors, such as the Global Fund, may have been counted for this indicator, a data quality audit will be conducted in PY5 to clarify data and avoid double counting of beneficiaries.

TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting: During PY4, 362 people living with HIV out of the 632 (58%) expected in COP 2014 were screened for TB. This fairly low coverage is linked to the qualification of health care providers, notably those in new HIV sites, who were not yet trained on HIV/TB co-infection. Training will be held in PY5 for providers.

Number of adults and children receiving antiretroviral therapy (ART) (current): During PY4, 786 people living with HIV received ARV treatment; this is well above the target of 175 set in the COP 2014. This achievement may be related to health zone management teams also counting patients on ARV that were supported by Global Fund programming. IHP and the Global Fund share coverage in four health zones (Manika, Dilala, Lubudi, and Lualaba) where the Pima CD4 cartridges were also distributed. Monthly meetings between partners are organized by the health zone head physician to discuss results and potential problems related to the fight against HIV, share experiences to avoid duplication, and promote complementary strategies and activities.

Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging), or CD4 count or viral load: During PY4, the number of HIV-infected adults and children was 1,369 (292 in Q4).

Proportion of registered TB cases that are HIV-positive who are on ART: During PY4, 106 registered TB patients (2 from Kamina, 104 from Kolwezi) started or continued ART. The total number of registered TB cases with documented HIV-positive status during the reporting period was 185. Training and refresher training sessions of health care providers will take place in PY5 in order to improve results for this indicator.

Percentage of laboratories and Point of Care (POC) testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program: Sixty-nine laboratories supported by the project are capable of performing HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing program. The project will support health teams at the provincial and health zone levels in follow-up and quality control under the direction of the provincial referral laboratory.

Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation: IHP met the target of 1 laboratory.

Family planning and HIV integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services: Sixty-nine functional PMTCT sites, with the support of IHP, systematically integrated family planning and safe motherhood services. The project also ensured family planning commodities were available at all sites. Health providers were trained in long-term family planning methods. Post-training supervision by health zone management teams followed. Awareness-raising campaigns, including SMS messaging, were launched to inform the public about the availability of integrated HIV and family planning services at these sites.

6. Tuberculosis

A total of 12,163 new sputum positive pulmonary tuberculosis cases (MPT+) patients were diagnosed during the year, and 60% of them were tested for HIV. In the field of multi-drug resistant tuberculosis management, there were 46 confirmed cases as compared to the PMP target of 60 expected, for an achievement rate of 77%. For TB/HIV coinfection, the number of patients counseled and tested increased from 7,528 to 7,703, for a rate of 63%, surpassing the target of 60% in the PMP.

Table 32: Case notification rate in new sputum smear positive pulmonary TB (MPT+) cases per 100,000 populations in USG-supported areas[7]

Coordination	Total PY4 population	PY4Q1		PY4Q2		PY4Q3		PY4Q4		PY4			
		MPT+ new cases	Notification rate (%)	MPT+ new cases	Notification rate (%) (‰)	MPT+ new cases	Notification rate (%)	MPT+ new cases	Notification rate (%)	MPT+ new cases total	Notification rate (%)	Target (%)	Achievement (‰)
Bukavu	3,619,941	477	53	533	59	515	57	434	52	1,959	54	150	37
Kamina	1,992,502	841	169	866	174	905	182	916	184	3,528	177	150	119
Kole	934,614	303	130	292	125	266	114	299	128	1,160	124	150	83
Kolwezi	862,924	276	128	241	112	205	95	248	115	970	112	150	56
Luiza	1,397,312	356	102	322	92	335	96	226	65	1,239	89	150	54
Mwene Ditu	2,064,337	488	95	517	100	530	103	493	96	2,028	98	150	64
Tshumbe	858,699	173	81	151	70	165	77	203	95	692	81	150	57
Uvira	910,582	132	58	143	63	161	71	151	66	587	64	150	43
Total	**12,640,912**	3,046	**96**	3,065	**97**	3,082	**98**	2,970	94	12,163	96	150	63

*Note that numbers may not be exact due to rounding.

[7] The case notification rate is the number of new TB cases (positive or all forms) that can be found in a group of 100,000 people. For the DRC, a high prevalence country, it is around 150/100,000 inhabitants. IHP calculates this indicator annually as stated in its PMP and Performance Indicator Reference and Tracking Sheet (PIRTS). The formula is as follows:

$$\frac{\text{Number of new sputum smear positive pulmonary TB cases reported in the past year X 100,000}}{\text{Total population in the specified geographical area of the same year}}$$

Data source: tuberculosis treatment registry; place of collection: health center for diagnosis and treatment of TB and health center for treatment

Overall results for number of new MPT+ cases notified per 100,000 population in USG-supported areas are encouraging, with 11,915 new MPT+ cases notified in PY4 compared to 10,953 new MPT+ cases in PY3. The number of notified cases for PY4 will no doubt be higher when the Kolwezi data is added. This is equivalent to the notification of 94/100,000 positive cases (cf. 83/100,000 in the previous year). In addition, although the result is less than the PMP target of 214 MPT+ cases notified per 100,000 inhabitants, the result is close to 97/100,000 which is the annual national average achieved by the National Treatment Program (NTP) in 2013. During IHP PY4, the quarterly notification rate (per 100,000 population) fluctuated slightly (Q1: 95, Q2: 94, Q3: 100, Q4 : 88), with the best results achieved in PY4Q3 (April and June 2014), during which health workers implemented an active door-to-door screening strategy in Uvira, Bukavu, Luiza , Mwene Ditu, and Kamina.

To date, the project achieved an average rate of 63% for the notification of smear-positive cases (using the rate of 150 cases for 100,000 as recommended by WHO and the International Union Against Tuberculosis and Lung Disease). The lackluster performance in Uvira, Tshumbe, and Luiza is due to the delayed allocation of mini-lab kits and DOT kits for sputum sample collection and shipment to the diagnostic and treatment centers (CSDT), to recurrent stock outs (Luiza, Tshumbe) and to security problems (Uvira).

To accelerate the achievement of objectives during PY5, the project will focus on reinforcing the capacity of trained CHWs and health providers to detect TB (provision of awareness kits, bicycles, etc.). Mini awareness campaigns will be organized to inform the public about TB, care and treatment, especially in areas where CHWs have been trained.

Percent of all registered TB patients who are tested for HIV through USG-supported programs: PY4 surpassed its PMP target (60%) with 63% of MPT+ patients tested for HIV across all 78 health zones (cf. 32% and 55% for PY2 and PY3, respectively). In the province of Katanga alone, the rate of achievement for tuberculosis patients with access to HIV diagnosis and comprehensive care is nearly 150%.

Table 33: Number and percentage of TB patients tested for HIV in PY4 by coordination

Coordination	MPT+ new cases	TB cases counseled and tested for HIV	%
Bukavu	1,959	1,363	70
Kamina	3,528	3,052	87
Kole	1,160	509	44
Kolwezi	970	790	81
Luiza	1,239	554	45
Mwene Ditu	2,028	975	48
Tshumbe	692	151	22
Uvira	587	216	37
PY4 Total	**12,163**	**7,610**	63

During PY4, IHP worked with Global Fund partners IMA/SANRU and World Vision to consolidate interventions against TB/HIV co-infection in HIV care sites in provinces where IHP no longer has a presence and in Katanga where HIV activities are being scaled up. The availability of rapid tests and other HIV supplies improved overall in these two districts in Katanga (Kolwezi and Haut Lomami) largely due to the increased supervision of sites by two newly-hired HIV technical staff.

Table 34: Number of TB patients tested for HIV in PY4 by quarter

	PY4Q1		PY4Q2		PY4Q3		PY4Q4		PY4	
	Counseled	Tested	Counseled	Tested	Counseled	Tested	Counseled	Tested	Counseled	Tested
Bukavu	477	315	533	332	515	390	434	326	1,959	1,363
Kamina	841	813	866	735	905	812	916	692	3,528	3,052
Kole	303	172	292	123	266	84	299	130	1,160	509
Kolwezi	276	380	241	186	205	142	248	82	970	790
Luiza	356	156	322	146	335	137	226	115	1,239	554
Mwene Ditu	488	301	517	231	530	161	493	282	2,028	975
Tshumbe	173	31	151	42	165	33	203	45	692	151
Uvira	132	86	143	31	161	65	151	34	587	216
PY4 Total	**3046**	**2254**	**3065**	**1826**	**3082**	**1824**	**2970**	**1706**	**12163**	**7610**

Table 35: Number of multi-drug tuberculosis (MDR-TB) cases detected in PY4 by coordination

Coordination	PY3	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4	Target PMP	Achievement %
	MDR-TB confirmed	MD-TB confirmed	MDR-TB confirmed	MDR-TB confirmed	MDR-TB confirmed	MDR-TB confirmed		
Bukavu	**6**	3	7	8	9	27	16	169
Kamina	**2**	0	0	4	0	4	10	40
Kole	**2**	0	0	0	0	0	5	0
Kolwezi	**0**	1	0	1	2	4	4	100
Luiza	**1**	0	1	1	0	2	7	29
Mwene Ditu	**2**	0	0	0	4	4	10	40
Tshumbe	**1**	0	0	0	0	0	4	0
Uvira	**3**	1	2	2	0	5	4	125
Total	**17**	5	10	16	15	**46**	**60**	**77**

The fight against multi-drug resistant tuberculosis: The total number of MDR cases detected in PY4 was 46, or 77% of the target (60), and nearly 3 times the number of MDR cases confirmed in PY3. These good results can be attributed to a combination of factors: the availability of IHP-procured GenExpert at the CSDTs and provincial laboratories; a transportation plan to take MDR samples between facilities; and caregiver training for MDR-TB patients for health zone management teams, nurses and lab technicians in Uvira, Bukavu, and Luiza. The fight against multidrug-resistant tuberculosis (MDR-TB) is a new initiative that the National TB Program is currently implementing in the DRC. IHP supported the program by arranging related trainings, organizing the supply chain, and transporting sputum samples from the health facilities to the National Reference Laboratory via the central health zone offices and the provincial coordination unit for leprosy and TB (CPLT). Additionally, the installation of GeneXpert should strengthen the decentralization of MDR-TB among the seven CPLTs in the provinces supported by the project. The Kole and Tshumbe coordination offices began this initiative last in relation to other coordination offices and still require close supervision of service providers and close monitoring of the MDR-TB activities package.

To further improve the management of MDR-TB, the project has planned to:

- Assist with transportation of NTP-provided MDR-TB supplies from the provincial level to health zone facilities;
- Support the installation of USAID-donated GenExpert equipment in Kamina, Kolwezi, Tshikapa, and Kananga;
- Fund the collection and transportation of sputum samples from MDR sites to GenExpert sites in Bukavu, Uvira, Mbuji Mayi, Kananga, Kolwezi, Kamina and Tshikapa, as well as to the culture laboratories in Kinshasa and Lubumbashi.

Number of USG-assisted service delivery points experiencing stock out of RH (rifampicin/isoniazid) combination: The number of facilities that experienced stock outs of RH decreased from 34 health facilities on average in PY3 to 17 health facilities in PY4. The Kamina coordination reported the largest number of stock outs.

Table 36: Number of USG-assisted service delivery points experiencing stock out of RH (rifampicin/isoniazid) combination

Coordination	PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4 Average
Bukavu	4	4	2	2	2
Kamina	1	9	5	15	15
Kole	1	4	2	1	1
Kolwezi	0	0	0	0	0
Luiza	1	5	5	1	1
Mwene Ditu	0	0	0	0	0
Tshumbe	2	1	5	0	0
Uvira	0	0	0	0	0
Total	**10**	**23**	**19**	**19**	**19**

Stock outs are commonly due to the delays in receiving transportation funding tied to lengthy CAG/Global Fund procedures. To remedy this situation, the project will pre-position the TB supplies (medications and lab equipment) in the health zones in order to prevent stock outs.

The main reasons for the current situation are :

- Stock out of commodities, especially anti-TB drugs, in the supported health zones which are under the direct responsibility of the National TB Control Program (PNLT) (the PNLT occasionally requests IHP to assist with transport of these commodities)
- Frequent movement of qualified staff and lack of appropriate training of new staff in TB diagnosis and care
- Insufficient implementation of successful community-based strategies that involve community-based organizations (CBO), health development committees (CODESA), TB support group Club d'Amis Damien (CAD), and active TB screening through a door-to-door strategy in low performing health zones

The project has learned the following lessons to improve the situation going forward:

- Strengthen proven community-based strategies and combine them with CBO, CODESA, and CAD involvement as well as active TB screening for more successful programs
- Ensure that a full integrated package of TB activities (including clinical and community activities; lab quality control and accreditation process; co-infection and multi-drug resistant TB (TB-MR) related

activities; and reliable supply chain management of TB drugs) is planned and implemented in target priority weak performing health zones.

7. **Nutrition**

Activities on the integration of Infant Young Child Feeding (IYCF): From July 11 to August 2, 2014, the project facilitated the training of 18 members of health zone management teams, two from the district health team, four IHP staff, community health workers, and health care providers from two health zones (Kabongo and Kitenge) on the integration of IYCF in the Haut Lomami district.

From September 25 to October 13, 2014, IHP participated in a joint post-training supervision mission with staff from the national nutrition program (PRONANUT) at the national and provincial levels and health zone management teams to the health zones of Dibaya, Luiza, and Kalomba to oversee activities promoting IYCF rolled out by trained health care providers and CHWs and confirm that communities are starting to apply best feeding practices. Data presented in this section for PY4 were validated by all 78 health zones, indicating a completion rate of 100%.

Number of children under 5 years of age who received vitamin A: During PY4, the project exceeded the annual target (2,520,338) by distributing vitamin A to 3,378,133 children under five years of age (134% achievement). The project distributed 1,743,109 during PY4Q3 and 1,635,024 during PY4Q1 as scheduled.

Number of pregnant women who have received iron-folate tablets to prevent anemia during the last five months of pregnancy: During PY4, 504,282 pregnant women received iron-folate, exceeding the annual target of 405,168 for an achievement rate of 124% and increasing by 11% since PY3 (450,214).

This high coverage is due mainly to the availability of commodities in health centers and the sound management of essential generic drugs, including close monitoring of inventory. IHP will maintain this performance by closely monitoring commodity management and regularly supplying health zones with products.

Number of mothers of children 2 years of age or less who have received nutritional counseling for their children: During PY4, 574,577 women received nutritional counseling for their children, exceeding the annual target of 409,824 for an achievement rate of 140%. The coverage increased by 27% from the previous year (419,122), due in part to the promotion of IYCF in the targeted health facilities and in the communities.

Despite the increase, reports from CHWs, who are key in providing nutritional counseling to mothers and caregivers through home visits and support group meetings, frequently are not counted by the health zones. Often, reports that are sent to the health centers do not get forwarded to the health zone central office. The majority of health zone central offices are not monitoring data collection and submission closely enough. In some instances, CHWs do not even have data collection tools to use. The project plans to continue to emphasize close monitoring by health zones and will continue to ensure that collection and management tools are available to CHWs working to promote nutrition counseling. The project also will focus on health zones with low levels of post-training monitoring plan achievement and supportive supervision.

Number of breastfeeding mothers receiving vitamin A: During PY4, only 138,003 (38%) breastfeeding mothers received vitamin A, falling short of the annual target of 361,052. The project did not meet the target due to insufficient quantity of vitamin A in the health centers. The project will emphasize close monitoring of vitamin A supply in health facilities and to encourage distribution when they are available. This supplement is provided to breastfeeding women during routine postnatal visits. The vitamin A ordered by IHP only arrived at the end of

PY4Q3; distribution via the CDRs began only over the course of the last quarter of the year (PY4Q4). On the other hand, data on the supplementation of children under five months of age was reported during a mass campaign, accomplished by a door-to-door strategy; as a result, the target was reached and even exceeded.

Number of USG-supported health facilities experiencing stock outs of iron-folate: During PY4, the number of health facilities (489) experiencing stock outs of iron-folate exceeded the annual target (400) and last project year's (452) result. The high stock outs result from ordering insufficient amount of iron-folate on the part of health facilities. In addition, monitoring the supply chain of iron-folate by the health zone management teams needs to be further strengthened. During its first two years, IHP experienced iron-folate supply challenges. After PY3, all health zones were provided with supplies and should not have experienced further stock outs. However, certain health zones continued to experience stock outs for the following reasons:

- Poor prescription practices by health providers who do not adhere to the flow charts, resulting in a waste of products;
- Lack of information on product availability and some providers do not know when to place an order or when to restock;
- Emphasis on drugs used for more profitable curative care services at the expense of drugs used for free consultations such as prenatal and pre-school consultations.

8. Sexual and Gender-based Violence

During PY4, IHP was not able to train health care providers in Kolwezi on the management of sexual assault cases as planned: there was a lack of time and limited availability of trainers after the period when the spending of the project was limited. The Bukavu and Uvira coordination offices distributed post-exposure prophylaxis (PEP) kits in the health facilities that receive and treat victims of sexual violence. It should be noted that throughout the life of the project, only four coordination offices received PEP kits: Bukavu and Uvira (which received their PEP kits in April 2014) and Kolwezi and Kamina (where PEP kits were delivered and distributed in August 2014). As of this report, Bukavu had received 550 kits and used 164, for a balance of 386 available; Uvira received 300 and used 29, for a balance of 271 available kits; Kamina received 100 and has not used any of them; and Kolwezi received 100 and used 92, for a balance of 8 available kits.

There were 3,886 reported cases of sexual violence during this project year, which was slightly lower compared to that of PY3 (4,144). About 99% of victims were women or girls. The decrease in the numbers of cases is due in part to the project's efforts to raise awareness via community outreach by Champion Communities and SMS messaging by CHWs. About 61% of the victims were received, examined, and treated at health facilities within 72 hours; 39% were examined and treated between 72 and 120 hours after the attack. It should be noted that the location of the crime is not necessarily near a health center or its surroundings, so delays can be related to distance, accessibility to a health center that treats these cases, hesitation on the part of the victim, feelings of shame, and victims taking time to discuss their situation; however, care begins as soon as the victim arrives at the center. Most of the attacks reported were perpetrated by armed men or members of the family, including partners and spouses.

In Luiza, cases have not been reported since February 2014 when Doctors of the World, a U.S.-based humanitarian organization, ended its involvement in the region. To ensure proper care of victims, IHP will continue to supply PEP kits to health zones, conduct awareness-raising activities in the communities, and provide supportive supervision to health care staff.

The table below shows the number of reported sexual violence victims treated at health facilities.

Table 37: Number of people impacted by GBV services funded by the U.S. Government, disaggregated by sex and period of arrival at a health facility						
Health zone	**Number of people reporting sexual violence in USG-supported health clinic**		**Number of people reporting sexual violence in USG-supported clinic within 72 hours**	**Number of people reporting sexual violence in USG-supported clinic between 72 and 120 hours**	**Number of people reporting sexual violence in USG-supported clinic given ARVs**	**Number of people reporting sexual violence in USG-supported clinic given emergency contraceptive**
	Females	Males				
Bukavu	2,826	12	1,749	1,091	1,494	1,542
Kamina	52	24	29	25	4	2
Kole	104	19	69	37	26	27
Kolwezi	1,511	1,526	0	1,511	0	0
Luiza	332	15	132	200	65	92
Mwene Ditu	0	15	0	0	0	0
Tshumbe	14	14	8	6	5	2
Uvira	498	21	375	138	337	337
PY4 Total	**5,337**	**1,646**	**2,362**	**3,008**	**1,931**	**2,002**

Fistula: During PY4, a total of 240 women suffering from urogenital fistula benefitted from care under the project. Women between the ages of 20 and 45 years old were the most affected. The Kaziba GRH in Bukavu, the only hospital with the capability to do this work, carried out the surgeries under an IHP sub-grant. About 20 fistula repairs were done per month over the course of the year. There were 128 cases of vesico-vaginal fistula, 34 vesico-utero-vaginal cases, and 41 victims have been incontinent (see Appendix 5).

Most fistula cases are caused by prolonged, unrelieved obstructed labor, especially for women who give birth at home without medical assistance. The repair success rate is 80% (194 cases) and 19% failure (46 cases). Proper monitoring of a woman in labor using the partograph could help reduce fistula cases but this important tool is not yet used or available in all maternity clinics. If the repair fails, the woman is asked to recuperate from the intervention and then consult again with a surgeon. There are cases that require plastic surgery, but this option is neither available nor feasible in the context of this project.

Next quarter actions to be taken: During joint supervision visits, health care providers at Kaziba hospital will be trained in the correct use of the partograph, provided by IHP. In addition, the project will support community mobilization activities to promote use of services at maternity clinics where pregnant women can await delivery thus avoiding the need to seek transportation and travel long distances to give birth when labor starts.

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

1. **Continued integration of the FOSACOF approach**

IHP's *fully functional service delivery point* (FOSACOF) approach is used in target health facilities as a standards-based tool centered around nine criteria reflecting the national norms established by the MOH in order to improve the quality and availability of services offered to the population.

During PY4Q4, 82 new health facilities integrated FOSACOF, which is almost double the number seen in PY4Q3 (44). This makes 227 total structures in PY4 2014, as Bukavu, Kolwezi, and Kamina were able to integrate the approach in 86, 50 and 48 sites, respectively. This result was achieved through the involvement of local health authorities, the motivation of care providers, and the ownership of the approach by the community. Finally, it should be noted that the result of PY4 (227) is lower than that of PY3 (504) due to budgetary constraints during the first three quarters of the year.

Table 38: Health facilities integrating the FOSACOF approach by coordination offices in PY4

Coordination office	Cumulative PY1-PY3	PY4 Q1	PY4 Q2	PY4 Q3	PY4 Q4	Total PY4	Cumulative PY1- PY4	# of structures (health centers and hospitals)	Integration rate (%)
Bukavu	67	27	0	44	15	86	**153**	421	36
Kamina	29	48	0	0	0	48	**77**	211	36
Kole	49	26	0	0	1	27	**76**	137	55
Kolwezi	40	0	0	0	50	50	**90**	114	79
Luiza	93	0	0	0	0	0	**93**	179	52
Mwene Ditu	97	0	0	0	0	0	**97**	180	54
Tshumbe	93	0	0	0	0	0	**93**	127	73
Uvira	36	0	0	0	16	16	**52**	107	49
PY4 Total	**504**	**101**	**0**	**44**	**82**	**227**	**731**	**1,476**	**50**

During this same period, the project evaluated 288 of 1,476 health facilities, and the results show that 63.8% of the evaluated structures (i.e., 184 out of 288) exceeded 50% of the quality threshold and 7.6% (22 out of 288) were below 25%, as they had just recently integrated the approach.

Table 39: Evaluation of the evolution of qualitative data in health facilities that have integrated the Fully Functional Service Delivery Point approach (FOSACOF) by coordination office

Coordination office	# of health facilities evaluated	Class D <25%	Class C 25< 50%	Class B 50<79%	Class A ≥80%
Bukavu	38	3	19	10	6
Kamina	15	2	6	5	2
Kole	18	0	6	8	4
Kolwezi	66	9	14	38	5
Luiza	19	0	1	17	1
Mwene Ditu	71	0	21	46	4
Tshumbe	24	0	4	19	1
Uvira	37	8	11	14	4
Total IHP	**288**	**22**	**82**	**157**	**27**

The remaining challenge is the application of FOSACOF in the Kamina and Uvira coordination offices, which have not yet achieved a 50% FOSACOF integration rate. The next steps are:

1. Work with the MOH so that they are able to full adopt the approach, to ensure continuity and sustainability;
2. Support the other coordination offices (Kole, Luiza, Mwene Ditu, and Tshumbe) to focus on implementing FOSACOF evaluations in the health facilities to follow the evolution of service quality in the health structures through recovery plans.

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

RBF implementation began on November 1, 2013, at which time contracts were signed with 135 RBF participating entities (118 health centers, 7 health zone management teams, 7 general referral hospitals). IHP also signed contracts with 14 community-based organizations (2 per health zone) assigned to undertake verification of health center data. Given that RBF activities began in November 2013, the quarterly periods are as follows:

- First quarter: November 2013-January 2014
- Second quarter: February-April 2014
- Third quarter: May-July 2014
- Fourth quarter: August-September 2014 (this "quarter" was shortened to just two months to return to and respect the normal fiscal year calendar that began October 1, 2014)

The cycle of RBF activities is six months and includes service delivery for three months, verification and counter-verification, and the payment process. During the third quarter (May-July 2014), all activities in the six-month cycle were implemented, but given that the data had not yet been validated at the time of the annual report, we made the decision that we would not yet present them. The process of verification and counter-verification is a prerequisite to validating the data. For IHP PY5Q1, RBF data collection and reporting will be aligned with the overall IHP quarterly reporting cycle.

RBF is a strategy to improve performance and outcomes of health services by linking incentives with results. RBF contractors receive payment from IHP according to contractual performance-based criteria and a sliding pay

scale that is linked to the level of attainment of agreed-upon targets. This report presents the achievements of the first three quarters of implementation of the approach for the services during two quarters and checks-against-verification and payment.

The results related to maternal and child health indicators show that ANC 1 was covered at 86% in the first quarter and 80% in the second quarter; VAT 2+ at 75% in the first quarter and 80% the second quarter; and ANC 4 at 46% in the first quarter and 62% in the second quarter. High-risk pregnancies were referred at a rate of 65% in the first quarter and 81% in the second quarter, deliveries at 73% in the first quarter and 70% in the second, and at least two postnatal visits at 70% in the first quarter and 80% in the second. DTP HepB-Hib3 vaccination was 84% in the first quarter and 87% in the second quarter.

These figures are close to the results of the 2013 DRC Demographic and Health Survey (DHS), but exceed DHS figures for VAT 2+. The IHP RBF health zones achieved 84% in the first quarter and 87% in the second quarter, while the 2013-2014 DRC DHS result was 66%. The IHP RBF results are also close to the results of the International Business & Technical Consultants, Inc. (IBTCI) baseline assessment, which is comparable to the 2013-2014 DRC DHS results. In the course of data verification, some RBF data were refuted due to errors made in filling out the required management forms. Thus, there is reason to believe that in reality the RBF numbers in the health zones might be higher than those reported.

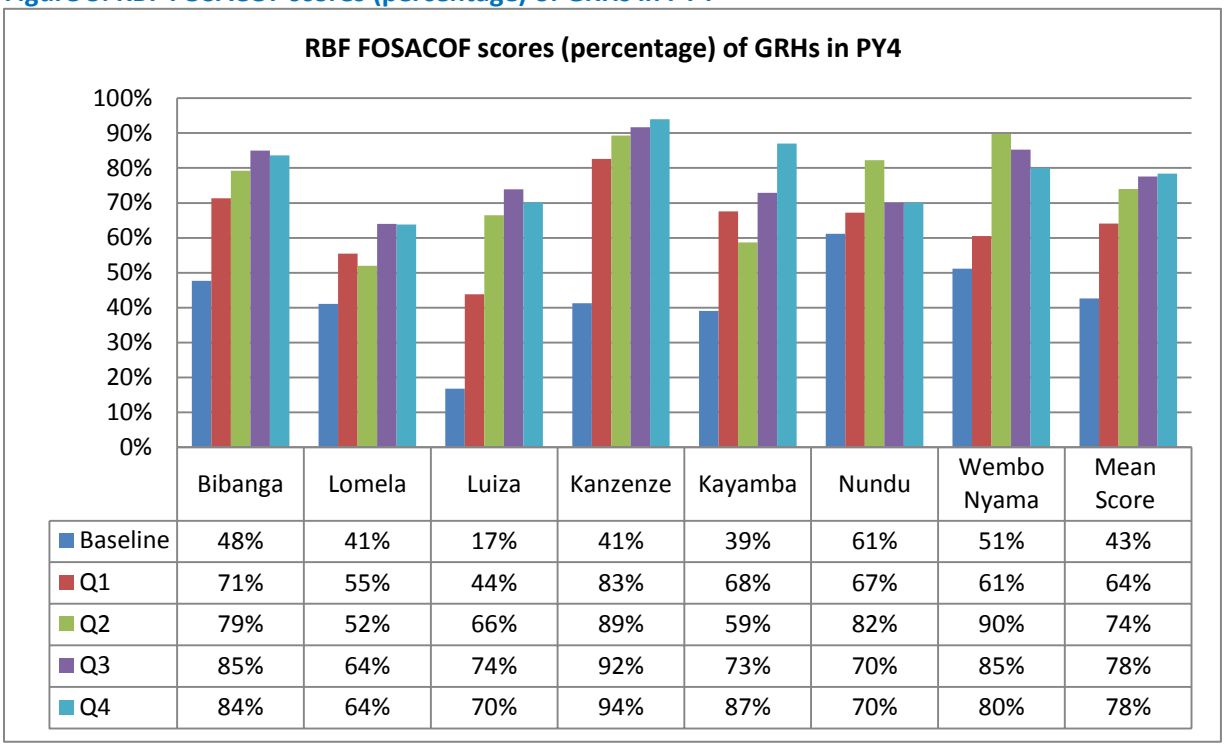
Table 40 summarizes the progress of verified and validated FOSACOF scores for health centers and GRHs from the baseline to the fourth quarter of the first year of RBF activities.

Table 40: Verified and validated FOSACOF scores for health centers and GRHs

	GRH (%)	Health centers (%)
Baseline	43	32
Q1	64	44
Q2	74	54
Q3	78	60
Q4	78	61

The GRHs have made significant efforts to improve quality and have become functional, with an overall FOSACOF score of 74% after 6 months of implementation. However, they had an overall score of 39% for PY4, all quality criteria considered. The health centers improved their overall score of 33% in the baseline assessment to 43% in the first quarter and reached 45% in the second quarter.

Figure 3: RBF FOSACOF scores (percentage) of GRHs in PY4



	Bibanga	Lomela	Luiza	Kanzenze	Kayamba	Nundu	Wembo Nyama	Mean Score
Baseline	48%	41%	17%	41%	39%	61%	51%	43%
Q1	71%	55%	44%	83%	68%	67%	61%	64%
Q2	79%	52%	66%	89%	59%	82%	90%	74%
Q3	85%	64%	74%	92%	73%	70%	85%	78%
Q4	84%	64%	70%	94%	87%	70%	80%	78%

Table 41, below, summarizes the progress of verified and validated FOSACOF scores for health centers and GRHs from the baseline to the fourth quarter of the first year of RBF activities. The table illustrates that during the third quarter, more than two-thirds of the health facilities, or 67%, are moderately functional, while 2 percent are still not functional; and 8% are fully functional. Numbers may not match exactly due to rounding.

Table 41: RBF results by health zone and performance category

RBF health zone	Health center with performance below 50%	Health center with performance 50-80%	Health centers with performance > 80%	Total health facility
Bibanga	4	11	2	17
Kanzenze	3	6	6	15
Kayamba	4	9	0	13
Lomela	15	4	0	19
Luiza	1	16	1	18
Nundu	3	18	0	21
Wembo Nyama	0	15	0	15
Total	**30**	**79**	**9**	**118**
%	**25**	**67**	**8**	**100**

Health zone management team indicators related to the supervisory functions of health facilities and medication management need improvement: the results attained against the overall annual targets are only 45% for the supervision of health facilities, 39% for support to community mobilization, 34% for support to WASH activities, 12% for the validation of drug orders by the quantification committee, and 13% for stock outs.

With respect to payment, GRHs received $ 72,453 in the first quarter, a 74% achievement of the target, and $75,358 for an achievement of 87.6% in the second quarter. Health centers were awarded $ 72,129 in the first quarter for a completion rate of 67.2% and $91,435 for an achievement rate of 76.2% in the second quarter. The health zone management teams received $ 10,725 with a completion rate of 64% in the first quarter and $13,969 in the second quarter for an achievement of 83%. However, the high achievements of the health zone management teams in the second quarter related to setting easily achievable targets.

At this stage, it was found that the health zone central offices are the weak link in the system at the operational level. There are extenuating circumstances related to the problems of understanding indicators or availability of scarce drugs; however, improving the management of health zone management teams is an important challenge to maintain and improve the performance achieved.

There is room for improvement in several areas: maintenance of management tools, health information, community involvement, effective medication management, supervision of secondary structures, provider support, CBO outreach, organization of IHP coordination offices to perform more of the *Agence d'Achat de Performance* (AAP) RBF duties[8], and the management of the RBF program at the MOH central level. During the second year of implementation of the IHP RBF model, IHP will work with the MOH RBF unit to address any improvements in the RBF model and tools, particularly based on the findings and recommendations of the mid-term assessment conducted recently by IBTCI. It will be critical to consider the needed improvements as IHP revises the contracts to all involved parties for the second year of implementation.

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

In PY4, the number of patients referred by health centers to the GRH was 213,788 and represents 4% of the number of patients seen and consulted in health centers.

[8] AAP is the fiduciary body in charge of overseeing the IHP-contracted entities and ensuring that they are fulfilling their responsibilities, working in compliance with the contractual regulations, and ensuring transparency of all of their RBF activities and operations.

Table 42: Number and percentage of patients referred to GRHs

Coordination Office	PY4Q1		PY4Q2		PY4Q3		PY4Q4			PY4	
	Patients referred to GRH	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Patients referred to GRH**	**Patients seen by a CHW or health care provider**	**Rate (%)**
Bukavu	19,460	455,368	18,687	512,145	16 315	478,616	20,318	480,786	74,780	1,926,915	4
Kamina	4,337	211,394	3,698	194,864	3 860	202,746	2,930	179,379	14,825	788,383	2
Kole	4,941	96,005	5,398	87,556	5 591	89,302	5,663	90,583	21,593	363,446	6
Kolwezi	3,187	105,171	2,571	118,490	1 521	103,261	1,474	94,631	8,753	421,553	2
Luiza	2,314	134,481	1,618	137,930	1 444	129,500	1,912	123,407	7,288	525,318	1
Mwene Ditu	11,488	204,457	12,331	199,963	13 687	217,327	14,437	232,385	51,943	854,132	6
Tshumbe	5,030	68,051	4,760	70,738	5 490	67,956	5,792	77,599	21,072	284,344	7
Uvira	3,416	79,019	3,556	73,022	3,298	74,583	3,264	67,283	13,534	293,907	5
PY4 Total	**54,173**	**1,353,946**	**52,619**	**1,394, 708**	**51,206**	**1,363,291**	**55,790**	**1,346,053**	**213,788**	**5,457,998**	**4**

This represents an increase over the number of referrals recorded during PY3 (134,376). This is due to head nurses properly using flow charts and to health centers not replacing the GRHs in trying to apply CPA. Some health areas (e.g., Bilomba and Kalomba) in Luiza performed well because they used health center bicycles as a means of transportation to refer patients, improving the quality of care for patients, and improving hygiene conditions in the GRHs. CHWs referred 28% of patients seen (around 20,000 cases) to health centers and managed the remaining cases (72%) at their level. These figures provide evidence for continuing to support and strengthen the community-level health system, particularly i-CCM.

Table 43: Number and percentage of patients referred to health centers

	PY4Q1		PY4Q2		PY4Q3		PY4Q4		Total PY4		Rate (%)
	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center	Patients seen by a CHW	
Bukavu	379	1,374	901	1,508	307	1,454	1,115	5,421	2,702	9,757	28
Kamina	946	6,555	736	5,451	648	3,625	1,172	3,558	3,502	19,189	18
Kole	827	2,186	288	843	295	2,070	343	3, 956	1,753	9,055	19
Kolwezi	66	872	112	671	188	1,124	156	1,300	522	3,967	13
Luiza	171	1,696	98	1,781	220	2,666	373	2,908	862	9,051	10
Mwene Ditu	813	2,240	709	2,442	918	3,465	3,511	4,657	5,951	12,804	47
Tshumbe	293	515	1,514	2,517	1,123	1,246	1,178	1,784	4108	6,062	68
Uvira	181	795	167	428	84	592	143	802	575	2,617	22
PY4 Total	3,676	16,233	4,525	15,641	3,783	16,242	**7,991**	**24,386**	**19,975**	**72,502**	**28**

INTERMEDIATE RESULT 3: KNOWLEDGE, ATTITUDES, AND PRACTICES TO SUPPORT HEALTH-SEEKING BEHAVIORS

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

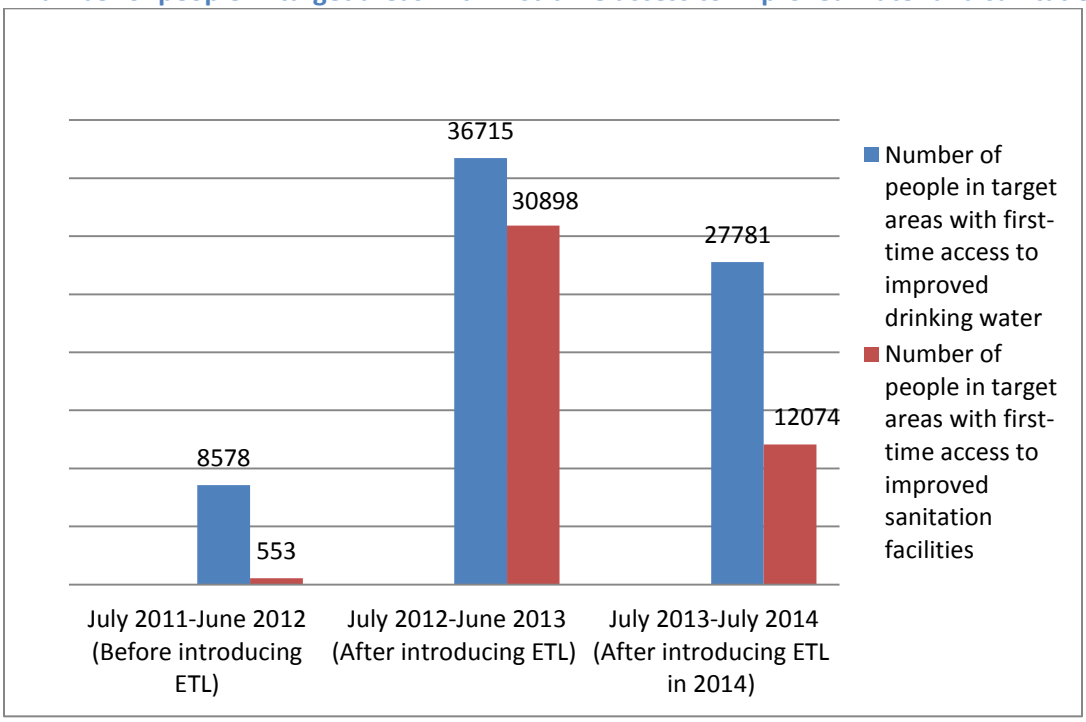
1. Education Through Listening

Education Through Listening (ETL) has been adopted by IHP as a BCC approach that enables community health workers and volunteers to encourage positive and community-driven health-seeking behavior change. Designed as a participatory teaching method, ETL promotes behavior change through participant-focused discussions in which community members identify local health challenges and discuss potential solutions. ETL has been incorporated into a wide variety of project initiatives across the target health zones, including CODESAs, Champion Communities, Champion Men, and youth associations.

During PY4Q4, ETL was a key BCC intervention. In Mwene Ditu, the Network of Congolese Associations of Youth Against AIDS (RACOJ) brought together youth associations to conduct 83 youth-led ETL sessions with their peers on HIV/AIDS prevention, reproductive health, and community involvement. Also this quarter, Champion Communities and Champion Men groups in Dibaya, Ndekesha, and Bilomba used ETL to support a mass polio vaccination campaign facilitated by the project across the Kasaï Occidental province.

In August 2014, BCC consultant and ETL expert Amélie Sow-Dia traveled to Mwene Ditu to evaluate the implementation and effects of the ETL approach. As part of her evaluation, she found that ETL has contributed significantly to the WASH component of IHP. Prior to the introduction of ETL and Champion Communities in the Wikong health zone, much of the population did not have access to potable water or sanitation facilities. Since the introduction of ETL in 2013, the number of people in the Wikong health zone with access to potable water and sanitation facilities has dramatically increased, which can be seen in the graph below. Based on interviews with M&E staff from the Mwene Ditu coordination office, the consultant reported that 68 improved water sources have been built in Wikong health zone since the introduction of ETL. This development contributes to 72 percent of the health zone's population access potable water and places it within reach of the IHP end-of-project target of 80 percent.

Figure 4: Number of people in target areas with first-time access to improved water and sanitation facilities



Challenges: Despite the positive outcomes ETL has contributed to the project, there is room for improvement. As the project begins its final year, a key challenge is ensuring the sustainability of ETL. While the integration of ETL in other project initiatives is promising, it is important that master ETL facilitators are trained in as many CODESAs, Champion Communities, youth organizations, and other community groups as possible.

Although budget constraints have also limited the number of formal five-day ETL training sessions, BCC experts have conducted informal half-day briefings which they supplement with support from the field during ETL campaigns.

Next steps: BCC experts in the coordination offices will continue to provide supervisory support to community groups conducting ETL outreach sessions. The project will also continue to promote the integration of ETL in other project initiatives

2. Youth Associations

Youth associations play a vital role in the promotion of healthy practices and behaviors. They facilitate active participation of young people in their communities, and create a voice for young people on issues related to health and development.

Of the current 257 NGOs identified by IHP, more than half (55%) are active (N=143). Working with and through the youth NGOs and associations has proven to be an effective means of conveying vital health and hygiene information to young people and to support their community development initiatives. A few highlights of this quarter's youth activities follow, and the number of youth organizations carrying out awareness-raising activities by coordination office is found in Table 41.

In the Dilala health zone, two youth associations participated in two training sessions. Topics included sexual and gender based violence and STIs. After the training, the youth associations held 13 group sessions on the same themes for 132 young people in their communities. As a result of these group sessions, 14 cases of STIs were referred to health centers and three cases of sexual violence were reported to local authorities.

In Lodja, 12 youth associations educated 422 people on the advantages of contraceptive methods, and condoms were also distributed during these outreach meetings. The number of awareness-raising activities completed by youth associations this quarter can be seen in Table 44 below.

Table 44: Number of youth organization completing youth awareness raising activities*

Coordination Office	PY4Q1	PY4Q2	PY4Q3	PY4Q4
Bukavu	8 (21)	5 (10)	55 (8)	10 (55)
Kamina	5 (12)	5 (12)	3 (7)	8 (8)
Kole	8 (8)	8 (8)	6 (6)	15 (23)
Kolwezi	5 (5)	5 (5)	52 (9)	13 (9)
Luiza	10 (10)	15 (15)	12 (8)	12 (8)
Mwene Ditu	74 (76)	74 (76)	59 (60)	76 (78)
Tshumbe	5 (5)	5 (5)	1 (0)	7 (2)
Uvira	15 (20)	15 (20)	13 (75)	15 (34)
Total	130 (157)	132 (151)	106 (268)	143 (257)

**The second number, in parentheses, represents the number of youth associations identified by the project this year. The first number, not in parentheses, represents the number of active youth associations.*

Challenges: During this quarter, the number of youth associations that were identified in project health zones decreased from 268 to 257 due to poor reporting by project health zones; several health areas did not fully complete supervision of youth organizations prior to the end of the reporting period, and were unable to provide information to their respective health zones on the youth organizations in their territories. The health zones, after receiving the reports, are responsible for compiling a list of approved youth associations and sending to the project coordination office.

IR 3.2: Health advocacy and community mobilization organizations strengthened

1. **CODESA: Health advocacy and community mobilization**

CODESA members are responsible for disseminating health information to the local populations. They interact with community members, listening to their views and concerns and educating them on identifying health problems and causes, as well seeking solutions. CODESA members promote behavior change to ensure prevention and treatment of disease through awareness-raising activities and community mobilization. Community mobilization, which encourages local responsibility for community health, is central to the long-term behavior change process. To support this process, IHP has implemented several innovative BCC approaches, including Champion Communities, ETL, and mHealth. IHP also utilizes more traditional BCC interventions, such as building the capacity of local partners such as CODESAs to carry out their own communication action plans, enabling them to actively engage with local populations.

During PY4Q4, IHP revitalized 1,322 CODESAs, reaching 94.6% of the annual goal of 1,398. Of these revitalized CODESAs, 1,265 have developed a communication action plan, to be implemented with the assistance of IHP and community mobilizers. For example, of the 129 CODESAs identified by the coordination office in Kole, by the end of project year 4, 100% have been revitalized and have a corresponding communication action plan. See Table 12, presented on page 19, for data on revitalized CODESAs.

IHP has supported many CODESAs in implementing BCC interventions this quarter. In the Kasaï Occidental province, for example, the project facilitated the mobilization of all CODESAs in the province's 9 health zones to support a Ministry of Health mass polio vaccination campaign. CODESA members led community mobilization interventions in churches, schools, and households. After extensive preparatory meetings and briefings to organize the BCC campaign, the CODESA members counted households with children under the age of five, and worked with Ministry of Health vaccination teams to ensure the children received the required vaccinations. They also helped dispel rumors current in the community regarding vaccination. These same types of actions were made by CODESAs in all health zones.

CODESAs were also actively involved in handling a dangerous outbreak of diarrhea in the Luiza health zone in July 2014. CODESA members conducted outreach initiatives to raise awareness about the importance of washing hands at critical moments, using hygienic latrines, only drinking water collected from improved water sources and properly conserving potable water, and thoroughly cooking and preserving food. The Luiza CODESA BCC campaign included 14 group community mobilization sessions in churches and 634 outreach visits to households. CODESAs also distributed 100 informational announcements to local churches to be read by pastors to their congregations regarding prevention of diarrhea. A WASH committee was also formed to maintain potable water sources.

Challenges: While the number of functional CODESAs with communication action plans continues to increase, this growth is challenged by a lack of financial resources. Some health zones are unable to properly supervise their community volunteers due to a lack of training and resources. Many CODESAs lack office facilities that would allow them to archive valuable documents. There remains an insufficient level of coordination between CODESAs and other community stakeholders, including religious groups, teachers, local authorities, CBOs, and other private leaders.

Next steps: IHP has two primary goals for next quarter to ensure that CODESAs continue to grow in support and influence. With the assistance of the health districts, the project will continue to provide CODESAs with

management tools (such as reporting documents and meeting facilitation guidelines) and will guide health zones in supervising community activities.

IHP will also organize, together with the PNCPS, the MOH primary health office (B5), health districts, and the IHP team, joint supervisory missions to support the revitalization of CODESAs. Finally, the project will continue to facilitate the relationship between CODESAs and other stakeholders in each health area.

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

1. **Behavior Change Communication (BCC)**

Targeted SMS messages were particularly effective during the course of the year. For example, in Bunkeya (Kolwezi health district), 472 women received counseling on CPN, vaccination, and the use of LLINs through a targeted SMS campaign. Prior to PY4, women were rarely the targeted recipients of SMS messages, and this campaign increased their feelings of empowerment related to their families' health. Men are now also encouraged to share SMS messages with women. In the Bibanga, Dibaya, and Dilala health zones, approximately 68 teachers received SMS messages that they then disseminated to their students, who shared these messages with their peers. The SMS themes focused on responsible sexual behaviors, early marriage, sexually transmitted disease, and hygiene.

- In the Bunkeya health area, 10 male heads of household who received SMS messages on the benefits of exclusive breastfeeding report encouraging their wives to practice exclusive breastfeeding correctly;
- In the Kabongo health zone, 41 couples stated that they have an open dialogue in the household about the SMS health messages they receive;
- The chief of Bayeke Bunkeya launched a week of awareness-raising about the benefits of breastfeeding, using the IHP SMS messages he received. The chief invited his people to read the messages, to share the information, and to act according to the recommendations.

The CUGs continue to facilitate communication between community members engaged in mobilization efforts via the Champion Community approach, both within health areas and across health areas. They allow community members to confidentially receive and exchange information. During this quarter, there were six educational interactive discussions (*causeries)* were held on vaccination through the aid of CUGs, involving 87 women with children under 11 months old in for residents of the Kamina and Kolwezi health areas. Using the speakerphone, the phone allowed the nurses in the health center to respond to women's questions. Following this *causerie,* 56 of the participants brought their children for vaccinations before they began school.

Challenges: There is a lack of electricity to recharge batteries in rural areas. Beyond this technical issue, women and youth frequently lack access to CUG phones, as CUG holders are frequently men.

Next steps: In the next quarter, the project will seek to encourage the Champion Communities to purchase their own telephones, which should enable broader access to these CUGs by women and youth. IHP will pay special attention to increasing individuals' access to CUG phones, particularly among women and youth. Further guidance will also be given to the health zone management teams on how to educate local populations and stakeholders about the importance and benefits of CUGs.

2. Champion Communities and Champion Men Initiatives

Champion Communities: During this quarter, the project supported the establishment of three new champion communities, one in the health zone of Mwana in Bukavu, and two in the health zone of Lodja in Kole. This brings the total number of champion communities supported by IHP to 33. During this quarter, IHP provided financial assistance to 26 champion communities for income-generating activities.

This year, IHP assessed participating IHP Champion Communities using questionnaires that focused on the community's progress with the communication action plans, except for the newly-formed champion communities this quarter, and Fungurume (Kolwezi), where the Champion Communities, established under another USAID activity (ProVIC, the Integrated HIV and AIDS project), have not yet fully transitioned to the IHP Champion Community model.

To address sustainability and in support of making the champion communities autonomous, IHP has made it possible for four champion communities in Kolwezi and Luiza to finalize their status as independent NGOs. Their statutes, which have been developed with guidance from IHP staff, have been sent to political and judicial authorities for approval. The finalized and signed documents will appear in next quarterly report (October – December 2014).

Results from preliminary evaluations of the champion communities have been encouraging. From June 16-19, 2014, Lulua Health District evaluated action plans in Tuibake, Sanga, and Bante.

Table 45: Champion Community - Tuibake

Period	Second half of 2012				First half of 2013				Second half of 2013				First half of 2014			
Indicator	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**	**Champion communities**	**Family planning**	**IPTp 2**	**WASH**
Baseline[9]	45	156	140	0	6219	967	861	1,178	7,339	862	711	770	7,339	862	711	770
Fixed targets	7,206	990	876	400	7,362	1,014	900	400	7,362	1,014	900	400	8,862	1,212	1074	400
Targets obtained	6,219	967	861	1,178	7,339	862	711	770	7, 028	758	538	382	7458	857	377	493
Percentage of target reached	90	98	98	29	110	85	79	19	95	75	60	10	84	71	4	12

[9]These are the descriptions of the indicators used for Tables 45 and 46:

- Baseline: Baseline data for the eight health centers prior to the Champion Community intervention
- Fixed targets: Indicator target set by the Champion Communities
- Targets obtained: Level reached by Champion Communities after six months of activities
- Percentage of target reached: Achievement rate (%) compared to the target

Table 46: Champion Community - Nsanga Bantu

Period	2nd half of 2013				1st half of 2014			
Indicator	**Curative care**	**Family planning**	**ANC4**	**TB**	**Curative care**	**Family planning**	**ANC4**	**TB**
Baseline	1,013	107	39	44	6,985	771	411	314
Fixed target	8,688	1,194	504	408	10,950	1,470	624	450
Targets obtained	6,985	771	411	314	6,332	811	518	347
Percentage of target reached	80	65	60	80	62	55	85	77

The tables above indicate:

- A more than 25% increase in curative care visits in eight health areas in two of the communities. These results are due in large part to the efforts of the champion communities. Through constant exchanges and involvement of religious leaders, champion community members were able to effectively promote messages on self-medication, beliefs, and orientation of illnesses.
- A 30% increase in the utilization rate of modern family planning methods (e.g., pills, condoms, Depo-Provera, cycle beads) from the campaign IHP conducted through the Closed User Group (CUG) phone messaging system (not from the use of modern methods). The indicator is: Number of new acceptors for any modern contraceptive method in USG-supported family planning service delivery points.
- There was a 75% increase in the detection rate of tuberculosis (confirmed new smear positive TB cases detected by microscopy) after an SMS campaign to raise awareness on TB was launched. "Screening" (*dépistage* in French) will be corrected to report a 75% increase in the number of new smear positive TB cases detected. The indicator is: Number of new smear positive TB cases detected.

The involvement of the champion communities and their steering committees has been remarkable. There has been increased participation and involvement in activities from community leaders and supervisors of the health areas in addition to increased awareness in healthy practices and participation by community members, and 20 men involved in the Champion Man initiative have distributed kits to households, and dispelled rumors surrounding these kits. Kits are designed for both literate and illiterate households, with printed images and practice guides on prenatal and maternal and child health to encourage men's participation in their wives' and family's health.

Interventions in Tshikisha and Mfuamba health zones have also contributed to the improvement of indicators of the champion communities. Marked increases in discussions about health amongst couples may be related to CUGs and SMS campaigns about CPN4.

Similar activities were reported by the Mwene Ditu and Kole coordination offices. Champion communities organized ETL meetings about early education interventions and family planning. The champion communities conducted a mini campaign on family planning and community-based distribution of contraceptives in the health zone in July 2014. The IHP coordination offices collected and verified the following results of the mini campaign:

- 1,543 messages sent about family planning
- 1,393 individuals were reached including 1315 women and 78 men
- 307 individuals were counseled on modern family planning methods
- 214 new practitioners

Challenges: Although members of the champion communities have been approached by other organizations requesting assistance in awareness-raising activities, they do not have the financial capacity or materials to take on these initiatives.

Next Steps: The project will organize supervisory trainings for champion communities to reinforce their capacity in the implementation and management of income-generating activities, continue to work with champion communities to develop and elaborate their statutes and internal policies to obtain legal status as NGOs, seek out and support partnerships between the communities and health facilities through the establishment of respectful and collaborative initiatives to long lasting relationships and help the champion communities liaise with cellular companies to establish relationships and ensure continuity of the CUG and *ligne verte* activities.

Champion Man Initiative: The champion man Initiative continues to be implemented throughout all target project health zones. The initiative allows men to become positive role models in their communities and motivates them to engage others in discussions about healthy practices and behaviors.

In the Kanda Kanda health zone, 29 men have informed project staff that they have been conducting outreach to members of their communities and parishes to encourage men to help women with household chores, sexual responsibility, early childhood development, and hygiene, as well as referring families with members suffering from illnesses. In Luiza, health centers verified that 131 champion men contributed the improvement of indicators in family planning and CPN4 through exchanges with 64 households in the community.

Challenges: The project has noted fatigue with the champion man initiative from participants due to insufficient support and/or other commitments, as well as the expected obstacle of entrenched cultural and religious norms surrounding masculinity and traditional gender roles such as the desire for large families and the fact that it is not "manly" for men to be implicated in family health matters. The champion men are members of their respective champion communities. As such, the motivation of the champion men would include moral support and encouragement from the members of the community they serve and would also benefit from grants to the champion community. Upon successful implementation of the first six-month action plan of the champion community, IHP provides a $1,000 grant to each champion community (disbursed in two $500 payments) to support the implementation of the next champion community action plan (which integrates champion man activities) and income-generating activities (IGA). IGA would ensure the sustainability of champion community activities and would also help them in obtaining official status as a non-governmental organization, which would allow them to sign contracts with other partners. In addition, IHP will continue the champion man initiative through field visit for monitoring as well as supportive supervision. IHP will further document the lessons learned from the champion man and the champion community efforts.

Next steps: IHP will continue to collaborate with target health zones to implement the champion man initiative in other health areas and will collaborate with religious leaders to introduce the initiative in action groups.

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

During the four years of IHP, the operational planning processes of the supported provinces have evolved at different speeds due to several reasons, including overlap in areas such as health vaccination campaigns, the lack of funds allocated to activities (IHP had allocated funding for the planning process but this fell short of what was needed on the ground), the low level of stakeholder involvement in supporting the operations of the health zones, and the weak leadership of some DPS.

Katanga and part of Kasaï Oriental (the new Sankuru DPS) are the last provinces to engage in this process, while Sud Kivu has already finalized it at the beginning of the year. IHP has been involved in this process by supporting provinces and health zones in taking ownership of the planning process for better management of the activities of primary health care. There is no other document that health zones use pending the approval of the AOP. The AOP is the only reference document. During the development of the 2014 AOPs, health zones used the 2013 AOPs.

The following table shows the status of validation for the AOPs.

Table 47: Status of Annual Operational Plans

N°	Provinces	DPS	# of health zones per DPS	# health zones supported by IHP	# of health zones with validated AOPs	# of health zones with AOPs adopted by advisory boards	% of IHP health zones with AOPs approved by advisory boards
1	**Katanga**	Lualaba	14	8	8	0	0
		Haut Lomami	16	9	9	8	89
2	**Sud Kivu**	Sud Kivu	34	27	27	27	100
3	**Kasaï Oriental**	Kasaï Oriental	19	3	3	3	100
		Sankuru	16	16	16	6	38
		Lomami	16	6	6	6	100
4	**Kasaï Occidental**	Kasaï	25	1	1	1	100
		Kasaï Central	18	8	8	8	100
Total			**158**	**78**	**78**	**59**	**76**

All 78 IHP health zones benefitted from technical and financial support in finalizing the Annual Operational Plans (AOPs). Fifty-nine health zones validated their AOPs under the guidance of the PNDS, the board of directors. In Katanga, all 17 IHP-supported health zones defended their AOPs at the DPS, but the eight supported health zones in Kolwezi, as well as the Kinkondja health zone in Kamina, have validated their AOPs at the level of their respective administrative boards. In Sankuru, six health zones out of 16 in the district of Sankuru (new Sankuru DPS) validated their AOPs with their respective administrative boards. The unavailability of the provincial medical inspector (MIP) or his delegates prevented some health zones from organizing and holding administrative boards.

Particular attention will be paid to Katanga and Sankuru during the planning process, which will start soon. Moreover, IHP helped the D5 (the officer in charge of primary health care) in the writing and approval of a guide

to conducting and arranging periodic reviews at the health zone and the DPS; this document will allow for a good analysis of the situation on the ground and lead to effective and efficient decision-making.

PROJECT MANAGEMENT

1. **Success stories:** During this quarter, the project produced 11 success stories for a total of 35 for PY4 (as compared to 24 from PY1-PY3), exceeding the target of 30 stories per project year.

2. **Cost share:** As of September 30, 2014, IHP has booked $3,213,548.15 of cost share. At full obligation, the project is required to book a total of $4,193,013.87, which means the project needs to book $979,465.72 to meet its cost share requirement.

The following activities are yet to be booked as cost share:

- Once all backing documents are received for the four remaining Project CURE containers of donated medical supplies, the project will book the fair market value of $1,091,392.36. Once the MSH Contract Officer approves and this value is booked, the project would meet its cost share requirement.
- The project has submitted for booking $19,267 for the Implanon insertion training kits donated by Merck.
- The project also anticipates booking as cost share about $200,000 from the HPP project for technical support in 27 health zones shared with IHP.
- U.S.-based Brothers' Brother Foundation shipped a 20-foot container of donated beds, mattresses, bikes and other medical equipment with a market value quoted at $8,000. The project will book this value as cost share once proof of delivery documents are received.

3. **Procurement Updates**
   - **Status of the PY3 pharmaceutical order:** The final shipment for the PY3 pharmaceutical order arrived in early August 2014. Amoxicillin was the only outstanding product; all CDRs received two types of Amoxicillin (250 mg/5 ml powder for oral suspension and 500 mg capsules) in September 2014.
   - **Status of the PY4 pharmaceutical order:** The PY4 pharmaceutical order was placed with Amsterdam-based vendor IDA in July 2014 and will be shipped to final destination by global shipping and logistics experts Kuehne & Nagel. Fresh products and cold chain supply will be airlifted from Amsterdam.
   - **Arrival dates**: The import permits for the PY4 order have not been received yet; estimated date of arrival in DRC is between December and April 2015. All products scheduled to depart in the first shipment from Shanghai are being prepared for departure at end of October 2014 once all permits are received and inspections conducted. The following shipments departing from Amsterdam, Singapore, Mumbai, and Chennai are still planned to arrive at the six final destinations starting from December 2014 through April 2015.
   - **Status of the medical equipment procurements:** The final shipment for the medical equipment order arrived to the final destination and cleared as of September 2014.

FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

1. Family planning

During the first two quarters of PY4 (PY4Q1 and PY4Q2), when the project was operating under the interim plan and budget restrictions, only the management teams of the health zones and health districts were able to go into the field to make supervision visits. The main activities carried out in terms of family planning compliance include: ensuring contraceptive supplies so that clients can make an educated selection from a range of methods; planning and organization post-training providers and community-based distributors, including monitoring of contraceptive management; and the distribution of management tools.

Two people were also supported by IHP to attend a refresher training on Implanon NXT organized by Merck on October 31, 2013; they attended a second training in November 2013, when Merck held an additional training on classic Implanon NXT, including the Tiahrt Amendment, management of side effects, and advantages and disadvantages of the method. There were two sets of workshop on the insertion of Implanon NXT sponsored by the Merck pharmaceutical company. Five officials from the National Reproductive Health Program (PNSR) and provincial representatives (from Katanga, Kasaï Occidental and Oriental, and Sud Kivu) participated during the first phase. Almost all national trainers and two provincial trainers attended the second workshop because it was held during the period when IHP's spending was restricted. IHP plans to support on-the-job training for the central and provincial trainers during the competency-based integrated MNH/FP post-training follow up and supportive supervision visits. In January 2014, IHP received 30 training kits from Merck, 200 Implanon PARSS placebos, 200 conventional placebos, and 300 NXT placebos from CARE-Goma, as well as 200 conventional placebos and 300 NXT placebos from IMA/SANRU. These products were donated by Merck via ASSP/IMA and have already been booked as cost share. IHP covered the shipping costs from Kinshasa to the health facilities.

In PY4Q3, 134 staff reported having completed the training on USG family planning legislative policies. Of those staff members, 120 are from IHP coordination offices and 14 from provincial health services in Mbuji Mayi and Kananga. Only 58 certificates of course completion have been collected so far. Most of the staff reported not being able to retrieve their certificates from the site. Eventually we were able to download 98 out of 120 certificates. The rest (22 staff) were not able to get their certificates due to problematic internet connections in the coordination offices. IHP IT staff members are providing technical support to overcome the specific challenges individual staff members are facing.

IHP provided technical support to the development of the National Strategic Plan for family planning, which was adopted on January 10, 2014, by the Multi-sectoral Technical Committee on Family Planning (CTMP), and published and distributed to all levels of the health system. This plan covers the period 2014-2020, reflects the recommendations of the 2009 National Conference on Repositioning Family Planning, and provides a framework for all family planning activities in the DRC. The National Program for Reproductive Health, with the support of partners and stakeholders, continues to push for uniform application of the existing legislation on reproductive health issues and the adoption of a comprehensive law. The law was resubmitted to the National Assembly, which sent it to the Supreme Court of Justice to examine its constitutional basis before continuing the debate.

For PY4 , IHP trained 372 people in long-term methods (IUD , Implanon), including those who have been trained in the skills-based approach developed by the MOH, in which the people selected to participate already have some family planning experience (the competency-based approach includes modules on maternal, newborn and child health along with family planning).

2. HIV and AIDS

All IHP activities related to HIV and AIDS were in compliance with the PEPFAR team's orientation and guidance and relevant USG legislation and requirements. Staff have attended relevant training offered in the context of PEPAR (e.g., OGAC New Generation Indicators-NGI); all COP 2014 planning and relevant documentation was completed; and all PEPFAR reporting requirements were met (e.g., semiannual and annual reporting, 2014 PEPFAR Expenditures Analysis and input to the PEPFAR Record and Organization Management Information System (PROMIS).

ENVIRONMENTAL MONITORING AND MITIGATION PLAN

IHP supported the following activities, including active involvement of the population in awareness sessions to master approaches and appropriate knowledge and ownership of the projects:

- **Ventilated Improved Pit (VIP) Latrines:** During PY4, IHP supported the construction of 526 VIP latrines (503 of which were in the Kole health zone) during community outreach events in the Ishenga health area. Community leaders and WASH supervisors from the project and health zone management teams presented different models and their usage to community members. The ventilation aspect of these latrines is constructed from large bamboo. Nine VIP latrines were built in Bukavu, seven in Uvira, four in Kolwezi, and three in Luiza.
- **Handwashing stations**: IHP supported the construction of 338 handwashing stations, alongside newly-built household latrines, in Kole (246), Luiza (69), and Kolwezi (23).
- **Incinerators:** In the coordination offices of Luiza, Mbuji Mayi and Kamina, the construction of incinerators was planned for PY3 but the project was not able to provide this support until PY4 when the necessary materials and tools arrived. Twenty-three incinerators were constructed in total, including three in Luiza, six in Kolwezi, 12 in Bukavu, and two in Uvira.
- **Placenta disposal pits:** The project supported the construction of 23 placentas pits were constructed during PY4, one of which was built exclusively by the Ishenga health center in the coordination of Kole.
- **External Trash Bins:** IHP supported the digging of a total of 186 garbage holes, including 178 in the households of four villages (Ikfutu, Okonga, Topeko, and Tshendjo) in the Ishenga health area in the Kole health zone, five in Kolwezi, and three in Bukavu. In Luiza, 260 external bins are being built in the health areas of Bilomba, Luambo, and Ndekesha in collaboration with their respective health committees.
- **Internal Trash Bins:** The project provided 1,150 internal trash bins in Luiza, 39 in Kamina and 7 in Kolwezi, for a total of 1,196 in PY4. Moreover, the Tshumbe coordination office trained water, hygiene and sanitation community leaders and supervisors in Dikungu, Tshumbe, and Wembonyama in the regular maintenance of waste management devices in their health facilities.
- **Training in hospital hygiene:** IHP provided CLTS training in PY4Q4 in Uvira, as well as refresher trainings on hospital hygiene as needed. In Tshumbe, there was no formal training on this topic, but the WASH and BCC technical assistants helped community leaders and WASH technicians from the health zones of Dikungu, Tshumbe, and Wembonyama hold briefings in PY4Q1 and PY4Q2 on the management of biomedical waste for 46 GRH providers and the donation of 35 hospital hygiene data sheets. In addition, 6 Ishenga health center providers were briefed on the importance of hospital hygiene.

During the implementation of these activities, IHP experienced no issues regarding environmental compliance. Health care providers have been briefed on how to use and complete a checklist concerning medical waste management and to have a related action plan.

CHALLENGES ENCOUNTERED

The main challenges that the project experienced during PY4 included the following:

Technical constraints: The 70% target set by the MOH for accelerating the reduction of maternal and infant mortality was not attained by the majority of the health zones. IHP will intensify efforts to revitalize the community care sites, strengthen community mobilization, and train additional community care site workers in the management of three priority illnesses (diarrhea, pneumonia, and malaria). The MOH target to treat at least 70% of all cases is difficult to achieve for most health zones as only patients with complicated diarrhea (e.g., severe dehydration) are regularly consulted in the health facilities. The other diarrhea cases are treated by parents or caretakers at home.

Convincing women to give birth in health facilities with assistance by skilled providers remains a major challenge in rural health areas, as many pregnant women continue to begin ANC consultations only in the last trimester of pregnancy, particularly in the coordination areas of Bukavu and Uvira. The project will continue to encourage the participation of local authorities and community leaders in raising awareness about the importance of prenatal care and childbirth in the health structures. The challenge is particularly evident in Shabunda, Kalole, and Lulingu health zones in the coordination of Bukavu, as well as in Hauts Plateaux d'Uvira and Nundu in the Uvira coordination (where women begin ANC only during the last trimester of pregnancy). The data presented and reported are cumulative and reflect a summary of data from the different health zones. However, if data were to be broken down by health zone, we would see that the results of the health zones mentioned above are much lower than other urban or semi-urban health zones of Bukavu and Uvira.

The rate of deliveries in health facilities attended by skilled providers in the coordination of Kamina is also low, but for different reasons than those cited for Sud Kivu; this is essentially related to the difficult accessibility of health facilities from villages and communities (50 to 100 kilometers in distance in the territory of Malemba Nkulu, for example). As a result, actions to improve the situation differ.

<u>Kamina:</u>

- Schedule ANC sessions during community outreach campaigns to overcome the geographical access issue
- Ensure the availability of ANC supplies and MNCH standards and guidelines, and brief head nurses on the new MNCH guidelines during monthly monitoring reviews and supervision missions

<u>Bukavu and Uvira:</u>

- In collaboration with community leaders and community health workers, strengthen the awareness-raising campaign for pregnant women and their families to attend at least three ANC visits before birth

The number of pregnant women who complete four ANC visits remains low, since many women only begin ANC visits when they feel the baby move. Awareness sessions in the community and through the CHWs are planned, in conjunction with sending SMS messages about the benefits of ANC.

Compliance with the national protocol on the use of RDTs (ratio of 1 RDT for 2 ACT) is not yet fully achieved in health facilities, despite the recommendation of the National Malaria Program. IHP will strengthen training on prevention and treatment of malaria cases through post-training follow-up visits and joint supervision missions with MOH and health zone management teams.

Budgetary Restrictions: The project was required to operate on an interim spending plan in the first quarter of PY4 due to a delay in funds obligation. The delay had negative consequences for the implementation of the IHP action plan, including support for the development of AOPs in the health zones and prioritization of activities since the project was able to focus exclusively on only four principal activities: the supply of medicines and medical commodities; technical and financial support to health zones; provision of medical equipment in rehabilitated facilities; and staffing activities related to RBF. The restriction was finally lifted, but it took longer than anticipated for the project to re-establish full operational capacity.

Logistics: 112 motorcycles were ordered and have arrived; however, the official records of 17 of the motorcycles do not match the identification numbers on their frames. The team continues to work to resolve this issue.

Security: There is recurring insecurity in certain health zones, such as Lemera, Ruzizi, Minova, Miti Murhesa, and in the territory of Malemba Nkulu. This has led to a migration of the population, mostly women and children, and has had a negative impact on project activities (e.g., stopping activities, inaccessibility of health facilities, late reporting, and inability to carry out planned supervision visits). IHP continues to work closely with the health zones and health authorities in the affected districts to provide technical and financial support to the activities within this uncertain environment.

Supply Chain System: Frequent vaccine stock outs are due to the delay in co-funding from the DRC government to purchase the vaccines. The lack of vaccines affects the project's ability to implement planned activities and attain the objectives of the project. IHP requested USAID support to identify and implement short (immediate), medium, and long-term solutions to the chronic vaccine shortages.

The last delivery of bed nets and SP dates back to June 2012. This has had a negative impact for malaria prevention efforts. The absence of kits for severe malaria still persists. Women are more likely to go to a facility that distributes mosquito nets and provides malaria treatment. Within this context, IHP encouraged health zones to use their money to purchase drugs for the treatment of severe malaria. Drugs are purchased but are sold at prices that are not affordable for the population, including pregnant women.

Some institutions have not yet mastered the calculation of their average monthly consumption of most commodities (e.g., ACTs and RDTs, iron/folic acid and ORS, etc.) to produce reliable quantifications. It is therefore very difficult to calculate the annual needs for health zones for a year of full coverage. In collaboration with SIAPS, during supervision visits IHP organized training and information sessions for service providers on the quantification and management of drugs.

Data Quality: Data quality remains a major challenge in the project due to hastily performed collection and interpretation without a careful analysis of all the data, despite the availability of tools for data collection. The project continues to provide tools to all health facilities, support monitoring meetings to ensure quality data, and perform data quality assessments. The project plans to continue the DQA exercises in other field offices during the next quarters.

PLANNED ACTIVITIES FOR NEXT QUARTER

IR 1

- ✓ Assist the health zone management team's capacity to develop the AOPs for 2015 as well as other plans (health coverage plan, communication plans, training, supervision plans) in the health zones supported by the coordination offices
- ✓ Provide basic equipment in health facilities, based on need, in the health zones supported by the eight coordination offices
- ✓ Provide medical supplies to renovated maternity wards as well as comprehensive MNCH kits in the health zones supported by the coordination offices
- ✓ Provide essential medicines and other specific commodities for family planning, HIV, TB, and malaria in health facilities supported by the coordination offices and establish an efficient management system of drugs and commodities
- ✓ Reinforce logistics and management of essential medicines and other specific commodities for family planning, HIV, TB, and malaria in the health zones supported by the eight coordination offices
- ✓ Improve the capacity of human resources to deliver MPA/CPA-plus services through supportive supervision on the use of health care flow charts (ordinograms) in the intervention zones in the coordination offices
- ✓ Strengthen activities at community care sites implementing integrated case management of childhood illnesses (i-CCM) through supportive supervision of community health workers (CHWs) and the provision of essential drugs and supplies, and management tools; including dissemination of communication materials on integration of ORS-Zinc
- ✓ Consolidate the WASH zonal approach in order to achieve the expected result: at least 80% of population in the selected health zones have access to improved drinking water and sanitation facilities by the end of the project
- ✓ Strengthen and mobilize IYCF support groups at the community level in supported health zones

IR 2

- ✓ Strengthen family planning activities through supportive supervision of service providers on clinical family planning methods, integration of CBD activities, integration of FP strategies at community care sites, and the distribution of monitoring and management tools and other necessary supplies, and ensure close collaborate and coordination with E2A project
- ✓ Strengthen routine immunizations in project-supported health zones by assisting the EPI with funding for transport for commodities, provision of tools to collect data, fuel, and other supplies for the maintenance of the cold chain, the supervision of workers from storage sites on the maintenance of the cold chain, and emphasizing supportive supervision to CHWs
- ✓ Strengthen the technical skills of maternal care service providers to ensure the quality of care for MNCH in project-supported the health zones through supportive supervision of a package covering family planning, Helping Babies Breathe (HBB), Kangaroo Mother Care (KMC), complicated birth management, AMTSL
- ✓ Distribute SP for intermittent preventive treatment of malaria for pregnant women (IPTp) and LLINs to prevent malaria
- ✓ Support health care providers to correctly manage cases of malaria in the health facilities through supportive supervision and provision of medicines and other commodities--for example, ACTs and RDTs
- ✓ Ensure transition to B+ of all 69 existing sites and transportation of DBS

- ✓ Strengthen the fight against TB, TB and HIV co-infection, and MDR-TB through supportive supervision of health providers, provision of reliable transportation of TB samples, and joint follow-up visits to supported health zones
- ✓ Implement and evaluate the RBF program, improving the capacity of CBOs to conduct counter-verification, organizing quarterly reviews of RBF data and health promotion activities, and providing management tools to CBOs to implement the RBF program
- ✓ Monitor, observe, and evaluate the RBF program through monthly updates of the database, organization of joint visits for follow-up and supervision with the health district teams and the health zone management teams, and the presentation of certificates for the health facilities that demonstrate the best performance

IR 3

- ✓ Implement and evaluate the ETL approach by training members of the community (including CODESAs), organizing ETL sessions on different themes (FP, CPN, malaria, TB, WASH, GBV, nutrition, HIV, MNCH, EPI, danger signs, key practices, i-CCM), and organizing post-training follow-up visits
- ✓ Conduct phone-based information campaigns and finance the quarterly dissemination of awareness-raising SMS messages on priority intervention areas in communities within IHP-supported health zones
- ✓ Select Champion Communities and follow up Champion Communities with the provision of technical and financial assistance in developing action plans post training

IR 4

- ✓ Provide technical and financial support to the various coordination organizations at the provincial level, including advisory boards, task forces, interagency coordination units, and other working groups
- ✓ Strengthen capacity of health zone management teams in the development of AOPs for 2015 and other plans (coverage plan for health facilities, communication plan, training plan, supervision plan) in supported health zones (Same as IR1.1, Activity 1)
- ✓ Provide financial and technical support for monitoring and evaluation systems
- ✓ Provide technical and financial support for provincial, district, and zonal health operations, in conformity with the sub grants provided by the project

LIST OF APPENDICES

Appendix 1: DRC-IHP Performance Monitoring Plan, PY4
Appendix 2: Distribution plan for family planning commodities PY4Q4*
Appendix 3: Distribution plan for PMI commodities PY4Q4*
Appendix 4: Summary of all training workshops conducted during PY4*
Appendix 5: Memorandum of Understanding between SANRU, PMI, and IHP
Appendix 6: Fistula Care Data PY4Q4
Appendix 7: DRC-IHP Accruals Report July to September 2014
Appendix 8: DRC-IHP Organizational Chart
Appendix 9: DRC-IHP SF425 July to September 2014
Appendix 10: DRC-IHP International Travel/STTA Plan, PY4*

*Appendices 2, 3, 4, and 10 are attached separately as Excel files

SUCCESS STORIES

The success stories are attached on the following pages.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Fighting Malnutrition in Kolwezi by Promoting Exclusive Breastfeeding

Exclusive breastfeeding and child feeding support groups helped decrease cases of malnutrition and diarrhea in Kolwezi.

Photo: International Rescue Committee

Members of the exclusive breastfeeding support group in Bunkeya meet.

"We are now fully aware of the benefits of exclusive breastfeeding for both our children and ourselves, as opposed to misleading and false information we used to receive from our grandmothers, aunts, or friends."

- ***Clementine Kalonda, breastfeeding support group member, Bunkeya, Kolwezi***

Breastmilk provides all nutrients an infant needs and contains antibodies that help protect them from common childhood illnesses.[1] Yet, in the Democratic Republic of Congo (DRC), an average of only 49% of infants aged 0 to six months are exclusively breastfed.[2] In Bunkeya health zone in Kolwezi, this rate-- at 15% in 2013[3]-- was well below the average. Low exclusive breastfeeding is linked to increased diarrhea and malnutrition: in Bunkeya, 52% of infants 0 to six months suffered from chronic diarrhea and 30% were malnourished.[4] According to the 2013-2014 Demographic and Health Survey, misinformation and rumors also contribute to a low rate of exclusive breastfeeding.

To address these challenges, the USAID-funded Integrated Health Project (DRC-IHP) trained the Bunkeya health zone management team, health providers, and community health workers on Essential Nutrition Actions (ENA) and Infant and Young Child Feeding (IYCF) strategies. DRC-IHP supported the creation of IYCF support groups and a one-week awareness-raising campaign on ENA and exclusive breastfeeding, including door-to-door home visits. The project also helped establish discussion forums in communities to encourage breastfeeding and expectant mothers to share experiences and best practices. More than 1,500 women from Bunkeya have participated in these activities to date.

As a result of these initiatives, from March to August 2014, exclusive breastfeeding of infants 0 to six months increased to 50%, while cases of chronic diarrhea dropped from 52% to 28%, and severe acute malnutrition cases dropped from 30% to 19%[5].

"I exclusively breastfed my daughter, and she is healthier than my other children were," said Clementine Kalonda,[6] a breastfeeding support group member. "The discussion forum is a unique opportunity to freely share my experience with, and learn from, other mothers."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] "Ten Facts on Breastfeeding," World Health Organization
[2] DRC Demographic and Health Survey, 2013-2014
[3] Bunkeya Health Zone Report, 2013
[4] Bunkeya Health Zone Report, 2013
[5] Bunkeya Health Zone Report, 2013, PRONANUT data
[6] Name changed for privacy

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Community Leaders Work to Combat Diarrhea Outbreak in Luiza

CODESA members implement a BCC campaign in the Bambaie health area, reducing the incidence of diarrhea by 65%.

Photo: Overseas Strategic Consulting, Ltd.

A young girl uses a new handwashing station in Luiza.

"We were shaken by the diarrhea outbreak during the last three months, but the CODESA members really helped us with the advice they provided...We salute their bravery, dedication, and the sacrifices they made on our behalf."

- Mme Mbombo, age 36, resident of Bambaie

In the Democratic Republic of Congo (DRC), diarrhea is among the most deadly illnesses for children under the age of five, especially if victims do not receive early treatment. At the same time, diarrhea is also a largely preventable illness if key protective measures are followed, including washing hands with soap at "critical moments" (such as after using the toilet, while washing a child, and before handling food), using hygienic toilets, conserving and consuming pure water, properly cooking food, and de-worming children. However, communities often do not associate the absence of these behaviors with diarrhea, making it difficult for community health volunteers and officials to change harmful behaviors and combat the disease.

In July 2014, an epidemic of diarrhea broke out in the Luiza health zone, with 904 recorded cases. In the Bambaie health area of Luiza, one of the areas hardest hit by the epidemic, there were 31 cases recorded in July alone. In response, the USAID-funded DRC-Integrated Health Project (DRC-IHP), along with the Luiza health zone management team, the World Health Organization, UNICEF, local non-governmental organization partners, and community-based health development committee (CODESA) members, formed a crisis committee to solve the problem at the community level.

CODESA members, supported by DRC-IHP, developed a behavior change communications (BCC) plan to raise awareness of the causes of diarrhea. This plan included the distribution of 25 educational announcements read by church leaders during services, 100 SMS messages sent to community members, 56 household visits, 32 sessions focused on Education through Listening (ETL), and the creation of a water, sanitation, and hygiene (WASH) committee.

As a result, 20 households (out of a total of 1,476 in the Bambaie health area) constructed latrines (five of which have handwashing posts), and the WASH committee maintained two sources of potable water in the community. The number of reported diarrhea cases fell from 31 in July to 11 by August 2014, and to 8 cases in September 2014.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Results-based Financing Improves Service Utilization in Osomba Health Center

Results-based financing program pushes health center to improve quality of services, staff attendance, and infrastructure to increase patient visits.

Photo: Management Sciences for Health

Head nurse Marie Jeanne Osomba at the Osomba health center in Wembonyama

"The way we evaluate the quality of our services has changed. We work with the community, and we have established a community suggestion box to help us identify ways to strengthen ties with the community. The community has increased confidence in us, resulting in improved service utilization rates."

- ***Head nurse Marie Jeanne Osomba***

During the first half of 2013, the Osomba health center in the Wembonyama health zone in the Kasaï Oriental province of Democratic Republic of Congo (DRC) reached just under 9% of expected curative service utilization. People still became ill in Osomba, but the health center's poor infrastructure and poor service quality--combined with stock outs of essential medicines and low staff availability--discouraged attendance of those needing care.

To support under-performing health facilities like the Osomba health center, the USAID-funded Integrated Health Project in the DRC (DRC-IHP) launched an innovative results-based financing (RBF) program in October 2013 in seven health zones, including Wembonyama, where the Osomba health center is located. DRC-IHP's RBF program provides financial incentives for health facilities that achieve pre-determined and mutually-agreed upon goals linked to improved access to care, quality of services, resource management, and community engagement. The project also provided health structures with essential medicines and management tools, followed by coaching of health care providers during follow-up visits and work plan development.

The health center reinvested the $778 incentive received in the first quarter to repaint the walls and to purchase a registry book and other office supplies. The center also strengthened community outreach by working with community leaders. Data accuracy has also improved from almost 37% to nearly 85% from the first to the second quarter of 2014, according to quarterly verifications conducted by the health zone management team and counter-verifications conducted by a selected local non-governmental organization.

After the launch of the RBF program, from February to July 2014, the service utilization rate climbed to 27%, compared to slightly less than 9% during the same period a year earlier. Head nurse Marie Jeanne Osamba asserts, "The community has increased confidence in us, resulting in improved service utilization rates."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Spacing Births to Reduce Health Risks for Families in Lodja

A couple in Lodja became community-based distributors of family planning methods after experiencing birth spacing success in their family.

Photo: Management Sciences for Health

Family planning method acceptors Opanga and Akao with one of their children in Lodja.

"I can attest that Depo-Provera has been an effective method for our family in order to better space the births of our children."

- Opanga, Lodja, DRC

Opanga and his wife, Akao, have four children who were born so close to each other that neighbors in their community of Lodja in the district of Sankuru in the Democratic Republic of Congo often teased the couple. Teasing aside, multiple closely-spaced pregnancies are no joking matter, as they come with a dramatically higher risk of maternal, infant, neonatal, and perinatal mortality.

But in 2011, Opanga attended a family planning awareness-raising event put on by members of *Ebenezer Global Multisectoriel*, a local organization trained and supported by the USAID-funded DRC-Integrated Health Project (DRC-IHP) to educate communities about the importance of family planning and the methods available at their health centers. Opanga shared this information with Akao, and together they decided to visit the Edinga Health Center in Lodja to speak to the nurse about their options. They chose to use Depo-Provera for longer birth spacing.

Akao did not get pregnant for three years, which prompted curious neighbors to wonder why. Opanga and Akao spoke to 24 couples about family planning and convinced four couples to accept modern family planning methods. In February 2014, Opanga and Akao were chosen by the Lodja health zone management team, supported by DRC-IHP, to be trained as community-based distributors (CBD) of family planning products. They joined 82 other CBDs in Lodja to help improve contraceptive use. From February to August 2014, 538 couples received counseling and accepted a family planning method thanks to the efforts of Opanga, Akao, and fellow CBDs.

"I can attest that Depo-Provera has been an effective method for us to space the birth of our children," said Opanga. In addition, the couple's friends appreciate their efforts to save lives. One such friend, Henriette Omoyi, who now uses Depo-Provera thanks to the couple's advocacy efforts, notes that her husband now is in favor of family planning because she had previously given birth twice in close succession and had suffered from anemia during her pregnancies.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Improving Care of Sexual Violence Victims in Kole: Alice's Story

Thanks to technical and financial support from the DRC-Integrated Health Project, referral of sexual violence victims to health care has improved in Kole.

Photo: Management Sciences for Health

GBV survivors and their families stand in front of the Synergie Kole center.

"…despite the attack, I am in good health again and I can continue my studies."

- Alice Kabena, 14, sexual violence survivor referred for medical care in Kole

After 14-year-old Alice Kabena[1] was sexually assaulted in March 2014, she received medical and psychosocial care at the Kole General Referral Hospital. She was referred there by the rape support group *Synergie Kole*. In the Kole health zone of the Democratic Republic of Congo, about 4.36% of an estimated population of 46,562 women and girls like Alice reported being sexually assaulted in 2013. However, only about half of those reported cases were referred to health facilities for proper medical care, despite health risks such as unwanted pregnancy and sexually transmitted infections.

To address this issue, the USAID-funded DRC-Integrated Health Project (DRC-IHP) has been working with local health units and *Synergie Kole* to advocate for medical attention for rape victims. In May 2013, DRC-IHP trained members of the Sankuru district health management team, including eight health care providers from the general referral hospital in Kole, on the medical care and treatment of sexual violence victims. DRC-IHP also provides technical and financial support to *Synergie Kole* to mobilize the community on raising awareness of sexual violence, work with community leaders and the police on advocating for and implementing laws that punish perpetrators of sexual violence, and provide psychosocial support to victims.

Because of DRC-IHP's involvement in improving care of sexual violence victims, and providing Post-Exposure Prophylaxis (PEP) kits, referrals rose to 143 in Kole in 2013 (compared to zero referrals in 2011 and 72 in 2012), 48 of which were referred within 72 hours. Most of those referred were under 18 years old (68 girls were 10 years old or younger, 62 girls were 10 to 17 years old, and 13 women were 18 or older).

"Thanks to *Synergie* and IHP, despite the attack, I am in good health again and can continue my studies," Alice said. Her attacker was eventually arrested by local authorities and prosecuted for rape.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] Name has been changed for privacy

USAID FROM THE AMERICAN PEOPLE | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

The Golden Minute: Saving Newborns' Lives in the DRC through the "Helping Babies Breathe" Method

When a baby struggled to breathe upon delivery, a birth attendant in Luiza used the "Helping Babies Breathe" technique she learned to resuscitate the child within the first minute of life.

Photo: Management Sciences for Health

Marie Miambokila Mumba and her three-month-old twins at home in Luiza, November 2014.

"I thank God and Judith and her team at the maternity unit for saving my child's life. If it had been a few years ago, my baby would have died."

- Marie Miambokila Mumba, 38, Luiza, DRC

Marie Miambokila Mumba, 38, had a smooth pregnancy and attended all of her scheduled prenatal consultations at the Tutante health center in Luiza, located in the province of Kasaï Oriental in the Democratic Republic of Congo (DRC). When she gave birth at the Luiza General Referral Hospital (GRH) in August 2014, the baby was delivered safely by skilled birth attendant Judith Kambuyi.

However, within moments, Judith realized that there was a second baby. Despite the prenatal consultations, the Tutante health center staff had not detected that Marie was carrying twins. But the second baby was struggling to breathe upon delivery. Judith, trained in the Helping Babies Breathe® (HBB) technique, acted quickly to assess and resuscitate the child during the first critical minute after delivery, called "The Golden Minute."

The HBB training that Judith attended in August 2012 was organized by the USAID-funded DRC-Integrated Health Project (DRC-IHP) as a response to high neonatal mortality rates in the DRC--approximately 104 deaths for every 1,000 live births. HBB is an evidence-based neonatal resuscitation approach for resource-limited settings that promotes attendance of skilled attendants at birth, assessment of every baby, temperature support, stimulation to breathe, and assisted ventilation as needed, all within "The Golden Minute" after birth.

Prior to the HBB training, the hospital in Luiza struggled with a high infant mortality rate. Thanks to the HBB training and other capacity building, such as training on Active Management of the Third Stage of Labor (AMTSL), as well as the provision of caesarian kits and neonatal resuscitation kits, the hospital has been able to save 22 babies who were delivered in distress from January to September 2014.

"It's a source of pride to save lives," said Judith, who was trained with 11 other nursing staff from Luiza GRH. "I have been a birth attendant for 24 years, but it was IHP that made me more effective as a result of the HBB training."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID FROM THE AMERICAN PEOPLE | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Reducing Maternal and Neonatal Mortality through Reliable Blood Banks

Donated blood saves the life of a young mother in Uvira following childbirth complications.

Photo: International Rescue Committee

Donors give blood in Uvira.

"Our daughter would have died if it was not for the blood drive. We would like to recommend to DRC-IHP to organize blood drives across the country to save women and children's lives."

- Mother of Christine, blood donor recipient in Uvira

When twenty-year-old Christine[1] gave birth at the health center of Kabinda in Uvira in eastern Democratic Republic of Congo (DRC), she suffered from a ruptured uterus during delivery. The nurse referred her to the Uvira General Referral Hospital (GRH), where health workers confirmed that her life was in danger due to blood loss.

Every day, approximately 800[2] women die due to complications from pregnancy or childbirth, including postpartum hemorrhaging, infection, hypertension during pregnancy (preeclampsia and eclampsia), and unsafe or untreated abortions. Nearly 99% of these deaths happen in developing countries, and half of those in Sub-Saharan African. In the DRC, the maternal and neonatal mortality rates remain high, with 846 maternal deaths for every 100,000 live births and 28 neonatal deaths (0-28 days) per 1,000 births.[3]

To help prevent maternal mortality, the USAID-funded DRC-Integrated Health Project (IHP), in collaboration with the Congolese Ministry of Health at the local level, identified a reliable blood bank and source of donors to treat hemorrhage cases. In August 2014, DRC-IHP supported the organization of a three-day blood drive campaign in the health zone of Uvira. Due to the campaign's success, the Uvira GRH blood bank was able to add to the stock 69 bags of safe blood.[4] During the few weeks that followed the campaign, the number of screened blood bags stocked at Uvira GRH rose from 290 to 1,993.

Christine's mother affirmed, "Our daughter would have died if it was not for the blood drive." After two surgeries and the transfusion of six bags of blood, Christine was safely out of danger and on her way to recovery.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

---

[1] Name has been changed for confidentiality
[2] World Health Organization, May 2014
[3] DRC Demographic and Health Survey, 2013-2014
[4] According to DRC Ministry of Health standards, blood is deemed safe when tested and cleared for Hepatitis B and C, HIV, and Syphilis.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Rapid and Accurate: Improving Malaria Case Management for Children in Tshumbe using Rapid Diagnostic Tests

The use of RDTs to quickly and accurately diagnose malaria cases leads to proper treatment of sick children in Tshumbe.

Photo: Management Sciences for Health

A mother holds her child while a nurse administers an RDT in a Tshumbe health facility.

"The RDT provides more accurate results in a short amount of time and allows us to treat the patient quickly and properly. The old system was painstaking, and we had to wait 24 hours for the results."

- Head nurse Albert Kasongo of Tshumbe

Malaria is the leading cause of death for children under five living in Tshumbe, Democratic Republic of Congo (DRC). In May 2014, about 60% of children (119 out of 197) who were brought in for consultations had fevers and were suspected to have malaria. They were immediately put on Artemisinin-Based Combination Therapy (ACT) without being tested to confirm malaria. Even though there were Rapid Diagnostic Tests (RDTs) at the health facilities, health providers were not yet trained on how to use them properly.

In response, the USAID-funded DRC-Integrated Health Project (DRC-IHP), with the national malaria control program (PNLP), trained 20 health providers in June 2014 on the utilization of RDTs and health flow charts which are part of the new national directives governing malaria prevention and treatment at the health center level. After the one-week training, the head nurse from Tshumbe trained 14 other health providers working within the health area covered by the health center.

At the end of July 2014, 104 of 130 (80%) children under five seen for high fever were properly diagnosed with malaria using RDTs (the other 20% did not have malaria). Using RDTs not only ensures proper diagnosis and treatment of malaria, but also prompts further investigation to find out the real cause of high fever in the case of a negative RDT. Based on this data, if 80% of an estimated 1,560 yearly cases of high fever seen in the Tshumbe health area are confirmed by RDT to be malaria, the project will be able to save 312 unnecessary doses of ACT per year.

Albert Kasongo, the head nurse of Tshumbe, said he is very happy to see that that data obtained at the end of July show the advantages of using RDT to diagnose malaria.

"The RDT provides results in a short amount of time and allows us to treat the patient quickly and properly. The old system (microscopy) was painstaking, and we had to wait 24 hours for the results. I thank DRC-IHP for this opportunity to better manage high fever cases at the health center level," Mr. Kasongo said.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Fighting Diarrhea by Improving Water, Hygiene, and Sanitation Conditions in Kasaï Oriental

After the rehabilitation of two water sources and the construction of 173 latrines in July 2013, the number of diarrhea cases per month has decreased from three to one for every 10 children in Okako.

Photo: Management Sciences for Health

Women fetch water from the Opemba water source, which was rehabilitated by the Okako community with the support of DRC-IHP.

"Because of the project's help to repair our water sources, the community now has access to safe drinking water. We are thankful."

-Kahodi, Okako village chief

In February 2012, in the village of Okako in the Dikungu health zone, Kasaï Oriental, Democratic Republic of Congo (DRC), three out of 10 children under five years of age had diarrhea. Only 40% of households had latrines, about 80% of households defecated in the open air, and all households accessed drinking water from unsafe water sources.[1]

In May 2013, to improve water, sanitation, and hygiene (WASH) conditions in targeted communities, including Okako, the USAID-funded DRC-Integrated Health Project (DRC-IHP) launched community awareness campaigns on the risks of unsafe drinking water and poor hygiene and sanitation infrastructure. Working with local Ministry of Health staff, the project supported the establishment of a community-elected WASH committee and trained members on the health benefits of drinking from improved water sources, hand washing, taking out household trash, and the use of latrines.

To rehabilitate two water sources and construct household latrines, IHP trained a local mason and provided cement and steel, while the community contributed materials that were sourced locally (e.g., gravel, sand, and sticks). The WASH committee led awareness-raising sessions to guide community members on how to properly use and maintain latrines and to promote drinking water from rehabilitated sources only.

Today, 1,684 people in Okako have access to safe drinking water; 88% of households (1,384 people) now have latrines; and the number of households practicing open defecation fell to 20%. A survey in 20 households in June 2014 documented that monthly diarrhea cases for children under age five had decreased to one child out of 10.[2]

The village chief of Okako confirms, "Because of the project's help to repair our water sources, the community now has access to safe drinking water. We are thankful."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

[1] Dikungu health zone Knowledge, Attitude, and Practice (KAP) survey in Okako, February 2012

[2] Dikungu health zone KAP survey in Okako, June 2014

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Happier and Healthier: A Family in Tshumbe Enjoy the Benefits of Family Planning

A couple in Tshumbe accepted a family planning method after losing two children to poor health caused by poorly-spaced births.

Photo: Management Sciences for Health

Family planning acceptors and CBDs Thérèse Ewango and Jules Okende with their child at home in Tshumbe.

"We are happier and healthier. Since using family planning, we have decided to have one more child. Our children are in better health, and we have better control of our finances since we do not have to spend as much on health care anymore."

- ***Jules Okende, family planning acceptor in Tshumbe***

In 2011, Thérèse Ewango lost two of her three children to malnutrition. Thérèse, who lives in Tshumbe in the Kasaï Oriental province of the Democratic Republic of Congo (DRC), became pregnant within six months after the birth of each of her children; she thought their deaths could have been the result of poor birth spacing. She herself was often sick. Unable to financially support several children and uninformed about family planning options that promote optimal birth spacing, many families in Tshumbe have malnourished children. In July 2011, eight children out of 231 suffering from malnutrition died (3.46%).

In January 2012, Thérèse was visited by community-based distributors (CBD) who spoke to her and her husband about various contraceptive methods. They explained the importance of family planning, especially its role in child spacing and child survival. After the visit, Thérèse and her husband decided to use Depo-Provera.

The CBDs in Tshumbe were trained in September 2011 by the USAID-funded DRC-funded Integrated Health Project (DRC-IHP) and the Ministry of Health. With the goal of increasing family planning acceptors in the Tshumbe area, the curriculum focused on training caregivers to provide family planning methods and carry out door-to-door outreach to inform couples of various contraceptive options. The project also provided family planning commodities for the Tshumbe health zone.

Door-to-door outreach efforts and the availability of family planning supplies resulted in 3,793 new family planning acceptors between January and July 2014.

More than two years after deciding to use family planning, Thérèse and her husband, Jules Okende, say they are happier and healthier. "Since using family planning, we decided to have one more child," Jules said. "Our children are in better health, and we have better control of our finances since we do not have to spend as much on health care anymore."

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

USAID | DEMOCRATIC REPUBLIC OF CONGO

SUCCESS STORY

Improving Health Services in a Remote Congolese Village through Results-based Financing

Under the Results-based Financing program, the Lufwishi health center was able to increase utilization of services by improving quality of care and infrastructure.

Photo: Management Sciences for Health

Health zone officials cross one of the rivers that surround the community of Lufwishi.

"Now we are motivated to more than ever to monitor and evaluate performance of health centers, including Lufwishi."

- ***Dr. Amide Ngongo, health zone medical chief***

Lufwishi is a remote community isolated by rivers in the Katanga province of the Democratic Republic of Congo (DRC). As health officials rarely came to supervise the health center, the quality of services and the physical state of the building deteriorated. The curative care utilization rate was only 14% in 2013 compared to the national average of 35%.

To support under-performing health facilities like the Lufwishi health center, the USAID-funded Integrated Health Project in the DRC (DRC-IHP) launched an innovative results-based financing (RBF) program in October 2013 in seven health zones, including Kayamba where the Lufwishi health center is located. DRC-IHP's RBF program provides financial incentives for health facilities that achieve pre-determined and mutually-agreed upon goals linked to improved access to care, quality of services, resource management, and community engagement. The project also provided health facilities with essential medicines and management tools, followed by the coaching of caregivers during supervision visits and workplan development. IHP also provides supervisors from the health zone central office with incentives when the health centers they supervise perform well.

During the RBF pilot year, the Lufwishi health center was awarded $1,262 for the first two quarters of the RBF pilot year after health center data quality was audited by the health zone management team and DRC-IHP staff. With the funds, the Lufwishi health center installed a fence around the facility, painted and plastered the walls, and set up waste bins. The center also built shelves to organize drugs and other supplies. Newly-motivated health center staff began to strengthen community outreach to promote health services and announce the availability of commodities at the health center. Because of these efforts, the service utilization rate increased from 14% prior to the intervention to 81% by May 2014. Examples of improved health services in Lufwishi include an increase in referrals of high-risk pregnancy (from zero at the end of 2013 to 33% in May 2014) and an increase in the percentage of infants receiving the third dose of the DTP vaccine from 71% to 83% in the same period.

"Before we received bonuses under the RBF program, we only visited clinics during the dry season (when the rivers are low). Now, we are motivated more than ever to monitor and evaluate performance of health centers, including Lufwishi," said health zone medical chief Dr. Amide Ngongo.

Led by Management Sciences for Health with partners the International Rescue Committee and Overseas Strategic Consulting, Ltd., DRC-IHP is working to improve the basic health conditions of the Congolese people in 78 health zones in four provinces.

Annex 1: DRC-IHP Performance Management Plan, PY4			PY4Q1	PY4Q2	PY4Q3	PY4Q4	PY4		PY4 Achievement (%)
Indicateur		Définition					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	136,740	136,318	137,298	152,626	**562,982**	**450,000**	**125**
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	57,830	53,708	52,626	61,366	**225,530**	**165,000**	**137**
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	151,335	152,332	152,975	149,678	**606,320**	**497,399**	**122**
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	201,111	179,496	178,610	188,356	**747,573**	**640,349**	**117**
4	**FP:** Number of USG-supported delivery points providing family planning (FP) counseling or services	Number of USG-supported service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service	2,115	2,115	2,115	2,025	**2,025**	**2,000**	**101**
	Disaggregated by type of service delivery:	*(a) Health facility based*	1,751	1,751	1,751	1,542	**1,542**	**1,600**	**96**
		(b) Community-level based	364	364	364	483	**483**	**400**	**121**
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	47	42	38	56	**56**	**100**	**56**

6	**MNCH:** Percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	130,403	138,042	142,835	134,882	**546,162**	**510,830**	**107**
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**101%**	**106%**	**113%**	**107%**	**107%**	**95%**	
7	**MNCH:** Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	54,855	60,339	63,596	67,364	**246,154**	**334,951**	**73**
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/Denominator (in percentage)	**42.6%**	**46.5%**	**50.3%**	**53.3%**	**0**	**62%**	**78**
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	111,453	115,664	116,624	116,486	**460,227**	**449,208**	**102**
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**86%**	**89%**	**92%**	**92%**	**1**	**83%**	**108**
9	**MNCH:** Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	Numerator: Number of women giving birth who received AMSTL through USG-supported programs in IHP target area	101,438	106,583	107,626	109,188	**424,835**	**425,518**	**100**
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	111,453	115,664	116,624	116,486	**460,227**	**449,208**	

		Numerator/ Denominator (in percentage)	**91%**	**92%**	**92%**	**94%**	**92%**	**95%**	**97**
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)	105,899	110,973	111,792	111,483	**440,147**	**540,244**	**81**
11	**MNCH:** Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area	104,420	111,134	112,609	111,630	**439,793**	**430,006**	**102**
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	128,878	129,787	126,409	126,409	**511,483**	**430,006**	
		Numerator/ Denominator (in percentage)	**81%**	**86%**	**89%**	**88%**	**86%**	**100%**	**86**
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)	8,058	6,819	8,608	11,335	**34,820**	**32,415**	**107**
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)	128,089	141,479	122,483	103,341	**495,392**	**573,232**	**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)	67,850	70,548	72,131	78,374	**288,903**	**764,318**	**68**
		Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	46,810	58,894	64,033	63,871	**233,608**		
15	**MNCH:** Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs =	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	111,071	111,390	116,587	118,008	**457,056**	**425,017**	**108**
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	112,446	113,239	110,292	110,292	**446,269**	**471,363**	
		Numerator/ Denominator (in percentage)	**99%**	**98%**	**106%**	**107%**	**102%**	**90%**	**114**
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	4,696	6,652	6,833	6,292	**24,473**	**21,251**	**115**
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	115,767	118,042	123,420	124,300	**481,529**	**425,017**	
		Numerator/ Denominator (in percentage)	**4%**	**6%**	**6%**	**5%**	**5%**	**5%**	**102**
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	103,842	104,924	112,889	110,200	**431,855**	**425,017**	**102**

		target area							
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	112,446	113,239	110,292	110,292	**446,269**	**471,363**	
		Numerator/ Denominator (in percentage)	**92%**	**93%**	**102%**	**100%**	**1**	**90%**	**107**
18	**MNCH:** Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	154	215	197	216	**216**	**100**	**216**
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	1,635,024	0	1,743,109	0	**3,378,133**	**2,520,338**	**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 during the last five months of pregnancy	121,019	118,742	136,753	127,768	**504,282**	**405,169**	**124**
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	128,878	129,787	126,409	126,409	**511,483**	**540,244**	
		Numerator/ Denominator (in percentage)	**94%**	**91%**	**108%**	**101%**	**99%**	**75%**	**131**
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)	120,628	126,664	161,462	165,823	**574,577**	**409,823**	**140**
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	34,693	32,907	34,109	36,294	**138,003**	**361,051**	**38**

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	399	488	436	489	**489**	**100**	**489**
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)	3,046	3,065	3,082	2,970	**12,163**	**28,903**	**42**
		Denominator: Total population in the specified geographical area	3,160,228	3,160,228	3,160,228	3,160,228	**12,640,912**	**13,506,106**	
		Numerator/ Denominator (per 100,000 population)	**96**	**97**	**98**	**94**	**96**	**214**	**45**
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	2,254	1,826	1,824	1,706	**7,610**	**17,342**	**44**
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	3,046	3,065	3,082	2,970	**12,163**	**28,903**	
		Numerator/ Denominator (in percentage)	**74**	**60**	**59**	**57**	**63**	**60**	**105**
26	**TB:** Case detection rate	Numerator: Number of new smear positive TB cases detected	3,046	3,065	3,082	2,970	**12,163**	**14,181**	**86**
		Denominator: Estimated number of TB cases expected	4,833	4,867	4,867	4,867	**19,434**	**20,259**	
		Numerator/ Denominator (in percentage)	**63%**	**63%**	**63%**	**61%**	**63%**	**70%**	**89**
27	**TB:** Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	5	10	16	15	**46**	**60**	**77**
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	10	23	19	19	**19**	**0**	
29	**Percentage of PEPFAR-supported**	***Percent =(Num/Den)x100***	85%	98%	100%	100%	**100%**		

	sites achieving 90% ARV or ART coverage for HIV+ pregnant women	***Numerator:*** Number of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	44	51	52	69	69		
		Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	52	52	52	69	69		
30	**Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results) (DSD)**	Percent =(Num/Den)x100	79%	74%	81%	77%	80%	86%	**93**
		Numerator: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	4,617	4,649	4,735	4,777	18,778	17,722	**106**
		Denominator: Number of new ANC and L&D clients	5,812	6,022	5,787	5,904	23,525	20605	
31	**Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)**	***Percent =(Num/Den)x100***	241%	100%	132%	128%	147%	84	**174**
		Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	89	59	64	42	254	152	**167**
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	37	46	35	55	173	180	
32	**Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (DSD)**	Number of female sex workers (FSW) reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	0	0	0	0	0	60	
33	**Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (DSD)**	Number of individuals who received T&C services for HIV and received their test results during the reporting period	8,019	11,636	9,676	9,880	39,211	30,330	**129**

34	**"Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)**	Number of HIV positive adults and children (aggregated by age/sex : female, male , <15 and <15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	245	358	483	296	1,382	696	**199**
35	**Number of HIV-positive adults and children receiving a minimum of one clinical service (DSD)**	Number of HIV-positive adults and children –aggregated by age/sex , female, male , <15 and > 15) in the reporting period receiving a minimum of one clinical service (DSD)	282	299	206	202	989	696	**142**
36	**TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting**	***Percent =(Num/Den)x100***	23%	2%	14%	12%	19%	90%	**142**
		Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	86	44	80	152	362	623	**58**
		Denominator: Number of patient HIV-positive	371	375	611	505	1,862	696	
37	**Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD)**	Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD) (aggregated by age/sex , female, male , <15 and >15) in the reporting period	5	13	19	26	63	175	**36**
38	**Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load**	Number of HIV-infected adults and children newly enrolled in clinical care (aggregated by age/sex , female, male , <15 and >15) during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	240	356	481	292	1,369		
39	**Proportion of registered TB cases who are HIV-positive who are on ART**	***Percent =(Num/Den)x100***	67%	100%	71%	78%	57%		
		Numerator: The number of registered TB cases with documented HIV-positive status who start or continue ART during the reporting period	2	7	46	51	106		

		Denominator: The number of registered TB cases with documented HIV-positive status during the reporting period	3	9	55	118	185		
40	**Percentage of laboratories and POC testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program**	***Percent =(Num/Den)x100***	100%	100%	100%	100%	100%	61%	
		Number of PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing on HIV serologic/diagnostic testing , CD4, EID and TB diagnostic	52	52	52	69	69	38	182
		Denominator : Total number of laboratories and testing sites	52	52	52	69	69	62	
41	**Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation**	Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation aggregated by site support type (DSD and TA)	1	1	1	1	1	1	100
42	**Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services**	***Percent =(Num/Den)x100***	100%	100%	100%	100%	100%	61%	
		Numerator: Number of service delivery points supported by PEPFAR for HIV services that are directly providing integrated voluntary family planning services	52	52	52	69	69	38	182
		Denominator: Total number of PEPFAR-supported HIV service delivery points	52	52	52	69	69	62	
IR 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									
43	***L+M+G:** % of general reference hospitals GRHs implementing complementary package of activities	Numerator: # of GRHs implementing CPA	69	72	71	71	71	55	129

	CPA	Denominator: Total # of GRHs	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**86%**	**90%**	**91%**	**91%**	91%	71%	**129**
44	***L+M+G:** % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	21	23	21	21	21	23	**91**
		Denominator: Total # of GRHs	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**26%**	**29%**	**27%**	**27%**	27%	29%	**90**
45	***L+M+G:** % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	1,346	1,388	1,360	1,382	1,382	979	**141**
		Denominator: Total # of health centers	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**95%**	**97%**	**95%**	**99%**	99%	70%	**141**
46	***L+M+G:** % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	106	119	118	120	120	419	**29**
		Denominator: Total # of health centers	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**7%**	**8%**	**8%**	**9%**	9%	30%	**28**
47	**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/	71,668	71,379	82,875	91,665	317,588	459,208	**69**
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	128,878	129,787	126,409	126,409	511,483	540,244	
		Numerator/ Denominator (in percentage)	**56%**	**55%**	**66%**	**73%**	62%	85%	**73**

48	**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	301	561	506	260	260	100	**260**
49	**MALARIA:** Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	0	0	0	0	0	455,000	
50	**MALARIA:** Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	18,210	3,008	1,340	3,600	26,158	455,000	**6**
50.1		*(a) through campaigns*	0	0	0	0	0		
50.2		*(b) through health facilities*	18,210	3,008	1,340	3,600	26,158	455,000	**6**
50.3		*(c) through the private/commercial sector*	0	0	0	0	0		
50.4		*(d) through other distribution channels*	0	0	0	0	0		
50.5		*(e) through voucher schemes*	0	0	0	0	0		
51	**MALARIA:** Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female)	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	46	124	653	537	1,360	1,750	**78**
		Male	40	112	585	455	1,192	1,167	**102**
		Female	6	12	68	82	168	583	**29**

52	**MALARIA:** Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	0	153,257	0	313,247	466,504	3,000,000	**16**
53	**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		
54	**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)	130,121	104,251	198,535	247,806	680,713	3,000,000	**23**
55	**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	46	124	653	537	1,360	2,350	**58**
56	**MALARIA:** Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	0	0	0	0	0	3,500,000	**0**
57	**MALARIA:** Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	543,180	567,418	569,525	458,918	2,139,041	2,500,000	**86**
57.1	Disaggregated in 3 sub-categories:	*(a) to health facilities*	546,506	564,601	566,818	458,192	2,136,117	2,440,204	**88**
57.2		*(b) to community health workers (HBMF, CCM)*	4,449	7,983	7,973	9,623	30,028	59,796	**50**
57.3		*(c) to the private/commercial sector*	0	0	0	0	0	0	
58	**MALARIA:** Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds Disaggregate in 3 sub-categories:	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	46	124	653	554	1,377	2,400	**57**

	(a) Number of health facility workers trained (male/female)	*Male*	40	112	410	455	1,017	1,167	**87**
		Female	6	12	59	82	159	583	**27**
	(b) Nombre d'agents communautaires formés (sexe masculin/sexe féminin)	*Male*	0	0	124	0	124	400	**31**
		Female	0	0	16	17	33	200	**17**
	(c) Nombre de techniciens de laboratoire formés (sexe masculin/sexe féminin)	*Male*	0	0	40	0	40	40	**100**
		Female	0	0	4	0	4	10	**40**
59	**MALARIA:** Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	0	0	0	0	0	4,000,000	**0**
60	**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	275,532	252,500	256,375	381,154	1,165,561	2,500,000	**47**
IR 1.2: Community-based health care services and products in target health zones increased									
61	***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/	1,252	1,299	1,305	1,295	1,288	1,398	**93**
		Denominator: Total # of communities in IHP target area	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/Denominator (in percentage)	**88%**	**91%**	**92%**	**93%**	92%	100%	**92**

62	**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)	21,244	8,032	135,631	67,724	**232,631**	**1,450,402**	**16**
63	**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)	24,296	41,500	60,610	107,830	**234,236**	**1,450,402**	**16**
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased									
64	***L+M+G:** % of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	Leadership Development Program (LDP) team made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas. Numerator: Number of HZ with leadership that has undergone LDP training	31	39	56	55	**55**	**78**	**71**
		Denominator: Total number of IHP health zones	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**39%**	**49%**	**72%**	**71%**	**71%**	**100%**	
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									
65	***L+M+G:** Percent of health zones (HZs) with validated action plans	Numerator: # HZ with validated actions plans	77	42	58	59	**59**	**78**	**76**
		Denominator: Total # HZs in IHP target area	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**96%**	**53%**	**74%**	**76%**	**76%**	**100%**	**76**

65.1	***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)	791	1,009	968	1,050	**954**	**1,258**	**76**
		Denominator: Total number of health centers in IHP areas	1,419	1,425	1,425	1,398	**1,398**	**1,398**	
		Numerator/ Denominator (in percentage)	**56%**	**71%**	**68%**	**75%**	**68%**	**90%**	**76**
65.2	***L+M+G:** Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies (Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	60	64	71	68	**66**	**70**	**94**
		Denominator: Total number of hospitals in IHP areas	80	80	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**75%**	**80%**	**91%**	**88%**	**84%**	**90%**	**94**
66	**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	0	0	0	93	**93**	**200**	**47**
67	**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	1,253	912	905	2,300	**5,370**	**4,000**	**134**

68	**GENDER:** # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	0	12	0	199	211	16	**1,319**
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted									
69	***L+M+G:** % of health centers meeting all nine FOSACOF minimum standards, disaggregated by type of health facility (Please create another row for hospitals with same indicator)	Numerator: # of health centers meeting all nine FOSACOF minimum standards	605	605	649	716	716	690	**104**
		Denominator: Total # of facilities	1,419	1,425	1,425	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**43%**	**42%**	**46%**	**51%**	51%	49%	**104**
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized									
70	% 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	3,676	4,525	3,783	7,991	19,975	42,257	**47**
		Denominator: Total # of patients seen by a CHW	16,233	15,641	16,242	24,386	72,502		
		Numerator/ Denominator (in percentage)	**23%**	**29%**	**23%**	**33%**	28%		
71	% 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	54,173	52,619	51,206	55,790	213,788	44,069	**485**
		Denominator: Total number of patients seen by a CHW or health care provider	1,353,946	1,394,708	1,363,291	1,346,053	5,457,998	3,348,028	
		Numerator/ Denominator (in percentage)	**4.0%**	**3.8%**	**3.8%**	**4.1%**	4%	1.3%	**298**
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									
72	***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	130	109	106	79	79	N/A	

		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	144	206	268	309	309	N/A	
		Numerator/ Denominator (in percentage)	**90%**	**53%**	**40%**	**26%**	26%	**20**	**128**
73	***L+M+G:** # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	0	0	2	7	9	**16**	
74	***L+M+G:** # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	0	0	2	4	6	**26**	**23**
75	***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	130	132	106	143	143	**120**	
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched									
76	**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	841	1,080	1,113	1,265	1,075	**1,038**	**104**
77	**BCC:** # of educational SMS messages during BCC campaigns or mini campaigns on malaria, nutrition and/or family planning	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	59,244	96,524	110,700	102,812	369,280	**480,000**	**77**
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									
78	***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")	79	49	51	62	62	**78**	**79**
		Denominator: Total # of health zones	80	80	78	78	78	**78**	
		Numerator/ Denominator (in percentage)	**99%**	**61%**	**65%**	**79%**	79%	**100%**	

79	***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	60	65	43	48	48	78	**62**
		Denominator: Total # of health zones	80	80	78	78	78	78	
		Numerator/ Denominator (in percentage)	**75%**	**81%**	**55%**	**62%**	1	100%	**62**
Project Management									
80	**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.)	6	10	8	8	32	30	**107**

SANRU

MEMORANDUM D'ENTENTE POUR LE PRET DES TDR (test de diagnostic rapide) DE LUTTE CONTRE LE PALUDISME DANS LES ZONES DE SANTE DU KATANGA et DE LA PROVINCE ORIENTALE

SIGNE ENTRE SANRU asbl, LE PROJET DE SANTE INTEGRE (PROSANI) et le PROJET PMI-EXPANSION.

AOUT 2014

nak

ENTRE:

1. D'une part l'ASBL SOINS DE SANTE PRIMAIRE EN MILIEU RURAL, en sigle "SANRU asbl", agissant dans le cadre du projet Fonds Mondial de lutte contre le SIDA et le paludisme, dont les bureaux sont établis à KINSHASA, 76 avenue de la justice, dans la commune de la GOMBE, ici représenté par Dr. GOMA MIEZI KINTAUDI, Directeur Exécutif, ci-après dénommée "SANRUasbl" :

ET d'autre part:

2. Le projet de sante intégré (PROSANI), mis en œuvre par Management science for Heath(MSH) finance par l'USAID, dont la représentation en RDC est établie au 8-avenue des citronniers, à KINSHASA-GOMBE, représenté par Dr OUSMANE FAYE, chef de projet, ci-après dénommé "PROJET PROSANI/USAID".

3. Et le projet PMI-Expansion, dont la représentation en RDC est établie au 4630, avenue de la science, à KINSHASA-GOMBE, représenté par Dr. Louis AKULAYI, chef de projet.

SANRU asbl , PROSANI et PMI-expansion étant collectivement appelées « parties ».

Considérant :

La nécessité urgente de faire face au cas de rupture de stock en test de diagnostic rapide (TDR) dans les les zones de santé de la province de KATANGA et de la province orientale.

La requête des prêts de TDR formulée par l'USAID/PMI pour le compte de son projet de sante intégré en date du 28 juin 2014 et appuyée par le programme national de lutte contre le paludisme et dont la désignation et les quantités sont contenues dans ladite requête.

AINSI, IL A ETE CONVENU ET ARRETE CE QUI SUIT :

Article 1 :

Sur demande et recommandation du PNLP, SANRU asbl prête au projet PROSANI /USAID une quantité de 11600 kits de 25 TDR (test de dépistage rapide) dont la répartition est reprise dans le tableau que voici :

Kalemie	Kamina	Kolwezi	Kisangani	TOTAL
1 400	3 600	1 600	5 000	11 600

MK

Article 2 :

Les intrants CIF dédouanés par USAID/PMI seront livres dans le dépôt SANRU asbl de KINSHASA au plus tard au dernier trimestre de l'an 2014.

FAIT A KINSHASA, le

Pour et au nom de PROSANI OUSMANE FAYE COP PROSANI	Pour et au nom de SANRU asbl NGOMA MIEZI KINTAUDI Directeur Exécutif	Pour et au nom de PMI-Exp Louis AKULAYI COP
DATE : 20/10/2014	DATE : 21/10/2014	DATE : 20/10/14

Appendix 6: Fistula Care Data PY4Q4

Hospital	Period	Age				Etiology							Diagnostic																				Results		
		Under 20 years	20 - 35 years	35 - 45 years	Over 45 years	Others	Home Birth	Curettage	Difficult labor at health center	C-section	Post-operation	Other trauma	FVV	FVV Récidive + Incontinence	FUVV	FRV	FVVR1	FVVR2	FVVR3	FUVVR3	FVVR4	FVVR5	FCV	FUVR1	FUVR2	FRVR2	FRVR3	Incontinence	Incontinence Récidive	Incontinence Urinaire Résiduelle	Rupture Uréthrale	Unsuccessful reparation	Successful reparation	Death
KAZIBA	PY4Q1	3	35	13	9	10	22	0	27	0	0	0	27	1	6	4	1	1	3	0	1	1	0	0	0	1	1	9	1	3	0	14	46	0
	PY4Q2	4	31	11	14	11	21	0	36	0	0	0	36	0	10	3	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	11	49	0
	PY4Q3	1	36	11	12	11	16	0	31	0	0	0	31	0	12	5	0	0	1	0	0	0	0	0	0	0	0	10	0	0	0	12	48	0
	PY4Q4	2	34	14	10	13	21	0	34	0	0	0	34	4	6	5	0	1	0	0	0	0	0	0	0	0	0	11	0	0	0	9	51	**0**
	PY4 Total	10	136	49	45	45	80	0	128	0	0	0	128	5	34	17	1	2	4	0	1	1	0	0	0	1	1	41	1	3	0	46	194	**0**

APPENDIX 7: Accruals Report, July to September 2014

USAID/DRC
Financial Management Office
Accruals Worksheet for the period
July 1, 2014 - September 30, 2014

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

Vendor: MANAGEMENT SCIENCES FOR HEALTH, INC

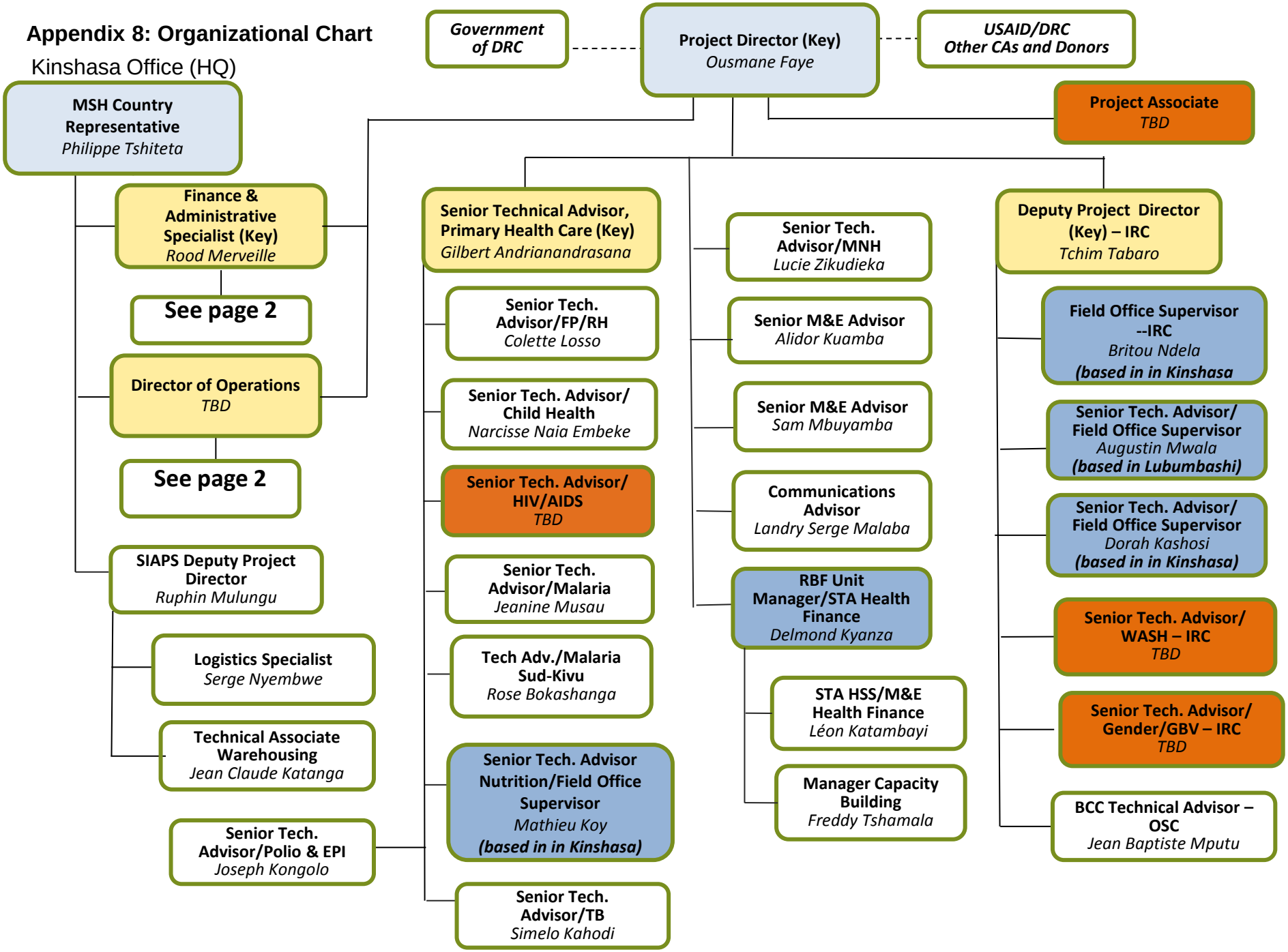
RFA OAA-10-000006

			A	B	C	D	E	F= (C + D+ E)	G = B - F	H=A-F
Program Area	**Program Element**	**BFY Fund**	**Estimated LOP Budget**	**Obligations**	**Disbursements (Oct 2010 - June 2014)**	**Quarter 3 - Disbursement (July-September 2014)**	**Quarter 3 Accruals (September 2014)**	**Project Total to Date (including accrual)**	**Obligations remaining (Pipeline)**	**Estimated Balance**
A11	A047- HIV/AIDS	GH-AIDS/2010/201	$ 14,743,405.00	$ 7,669,613.00	$ 7,263,332.05	$ 135,342.31	$ 202,180.73	$ 7,600,855.10	$68,757.90	$ 7,142,549.90
A11	A048 - TB	GH-C/2010/2011	$ 17,286,763.00	$ 12,866,667.00	$ 10,958,366.89	$ 432,020.84	$ 1,150,734.83	$ 12,541,122.56	$325,544.44	$ 4,745,640.44
A11	A049 - Malaria	GH-C/20102011	$ 20,245,000.00	$ 17,344,982.33	$ 14,503,355.57	$ 640,662.66	$ 1,513,122.20	$ 16,657,140.43	$687,841.90	$ 3,587,859.57
A11	A052- MCH	GH-C/20102011	$ 45,731,306.00	$ 52,458,614.83	$ 36,988,492.10	$ 2,425,741.08	$ 4,707,077.17	$ 44,121,310.35	$8,337,304.48	$ 1,609,995.65
A11	A053 - FP/RH	GH-C-POP/2010/201	$ 20,625,615.00	$ 15,958,948.00	$ 14,050,276.80	$ 599,126.10	$ 1,302,188.74	$ 15,951,591.63	$7,356.37	$ 4,674,023.37
A11	A054 - WASH	ES/2010/2011	$ 12,610,800.00	$ 11,725,018.67	$ 8,912,513.77	$ 407,147.65	$ 956,716.40	$ 10,276,377.82	$1,448,640.85	$ 2,334,422.18
A11	A142- Nutrition	GH-C-GFSI/2010/201	$ 8,524,240.00	$ 5,590,229.80	$ 4,947,465.77	$ 260,557.44	$ 254,412.58	$ 5,462,435.79	$127,794.01	$ 3,061,804.21
Grand Total			$ 139,767,129.00	$ 123,614,073.63	$ 97,623,802.95	$ 4,900,598.08	$ 10,086,432.66	$ 112,610,833.69	$11,003,239.94	$ 27,156,295.31

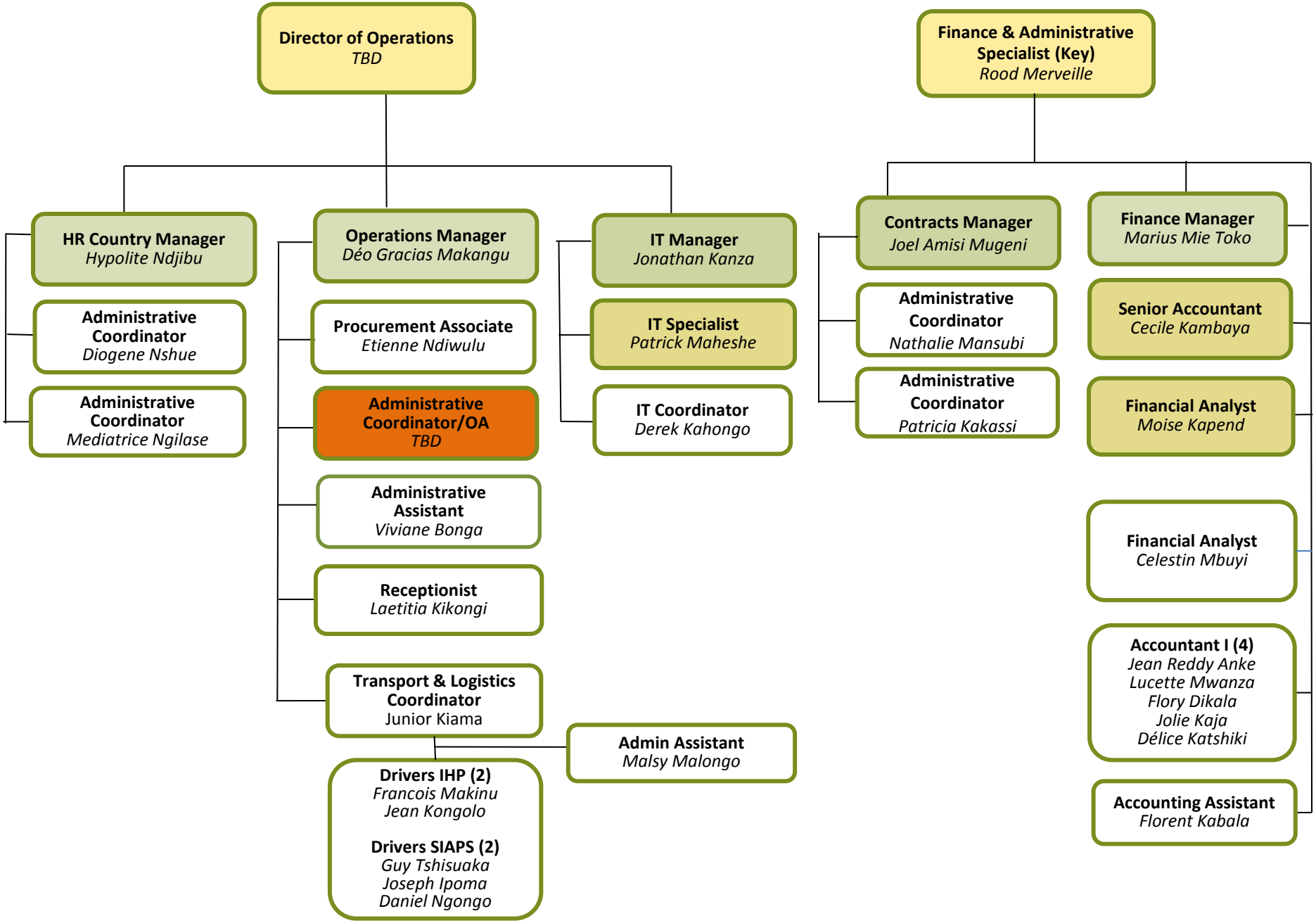
Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal.

Appendix 8: Organizational Chart

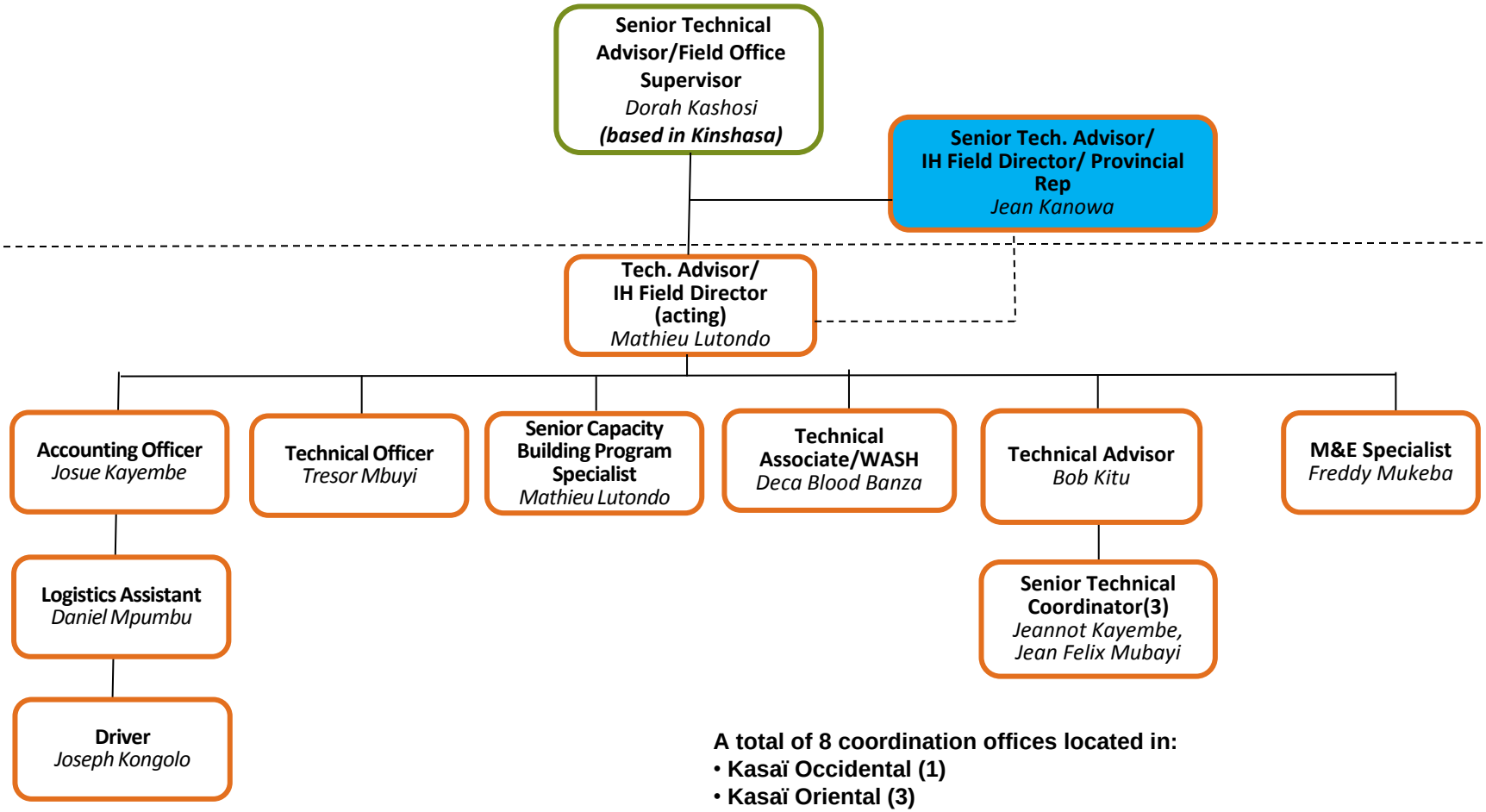
Kinshasa Office (HQ)



Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasaï Occidental

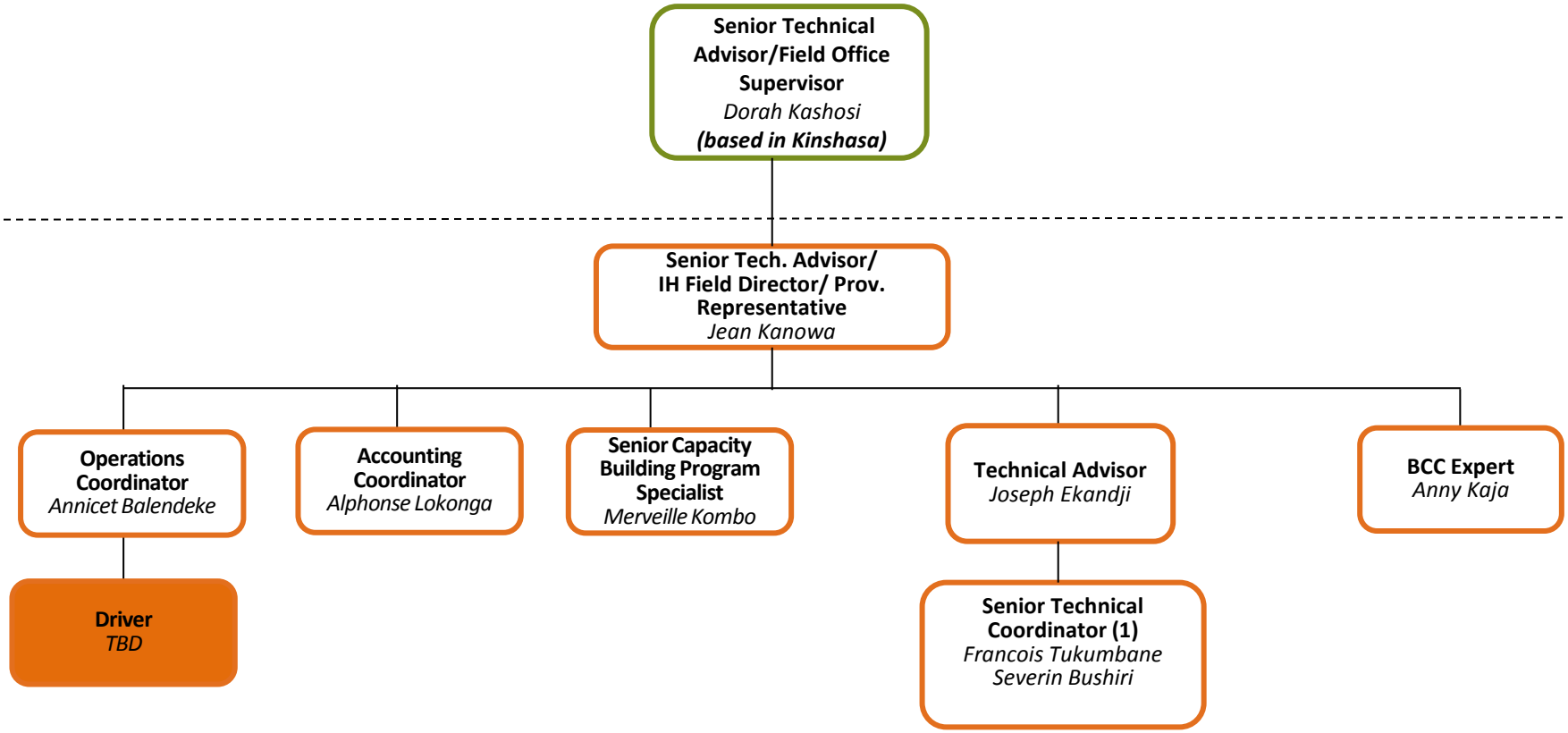


A total of 8 coordination offices located in:

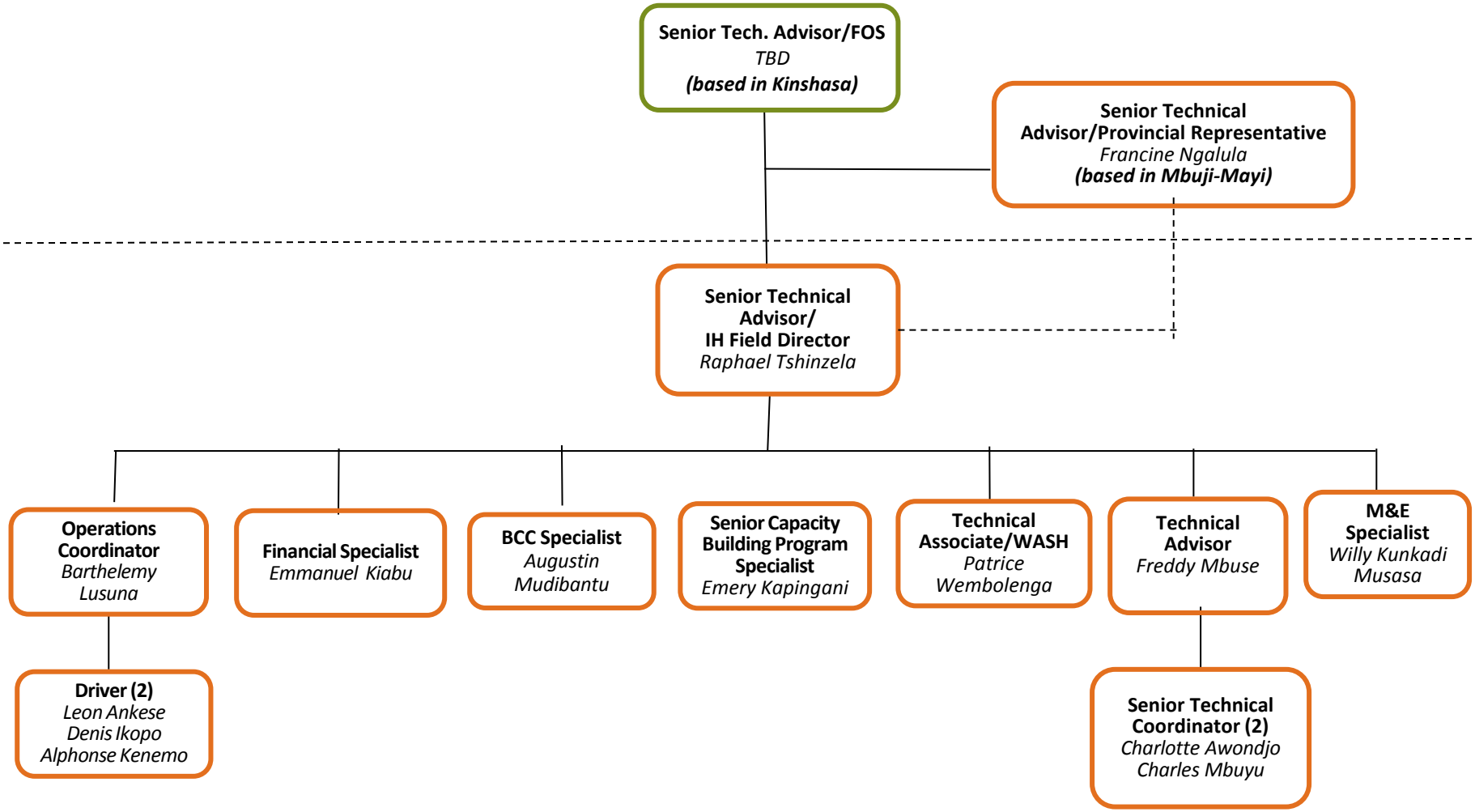
- **Kasaï Occidental (1)**
- **Kasaï Oriental (3)**
- **Katanga (2)**
- **Sud Kivu (2)**

Three satellite offices are located in Mbuji Mayi, Kananga and Lubumbashi, mainly for provincial representation purposes. The Bukavu field office also hosts the provincial representation for Sud Kivu.

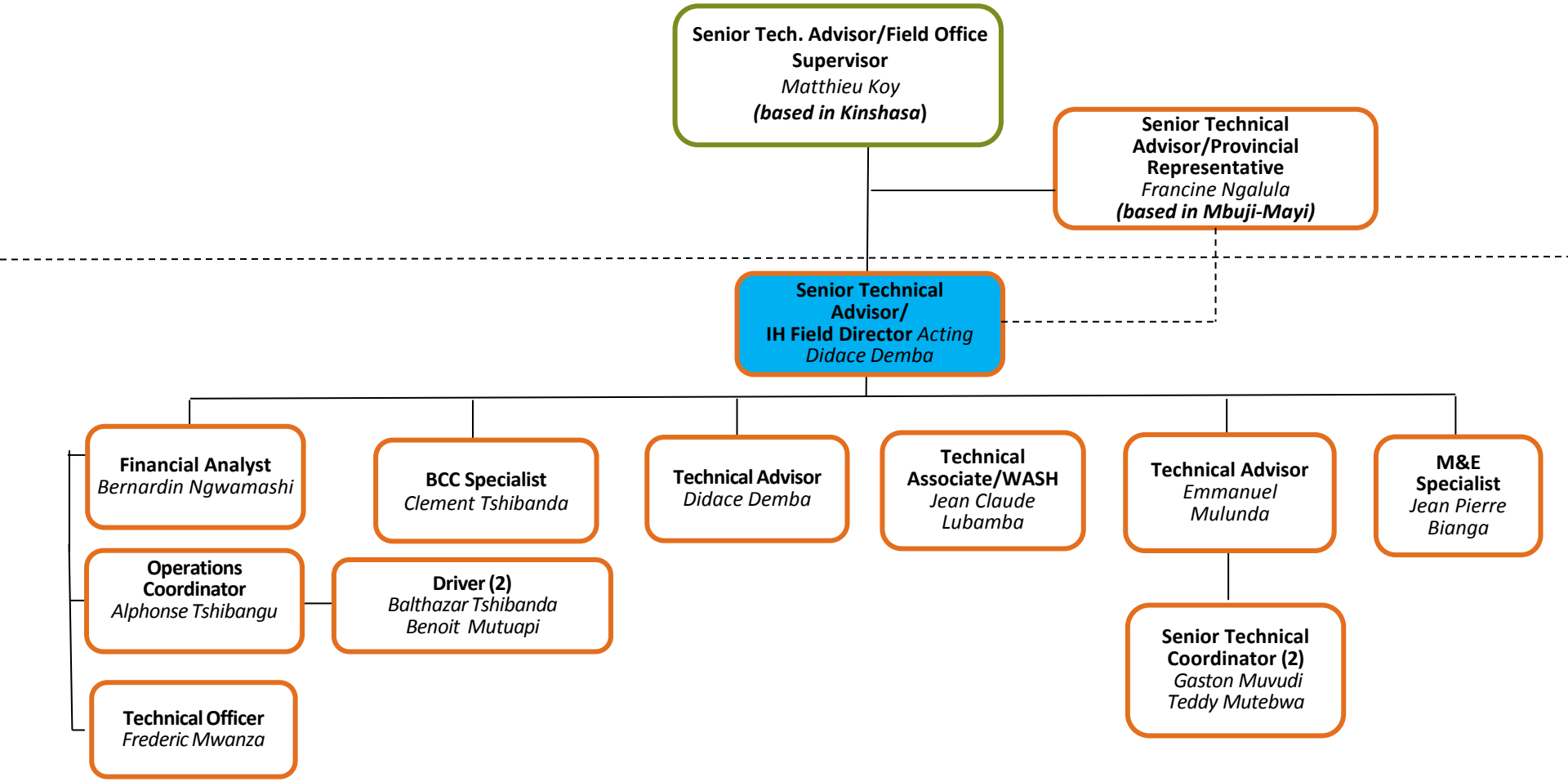
IHP Field Office: Kananga, Kasaï Occidental



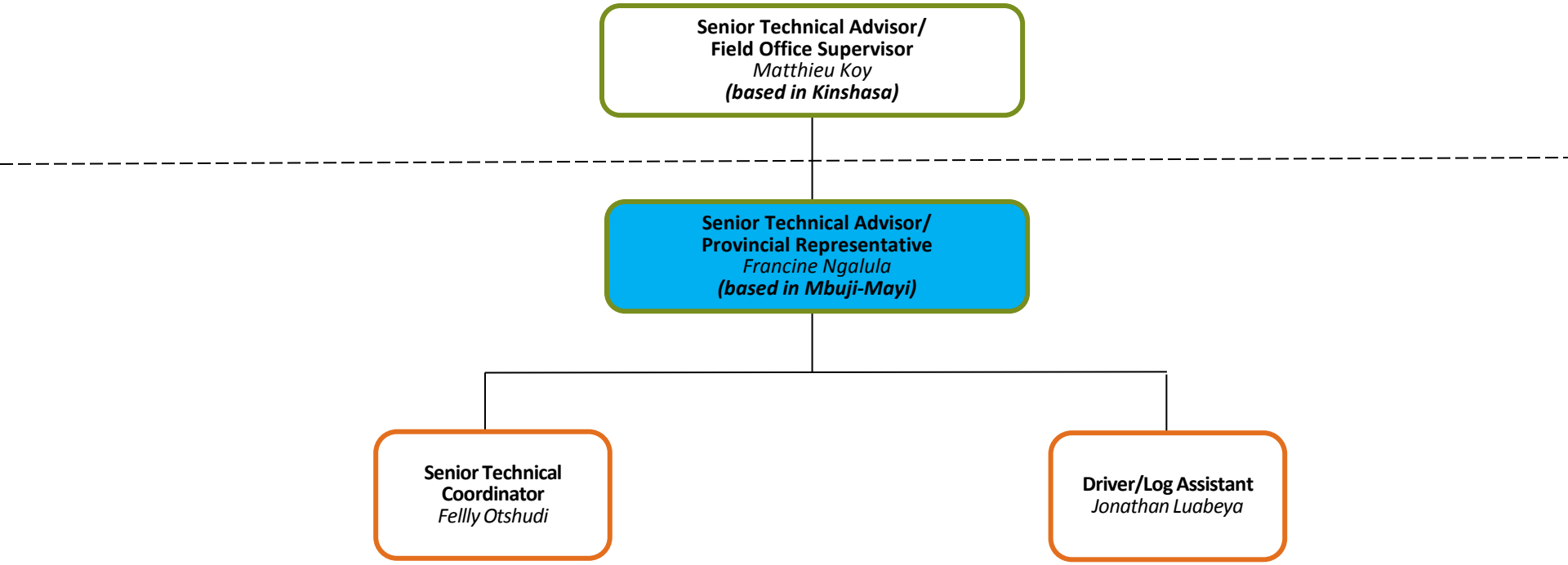
IHP Field Office: Kole (Lodja), Kasaï Oriental



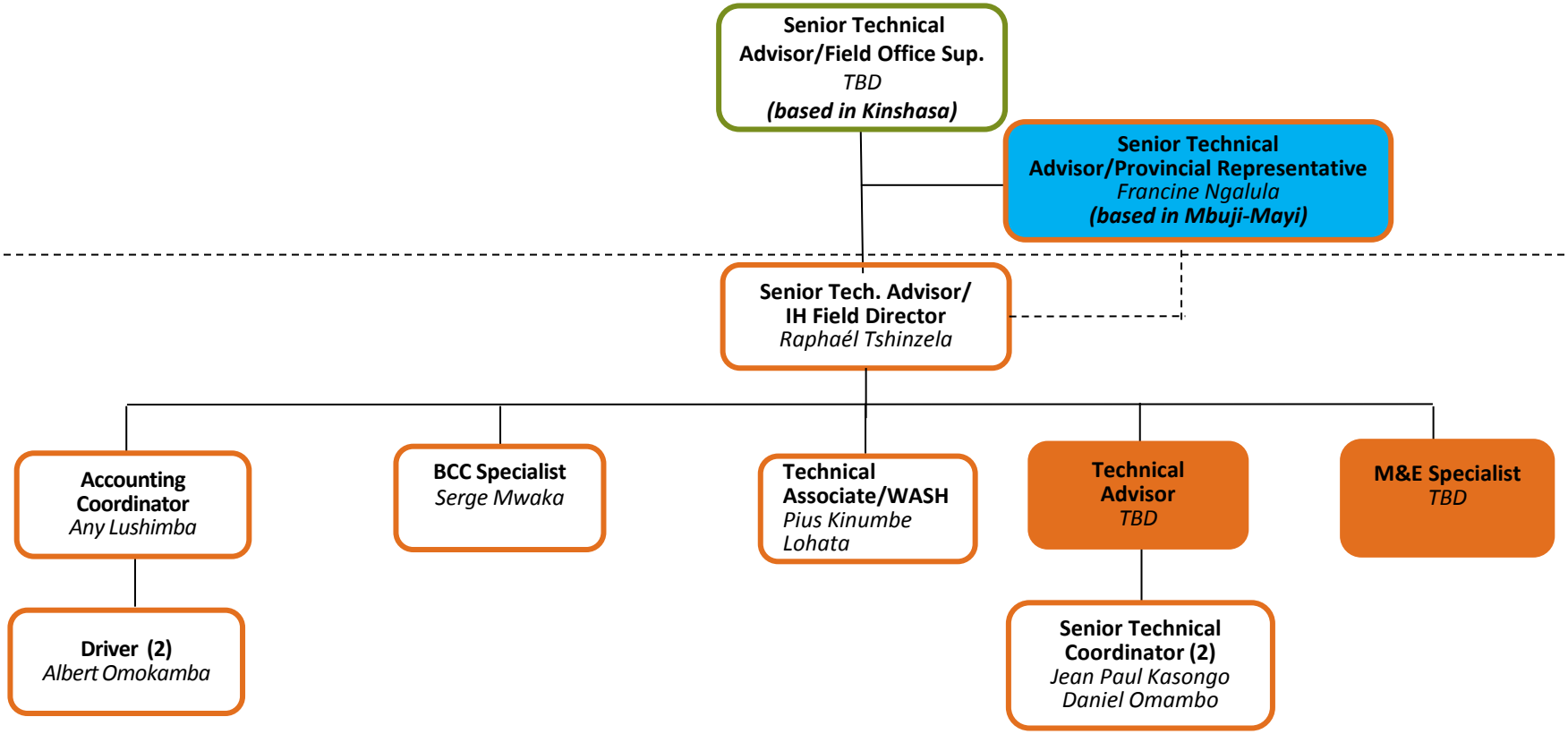
IHP Field Office: Mwene-Ditu, Kasaï Oriental



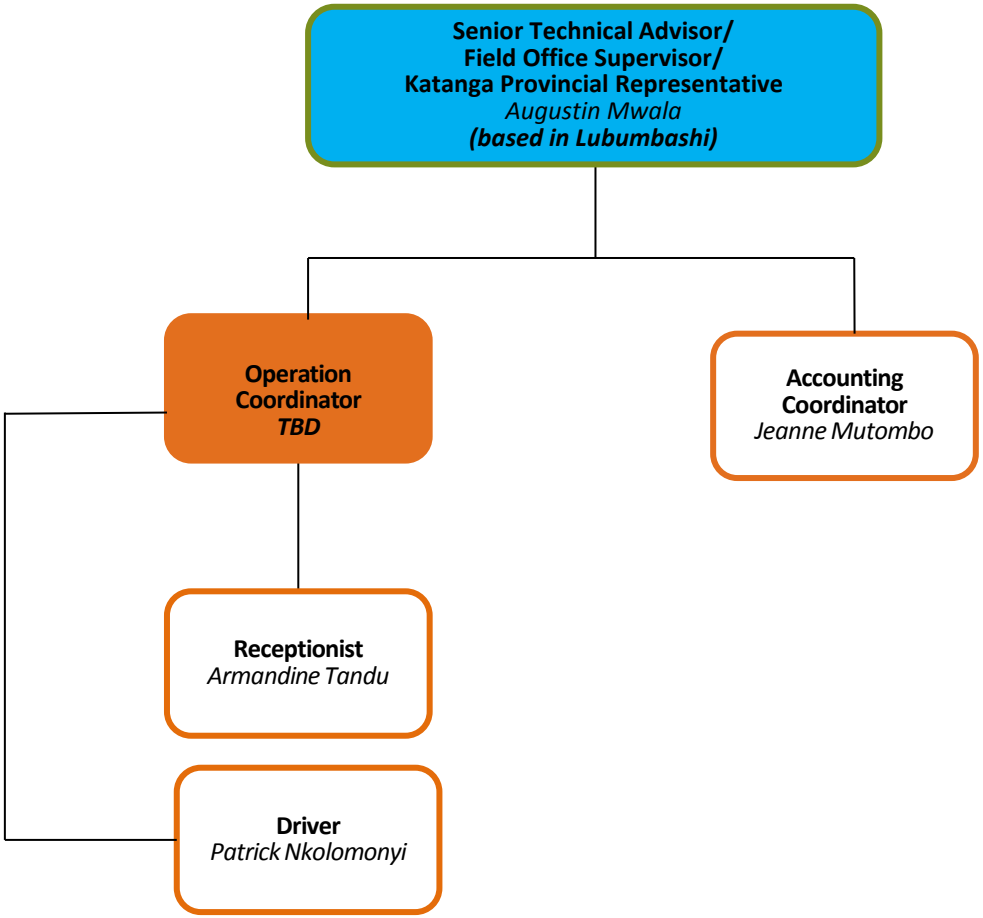
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



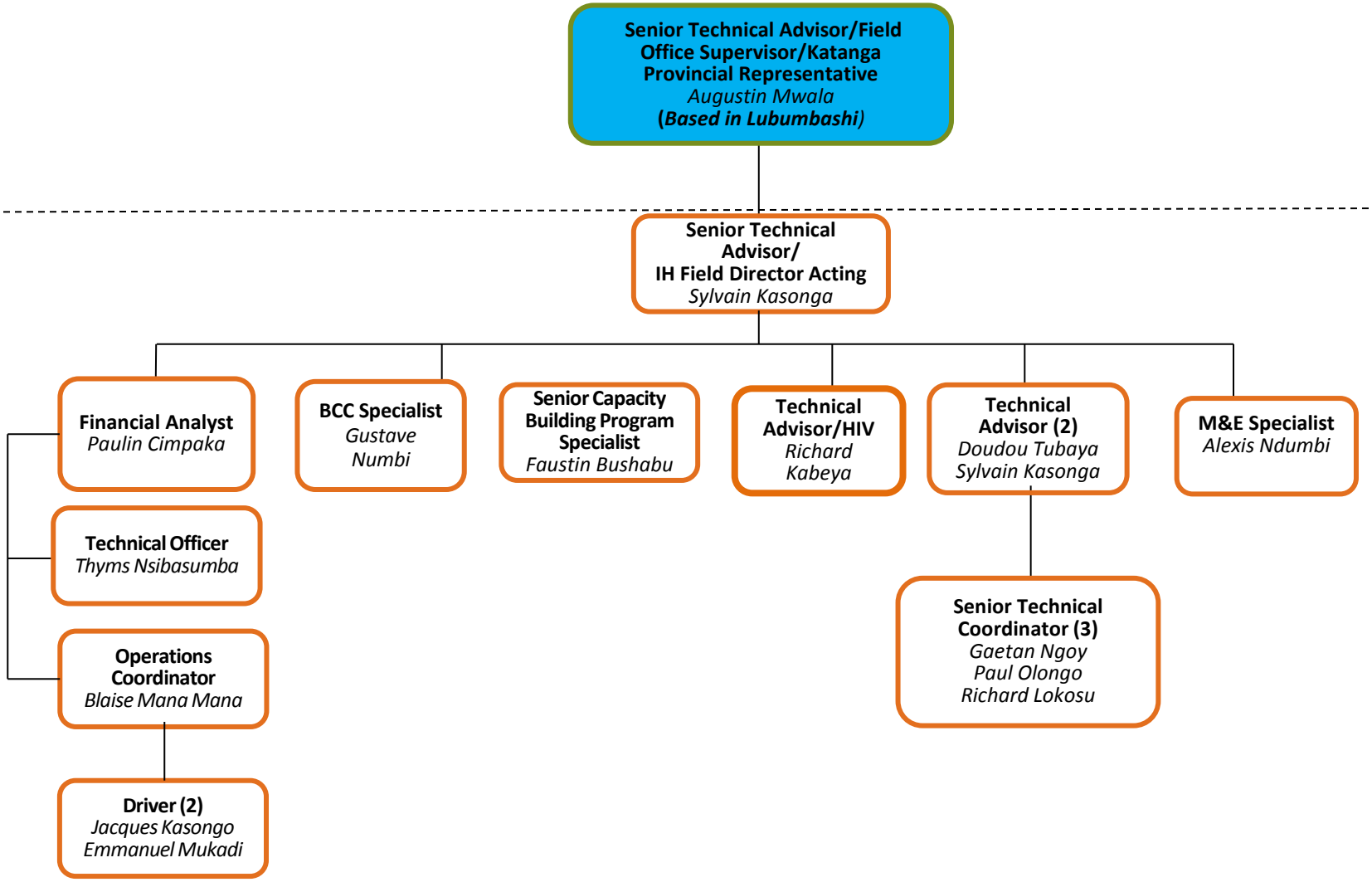
IHP Field Office: Tshumbe, Kasaï Oriental



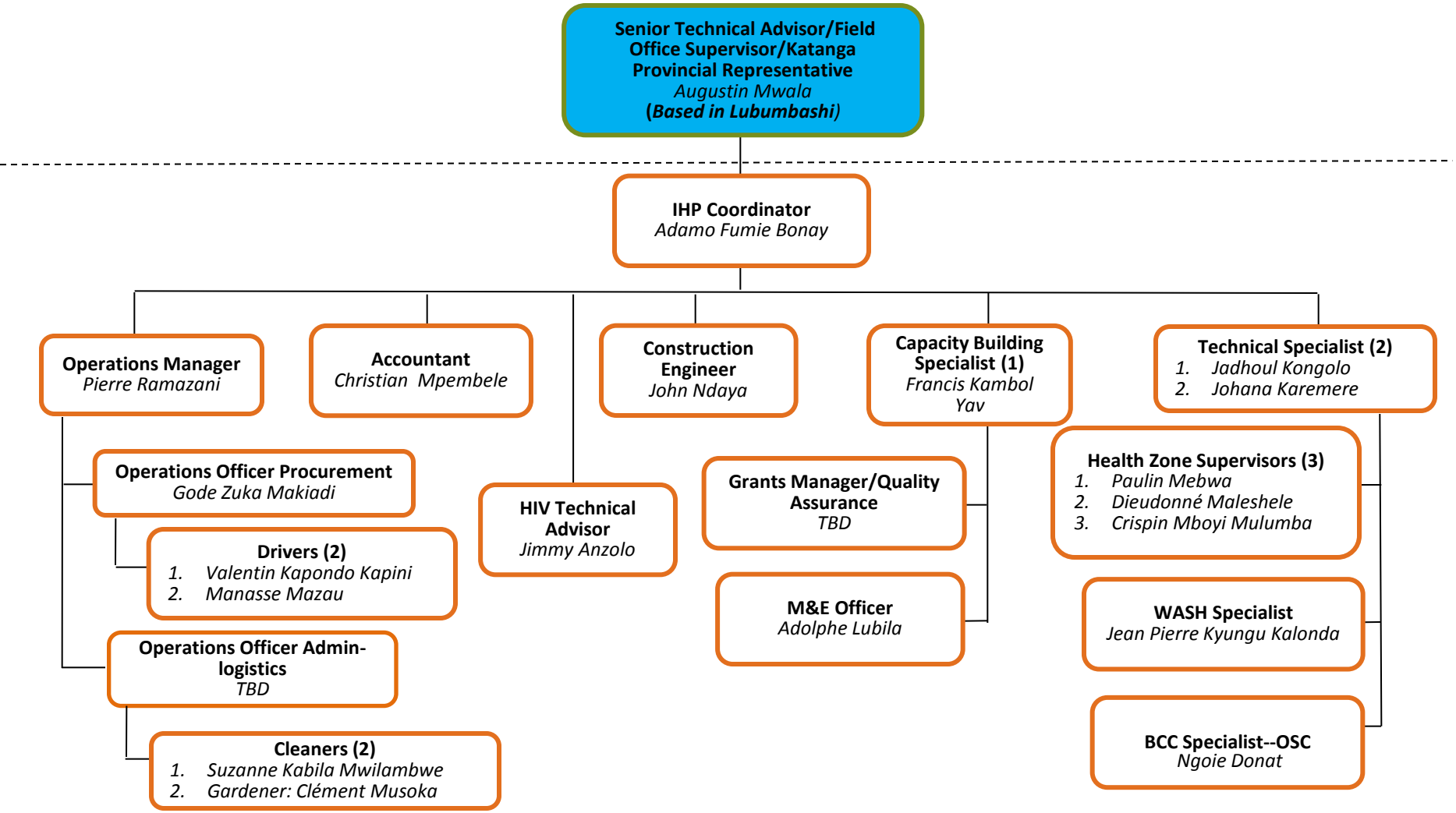
IHP Field Satellite Office: Lubumbashi, Katanga



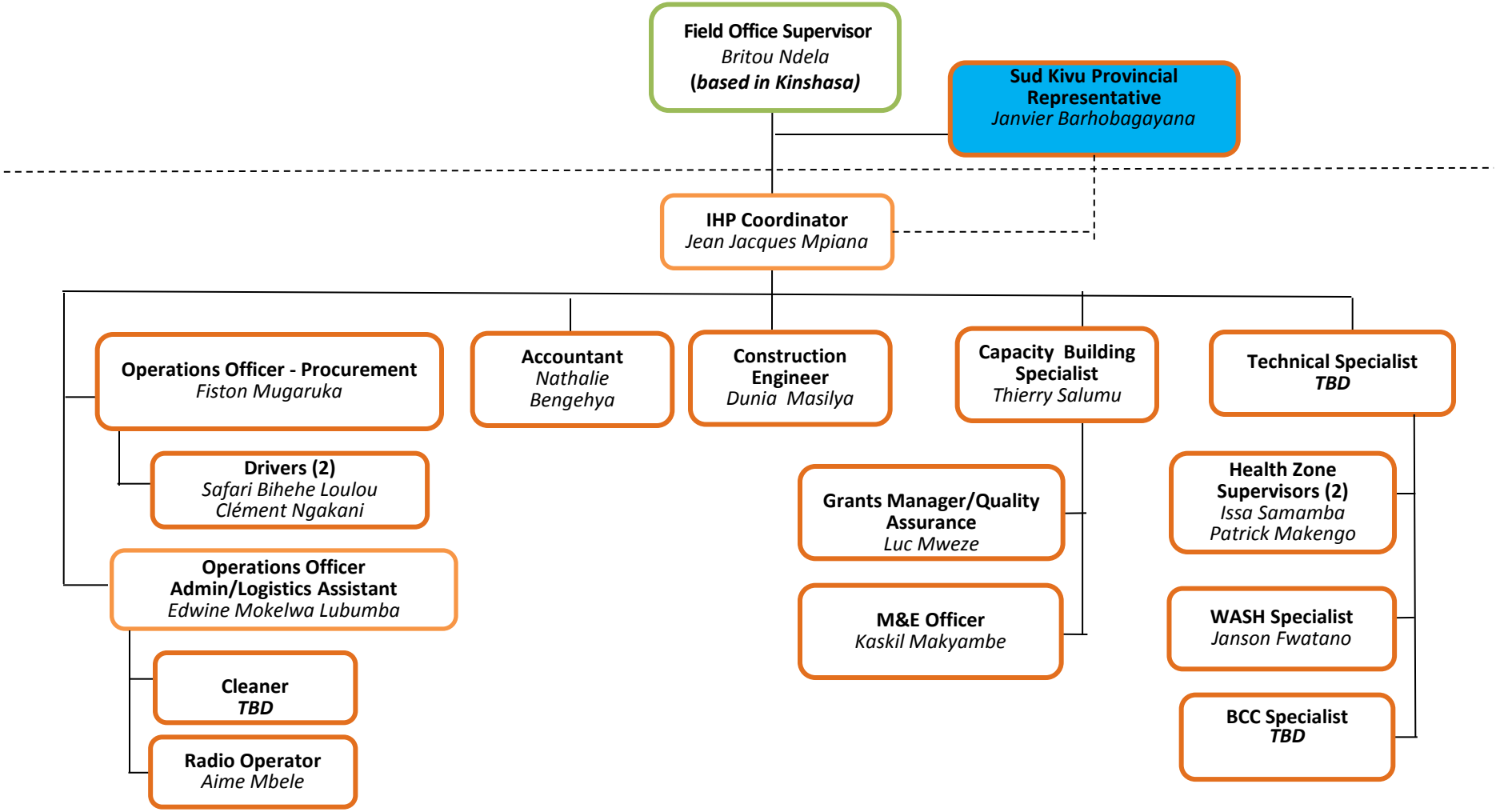
IHP Field Office: Kamina, Katanga



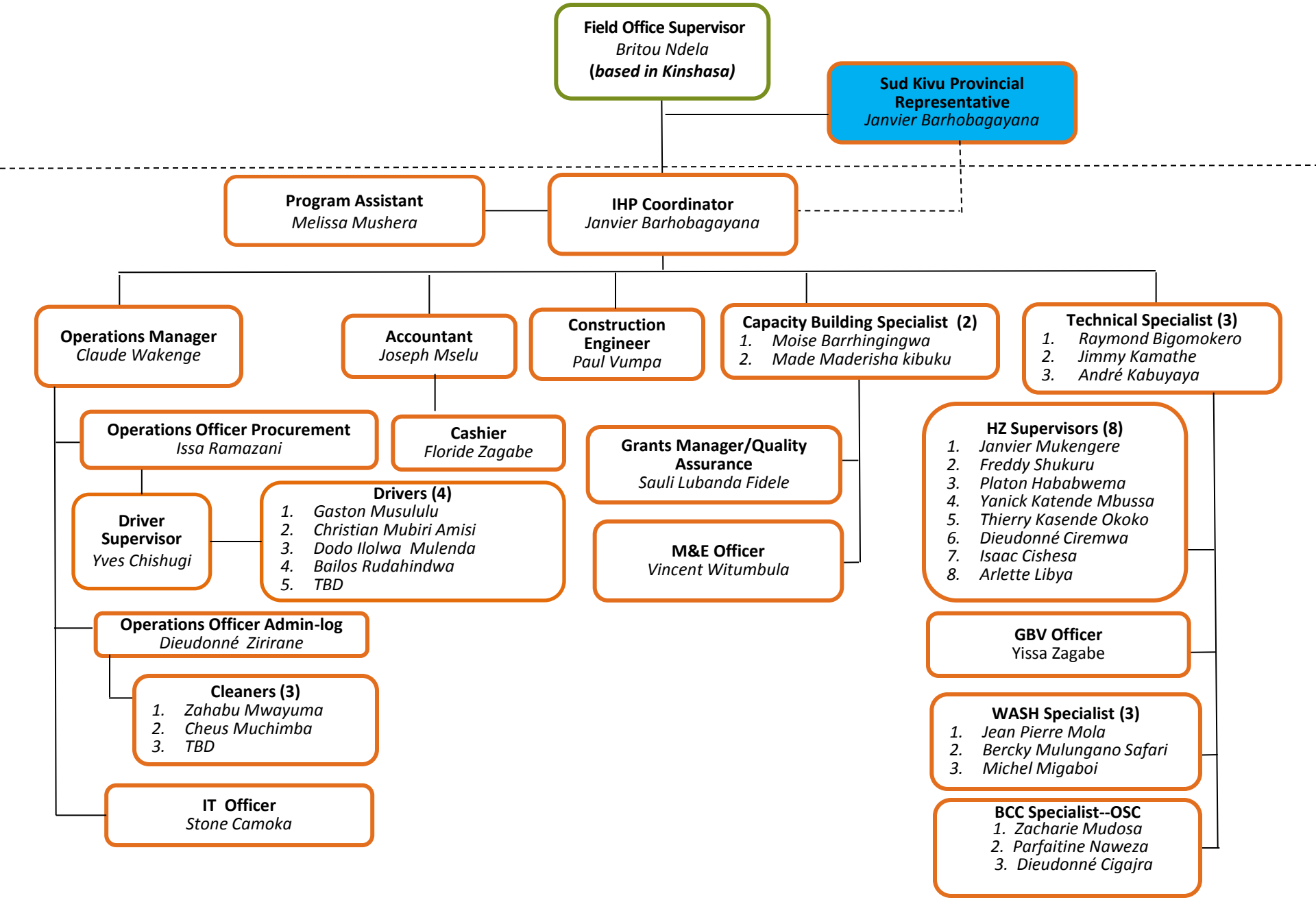
IHP Field Office: Kolwezi, Katanga



IHP Field Office: Uvira, Sud Kivu



IHP Field Office: Bukavu, Sud Kivu



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.
200 Rivers Edge Drive, Medford, MA 02155
United States

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	09/30/2014

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	$102,893,689.00
b. Cash Disbursements	$102,524,457.45
c. Cash on Hand (line a minus b)	$369,231.55
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$123,614,073.63
e. Federal share of expenditures	$102,524,457.45
f. Federal share of unliquidated obligations	$0.00
g. Total Federal share (sum of lines e and f)	$102,524,457.45
h. Unobligated balance of Federal funds (line d minus g)	$21,089,616.18
Recipient Share:	
i. Total recipient share required	$4,193,013.88
j. Recipient share of expenditures	$3,213,548.15
k. Remaining recipient share to be provided (line i minus j)	$979,465.73
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%	07/01/2014	09/30/2014	166,980.74	135,254.40	100%
	Local Proff	40%	07/01/2014	09/30/2014	839,252.25	335,700.90	100%
	Consultants	40%	07/01/2014	09/30/2014	26,750.00	10,700.00	100%
				g. Totals:	$ 1,514,638.29		

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, Sr Treasury Mgr	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) 10/30/2014
	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

IHP FAMILY PLANNING COMMODITIES SITUATION (JUILLET -SEPTEMBRE 2014, FY4Q4)

Coordination	Zones de santé	Pop totale 2014	Cible totale PF	Cible mensuelle	Dépo provera				Jadelle + Trocard				DIU			
					Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4
TSHUMBE	Dikungu-Tshumbe	140,529	29,511	2,459	3,153	0	408	2,745	0	0	0	0	0	0	0	0
	Djalo-Ndjeka	77,698	16,317	1,360	173	1023	580	616	0	0	0	0	0	0	0	0
	Katako Kombe	130,571	27,420	2,285	675	348	573	450	16	0	0	16	0	0	0	0
	Lusambo	95,349	20,023	1,669	282	89	186	185	0	0	0	0	0	0	0	0
	Minga	158,522	33,290	2,774	5,072	0	416	4,656	0	0	0	0	0	0	0	0
	Pania Mutombo	77,572	16,290	1,358	289	0	183	106	0	0	0	0	0	0	0	0
	Tshumbe	96,566	20,279	1,690	0	1135	162	973	0	0	0	0	0	0	0	0
	Wembonyama	81,788	17,175	1,431	1,344	219	306	1,257	0	0	0	0	0	0	0	0
S/TOTAL 6		858,595	180,305	15,025	10,988	2,814	2,814	10,988	16	0	0	16	0	0	0	0
KOLE	Bena Dibele	90,606	19,027	1,586	7,651	0	5701	1,950	0	0	0	0	0	0	0	0
	Kole	91,298	19,173	1,598	10,267	0	4767	5,500	0	0	0	0	163	0	0	163
	Lodja	178,188	37,419	3,118	5,441	0	4026	1,415	50	84	134	0	0	21	20	1
	Lomela	107,088	22,489	1,874	6,415	0	400	6,015	0	0	0	0	54	0	0	54
	Omendjadi	125,722	26,402	2,200	3,495	0	2595	900	0	0	0	0	0	0	0	0
	Ototo	124,797	26,207	2,184	1,547	0	1547	0	0	0	0	0	49	0	49	0
	Tshudiloto	70,092	14,719	1,227	4,456	0	3270	1,186	0	0	0	0	0	0	0	0
	Vangakete	119,601	25,116	2,093	2,213	0	2213	0	50	0	50	0	54	0	54	0
S/TOTAL 2		907,392	190,552	15,879	41,485	0	24,519	16,966	100	84	184	0	320	21	123	218
MWENE DITU	Bibanga	152,313	31,986	2,665	11,445	0	615	10,830	0	54	34	20	0	141	0	141
	Wikong	118,955	24,981	2,082	8,426	0	272	8,154	225	0	0	225	135	0	0	135
	Dibindi	268,722	56,432	4,703	6,161	0	761	5,400	0	0	0	0	4	0	1	3
	Kalenda	207,366	43,547	3,629	9,692	0	445	9,247	0	1	0	1	0	0	0	0
	Kamiji	100,730	21,153	1,763	589	0	111	478	0	0	0	0	0	0	0	0
	Kanda Kanda	236,343	49,632	4,136	8,101	0	398	7,703	0	1	1	0	13	0	0	13
	Luputa	292,925	61,514	5,126	1,017	823	695	1,145	0	0	0	0	6	1	0	7
	Mpokolo	310,504	65,206	5,434	11,431	0	1384	10,047	0	0	0	0	131	0	1	130
	Mwene Ditu	416,134	87,388	7,282	11,586	438	796	11,228	7	98	105	0	67	0	25	42
S/TOTAL 2		2,103,993	441,839	36,820	68,448	1,261	5,477	64,232	232	154	140	246	356	142	27	471
LUIZA	Bilomba	86,265	18,116	1,510	6,635	0	350	6,285	25	22	2	45	71	0	0	71
	Dekese	139,514	29,298	2,441	4,917	0	943	3,974	40	22	0	62	65	0	0	65
	Dibaya	136,273	28,617	2,385	2,609	0	1078	1,531	35	22	12	45	83	0	0	83
	Kalomba	143,965	30,233	2,519	1,575	0	502	1,073	36	22	1	57	91	0	4	87
	Luambo	268,088	56,298	4,692	4,961	0	1116	3,845	49	22	11	60	46	0	0	46
	Lubondaie	153,294	32,192	2,683	835	0	543	292	40	22	18	44	78	0	0	78
	Luiza	164,109	34,463	2,872	3,777	0	464	3,313	7	22	0	29	73	0	0	73
	Ndekesha	152,747	32,077	2,673	3,140	0	539	2,601	40	22	0	62	77	0	0	77
	Yangala	153,057	32,142	2,678	13,082	0	502	12,580	65	22	2	85	173	0	0	173
S/TOTAL 4		1,397,312	293,436	24,453	41,531	0	6,037	35,494	337	198	46	489	757	0	4	753
BUKAVU	Bagira-Kasha	97,499	20,475	1,706	2,172	0	7	2,165	23	0	5	18	78	0	0	78
	Bunyakiri	151,205	31,753	2,646	1,196	0	154	1,042	12	0	12	0	56	0	0	56
	Ibanda	316,176	66,397	5,533	423	247	369	301	28	0	28	0	11	0	11	0
	Idjwi	242,752	50,978	4,248	1,982	28	2010	0	0	0	0	0	3,088	0	0	3,088
	Kadutu	199,033	41,797	3,483	450	0	183	267	20	0	4	16	3	0	0	3
	Kalole	103,482	21,731	1,811	131	0	62	69	0	0	0	0	100	0	0	100
	Kalonge	182,345	38,292	3,191	209	180	203	186	10	0	4	6	0	0	0	0
	Kamituga	157,091	32,989	2,749	125	80	242	-37	7	0	0	7	7	0	0	7
	Kaniola	174,515	36,648	3,054	900	191	460	631	0	0	0	0	35	0	2	33
	Katana	200,004	42,001	3,500	824	358	1182	0	55	0	55	0	956	0	46	910
	Kaziba	118,249	24,832	2,069	200	0	200	0	30	0	4	26	300	0	9	291
	Kitutu	130,999	27,510	2,292	3,499	0	56	3,443	0	0	0	0	248	0	0	248
	Lulingu	158,111	33,203	2,767	100	101	201	0	2	0	2	0	0	0	0	0
	Minova	195,736	41,105	3,425	408	0	408	0	21	0	21	0	0	0	0	0
	Miti-Murhesa	204,598	42,966	3,580	1,111	1684	2,660	135	109	0	109	0	78	0	11	67
	Mubumbano	170,091	35,719	2,977	525	5	92	438	0	0	0	0	10	0	0	10
	Mulungu	138,469	29,078	2,423	1,006	0	73	1,079	6	0	6	12	0	0	0	0
	Mwana	132,027	27,726	2,310	6,044	0	171	5,873	0	0	0	0	9	0	0	9
	Mwenga	125,478	26,350	2,196	2,263	0	138	2,125	1	0	1	0	30	0	0	30
	Nyangezi	137,186	28,809	2,401	559	0	39	520	0	0	0	0	62	0	1	61
	Shabunda Centre	142,854	29,999	2,500	2,861	1096	375	3,582	10	0	10	0	851	0	0	851
	Walungu	250,637	52,634	4,386	3,590	341	514	3,417	0	0	0	0	44	0	0	44
S/TOTAL 5		3,728,537	782,993	65,249	30,578	4,311	9,799	25,236	334	0	261	85	5,966	0	80	5,886
KOLWEZI	Bunkeya	48,861	10,261	855	2,282	0	1720	562	18	10	15	13	81	0	42	39
	Dilala	111,673	23,451	1,954	2,972	0	2372	600	333	10	66	277	770	0	103	667
	Fungurume	104,029	21,846	1,821	464	0	292	172	110	10	28	92	176	0	84	92
	Kanzenze	87,566	18,389	1,532	3,704	0	2227	1,477	657	30	228	459	613	0	258	355
	Lualaba	93,478	19,630	1,636	627	0	317	310	42	10	13	39	7	0	5	2
	Lubudi	114,128	23,967	1,997	4,075	0	2436	1,639	108	10	27	91	176	0	95	81
	Manika	211,634	44,443	3,704	1,210	0	739	471	6	10	10	6	6	0	5	1
	Mutshatsha	66,421	13,948	1,162	291	0	202	89	15	10	4	21	0	0	0	0
S/TOTAL 6		837,790	175,936	14,661	15,625	0	10,305	5,320	1,289	100	391	998	1,829	0	592	1,237
UVIRA	Lemera	143,065	30,044	2,504	10,208	0	59	10,149	12	0	1	11	190	0	0	190
	Nundu	223,455	46,926	3,910	11,265	0	177	11,088	59	0	2	57	217	0	0	217
	Hauts Plateaux	105,449	22,144	1,845	8,044	0	77	7,967	0	0	0	0	78	0	0	78
	Uvira	261,907	55,001	4,583	21,885	0	77	21,808	41	0	1	40	296	0	0	296
	Ruzizi	132,061	27,733	2,311	16,171	0	216	15,955	73	0	23	50	248	0	1	247
TOTAL		865,939	181,847	15,154	67,573	0	606	66,967	185	0	27	158	1,029	0	1	1,028
KAMINA	Kabongo	346,944	72,858	6,072	2697	0	187	2,510	0	20	0	20	0	0	0	0
	Kinkondja	241,099	50,631	4,219	2755	0	240	2,515	12	0	2	10	1	0	0	1
	Songa	173,846	36,508	3,042	483	0	294	189	4	0	0	4	0	0	0	0
	Kayamba	101,473	21,309	1,776	4228	0	48	4,180	27	0	1	26	76	0	1	75
	Kitenge	268,633	56,413	4,701	5694	0	193	5,501	51	0	8	43	0	0	0	0
	Lwamba	128,990	27,088	2,257	3823	0	65	3,758	38	0	0	38	88	0	0	88
	Malemba	251,724	52,862	4,405	2476	0	196	2,280	0	0	0	0	0	0	0	0
	Mukanga	208,104	43,702	3,642	3600	0	134	3,466	0	0	0	0	0	0	0	0
	Mulongo	276,864	58,141	4,845	900	0	158	742	21	0	3	18	0	0	0	0
S/TOTAL 8		1,997,678	419,512	34,959	26,656	0	1,515	25,141	153	20	14	159	165	0	1	164
TOTAL GENERAL		12,697,235	2,666,420	222,202	302,884	8,386	61,072	250,344	2,646	556	1,063	2,151	10,422	163	828	9,757

Zones de santé	Colliers du cycle				Condom female				Microgynon			
	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4
Dikungu-Tshumbe	758	0	38	720	0	0	0	0	1,986	0	308	1,678
Djalo-Ndjeka	130	889	131	888	0	0	0	0	349	24	222	151
Katako Kombe	278	22	143	157	0	0	0	0	781	196	482	495
Lusambo	243	0	86	157	0	0	0	0	144	264	137	271
Minga	470	0	95	375	0	0	0	0	694	0	154	540
Pania Mutombo	283	0	150	133	0	0	0	0	5,125	13051	348	17,828
Tshumbe	0	571	26	545	0	40	0	40	60	0	29	31
Wembonyama	583	0	111	472	0	0	0	0	105	357	69	393
S/TOTAL 6	2,745	1,482	780	3,447	0	40	0	40	9,244	13,892	1,749	21,387
Bena Dibele	1,063	0	906	157	3,507	0	3,507	0	5,084	0	39	5,045
Kole	2,249	0	1,354	895	2,127	0	127	2,000	3,007	5,340	303	8,044
Lodja	7,836	0	0	7,836	13,265	0	12,264	1,001	925	4,920	170	5,675
Lomela	0	0	0	0	4,480	0	600	3,880	12,252	6,060	381	17,931
Omendjadi	2,299	0	2,199	100	5,711	0	4,121	1,590	2,628	5,400	15	8,013
Ototo	2,641	0	2,612	29	5,993	0	5,993	0	1,238	5,400	120	6,518
Tshudiloto	1,498	0	865	633	4,981	0	4,431	550	1,323	1,170	92	2,401
Vangakete	880	0	880	0	7,136	0	7,136	0	1,040	7,400	268	8,172
S/TOTAL 2	18,466	0	8,816	9,650	47,200	0	38,179	9,021	27,497	35,690	1,388	61,799
Bibanga	1,847	0	116	1,731	944	377	441	880	2,877	15342	372	17,847
Wikong	165	15	34	146	48	300	68	280	1,026	12342	228	13,140
Dibindi	479	0	56	423	6,530	200	90	6,640	30	27068	1034	26,064
Kalenda	431	100	53	478	44	300	27	317	2,110	21515	550	23,075
Kamiji	155	19	19	155	110	200	0	310	88	10146	56	10,178
Kanda Kanda	108	105	91	122	6	378	32	352	2,911	23806	427	26,290
Luputa	405	339	152	592	184	511	323	372	772	29506	679	29,599
Mpokolo	188	300	117	371	82	1324	1204	202	218	31277	1973	29,522
Mwene Ditu	1,450	228	220	1,458	2,294	185	180	2,299	1,279	73858	682	74,455
S/TOTAL 2	5,228	1,106	858	5,476	10,242	3,775	2,365	11,652	11,311	244,860	6,001	250,170
Bilomba	1,313	0	142	1,171	3,163	0	602	2,561	8,071	67088	69	75,090
Dekese	463	0	313	150	0	0	0	0	6,505	67088	6515	67,078
Dibaya	245	0	67	178	3,329	0	552	2,777	291	67088	1942	65,437
Kalomba	367	0	205	162	2,235	0	807	1,428	1,882	67088	95	68,875
Luambo	218	0	28	190	6,120	0	1479	4,641	339	67144	1295	66,188
Lubondaie	249	0	104	145	5,626	0	190	5,436	251	67144	2455	64,940
Luiza	309	0	118	191	6,972	0	3432	3,540	3,406	67144	344	70,206
Ndekesha	633	0	30	603	3,050	0	2163	887	1,345	67088	0	68,433
Yangala	4,014	0	155	3,859	3,064	0	1649	1,415	9,285	67088	514	75,859
S/TOTAL 4	7,811	0	1,162	6,649	33,559	0	10,874	22,685	31,375	603,960	13,229	622,106
Bagira-Kasha	642	0	38	604	3,240	0	775	2,465	1,834	0	48	1,786
Bunyakiri	1,279	0	23	1,256	3,170	0	316	2,854	6,283	0	646	5,637
Ibanda	128	0	40	88	57	0	7	50	230	0	117	113
Idjwi	124,232	0	107	124,125	30,985	0	34	30,951	10,497	0	3,456	7,041
Kadutu	77	0	77	0	782	0	0	782	2,039	0	0	2,039
Kalole	672	0	18	654	17,982	0	166	17,816	3,760	0	162	3,598
Kalonge	460	0	4	456	3,002	0	1	3,001	311	0	232	79
Kamituga	3,359	0	41	3,318	3,839	0	60	3,779	3,825	0	677	3,148
Kaniola	114	0	114	0	2,891	0	1,062	1,829	606	0	549	57
Katana	266	0	253	13	1,594	0	238	1,356	183,664	0	4,804	178,860
Kaziba	1,275	0	100	1,175	1,695	0	128	1,567	5	116	121	0
Kitutu	690	0	17	673	1,615	0	121	1,494	2,295	0	425	1,870
Lulingu	6	0	6	0	510	0	470	40	1,563	0	234	1,329
Minova	71	0	5	66	497	0	0	497	309	0	320	-11
Miti-Murhesa	303	0	109	194	3,082	0	4,175	-1,093	614	0	0	614
Mubumbano	71	0	11	60	747	0	55	692	9	0	6	3
Mulungu	154	0	100	54	140	0	46	94	6	0	6	0
Mwana	26,526	0	44	26,482	15,827	0	382	15,445	2,137	0	34	2,103
Mwenga	1,461	0	46	1,415	6,791	0	39	6,752	2,461	0	48	2,413
Nyangezi	684	0	74	610	2,638	0	0	2,638	929	0	2	927
Shabunda Centre	1,216	0	28	1,188	233,000	0	285	232,715	4,507	0	612	3,895
Walungu	3,451	0	22	3,429	2,215	0	360	1,855	3,184	0	135	3,049
S/TOTAL 5	167,137	0	1,277	165,860	336,299	0	8,720	327,579	231,068	116	12,634	218,550
Bunkeya	1,676	30	890	816	1,780	250	1,064	966	360	130	332	158
Dilala	433	40	317	156	9,896	250	5,811	4,335	646	140	438	348
Fungurume	732	30	375	387	1,383	250	834	799	30	130	130	30
Kanzenze	751	30	585	196	863	250	628	485	30	150	150	30
Lualaba	446	30	268	208	472	250	375	347	50	130	130	50
Lubudi	435	30	264	201	30,609	250	11,186	19,673	486	140	377	249
Manika	647	30	372	305	80	250	250	80	23	130	130	23
Mutshatsha	401	30	284	147	372	250	333	289	83	130	133	80
S/TOTAL 6	5,521	250	3,355	2,416	45,455	2,000	20,481	26,974	1,708	1,080	1,820	968
Lemera	1,380	0	60	1,320	9,476	0	545	8,931	10,671	0	208	10,463
Nundu	1,573	0	61	1,512	2,686	0	1,399	1,287	7,200	0	0	7,200
Hauts Plateaux	955	0	10	945	6,338	0	136	6,202	2,104	0	2	2,102
Uvira	1,409	0	50	1,359	20,952	0	252	20,700	13,388	0	35	13,353
Ruzizi	305	0	109	196	14,417	0	1,492	12,925	7,030	0	8	7,022
TOTAL	5,622	0	290	5,332	53,869	0	3,824	50,045	40,393	0	253	40,140
Kabongo	842	0	69	773	906	0	36	870	2984	0	470	2,514
Kinkondja	172	0	172	0	801	0	383	418	681	0	57	624
Songa	273	0	32	241	348	0	72	276	251	0	0	251
Kayamba	446	0	47	399	668	0	181	487	4822	0	124	4,698
Kitenge	114	0	86	28	0	0	0	0	9996	0	2901	7,095
Lwamba	192	0	47	145	132	0	0	132	3054	0	53	3,001
Malemba	1330	0	31	1,299	1276	0	158	1,118	3810	0	111	3,699
Mukanga	831	0	55	776	100	0	0	100	5492	0	94	5,398
Mulongo	393	0	40	353	0	0	0	0	4684	0	210	4,474
S/TOTAL 8	4,593	0	579	4,014	4,231	0	830	3,401	35,774	0	4,020	31,754
TOTAL GENERAL	217,123	2,838	17,117	202,844	530,855	5,815	85,273	451,397	388,370	899,598	41,094	1,246,874

Zones de santé	Combinaison 3 /COC Lo-femenal				Condom male				Ovrette				Microlut			
	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4	Balance fin Q3	Qty recue Q4	Qty distribuée Q4	Balance Fin Q4
Dikungu-Tshumbe	0	0	0	0	28,083	0	25,520	2,563	0	0	0	0	0	50	50	0
Djalo-Ndjeka	0	0	0	0	0	6551	6,434	117	0	0	0	0	0	0	0	0
Katako Kombe	0	0	0	0	9,312	23258	18,297	14,273	0	0	0	0	334	0	177	157
Lusambo	0	0	0	0	1,397	5192	4,377	2,212	0	0	0	0	50	0	20	30
Minga	0	0	0	0	18,016	0	10,353	7,663	0	0	0	0	0	451	114	337
Pania Mutombo	0	0	0	0	2,508	39412	10,560	31,360	0	0	0	0	385	36	84	337
Tshumbe	0	0	0	0	0	39412	30,302	9,110	0	0	0	0	0	0	0	0
Wembonyama	0	0	0	0	1,843	41971	30,799	13,015	0	0	0	0	0	0	0	0
S/TOTAL 6	0	0	0	0	61,159	155,796	136,642	80,313	0	0	0	0	769	537	445	861
Bena Dibele	5,045	0	4,251	794	8,455	0	8,455	0	0	0	0	0	0	0	0	0
Kole	25,544	0	5,684	19,860	15,866	54812	27,388	43,290	0	0	0	0	205	0	0	205
Lodja	7,280	0	5,574	1,706	15,136	0	7,328	7,808	0	0	0	0	0	0	0	0
Lomela	29,131	0	7,021	22,110	0	0	0	0	0	0	0	0	0	0	0	0
Omendjadi	8,013	0	1,963	6,050	2,159	0	2,159	0	0	0	0	0	0	0	0	0
Ototo	6,518	0	6,518	0	5,290	0	5,290	0	0	0	0	0	0	0	0	0
Tshudiloto	2,401	0	2,401	0	0	20,900	19,900	1,000	0	0	0	0	0	0	0	0
Vangakete	8,172	0	8,172	0	6,905	0	6,905	0	0	0	0	0	0	0	0	0
S/TOTAL 2	92,104	0	41,584	50,520	53,811	75,712	77,425	52,098	0	0	0	0	205	0	0	205
Bibanga	878	0	115	763	6,648	115952	11,993	110,607	490	165	157	498	57	0	37	20
Wikong	342	0	0	342	7,304	93266	10,378	90,192	3	223	34	192	60	0	0	60
Dibindi	18	2045	231	1,832	13,234	204554	37,342	180,446	60	901	571	390	0	0	0	0
Kalenda	398	1514	67	1,845	346	162584	11,434	151,496	121	733	27	827	99	0	5	94
Kamiji	32	65	7	90	700	76677	4,236	73,141	333	21	4	350	122	0	26	96
Kanda Kanda	5,054	4044	555	8,543	2,951	179907	23,486	159,372	579	629	318	890	0	0	4	-4
Luputa	0	25	25	0	2,733	222978	24,495	201,216	0	0	0	0	325	0	13	312
Mpokolo	39	0	38	1	773	236359	40,984	196,148	202	46	131	117	0	0	0	0
Mwene Ditu	1,251	2773	187	3,837	58,647	558154	24,111	592,690	754	174	191	737	560	0	9	551
S/TOTAL 2	8,012	10,466	1,225	17,253	93,336	1,850,431	188,459	1,755,308	2,542	2,892	1,433	4,001	1,223	0	94	1,129
Bilomba	8,138	0	332	7,806	12,773	166600	8244	171,129	318	0	25	293	552	0	33	519
Dekese	6,505	0	0	6,505	49,636	166600	0	216,236	976	0	0	976	536	0	0	536
Dibaya	291	0	0	291	4,321	166700	25374	145,647	319	0	316	3	0	0	0	0
Kalomba	2,117	0	310	1,807	0	166600	3945	162,655	914	0	820	94	60	0	0	60
Luambo	204	0	204	0	2,985	166600	11019	158,566	132	0	47	85	27	0	0	27
Lubondaie	251	0	0	251	30,133	166700	16304	180,529	69	0	0	69	728	0	0	728
Luiza	3,473	0	178	3,295	618	166800	14243	153,175	2,797	0	266	2,531	2,055	0	55	2,000
Ndekesha	1,671	0	492	1,179	16,069	166700	15188	167,581	509	0	268	241	0	0	0	0
Yangala	9,285	0	0	9,285	28,588	166600	3100	192,088	0	0	0	0	0	0	0	0
S/TOTAL 4	31,935	0	1,516	30,419	145,123	1,499,900	97,417	1,547,606	6,034	0	1,742	4,292	3,958	0	88	3,870
Bagira-Kasha	256	0	0	256	82,409	0	15,909	66,500	271	0	0	271	0	0	0	0
Bunyakiri	426	0	391	35	11,564	0	4,536	7,028	141	0	141	0	0	0	0	0
Ibanda	77	252	329	0	26,092	0	17,796	8,296	0	0	0	0	0	0	0	0
Idjwi	0	0	0	0	39,589	0	13,138	26,451	2,468	0	0	2,468	3,155	0	453	2,702
Kadutu	45	0	0	45	22,575	0	10,500	12,075	66	0	66	0	7,651	0	0	7,651
Kalole	72	45	117	0	33,362	0	2,481	30,881	826	0	381	445	1,419	0	171	1,248
Kalonge	78	0	62	16	19,972	0	3,340	16,632	1,842	0	30	1,812	19	0	0	19
Kamituga	0	0	0	0	17,230	0	6,108	11,122	56	0	0	56	0	0	0	0
Kaniola	0	30	30	0	3,257	0	3,257	0	0	0	0	0	500	0	0	500
Katana	300	0	18	282	26,926	0	16,438	10,488	182,960	0	5,428	177,532	0	0	0	0
Kaziba	290	0	66	224	58	0	58	0	483	0	249	234	32	0	0	32
Kitutu	0	0	0	0	11,466	0	4,709	6,757	3,433	0	0	3,433	3,300	0	0	3,300
Lulingu	308	0	308	0	2,408	0	2,408	0	258	0	81	177	0	0	0	0
Minova	122	0	122	0	26,420	0	8,805	17,615	257	502	759	0	2	0	0	2
Miti-Murhesa	2,909	500	3,409	0	4,807	0	4,807	0	22	0	0	22	362	0	0	362
Mubumbano	11	0	11	0	25,564	0	1,130	24,434	0	0	0	0	0	0	0	0
Mulungu	0	0	0	0	7,680	0	2,414	5,266	129	0	40	89	0	0	0	0
Mwana	61	0	0	61	3,618	0	3,618	0	3,312	0	25	3,287	2,998	0	0	2,998
Mwenga	980	0	0	980	6,180	957	7,137	0	51	0	0	51	1,146	0	3	1,143
Nyangezi	0	0	0	0	9,417	0	8,729	688	250	0	55	195	72	0	0	72
Shabunda Centre	921	0	0	921	1,088	0	1,088	0	510	0	129	381	1,839	0	99	1,740
Walungu	78	0	49	29	334,792	0	8,208	326,584	21,291	0	157	21,134	97,012	0	0	97,012
S/TOTAL 5	6,934	827	4,912	2,849	716,474	957	146,614	570,817	218,626	502	7,541	211,587	119,507	0	726	118,781
Bunkeya	299	0	183	116	40,006	500	21,859	18,647	446	0	309	137	0	0	0	0
Dilala	2,832	0	1,605	1,227	324,640	500	32,201	292,939	525	0	335	190	0	0	0	0
Fungurume	0	0	0	0	29,731	500	14,731	15,500	679	0	380	299	0	0	0	0
Kanzenze	10,885	0	7,374	3,511	19,145	500	11,853	7,792	868	0	407	461	7,765	0	5,061	2,704
Lualaba	2,460	0	1,498	962	13,197	500	5,532	8,165	521	0	272	249	0	0	0	0
Lubudi	3,523	0	1,988	1,535	11,242	500	6,378	5,364	9,965	0	5,816	4,149	0	0	0	0
Manika	1,288	0	822	466	7,580	500	5,666	2,414	3,810	0	2,334	1,476	0	0	0	0
Mutshatsha	136	0	86	50	9,307	500	4490	5,317	145	0	116	29	0	0	0	0
S/TOTAL 6	21,423	0	13,556	7,867	454,848	4,000	102,710	356,138	16,959	0	9,969	6,990	7,765	0	5,061	2,704
Lemera	22,237	0	31	22,206	114,234	0	7,224	107,010	0	0	0	0	0	0	0	0
Nundu	20,334	0	210	20,124	44,964	0	7,933	37,031	0	0	0	0	0	0	0	0
Hauts Plateaux	12,155	0	7	12,148	12,012	0	1,246	10,766	0	0	0	0	0	0	0	0
Uvira	43,759	0	47	43,712	387,515	0	5,470	382,045	0	0	0	0	0	0	0	0
Ruzizi	19,436	0	170	19,266	161,530	0	11,183	150,347	0	32	32	0	0	0	0	0
TOTAL	117,921	0	465	117,456	720,255	0	33,056	687,199	0	32	32	0	0	0	0	0
Kabongo	0	0	0	0	2143	6,048	2,973	5,218	478	0	100	378	0	0	0	0
Kinkondja	0	0	0	0	13500	5,040	4,896	13,644	0	0	0	0	0	0	0	0
Songa	462	0	112	350	190	0	190	0	1285	0	134	1,151	0	0	0	0
Kayamba	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kitenge	0	0	0	0	0	0	0	0	100	0	0	100	0	0	0	0
Lwamba	0	0	0	0	856	0	276	580	0	0	0	0	0	0	0	0
Malemba	0	0	0	0	2025	0	1,052	973	0	0	0	0	0	0	0	0
Mukanga	30	0	0	30	8559	0	913	7,646	0	0	0	0	0	0	0	0
Mulongo	0	0	0	0	0	0	0	0	507	0	12	495	0	0	0	0
S/TOTAL 8	492	0	112	380	27,273	11,088	10,300	28,061	2,370	0	246	2,124	0	0	0	0
TOTAL GENERAL	278,821	11,293	63,370	226,744	2,272,279	3,597,884	792,623	5,077,540	246,531	3,426	20,963	228,994	133,427	537	6,414	127,550

	N°	ZONE DE SANTE	POPULATION	TARGET	Artesunate+Amodiaquine, 100mg+270mg base, Tab, 6, Coformulation 14 ans et plus				Artesunate+Amodiaquine, 100mg+270mg base, Tab, 3, Coformulation 6-13ans			
					Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014
LUIZA	1	BILOMBA	21,567	-	1,664	1,555	1,145	2,074	2,183	1,725	913	2,995
	2	BULAPE	39,393	-	5,417	2,857	-	8,274	6,863	3,180	-	10,043
	3	DEKESE	34,878	-	4,365	2,515	627	6,253	4,285	2,830	495	6,620
	4	DIBAYA	34,068	-	625	1,155	1,189	591	659	1,333	1,595	397
	5	KALOMBA	35,991	-	2,873	2,570	2,238	3,205	3,615	2,831	1,352	5,094
	6	LWAMBO	67,023	-	3,011	4,146	3,299	3,858	7,046	5,224	5,877	6,393
	7	LUBONDAIE	38,325	-	2,845	2,559	1,013	4,391	3,879	3,257	1,647	5,489
	8	NDEKESHA	38,187	-	2,726	2,621	2,125	3,222	4,231	2,934	1,603	5,562
	9	TSHIKAJI	27,930	-	2,125	1,967	-	4,092	3,399	2,179	-	5,578
	10	YANGALA	38,265	-	4,477	2,726	1,097	6,106	4,950	3,000	1,232	6,718
		SOUS TOTAL I	-	-	30,128	24,671	12,733	42,066	41,110	28,493	14,714	54,889
MWENE DITU	1	BIBANGA	36,969	-	1,392	590	1,774	208	1,568	816	1,623	761
	2	KALENDA	51,840	-	1,325	3,338	1,900	2,763	728	1,004	1,252	480
	3	KAMIJI	24,450	-	2,155	1,176	789	2,542	575	549	431	693
	4	LUPUTA	71,097	-	1,554	1,685	1,951	1,288	1,193	1,437	1,444	1,186
	5	MPOKOLO	75,366	-	1,897	439	2,336	-	2,441	38	2,479	-
	6	WINKONG	29,739	-	1,613	380	983	1,010	793	396	550	639
		SOUS TOTAL II	-	-	9,936	7,608	9,733	7,811	7,298	4,240	7,779	3,759
TSHUMBE	1	DIKUNGU TSHUMBE	34,209	-	3,736	1,150	4,886	-	5,861	-	5,861	-
	3	DJALO NDJEKA	19,425	-	9,110	-	6,160	2,950	7,130	25	6,334	821
	4	KATAKO KOMBE	32,643	-	9,917	-	9,068	849	6,698	1,000	7,698	-
	5	MINGA	39,630	-	1,061	2,340	3,401	-	2,647	250	1,667	1,230
	6	LUSAMBO	23,838	-	2,870	700	3,570	-	5,613	100	5,713	-
	7	PANIA MUTOMBO	19,392	-	489	1,000	1,337	152	277	2,100	2,377	-
		SOUS TOTAL III	-	-	27,183	5,190	28,422		28,226	3,475	29,650	
KOLE	1	LOMELA	17,523	-	800	-	700	100	500	-	500	-
	2	OTOTO	32,136	-	6,429	75	565	5,939	2,550	75	2,625	-
	3	TSHUDILOTO	30,798	-	5,669	-	800	4,869	172	-	172	-
	4	VANGAKETE	27,576	-	7,326	600	7,926	-	251	-	251	-
		SOUS TOTAL IV	-	-	20,224	675	9,991	10,908	3,473	75	3,548	
KAMINA	1	KABONGO	88,953	-	2,245	5,890	7,431	704	26,402	6,084	4,449	28,037
	2	KAYAMBA	24,066	-	7,807	9,740	1,783	15,764	21,292	6,049	1,679	25,662
	3	KIKONDJA	60,963	-	15,812	9,950	1,866	23,896	34,413	6,449	4,614	36,248
	4	KITENGE	62,442	-	8,576	14,855	2,234	21,197	26,458	20,691	8,334	38,815
	5	LWAMBA	29,274	-	2,959	9,000	948	11,011	9,567	9,000	2,061	16,506
	6	MALEMBA NKULU	65,913	-	6,641	20,325	3,653	23,313	11,049	9,000	4,683	15,366
	7	MUKANGA	51,003	-	10,764	10,450	641	20,573	17,932	8,100	3,960	22,072
	8	MULONGO	73,692	-	13,705	16,291	3,249	26,747	20,237	10,958	1,236	29,959
	9	SONGA	41,817	-	1,157	2,037	988	2,206	4,334	6,787	1,017	10,104
		SOUS TOTAL V	-	-	69,666	98,538	22,793	145,411	171,684	83,118	32,033	222,769
KOLWEZI	1	BUNKEYA	14,016	-	257	1,300	1,435	122	5,107	967	750	5,324
	2	DILALA	28,755	-	793	1,200	1,495	498	3,422	2,775	2,000	4,197
	3	FUNGURUME	26,787	-	602	1,500	1,750	352	9,744	350	2,255	7,839
	4	KANZENZE	21,891	-	616	500	475	641	12,929	5,544	8,835	9,638
	5	LUALABA	24,072	-	9,265	-	1,070	8,195	7,090	-	1,235	5,855
	6	LUBUDI	29,388	-	-	2,900	2,420	480	1,595	60	1,655	-
	7	MANIKA	54,495	-	1,281	1,000	1,618	663	2,752	685	3,437	-
	8	MUTSHATSHA	17,103	-	1,401	-	550	851	4,207	-	1,470	2,737
		SOUS TOTAL VI	-	-	14,215	8,400	10,813	11,802	46,846	10,381	21,637	35,590
BUKAVU	1	BUNYAKIRI	35,631	-	677	1,725	2,402	-	1,576	5,942	6,659	859
	2	IBANDA	76,743	-	434	-	434	-	2,167	2,775	4,942	-
	3	IDJWI	58,920	-	1,214	1,521	2,735	-	1,523	1,208	2,107	624
	4	KADUTU	48,309	-	648	1,483	1,868	263	1,992	2,448	2,945	1,495
	5	KALOLE	25,116	-	-	-			1,800	1,800	3,000	600
	6	KALONGE	44,259	-	323	256	413	166	209	60	269	-
	7	KAMITUGA	38,130	-	753	1,288	1,502	539	1,283	1,797	1,897	1,183
	8	KANIOLA	42,357	-	809	92	816	85	1,537	247	764	1,020
	9	KATANA	48,546	-	2,507	3,314	3,408	2,413	5,015	6,961	4,406	7,570
	10	KAZIBA	28,701	-	-	-			150	-	150	-
	11	KALEHE	42,210	-	4,372	2,425	1,457	5,340	4,573	2,765	2,346	4,992
	12	KITUTU	31,797	-	3,608	2,075	3,660	2,023	4,894	5,794	4,309	6,379
	13	LULINGU	38,376	-	1,451	3,795	5,246	-	1,686	3,411	4,139	958
	14	MINOVA	47,508	-	940	1,326	1,515	751	2,189	1,200	2,361	1,028
	15	MITIMURHESA	49,659	-	3,948	-	893	3,055	7,680	250	491	7,439
	16	MUBUMBANO	41,283	-	23,802	-	396	23,406	17,747	-	246	17,501
	17	MULUNGU	33,609	-	1,568	-	225	1,343	3,281	-	550	2,731
	18	MWANA	32,046	-	-	400	400	-	-	-	-	-
	19	MWENGA	33,297	-	-	-			-	-	-	-
	20	NYANGEZI	30,456	-	984	994	1,050	928	1,224	1,400	1,170	1,454
	21	SHABUNDA	34,674	-	1,820	2,450	2,296	1,974	3,508	1,845	1,216	4,137
	22	WALUNGU	60,834	-	49,858	23,144	40,568	32,434	64,034	39,903	57,465	46,472
		SOUS TOTAL VII	-	-	99,716	46,288	71,284	74,720	128,068	79,806	101,432	106,442
UVIRA	1	HAUT PLATEAUX	27,153	-	-	1,450	700	750	350	1,000	550	800
	2	LEMERA	36,840	-	-	800	800	-	4,050	800	6,100	(1,250)
	3	NUNDU	57,540	-	2,975	1,400	3,050	1,325	10,575	1,000	4,150	7,425
	4	RUZIZI	34,005	-	675	100	657	118	10,575	-	5,175	5,400
	5	UVIRA	65,478	-	-	1,000	725	275	1,589	1,000	1,325	1,264
		SOUS TOTAL VIII	-	-	3,650	4,750	5,932	2,468	27,139	3,800	17,300	13,639
		TOTAL GENERAL			274,718	196,120	171,701	299,137	453,844	213,388	228,093	439,139

N°	ZONE DE SANTE	Artesunate+Amodiaquine, 50mg+135mg base, Tab, 3, Coformulation 1-5ans				Artesunate+Amodiaquine, 25mg+67.5mg base, Tab, 3, Coformulation 2-11mois				Dextrose (Glucose), 5%, 250ml, Perfusion, Unité				Dextrose (Glucose), 5%, 500ml, Perfusion, Unité			
		Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014
1	BILOMBA	1,983	1,855	881	2,957	217	167	113	271	-	-	-	-	-	-	-	-
2	BULAPE	6,212	3,359	-	9,571	332	310	-	642	-	-	-	-	-	-	-	-
3	DEKESE	3,951	2,988	916	6,023	529	305	74	760	-	-	-	-	-	-	-	-
4	DIBAYA	2,366	2,704	2,863	2,207	5,147	413	401	5,159	-	-	-	-	-	-	-	-
5	KALOMBA	4,258	2,773	1,419	5,612	593	266	386	473	-	-	-	-	-	-	-	-
6	LWAMBO	7,373	5,513	6,181	6,705	1,437	409	582	1,264	-	-	-	-	-	-	-	-
7	LUBONDAIE	3,569	3,378	1,801	5,146	180	313	410	83	-	-	-	-	-	-	-	-
8	NDEKESHA	2,858	3,107	1,793	4,172	477	176	502	151	-	-	-	-	-	-	-	-
9	TSHIKAJI	6,304	2,322	-	8,626	1,023	260	-	1,283	-	-	-	-	-	-	-	-
10	YANGALA	5,352	3,188	1,351	7,189	667	251	175	743	-	-	-	-	-	-	-	-
	SOUS TOTAL I	44,226	31,187	17,205	58,208	10,602	2,870	2,643	10,829	-	-	-	-	-	-	-	-
1	BIBANGA	1,397	4,532	3,542	2,387	1,023	1,586	788	1,821	-	-	-	-	-	-	-	-
2	KALENDA	1,319	3,700	3,265	1,754	667	2,741	1,365	2,043	-	-	-	-	-	-	-	-
3	KAMIJI	407	1,325	887	845	10,602	2,039	909	11,732	-	-	-	-	-	-	-	-
4	LUPUTA	1,235	2,300	2,875	660	707	2,577	966	2,318	-	-	-	-	-	-	-	-
5	MPOKOLO	1,417	3,400	2,894	1,923	616	292	381	527	-	-	-	-	-	-	-	-
6	WINKONG	781	1,550	2,058	273	272	156	332	96	-	-	-	-	-	-	-	-
	SOUS TOTAL II	6,556	16,807	15,521	7,842	13,887	9,391	4,741	18,537	-	-	-	-	-	-	-	-
1	DIKUNGU TSHUMBE	5,558	12	5,570	-	2,349	75	2,424	-	-	-	-	-	13	30	43	-
3	DJALO NDJEKA	9,765	-	7,160	2,605	5,676	-	5,676	-	-	-	-	-	60	259	319	-
4	KATAKO KOMBE	2,428	3,100	5,528	-	6,667	-	3,368	3,299	-	-	-	-	53	176	229	-
5	MINGA	480	1,700	2,180	-	1,188	1,100	2,288	-	-	-	-	-	90	150	139	101
6	LUSAMBO	6,050	-	6,050	-	2,479	150	1,047	1,582	-	-	-	-	57	35	92	-
7	PANIA MUTOMBO	1,269	1,100	1,720	649	215	200	403	12	-	-	-	-	70	105	171	4
	SOUS TOTAL III	25,550	5,912	28,208		18,574	1,525	15,206		-	-	-	-	343	755	993	105
1	LOMELA	1,500	-	1,500	-	25	-	25	-	-	-	-	-	-	-	-	-
2	OTOTO	15,698	75	774	14,999	1,033	-	141	892	-	-	-	-	891	1,494	126	2,259
3	TSHUDILOTO	6,328	-	1,396	4,932	1,079	360	425	1,014	-	-	-	-	30	30	53	7
4	VANGAKETE	9,810	4,500	14,097	213	743	28,120	12,274	16,589	-	-	-	-	8	130	138	-
	SOUS TOTAL IV	33,336	4,575	17,767	20,144	2,880	28,480	12,865	18,495	-	-	-	-	929	1,654	317	2,266
1	KABONGO	25,997	5,959	4,583	27,373	877	2,416	1,597	1,696	10	-	10	-	1,589	1,296	535	2,350
2	KAYAMBA	35,090	16,253	3,144	48,199	7,676	4,562	865	11,373	-	-	-	-	548	1,068	405	1,211
3	KIKONDJA	29,102	14,239	17,040	26,301	3,141	3,066	1,548	4,659	746	-	451	295	1,638	336	815	1,159
4	KITENGE	23,240	27,222	4,527	45,935	236	2,740	1,664	1,312	454	-	279	175	1,308	288	325	1,271
5	LWAMBA	9,632	14,400	2,595	21,437	1,270	2,250	880	2,640	16	150	142	24	389	144	156	377
6	MALEMBA NKULU	10,759	16,200	5,418	21,541	597	5,100	2,258	3,439	11	-	11	-	651	336	160	827
7	MUKANGA	9,732	11,700	3,066	18,366	1,772	2,700	1,640	2,832	11	40	51	-	494	45	80	459
8	MULONGO	22,026	23,558	5,347	40,237	293	2,477	2,667	103	376	-	376	-	1,776	1,056	968	1,864
9	SONGA	7,558	3,919	804	10,673	264	381	551	94	40	-	40	-	561	50	126	485
	SOUS TOTAL V	173,136	133,450	46,524	260,062	16,126	25,692	13,670	28,148	1,664	190	1,360		8,954	4,619	3,570	10,003
1	BUNKEYA	8,537	5,400	665	13,272	7,571	400	1,600	6,371	-	-	-	-	-	-	-	-
2	DILALA	2,193	950	1,977	1,166	2,349	55	2,404	-	-	-	-	-	-	-	-	-
3	FUNGURUME	4,473	150	2,718	1,905	218	630	460	388	-	-	-	-	-	-	-	-
4	KANZENZE	8,914	-	2,688	6,226	36,937	100	5,029	32,008	-	-	-	-	-	-	-	-
5	LUALABA	739	1,500	1,340	899	2,644	-	955	1,689	-	-	-	-	-	-	-	-
6	LUBUDI	3,994	-	3,994	-	4,662	230	4,880	12	-	-	-	-	-	-	-	-
7	MANIKA	6,319	400	121	6,598	1,382	-	1,382	-	-	-	-	-	-	-	-	-
8	MUTSHATSHA	4,702	95	1,500	3,297	900	1,800	485	2,215	-	-	-	-	-	-	-	-
	SOUS TOTAL VI	39,871	8,495	15,003	33,363	56,663	3,215	17,195	42,683	-	-	-	-	-	-	-	-
1	BUNYAKIRI	1,925	5,952	4,776	3,101	405	2,090	2,181	314	-	-	-	-	57	750	784	23
2	IBANDA	216	2,775	2,991	-	25	830	855	-	-	-	-	-	1,333	7,927	5,190	4,070
3	IDJWI	1,281	1,964	2,286	959	1,569	1,134	1,909	794	-	-	-	-	299	959	807	451
4	KADUTU	2,191	1,948	2,695	1,444	3,330	1,764	1,426	3,668	-	-	-	-	106	760	742	124
5	KALOLE	1,800	1,800	-	3,600	-	-	-	-	-	-	-	-	-	-	-	-
6	KALONGE	426	230	224	432	176	110	286	-	-	-	-	-	9	2	11	-
7	KAMITUGA	1,474	2,301	2,330	1,445	195	738	771	162	-	-	-	-	17	316	333	-
8	KANIOLA	3,501	719	1,596	2,624	531	170	701	-	-	-	-	-	47	64	111	-
9	KATANA	3,349	5,776	5,852	3,273	1,397	1,869	1,937	1,329	-	-	-	-	228	1,161	883	506
10	KAZIBA	100	-	100	-	250	200	450	-	-	-	-	-	-	-	-	-
11	KALEHE	5,160	4,520	3,524	6,156	937	1,206	629	1,514	-	-	-	-	194	699	680	213
12	KITUTU	3,468	3,518	3,991	2,995	2,595	1,525	1,519	2,601	-	-	-	-	269	865	615	519
13	LULINGU	1,155	1,211	1,949	417	185	875	1,060	-	-	-	-	-	160	437	345	252
14	MINOVA	1,998	1,476	2,202	1,272	1,082	375	508	949	-	-	-	-	238	591	552	277
15	MITIMURHESA	5,026	625	903	4,748	842	-	217	625	-	-	-	-	-	251	251	-
16	MUBUMBANO	25,562	-	350	25,212	13,308	-	404	12,904	-	-	-	-	-	-	-	-
17	MULUNGU	3,376	-	450	2,926	578	250	225	603	-	-	-	-	48	-	48	-
18	MWANA	-	-	-	-	-	46	46	-	-	-	-	-	-	1,334	1,334	-
19	MWENGA	20,400	9,000	6,350	23,050	48,000	10,000	1,304	56,696	-	-	-	-	-	-	-	-
20	NYANGEZI	642	1,696	1,398	940	558	1,025	407	1,176	-	-	-	-	5	12	17	-
21	SHABUNDA	3,512	1,905	1,114	4,303	754	2,975	674	3,055	-	-	-	-	122	472	450	144
22	WALUNGU	86,562	47,416	51,960	82,018	76,717	27,182	14,761	89,138	-	-	-	-	3,102	16,600	13,380	6,322
	SOUS TOTAL VII	173,124	94,832	97,041	170,915	153,434	54,364	32,270	175,528	-	-	-	-	6,234	33,200	26,533	12,901
1	HAUT PLATEAUX	-	600	600	-	-	300	300	-	-	-	-	-	-	-	-	-
2	LEMERA	10,175	7,200	7,025	10,350	475	500	775	200	-	-	-	-	-	-	-	-
3	NUNDU	13,900	7,800	5,075	16,625	699	800	1,076	423	-	-	-	-	-	-	-	-
4	RUZIZI	9,575	7,600	5,775	11,400	100	400	425	75	-	-	-	-	-	-	-	-
5	UVIRA	5,350	3,000	650	7,700	350	500	350	500	-	-	-	-	-	-	-	-
	SOUS TOTAL VIII	39,000	26,200	19,125	46,075	1,624	2,500	2,926	1,198	-	-	-	-	-	-	-	
	TOTAL GENERAL	534,799	321,458	256,394	599,863	273,790	128,037	101,516	300,311	1,664	190	1,360		16,460	40,228	31,413	25,275

N°	ZONE DE SANTE	Quinine Bichlorhydrate, 300mg/ml, 2ml, Amp, Unité				Quinine Sulfate, 300mg,Tab, 1000, Vrac				Test, Malaria, rapide, Ag P.f/Pan, 1 test, Unité				Sulfadoxine + Pyrimethamine, 500+25mg, Tab, 1000, Vrac				Moustiquaire impregnée d'insecticide (MILD)			
		Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014	Stock initial =report mois de juillet	Quantité recu de juillet à septembre 2014	Quantités distribuées de juillet à septembre 2014	Stock Total à la fin du mois septembre 2014
1	BILOMBA	-	-	-	-	-	-	-	-	1,699	1,200	2,004	895	10,318	-	3,485	6,833	-	-	-	-
2	BULAPE	-	-	-	-	-	-	-	-	866	-	-	866	13,124	-	-	13,124	-	-	-	-
3	DEKESE	-	-	-	-	-	-	-	-	3,751	2,470	2,005	4,216	16,477	-	3,567	12,910	-	-	-	-
4	DIBAYA	-	-	-	-	-	-	-	-	3,560	5,800	5,558	3,802	12,838	646	4,459	9,025	-	-	-	-
5	KALOMBA	-	-	-	-	-	-	-	-	2,441	3,200	3,091	2,550	2,045	1,000	3,045	-	-	-	-	-
6	LWAMBO	-	-	-	-	-	-	-	-	7,756	12,850	12,720	7,886	8,790	-	8,790	-	-	-	-	-
7	LUBONDAIE	-	-	-	-	-	-	-	-	2,261	2,450	4,711	-	15,965	-	4,968	10,997	-	-	-	-
8	NDEKESHA	-	-	-	-	-	-	-	-	1,095	4,500	4,459	1,136	11,400	-	7,027	4,373	-	-	-	-
9	TSHIKAJI	-	-	-	-	-	-	-	-	1,881	-	-	1,881	10,501	-	-	10,501	-	-	-	-
10	YANGALA	-	-	-	-	-	-	-	-	6,257	3,550	2,998	6,809	14,219	-	8,445	5,774	-	-	-	-
	SOUS TOTAL I	-	-	-	-	-	-	-	-	31,567	36,020	37,546	30,041	115,677	1,646	43,786	73,537	-	-	-	-
1	BIBANGA	-	-	-	-	-	-	-	-	16,388	-	7,763	8,625	9,726	24,663	7,909	26,480	-	-	-	-
2	KALENDA	-	-	-	-	-	-	-	-	12,463	-	9,104	3,359	13,653	4,089	9,871	7,871	-	-	-	-
3	KAMIJI	-	-	-	-	-	-	-	-	5,668	-	1,582	4,086	5,550	907	3,471	2,986	-	-	-	-
4	LUPUTA	-	-	-	-	-	-	-	-	9,821	4,680	10,118	4,383	24,227	64,630	11,617	77,240	-	-	-	-
5	MPOKOLO	-	-	-	-	-	-	-	-	15,744	350	8,479	7,615	19,053	35,382	18,749	35,686	-	-	-	-
6	WINKONG	-	-	-	-	-	-	-	-	1,567	5,375	3,974	2,968	10,913	538	6,215	5,236	-	-	-	-
	SOUS TOTAL II	-	-	-	-	-	-	-	-	61,651	10,405	41,020	31,036	83,122	130,209	57,832	155,499	-	-	-	-
1	DIKUNGU TSHUMBE	-	-	-	-	58	100	58	100	1,360	3,648	5,008	-	39,350	-	16,092	23,258	-	-	-	-
3	DJALO NDJEKA	20	200	220	-	-	-	-	-	2,666	10,575	5,778	7,463	21,758	-	13,637	8,121	-	-	-	-
4	KATAKO KOMBE	-	-	-	-	-	-	-	-	-	500	500	-	15	15,000	1,031	13,984	-	-	-	-
5	MINGA	-	-	-	-	-	-	-	-	1,106	4,800	3,763	2,143	1,496	1,700	3,187	9	-	-	-	-
6	LUSAMBO	-	-	-	-	-	-	-	-	1,577	5,000	3,178	3,399	4,294	6,000	10,294	-	-	-	-	-
7	PANIA MUTOMBO	-	-	-	-	-	-	-	-	966	3,500	2,869	1,597	1,766	1,150	2,916	-	-	-	-	-
	SOUS TOTAL III	20	200	220		58	100	58	100	7,675	28,023	21,096	14,602	68,679	23,850	47,157	45,372	-	-	-	-
1	LOMELA	12	700	712	-	-	200	200	-	900	-	900	-	-	-	4,264		-	-	-	-
2	OTOTO	600	-	-	600	960	-	210	750	10,216	4,950	1,050	14,116	18,060	-	625	17,435	-	-	-	-
3	TSHUDILOTO	223	65	288	-	1,500	-	1,100	400	2,457	-	2,457	-	19,362	-	13,982	5,380	-	-	-	-
4	VANGAKETE	500	-	500	-	-	586	586	-	-	1,125	200	925	-	9,000	10,717		-	-	-	-
	SOUS TOTAL IV	1,335	765	1,500		2,460	786	2,096	1,150	13,573	6,075	4,607	15,041	37,422	9,000	29,588	16,834	-	-	-	-
1	KABONGO	71	285	300	56	10,002	-	5,548	4,454	24,613	40,772	9,134	56,251	3,674	3,000	6,674	-	-	-	-	-
2	KAYAMBA	2,970	-	148	2,822	3,542	-	1,952	1,590	33,907	33,194	2,341	64,760	131	700	756	75	-	-	-	-
3	KIKONDJA	15,144	-	679	14,465	17,501	-	5,523	11,978	77,643	141,964	8,061	211,546	8,579	-	8,579	-	-	-	-	-
4	KITENGE	1,317	-	505	812	2,581	-	2,581	-	42,050	92,281	5,299	129,032	1,738	2,100	3,319	519	-	-	-	-
5	LWAMBA	3,681	-	395	3,286	66	3,000	3,066	-	19,137	60,750	5,796	74,091	2,596	5,100	6,138	1,558	-	-	-	-
6	MALEMBA NKULU	3,544	-	1,557	1,987	3,804	-	3,804	-	20,690	78,000	8,214	90,476	15,934	12,000	2,980	24,954	-	-	-	-
7	MUKANGA	5,697	-	1,096	4,601	1,662	218	1,880	-	14,512	22,500	3,446	33,566	13,149	9,300	5,364	17,085	7	-		7
8	MULONGO	22,408	-	1,802	20,606	67	3,700	3,767	-	99,561	109,475	15,449	193,587	1,043	13,200	8,675	5,568	-	-	-	-
9	SONGA	2,512	-	172	2,340	68	1,500	1,568	-	10,721	5,630	5,205	11,146	1,168	4,000	2,641	2,527	-	-	-	-
	SOUS TOTAL V	57,344	285	6,654	50,975	39,293	8,418	29,689	18,022	342,834	584,566	62,945	864,455	48,012	49,400	45,126	52,286	7	-	-	
1	BUNKEYA	-	-	-	-	-	-	-	-	853	4,000	2,800	2,053	1,395	2,600	3,995	-	-	-	-	-
2	DILALA	-	-	-	-	-	-	-	-	22,995	-	8,100	14,895	13,818	-	9,200	4,618	-	-	-	-
3	FUNGURUME	-	-	-	-	-	-	-	-	4,000	-	4,000	-	13,407	-	10,700	2,707	-	-	-	-
4	KANZENZE	-	-	-	-	-	-	-	-	14,004	13,350	10,350	17,004	11,580	-	7,000	4,580	-	-	-	-
5	LUALABA	-	-	-	-	-	-	-	-	13,630	-	11,580	2,050	8,694	-	8,694	-	-	-	-	-
6	LUBUDI	-	-	-	-	-	-	-	-	15,401	-	7,565	7,836	7,956	-	6,400	1,556	-	-	-	-
7	MANIKA	-	-	-	-	-	-	-	-	7,260	2,000	6,364	2,896	12,709	-	8,468	4,241	-	-	-	-
8	MUTSHATSHA	-	-	-	-	-	-	-	-	1,455	10,550	8,200	3,805	6,353	-	6,353	-	-	-	-	-
	SOUS TOTAL VI	-	-	-	-	-	-	-	-	79,598	29,900	58,959	50,539	75,912	2,600	60,810	17,702	-	-	-	-
1	BUNYAKIRI	-	-	-	-	130	11,076	9,646	1,560	75	5,800	4,739	1,136	50	11,080	8,140	2,990	-	-	-	-
2	IBANDA	-	-	-	-	394	500	106	788	-	700	675	25	3,597	15,700	15,230	4,067	-	-	-	-
3	IDJWI	-	-	-	-	5,807	7,570	8,432	4,945	3,276	6,865	10,141	-	33,707	48,000	25,610	56,097	-	-	-	-
4	KADUTU	-	-	-	-	724	6,200	4,204	2,720	1,079	2,838	3,103	814	11,196	7,250	9,161	9,285	-	-	-	-
5	KALOLE	-	-	-	-	-	-	-	-	405	405	-	810	1,500	-	500	1,000	-	-	-	-
6	KALONGE	-	-	-	-	287	-	23	264	231	325	491	65	2,485	1,500	1,351	2,634	-	-	-	-
7	KAMITUGA	-	-	-	-	1,934	5,403	5,183	2,154	2,664	5,092	6,852	904	6,378	6,937	4,723	8,592	-	-	-	-
8	KANIOLA	-	-	-	-	5,583	7,300	9,859	3,024	1,605	4,011	4,178	1,438	5,577	4,945	6,305	4,217	-	-	-	-
9	KATANA	-	-	-	-	1,406	3,840	5,246	-	42	4,685	4,727	-	8,682	4,947	5,484	8,145	151	50	77	124
10	KAZIBA	-	-	-	-	2,000	-	2,000	-	218	-	108	110	-	12,000	9,000	3,000	-	-	-	-
11	KALEHE	-	-	-	-	850	2,000	2,595	255	1,886	5,895	5,568	2,213	15,053	6,427	8,282	13,198	-	-	-	-
12	KITUTU	-	-	-	-	1,814	6,387	8,293		4,758	9,475	9,677	4,556	17,168	9,500	10,551	16,117	-	-	-	-
13	LULINGU	-	-	-	-	3,588	1,998	607	4,979	3,325	25,325	28,650	-	10,107	35,410	19,361	26,156	1,227	616	194	1,649
14	MINOVA	-	-	-	-	2,967	3,900	4,662	2,205	3,858	7,539	7,183	4,214	1,882	2,940	4,822	-	-	-	-	-
15	MITIMURHESA	-	-	-	-	-	600	494	106	3,286	2,106	1,969	3,423	966	5,321	2,060	4,227	-	-	-	-
16	MUBUMBANO	-	-	-	-	3,406	-	3,308	98	-	-	-	-	7,390	-	504	6,886	-	-	-	-
17	MULUNGU	-	-	-	-	-	-	-	-	-	-	-	-	8,700	9,000	5,300	12,400	-	-	-	-
18	MWANA	-	-	-	-	-	-	-	-	-	300	300	-	-	-			-	-	-	-
19	MWENGA	-	-	-	-	-	-	-	-	17,900	8,000	4,275	21,625	20,000	20,000	33,290	6,710	-	-	-	-
20	NYANGEZI	-	-	-	-	641	320	961	-	1,773	3,966	4,374	1,365	4,779	4,500	2,528	6,751	-	-	-	-
21	SHABUNDA	-	-	-	-	6,643	7,710	9,063	5,290	2,149	5,175	6,042	1,282	14,344	10,366	14,147	10,563	213	50	112	151
22	WALUNGU	-	-	-	-	38,174	64,804	78,370	24,608	48,530	98,502	145,957	1,075	173,561	215,823	191,046	198,338	1,591	716	383	1,924
	SOUS TOTAL VII	-	-	-	-	76,348	129,608	153,052	52,904	97,060	197,004	249,009	45,055	347,122	431,646	377,395	401,373	3,182	1,432	766	3,848
1	HAUT PLATEAUX	-	-	-	-	-	-	-	-	550	1,125	575	1,100	-	10,000	10,000	-	-	-	-	-
2	LEMERA	-	-	-	-	-	-	-	-	6,325	-	6,325	-	20,798	10,000	4,912	25,886	-	-	-	-
3	NUNDU	-	-	-	-	-	-	-	-	16,650	-	9,275	7,375	18,000	10,000	5,400	22,600	-	-	-	-
4	RUZIZI	-	-	-	-	-	-	-	-	22,450	-	11,000	11,450	3,900	10,000	10,000	3,900	-	-	-	-
5	UVIRA	-	-	-	-	-	-	-	-	16,925	-	6,125	10,800	1,700	-	300	1,400	-	-	-	-
	SOUS TOTAL VIII	-	-	-		-	-	-		62,900	1,125	33,300	30,725	44,398	40,000	30,612	53,786	-	-	-	-
	TOTAL GENERAL	58,699	1,250	8,374	51,575	118,159	138,912	184,895	72,176	696,858	893,118	508,482	1,081,494	820,344	688,351	692,306	816,389	3,189	1,432	766	3,855

Summary of competency-based training on Juillet _September 2014 /Q4 IHP Y4

N°	Domaine	Province	Bureau Coordination	Titre	Période		Participants		Budget	
					Début	Fin	M	F	Prévision	Utilisé
1	LMG/FOSACOF	Katanga	Kolwezi	Atelier FOSACOF des Prestataires et membres de la communauté de la ZS de Bunkeya	24/09/2014	26/09/2014	22	3	$ 5,603.50	$ 5,549.99
2			Kolwezi	Atelier FOSACOF des Prestataires et membres de la communauté de la ZS de Fungurume	24/09/2014	26/09/2014	51	7	$ 10,772.00	$ 10,682.44
3			Kolwezi	Atelier FOSACOF des Prestataires et membres de la communauté de la ZS de Mutshatsha	10/09/2014	12/09/2014	37	6	$ 5,876.50	$ 5,530.19
4			Kolwezi	Atelier FOSACOF des Prestataires et membres de la communauté de la ZS de Dilala	09/09/2014	11/09/2014	32	8	$ 6,654.00	$ 6,564.74
5		Sud Kivu	Uvira	Atelier FOSACOF des Prestataires et membres de la communauté des 4 ZS de Uvira (Uvira,Ruzizi,Nundu et Lemera)	22/08/2014	26/08/2014	62	16	$ 16,336.00	$ 15,691.00
6			Bukavu	Atelier FOSACOF des Prestataires et membres de la communauté de la ZS de Kamituga	24/09/2014	29/09/2014	20	5	$ 3,267.33	$ 3,090.00
7			Bukavu	Atelier FOSACOF des Prestataires et membres de la communauté des 3ZS de Bukavu (Bunyakiri,Minova et Kalonge)	03/07/2014	04/07/2014	21	4	$ 2,997.13	$ 2,907.13
8	LMG/CODESA	Katanga	Kolwezi	Formation des membres des CODESA de la ZS de Lubudi	22/08/2014	23/08/2014	29	3	$ 5,695.50	$ 5,690.98
9			Kolwezi	Formation des membres des CODESA de la ZS de Fungurume	27/08/2014	28/08/2014	36	0	$ 5,609.20	$ 5,604.35
10			Kolwezi	Formation des membres des CODESA de la ZS de Bunkeya	25/08/2014	26/08/2014	12	2	$ 2,933.80	$ 2,883.33
11	LMG/Ordinogrammes	Sud Kivu	Bukavu	Formation des Prestataires des CS de la ZS de Kaniola en Utilisation des Ordinogrammes du CS	27/08/2014	29/08/2014	25	7	$ 5,955.00	$ 5,325.00
12		Kasai Oriental	Kole	Formation des Prestataires des CS de la ZS de Lodja en Utilisation des Ordinogrammes du CS	10/07/2014	11/07/2014	17	5	$ 1,016.25	$ 785.70
13	SMNE	Kasai Occidental	Luiza	Formation des Prestataires des 2 ZS (Dibaya et Lubondaie) de Luiza en Approche Intégrée par Compétence de la Santé Maternelle et Infantile	21/07/2014	03/08/2014	30	28	$ 57,053.39	$ 47,682.96
14		Sud Kivu	Uvira	Formation des Relais communautaires de la ZS de Lemera en Approche communautaire de la Santé Maternelle et Infantile	26/07/2014	27/07/2014	16	1	$ 2,778.00	$ 2,778.00
15			Uvira	Formation des Relais communautaires de la ZS de Nundu en Approche Communautaire Intégrée par compétence de la Santé Maternelle et Infantile	24/07/2014	25/07/2014	8	5	$ 2,211.00	$ 2,211.00
16			Uvira	Formation des Prestataires des 5 ZS (Uvira,Nundu,Ruzizi, Lemera et Haut plateau) de Uvira en Approche Intégrée par Compétence de la Santé Maternelle et Infantile	26/09/2014	09/10/2014	14	14	$ 32,726.50	$ 30,610.50
17		Kasai Oriental	Mweneditu	Formation des Prestataires des 2 ZS (Bibanga et Kanda Kanda) de Mweneditu en Approche Intégrée par Compétence de la Santé Maternelle et Infantile	16/07/2014	29/07/2014	37	10	$ 48,776.83	$ 46,936.12
18	BCC	Kasai Oriental	Mweneditu	Formation des membres de la communauité de la ZS de Kanda Kanda sur la mise en œuvre de l'approche de la Communauté Championne	27/08/2014	29/08/2014	14	11	$ 3,998.00	$ 3,929.70
19			Mweneditu	Formation des membres de la communauité de la ZS de Kalenda sur la mise en œuvre de l'approche de la Communauté Championne	07/07/2014	09/07/2014	18	7	$ 4,001.60	$ 3,911.80
21			Bukavu	Formation des membres de la communauité de la ZS de Mwana sur la mise en œuvre de l'approche de la Communauté Championne	02/07/2014	04/07/2014	26	14	$ 6,894.00	$ 6,874.50
22	MALARIA	Kasai Oriental	Tshumbe	Formation des prestataires de la ZS de Tshumbe en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	17/07/2014	19/07/2014	26	3	$ 3,481.08	$ 3,224.50
23			Tshumbe	Formation des prestataires de la ZS de Minga en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	18/07/2014	20/07/2014	40	0	$ 8,144.60	$ 5,252.00
24			Tshumbe	Formation des prestataires de la ZS de Katako en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	18/07/2014	20/07/2014	36	1	$ 6,060.80	$ 4,720.60
25			Tshumbe	Formation des prestataires de la ZS de Dikungu en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	18/07/2014	20/07/2014	36	1	$ 5,885.80	$ 4,597.80
26			Tshumbe	Formation des prestataires de la ZS de Djalo en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	18/07/2014	20/07/2014	36	1	$ 5,089.80	$ 4,261.60
27			Tshumbe	Formation des prestataires de la ZS de Pania Mutombo en Nouveau Protocole thérapeutique du Paludisme,Analyse biologique et Traitement Intermittent Prosomptif	07/10/2014	09/10/2014	22	1	$ 5,247.20	$ 4,465.80
28		Katanga	Kolwezi	Formation des prestataires de la ZS de Lualaba sur les Nouvelles Directives de prise en Charge du Paludisme	29/08/2014	31/08/2014	27	5	$ 8,202.00	$ 8,074.94
29			Kolwezi	Formation des prestataires des ZS de Manika et Dilala sur les Nouvelles Directives de prise en Charge du Paludisme	26/08/2014	28/08/2014	36	17	$ 7,604.00	$ 7,099.25
30			Kolwezi	Formation des prestataires de la ZS de Kanzenze sur les Nouvelles Directives de prise en Charge du Paludisme	11/09/2014	13/09/2014	25	7	$ 8,531.40	$ 7,904.14
31		Sud Kivu	Bukavu	Refresh des prestataires de la ZS de Nyangezi sur la prise en Charge du Paludisme selon les Nouvelles Directives	03/07/2014	04/07/2014	29	4	$ 4,693.80	$ 4,538.50
32			Bukavu	Refresh des prestataires de la ZS de Kitutu sur la prise en Charge du Paludisme selon les Nouvelles Directives	01/08/2014	02/08/2014	42	6	$ 6,993.00	$ 6,821.00
33			Bukavu	Refresh des prestataires de la ZS de Kamituga sur la prise en Charge du Paludisme selon les Nouvelles Directives	30/07/2014	31/07/2014	39	9	$ 7,081.10	$ 6,738.50
34			Bukavu	Formation des prestataires des 3 ZS de BUKAVU (Ibanda,Kadutu et Kaziba) en Paludisme Grave	20/08/2014	23/08/2014	18	18	$ 9,981.00	$ 8,461.00
35		Kasai Oriental	Mweneditu	Refresh des prestataires de la ZS de Bibanga sur la prise en Charge du Paludisme selon les Nouvelles Directives	11/07/2014	13/07/2014	17	2	$ 5,151.50	$ 4,011.20

N°	Domaine	Province	Bureau Coordination	Titre	Période		Participants		Budget	
					Début	Fin	M	F	Prévision	Utilisé
36			Mweneditu	Refresh des prestataires de la ZS de Wikong sur la prise en Charge du Paludisme selon les Nouvelles Directives	01/07/2014	03/07/2014	15	2	$ 4,248.80	$ 4,043.03
37	PCIME	Kasai Oriental	Mweneditu	Formation des Relais Communautaires de la ZS de Luputa en PCIME/Sites des soins Communautaires	01/07/2014	07/07/2014	36	2	$ 11,810.70	$ 10,876.49
38			Tshumbe	Refresh de la Formation des Prestataires et Relais Communautaires de la ZS de Tshumbe en PCIME/Sites des soins Communautaires	06/08/2014	06/08/2014	13	2	$ 973.50	$ 845.75
39		Sud Kivu	Uvira	Formation des Relais Communautaires des 4 ZS de Uvira (Uvira,Ruzi,Lemera et Nundu) en PCIME/Sites des soins Communautaires	12/07/2014	14/07/2014	34	0	$ 9,760.00	$ 9,720.00
42	TB	Sud Kivu	Bukavu	Formation des prestataires et Techniciens de Laboratoire des 5 ZS de Bukavu (Bunyakiri,Kalonge,Katana,Miti,Minova) en Lutte contre la Tuberculose selon l'approche PATI 4 pour la détection des cas des	22/07/2014	26/07/2014	34	4	$ 10,550.74	$ 11,090.74
43			Bukavu	Formation des prestataires et Techniciens de Laboratoire des 5 ZS de Bukavu (Walungu,Mubumbano,Ibanda,Nyangezi,Kadutu) en Lutte contre la Tuberculose selon l'approche PATI 4 pour la détection des cas	09/09/2014	13/09/2014	51	9	$ 20,824.74	$ 19,438.74
45			Bukavu	Briefing des Practiciens traditionnels de la ZS de Kalonge en Lutte contre la Tuberculose selon l'approche PATI 4	28/08/2014	29/08/2014	40	0	$ 5,351.00	$ 5,217.00
46		Kasai Oriental	Mweneditu	Formation des prestataires et Techniciens de Laboratoire des 7 ZS de Mweneditu en Lutte contre la Tuberculose selon l'approche PATI 4	09/09/2014	13/09/2014	25	1	$ 11,058.00	$ 10,287.91
47	TB VIH	Sud Kivu	Uvira	Formation des prestataires et Techniciens de Laboratoire des 5 ZS de Uvira (Uvira,Nundu, Lemera,Ruzizi et Haut Plateau) en Lutte contre la Tuberculose selon l'approche co infection VIH/SIDA-TBC/PATI 4	28/07/2014	03/08/2014	35	2	$ 17,504.00	$ 17,488.00
49	PF	Katanga	Kolwezi	Formation des prestataires des ZS de Fungurume,Bunkeya,Lubudi et Lualaba en Méthode de planification Familiale à Longue Durée	21/07/2014	26/07/2014	12	10	$ 10,993.60	$ 10,385.97
50			Kolwezi	Formation des prestataires des ZS de Dilala, Kanzenze, Manika et Mutshatsha en Méthode de planification Familiale à Longue Durée	21/07/2014	26/07/2014	18	14	$ 13,097.80	$ 12,892.81
57	NUTRITION	Katanga	Kolwezi	Formation des Accoucheuses Traditionnellles de la ZS de Lubudi en Actions Essentielles en Nutrition	09/07/2014	11/07/2014	16	17	$ 7,498.50	$ 1,555.00
58			Kolwezi	Formation des Accoucheuses Traditionnellles de la ZS de Bunkeya en Actions Essentielles en Nutrition	13/07/2014	15/07/2014	24	9	$ 6,941.00	$ 6,914.00
							1309	**303**	**$ 453,914.99**	**$ 416,165.70**

PROVINCE	COORDINATION PROSANI	DOMAINE D'INTERVENTION	PERIODE	THEME DE LA FORMATION	LIEU	DUREE de la Formation	PARTICIPANTS									COUTS							
							CADRES		PRESTAI		COMMUN		TOTAL			COUTS DETAILLES						COUT GLOBAL	
																facilitation:		participants:		Voyage			
							M	F	M	F	M	F	M	F	T	Prevu	Décaissé	Prévu	Décaissé	prévu	Décaissé	CT PREVU	CT DECAISSE
KATANGA 1	KOLWEZI	PBF	PY4Q1	Atelier contractualisation FBR KANZENZE	ZS KANZENZE	4			19	2			19	2	21	7296.5	5734.37	5565	5560	1220	805	14081.5	12099.4
KASAI OCCIDENTAL	LUIZA	PBF	PY4Q1	Atelier Intégration programme de santé	ZS LUIZA	4			24	2			24	2	26	4385.64	4385.64	5848	5448	320	720	10553.6	10553.6
SUD KIVU 2	UVIRA	PBF	PY4Q1	Atelier Intégration programme de santé	ZS VUNDU	4			26	0			26	0	26	2192	1832	10115	11210	1070	1070	13377	14112
KASAI ORIENTAL 3	KOLE	PBF	PY4Q1	Atelier contractualisation FBR KANZENZE	LOMELA	3			1	27			1	27	28	8074.91	6456.52	7450	6249.3	3918.68	16105.85	19443.6	28811.7
KATANGA 2	KAMINA	PBF	PY4Q1	Atelier Intégration programme de santé	ZS KAYAMBA	4			17	3			17	3	20	3567.21	2038.31	6080	4230	90		9737.21	6268.31
KATANGA 2	KAMINA	PBF	PY4Q1	Atelier Intégration programme de santé	ZS KAYAMBA	2			6	1			6	1	7	2338.21	408.31	1170	994.54	1870		5378.21	1402.85
KASAI ORIENTAL 2	TSHUMBE	PBF	PY4Q1	Formation des prestataires de CS, HGR et Cadres ECZ en PBF/TSHUMBE	ZS WEMBONYAMA	4			41	4			41	4	45	3872.22	3364.53	8700	7413.8	2463.04	3064.68	15035.3	13843
KATANGA 1	KOLWEZI	PBF	PY4Q2	Verification des données FBR du T1 des structures dela ZS KANZENZE	ZS KANZENZE	7	18	1					18	1	19	4070.3	4476.09			2245	1616.09	6315.3	6092.18
KASAI ORIENTAL 1	MWENE DITU	PBF	PY4Q2	Atelier contractualisation PBF DE MBUJIMAYI ET BIBANGA	ZS BIBANGA	4			22	2			22	2	24	5975.64	4599.26	7435	6218	2000	1627	15410.6	12444.3
KASAI ORIENTAL 3	KOLE	PBF	PY4Q2	Formation de membres des OAC	LOMELA	7					11	0	11	0	11	1307.99	1307.99	2803	2803	1864.23	1864.23	5975.22	5975.22
KATANGA 2	KAMINA	PBF	PY4Q2	Verification des données PBF du T1 des structures dela ZS KAYAMBA	ZS KAYAMBA	2	8	1					8	1	9	4520	3882.8	420	210	1476	1391.6	6416	5484.4
KASAI ORIENTAL 1	MWENEDITU	PBF	PY4Q2	Formation des OAC	ZS BILANGA	5					9	9	9	9	18	1981	1682.29	2010	1448	610	290	4601	3420.29
KASAI ORIENTAL 1	MWENEDITU	PBF	PY4Q2	Verification des données PBF du T1 des structures dela ZS BILANGA	ZS BILANGA	14	9	1					9	1	10	2082	2065	2025	1605	946.4	886.2	5053.4	4556.2
KASAI ORIENTAL 2	TSHUMBE	PBF	PY4Q2	Verification des données FBR du T1 des structures dela ZS WEMBONYAMA	ZS WEMBONYAMA	12	13	0					13	0	13	3835	3370			1130.7	1130.7	4965.7	4500.7
KASAI ORIENTAL 2	TSHUMBE	PBF	PY4Q2	Formation des OAC sur la Verification des données FBR du T1 des structures dela ZS WEMBONYAMA	ZS WEMBONYAMA	3					12	8	12	8	20	710	1044.36	1289	1100.2	4643.8	582.25	6642.8	2726.81
SUD KIVU 2	UVIRA	PBF	PY4Q2	Intégration de programme de santé mission deVerification des données FBR du T1 des structures dela ZS WEMBONYAMA	ZS NUNDU	9	12	2					12	2	14	2040	2040	1900	1800		610	3940	4450

PROVINCE	COORDINATION PROSANI	DOMAINE D'INTERVENTION	PERIODE	THEME DE LA FORMATION	LIEU	DUREE de la Formation	PARTICIPANTS									COUTS							
							CADRES		PRESTAI		COMMUN		TOTAL			COUTS DETAILLES						COUT GLOBAL	
																facilitation:		participants:		Voyage			
							M	F	M	F	M	F	M	F	T	Prevu	Décaissé	Prévu	Décaissé	prévu	Décaissé	CT PREVU	CT DECAISSE
SUD KIVU 2	UVIRA	PBF	PY4Q2	Formation de membres des OAC en verification communautaire	ZS NUNDU	3					14	6	14	6	20	1968.5	1604	2202	4177	2780	1115	6950.5	6896
KASAI ORIENTAL 3	KOLE	PBF	PY4Q2	Verification des données FBR du T1 des structures dela ZS de LOMELA	LOMELA	15	6	2					6	2	8	2240	2240	345	345	1619.6	1619.6	4204.6	4204.6
KASAI OCCIDENTAL	LUIZA	PBF	PY4Q2	Verification des données FBR du T1 des structures dela ZS de LUIZA	ZS LUIZA	9	17	0					17	0	17	1379	1379	4480	4270	936	802.22	6795	6451.22
KASAI OCCIDENTAL	LUIZA	PBF	PY4Q2	Formation de membres des OAC en verification communautaire	ZS LUIZA	3					24	3	24	3	27	1361.31	1361.31	2820	2820	250		4431.31	4181.31
KATANGA 1	KOLWEZI	PBF	PY4Q2	Formation de membres des OAC en verification communautaire	ZS KANZENZE	3					15	8	15	8	23	2397.6	1871;94	5275	3205	910	781	8582.6	#VALUE!
KATANGA 2	KAMINA	PBF	PY4Q2	Formation de membres des OAC en verification communautaire	ZS KAYAMBA	3					13	7	13	7	20	1202.25	488.96	3826	2610	70	50	5098.25	3148.96
KATANGA 2	KAMINA	MALARIA	PY4Q3	Formation des prestataires des soins	KAMINA	3			12	5			12	5	17	444.5	372.41	2010	1845	130	130	2584.5	2347.41
KATANGA 2	KAMINA	HIV-PMA	PY4Q3	Formation des prestataires en HIV	KAMINA	3			18	5			18	5	23	847.75	499.92	4832	3737.2	5416	4274.2	11095.8	8511.28
KATANGA 2	KAMINA	HIV-PMA	PY4Q3	Formation des prestataires en HIV	KAMINA	5			31	9			31	9	40	4561.76	5500.36	16731	10924	2330	1274.54	23622.8	17698.7
KATANGA 2	KAMINA	MALARIA	PY4Q3	Formation des presttaires	KAMINA	3			19	4			19	4	23	404.65	250.51	2820	2373	190	170	3414.65	2793.51
KATANGA 2	KAMINA	MALARIA	PY4Q3	Formation des presttaires	KAMINA	5			31	4			31	4	35	504.05	395	4275	3689	360	429.7	5139.05	4513.7
KATANGA 2	KAMINA	MALARIA	PY4Q3	Formation des presttaires	KAMINA	3			27	5			27	5	32	467.7	415.46	3975	3540	290	280	4732.7	4235.46
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS KANIDA	2			27	5			27	5	32	766	752	2810	2742	1020	960	4596	4454
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS MITIMURESHA	2			28	7			28	7	35	764.6	772	3952	3457	1080	1130	5796.6	5359
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS KATANA	2			32	7			32	7	39	973	686	2909	2574	1220	1180	5102	4440
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	BUNYAKIRI	5			44	0			44	0	44	1102	1097	6206	5662.6	3220	3140	10528	9899.6
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	KAZIBU	2			12	8			12	8	20	723	903	1969	1505.5	670	660	3362	3068.5
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS KANIOLA	3			18	6			18	6	24	1045	792	2814	2640	940	850	4799	4282
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS IDJWI	2			41	1			41	1	42	775.6	716	3741	3650	1420	1420	5936.6	5786
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS WALUNGU	2			44	6			44	6	50	1028	854	4145	4023	1580	1504	6753	6381
SUD KIVU 1	BUKAVU	PALU	PY4Q3	Formation de prestataires en palu	ZS NYANGEZI	3			14	1			14	1	15	904	1004	1665	1710	710	590	3279	3304

PROVINCE	COORDINATION PROSANI	DOMAINE D'INTERVENTION	PERIODE	THEME DE LA FORMATION	LIEU	DUREE de la Formation	PARTICIPANTS									COUTS							
							CADRES		PRESTAI		COMMUN		TOTAL			COUTS DETAILLES						COUT GLOBAL	
																facilitation:		participants:		Voyage			
							M	F	M	F	M	F	M	F	T	Prevu	Décaissé	Prévu	Décaissé	prévu	Décaissé	CT PREVU	CT DECAISSE
KATANGA 1	KOLWEZI	ICCM	PY4Q3	Formation de prestataires DES SITES DE SOINS COMMUNAUTAIRES	ZS BUNKEYA	2			14	4			14	4	18	968	818.67	1130	920	540	440	2638	2178.67
KATANGA 1	KOLWEZI	SNIS	PY4Q3	Formation des cadres ECZS BUNKEYA ET DS KOLWEZI	ZS BUNKEYA	4	7	1					7	1	8	1321.56	1239.72	2030	2030	345	345	3696.56	3614.72
KATANGA 1	KOLWEZI	PEV	PY4Q3	Formation en Gestion PEV	ZS FUNGURUME	3			19	2			19	2	21	1666	1363.91	3097	2293	540	540	5303	4196.91
KATANGA 1	KOLWEZI	ORDINOGRAMME	PY4Q3	Formation des prestataires en ordinogramme	ZS BUNKEYA	1			14	0			14	0	14	1253	1168.15	1617	1281	730	580	3600	3029.15
KATANGA 1	KOLWEZI	PF	PY4Q3	Formation des BDC	ZS BUNKEYA	3					19	2	19	2	21	1226.5	836.3	2010	1893	780	580	4016.5	3309.3
KATANGA 1	KOLWEZI	ICCM	PY4Q3	Formation des prestataires des sites de soins communautaires	ZS BUNKEYA	2			14	4			14	4	18	968	818.67	1130	920	540	440	2638	2178.67
SUD KIVU 2	UVIRA	PALU	PY4Q3	Formation des prestataires sur la PEC palu simple	ZS RUZIZI	2			21	0			21	0	21	1544	974	2398	3010	1745	1745	5687	5729
SUD KIVU 2	UVIRA	PALU	PY4Q3	Formation des prestataires sur la PEC palu simple	ZS NUNDU	2			16	2			16	2	18	2406	656	2140	2815	595	1645	5141	5116
SUD KIVU 2	UVIRA	PALU	PY4Q3	Formation des prestataires sur la PEC palu simple	ZS LEMERA	2							0	0	0	1458	1068	4180	3650	835	755	6473	5473
SUD KIVU 2	UVIRA	TBC	PY4Q3	Formation des LEADERS COMMUNAUTAIRES EN TECHNIQUES DE COMMUNICATION ET DEPISTAGE DES CAS DE TBC	ZS NUNDU	2					18	2	18	2	20	1271	1248	1915	1915	545	495	3731	3658
SUD KIVU 2	UVIRA	PF	PY4Q3	Formation des prestataires en PF	ZS RUZIZI	7							0	0	0	1458	1068	4180	3650	835	755	6473	5473
SUD KIVU 2	UVIRA	TBC	PY4Q3	Formation des LEADERS COMMUNAUTAIRES EN TECHNIQUES DE COMMUNICATION ET DEPISTAGE DES CAS DE TBC	ZS UVIRA	2					40	0	40	0	40	1315	1115	4530	4455	880	880	6725	6450
SUD KIVU 2	UVIRA	ORDINOGRAMME	PY4Q3	Formation des prestataires en ORDINOGRAMME	ZS MINOVA	3			32	10			32	10	42	1030	914	5531	4750	1540	1280	8101	6944
SUD KIVU 2	UVIRA	PBF	PY4Q3	Formation EN PORTAIL WB	UVIRA	2	15	0					15	0	15	270	270	760	760	180	180	1210	1210
KASAI ORIENTAL 1	MWENEDITU	ICCM	PY4Q3	Formation des RECO en PCIME	WIKONG	3					10	0	10	0	10	1299.65	1257.04	2515	2116	610	577.83	4424.65	3950.87
KASAI ORIENTAL 1	MWENEDITU	ICCM	PY4Q3	Formation des RECO en PCIME	BIBANGA	4					10	0	10	0	10	1299.65	1257.04	2515	2116	610	577.83	4424.65	3950.87
KASAI ORIENTAL 1	MWENEDITU	ICCM	PY4Q3	Formation des IT en PCIME	BIBANGA	3			9	0			9	0	9	894.77	844.9	932	1128.5	90	246	1916.77	2219.4
KASAI ORIENTAL 1	MWENEDITU	ICCM	PY4Q3	Formation des IT en PCIME	WIKONG	3			9	1			9	1	10	1213.99	1066.5	1537	1539.5	580	540.97	3330.99	3146.97

PROVINCE	COORDINATION PROSANI	DOMAINE D'INTERVENTION	PERIODE	THEME DE LA FORMATION	LIEU	DUREE de la Formation	PARTICIPANTS									COUTS							
							CADRES		PRESTAI		COMMUN		TOTAL			COUTS DETAILLES						COUT GLOBAL	
																facilitation:		participants:		Voyage			
							M	F	M	F	M	F	M	F	T	Prevu	Décaissé	Prévu	Décaissé	prévu	Décaissé	CT PREVU	CT DECAISSE
KASAI ORIENTAL 1	MWENEDITU	AEN	PY4Q3	Formation des IT et RECO en ANJE	KALENDA	3			9	1			9	1	10	1213.99	1066.5	1537	1539.5	580	540.97	3330.99	3146.97
KASAI ORIENTAL 1	MWENEDITU	AEN	PY4Q3	Formation des IT et RECO en ANJE	KANDAKANDA	3			10	15			10	15	25	3592.57	2262.9	3185	2742.5	400	442	7177.57	5447.4
KASAI ORIENTAL 1	MWENEDITU	AEN	PY4Q3	Formation des IT et RECO en ANJE	WIKONG	3			7	18			7	18	25	3592.57	2288.3	3185	3172.5	486.4	639	7263.97	6099.8
KASAI ORIENTAL 3	KOLE	PAO	PY4Q3	Atelier de consolidation PAO district de SANKURU	SANKURU	3	49	2					49	2	51	2382.5	2415.54	9960	8652.1	3918.68	3695.15	16261.2	14762.8
KASAI ORIENTAL 2	TSHUMBE	ORDINOGRAMME	PY4Q3	Formation des prestataires en ordinogramme	TSHUMBE	5			18	2			18	2	20			5101.5	3167.2	400	240	5501.5	3407.16
KASAI ORIENTAL 2	TSHUMBE	ICCM	PY4Q3	Formation des prestataires en PCIME	MINGA	3			13	0			13	0	13			2718.88	2441.5	762.2	786	3481.08	3227.5
KASAI ORIENTAL 2	TSHUMBE	ICCM	PY4Q3	Formation RECO SITE	MINGA	5					193	15	193	15	208	1505.8	1356.26	4565	3875	180	111.28	6250.8	5342.54

Integrated Health Project (IHP) Year 5 International Travel and STTA Plan October 2014 - September 2015								
#	TECHNICAL AREA	SUGGESTED PERSON	ORG	TRAVEL DATES	INDICATIVE SCOPE OF WORK	ORIGIN/DESTINATION	LENGTH OF TRIP (DAYS)	STATUS
STTA/PROJECT MANAGEMENT AND MONITORING								
Quarter 1 Oct-Dec 2014								
1	Program Management	Kristin Cooney	MSH	October 4-17, 2014	Provide technical and management support and visit project sites	Boston/Kinshasa	14	Completed
2	Contracts	Kelley Scarmeas	MSH	October 18-24, 2014	Provide contractual technical and management support	Boston/Kinshasa	7	Completed
3	Communications	Elaisha Stokes	MSH	November 25-December 9,	Visit project sites to develop video that documents and promotes project results, specifically focusing on project's strongest contributions to “A Promise Renewed”	Boston/Kinshasa	15	Planned
4	Monitoring and Evaluation	Monita Baba Djara	MSH	November 30-December 13, 2014	Provide M&E technical support in preparation for project close-out	Boston/Kinshasa	14	Planned
Quarter 2 Jan-Mar 2015								
5	Operations	Christele Joseph-Pressat	MSH	January 15-30, 2015	Provide operational close-out support to Country Operations Management Unit (COMU) and project team	Boston/Kinshasa	15	Planned
6	BCC	TBD	OSC	February 1-15, 2015	Evaluation of the implementation of the Champion Communities approach	TBD/Kinshasa	15	Planned
7	Program Management	Kristin Cooney	MSH	February 13-28, 2015	Provide technical and management support and visit project sites	Boston/Kinshasa	15	Planned
8	BCC	Paul Neely	OSC	March 1-15, 2015	Evaluation of the implementation of CUG and SMS systems	Los Angeles/Kinshasa	15	Planned
Quarter 3 Apr-Jun 2015								
9	Program Management	Kristin Cooney	MSH	May 1-15, 2015	Provide technical and management support	Boston/Kinshasa	15	Planned
10	Contracts	Kelley Scarmeas	MSH	June 1-15, 2015	Provide contractual technical and management support	Boston/Kinshasa	15	Planned

#	TECHNICAL AREA	SUGGESTED PERSON	ORG	TRAVEL DATES	INDICATIVE SCOPE OF WORK	ORIGIN/DESTINATION	LENGTH OF TRIP (DAYS)	STATUS
STTA/PROJECT MANAGEMENT AND MONITORING								
11	Communications	Senior Communications Manager (TBD)	MSH	June 1-15, 2015	Develop materials that document and promote project results	Boston/Kinshasa	15	Planned
12	Operations	Christele Joseph-Pressat	MSH	June 15-30, 2015	Provide operational close-out support to Country Operations Management Unit (COMU) and project team	Boston/Kinshasa	15	Planned
Quarter 4 July - Sept 2015								
13	Program Management	Kristin Cooney	MSH	September 1-15, 2015	Provide technical and management support during close-out	Boston/Kinshasa	15	Planned
14	Program Management	Joan Marshall-Missiye	MSH	September 15-30, 2015	Provide technical and management support during close-out	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 11/15/2014).						

Integrated Health Project (IHP) Year 4 International Travel and STTA Plan October 2014 - September 2015								
#	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 2014								
1	Project Management	Rood Merveille	MSH	October 31-November 12, 2014	Home office orientation, briefing, and meetings with key staff	Kinshasa/Boston	13	Completed
2	i-CCM	Narcisse Embeke	MSH	November 12-22, 2014	Present a poster on winning abstract on Collaborative Approach at the American Public Health Association (APHA) Conference	Kinshasa/New Orleans	10	Ongoing
3	i-CCM	Dr. Fidele Ilunga Mubayi	MOH	November 12-22, 2014	Present a poster on winning abstract on Collaborative Approach at APHA Conference	Kinshasa/New Orleans	10	Ongoing
4	PEPFAR	Sam Mbuyamba	MSH	December 1-5, 2014	Attend PEPFAR DATIM Training of Trainers	Johannesburg	5	Planned
Quarter 2 Jan-March 2015								
5	Health	IHP Local Staff	MSH	March 2014	Conference participation if an abstract is accepted	Kinshasa/TBD	7	Planned
6	Health	IHP Local Staff/MOH	MSH or MOH	March 2014	Conference participation if an abstract is accepted	Kinshasa/TBD	7	Planned
Quarter 3 April-June 2015								
7	Health	IHP Local Staff	MSH	June 2014	Conference participation if an abstract is accepted	Kinshasa/TBD	7	Planned
8	Health	IHP Local Staff/MOH	MSH or MOH	June 2014	Conference participation if an abstract is accepted	Kinshasa/TBD	7	Planned
Quarter 4 Jul-Sep 2015								

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 11/15/2014.

Integrated Health Project (IHP) Year 5 International Travel and STTA Plan October 2014 - September 2015								
#	TECHNICAL AREA	SUGGESTED PERSON	ORG	TRAVEL DATES	INDICATIVE SCOPE OF WORK	ORIGIN/DESTINATION	LENGTH OF TRIP (DAYS)	STATUS
ALLOWANCES TRAVEL								
Quarter 1 Oct-Dec 2014								
Quarter 2 Jan-March 2015								
Quarter 3 April-June 2015								
1	COP dependent	Ousmane Faye dependent	MSH	June 2015	Education travel	DC/Kinshasa	23	Planned
2	COP dependent	Ousmane Faye dependent	MSH	June 2015	Education travel	DC/Kinshasa	23	Planned
Quarter 4 Jul-Sep 2015								
3	Finance/COMU Director	Rood Merveille	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Port-au-Prince	n/a	Planned
4	Finance/COMU Director dependent	Rood Merveille dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Port-au-Prince	n/a	Planned
5	Finance/COMU Director dependent	Rood Merveille dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Port-au-Prince	n/a	Planned
6	Finance/COMU Director dependent	Rood Merveille dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Port-au-Prince	n/a	Planned
7	STA	Gilbert Andrianandrasana	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Antananarivo	n/a	Planned
8	STA dependent	Gilbert Andrianandrasana dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Antananarivo	n/a	Planned
9	STA dependent	Gilbert Andrianandrasana dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Antananarivo	n/a	Planned
10	COP	Ousmane Faye	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Dakar	n/a	Planned
11	COP dependent	Ousmane Faye dependent	MSH	September 2015	End of post travel to Home of Record	Kinshasa/Dakar	n/a	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 11/15/2014).