DRC-IHP Quarterly Report: October-December 2014

April 2015

Development objective: To 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

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DRC-IHP Quarterly Report: Year 5, Quarter One (October 2014 to December 2014)
USAID Cooperative Agreement Number: AID-OAA-A-10-00054
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Cover photo: A mother holds her child while a laboratory technician sets up in Mwene Ditu.

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

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ACRONYMS

ACT	Artemisinin-based Combination Therapy
AMTSL	Active Management of Third Stage Labor
AOP	Annual Operational Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CBD	Community-based distribution or community-based distributor
CCIA	*Comité de Concertation Inter-agence* (Inter-Agency Coordination Committee)
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
ETL	Education through Listening
FFSDP	Fully Functional Service Delivery Point (see FOSACOF)
FOSACOF	*Formation Sanitaire Complètement Fonctionnelle* (Fully Functional Service Delivery Point)
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
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
KMC	Kangaroo Mother Care
LDP	Leadership Development Program
LLIN	Long-lasting Insecticide-treated Net
LMS	Leadership, Management, and Sustainability Program
MEG	*Médicaments génériques et essentiels* **(**Generic and Essential Medicines)
MDR-TB	Multidrug-Resistant Tuberculosis
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child Health
MPA	Minimum Package of Activities
MPT+	Microscopy Positive Pulmonary TB
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OSC	Overseas Strategic Consulting, Ltd.
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	National Malaria Control Program

PNLT	National TB Program
PPMRc	Procurement Planning and Monitoring Report for contraceptives
PRONANUT	National Nutrition Program
RBF	Results-Based Financing
RDT	Rapid diagnostic tests
SDP	Service Delivery Point
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
UNCoLS	UN Commission on Life-Saving Commodities
USAID	United States Agency for International Development
USG	United States Government
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water/Sanitation/Hygiene
WHO	World Health Organization

PROJECT BACKGROUND

This report covers the first quarter reporting period (October to December 2014) of year five of the five-year, USAID-funded Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC). Implemented by Management Sciences for Health, the International Rescue Committee, and Overseas Strategic Consulting, Ltd (MSH, IRC, and OSC), the five-year project (October 2010-September 2015) supports the DRC National Health Development Program.

Bukavu Coordination Office – 22 health zones
Kamina Coordination Office – 9 health zones
Luiza Coordination Office – 9 health zones
Mwene Ditu Coordination Office – 9 health zones
Kole Coordination Office – 8 health zones
Kolwezi Coordination Office – 8 health zones
Tshumbe Coordination Office – 8 health zones
Uvira Coordination Office – 5 health zones

IHP has two components – "Health 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.

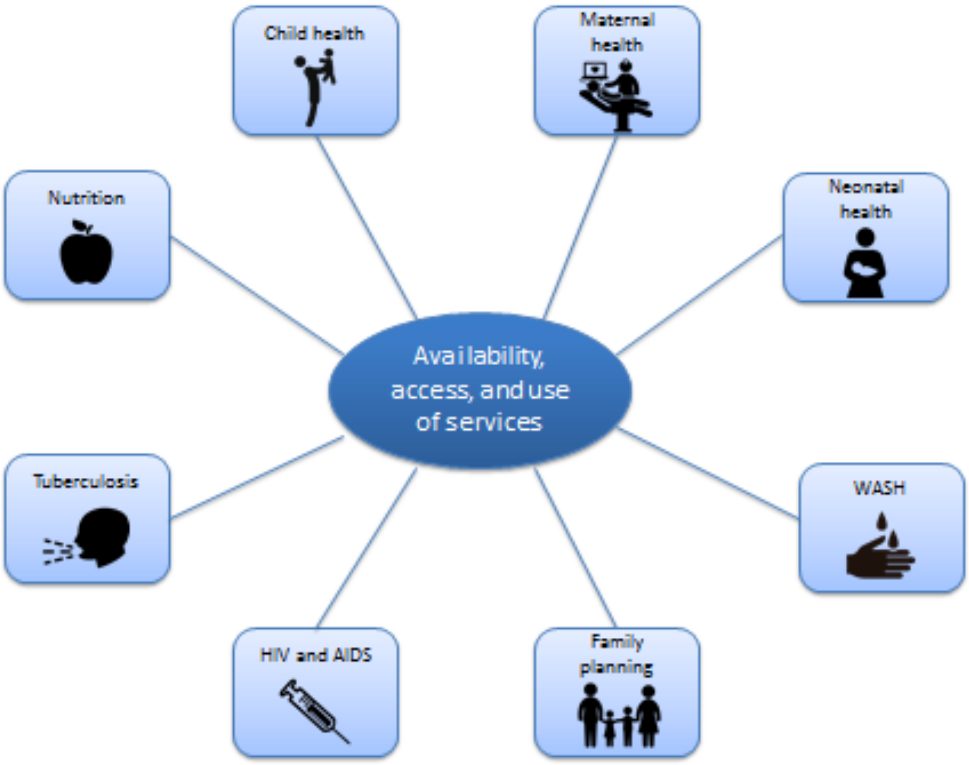
The project currently provides varying levels of support to 1,476 facilities (1,398 health centers and 78 general referral hospitals) in 78 health zones. Due to poor road conditions and hard-to-reach geographical areas of the majority of the target zones, in addition to establishing a project office 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. (See box at left)

With the project entering its fifth and final year of implementation**, IHP's *vision*** is that people in the 78 project health zones will participate more fully in determining their health outcomes by virtue of greater access to higher-quality comprehensive care; service delivery systems that are accountably and effectively managed in their interests; and family-centered communication about healthy behaviors that people understand and can act on in their daily lives.

The overarching *objective* of the project 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 (MNCH), nutrition, malaria, and tuberculosis (TB); HIV and AIDS; and water/sanitation/hygiene (WASH) in target health zones (see Figure 1).

[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 is reflected in modification #12 from USAID.

Figure 1: Availability, access, and use of services



The project reinforces a people- and team-centered approach to strengthening the health system in DRC, with a focus on four intermediate results detailed in Table 1 below. During this reporting period IHP continued to implement key strategies in all 78 targeted health zones.

Table 1: DRC-IHP Results Framework

Component 1: Services	Strategies by Sub-IR
Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	**IR 1.1:** Increased facility-based health care services/products • Provide material/equipment • Provide drugs, commodities, and materials
	IR 1.2: Increased community-based health care services/products • i-CCM at Community treatment sites • CODESA - Collaborative strategy at the community level
	IR 1.3 Effectively engaged provincial management • Leadership Development Program
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 • Training, Supportive Supervision
	IR 2.2: Minimum quality standards • Fully Functional Service Delivery Point (FOSACOF) • Results-based Financing (RBF)
	IR 2.3: PHC referral system for prevention, care and treatment
Intermediate Result 3: Knowledge, attitudes, and practices to support	**IR 3.1:** Health sector-community outreach linkages • CODESA

health-seeking behaviors increased in target health zones	• Youth outreach groups
	IR 3.2: Health advocacy/community mobilization organizations • Education Through Listening (ETL) • CODESA
	IR 3.3 Behavior change campaigns • BCC messaging
Component 2: Other Health Systems	
Intermediate Result 4: Health sector leadership and governance in target provinces improved	**IR 4.1:** Health sector policy alignment
	IR 4.2: Evidence-based strategic planning and decision-making
	IR 4.3: Community involvement in health policy/service delivery

EXECUTIVE SUMMARY

PROJECT PERFORMANCE[2]

The project tracks results for 15 groups of technical area indicators:

- Family planning (FP)
- Maternal, newborn and child health (MNCH);
- Nutrition
- Tuberculosis (TB)
- HIV and AIDS
- Malaria
- WASH
- Leadership, management and governance (L+M+G)
- Gender and gender-based violence (GBV)
- Referral systems
- Stock outs
- Health service quality and availability
- Community mobilization
- Behavior change communications (BCC), and
- Project management

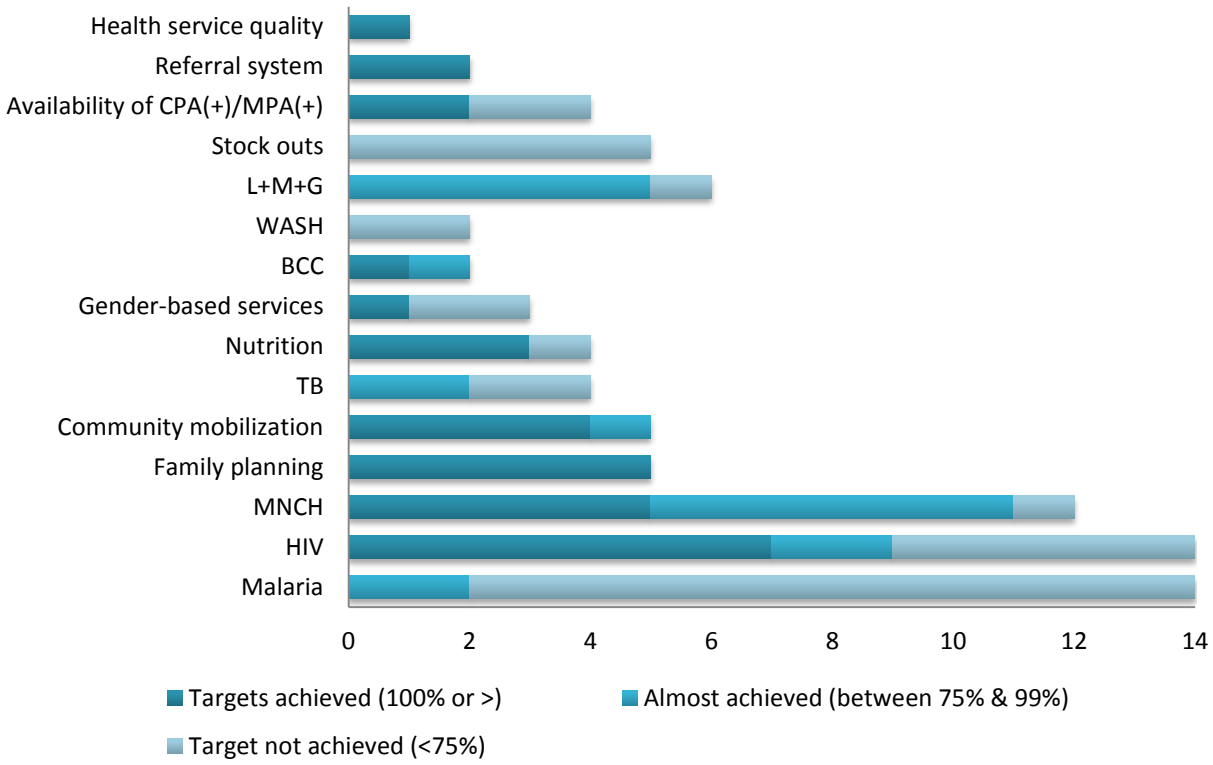
For the first quarter of project year five (PY5Q1), DRC- IHP exceeded or almost met (> 75% achievement) targets for more than half of the indicators for these technical areas (49 out of 83 indicators). Results were similar to the previous quarter, with particularly strong results in family planning, HIV, MNCH, community mobilization, and referral systems (please see Figure 2 below).

While performance is weaker in some sectors such as TB, WASH, and medicine stock outs, more emphasis on grassroots initiatives such as Community-Led Total Sanitation (CLTS), supportive supervision, and collaborative

[2] 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 and ongoing security issues preventing access to certain health zones. Finally, due to the change 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. The request was approved and is reflected in modification #12, dated January 28, 2015.

working groups are gradually contributing to some improvement. Specific details of these strategies are discussed in the body of the report.

Figure 2: Project performance - # of indicators achieved by domain



REPORTING KEY RESULTS

Access to and availability of MPA-plus and CPA-plus services and products (IR1)

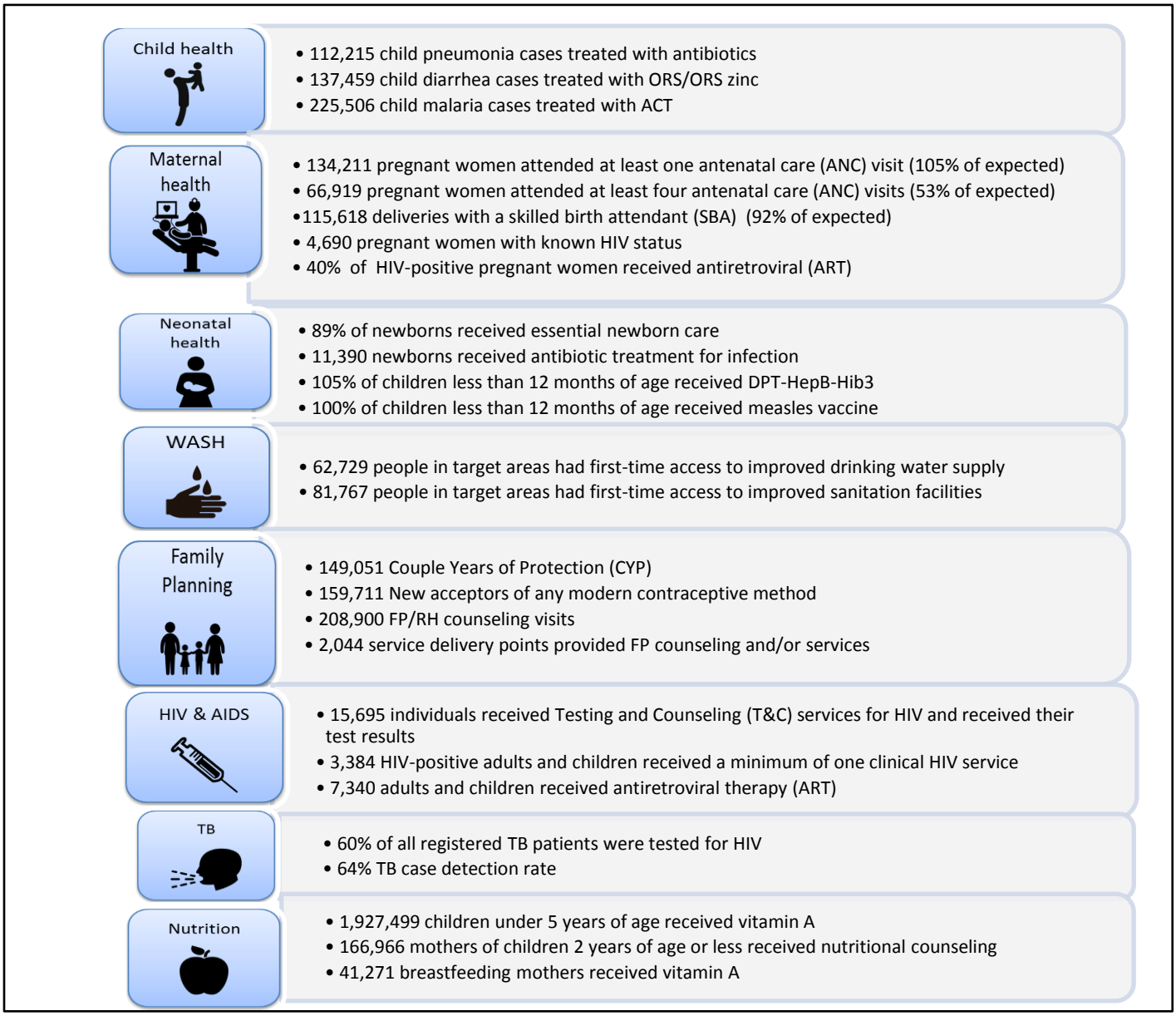
Uptake of curative services: During PY5Q1, the health services utilization rate in six of the eight IHP coordination offices continued to increase, exceeding the 35% national average utilization rate by 2% to 8%. Only two coordination offices, Luiza and Uvira, while slightly improving, continue to have utilization rates just below the national average (32% and 33%, respectively).

Access and availability of MPA/CPA and MPA-plus/CPA-services (IR1): As in previous quarters since PY3, IHP continues to show strong performance in this area, exceeding its 80% target with 1,382 of 1,398 health centers providing the MPA (99%) and 71 of 78 GRHs providing CPA (90%) during the reporting period. While most coordination offices continue to exceed targets for CPA and MPA services at hospitals and health centers, many are unable to meet the criteria for providing CPA-plus and MPA-plus services which requires additional investment in infrastructure, resources, and materials beyond current funding levels. CPA-plus and MPA-plus criteria are under review and are discussed in detail later in the report.

Availability and uptake of specific services: IHP provides materials and support for a broad spectrum of health services at the facility and community level. Service delivery performance remains strong in the areas of family planning; maternal, child, and neonatal health; and nutrition with most targets met or exceeded. Specific

challenges with low performing indicators are further discussed in the report. Key service delivery statistics are presented below in Figure 3.

Figure 3: In PY5Q1, USG-supported health facilities and community care sites in targeted areas provided the following:



PROJECT PERFORMANCE

COMPONENT 1: HEALTH SERVICES

The health sector of the DRC faces significant challenges with a high burden of infectious disease, insecurity in many areas, and poor infrastructure. While maternal and infant mortality are dropping, they remain a priority along with the related challenges of high rates of fertility, domestic violence, malnutrition, and poor access to services. DRC-IHP is helping to increase low-cost, high-impact health services, and access to them, in 78 targeted health zones. Based on innovative, evidence-based strategies, our assistance to the service delivery sector focuses on the primary health care and community levels. Activities for the quarter are summarized below.

Table 2: PY5Q1 Health service key activities at a glance

IR	Strategy	Key activities	Targeted zones
1	Provision of drugs, commodities, products	• Analysis and validation of health zone drug and commodities orders at the provincial level	All coordination offices
		• Drug task force meetings	Kolwezi (all health zones)
		• Quantification Committees	Luiza, Kole, and Tshumbe
		• Follow up on commodities management	Ototo, Vangakete, and Lodja
		• Health zone inventory data checks	Luiza, Kole, and Tshumbe
	Rehabilitation of infrastructure & equipment	• Rehabilitation of health center	Kolwezi (3 health centers)
		• Providing medical materials to health centers	All coordination offices
	Reinforce community care sites/collaborative approach	• 89 new HPP community care sites established	Kole and Tshumbe (3 health zones)
		• Supervision and monitoring of community care sites	Bukavu (10 health zones)
		• Supervision management of essential medicines at community care sites	Kole and Tshumbe
		• Providing drugs, materials, and management tools to community care sites	All coordination offices
	CLTS-WASH	• 68 new water sources	Kole, Tshumbe, Kolwezi, and Luiza
		• 7,628 new latrines constructed	Bukavu, Kamina, Kolwezi, Luiza, and Uvira
2	Clinical and managerial capacity building	• Clinical competencies training	Kamina, Luiza, Uvira, Bukavu, and Kolwezi (14 health zones)
		• Follow-up supervision	Bukavu, Luiza, Kamina, Kolwezi, Uvira, & Mwene Ditu (32 health zones)
	Results-based financing	• FOSACOF quality control evaluations-GRHs	Mwene Ditu, Kolwezi, Lodja, Luiza, Kamina, Tshumbe and Nundu
		• FOSACOF quality control evaluations-health centers	Mwene Ditu, Kolwezi, Lodja, Luiza, Kamina, Tshumbe, and

			Nundu (118 health centers)
3	BCC	• SMS message coupled with community group discussion and home visits	All coordination offices
	Community mobilization	• Rehabilitate CODESAs	All coordination offices except 3 health zones
		• Champion Communities/Champion Men initiatives	All coordination offices

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

Key IHP performance results for IR1 during PY5Q1 are summarized in Table 3 below and discussed in detail in the following section.

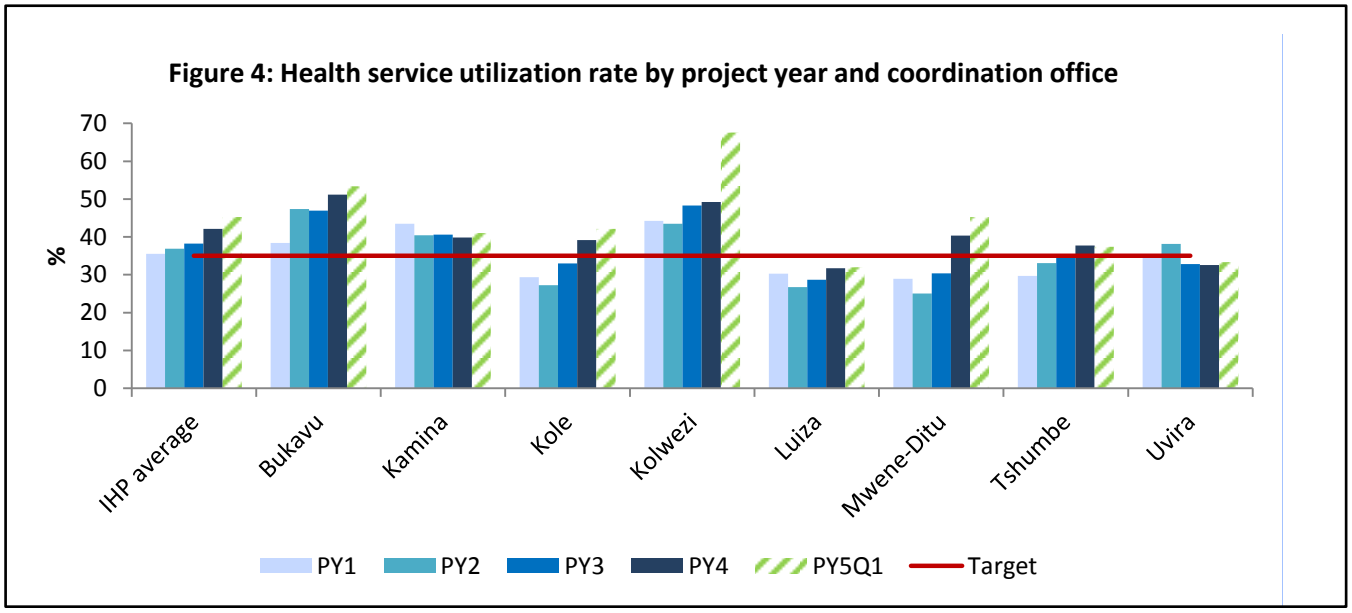
Table 3: Summary of IR 1 key results for PY5Q1 by Sub-IR

Sub-IR	Key Indicators		Results
1.1 Facility-based services and products	Utilization of health care services	🟢	Exceeded targets
	Availability of CPA/MPA	🟢	Exceeded targets
	Availability of CPA+/MPA+	🔴	Below targets
	Availability of medicines and equipment (stock outs)	🔴	Below targets
1.2 Community-based services and products	i-CCM – Pneumonia	🟡	Almost met targets
	i-CCM—Diarrhea	🔴	Below targets
	CLTS-WASH	🔴	Below targets
1.3 Leadership practices	Leadership Development Program desired measureable results achieved	🔴	Below targets

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

Utilization of health care services

During this quarter, the health services utilization rate in six of the eight IHP coordination offices showed continued progress--exceeding the 35% national average by 2% to 8%. Only two coordination offices, Luiza and Uvira, while slightly improving, continue to show utilization rates just below the national average (32% and 33%, respectively) (see Figure 4).



On average, the health utilization rate for curative services in IHP-supported health zones was 45%, up from 42% during the previous quarter (see Table 4). The project is further analyzing the data to examine what factors, in addition to security and geographic challenges, continue to contribute to the low performance of Luiza and Uvira to inform lessons learned and potential way forward for improvement.

Table 4: Curative services utilization (percentage) by month and by coordination office

Coordination	Oct 2014	Nov 2014	Dec 2014	PY5Q1 Average
Bukavu	56	51	53	53
Kamina	43	38	43	41
Kole	41	43	43	42
Kolwezi	62	70	70	68
Luiza	34	32	31	32
Mwene Ditu	44	45	46	45
Tshumbe	31	36	45	37
Uvira	32	33	35	33
Average by month	43	44	46	45

The spike in utilization rate for Kolwezi during this quarter reflects a change in how this coordination office reported on this indicator. Previously, the health facilities reported only patients who were residents of the health zone. However, in PY5Q1, Kolwezi reported total number of patients, including residents and internal migrants/ other non-residents. Since the total internal migrant population is unknown, the office did not re-calculate the total population in the denominator.

This statistical artifact highlights the fact that other areas with large numbers of internal migrants may also be underreporting real use of services, since they report only on community residents. It is difficult to establish actual population figures and determine the proportion of migrants and residents in order to properly adjust the denominator.

Next quarter, IHP will examine health zone records for areas that have significant migrant populations to determine how heavily migrants are using the services, since these figures have important implications for provision of supplies, commodities, and health personnel workload.

Availability of Health Services - Facility-based Minimum Package of Activities (MPA)/Complementary Package of Activities (CPA)

Building the capacity of health centers and hospitals to offer the full spectrum of health services is a key priority of IHP's strategy. As in previous quarters, the project made significant progress in this area, exceeding its 80% target--with 99% of health centers providing the MPA. In addition, 90% (70/78) of GRHs provided CPA during the reporting period (see Figure 5 and Tables 5 and 6). This is a significant improvement from the less than 10% of hospitals and health centers providing these services at the beginning of the project.

Figure 5: Percentage of general referral hospitals offering CPA and health centers offering MPA by project year

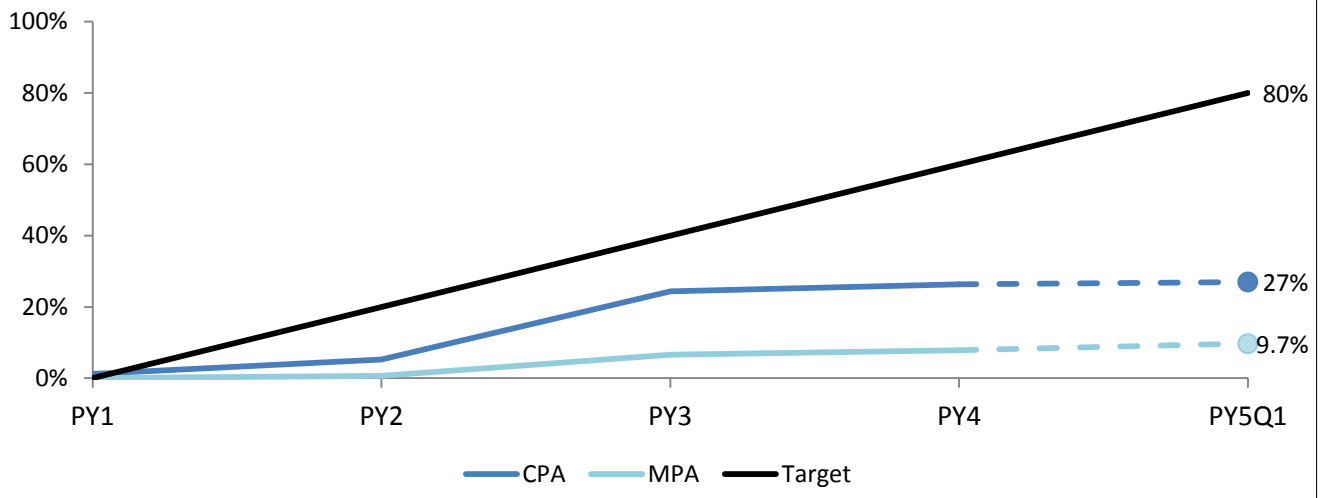


Table 5: Number of general reference hospitals providing CPA during PY5Q1

Coordination	Oct	Nov	Dec	Target	% of target
Bukavu	21	21	21	17	124
Kamina	6	6	6	7	86
Kole	7	7	7	6	117
Kolwezi	7	7	7	6	117
Luiza	9	9	9	8	113
Mwene Ditu	8	8	8	8	100
Tshumbe	8	8	8	6	133
Uvira	4	4	4	4	100
Total	70	70	70	62	113

Table 6: Number of health centers providing MPA during PY5Q1

Coordi-nation	Oct	Nov	Dec	Target	% of target
Bukavu	399	399	399	319	125
Kamina	201	201	201	161	125
Kole	129	129	129	103	125
Kolwezi	105	105	105	85	124
Luiza	170	170	170	136	125
Mwene Ditu	168	168	168	137	123
Tshumbe	118	118	118	95	124
Uvira	92	92	92	82	112
Total	1,382	1,382	1,382	1,118	124

CPA-plus and MPA-plus: While most coordination offices continue to exceed targets for CPA and MPA services at hospitals and health centers, many facilities are unable to meet the additional criteria included in CPA-plus and MPA-plus services. CPA-plus and MPA-plus consist of all services in the MPA and CPA as well as additional specialized services as further discussed below (see Figure 6 and tables 7 and 8 below).

Figure 6: Percentage of general reference hospitals offering CPA-plus and health centers offering MPA-plus by project year

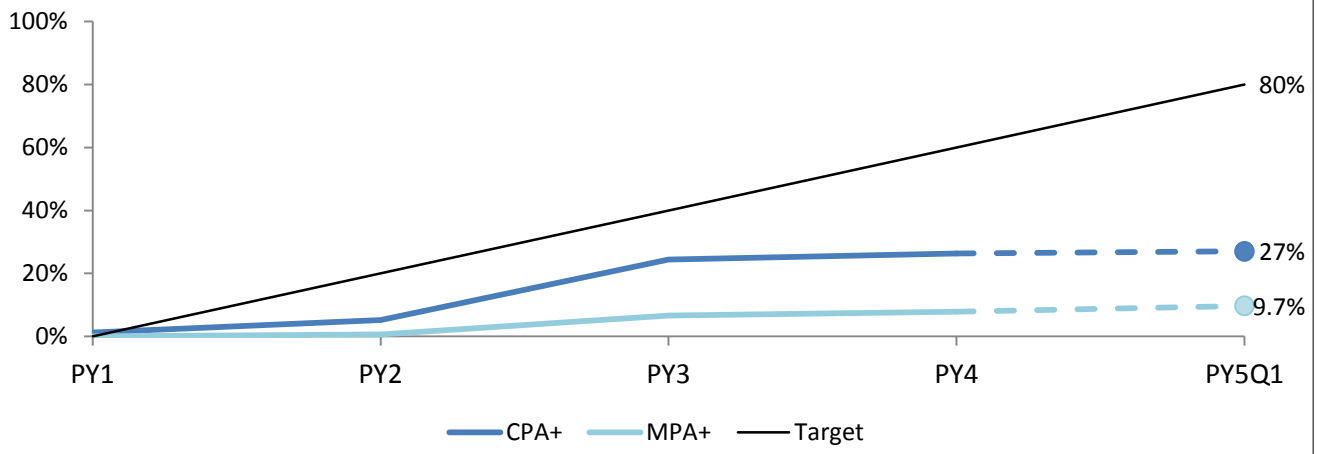


Table 7: Number of general reference hospitals implementing CPA-plus during PY5Q1

Coordination	Oct	Nov	Dec	Target	% of target
Bukavu	12	12	12	18	67
Kamina	0	0	0	6	0
Kole	1	1	1	6	17
Kolwezi	2	2	2	6	33
Luiza	0	0	0	8	0
Mwene Ditu	5	5	5	8	63
Tshumbe	0	0	0	6	0
Uvira	1	1	1	4	25
Total	21	21	21	62	34

Table 8: Number of health centers implementing MPA-plus during PY5Q1

Coordination	Oct	Nov	Dec	Target	% of target
Bukavu	48	48	48	320	15
Kamina	20	20	20	160	13
Kole	1	1	1	104	1
Kolwezi	29	29	29	84	35
Luiza	4	4	4	136	3
Mwene Ditu	21	21	21	136	15
Tshumbe	0	0	0	96	0
Uvira	13	13	13	82	16
Total	136	136	136	1,118	12

It is important to note that health zones which receive more IHP technical assistance and resources have come closer to achieving their CPA-plus/MPA-plus targets than those that do not receive the full scope of IHP interventions. The IHP database in field offices and Kinshasa needs to be set up to consider the new calculation of the MPA/CPA-plus indicators as indicated in Modification #12 to the IHP agreement. The PY5Q2 report will reflect the new figures.

Table 9 highlights specific CPA-plus/MPA-plus criteria that would require additional financial resources for hospitals and health centers to conduct training activities to offer a full complement of services.

Table 9: CPA-plus and MPA-plus components requiring additional resources to achieve targets
IHP MPA-Plus
1. **Preventive activities**
• PMTCT, including counseling, HIV testing, antiretroviral prophylaxis, family planning counseling, and cotrimoxazole, nutrition counseling, and referrals for treatment, if indicated
• Cotrimoxazole for exposed infants
• Distribution of IPTp and LLINs
• HIV information
2. **Curative activities**
• Clinic-based IMCI including treatment of malaria
• HIV and AIDS: PMTCT and blood transfusion testing, monitoring patients on antiretroviral therapy who have been diagnosed at GRH, management of opportunistic infections (Cotrimoxazole) and related nutritional support services
• IPTp for pregnant women
3. **Promotional activities**
• Environmental sanitation
• Improved latrines
5. Community activities
• Community-based IMCI (c-IMCI) including early recognition and referral for danger signs (for malaria)
• Potable water improvements: spring and well capping, improved water distribution systems, community water treatment
• Disease control: use of LLINs, environmental sanitation, etc.
IHP CPA-plus
1. Specialized services
• Fistula repair
• PMTCT-plus, to include provision and monitoring of ARV prophylaxis to HIV-infected women and exposed infants
• TB-HIV co-infection screening and treatment (entry point is PMTCT)
2. Laboratory testing and analyses
• HIV (with PMTCT as point of entry)

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. As part of its support for IHP, SIAPS carried out the following activities during PY5Q1:

Ensured the availability of drugs in health facilities

- In October 2014, SIAPS supported estimating drug needs for year 5 of the IHP. The order has been confirmed with the vendor, IDA, and the entire delivery is expected before June 2015.

- SIAPS contributed to the development of the IHP close-out plan and estimating the drug order for the post-IHP period.
- As in previous quarters, SIAPS followed up on deliveries of the second IHP drug order from PY3 with the IDA supplier and updated health zone credit lines at the CDRs. As of August 31, 2014, shipments received by the CDRs/warehouses covered 96% of the expected global delivery from IDA, and this situation has not changed through December 2014 (see Table 10).

Table 10: Status of delivery of IHP PY3 second order to IDA

Province	Warehouse/CDR	Order value (USD)	Delivery value as of December 31, 2014	% delivered	Value of remaining deliveries	% of remaining deliveries
Sud Kivu	**APAMESK**	435,721	427,936	98	7,785	2
Katanga	**CEDIMEK**	242,189	229,287	95	12,902	5
	KOLWEZI	163,156	151,390	93	11,766	7
Kasaï Occidental	**CADIMEK**	256,361	245,787	96	10,574	4
Kasaï Oriental	**CADMEKO**	249,789	242,891	97	6,898	3
	FODESA	222,680	222,230	100	451	0.2
Total order/delivery		**1,569,896**	**1,519,520**	**96**	**50,376**	**4**

*Numbers may not match exactly due to rounding

- With coordination by SIAPS, an overstock of 36,000 doses of adult ACT was redeployed from Lubumbashi to Bukavu. This stock expires in April 2015, but efforts are being made to transport it quickly to the health zones with the assistance of IHP and the National Malaria Control Program (PNLP in its French acronym) in Sud Kivu so it can be used prior to its expiration date.
- At the CDRs, SIAPS continued its usual support in the development of distribution plans and requisitions for the quantification of drugs to cover the quarterly needs of health facilities supported by IHP. This exercise was done for both products bought with IHP funds and for commodities from the President's Malaria Initiative (PMI), family planning, and HIV commodities.
- After receiving 720,000 LLINs in Sud Kivu province on behalf of IHP and PMI Extension, SIAPS coordinated the reception of additional LLINs in the provinces of Katanga and Kasaï.

Strengthen the management of essential medicines and medical supplies

- SIAPS provincial teams continued to consolidate drug consumption data from health zones and distribution records from the CDRs. During the last quarter, SIAPS analyzed CDR management reports and provided them with feedback for improvement (specifically in Sud Kivu).
- SIAPS provided financial and technical support to encode MEG management data from 27 health zones supported by IHP. This work was made available to update data on average monthly consumption for a few health zones.
- SIAPS continued its support for CDR supply planning to IHP- and PMI-supported health zones, and for the adjustment of credit lines and monitoring of storage conditions.

Support the quarterly management oversight of drugs in health zones and health facilities supported by IHP

In collaboration with the IHP staff and the DPS, SIAPS conducted supervision visits to two health zones (Dilala and Manika) in Kolwezi from October 6-7, 2014, and 13 health zones in Sud Kivu from December 2-14, 2014. Supervision visits focused on the following activities:

- Orient health zone supervisors on the use of thermo hygrometers provided to health facilities by IHP
- Monitor the recovery of funds generated by drugs in health facilities
- Keep management records and tools updated
- Actively collect medicines management data.

Other activities

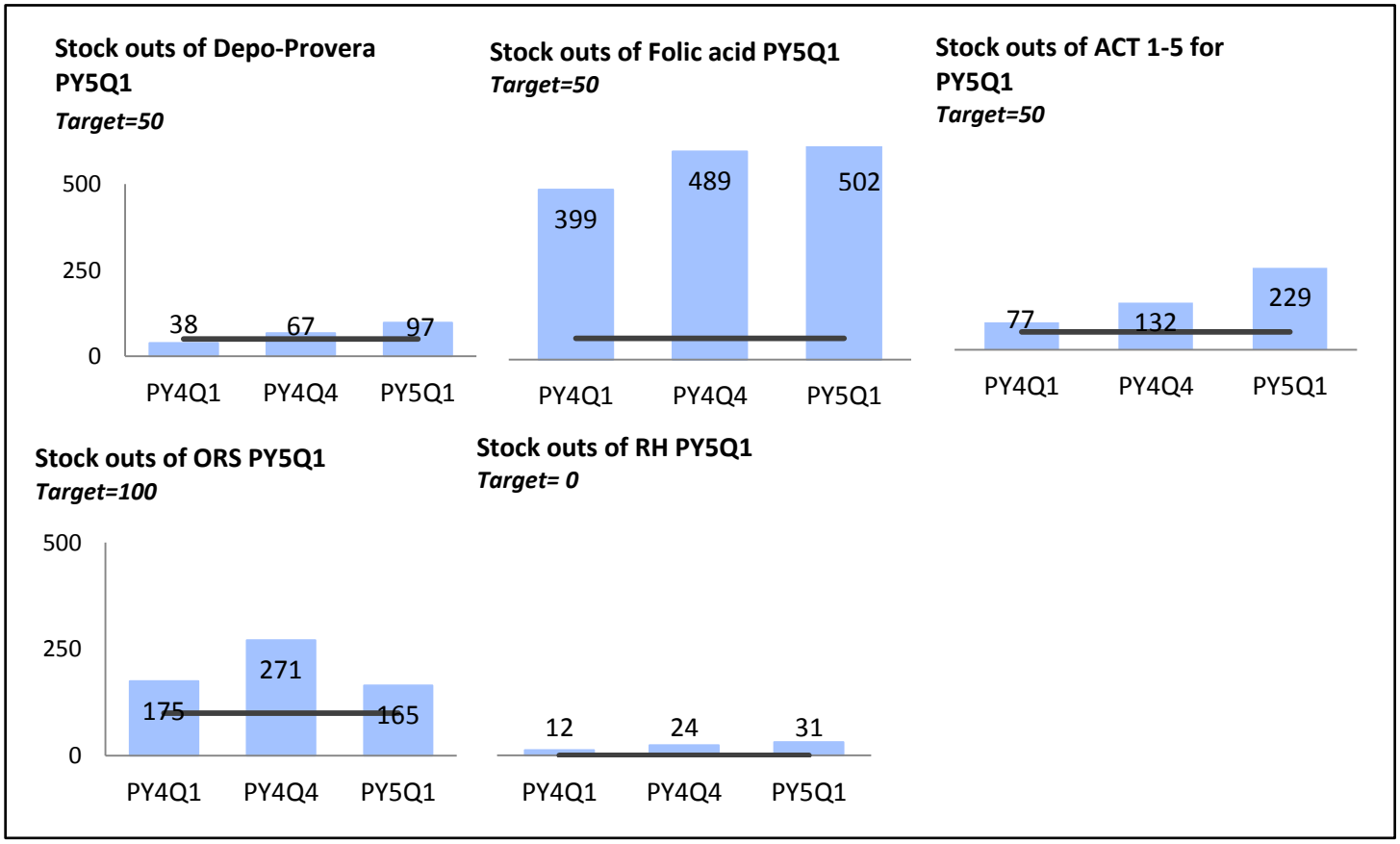
In order to improve storage conditions of drugs managed by MSH in Kinshasa, SIAPS conducted a survey that led to the identification of a new warehouse that meets the minimum storage standards. The move of the stock from the current warehouse will occur by March 2015. Additional activities included:

- Monitor and obtain import authorization for drugs from MOH's Third Direction (DPM);
- Produce the Procurement Plan and Monitoring Report for contraceptives (PPMRc), integrating information about family planning commodities managed by IHP, UNFPA, and PSI;
- Participate in and support the weekly meetings of the technical staff in the IHP coordination offices;
- Verify support documents of the invoices submitted for payment by the CDRs to MSH DRC Contracts Unit.

Tracer drug stock outs

Difficulty estimating needs for drugs and commodities, plus fragmented supply and distribution systems, continue to lead to stock outs at hospitals and health centers (see Figure 7). Procedures designed to control fraud can also slow down procurement. In addition, medicines are often held at the regional level until 30% of the expected payment is received. For example, Kamina, Kole, Tshumbe, and Luiza submitted their drug orders in September 2014, yet the orders did not arrive at the health facilities until December 2014 or January 2015. Tshudi Loto prepared its order in September 2014; it was delivered in January 2015.

Figure 7: PY5Q1 stock outs for tracer drugs



A few areas, including Kolwezi and Mwene Ditu, are reducing stock outs of tracer drugs and consistently perform better on this indicator. In addition, Depo-Provera and ORS are now more consistently available across all coordination offices. But folic acid and other tracer drug stock outs, due to longstanding supply chain issues, continue to be high (see Table 11). Most of the health zones received their pharmaceuticals in November 2014. All deliveries of PY3 pharmaceuticals to CDRs were completed in early September 2014; however, it can take another two months to complete the following steps: CDR official reception of pharmaceuticals with the involved parties (CDR, IHP, PIP, and SIAPS); sharing information on available stocks with health zones; and receiving, processing, and delivering health zone orders.

Table 11: Stock outs of tracer drugs by coordination office for PY4Q1, PY4Q4, and PY5Q1															
	Depo-Provera (target = 50)			ORS (target = 50)			Folic acid (target = 50)			Rifampin isoniazid (target = 0)			ACT 1-5 years (target = 50)		
	PY4 Q1	PY4 Q4	PY5 Q1	PY4 Q1	PY4 Q4	PY5 Q1	PY4 Q1	PY4 Q4	PY5 Q1	PY4 Q1	PY4 Q4	PY5 Q1	PY4 Q1	PY4 Q4	PY5 Q1
Bukavu	26	12	9	4	4	22	84	56	75	4	2	19	6	13	27
Kamina	0	20	49	10	38	53	68	120	135	2	18	7	22	26	106
Kole	4	29	35	23	44	39	47	92	83	0	3	1	4	6	53
Kolwezi	0	0	0	0	0	4	14	0	0	0	0	0	3	1	7
Luiza	1	0	0	73	13	0	78	67	87	2	1	2	33	40	21
Mwene Ditu	0	0	0	0	76	5	28	24	13	0	0	0	0	22	0
Tshumbe	7	6	4	61	93	41	56	48	40	4	0	2	6	15	14
Uvira	0	0	0	4	3	1	24	82	69	0	0	0	3	9	1
Total	38	67	97	175	271	165	399	489	502	12	24	31	77	132	229

To address these bottlenecks, IHP is implementing the following activities:

- **Provincial level:** In collaboration with SIAPS, IHP supported meetings of provincial essential drug committees in Luiza, Kolwezi, Bukavu, Mwene Ditu, Kamina, and Sankuru to analyze and validate health zone medicine orders.
- **Health zone level:** IHP set up drug quantification committees to help estimate actual needs. In addition, program staff conducted joint missions with the Ministry of Health and SIAPS to monitor stock management in health zones with frequent stock outs (Ototo, Vangakete, and Lodja). IHP also analyzed data on drugs delivered to rapidly redistribute medicines to Luiza and Wembonyama as needed during the quarter.

IHP will continue to work with SIAPS to ease bottlenecks that contribute to high stock out levels at the facility level. Consolidating the supply chain, streamlining procedures for ordering drugs, and building capacity to manage inventories and quantify drug orders will all help assure adequate supplies of medicines and commodities throughout the system.

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

Integrated Community Case Management (i-CCM)

Over the course of the project, IHP has established 382 community health sites in 38 health zones focused on the three main childhood health threats in the DRC: malaria, pneumonia, and diarrhea. Implementing evidence-based i-CCM strategies is critical to increasing access to vital health services for vulnerable populations, especially in hard-to-reach areas. Improving linkages between the community and the formal health sector through strong referral/counter-referral networks helps to assure an integrated approach to case management of key illnesses that contribute to high child mortality.

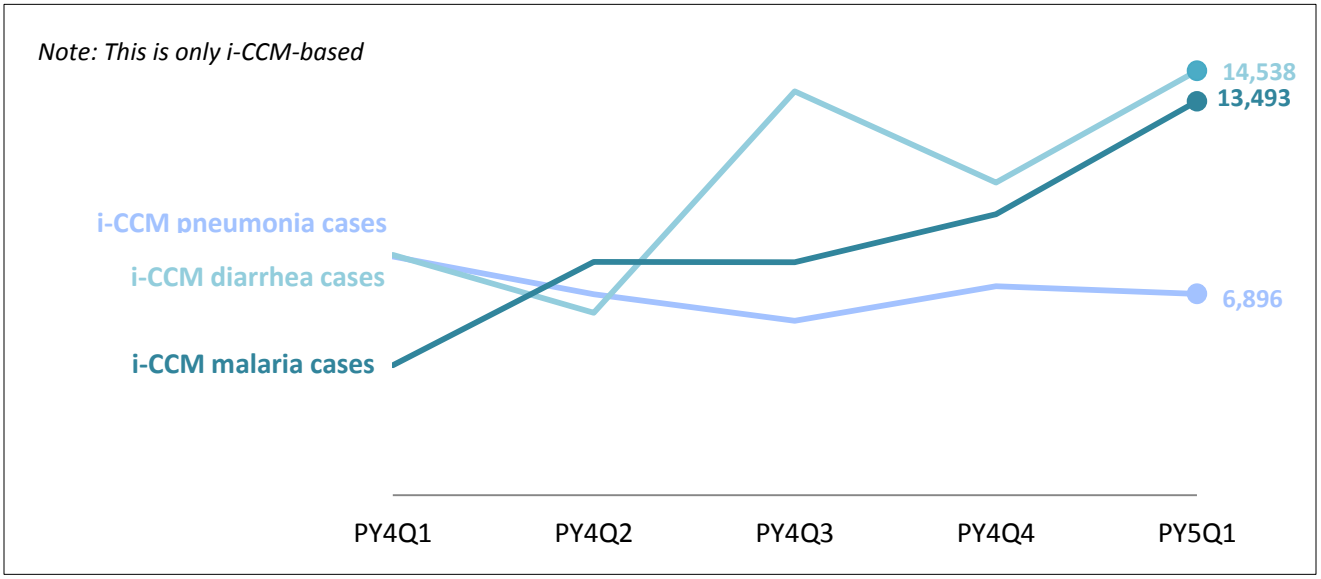
Given that IHP is now in its final year, the project created no new IHP community care sites, but did help establish 89 additional sites under the Health for Poorest Populations (HPP) project. HPP is a co-funded collaboration between USAID (through IHP) and UNICEF (Canadian funds); MSH is the implementing partner. In addition, in collaboration with provincial leadership, IHP conducted supervision visits to community care sites in Sud Kivu and the health district of Sankuru in the following health zones: Kaziba, Nyangenzi, Mubumbano, Idjwi,

Bunyakiri, Kalonge, Vangakete, Omendjadi, Lodja, and Wembonyama. These supervision visits reinforce the capacity of community care sites to provide services as well as advocate for community leaders to encourage community members to use those services.

IHP carried out monitoring visits to ensure that, as per guidelines, medicines are being distributed to community care sites based on the lines of credit of their respective health areas. The project monitored Kole and Tshumbe coordination areas to verify that medicines for community care sites are prepared by the CDRs and pass through the health centers. IHP continues to furnish medicines, management tools, and materials to community care sites in all project areas.

Key services offered by community care sites include treatment of childhood illnesses such as pneumonia, diarrhea, and malaria. Over the last year of the project, the number of cases treated at community care sites has declined slightly for pneumonia (76% of target) but the number of appropriately treated malaria and diarrhea cases has increased. There are two main reasons for the slight decline: (1) the CHWs at the i-CCM sites have improved diagnostic and data collection and reporting of pneumonia cases; and (2) there has been a delay in the replenishment of cotrimoxazole and amoxicillin stocks.

Figure 8: Number of pneumonia, diarrhea, and malaria cases treated at community care sites from PY4Q1 to PY5Q1



Over the course of PY5Q1, health workers at community sites treated 6,896 cases of childhood pneumonia, down slightly from 7,151 cases the previous quarter. However, while cases at Bukavu, Kamina, and Mwene Ditu declined, three health zones--Kole, Luiza, and Tshumbe--saw a significant rise in cases treated (see Table 12). There are two main reasons for the slight decline in treatment of malaria: (1) the CHWs at the i-CCM sites have improved diagnostic and data collection and reporting of pneumonia cases; and (2) the delay in replenishment of cotrimoxazole/amoxicillin stocks in some areas (which has since been corrected).

Table 12: Childhood pneumonia treated with antibiotics by i-CCM sites and total cases treated: health facility and i-CCM						
i-CCM sites				**PY5Q1 health facility + i-CCM sites**		
Coordination district	PY4Q4	PY5Q1 trend* (Oct-Dec)	PY5Q1 total	Total	Target	% of target achieved
Bukavu	2,236		625	35,026	42,806	82
Kamina	1,639		756	20,963	23,617	89
Kole	1,029		1,668	8,191	10,333	79
Kolwezi	119		151	4,005	10,333	39
Luiza	314		1,029	12,408	16,237	76
Mwene Ditu	1,456		760	19,984	23,617	85
Tshumbe	235		1,739	7,554	10,333	73
Uvira	123		168	4,084	10,333	40
Total	**7,151**		**6,896**	**112,215**	**147,607**	**76**

*Note: Y axis for PY5Q1 trend data is not comparable by coordination district. Sparkline axis is automatically set in Excel.

For diarrhea, IHP achieved 70% of the target of 196,812 cases treated this quarter. Most sites were able to treat more cases of diarrhea with ORS or ORS plus zinc for children under five than in the previous quarter. In fact, Bukavu, Luiza, and Tshumbe nearly doubled the number of cases treated. Only Kamina had a slight decline (from 3,888 to 3,500 cases) (see Table 13).

Table 13: Children under five with diarrhea treated with ORS or ORS plus zinc by i-CCM sites and total cases treated (health facility and i-CCM)						
i-CCM sites				**PY5Q1 health facility + i-CCM sites**		
Coordination District	PY4Q4	PY5Q1 trend* (Oct-Dec)	PY5Q1 total	Total	Target	% of target achieved
Bukavu	698		1,279	31,663	57,076	55
Kamina	3,888		3,500	23,897	31,490	76
Kole	2,269		2,713	9,846	13,777	71
Kolwezi	239		250	5,958	13,777	43
Luiza	605		1,610	20,257	21,649	94
Mwene Ditu	1,553		2,200	21,996	31,490	70
Tshumbe	1,004		2,582	9,514	13,777	69
Uvira	456		404	14,328	13,777	104
Total	**10,712**		**14,538**	**137,459**	**196,812**	**70**

*Note: Y Axis for PY5Q1 trend data is not comparable by coordination district. Sparkline axis is automatically set in Excel.

All coordination areas except Kamina, Kolwezi and Tshumbe showed a significant increase in malaria cases treated (see Table 14). This is an encouraging trend after several quarters of decline.

Table 14: Children under five with malaria treated by i-CCM sites and total cases treated (health facility + CCM)						
	i-CCM sites			PY5Q1 health facilities+ i-CCM sites		
Coordination District	PY4Q4	PY5Q1 Trend* (Oct-Dec)	PY5Q1 Total	Total	Target	% of target achieved
Bukavu	443		1,276	58,353	N/A	N/A
Kamina	3,568		2,286	39,137	N/A	N/A
Kole	142		2,509	10,130	N/A	N/A
Kolwezi	875		727	15,912	N/A	N/A
Luiza	293		811	33,412	N/A	N/A
Mwene Ditu	1,595		5,394	37,138	N/A	N/A
Tshumbe	2,163		1,870	17,354	N/A	N/A
Uvira	544		624	16,074	N/A	N/A
Total	**9,623**		13,493	225,506	N/A	N/A

*Note: Y Axis for PY5Q1 trend data is not comparable by coordination district. Sparkline axis is automatically set in Excel.

IHP's work with health facilities and community care sites contributes to DRC's commitment to reducing under-five mortality as set out in the "A Promise Renewed" (APR) strategy. In June 2012, the DRC participated in the Global Child Survival Call to Action meeting held in Ethiopia which formed the basis for the APR initiative. 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 to address bottlenecks and barriers in the health system. The Action Framework aims to reduce, by the year 2015, under-five mortality by 48% and maternal mortality by 31%--saving the lives of 430,000 children and 7,900 mothers. IHP supports 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 HPP[3]). In 25 zones, IHP is the primary provider of support.

IHP's contributions to APR objectives during the quarter are detailed in the box below.

[3] HPP is financed by UNICEF and implemented by MSH. The geographical coverage of the three main approaches included in this project is as follows: (1) Family kits: implemented in six health zones; (2) i-CCM sites: implemented in 22 health zones; and (3) Promotion of essential family practices: implemented in all 27 health zones. By the end of 2015, it is anticipated that the family kits approach will be implemented in a total of 12 health zones, while other approaches will cover the 27 health zones.

A Promise Renewed

Strategy 1: Universal coverage for vulnerable populations (pregnant women and children under five) family kits/voucher approach: IHP continued to assist with the distribution of HPP-funded family kits. During the current reporting period, the health zones of Fungurume (Kolwezi coordination) and Kinkondja (Kamina coordination) were included in addition to four other health zones (Dibaya, Ndekesha, Kanda Kanda,, and Vangakete). Across 18 health areas within six health zones, IHP distributed 32,727 IMCI kits, 3,009 antenatal consultation kits and 2,184 birthing kits to 30,110 households.

The project plans to cover all health areas located in these six health zones. In the 25 red health zones, additional community care sites have not been established. The project carried out post-training monitoring and joint supervision with the provincial health management team in the health zones of Bunyakiri, Kalonge, Kaziba, Nyangenzi, Mubumbano, Idjwi (Bukavu), Vangakete, Omendjadi, Lodja (Kole), and Wembonyama (Tshumbe). The monitoring will continue during the next reporting period in the low-performing health zones covered by the coordination office of Kolwezi.

Strategy 2: Support for health services at the peripheral level including reference facilities*:* The project continued to provide medical supplies and small equipment to health facilities in the priority health zones. During the current reporting period, the maternity clinic of Ndekesha was rehabilitated in order to bolster the packet of activities implemented there.

Strategy 3: Improve health zone governance and management: IHP provided technical and financial support in the development of Annual Operational Plans in the health zones managed by the coordination offices of Luiza, Kole, and Tshumbe, in addition to the priority health zones. This support will be ramped up to the all health zones. In addition, the project plans to carry out a routine data quality analysis in certain health zones managed by the coordination offices of Kolwezi, Kole, and Tshumbe in order to improve reporting.

Strategy 4: Strengthen human resources (health facility service providers: staff motivation, quality training): Twenty-seven health providers participated in a competency-based MNCH training in the health zone of Fungurume. A post-training monitoring mission was carried out in the health zone of Kabongo.

Strategy 5: Communication for Development: Several awareness-raising campaigns were organized in the priority health zones.

1. About 149 mothers attended an exclusive breastfeeding session in the health zones of Mutshatsha and Fungurume (Kolwezi coordination)
2. 165 pregnant women attended an ANC 4 learning session in the health zone of Bunkeya
3. 98 child caregivers attended a session on the utilization of health care services in Malemba Nkulu
4. 264 child caregivers attended a vaccination learning session in Lodja and Vangakete

During the next reporting period, IHP plans to develop communication tools for maternal and child health, specifically on diarrhea.

Strategy 6: Community Mobilization: 33 Champion Communities organized awareness-raising campaigns while 1,306 CODESA action plans to address community health matters were approved.

WASH Activities

Another key IHP strategy for improving health is making sure that more people have access safe drinking water and improved sanitation facilities. During this quarter, IHP and partners constructed 68 new sources of clean water and 7,628 new latrines. This infrastructure provided 62,729 people with access to safe drinking water and 81,767 people with access to improved sanitation facilities for the first time (Table 15). While such progress is meaningful to individual communities, the numbers remain below the target of 362,601 individuals with first-time access to improved drinking water (17% achievement) and improved sanitation services (23% achievement).

Table 15: IHP WASH indicators results per IHP coordination for PY5Q1

	Target	First-time access to improved drinking water supply as a result of USG support		First-time access to improved sanitation facilities as a result of USG support	
		n	%	n	%
Bukavu	87,503	0	0	23,249	27
Kamina	33,454	0	0	1,538	5
Kole	37,472	11,068	30	2,474	7
Kolwezi	18,039	13,593	75	23,194	129
Luiza	50,075	23,182	46	8,855	18
Mwene Ditu	80,670	10,105	13	0	0
Tshumbe	27,367	4,781	18	20,000	73
Uvira	28,021	0	0	2,457	9
PY5Q1 total	**362,601**	**62,729**	**17**	**81,767**	**23**

IHP WASH teams increased supportive supervision in areas with low performance for water and sanitation initiatives (Mwene Ditu and Kole for water and sanitation access and Kolwezi for water access). Supervision visits started in November in Kolwezi and will continue into the second quarter of PY5 to provide technical assistance to integrate information on the importance of a safe community water source into prevention awareness activities taking place in this region. IHP conducted joint supervision visits with health district teams in Uvira and Kolwezi. In Kolwezi and Kole, IHP support contributed to an increase from 0 to 13,593 and from 659 to 11,068 (respectively) individuals with first time access to improved drinking water during this quarter.

In addition, IHP paid delayed incentives to reinvigorate efforts to construct and rehabilitate water and sanitation facilities in Kole and Mwene Ditu. This, along with increased involvement of village chiefs in leading CLTS projects and awareness raising activities in their areas, will likely contribute to further gains in the next quarter in these areas. The project will continue to discuss with USAID the need to adjust or refocus targets.

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

Leadership Development Program

The 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 facilitates the

transfer of skills and knowledge to help health workers face and address challenges, create an environment that motivates staff, and reinforce 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 PY5Q1, a total of 54 LDP projects were implemented and evaluated, i.e., one project per LDP team. Most of the LDP projects finalized during this quarter focused on improving TB or maternal and child health services. In all, 24 teams achieved their expected results (see Table 16).

Table 16: LDP projects per technical area during PY5Q1

Areas	Number of projects implemented	Number of projects achieving expected results	Achievement rate (in %)
MNCH	24	15	63
Family planning	5	3	60
TB	13	3	23
HIV	1	0	0
L+M+G	3	0	0
Utilization of services	8	3	38
Total	54	24	44

Several health zones (Dekese, Dibaya, Luiza, Luambo, and Ndekesha) achieved significant improvement in uptake of ANC4 services, ranging from 6% to 22% over target, representing actual gains of 20% to 50% over baseline. More follow-up could encourage teams to achieve their results as an additional 6 teams were within 5% of successfully achieving their targets. Some teams perhaps set unrealistically high targets (i.e. improving IPTp rates by 75% in a 6 month period) but still made important gains in uptake and quality of services. IHP will increase follow-up of LDP teams to help improve achievement rates and foster knowledge exchange between teams to share successful leadership and management practices for improving service delivery. IHP plans to thoroughly document lessons learned on the LDP in the final report.

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

During PY5Q1, IHP continued to support quality improvement of MPA-plus and CPA-plus services through the following activities: on-the-job provider competency training, including briefings during monthly monitoring meetings and regular supportive supervision visits; FOSACOF; results-based financing; and referral systems strengthening.

Key IHP performance results for IR2 during PY5Q1 are summarized in Table 17 below and discussed in detail in the following sections.

Table 17: Summary of key IR 2 results for PY5Q1			
	Key indicators		**Results**
	2.1 Clinical & management capacity		
Maternal health	• Service delivery (ANC 1, SBA)		Exceeded targets
	• Service delivery (ANC 4)		Almost met targets
	• Quality of care (AMTSL, PPV)		Almost met targets
Neonatal health	• NN receiving essential care		Almost met targets
	• Newborns receiving antibiotics for infection		Exceeded targets
Child health	• Vaccinations (under 12 months)		Exceeded targets
	• Pneumonia, diarrhea, malaria treatment		Almost met targets
Family planning	• Service delivery (counseling, new adopters)		Exceeded targets
	• Couple Years of Protection		Exceeded targets
	• Service delivery points		Exceeded targets
Nutrition	• Children under 5 receiving vitamin A		Exceeded targets
	• Pregnant women receiving iron folate		Exceeded targets
	• BF mothers receiving vitamin A		Below targets
	• Nutritional counseling		Exceeded targets
Malaria	• Service delivery (IPTp)		Almost met targets
	• Commodities purchased		Below targets
	• Commodities distributed		Below targets
	• Health workers trained		Below targets
HIV and AIDS	• Service delivery (testing and counseling, HIV services, ART, new enrollees)		Exceeded targets
	• Service delivery and prevention (known status, key populations reached)		Almost met targets
	• Service delivery (% ART, PMTCT, TB screen, TB ART, Lab)		Below targets
Tuberculosis	• Quality services		Below targets
	• TB case detection rate		Almost met targets
	• MDR TB cases detected		Below targets
Gender-based violence	• Health care workers trained in GBV service		Below targets
	• GBV service delivery		Exceeded targets
	• GBV BCC campaigns		Below targets
2.2 Minimum quality	• HC meeting minimum FOSACOF standards		Met targets
	• GRH meeting minimum FOSACOF standards		Met targets
2.3 Referral systems	• Patients referred to HC		Exceeded targets
	• Patients referred to GRH		Exceeded targets

Due to financial constraints during PY4, the project was unable to implement all of the planned malaria training activities. No additional trainings were included in the PY5 workplan to close the training gap. In the next quarterly report, we will be able to comment on whether the IHP-supported integrated supervision visits through subgrants with the health zones produced an improvement in malaria commodity distribution and service utilization. Performance on three TB indicators were above 94%, with an outstanding result of 227% for TB/MDR (please see comments in the TB section of the report). The supply chain of TB and malaria

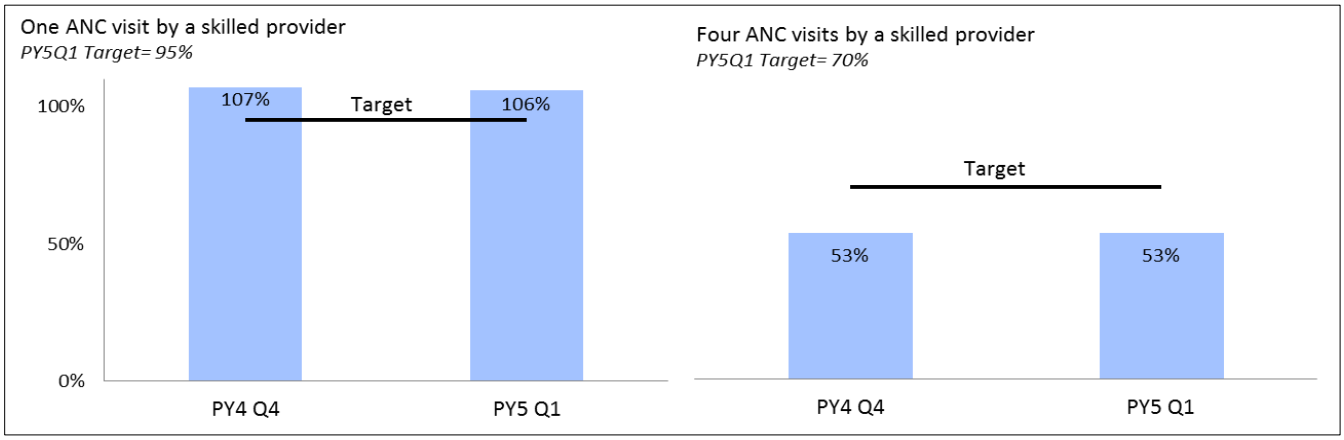
commodities, particularly to the CDR level, remains a challenge. IHP will continue to discuss these challenges with USAID, and will meet specifically with the PMI team to review and clarify concerns on malaria performance.

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

Maternal, Newborn, and Child Health (MNCH)

During this quarter, IHP achieved 106% of its 95% target for the number of pregnant women attending at least one antenatal care (ANC) visit (see Figure 9).

Figure 9: Pregnant women attending at least one antenatal care (ANC1)/ four antenatal care (ANC4) visits with skilled providers at USG-supported health facilities



The coordination offices in Bukavu, Kole and Kolwezi exceeded their targets; Kamina, with 92% of its target met, was the lowest performing (see Table 18). Please note that Figure 9, above, reports on the indicator "% of pregnant women attending one antenatal care visit…" (106%) while Table 18, below, reports the number of pregnant women, with 102% representing the percent of the target achieved, as stated in the column title. The same comment applies to women attending four antenatal care visits.

Table 18: Number of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities

	Oct-14	Nov-14	Dec-14	PY5Q1	Target	% of target achieved
Bukavu	13,741	13,804	13,439	40,984	38,326	107
Kamina	6,478	6,524	6,382	19,384	21,145	92
Kole	3,591	3,419	3,306	10,316	9,251	112
Kolwezi	4,061	3,589	3,607	11,257	9,251	122
Luiza	4,825	4,685	4,648	14,158	14,537	97
Mwene Ditu	6,862	6,767	6,971	20,600	21,145	97
Tshumbe	2,840	2,808	2,851	8,499	9,251	92
Uvira	2,953	3,180	2,880	9,013	9,251	97
Total	**45,351**	**44,776**	**44,084**	**134,211**	**132,157**	**102**

Priorities next quarter should include a Routine Data Quality Assessment (RDQA) in Bukavu, Kole, and Kolwezi to validate the numbers reported, as well as a monitoring and supervision visit to health zones in Kamina to understand obstacles and provide technical assistance to improve the number of pregnant women attending at least one antenatal care visit in these health zones.

ANC4 visits: The number of pregnant women who completed at least four ANC visits decreased slightly this quarter--from 67,364 in PY4Q4 to 66,919, although the percentage remains the same at 53% (See Figure 9 above).

This quarter, seven out of eight coordination offices did not meet their targets, with a performance as low as 47% (see Table 19). The health zones that are mainly contributing to Bukavu, Uvira, and Kamina's underperformance have ANC4 visit rates below 50%. In Kamina, eight out of nine health zones are concerned; Kayamba health zone where RBF is implemented has an ANC4 visit rate of 65%. In Uvira office the Uvira health zone (50%) and Nundu RBF health zone (49%) have the best rate. The Haut Plateaux health zone has the lowest rate with only 13% coverage of ANC4, whereas Lemera and Ruzizi performed at 46%.

Table 19: Number of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities

	Oct-14	Nov-14	Dec-14	PY5Q1	Target	% of target achieved
Bukavu	5,009	5,134	5,599	15,742	28,240	56
Kamina	2,450	2,532	2,328	7,310	15,581	47
Kole	2,311	2,371	2,278	6,960	6,817	102
Kolwezi	1,311	1,626	1,622	4,559	6,817	67
Luiza	3,080	3,152	2,921	9,153	10,712	85
Mwene Ditu	4,422	4,414	4,531	13,367	15,581	86
Tshumbe	1,957	1,884	1,968	5,809	6,817	85
Uvira	1,255	1,426	1,338	4,019	6,817	59
Total	**21,795**	**22,539**	**22,585**	**66,919**	**97,379**	**69**

IHP has found this target particularly difficult to achieve, despite awareness-raising and other facility- and community-based efforts. Women in the project areas tend to delay ANC visits until later in pregnancy--often during the third trimester. This behavior appears linked to traditions, including a norm of not announcing pregnancy early. To inform future programming, IHP will further analyze why particular health zones do or do not meet targets.

Deliveries with a skilled birth attendant (SBA): This quarter the number of deliveries with a skilled birth attendant (115,618), decreased compared to the previous quarter 116,486. However the percentage of deliveries with a skilled birth attendant (SBA) is 92% and exceeds the PMP target (85%) for PY5Q1.

Table 20: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities						
	Oct-14	**Nov-14**	**Dec-14**	**PY5Q1**	**Target**	**% of target achieved**
Bukavu	11,905	10,766	11,155	33,826	34,291	99
Kamina	5,361	4,849	4,955	15,165	18,920	80
Kole	3,040	2,916	2,957	8,913	8,277	108
Kolwezi	3,605	3,507	3,371	10,483	8,277	127
Luiza	4,669	4,435	4,356	13,460	13,007	103
Mwene Ditu	6,435	6,340	6,463	19,238	18,919	102
Tshumbe	2,569	2,531	2,569	7,669	8,277	93
Uvira	2,276	2,373	2,215	6,864	8,277	83
Total	**39,860**	**37,717**	**38,041**	**115,618**	**118,246**	**98**

The coordination offices of Kole, Kolwezi, Luiza, and Mwene Ditu exceeded their PY5Q1 target, but Kamina and Uvira were below target at 80% and 83% respectively (see Table 20).

IHP will continue to assist the health zone management teams to provide supportive supervision and monitoring visits to head nurses to work on improving infrastructure and services. The project will also encourage community leaders to conduct outreach on the advantages of giving birth at health facilities, and promote community-level follow up for pregnant women, particularly in the last month of pregnancy.

Active Management of the Third Stage of Labor (AMTSL) and Postpartum/Neonatal visits: The number of women receiving Active Management of the Third Stage of Labor (AMTSL) increased slightly from 109,188 in PY4Q4 to 109,349 in PY5Q1 (see Table 21). The overall performance for number women who delivered with AMSTL in PY5Q1 is 93%, which is lower than the performance in PY4Q1 (100%) and PY3Q1 (105%). The coordination offices that did not meet their expected performance include Bukavu (91%), Tshumbe (89%), Kamina (79%), and Uvira (76%).

Table 21: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs						
	Oct-14	**Nov-14**	**Dec-14**	**PY5Q1**	**Target**	**% of target achieved**
Bukavu	10,964	9,800	10,388	31,152	34,291	91
Kamina	5,306	4,727	4,900	14,933	18,920	79
Kole	2,705	2,669	2,466	7,840	8,277	95
Kolwezi	3,192	2,991	3,,283	9,466	8,277	114
Luiza	4,618	4,426	4,350	13,394	13,007	103
Mwene Ditu	6,294	6,264	638	18,896	18,919	100
Tshumbe	2,409	2,473	2,494	7,376	8,277	89
Uvira	2,076	2,168	2,048	6,292	8,277	76
Total	**37,564**	**35,518**	**36,267**	**109,349**	**118,246**	**93**

For the percentage of women receiving AMTSL, the coordination office of Luiza was the only one that achieved the target of 100% (see Table 22). Kole had the lowest coverage rate (88%) due to the health zones of Omendjadi and Tshudi Loto that underperformed at 67% and 34% respectively. These latter health zones reported stock outs of oxytocin during September (partial month) and October 2014. IHP will continue to work with SIAPS to further improve the supply chain of commodities in general with a critical oversight on UN Commission on Life-Saving Commodities (UNCoLS) like oxytocin. Please note that the indicator is the percentage of women receiving AMTSL while the column in the table clearly states percentage of target achieved. The percentage of target achieved is a different statistic than the percentage of women receiving AMTSL.

Table 22: Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

	PY1Q1	PY2Q1	PY3Q1	PY4Q1	PY4Q4	PY5Q1
Bukavu	98	78	84	85	94	92
Kamina	96	83	99	99	97	98
Kole	67	89	93	71	91	88
Kolwezi	18	41	91	95	84	90
Luiza	35	87	95	99	97	100
Mwene Ditu	71	85	98	98	98	98
Tshumbe	74	83	97	86	86	96
Uvira	N/A	65	82	91	92	92

In the Luiza coordination office, 8 out of 9 health zones had an AMSTL coverage rate at 100%, suggesting that all women who delivered even by C-section benefitted from AMTSL. Therefore, it is critical to check the quality of the data reported. To do so, IHP will include the AMSTL-related indicator in the upcoming RDQA exercise. Field visits, monitoring and supervision activities should prioritize supporting low-performing health zones such Omendjadi and Tshudi Loto. Based on the outcome of the RDQA, IHP may consider revising the AMTSL target. Project performance overall for postpartum/newborn visits within three days of birth is at 80% of the target number of 139,113 postpartum/newborn visits within three days of birth; this represents a 15% increase compared to 111,843 in PY4Q4. The Kolwezi coordination office exceeded its target (105%); this performance is reported to be the result of data collection improvement actions including provision of tools and briefing of providers.

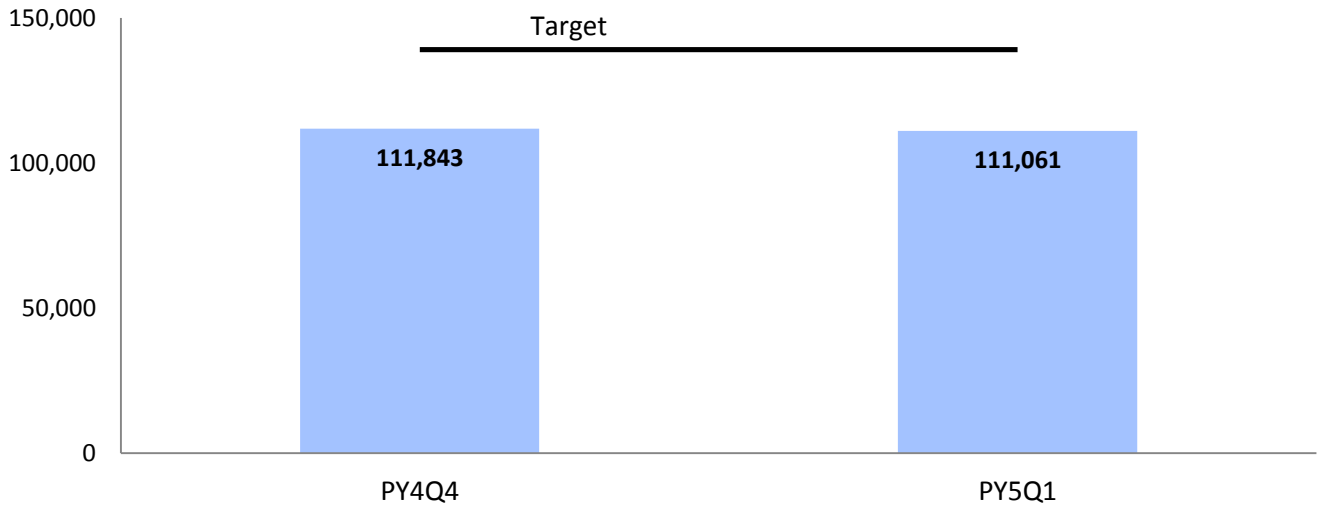
The coordination offices of Kamina (60%), Uvira (66%), Kole (77%), and Tshumbe (78) had the lowest reported performance. The low coverage is linked to factors such as private facilities that are reluctant to report and home births.

IHP will provide technical support to health zones to improve data collection by providing tools and by briefing providers; organize mini campaigns to motivate women to deliver in health facilities; and involve community health workers (CHWs) to identify and refer women who deliver at home to health facilities.

It should be noted that Kamina and Uvira have more “hard to reach” health facilities than other health zones. There is an increased inaccessibility to health facilities during the rainy season. However, Kamina and Uvira performed well for the percentage of women receiving AMSTL.

Figure 10: Number of postpartum/newborn visits within 3 days of birth

PY5Q1 Target=139,113



Essential Newborn Care

During the quarter, 111,735 newborns received essential care, representing overall performance of 87%. The low performing coordination offices of Kamina (72%), Uvira (82%) and Tshumbe (92%) are the main contributors to the fact that overall, achievement is down ten percentage points from the previous quarter (Table 23). The main factor that was commonly reported by low performing coordination offices as well as those with good performance (i.e., Mwene Ditu [102%], Luiza [103%], Kolwezi [118%] and Kole [104%]) is data collection related: understanding how the indicator should be reported, availability of tools, and denominator underestimation.

IHP will work with health zone management teams/MOH teams to ensure that underperforming health zones receive monitoring and supervision field visits by the end of April 2015 and to include consider this indicator in the next RDQA exercises.

Table 23: Number of newborns receiving essential newborn care through USG-supported programs

	Oct-14	Nov-14	Dec-14	PY5Q1	Target	% achievement
Bukavu	11,627	10,370	10,274	32,271	34,147	95
Kamina	5,181	4,818	4,282	14,281	18,840	76
Kole	3,075	2,791	2,686	8,552	8,242	104
Kolwezi	3,420	3,271	3,075	9,766	8,242	118
Luiza	4,617	4,441	4,302	13,360	12,952	103
Mwene Ditu	6,371	6,342	6,414	19,127	18,840	102
Tshumbe	2,538	2,487	2,557	7,582	8,242	92
Uvira	2,211	2,388	2,197	6,796	8,242	82
Total	**39,040**	**36,908**	**35,787**	**111,735**	**117,747**	**95**

Table 24: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs						
	Oct-14	**Nov-14**	**Dec-14**	**PY5Q1**	**Target**	**% achievement**
Bukavu	495	453	773	1,721	2,421	71
Kamina	384	384	280	1,048	1,336	78
Kole	302	278	253	833	584	143
Kolwezi	1,264	1,093	1,011	3,368	584	577
Luiza	1,502	804	644	2,950	918	321
Mwene Ditu	217	234	151	602	1,336	45
Tshumbe	31	55	49	135	584	23
Uvira	251	248	234	733	584	126
Total	**4,446**	**3,549**	**3,395**	**11,390**	**8,347**	**136**

During PY5Q1, IHP performance was as high as 136% for this indicator. Outliers include on the one hand Kolwezi with 576% of the target and Luiza with 316%, and on the other hand Tshumbe, which achieved only 23% of target (see Table 24). The main factor that was commonly reported by both low-performing and high-performing coordination offices is related to data collection: understanding how the indicator should be reported, availability of tools, and underestimation of the denominator. However, on this and other indicators in this section, the project will discuss with USAID the possibility of revising some targets.

Challenges include poorly-trained providers plus a population lacking knowledge about danger signs, with traditional beliefs that cause parents to delay seeking medical care.

Before the end of April 2015, IHP will conduct monitoring and supervision visits to better educate providers on the national protocol on newborn-infection diagnosis and treatment as well on reporting of relevant data. It will be useful to also assess the data quality.

Helping Babies Breathe (HBB)

The reporting template for data collection for neonatal resuscitation has not yet been integrated into the SNIS. Examination of the data that we do have for PY5Q1, presented below in table 25, reveals a range of results--between a low of 79% in Kolwezi and 100% in Tshumbe--for newborns being successfully revived. The project will continue to support additional health providers by providing resuscitation kits in the remaining health zones that have not yet been supplied.

Table 25: Number of babies resuscitated									
	Bukavu	**Mwene Ditu**	**Luiza**	**Kolwezi**	**Uvira**	**Kole**	**Tshumbe**	**Kamina**	**Total**
Number of babies with neonatal asphyxia	265	74	41	111	94	21	36	40	682
Number of babies resuscitated after neonatal intensive care	237	73	37	88	87	20	36	33	611
% of babies resuscitated after neonatal intensive care	89	99	90	79	93	95	100	83	90

Expanded Program on Immunization (EPI)

Immunization coverage by coordination and vaccination type: IHP exceeded the target of 90% immunization coverage, for tetanus, BCG, DTP HepB-HIB1, DTP HepB-HIB3, TOPV3, and measles (see Table 26). However, the breakdown by coordination office shows Tshumbe, Uvira, Kole, and Kamina performed below the target for tetanus vaccine 2+, even though their performance generally increased as compare to PY4Q4.

For the vaccine PCV13-3, coverage was as low as 10% (although it increased from 8% the previous quarter). Here Kolwezi appears to be the outlier--performing at a surprising 143%, up from a reported 0% in PY4Q4. We will re-analyze this data.

The vaccine PCV13-3 is relatively new in the DRC but is already integrated into all IHP-support health zones. Weak performance in meeting targets for this vaccine can be explained by frequent stock outs, due in turn to the government's difficulty to make co-share funds available to procure the product in a timely manner. All other vaccines are provided by the Global Alliance for Vaccines and Immunization (GAVI) with no government co-share requirement; few stock outs are reported for the other vaccines.

Table 26: Immunization coverage by coordination and vaccination type							
	Tetanus vaccine 2+	BCG (%)	DTP HepB-Hib1	DTP HepB-Hib3	TOPV 3 (%)	Measles (%)	PCV13_3 (%)
Bukavu	97	88	113	109	108	99	0
Kamina	85	109	107	101	103	104	0
Kole	87	71	103	95	91	102	0
Kolwezi	126	155	156	146	146	126	137
Luiza	99	110	112	108	107	103	47
Mwene Ditu	105	108	101	98	93	100	0
Tshumbe	86	75	104	89	100	87	0
Uvira	86	52	102	99	98	81	69
PY5Q1 coverage (%)	96	97	111	105	105	100	10

Drop-out rate in DPT-HepB-Hib3: Most children receive all three doses of DPT-HepB-Hib. The overall drop-out rate between DPT-HepB-HiB1 and DPT-HepB-Hib3 was as low as 5% during PY5Q1--well within the EPI/MOH recommended range of between 0 and 10 (see Table 27).

Table 27: Drop-out rate in DPT-HepB-Hib3			
	# DPT1	# DPT3	Drop-out rate
Bukavu	35,740	34,490	4
Kamina	18,664	17,502	6
Kole	8,393	7,708	8
Kolwezi	11,710	11,019	6
Luiza	13,619	13,114	4
Mwene Ditu	18,253	17,718	3
Tshumbe	7,824	6,663	15
Uvira	8,124	7,872	3
Total	**122,327**	**116,086**	**5**

*Numbers may not match exactly due to rounding

However, with a drop-out rate of 15%, Tshumbe underperformed. IHP will be following up with and providing technical support to help the health zone management team of Tshumbe trace children that missed DPT-HepB-Hib3.

IHP will continue its support to EPI/MOH to improve coordination (mainly through the interagency coordination committee, or CCIA in its French acronym) and strengthen the vaccine cold chain--providing fuel for refrigerators and other commodities as well as technical maintenance of both solar and fuel refrigerators. IHP will continue advocating to EPI/MOH for a greater availability of vaccines and to the CCIA members to strengthen the joint support to the approach of reaching every child.

***Polio eradication*:** No cases of acute flaccid paralysis were reported this quarter. IHP will continue technical support to the surveillance endeavors.

Family Planning

Couple Years of Protection (CYP): IHP again exceeded targets, with 132% for CYP for all modern methods. Among IHP coordination offices, Uvira was the only one underperforming (at 87%)--due mainly to stock outs of contraceptives in several health facilities inaccessible during the rainy season. We will gather lessons learned from the offices that exceeded targets, during upcoming monitoring visits and RDQA exercises.

Table 28: Couple years of protection (CYP) in USG-supported programs

	Oct-14	Nov-14	Dec-14	Total PY5Q1	Target	% achievement
Bukavu	14,676	12,120	11,901	38,696	32,625	119
Kamina	9,413	7,676	7,904	24,993	18,000	139
Kole	3,531	3,256	2,976	9,763	7,875	124
Kolwezi	5,249	5,732	3,443	14,424	7,875	183
Luiza	5,685	5,496	5,306	16,488	12,375	133
Mwene Ditu	8,812	8,731	8,805	26,349	18,000	146
Tshumbe	3,847	3,866	3,748	11,462	7,875	146
Uvira	2,395	2,237	2,244	6,876	7,875	87
Total	**53,608**	**49,114**	**46,328**	**149,051**	**112,500**	**132**

New acceptors of any modern contraceptive method: Continuing the trend seen during year four, Tshumbe, Luiza, Kolwezi, Kamina, and Kole significantly exceeded targets for new acceptors this quarter. Overall IHP performance rose to 125%--even higher than the previous quarter's achievement of 120%. As above, the project will document the factors behind their success.

Table 29: Number of new acceptors of any modern contraceptive method in USG-supported family planning service delivery points

	Oct-14	Nov-14	Dec-14	PY5Q1	Target PY5Q1	% achievement
Bukavu	10,425	10,389	10,361	31,175	37,137	84
Kamina	8,611	7,355	7,476	23,442	20,489	114
Kole	4,620	4,153	4,304	13,077	8,964	146
Kolwezi	7,064	5,683	2,816	15,563	8,964	174
Luiza	6,202	6,414	6,279	18,895	14,087	134
Mwene Ditu	8,855	8,510	9,590	26,955	20,489	132
Tshumbe	5,644	8,451	8,947	23,042	8,964	257
Uvira	2,296	2,796	2,470	7,562	8,964	84
Total	**53,717**	**53,751**	**52,243**	**159,711**	**128,058**	**125**

Number of health facilities experiencing stock outs of Depo-Provera: During this quarter, 97 service delivery points reported stock outs of Depo-Provera. These results exceed the planned maximum of 50 for this year. A

mix of factors appears to be behind the stock outs. In some cases the product may have been available at central distribution offices, but did not get to facilities in a timely fashion due to late ordering, lack of data on monthly consumption rates, and/or insufficient quantification skills. IHP will continue to address these issues in collaboration with SIAPS, USAID|DELIVER, and SCMS through building capacity throughout the supply chain in the coordination offices that have the most stock outs.

Nutrition

IHP continues to show strong performance in in meeting its targets for vitamin A supplements for children under 5 and iron and folic acid for pregnant women. While breastfeeding women receiving vitamin A is still below target, this quarter saw an increase from 36,294 to 41,271 women benefiting from this initiative (44% of PY5Q1 target).

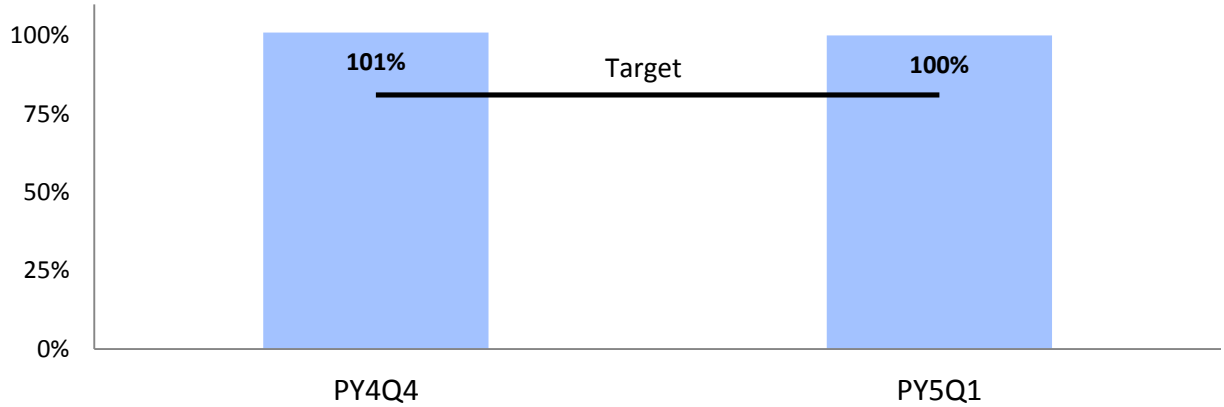
Table 30: Nutrition indicators by coordination for PY5Q1

Coordination office	# of children under 5 years who received vitamin A supplements	# of pregnant women who received iron & folic acid supplements	# of breastfeeding women who received vitamin A supplements
Bukavu	514,670	42,539	19,997
Kamina	263,958	10,094	5,244
Kole	147,414	5,804	1,548
Kolwezi	243,003	15,530	2,671
Luiza	261,232	12,196	2,670
Mwene Ditu	186,006	28,920	4,847
Tshumbe	140,523	8,225	654
Uvira	170,693	3,207	3,640
PY5Q1	1,927,499	126,515	41,271
Target	573,987	122,500	92,971
% target achieved	**336**	**103**	**44**

Figure 11: Proportion of pregnant women who received ironfolate to prevent anemia

PY5Q1 Target= 81%

*USG-supported service delivery points



Iron folate to prevent anemia for pregnant women: IHP exceeded targets by 19%--reaching 126,515 women against a target of 112,500. The number declined slightly from the previous quarter; however, IHP will need to explore why.

Iron folate and other commodities provided during antenatal visits help motivate women to complete their prenatal clinic visits. Therefore, it is important that IHP continue supporting the MOH to:

- Ensure that distribution centers and health facilities receive a stable supply of commodities
- Organize training and supervision on the use of essential medicines based on the national protocol.

IHP may consider reassessing the targets and eventually revising them as needed.

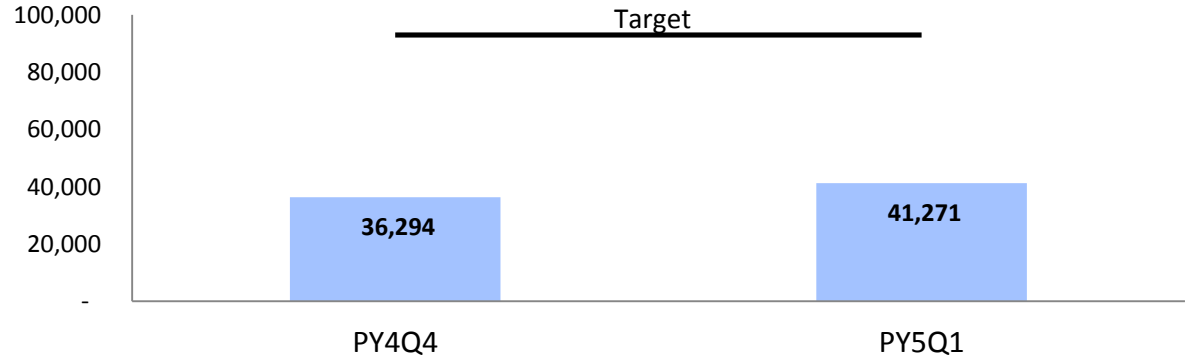
Nutritional counseling for mothers of children 2 years old and under: IHP achievement against the target is still high-- 158% in PY5Q1. This represents a slight increase in the number of mothers of children 2 years or less receiving nutritional counseling for their children (from 165,823 in PY4Q4 to 166,532 in PY5Q1). The counseling was provided by CHWs during their home visits and IYCF support group meetings. IHP may consider reassessing the targets and eventually revising them as needed.

Breastfeeding mothers receiving vitamin A: IHP reached only 44% of the target: 41,271 breastfeeding mothers received vitamin A against a target of 92,971. This does represent a four-point improvement over the previous quarter's performance of 40 percent. The main reason reported by and discussed with health zone management teams is the insufficient quantity of vitamin A in the health centers. However, IHP ordered enough vitamin A based on the number of breastfeeding mothers expected in IHP-supported health facilities. During the next quarter IHP will work with PRONANUT to ascertain the root causes that need to be addressed.

Figure 12: Number of breastfeeding mothers receiving vitamin A

PY5Q1 Target= 92,971

*USG-supported service delivery points



Number of USG-supported health facilities experiencing stock outs of iron folate: During PY5Q1, 502 health facilities reported experiencing stock outs of iron folate--10 times the target of not more than 50. IHP recently learned that in health facilities the iron folate may also be used to treat other patients with general conditions involving anemia, which would explain the shortages.

As a tracer drug, iron folate will be included when assessing and documenting the stock outs of essential medicines in collaboration with SIAPS, USAID|DELIVER, and SCMS.

Malaria

Pregnant women who received at least two doses of Sulfadoxine-Pyrimethamine (SP) during ANC visits: During the quarter, 88,567 pregnant women received two doses of SP (IPTp2)--representing 70% of the target, and a 6% increase over the previous quarter. The coordination offices of Mwene Ditu and Kole performed above the annual target (2 doses of SP for 85% of expected pregnant women) set by the PNLP.

With a coverage rate of 44%, Uvira is the only coordination office performing below 60%. Even though the general trend is encouraging mainly due to the improvement of the availability of SP, IHP will address stock outs of SP, as recommended previously for other essential medicines.

Distribution of 455,000 LLINs during antenatal care in 69 health zones that are not covered by the Global Fund: The number of LLINs available at the CDRs in Kamina, Kolwezi, Bukavu, and Mwene Ditu exceeded what IHP was able to distribute before its closeout. In addition IHP's approved budget did not include all CDR storage fees or distribution to the 69 target health zones. Therefore, IHP consulted with PMI and its implementing partners including SIAPS, DELIVER and PMI Expansion: the group agreed that IHP will manage about 500,000 LLINs, enough for routine distribution to pregnant women during ANC and preschool children during preschool consultations (PSC). Prior to finalizing this agreement, 18,948 LLINs were distributed in Bukavu and Tshumbe (see Table 31). The coordination offices, in collaboration with SIAPS and the PNLP, will implement the distribution plans and will work with the CDRs to transport the LLINs to the health zones.

Table 31: Number of LLINs purchased with USG funds and distributed

	PY5Q1		
	ANC	**PSC**	**Total**
Bukavu	13,980	4,198	18,178
Kamina	0	0	0
Kole	0	0	0
Kolwezi	0	0	0
Luiza	0	0	0
Mwene Ditu	0	0	0
Tshumbe	437	333	770
Uvira	0	0	0
TOTAL PY5Q1	**14,417**	**4,531**	**18,948**

Correctly managing malaria cases in health facilities through training, distribution of medicine and commodities (Artemisinin-based Combination Therapy or ACT, Rapid Diagnostic Tests or RDT, and supervision): During PY5Q1, 225,506 doses of ACT to children under 5 were distributed by IHP-supported health facilities (212,013 doses) and community care sites (13,493 doses for children 1-5 years old). The overall distribution of ACTs to children under 5 this quarter increased compared to the total ACTs quantities distributed in PY4Q4 (211,236 doses), a significant contribution from the distribution of ACTs at community case management sites increasing by 40% (from 9,623 in PY4). This was largely due to the newly-implemented IHP and HPP i-CCM sites.

IHP will continue reinforcing technical support to the i-CCM sites, 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.

Number of USG-funded malaria rapid-diagnostic tests (malaria-RDTs) purchased and distributed: IHP partners distributed 347,496 malaria rapid-diagnostic tests during quarter one of year five. This was 56% of the target number; it represents a reduction from the previous quarter. Kamina, Kole, Mwene Ditu, Uvira, and Tshumbe are the coordination offices where RDTs distribution decreased. Mwene Ditu registered the greatest reduction, while Bukavu reported the strongest increased distribution. The motivation of health care providers (including training, supervision, activity free of charge, etc.) is commonly cited as the main challenge that needs to be addressed when discussing this issue with the health zone management team and head nurses. IHP will discuss this issue further with the PMI team.

The ratio of treatment doses to rapid-diagnostic tests (ACT/RDT), estimated according to the distribution to health facilities at 1.22/1, is still far from the PNLP/MOH norm of 1 ACT to 2 RDTs; however, the proportion of children under five with malaria treated correctly following the national protocol was estimated at 89% (see Table 32). IHP recommends approaching the PNLP/MOH norm through supportive supervision. IHP will need to work with PNLP/MOH to assess the root causes of noncompliance with the national protocol.

Table 32: Proportion of children under five with malaria treated correctly following the national protocol

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY5Q1 Total
Children<5 years admitted for malaria treatment	82,081	54,622	28,791	28,370	30,086	60,346	20,111	22,647	327,054
Children < 5 years treated for malaria according to national protocol	84,438	37,311	26,118	20,624	28,101	54,894	19,400	19,150	290,036
Percentage treated according to national protocol	**103**	**68**	**91**	**73**	**93**	**91**	**96**	**85**	**89**

Number of USG-supported service delivery point with ACT stock out for the under 5 age group: The number of service delivery points (SDP) experiencing ACT stock outs for the under-5 age group continues to decrease. During PY5Q1, 229 SDP experienced stock outs of ACT, compared with 260 SDPs the prior quarter. But the target is a maximum of 50 stock outs. In collaboration with PMI implementing partners, IHP will continue to improve the supply chain management of malaria commodities, and document what is working well and what is not.

Tuberculosis

TB detection rate by coordination for PY5Q1: During PY5Q1, a total of 3,177 new sputum positive pulmonary tuberculosis cases (MPT+) patients were diagnosed, and the TB detection rate reached 66%. Compared to

PY3Q4 (63%), there is a slight increase. The overall IHP performance reported is influenced by the highest achievement in Kamina (126%) and the lowest achievement by Bukavu (38%). The main factor of the low performance is that most of the population is not exposed enough to key TB messages. In addition, patients with productive coughs are regularly referred to traditional healers instead.

IHP continued to experience delayed availability of TB data in Kolwezi where the National TB Control Program (PNLT in its French acronym) provincial coordinator declared they are no longer receiving funding from Kinshasa to regularly organize the quarterly review and reporting meetings.

Figure 13: Case Detection Rate
PY5Q1 Target= 70%

*USG-supported service delivery points

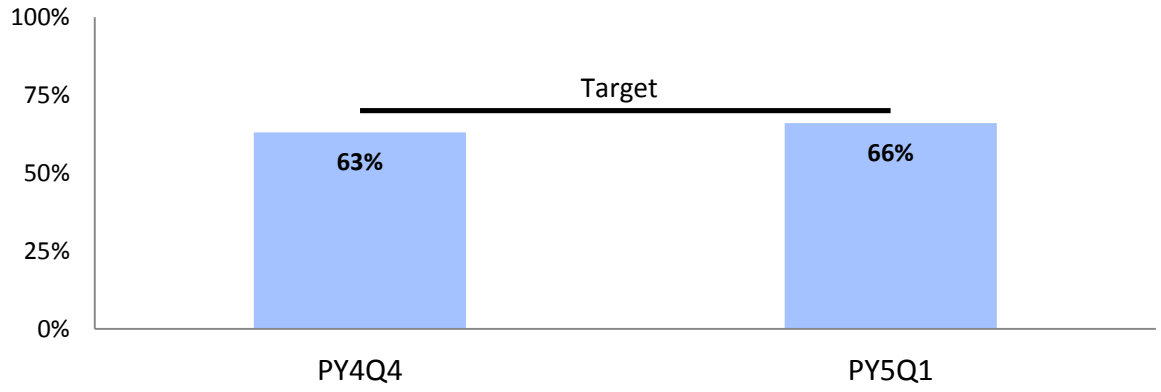


Table 33: TB case detection rate

	MPT+ new cases	Expected	Detection rate (%)
Bukavu	516	1,357	38
Kamina	942	747	126
Kole	313	350	89
Kolwezi	218	324	67
Luiza	309	524	59
Mwene Ditu	502	774	65
Tshumbe	162	322	50
Uvira	155	341	45
TOTAL	**3,117**	**4,740**	**66**

By the end of next quarter IHP will address the TB data retention with the leadership of the PNLT based in Kinshasa. The detection rate will be higher with Kolwezi data included. IHP will continue reinforcing the capacity of trained CHWs and health providers to detect TB including provision of awareness kits, and organizing mini awareness campaigns to inform the public about TB, care and treatment, especially in areas where CHWs have been trained.

Case notification rate in new sputum smear positive pulmonary TB cases in USG-supported areas: During this quarter, the notification rate (per 100,000 people) had increased to 99/100,000 compared to PY4Q4 (86/100,000). The difference in performance can be attributed to the completion of reports across the project (Kolwezi did not report in PY4Q4, for instance). In any case, the IHP performance against the PMP target (214/100,000) is as low as 46%.

IHP will continue to work with the PNLT to improve the reporting completion and advocate for permanent availability of mini-lab kits and DOT kits for sputum sample collection and shipment to the diagnostic and treatment centers (CSDT). IHP will provide technical support to health zones to ensure that community health workers implement an active door-to-door screening strategy through periodic mini campaigns.

Table 34: TB notification rate in PY5Q1

Coordination	Total population	MPT+ new cases	Notification rate
Bukavu	904,985	516	57
Kamina	498,125	942	189
Kole	233,653	313	134
Kolwezi	215,731	218	101
Luiza	349,328	309	88
Mwene Ditu	516,084	502	97
Tshumbe	214,675	162	75
Uvira	227,645	155	68
PY5Q1 Total	**3,160,228**	**3,117**	**99**

TB patients who are tested for HIV through USG-supported programs: Despite having incomplete data (see note on Kolwezi above), PY5Q1 performance reached 96% with 60% of MPT+ patients counseled and tested for HIV across all 78 health zones against PMP target (62%). IHP welcomes having OGAC/PEPFAR input with finding a solution to provide the needed support for TB/HIV activities (including HIV tests, ARVs, training of providers) from the Global Fund in the two Kasaïs and Sud Kivu, as well as with resolving the ongoing uncertainty in the delivery of TB commodities.

Figure 14: Percent of all registered TB patients who are tested for HIV

PY5Q1 Target= 62% *USG-supported service delivery points

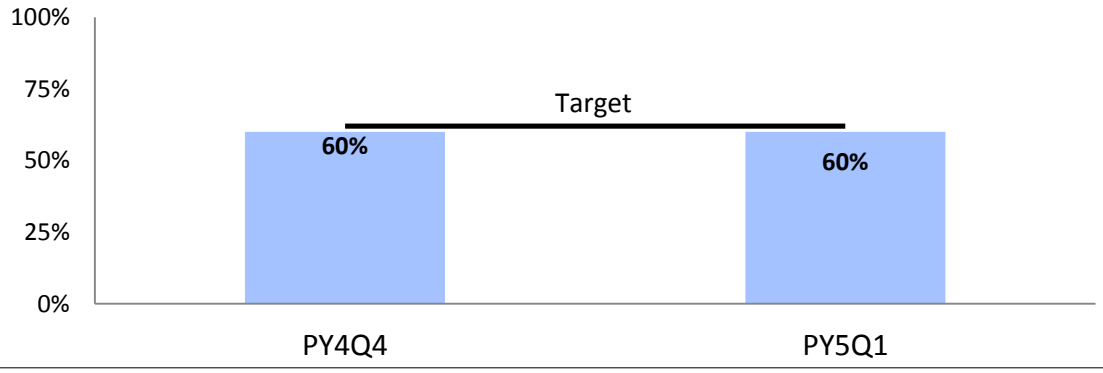


Table 35: Number of TB patients counseled and tested for HIV								
	Oct-14		Nov-14		Dec-14		PY5Q1	
	Counseled	Tested	Counseled	Tested	Counseled	Tested	Counseled	Tested
Bukavu	158	108	177	114	181	137	516	359
Kamina	247	236	345	309	350	336	942	881
Kole	107	38	110	43	96	45	313	126
Kolwezi	0	0	0	0	218	115	218	115
Luiza	106	78	96	50	107	72	309	200
Mwene Ditu	164	69	169	37	169	20	502	126
Tshumbe	66	15	47	12	49	10	162	37
Uvira	0	0	0	0	155	33	155	33
PY5Q1 Total	**848**	**544**	**944**	**565**	**1325**	**768**	**3,117**	**1,877**

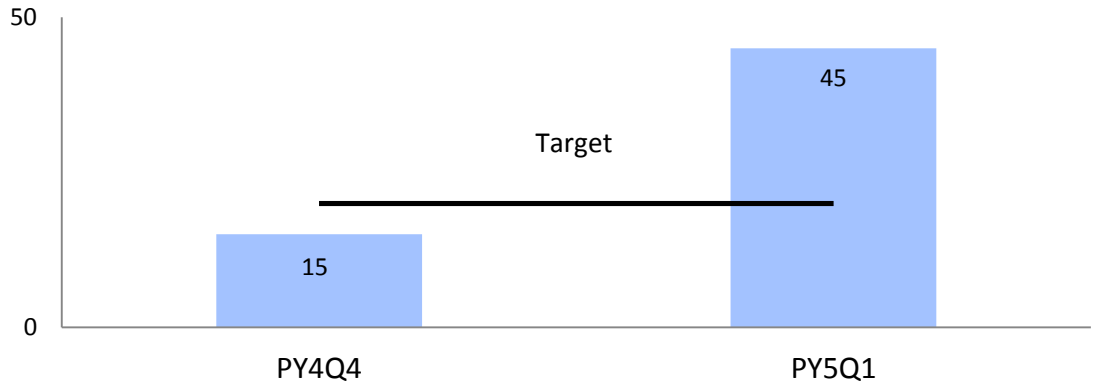
The fight against multi-drug resistant tuberculosis (MDR-TB): The total number of MDR-TB cases detected in PY5Q1 was 45, or 227% of the target (20). That almost doubled the number of MDR cases confirmed in PY4Q4 (15). The coordination office of Mwene Ditu is the greatest contributor to these good results with 24 MDR-TB cases. IHP identified the following combination of factors moving forward: the availability of IHP-procured GenExpert at the CSDTs and provincial laboratories; a transportation plan to take MDR-TB samples between facilities; and formative supervision of providers for MDR-TB patients for health zone management teams, nurses and lab technicians in Uvira, Bukavu, and Luiza.

Table 36 : Number of multi-drug resistant (MDR) TB cases detected						
	Oct-14	Nov-14	Dec-14	Total PY5Q1	Target	% achievement
Bukavu	1	3	2	6	6	100
Kamina	0	0	0	0	3	0
Kole	0	1	0	1	1	100
Kolwezi	0	0	7	7	2	350
Luiza	3	3	0	6	2	300
Mwene Ditu	0	0	24	24	3	800
Tshumbe	0	0	0	0	1	0
Uvira	0	0	1	1	2	50
PY5Q1 Total	**4**	**7**	**34**	**45**	**20**	**225**

Figure 15: Number of multi-drug resistant (MDR) TB cases detected

PY5Q1 Target= 20

*USG-supported service delivery points



In order to keep improving the management of MDR-TB performance, 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 and provision of required supplies 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
- Provide funding for shipping MDR-TB drugs as needed
- Support the national TB program initiative to target prisons in IHP-supported health zones

USG-assisted service delivery points experiencing stock out of rifampicin/isoniazid (RH) combination: The number of facilities that experienced stock outs of RH increased from 24 health facilities health facilities in PY4Q4 to 31 in PY5Q1. Bukavu reported the largest number of health facilities experiencing stock outs (19).

Table 37: Number of USG- assisted service delivery points experiencing stock out of rifampicin/isoniazid (RH) combination

	Oct-14	Nov-14	Dec-14	Average PY5Q1
Bukavu	1	0	19	19
Kamina	14	4	7	7
Kole	2	0	1	1
Kolwezi	0	0	0	0
Luiza	1	6	2	2
Mwene Ditu	0	0	0	0
Tshumbe	0	1	2	2
Uvira	0	0	0	0
PY5Q1 Total	**18**	**11**	**31**	**31**

HIV and AIDS

At the beginning of the quarter, IHP enrolled a total of 41 PMTCT sites in Kolwezi and 28 in Kamina. However, the project will consider PEPFAR recommendations that include: (1) investing funding in sites with higher HIV prevalence, i.e., the potential or proven capacity to detect at least four HIV-positive persons per year; and (2) transitioning sites to Option B+.

Currently all IHP-supported sites use the provider-initiated testing and counseling (PITC) strategy to ensure evidence-based actions. The transition of IHP-supported sites from option A to option B+ is underway, with the overall challenge of an approved PY5 workplan that considered a closeout context that did not include training activities. As of PY5Q1, in Kolwezi, 27 out of 41 sites had integrated option B+ (66%), and all sites were to make the transition as of the end of PY5Q2. However, in Kamina, where the rainy season damaged roads and isolated many of the IHP sites, transition is expected now for PY5Q3 during the dry season when sites will be reachable again for supportive supervision visits.

Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women: During the reporting period, only 9% of sites (6/69) were achieving 90% ART coverage. The six sites with 90% ART coverage include two sites in Kamina and four in Kolwezi. They shifted from option A to the option B+ strategy, in accordance with WHO guidelines and PEPFAR recommendations. IHP will continue to work on transitioning additional sites from option A to option B+. The priority will be given to HIV sites with higher potential of finding more HIV positive persons. All IHP-supported sites provide counseling and testing using the PITC strategy. The transition of IHP-supported sites from option A to option B+ is underway, with the overall challenge of an approved PY5 workplan that considered a closeout context where training activities were not included. As of PY5Q1, in Kolwezi, 27 out of 41 sites have already integrated option B+

Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results): At the end of the quarter, 4,690 women knew their HIV status, out of 6,243 who were tested during ANC visits (75%). In Kolwezi, 81% of counseled and tested women knew their HIV status; in Kamina, only 65%. This was based on 1,392 women who knew their HIV status out of 2,157 seen at ANC; however, not all of these women were counseled and tested. The Kamina sites experienced some stock out of HIV tests during the period; in fact, only 1,446 women were counseled and tested, and out of those, 1,392 received their test results (96%). A training/refresher session for providers in Kamina during PY5Q2 is expected to help, as should community awareness-raising activities on the importance of knowing one's status.

Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (PMTCT) during pregnancy and delivery: During PY5Q1, 48 of 120 (40%) of pregnant women in Kamina and Kolwezi received ARVs to reduce the risk of transmitting the virus to their infants during pregnancy, labor, or while breastfeeding. (In Kamina, the numbers were 7 of 44; in Kolwezi, 41 of 112). We expect coverage to improve as the use of option B+ increases during PY5Q2. IHP will provide financial support to providers and CHWs/PLWHA to actively seek out and bring in for services HIV+ pregnant women who need to be on ART to close the gap. IHP will also conduct a refresher/training of health workers during supportive supervision visits.

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: A total of 82 female sex workers were reached individually or in small groups. Seventeen sex workers were reached in Kamina, where the intervention was carried out in the health zones of Mulongo (11) and Songa (6). In Kolwezi 65 sex workers were reached in the health zones of Bunkeya (61) and Kanzenze (4). IHP collaborated with Family Health International

(FHI360 ROADS II Project) primarily in the area of awareness-raising activities. Meanwhile, HIV testing and care were provided at health facilities supported by IHP.

Number of individuals who received testing and counseling (T&C) services for HIV and received their test results: In IHP facilities, 15,695 individuals were counseled and tested for HIV, and received their test results during this quarter (8,607 in Kamina and 7,088 in Kolwezi). We attribute this level to awareness-raising activities in the communities, availability of rapid screening tests, improved 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, 2,566 individuals received at least one clinical assessment to determine their WHO staging of the infection as well as their ART eligibility (Kolwezi, 2538; Kamina, 28). Kamina reported only PLWHA who were assessed for CD4.

In the second quarter, indicator numbers should rise as reports include those clinically assessed as well. 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, especially in Kolwezi. However, viral load data remains unavailable because of lack of equipment.

Number of HIV-positive adults and children receiving a minimum of one clinical service: A total of 4,404 HIV-positive adults and children received at least one clinical service in the HIV sites (Kolwezi: 4,365; Kamina: 39). In Kolwezi, 2,509 patients from the eight sites in the Fungurume health zone were added under IHP after they were in the care of the now-closed DRC Integrated HIV and AIDS Project (ProVIC). IHP was unable to collect additional information for Kamina due to inaccessibility by road and phone of most Kamina health zones and sites during the high rainy season period. During the dry season, IHP will conduct field visits and collect and update the figures. In Kolwezi, among HIV-positive people, 2,089 received ART in addition to other clinical services such as cotrimoxazole and other HIV commodities provided by the public-private partnership with mining companies. In Kamina, all PLWHA received ART. Other organizations, such as the Global Fund, may have been counted for this indicator.

TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting: During the quarter, 423 people out of the 4,404 PLWHA (10%) were screened for TB. A lack of training for health care providers can explain the low numbers, especially in new sites where training had not yet been given on HIV/TB co-infection. Training is being planned.

Number of adults and children receiving antiretroviral therapy (ART) (current): In PY5Q1, 2,8484 PLWHA are reported as having received ARV treatment (2,809 in Kolwezi and 39 in Kamina). However, in Kolwezi, the health zone management teams also may have counted patients supported by the Global Fund. IHP and the Global Fund share coverage in four health zones (Manika, Dilala, Lubudi, and Lualaba) where the Pima CD4 cartridges were also distributed.

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: The number of HIV-infected adults and children was 394 (Kolwezi – 378; Kamina – 6). Kamina reported only PLWHA who were assessed for CD4, not those clinically assessed. Next quarter this reporting artefact will be remedied.

Proportion of registered TB cases that are HIV-positive who are on ART: Of 860 people suffering with TB and documented HIV positive, only 194 were on ART, all in Kolwezi. Of these, 501 came from Fungurume health zone, which IHP inherited from ProVIC without information about their HIV treatment. Another 359 cane from old IHP Kolwezi health zones; among those, 194 (54%) were already on ART while 165 (46%) needed to stabilize their TB infection before beginning ART. In PY5Q2 and Q3, Fungurume TB/HIV information will be completed, and Kamina co-infection activities improved through supportive supervision visits to increase documented TB/HIV-positive patients on ART. Training and refresher sessions of health care providers are planned to improve results for this indicator during this year.

Percentage of laboratories and Point of Care (POC) testing sites that performs HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program: This quarter, 18 of 69 laboratories successfully participated in an analyte-specific proficiency testing (PT) program (26%). However, all POCs and laboratories conduct HIV testing.

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 one laboratory.

Family planning and HIV integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services: With IHP support, 69 PMTCT sites integrated family planning and safe motherhood services. The project also ensured that 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 encourage people to take advantage of integrated HIV and family planning services at these sites.

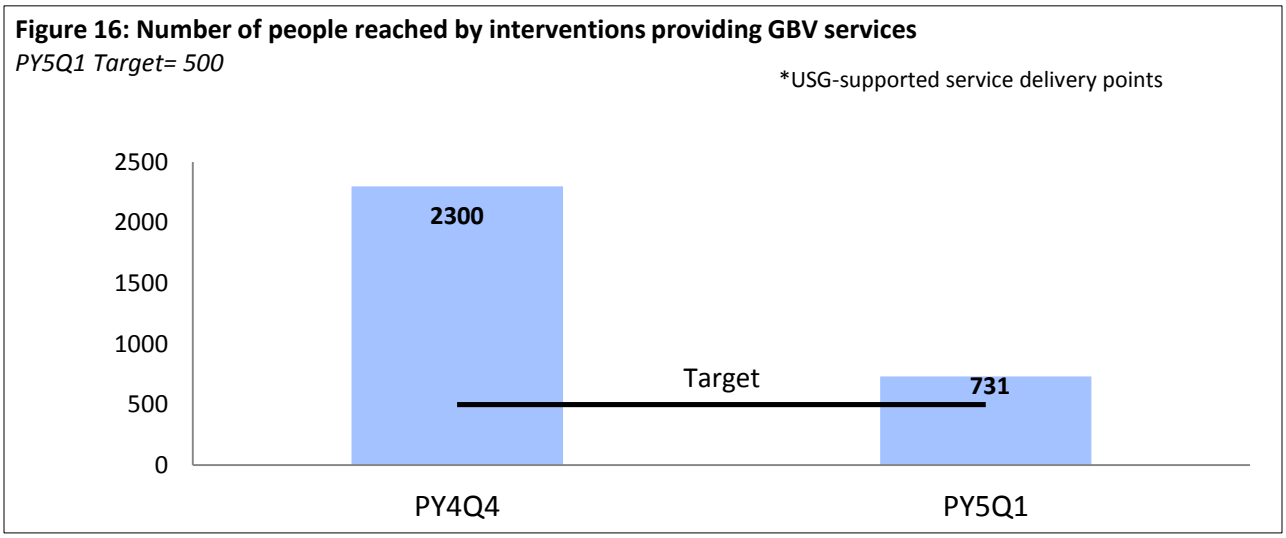
Sexual and Gender-based Violence

Sud Kivu is the province of DRC with the highest prevalence of gender-based violence (GBV), due to ongoing instability. Since grassroots groups and NGOs are working intensively in Bukavu and Uvira, sexual violence is also more likely to be reported. Not surprisingly, Bukavu and Uvira coordination offices reported 90% of the cases of sexual violence registered in IHP areas during this quarter; 99% of the victims are women or girls (see Table 38).

Table 38: Number of people reached by GBV services funded by the U.S. Government, disaggregated by sex and period of arrival at a health facility						
	Sex distribution		Number of people reporting sexual violence in USG-supported health clinic			
	Females	Males	Within 72 hours	Between 72 and 120 hours	Given ARVs	Given emergency contraceptive
Bukavu	555	4	296	263	261	284
Kamina	15	0	14	1	0	2
Kole	36	5	29	12	14	12
Kolwezi	0	0	0	0	0	0
Luiza	2	0	2	0	3	2
Mwene Ditu	0	0	0	0	0	0
Tshumbe	12	0	9	3	6	5
Uvira	95	7	91	11	87	79
Total	**715**	**16**	**441**	**290**	**371**	**384**

Figure 16: Number of people reached by interventions providing GBV services

PY5Q1 Target= 500



In the new Sankuru Provincial Health Division, where Tshumbe and Kole are located, IHP funded a local NGO, Synergie, through a sub-grant. IHP also provided sub-grants to two local NGOs working on GBV in Kamina (BATWA BEMBA and AFEDEPE). In addition, the project provided more post-exposure prophylaxis (PEP) kits to prevent HIV in victims of sexual violence. IHP also supported the competency-based training of health provider teams on an integrated package of services including essential obstetric and newborn care, family planning, and gender-based violence in Kole, Tshumbe, Kamina, Luiza, and Mwene Ditu. IHP will continue to support health providers to improve the quality of care for victims through supportive, formative supervision.

Fistula

Following a sub-grant received from IHP, the Kaziba GRH was able to treat 60 women suffering from urogenital fistula—about 20 a month. Most fistula patients (72%) are 20-34 years old, although some are in their fifties.

Most fistula cases (80%) are caused by prolonged, unrelieved obstructed labor, especially for women who give birth at home without medical assistance. The home deliveries represent 38% (23/60). 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. The repair success rate is 90% (54 of the 60 cases). Please see Appendix 4 for the breakdown of data.

During the next quarter, in joint supervision visits IHP will train health care providers in Kaziba and other health zones referring cases to Kaziba GRH in the correct use of the partograph. In addition, the project will support community mobilization activities to promote use of maternity clinics where pregnant women can await delivery, avoiding the need to travel long distances when labor starts.

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

FOSACOF CRITERIA
1. Infrastructure
2. Equipment
3. Essential drugs and supplies
4. Personnel
5. In-service training
6. Community approach
7. Community support
8. Clinical quality
9. Management

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.

Due to the commitment and leadership of health zone management teams, 262 health facilities (health centers and GRHs) received an evaluation on the quality of services and care using the FOSACOF strategy during PY5Q1. Of these 262, 125 health facilities are situated in the 7 health zones implementing RBF (Uvira, Bibanga, Lomela, Wembonyama, Luiza, Kanzenze and Kayamba) and 137 health facilities in other health zones that have not integrated RBF.

Table 39 shows that in 77% (91/118) of health centers with RBF, the FOSACOF score is above 50% and 8% (9/118) were fully functional. Compare to health centers without RBF only 40% (75/181) had FOSACOF performance above 50% and 1% reported as fully functional. This comparison between health facilities with and without RBF is meant to contribute documenting the value added from RBF in quality improvement of health services. One of the limitations includes the fact that for PY5Q1, the RBF FOSACOF information concerns only November and December 2014. The RBF first quarter starts November 2014 and ends January 2015.

Table 39: FOSACOF evaluation in health centers with and without RBF by coordination office during PY5Q1										
Coordination office	**# of health centers without RBF evaluated**	**Class D <25%**	**Class C 25< 50%**	**Class B 50<79%**	**Class A ≥80%**	**# of health centers with RBF evaluated**	**Class D <25%**	**Class C 25< 50%**	**Class B 50<79%**	**Class A ≥80%**
Bukavu	5	0	3	2	0	N/A	N/A	N/A	N/A	N/A
Kamina	5	2	3		0	13	0	2	11	0
Kole	37	3	34	0	0	19	0	15	4	0
Kolwezi	20	13	7	0	0	15	0	3	6	6
Luiza	15	5	8	2	0	18	0	1	16	1
Mwene Ditu	64	0	14	47	3	17	0	3	13	1
Tshumbe	7	0	3	4	0	15	0	0	14	1
Uvira	28	0	11	17	0	21	0	3	18	0
Total	**181**	**23**	**83**	**72**	**3**	**118**	**0**	**27**	**82**	**9**
% achieved		**13**	**46**	**40**	**1**		**0**	**23**	**69**	**8**

During the next four months, IHP will provide technical and financial support to capitalization workshops in coordination offices in order to document lessons learned in implementing FOSACOF.

Implement a results-based financing (RBF) program

RBF is a strategy to improve 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 achievement of agreed-upon targets.

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

During this quarter the performance of referrals to health centers from the CHWs and to GRHs from health centers exceeded the PMP targets above 300%. In general, the same level of performance was observed during previous quarters. It is most likely that the targets were underestimated and may need to be revised. By end of April 2015, IHP will conduct an assessment on the quality of the data related to patients referred to health centers and to the GRHs. In addition, it is important for IHP to further assess the referral system by documenting the quality of the referrals and counter-referrals at each level.

Table 40: Number and percentage of patients referred to GRHs

	Oct-14		Nov-14		Dec-14		PY5Q1		
	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	5,904	176,540	8,150	162,499	6,230	166,813	20,284	505,852	4
Kamina	1,262	71,518	1,301	62,366	1,365	58,792	3,928	192,676	2
Kole	2,016	31,756	1,998	33,203	2,051	33,438	6,065	98,397	6
Kolwezi	663	44,830	732	50,604	969	50,443	2,364	145,877	2
Luiza	392	46,646	383	44,140	238	42,435	1,013	133,221	1
Mwene Ditu	4,547	75,793	4,669	78,249	4,781	79,477	13,997	233,519	6
Tshumbe	2,098	19,551	2,212	22,938	2,243	28,388	6,553	70,877	9
Uvira	1,167	24,284	1,161	24,922	1,221	26,619	3,549	75,825	5
PY5Q1 Total	**18,049**	**490,918**	**20,606**	**478,921**	**19,098**	**486,405**	**57,753**	**1,456,244**	**4**

Table 41: Number and percentage of patients referred to health centers

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	PY5Q1
Patients referred to health center by a CHW	478	760	414	129	265	1,696	1,455	343	5,540
Patients seen by a CHW	2,265	8,865	7,807	1,420	5,557	4,244	2,957	1,024	34,139
PY5Q1 (%)	**21%**	**9%**	**5%**	**9%**	**5%**	**40%**	**49%**	**33%**	**16.2%**

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

Community participation is one of nine principles of primary health care adopted by the DRC national strategy. IHP is using approaches such as Community Champions, Education through Listening, and mHealth to encourage exchange of health knowledge, change attitudes harmful to health, and help communities support healthy behaviors and use of health care services. Through these approaches, IHP is helping maximize health sector-community outreach linkages, foster health advocacy and community mobilization, and facilitate behavior change communications (BCC) (see Table 42).

Table 42: Summary of IR 3 key results for PY5Q1 by Sub-IR			
Sub-IR	**Key Indicators**		**Results**
1.1 Health sector-community outreach linkages	Youth and vulnerable group NGO participation		Exceeded targets
	Active Champion Communities		Exceeded targets
1.2 Health advocacy and community mobilization	Rehabilitated CODESAs		Almost met targets
1.3 Behavior Change Communication	Functional CODESAs with communication action plans mHealth text messaging		Exceeded targets Almost met targets

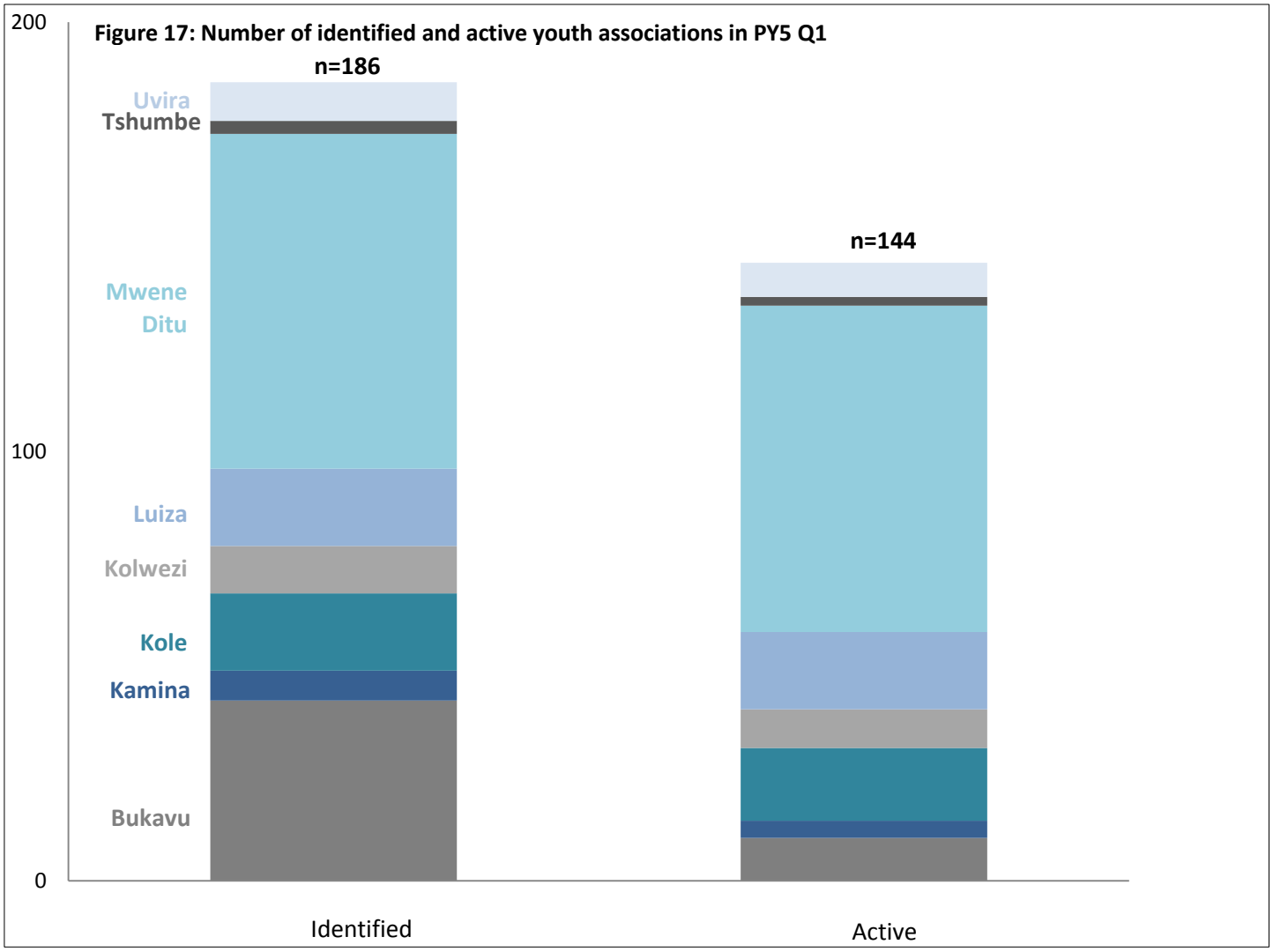
In Education Through Listening (ETL), a key strategy of IHP's BCC approach, community health workers and volunteers encourage behavior change as community members identify local health challenges and discuss potential solutions. An innovative, participatory approach, ETL has proven useful in a wide variety of initiatives including CODESAs, Champion Communities, Champion Men, and youth associations. Youth organizations and community groups used ETL this quarter to organize group and individual conversations on family planning, STIs, child marriages, TB, and unplanned pregnancies (see below).

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

Youth Associations

IHP continues to prioritize collaboration with youth organizations since their influence is particularly valuable in reaching peers in the community as they transition to adulthood, begin to start families, and take on community leadership roles. During this quarter, the number of active youth organizations remained fairly stable, with 144 associations conducting outreach activities, an increase of one over last quarter. IHP provided technical guidance and support in conducting awareness-raising campaigns among students and other adolescent groups and encouraged community leaders to support youth outreach activities. In addition, the project developed a map of active youth organizations in four IHP project health areas (Nuru, Kabushwa, Kabamaba, and Mugeri). The map will help IHP to track the development of youth associations and integrate them into project activities.

Table 43: Number of youth organization completing youth awareness raising activities		
Coordination office	**Number of associations identified**	**Number of active associations**
Bukavu	42	10
Kamina	7	4
Kole	18	17
Kolwezi	11	9
Luiza	18	18
Mwene Ditu	78	76
Tshumbe	3	2
Uvira	9	8
Total	186	144



Highlights of this quarter's activities include:

- In Kole, a youth organization held ETL sessions and group conversations with peers on family planning, STIs, and child marriages, with planning help from IHP.
- In Bukavu, the Katana Farmers Movement Network (REMOPAK), a youth NGO in Katana and Walungu health zones, and the Association of Women for the Promotion of Family Health (APROSAF) held a week-long awareness raising campaign to teach local youth about family planning, young couples' issues, STIs, child marriages, and unplanned pregnancies.

As part of this campaign, these two NGOs developed a map of active youth organizations in four health areas (Nuru, Kabushwa, Kabamaba, and Mugeri), mobilized community leaders to support youth outreach efforts, disseminated SMS messages on HIV testing and unplanned pregnancies to local youth, and prepared and performed skits on HIV testing and unplanned pregnancies for student groups in schools and churches. Their efforts persuaded 14 youth NGOs with approximately 2,000 total members to become active in promoting youth reproductive health.

Population reached through health messaging:

- ✓ 1,257 young married couples were educated about common myths regarding family planning methods
  - 635 referred to health centers for further information
  - 83 couples adopted a modern method of contraception
- ✓ 950 youth, 450 boys and 500 girls, were taught about STIs (HIV and AIDS, syphilis, and gonorrhea)
- ✓ 873 youth, 493 boys and 380 girls, were taught about child marriages and unplanned pregnancies
- ✓ With the guidance of REMOPAK trainers, 8 youth participated in a health and development radio broadcast on Radio Maendeleo, a radio station in Bukavu
- ✓ REMOPAK and APROSAF collaborated with local radio stations to produce and air 13 radio advertisements on health and development
  - airtime and technical support donated by the stations
- ✓ 164 youth, 109 boys and 55 girls, in Walungu health zone learned about voluntary HIV screening and HIV and AIDS risk factors

IR 3.2: Health advocacy and community mobilization organizations strengthened

CODESA: Health advocacy and community mobilization

As above, Champion Communities, Education Through Listening (ETL), and mHealth all support community organizations and their work of mobilization. IHP also uses more traditional BCC interventions such as building the capacity of local partners (including CODESAs) to carry out their own communication action plans, enabling stakeholders and community leaders to actively engage with local populations.

CODESAs played an integral role in the increased use of community health care services and products across IHP project health zones. With their active leadership roles in the community, CODESA members are an effective means of community mobilization. Members led discussions, group conversations, awareness-raising sessions, and community outreach initiatives to encourage the adoption of positive health behaviors at the community level. CODESAs also serve as an intermediary between the health centers and the local population, encouraging individuals within their communities to use the health centers' services.

- During PY5Q1, IHP supported 1,306 functional CODESA[4] across the project health zones through the development of action plans, statutes, and other management tools. This figure represents 93.5% of the quarterly goal. Of the 1,306 functional CODESAs, 1,258 have developed and implemented actions plans (see Table 44).

[4] IHP considers the following criteria for CODESA, which are recommended by the MOH:

- All CODESA members reside and work in the health area
- Among the CODESA members, 30% are women and 30% are youth
- CODESA meets monthly and produces meeting reports
- CODESA members are trained in BCC and community participation

Table 44: Number of revitalized and functional CODESAs for PY5Q1					
Coordination Office	**CODESAS identified**	**CODESAs revitalized and functional**		**Revitalized and functional CODESAs with an action plan**	
		N	**%**	**n**	**%**
Bukavu	399	396	99	380	95
Kamina	202	195	97	194	96
Kole	129	129	100	129	100
Kolwezi	106	99	93	92	87
Luiza	170	147	86	137	81
Mwene Ditu	171	168	98	168	98
Tshumbe	119	92	77	83	70
Uvira	102	80	78	71	70
TOTAL	**1,398**	**1,306**	**93**	**1,254**	**90**

Highlights from this quarter include:

- In Kole and Tshumbe in Kasai Oriental, CODESAs assisted in educating women of reproductive age (ages 13 -45) on the benefits of modern family planning methods.
- In Bukavu, the Luchiga health area CODESA set a community goal of purchasing a vehicle to use as an ambulance. Living on the hillsides and mountains of the high plateau, the people of Luchiga health area struggled to reach their local health center. The community purchased a small Jeep, funded entirely through community donations, enabling faster emergency travel to the local health center.
- In the health zone of Walungu (Nyanja health area), the CODESA contributed to development of a potable water storage system for the local health center. The same CODESA also developed a chicken-raising initiative to help support CODESA members and their families.

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

Behavior Change Communication (BCC)

Mini-campaigns: During this quarter, IHP and partners organized 12 mini-campaigns involving community, religious, and traditional leaders. They focused on antenatal care, family planning, exclusive breastfeeding, diarrhea, TB, and malaria. The health zones reported that 18,491 people were exposed to the mini-campaign messages and observed the following positive attitudes in health facilities: more husbands accompanying their wives to health facilities for preschool consultation, vaccination, family planning, and ANC.

For example, to increase the TB detection rate, the project supported the development of a youth organization, *Club des Amis de Damien* (CAD), in the five CSDTs in Dibaya and Lubondaie health zones. CAD has a special interest in TB, as many of its members are former TB patients who now work to combat the disease. IHP assisted CAD in creating an outreach plan, transmitting SMS messages to the community, and co-led outreach briefings with health zone workers and registered nurses. Similar activities took place throughout the quarter in 6 of the 8 coordination areas (see Table 45).

Table 45: Number of mini-campaigns carried out during PY5Q1

Coordination	# of cam-paigns	Health zone	Topics	Participants	Targets
Kolwezi	3	Mutshatsha (1) Fungurume (1)	Exclusive breastfeeding	Health zone management team, Champion Community, CODESA, and Community-based organizations (CBOs)	Mothers with children under six months, pregnant women and their husbands
		Bunkeya (1)	Antenatal care	Health zone management team, CODESA, and local volunteers	Pregnant women, their husbands, and nearby parents, 41 women consulted
Kole	4	Vangateke (1)	Family planning	Health zone management team, CODESA, and congregations of local churches	Couples, 464 of whom accepted a new method of family planning
		Bena Dibele (1)	Antenatal care	Health zone management team, CODESA, and local volunteers	Pregnant women, 180 women consulted
		Lodja (1)	Pre-school vaccinations	Champion Community	Mothers with children under one year, 103 children vaccinated
		Vangakete (1)	Pre-school vaccinations	Health zone management team and CODESA	Mothers with children under one year, 161 vaccinated
Bukavu	2	Miti Murhesa (1)	TB	Health zone management team, CODESA, and CBOs	Four health areas, nine new cases of TB detected and directed for treatment
Uvira	1	Uvira (1)	Diarrhea	Champion Community and CODESA	Four health areas
Kamina	1	Malemba (1)	Malaria	Champion Community	One health area, 98 cases referred for treatment
Luiza	1	Dibaya and Lubondaie	TB	Health zone management team and CAD	Two health zones, 44 new cases of TB detected and referred for treatment

Additional highlights from this quarter include:

- IHP and community partners visited 428 households (341 in Dibaya and 87 in Lubondaie)
- IHP and community partners held 1,570 ETL sessions (1,512 in Dibaya and 58 in Lubondaie)
- IHP and community partners visited 47 households to conduct Directly Observed Treatment Short Courses (37 in Dibaya and 12 in Lubondaie)
- Community health workers collected 129 sputum samples--68 in Dibaya and 61 in Lubondaie—of which 44 samples tested positive for TB, 28 in Dibaya and 16 in Lubondaie

mHealth

During this quarter, IHP continued to carry out mHealth campaigns through SMS messages. These messages raised awareness of health issues within communities, particularly among target individuals and households. Over the course of PY5Q1, IHP assisted in transmitting 122,025 SMS messages, surpassing the quarter's goal of 120,000 messages. Table 46 below shows the number of SMS messages sent in each IHP project health area.

Table 46: Number of SMS messages sent by health area during PY5Q1

Health topic	n	%	Number of districts implemented in PY5Q1
Tuberculosis	15,236	12	3
Malaria	21,091	17	6
Family planning	1,6241	13	4
MNCH	46,498	38	7
WASH	777	1	1
Exclusive breastfeeding	7,578	6	4
Diarrhea/cholera	9,894	8	3
Vaccination	4,710	4	1
Total	**122,025**	**100**	**29**

The messages informed men and women of reproductive age about the value of antenatal care and family planning, and encouraged the use of both services. Given that men remain the primary users of mobile phones in the DRC, SMS messages were designed to target both men and women, and encourage men to discuss family planning options with their partners.

In Tshumbe, 6,388 SMS messages were sent to 3,368 women and pregnant girls (ages 13-18). Of these women, 132 began attending antenatal care sessions and 174 began using some form of modern contraceptive (Jadelle, Depo-Provera, IUD, cycle beads, etc.). Similarly in Lomela health zone, in Kole, 325 out of 1,930 reproductive age women, including 234 pregnant women and 91 women who had recently given birth, were educated about antenatal and postnatal care, family planning, and exclusive breastfeeding.

In all health zones in Kolwezi, an SMS campaign sent out 4,710 SMS messages in support of a MoH-led initiative for polio vaccination and vitamin A supplements.

SMS messages on health topics including diarrhea were being read to church congregations by parish secretaries and worship leaders at the end of services, according the health workers in the zones of Ndekesha, Dibaya, and Lodja Champion Communities.

During this quarter, the project celebrated the Katana Champion Community in Bukavu. IHP also supported six other Champion Communities to develop sustainability plans so they can continue and become NGOs after IHP ends (two in Bukavu, two in Uvira, and two in Kole). Celebrations are currently pending for 11 more Champion Communities (six in Luiza, three in Kolwezi, and two in Tshumbe). In anticipation of collecting the signature of the statutes, IHP has initiated advocacy training sessions for members of the Champion Community Pilot Committees (CPCC) in seven of the eight project coordination offices.

Champion Communities conducted mid-term self-evaluations in all project-supported coordination offices. Based on these evaluations, IHP encouraged the Champion Communities to focus on concrete, achievable activities such as increasing the number of house visits, ensuring illnesses are referred to the health center, and constructing latrines and refuse pits for households.

Malemba Champion Community in the Kamina coordination office, for instance, experienced great success implementing their refocused activities this past quarter. The community set three measurable targets for health promotion in their four areas:

- Refer 62 new cases of TB to the CSDTs,
- Dig 271 new refuse pits for household waste disposal, and
- construct 195 new latrines for individual households.

Throughout the quarter, volunteers sent SMS messages on TB detection to community residents, conducted household visits using ETL, referred individuals with coughs to CDSTs for testing, and mobilized the four health areas to dig refuse pits and build latrines. These efforts produced the following results:

- Diagnosed and referred 68 new cases of TB for treatment,
- Dug 197 new refuse pits
- Constructed 142 new latrines in the community.

Champion Men Initiative

Based on the positive deviance model, the Champion Man initiative continues to be implemented in 5 of 8 coordination offices, especially those with Champion Communities (see Table 47 below). This initiative encourages men to model positive behaviors encouraging gender equality for their families and communities.

As an example, in the Nundu health zone, 14 men have committed publicly to taking an equal part in their children's health care. These men promised to take their children for doctor's visits, and ensure that their children receive all prescribed medications. These changes in behavior are encouraging, as these activities have traditionally been a woman's responsibility.

Table 47: Coordination and health zones using the "Champion Men" approach

Coordination	Health zone
Kole	Lomela
Kolwezi	Dilala
Luiza	Dibaya, Luiza, and Ndekesha
Mwene Ditu	Kanda Kanda and Mwene Ditu
Uvira	Nundu

Challenges in implementing IR3 this quarter

- IHP staff provided technical guidance to 144 youth organizations. However, outreach efforts can encounter stiff resistance due to traditions that encourage early marriage. In addition, rumors about negative effects of contraceptives persist and have actually led to a decline in use among young couples.

- Although IHP has formed productive partnerships with organizations like REMOPAK and APROSAF, leaders of these groups claim they are not receiving sufficient support to continue with project efforts.

- CODESAs and community health workers often say they are discouraged by the lack of incentives for their work. Those without reliable, paid work are concerned that their volunteer work is preventing them from earning an income.[5]

- BCC outreach initiatives and campaigns continue to reach thousands. But because of long distances--sometimes over 50 kilometers--between some households and the nearest CSDT, plus the lingering fear of rejection by family and community, TB sufferers sometimes still hide their illness instead of getting treated.

- Network disruptions sometimes cause project SMS messages to go undelivered and data uploads to be delayed. Target populations like women and youth continue to have limited access to mobiles, as most phones are still controlled by the male head of household.

- Although results from Champion Man are encouraging, some men have withdrawn from the initiative due to lack of compensation. Entrenched paternalistic cultural practices work against a rapid uptake in male participation as well.

Next steps: To address the challenges of this quarter, during the next quarter IHP plans to:

- Encourage more youth organizations to participate in outreach events, engage more youth, and train youth leaders.

- Support health zone supervisors and registered nurses to train CODESA members in the use of management tools such as household visit interview guidelines and organizational assessments. In

[5] IHP's contribution to the motivation of the CODESA includes the following: support for monthly monitoring meeting ($15/month); provision of one bicycle; reimbursement of transportation costs during the BCC mini-campaigns; and provision of other BCC materials. IHP channels this contribution through the health zone; the health center head nurse needs to explain why/if the CODESA and CHWs are not getting everything the project provides for them. IHP started testing a different approach of motivating the CODESAs with a specific amount directly linked to rewarding their performance in the new RBF contracts to health centers in the seven RBF pilot health zones.

addition, IHP project staff will organize supervisory trips with representatives from the health zones to monitor and evaluate CODESA activities and progress.

- Encourage Champion Communities to purchase mobile phones for use in their community. IHP staff will train local supervisors on data collection tools. IHP will continue to install Frontline computer software for sending SMS messages within communities, and encourage its use.

- Continue to conduct supervisory trainings with Champion Communities to develop their competencies, including the ability to manage income-generating activities, and encourage Champion Communities to share experiences with other locales to spread best practices. IHP will also aid the Champion Communities in finalizing their formal documents by advocating with local authorities to secure signatures to formalize their status as NGOs.

  Continue to collaborate with the health zones to implement the Champion Man initiative in the Champion Communities.

COMPONENT 2: HEALTH SYSTEMS STRENGTHENING

The decentralization process of the health system reached an active implementation phase with the MOH's official letter announcing the new 26 Provincial Health Divisions and their staff members. It is expected that there will be more opportunity for IHP and other partners to further support strengthening Provincial health governance—including management, coordination, and communication.

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

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

Table 48: Summary of IR 4 Key Results for PY5Q1 by Sub-IR

Sub-IR	Key Indicators		Results
4.1 Provincial health sector policies aligned with national policy	Health zones with AOPs based on national policy		Almost met targets
	Health zone management teams with appropriate management system tools		Below targets

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

During PY5Q1 the 78 IHP-supported health zones conducted an evaluation of their respective 2014 AOPs. This is a self-assessment exercise and the first step of the process of developing their 2015 AOPs. IHP was able to provide technical support to some health zones during the monitoring field visits; however, part of the financial support IHP provides regularly to health zones through the fix obligation grants (FOG) signed with them also contributes this AOP self-evaluation. The FOGs also provide health zones the means to organize monthly monitoring meetings to analyze their data and report their results. During PY5Q2, in addition to the above support provided IHP will be contributing technically and financially to the AOPs consolidation workshops at DPS level in a complementary manner with other Provincial Division of Health (DPS) and health zone partners.

The 2015 AOPs are being developed in the context of the implementation of the new health sector reform that led to establishing 26 new DPS across the country. The 78 IHP-supported health zones are now managed by 8 new DPS teams.

Table 49: Number new health zones that guided the 2015 AOP process by province and coordination offices

N°	Provinces	New DPS	IHP Coordination Office	# health zones supported by IHP	# of health zones with evaluated 2014 AOPs
1	**Katanga**	Lualaba	Kolwezi	8	8
		Haut Lomami	Kamina	9	9
2	**Sud Kivu**	Sud Kivu	Bukavu	22	22
			Uvira	5	5
3	**Kasai Oriental**	Kasaï Oriental	Mwene Ditu	3	3
		Lomami		6	6
		Sankuru	Kole	8	8
			Tshumbe	8	8
4	**Kasai Occidental**	Kasaï	Luiza	1	1
		Kasaï Central		8	8
Total			**158**	**78**	**78**

Health zone management teams with a performance management system that includes essential components
During this quarter the percentage of health zone management teams with a performance management system that includes essential components increased slightly from 62% in PY4Q4 to 64%. However, the performance remains low.

IHP will collaborate with the new provincial health management teams to ensure that the health zones improve their performance management system that includes any of the three essential components: 1) up-to-date job descriptions and organigrams, 2) workplans (including supervision plan and guide), and 3) performance review reports. Sub-grants may be required in order include more specific deliverables.

PROJECT MANAGEMENT

Success stories: During this quarter, the project produced 9 success stories to contribute towards the annual target of 30 stories. They are found in the last section of the report.

Cost share: As of December 31, 2014, IHP has booked $3,213,548.15. The required amount for the current level of obligation is $3,708,422, a remaining balance of $494,874.08. 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:

- In the next reporting period, the four remaining Project CURE containers of donated medical supplies, the project will book the fair market value of $844,515.33.

- The project also anticipates booking as cost share about $472,666 from the HPP project for technical support in 27 health zones shared with IHP. This cost share is pending approval from the MSH Contract Officer. An additional $1,146,566 will be submitted to the Contract Officer for review once the HPP team provides all necessary documentation.
- 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.
- The project received $18,693 worth of neonatal resuscitation supplies from LDS Charities. This was approved by Contracts but Accounts Payable has not booked the amount yet.

Procurement Updates

- **Status of the PY3 pharmaceutical order:** The outstanding product for the PY3 pharmaceutical order, amoxicillin, was delivered in early November 2014 but is still under customs clearance as of the submission of this report. IDA reported that the erythromycin in the IHP PY3 order would not be available in the market for several months. IHP opted to replace it with the amoxicillin dispersible, which is among the priority drugs for under-five pneumonia treatment.
- **Status of the PY4 pharmaceutical order:** Delivery dates for the PY4 pharmaceutical order will be met as scheduled. Shipping has been started to final destination by the global shipping and logistics firm Kuehne & Nagel.
- **Status of the IHP Year 5 Pharmaceutical Order:** The PY5 pharmaceutical order was placed with Amsterdam-based vendors IDA Foundation and Imres Medical Solutions in December 2014 and will be shipped to final destination by Kuehne & Nagel. The import permits for the PY5 order have not been received yet as of the submission of this report.
- **Status of the non-pharmaceutical procurements:** All DRC purchases above $3,000 continue to be reviewed and approved by the Supply Chain Team at MSH home office to ensure proper policies and procedures continue to be followed.

Warehousing: In order to improve storage conditions of drugs managed by MSH in Kinshasa, SIAPS conducted a survey that led to the identification of a new warehouse that meets the minimum storage standards. The move of the stock from the actual warehouse will occur by March 2015.

IHP Closeout: With support from home office staff, IHP is implementing a closeout action plan that includes management of human resources, communication, contracts, operations, logistics, and finance.

- **Human resources management**: In compliance with DRC labor law, IHP followed all required steps to ensure that the project staff was well prepared for closeout. In addition to a written notification that was shared with the staff, verbal communication through staff meetings and individual counseling meetings took place.
- **Communication**: IHP developed a draft communication plan to share the project's achievements, challenges, and lessons learned to all stakeholders at central and decentralized levels. IHP shared the document with USAID for their input. IHP also shared with USAID draft videos that provide lively testimonies from the project beneficiaries and USAID. The communication plan can be found in Appendix 5.
- **Contracts management**: The contractual requirements with MSH partners and other sub-grantees are being regularly followed up.
- **Operations and logistics**: The draft of inventory of IHP assets was completed; and a verification process was triggered to ensure that all the information will be checked prior to finalizing the inventory reports

and the related disposition plans. IHP is also closely following up with the different leases including those for offices (Kinshasa and coordination) and equipment.

- **Financial management**: The project is doing its usual close budget and finance monitoring: a strong tracking system of vendors' invoices and advances has been provided to field offices as well as individuals.
- **Internal audit:** During the reporting period, IHP continued to benefit from internal audit support in order to further strengthen project control systems and mitigate the risks of misuse of project resources. In the next quarterly report, IHP will share audit findings and eventual actions as needed.

FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

1. Family planning

During the reporting period, the main activities carried out in terms of family planning compliance included the following: provide contraceptive supplies so that clients can make an educated selection from a range of methods; plan and organize post-training providers and community-based distributors, including monitoring of contraceptive management; and distribute management tools.

During PY5Q1, 80 IHP staff based in Kinshasa and the coordination offices completed the Voluntary Family Planning course as required by the MSH Corporate Contracts Office. The online course provided an overview of voluntary family planning and the legislative and policy requirements that govern USG-funded activities, projects, and services. The course was designed for staff to have basic knowledge of these requirements in order to comply with applicable laws and policies, monitor program quality and compliance, and know what to do when possible violations occur. The Chief Operating Officer made it mandatory for MSH staff, including managers and technical staff, to complete the course.

During the next few months, IHP will continue to assessing vulnerabilities that may lead to non-compliance and vulnerability related to the Tiahrt amendment through field visits for post-training follow-up, supervision, and RBF monitoring and verification activities.

2. HIV and AIDS

All IHP activities related to HIV and AIDS continue to be carried out in compliance with the PEPFAR team's orientation and guidance, and relevant USG legislation and requirements.

Providers at the Fungurume health zone were briefed in the implementation of option B+ in the care of patients living with HIV. HIV monitoring visits with the USAID/PEPFAR team during the month of December 2014 were carried out at the central health zone offices and selected HIV and AIDS sites in Kamina (Kabongo, Kinkondja, Malemba Nkulu, and Mulongo) and Kolwezi (Fungurume, Lualaba, and Dilala).

A blood collection campaign was carried out in the Uvira health zone. The health zones of Ruzizi, Nundu, and Lemera are waiting for supplies in order to carry out similar campaigns. HIV sites that have Pima equipment have not been fully functioning due to stock out of Pima cartridges and other related commodities.

ENVIRONMENTAL MONITORING AND MITIGATION PLAN

The project monitored environmental compliance, particularly related to medical waste management. The IHP staff members were not able to visit all the supported health facilities (1,398 health centers and 78 GRHs), but they were able to visit all the health facilities in the seven RBF health zones during the verification of RBF results reported. No issues of environmental non-compliance were reported. Health facilities continued to invest their resources to further improve their FOSACOF score which includes environmental compliance. In addition, in Kamina and Kolwezi, the monitoring of HIV and AIDS activities conducted in selected sites in Kamina (Kabongo, Kinkonja, Malemba Nkulu and Mulongo) and Kolwezi (Fungurume, Lualaba, and Dilala) checked on the environmental compliance and no violation was reported.

The other activities with high risk of violation include the quality of the WASH-related infrastructure and facilities. During this quarter, IHP provided technical and financial support to renovate 68 water sources and 7,628 household ventilated improved pit (VIP) latrines that respect the environmental compliance guidelines. IHP will continue to monitor WASH facilities (including 111 water sources and 25,898 familial latrines built in PY4) and the quality of the drinking water from the improved sources. IHP will also provide technical support to the WASH committees in charge of their maintenance

CHALLENGES ENCOUNTERED

The main challenges that the project experienced during PY5Q1 included the following:

Security: There is recurring insecurity in certain health zones, such as Bunyakiri, Shabunda, Mwenga, Miti Murhesa, Mulungu, Lulingu, Mubumbano, Kaniola, Lemera, Nundu, Uvira, Ruzizi, and Haut Plateaux. 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 vaccines. The lack of vaccines affects the project's ability to implement planned activities and achieve 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 number of bed nets available at the CDRs in Kamina, Kolwezi, Bukavu, and Mwene Ditu exceed what IHP is able to distribute before its closeout. In addition, IHP's approved budget did not include all CDR storage fees or distribution to the 69 target health zones. IHP consulted with PMI and its implementing partners, including SIAPS, USAID|DELIVER, and PMI Expansion to come up with a solution: the group agreed that IHP will manage about 500,000 LLINs, enough for routine distribution to pregnant women during ANC and preschool children during preschool consultations (PSC). The distribution of these LLINs will start during the next quarter.

IHP completed the baseline assessment of the study on rectal artesunate, and the draft report was shared with PMI for comments. However, IHP was unable to continue with the intervention phase of the study because the rectal artesunate was not available. IHP worked with PMI to try to borrow the product from IMA/Santé Rurale (SANRU) prior to launching the intervention activities, but this initiative was not successful. PMI and IHP agreed to wait until the rectal artesunate is provided USAID|DELIVER as ordered and planned to deliver by the end of

March 2015. IHP and PMI will work together to make sure that the study will be included in and completed during the bridge project.

Some institutions have not yet mastered the calculation of their average monthly consumption of many of the 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. IHP will continue to address these issues in collaboration with SIAPS, USAID|DELIVER Project, and SCMS through building capacity throughout the supply chain in the coordination offices that have the most stock outs.

Data Quality: Despite the availability of tools for data collection, data quality remains a major challenge in the project due to hastily performed collection and interpretation without a careful analysis of all the data. The project continues to provide tools to all health facilities, support monitoring meetings to ensure quality data, and perform data quality assessments. As a priority activity during the next following quarters, the project plans to continue the DQA exercises for selected indicators identified in the narrative of this report.

WAY FORWARD: PLANNED ACTIVITIES FOR NEXT QUARTER

In the final year of the IHP project priority activities will focus on consolidating gains and strengthening progress made in key service delivery areas as discussed in the report. Supportive supervision, data quality assessment, and joint technical assessment visits will emphasize documenting lessons learned and best practices as the project comes to a close. The following key activities, presented by IR, will be the focus of PY5Q2 efforts:

IR 1

- ✓ Provide technical support for quarterly FOSACOF evaluations and remedial action plans in 4 health zones and promote exchange of knowledge and best practices between health zones
- ✓ Continue rehabilitation of health facilities as planned, including constructing incinerators, hand washing stations, waste management materials, and latrines.
- ✓ Provide basic equipment and materials to health facilities, based on need, in the health zones supported by the eight 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 continue to 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 including reinforcing capacity to estimate needs, manage inventories, and assure timely transport of drugs and commodities through drug management report reviews, quarterly drug management and drug quantification working groups, inventory monitoring, supportive supervision and follow-up
- ✓ 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 community involvement in health zone management by providing ongoing support to CODESAs to develop and implement action plans

- ✓ Consolidate the WASH gains by focusing on establishing and revitalizing the CLTS approach at the community level to set up WASH committees and develop action plans, construct latrines, improve water sources, water quality monitoring, installation monitoring and maintenance, supervision and follow-up visits, celebrating achievements, holding awareness events, and by providing technical and financial assistance.
- ✓ Strengthen and mobilize IYCF support groups at the community level in supported health zones through supportive supervision, knowledge exchange forums, and providing materials for monitoring and data collection
- ✓ Strengthen Provincial and District health management capacity through the LDP approach by supporting the development and implementation of action plans and monitoring achievement of results, and promoting inter-zonal exchange of knowledge and best practices

IR 2

- ✓ Strengthen family planning activities through supportive supervision of service providers on clinical family planning methods, integration of community-based distribution (CBD) activities, integration of FP strategies at community care sites, and the distribution of monitoring and management tools and other necessary supplies and commodities, 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 and post-training follow-up 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),LLINs, ACT, RDT, and lab reagents to strengthen malaria prevention and treatment programs
- ✓ 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 by conducting a needs assessment and providing technical assistance for supportive supervision and follow-up for roll-out
- ✓ Strengthen the fight against HIV through supportive supervision and post-training follow-up, providing management and data collection tools, and provision of logistical support for medicines and materials
- ✓ 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 as well as providing technical and financial assistance for mini-community and school-based campaigns 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, exchanging knowledge and lessons learned, annual evaluations, and achieving NGO status
- ✓ Conduct joint supportive supervision and follow-up visits on BCC activities with the MOH

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
- ✓ 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

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SUCCESS STORIES

The success stories are attached on the following pages.

USAID | DEMOCRATIC REPUBLIC OF CONGO

FROM THE AMERICAN PEOPLE

SUCCESS STORY

Results-based Financing Improves Health Services through Incentives and Better Management

Through a Results-based financing approach, a hospital in the DR Congo improved the quality of its services in addition to lowering its fees for community care seekers.

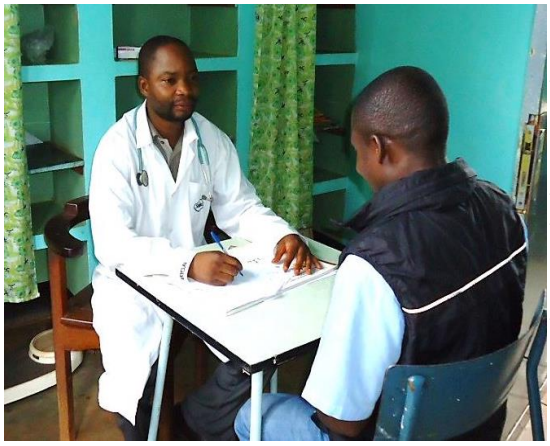

Photo: International Rescue Committee

Dr. Willy Musau consults with a patient in the Kanzenze General Referral Hospital.

We see…improvement in the quality of care, proper utilization of services and overall patient satisfaction. The RBF approach has also created a small increase in revenue for the service providers.

--Dr. Bruno Mwenya, chief physician of the Kanzenze health zone.

When assessed for its overall quality of services at the end of 2012, the Kanzenze General Referral Hospital (GRH) in the province of Katanga, Democratic Republic Congo (DRC), scored a disappointing 36 percent, indicating that it was underperforming in many categories.

In 2013, the USAID-funded DRC Integrated Health Project (DRC-IHP) launched a pilot Results-based Financing (RBF) program in Kanzenze and six other health zones to see if financial incentives and goal-setting could improve access to care, quality of services, and community engagement.

To kick-start the process, the Kanzenze GRH received $3,600 in November 2013. The GRH formed a steering committee that prioritized various improvements: lower fees for community members; recruitment and training of staff; and linking staff bonuses to performance. Hospital staff also received refresher training on patient care protocols.

“After six months, due to our improving performance visibly, we received an additional $22,000, which we reinvested in order to refurbish and paint the walls, and repair electrical wiring in the pediatric ward,” said Dr. Willy Musau, acting medical director.

As goals were agreed upon and results-based financing implemented between 2013 and 2014, all indicators significantly improved. For instance, the number of qualified health professionals more than doubled, from 8 in 2013 to 18 in 2014. Average monthly revenue jumped from 1.75 million to 2.85 million Congolese Francs (from $1,800 to $3,000). Hospital admissions nearly tripled (from 687 to 1,812). The overall service quality indicator soared from 36 to 94 percent. The in-hospital mortality rate dropped (from 2.6 to 1.3).

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Community Members Use Trust, Persuasion to Screen TB Sufferers at Home, and Lead Them to Treatment

Community health workers and volunteers lead record-setting outreach campaign to identify TB sufferers in the Miti Murhesa health zone.

Photo: Overseas Strategic Consulting, Ltd.

Community health workers use community messaging to encourage families to get tested for TB.

"We have never even achieved results like this in a year. Our health area's goal is to receive the same support from all of our partners to cover all of our 18 health areas…."

-Mr. Masiala, nurse supervisor, Miti Murhesa health zone

Tuberculosis (TB) is one of the leading causes of death and disability in Democratic Republic of Congo (DRC), with half of all cases of this extremely infectious disease undetected and untreated. The national average for detection is only 51 percent of the expected cases. In Sud Kivu province, the detection rate was until recently only 27 percent, due to conflict, rugged terrain, and difficulty mobilizing community volunteers for outreach. And within the province, in the Miti Murhesa health zone, only eight percent of expected cases of TB were being identified.

To control the spread of TB, the Ministry of Health developed a National Tuberculosis Strategy Plan for 2014-2017 and a National Tuberculosis Program (PLNT). The program depends heavily on community health workers (CHW) at the grassroots level—people who know the community well and whom residents trust. CHWs screen for TB cases house by house, collecting sputum samples from people they suspect might be positive (e.g., people with a persistent cough). If a test comes back positive, the volunteer refers the individual to a local treatment center.

In November 2014, the USAID-funded DRC-Integrated Health Project's (DRC-IHP) supported TB awareness, screening, and referral in Miti Murhesa and 4 other health zones. In Miti Murhesa, IHP trained 50 CHWs, plus community leaders, and health managers on TB prevention, identification, referral, and treatment. During outreach, health workers visited 553 households, identifying 159 individuals with respiratory symptoms and educated them on the risks of TB. Of those, 120 were persuaded to submit sputum samples for TB testing.

As a result of this campaign, 9 new TB cases were detected in 3 health areas of Miti Murhesa; this represents a 50% increase in the number of TB cases (6) expected each quarter in the health zone. Further improvements are expected due to continued community outreach. The campaign provided a valuable opportunity for CHWs, nurses and health clinic workers, and community leaders to work together on a key health issue in their community. The high proportion of suspected cases detected in the 500+ households, as well as the high proportion of individuals submitting sputum for analysis, demonstrate the value of a community-led approach to TB.

One volunteer and mother of two, Zawadi, praised the campaign: "Our joint work with the nurses and health centers enabled us to mobilize and test people in a way that has never been done here before."

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Refrigerators Powered by Sunshine Help More Children Get Vaccines

Thanks to solar-powered refrigerators provided by DRC-IHP, vaccination coverage against childhood diseases increased in a remote community in DRC.

A nurse in the Mwambayi health center vaccinates a child against polio.

Photo: Management Sciences for Health

It takes three days and a few river crossings to trek 135 kilometers by bicycle from the nearest health zone office to Mwambayi, Katanga Province, Democratic Republic of Congo (DRC). Until recently, because the village health center lacked electricity, it had no way to keep vaccines cold once they arrived. Mwambayi's average vaccination coverage for children hovered around 83 percent, short of the annual target of 90 percent.

To keep the cold chain going so that vaccines remain active, in September 2014 the USAID-funded DRC-Integrated Health Project (IHP) installed a solar-powered refrigerator at the Mwambayi health center. Solar refrigerators have the advantage of being cost effective and pollution free—and their investment costs are 90% less than fuel-powered refrigerators within three to five years.

Within two months, vaccination coverage in Mwambayi jumped to 95 percent. Two other health areas about 45 kilometers north of Mwambayi also benefited from the refrigeration unit. From one quarter to the next, vaccine coverage rose from 85 to 92 percent in Nyundo and from 85 to 95 percent in Kalungu.

Before the solar-powered refrigerator was installed, children living far from the center were not immunized because the vaccines could not be kept cold enough on the journey, according to Banza Muleya, head nurse at the health center.

"We are now able to further expand our immunization reach with vaccines of good quality because of the onsite refrigeration unit in Mwambayi," Muleya said.

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We are now able to further expand our immunization reach with vaccines of good quality because of the onsite refrigeration unit.

- ***Banza Muleya, head nurse at the Mwambayi health center***

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Setting--and Meeting--Targets for Better TB Detection and Care

In a leadership workshop, health officials vowed to raise TB detection and treatment rates from 60 to 85 percent. New skills helped them exceed their goal.

Photo: Management Sciences for Health

A TB patient takes his medicine at a TB treatment and detection center in Dibindi

We are very proud of the result achieved, allowing more people to get treated early on and avoiding spread of the disease (TB).”

- ***Dr. Roger Mudibu, chief medical officer, health zone of Dibindi***

Tuberculosis sufferers often do not realize they have TB, so an important part of treating the disease is educating communities, screening individuals, and finding those who need treatment. In the Dibindi health zone in Kasaï Oriental Province of the Democratic Republic of Congo (DRC), the detection rate at 60% was only two-thirds of those likely to be infected—leaving many in this zone of 260,000 people untreated. The national target for TB detection is 70 percent.

To help improve the TB detection rate, the USAID-funded DRC-Integrated Health Project (DRC-IHP) invited the Dibindi health zone management team to attend a Leadership Development Program (LDP) workshop in April 2013. In an LDP workshop, participants set program goals, analyze major challenges, and learn new leadership and management techniques to achieve their targets.

As their Leadership Development Program desired measurable result, the Dibindi team set a target of increasing TB detection from 66 to 80 percent--or 154 TB patients--by the end of June 2014.

IHP staff collaborated with local health officials to provide TB testing and treatment in two health centers that had not previously offered it. And the project engaged a TB support group to raise TB awareness in the community. From January to June 2014, these volunteers held 120 public information sessions in churches and other arenas. From this work alone, 257 suspected TB cases were referred to health centers for testing and treatment. By the end of June 2014, the TB detection rate soared above the national target, reaching 85 percent and rising.

“The credit for this fantastic result must go to the Leadership Development Program workshop that we attended in April 2013 in Tshilumba,” said Dr. Roger Mudibu, the health zone chief medical officer. “We are very proud of the result achieved, allowing more people to get treated early on and avoiding spread of the disease.”

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SUCCESS STORY

Fix it and They Will Come: Serving More Patients by Renovating Health Centers

With local partners, the Integrated Health Project brought new life to a dilapidated clinic and saw utilization rates rise from 40 to 72 percent within three months.

Photo: Management Sciences for Health

Chief Ntambo accompanies health officials during a visit to the Kamoa health center in Kanzenze.

We are very pleased with the results. We have urged staff and the community to maintain the building** and **to ensure its cleanliness, because a clean and well-organized health structure allows for better service delivery.

--Chief Ntambo of Kamoa village

The Kamoa health center symbolized many of the challenges that Congolese face in their health system. In dire need of repairs, the two-room center lacked essential equipment such as a delivery bed and medications. It had no incinerator or waste disposal system. It was built to serve some 5,000 villagers in Katanga Province, but because of its dilapidation, residents preferred to walk to the general referral hospital 13 kilometers away. The health center's utilization rate was only 40 percent—only slightly higher than the national average of 35 percent.

To make the center more functional and encourage the population to use it, the USAID-funded Democratic Republic of Congo-Integrated Health Project (DRC-IHP) worked with the Kanzenze health zone management team to repair and refurbish it. In consultation with local residents, the project hired a construction firm. Led by village chief Ntambo, the Kamoa community also mobilized to transport water, gravel, and sand, and provide meals for the masons.

After three months of work, the new Kamoa health center boasted a treatment room, two separate consultation rooms for men and women, an office for staff, reception area, and waiting room—plus an incinerator and latrines.

In just three months (October to December 2014), the utilization rate in Kamoa jumped from 40 to 72 percent.

"Today we have a modern health center with all the services that a health center is supposed to provide," said Dr. Bruno Mwenya, medical director for the health zone.

"We are very pleased with the results," said Chief Ntambo. "We have urged staff and the community to maintain the building and to ensure its cleanliness, because a clean and well-organized health structure allows for better service delivery."

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Feeding Baby Ali: Better Nutrition with Local Foods Gives Children a Healthier Start

Baby Ali was severely malnourished until his mother learned from a support group how to make more nutritious food from local ingredients.

Photo: Management Sciences for Health

Thérèse Nakaji and husband Lady Mbuyi feeding their son Ali with homemade food following a recipe learned from the infant and young child feeding support group in Luiza.

My children now have a chance for a healthier growth, development, and life.

- ***Thérèse Nakaji, mother of five, in Luiza, Kasaï Occidental, DRC***

Sometimes it is not just lack of food that causes malnutrition, but lack of knowledge--particularly on how best to feed infants and children. In the Democratic Republic of Congo, the USAID-funded Integrated Health Project (DRC-IHP) promotes nutrition education along with a spectrum of health services and support for families. In the small town of Luiza, three out of five children are malnourished. Poverty contributes, but so does lack of birth spacing and low awareness of good nutrition.

In April 2014, two community health workers (CHW), Salomé Nambombo and Monique Mputu, were on a house-to-house visit in Luiza and found all five of 22-year-old Thérèse Nakaji's children were malnourished. Particularly affected was Ali, who at one year weighed only 13.2 pounds (6 kilograms) and measured 23.8 inches (60.5 centimeters).

The CHWs, who had been trained in infant and young child feeding (IYCF) and family planning by DRC-IHP, taught Thérèse and her husband, Lady Mbuyi, the importance of breastfeeding, how to better feed all their children, and the benefits of family planning. They also invited Thérèse to join an IYCF support group, where health workers led cooking demonstrations with local foods to show that nutritious meals can be both easy to prepare and affordable.

Despite modest means, Thérèse now cooks three times a week the recipes she learned from the support group. Family meals may include amaranth soup, maize-flour porridge, caterpillar powder, red oil, and iodine-fortified salt. While the whole family benefits, Ali has made a dramatic recovery. After three months of better food, he weighed nearly 20 pounds (9 kg).

"I would like to sincerely thank the community health workers who helped me gain vital knowledge on infant nutrition and feeding through their support group and taught me how to prepare nutritious food," said Thérèse.

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SUCCESS STORY

Results-based Financing Dramatically Boosts TB Detection and Treatment

Thanks to a performance-based contract, the Bibanga health zone quadrupled its detection and treatment of TB cases, through mobile laboratories, community outreach, and health worker education.

Photo: Management Sciences for Health

A lab technician works in a mobile laboratory in the Bibanga health zone.

The funds we receive each quarter have allowed us to improve community outreach, motivate staff, and support the functioning of the mobile laboratory.

- ***Dr. Jean Michel Mutombo, chief medical doctor of the Bibanga health zone***

In 2013, fewer than one in five people with tuberculosis (TB) were being treated for the disease in Bibanga health zone, Democratic Republic of Congo (DRC). The TB detection rate was only 17 percent compared to the national target of 75 percent. (The detection rate compares the number of cases detected by health workers versus the number of cases estimated to exist by the World Health Organization based on local conditions.)

In November 2013, Bibanga health zone became one of seven zones in DRC where the USAID-funded Integrated Health Project (DRC-IHP) is improving facility performance through Results-based Financing (RBF). Under RBF, facility managers and funders agree on goals and activities to improve access to care, quality of services, resource management, and community engagement. The closer the facility comes to meeting its targets, the more funding it receives.

One provision in the contract with Bibanga's general referral hospital supports mobile laboratory visits to remote areas, where laboratory technicians screen patients and test sputum free of charge. All individuals testing positive are immediately put on treatment. The health zone management team has coached nurses to follow up these patients and also trained health center nurses to refer suspected cases to the tuberculosis screening and treatment centers (CSDT).

Community health workers also spread the word about TB at Sunday church services and go door to door to screen for people who are coughing, then refer them to the CSDT. This outreach leads to the identification of about 33 suspected cases each quarter. The hospital receives $10,000 each quarter to fund this and other outreach.

"In about a year, we have improved the TB detection rate from 17 to 72 percent, thanks to the RBF program," reports Dr. Jean Michel Mutombo, chief medical officer of the health zone. "The funds we receive each quarter have allowed us to improve community outreach, motivate staff, and support the functioning of the mobile laboratory. We are satisfied with the program, and we would like to share our experiences with others."

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. In November 2013, 135 RBF health entities (118 health centers, 7 health zones, and 7 general referral hospitals) signed performance contracts under the program. IHP has also contracted with 14 community-based organizations (2 per health zone) to verify health center data.

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Revitalizing Health Services through Performance Contracts and Results-based Financing

A performance contract and results-based financial incentives helped renovate a hospital and increase quality of services through coaching and training.

Photo: Management Sciences for Health

Health officials show off a newly-built well at the Wembonyama Hospital.

We are proud that our 60-year-old hospital now attracts people from other health zones…because of the improved quality of service and infrastructure.

- ***Pastor Jean Francois Kalombo, Wembonyama General Referral Hospital (GRH)***

Until recently, if you went to the Wembonyama Hospital in the Democratic Republic of Congo (DRC), in addition to your health challenges you would need to haul your own drinking and bathing water or get family members to do so. The water and plumbing system at this 71- bed referral facility had languished unrepaired for years.

In October 2013, Wembonyama health zone became one of seven zones in DRC where the Integrated Health Project (DRC-IHP) is improving facilities through “results-based financing” (RBF). Under RBF, facility managers and funders agree on goals and activities to improve access to care, quality of services, resource management, and community engagement. Then funding provides incentives: The closer the facility comes to meeting its targets, the more funding it receives.

In this case, the performance contract included fixing the plumbing. A $12,000 payment helped to rehabilitate the well and pipes to supply both the hospital and local community with clean water. The health zone management team also renovated the pediatric ward of the hospital, repaired ceilings, installed a fence, and provided bonuses to hospital employees.

In addition to infrastructure improvements, RBF provides management tools and training, followed by coaching of health care providers during follow-up visits. The Wembonyana hospital is visibly rejuvenated.

“Through the implementation of RBF, the hospital improved its ability to care for patients,” said Jean François Kalombo, the pastor of the Methodist church that operates the hospital. “We are even prouder to say that our 60-year-old hospital now attracts people from other health zones to seek treatment because of the improved quality of service and infrastructure.”

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

"Champion Community" Champions Family Planning to Reduce Maternal and Child Mortality

After leadership training, community members improve knowledge and use of family planning services through a coordinated outreach campaign.

Photo: Overseas Strategic Consulting, Ltd.

A community health worker facilitates an educational session on family planning methods.

We decided to raise awareness through [group info sessions and public messaging] so that the village leaders educate their own people.

--Nikolas Loleke, Vice President of the Tokadjimo Champion Community Steering Committee

The Democratic Republic of Congo (DRC) ranks among the top 20 countries with the highest death rates of mothers and children, often due to health complications resulting from poor family planning and lack of birth spacing. In the Kole health zone, the USAID-funded DRC Integrated Health Program (DRC-IHP) is addressing this challenge through the grassroots Champion Community approach.

In late 2014, the program helped community members create a Champion Community of health workers and volunteers called *Tokadjimo ("*We are changing" in the local language). IHP trained 30 leaders of the Champion Community in management and leadership skills such as developing an action plan, defining targets, and incorporating sustainability strategies for awareness and action. The committee chose to boost the use of modern family planning as one of their priorities. Strategies would include increasing knowledge through interpersonal communication and community messaging.

Champion Community members (14 women and 7 men) organized group sessions in which they educated more than 1,000 women of reproductive age on family planning methods. In addition, they arranged for messages to be delivered at churches, markets, and other public places to encourage people to visit health centers for family planning services.

"We decided to raise awareness through these two communication channels so that the village leaders educate their own people," said Nikolas Loleke, Tokadjimo Champion Community Steering Committee Vice President. Within three months, the Champion Community reached approximately 600 women through the outreach campaign. Another 500 women participated in counseling sessions organized by health centers. More than 60 percent of women counseled accepted to use one of the family planning modern methods she learned about during home and health center visits.

Thanks largely to this outreach campaign, the proportion of women of reproductive age visiting the local health center rose from approximately 36 to 53 percent over just three months.

The Champion Community approach shows again the importance of grassroots involvement and local action on health behavior.

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Appendix 1: DRC Integrated Health Project Performance Monitoring Plan, PY5Q1

Indicateur		Définition	Oct-14	Nov-14	Dec-14	PY5Q1		
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						**Achievement**	**Target**	**Achievement Rate (%)**
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	53,608	49,114	46,328	**149,051**	**112,500**	**132**
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	20,346	18,778	17,998	**57,123**	**41,250**	**138**
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	53,717	53,751	52,243	**159,711**	**128,058**	**125**
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	66,043	68,543	74,314	**208,900**	**164,890**	**127**
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	2,044	2,044	2,044	**2,044**	**2,000**	**102**
	Disaggregated by type of service delivery:	*(a) Health facility based*	1,561	1,561	1,561	**1,561**	**1,600**	**98**
		(b) Community-level based	483	483	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	48	#VALUE!	97	**97**	**50**	**194**

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	45,351	44,776	44,084	**134,211**	**132,157**	
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	42,052	42,052	42,052	**126,156**	**139,113**	
		Numerator/ Denominator (in percentage)	**108%**	**106%**	**105%**	**106%**	**95%**	**112**
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	21,795	22,539	22,585	**66,919**	**97,379**	
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	42,052	42,052	42,052	**126,156**	**139,113**	
		Numerator/Denominator (in percentage)	**51.8%**	**53.6%**	**53.7%**	**53.0%**	**70%**	**76**
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	39,860	37,717	38,041	**115,618**	**118,246**	
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	42,052	42,052	42,052	**126,156**	**139,113**	
		Numerator/ Denominator (in percentage)	**94.8%**	**89.7%**	**90.5%**	**91.6%**	**85%**	**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	37,564	35,518	36,267	**109,349**	**118,246**	
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	39,860	37,717	38,041	**115,618**	**118,246**	
		Numerator/ Denominator (in percentage)	**94.2%**	**94.2%**	**95.3%**	**94.6%**	**100%**	**95**
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	38,246	36,061	36,754	**111,061**	**139,113**	**80**

		mothers/newborns who did not have SBA delivery) (4% Tot Pop)						
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	39,040	36,908	35,787	**111,735**	**117,747**	
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	42,052	42,052	42,052	**126,156**	**117,747**	
		Numerator/ Denominator (in percentage)	**92.8%**	**87.8%**	**85.1%**	**88.6%**	**100%**	**89**
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)	4,446	3,549	3,395	**11,390**	**8,347**	**136**
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)	35,898	35,551	40,766	**112,215**	**147,607**	**76**
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)	41,189	46,430	49,840	**137,459**	**196,812**	**70**
15	**MNCH:** Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs =	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	39,079	37,842	39,165	**116,086**	**108,655**	
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	36,764	36,764	36,764	**110,292**	**121,376**	

		Numerator/ Denominator (in percentage)	**106.3%**	**102.9%**	**106.5%**	**105%**	**90%**	**118**
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	2,276	2,872	1,093	**6,241**	**5,433**	
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	41,355	40,714	40,258	**122,327**	**108,655**	
		Numerator/ Denominator (in percentage)	**5.5%**	**7.1%**	**2.7%**	**5.1%**	**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 target area	36,589	36,189	37,759	**110,537**	**108,655**	
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	36,764	36,764	36,764	**110,292**	**121,376**	
		Numerator/ Denominator (in percentage)	**99.5%**	**98.4%**	**102.7%**	**100%**	**90%**	**112**
18	**MNCH:** Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	243	126	165	**165**	**50**	**330**
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	374,148	1,291,662	261,689	**1,927,499**	**573,987**	**336**
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	45,024	38,702	42,789	**126,515**	**112,500**	
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	42,052	42,052	42,052	**126,156**	**139,113**	
		Numerator/ Denominator (in percentage)	**107%**	**92%**	**102%**	**100%**	**81%**	**124**
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)	58,794	57,037	51,135	**166,966**	**105,530**	**158**

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	12,952	14,053	14,266	**41,271**	**92,971**	**44**
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	508	489	502	**502**	**50**	**1,004**
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)	848	944	1,325	**3,117**	**7,226**	
		Denominator: Total population in the specified geographical area	1,053,409	1,053,409	1,053,409	**3,160,228**	**3,255,035**	
		Numerator/ Denominator (per 100,000 population)	**80.5**	**89.6**	**125.8**	**98.6**	**214**	**46**
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	544	565	768	**1,877**	**4,480**	
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	848	944	1,325	**3,117**	**7,226**	
		Numerator/ Denominator (in percentage)	**64**	**60**	**58**	**60%**	**62%**	**97**
26	**TB:** Case detection rate	Numerator: Number of new smear positive TB cases detected	848	944	1,325	**3,117**	**3,652**	
		Denominator: Estimated number of TB cases expected	1,580	1,580	1,580	**4,740**	**5,217**	
		Numerator/ Denominator (in percentage)	**53.7%**	**59.7%**	**83.9%**	**66%**	**70%**	**94**
27	**TB:** Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	4	7	34	**45**	**20**	**227**
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	18	11	31	**31**	**0**	**0**

29	Percentage of PEPFAR-supported 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	6	6	6	**6**	**69**	
		Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	69	69	69	**69**	**69**	
		Percent =(Num/Den)x100	9%	9%	9%	**9%**	**100%**	**9**
30	Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results) (DSD)	***Numerator***: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	1,708	1,542	1,440	**4,690**	**5,474**	
		Denominator: Number of new ANC and L&D clients	2,376	2,095	1,772	**6,243**	**6,002**	
		Percent =(Num/Den)x100	72%	74%	81%	**75%**	**91%**	**82**
31	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	***Numerator:*** Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	14	20	14	**48**	**49**	
		Denominator: Number of HIV- positive pregnant women identified in the reporting period (including known HIV-positive at entry)	46	42	32	**120**	**52**	
		Percent =(Num/Den)x100	30%	48%	44%	**40%**	**93%**	**43**
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	11	0	71	**82**	**108**	**76**
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	6,796	4,087	4,812	**15,695**	**8,750**	**179**

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)	774	1,101	691	**2,566**	**204**	**1,259**
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)	3,092	4,378	2,683	**3,384**	**204**	**1,661**
36	TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	***Numerator***: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	270	399	213	**882**	**183**	
		Denominator: Number of patient HIV-positive	3,112	4,377	2,688	**10,177**	**204**	
		Percent =(Num/Den)x100	9%	9%	8%	**9%**	**90%**	**10**
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	2,371	2,844	2,125	**7,340**	**168**	**4,376**
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	144	152	98	**394**	**125**	**315**
39	Proportion of registered TB cases who are HIV-positive who are on ART	***Numerator***: The number of registered TB cases with documented HIV-positive status who start or continue ART during the reporting period	47	66	85	**198**	**130**	
		Denominator: The number of registered TB cases with documented HIV-positive status during the reporting period	239	392	233	**864**	**150**	
		Percent =(Num/Den)x100	20%	17%	36%	**23%**	**87%**	**26**

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	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	17	18	18	**18**	**14**	
		Denominator : Total number of laboratories and testing sites	69	69	69	**69**	**69**	
		Percent =(Num/Den)x100	25%	26%	26%	**26%**	**20%**	**128**
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)	0	0	0	**0**	**1**	**0**
42	Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	***Numerator***: Number of service delivery points supported by PEPFAR for HIV services that are directly providing integrated voluntary family planning services	69	69	69	**69**	**14**	
		Denominator: Total number of PEPFAR-supported HIV service delivery points	69	69	69	**69**	**69**	
		Percent =(Num/Den)x100	100%	100%	100%	**100%**	**20%**	**502**
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 CPA	Numerator: # of GRHs implementing CPA	70	70	70	**70**	**62**	
		Denominator: Total # of GRHs	78	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**90%**	**90%**	**90%**	**90%**	**79%**	**113**

44	***L+M+G:** % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	21	21	21	**21**	**31**	
		Denominator: Total # of GRHs	78	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**27%**	**27%**	**27%**	**27%**	**40%**	**68**
45	***L+M+G:** % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	1,382	1,382	1,382	**1,382**	**1,118**	
		Denominator: Total # of health centers	1,398	1,398	1,398	**1,398**	**1,398**	
		Numerator/ Denominator (in percentage)	**99%**	**99%**	**99%**	**99%**	**80%**	**124**
46	***L+M+G:** % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	136	136	136	**136**	**559**	
		Denominator: Total # of health centers	1,398	1,398	1,398	**1,398**	**1,398**	
		Numerator/ Denominator (in percentage)	**9.7%**	**9.7%**	**9.7%**	**9.7%**	**40%**	**24**
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/	30,681	30,040	27,846	**88,567**	**118,246**	
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	42,052	42,052	42,052	**126,156**	**139,113**	
		Numerator/ Denominator (in percentage)	**73%**	**71%**	**66%**	**70%**	**85%**	**83**
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	172	531	229	**229**	**50**	**458**

49	**MALARIA:** Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	0	0	0	**0**	**113,750**	**0**
50	**MALARIA:** Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	1,304	8,266	9,378	**18,948**	**113,750**	**17**
50.1		*(a) through campaigns*	0	0	0	**0**	**0**	**0**
50.2		*(b) through health facilities*	1,304	8,266	9,378	**18,948**	**113,750**	**17**
50.3		*(c) through the private/commercial sector*	0	0	0	**0**	**0**	**0**
50.4		*(d) through other distribution channels*	0	0	0	**0**	**0**	**0**
50.5		*(e) through voucher schemes*	0	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	20	0	0	**20**	**219**	**9**
		Male	18	0	0	**18**	**146**	**12**
		Female	2	0	0	**2**	**73**	**3**
52	**MALARIA:** Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	114,923	91,593	72,037	**278,553**	**750,000**	**37**
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**	**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)	121,463	118,949	89,016	**329,428**	**750,000**	**44**

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	0	0	0	**0**	**294**	**0**
56	**MALARIA:** Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	220,972	188,365	95,871	**505,208**	**875,000**	**58**
57	**MALARIA:** Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	141,289	145,160	138,476	**424,925**	**625,000**	**68**
	Disaggregated in 3 sub-categories:	*(a) to health facilities*	136,880	139,109	131,011	**407,000**	**610,051**	**67**
		(b) to community health workers (HBMF, CCM)	4,409	6,051	7,465	**17,925**	**14,949**	**120**
		(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	0	0	0	**0**	**300**	**0**
	(a) Number of health facility workers trained (male/female)	*Male*	0	0	0	**0**	**146**	**0**
		Female	0	0	0	**0**	**73**	**0**
	(b) Nombre d'agents communautaires formés (sexe masculin/sexe féminin)	*Male*	0	0	0	**0**	**50**	**0**
		Female	0	0	0	**0**	**25**	**0**
	(c) Nombre de techniciens de laboratoire formés (sexe masculin/sexe féminin)	*Male*	0	0	0	**0**	**5**	**0**

		Female	0	0	0	**0**	**1**	**0**
59	**MALARIA:** Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	95,570	202,954	53,158	**351,682**	**1,000,000**	**35**
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	96,682	129,360	121,454	**347,496**	**625,000**	**56**
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/	1,306	1,306	1,306	**1,306**	**1,398**	
		Denominator: Total # of communities in IHP target area	1,398	1,398	1,398	**1,398**	**1,398**	
		Numerator/Denominator (in percentage)	**93.4%**	**93.4%**	**93.4%**	**93.4%**	**100%**	**93**
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)	19,803	27,077	15,849	**62,729**	**362,601**	**17**
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)	24,092	13,392	44,283	**81,767**	**362,601**	**23**
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	18	19	17	**54**	**78**	

		Denominator: Total number of IHP health zones	78	78	78	78	78	
		Numerator/ Denominator (in percentage)	**23%**	**24%**	**22%**	**69%**	**100%**	**69**
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	78	78	78	78	78	
		Denominator: Total # HZs in IHP target area	78	78	78	78	78	
		Numerator/ Denominator (in percentage)	**100%**	**100%**	**100%**	**100%**	**100%**	**100**
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)	1,107	1,079	1,126	1,104	1,398	
		Denominator: Total number of health centers in IHP areas	1,398	1,398	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	**79.2%**	**77.2%**	**80.5%**	**79.0%**	**100%**	**79**
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)	68	70	75	71	78	
		Denominator: Total number of hospitals in IHP areas	78	78	78	78	78	

		Numerator/ Denominator (in percentage)	**87.2%**	**89.7%**	**96.2%**	**91.0%**	**100%**	**91**
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	**0**	**20**	**0**
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	294	241	196	**731**	**500**	**146**
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	0	0	**0**	**2**	**0**
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	731	731	731	**731**	**700**	
		Denominator: Total # of facilities	1,476	1,476	1,476	**1,476**	**1,398**	
		Numerator/ Denominator (in percentage)	**50%**	**50%**	**50%**	**50%**	**50%**	**99**
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	1,665	2,116	1,759	**5,540**	**10,881**	
		Denominator: Total # of patients seen by a CHW	13,482	9,949	10,708	**34,139**	**217,620**	
		Numerator/ Denominator (in percentage)	**12%**	**21%**	**16%**	**16%**	5%	**325**
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	18,049	20,606	19,205	**57,860**	**11197**	

		Denominator: Total number of patients seen by a CHW or health care provider	490,918	478,921	498,232	1,468,071	862,117	
		Numerator/ Denominator (in percentage)	**3.7%**	**4.3%**	**3.9%**	**4%**	**1.3%**	**303**
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	211	230	227	227	15	
		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	337	337	337	337	25	
		Numerator/ Denominator (in percentage)	**63%**	**68%**	**67%**	**67%**	**60%**	**112**
73	***L+M+G:** # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	33	33	33	99	7	**1,523**
74	***L+M+G:** # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	33	33	33	33	7	**508**
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	144	144	144	144	30	**480**
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	1,265	1,252	1,246	1,254	1,060	**118**
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)	18,273	10,631	93,121	122,025	125,000	**98**
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")	70	70	70	**70**	**78**	
		Denominator: Total # of health zones	78	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**90%**	**90%**	**90%**	**90%**	**100%**	**90**
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	49	50	50	**50**	**78**	
		Denominator: Total # of health zones	78	78	78	**78**	**78**	
		Numerator/ Denominator (in percentage)	**63%**	**64%**	**64%**	**64%**	**100%**	**64**
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.)	5	2	3	**9**	**8**	**112**

Appendix 2: Distribution Summary of Family Planning Commodities, October to December 2014

Commodity	October 14	November 14	December 14
Collier du cycle	3940	4047	16505
Condom féminin	14535	18441	56660
Condom masculin	396092	953353	472932
Depo Provera	12683	22268	41205
Jadelle + trocar	566	413	736
Microgynon	18559	12990	15471
Microlut	700	431	793
Combinaison 3	7128	5853	11332
Ovrette	2015	2651	2770
Pillule d'urgence	0	0	0
Stérilet TCU 380 A	22	37	160
Implanon	11	46	20
Kit d'insertion de Jadelle	0	19	0

Projet de Santé Intégré
en République Démocratique du Congo

USAID
DU PEUPLE AMERICAIN

Plan de Communication

Coordonnées de contact en RDC :
4, Citronniers, Q. Golf, GOMBE
Directeur du Projet : Dr. Ousmane Faye, +243 0992006180
Responsable administratif et financier : Rood Merveille, +243 0992909670
Responsable Communication: Landry S. Malaba, +243970007795

Coordonnées de contact aux États-Unis :
200 Rivers Edge Drive / Medford, MA / 02155784
Directeur, Portefeuille du pays : Kristin Cooney, Tél. : +1 617-250-9168
DRC-IHP Cooperative Agreement No.AID-OAA-A-10-00054

Janvier 2015

Table des matières

1. Contexte et Justification

Le Projet de Santé Intégré en République Démocratique du Congo (PROSANI) est un accord de coopération entre le gouvernement de la République Démocratique du Congo (RDC) et le gouvernement des Etats-Unis d'Amérique, financé par l'Agence Américaine pour le Développement International (USAID) pour une durée de cinq ans (30 Septembre 2010 au 29 Septembre 2015). Il est mis en œuvre par un consortium de trois organisations internationales à savoir Management Sciences for Health (MSH), International Rescue Committee (IRC) et Overseas Strategic Consulting Ltd (OSC). PROSANI intervient dans 4 provinces en RDC : le Kasaï Occidental, le Kasaï Oriental, le Katanga et le Sud-Kivu et assure un appui global dans les soins de santé primaires à 80 zones de santé (réduites à 78 depuis mai 2014). Il dessert une population estimée à environ 12 millions d'habitants.

Le Projet est conçu pour appuyer le Ministère de la Santé Publique dans la mise en œuvre du Programme National de Développement Sanitaire portant sur le renforcement du système de santé et l'appui au développement des zones de santé.

Les principales composantes du Projet sont: la planification familiale et la santé de la reproduction, la santé maternelle, néonatale et infantile, la nutrition, le paludisme, la tuberculose, le VIH et SIDA ainsi que l'eau, l'hygiène et l'assainissement.

Le Projet assure le renforcement des capacités en leadership et gouvernance des cadres et des prestataires de service du Ministère de la Santé Publique et de la communauté afin d'améliorer l'accès, la disponibilité et la qualité des services dans les 78 zones de santé ciblées.

Durant la dernière année de mise en œuvre du projet, il s'avère impérieux de communiquer avec les différents partenaires clés en l'occurrence le Gouvernement Congolais à travers le Ministère de la Santé Publique sur les principaux résultats, les succès et leçons apprises mais aussi l'appropriation des acquis de PROSANI par les bénéficiaires au cours de cinq années d'exécution. Il s'agira aussi de communiquer sur le processus de désengagement de PROSANI quant à son appui dans les zones d'intervention et de se prononcer sur le mécanisme de relève et continuité par les bénéficiaires.

Deux axes feront l'objet de cette communication à savoir : le niveau interne et le niveau externe.
Au niveau interne, la communication concernera le personnel et les partenaires de mise en œuvre du Projet. Au niveau externe, il s'agira essentiellement des niveaux central, intermédiaire et opérationnel du Ministère de la Santé Publique.

Notre plan de communication va recourir d'une part aux medias de masse traditionnels notamment audio, audiovisuel et document écrit et d'autre part à la communication numérique y compris les medias sociaux.
« Raconter notre histoire » sera l'un des styles privilégiés de manière à documenter la réalité à travers les points de vue personnels des bénéficiaires, des agents de santé communautaires, des prestataires de service et parties prenantes du projet, témoignant de l'amélioration de la santé ainsi que des vies sauvées dans la communauté.

2. Objectifs

- Communiquer les résultats de PROSANI aux différents publics, notamment le Ministère de la Santé Publique (MSP) de la RDC, l'USAID, MSH dans son ensemble, les communautés IRC et OSC, aux Organisations internationales non gouvernementales de développement et de la santé publique, ainsi que les peuples congolais et américain;
- Partager les informations sur les leçons apprises, les bonnes pratiques, les méthodes et outils éprouvés avec d'autres programmes des pouvoirs publics et bailleurs;
- Plaidoyer pour la pérennisation des acquis ;
- Informer officiellement toutes les parties prenantes sur la fin du projet et les mécanismes de désengagement ;
- Informer à l'interne le personnel du projet sur le processus de clôture par étape.

3. Stratégies de Communication

La stratégie de communication de PROSANI est de fournir des informations exactes à ce jour sur l'appui du projet, à l'intention des parties prenantes, qui illustrent la manière dont les résultats ont été atteints dans les 4 provinces d'intervention et à travers ses différents volets.
La communication de proximité sera privilégiée pour des échanges avec les différents partenaires mais aussi la communication par des supports écrits, audio et audiovisuels sans oublier les medias sociaux feront notre base de contact et de dissémination de l'information.
La communication non classique par le poster et l'affichage d'images y compris la cartographie de différentes interventions du projet viendra en appui à la stratégie pour une meilleure expression.

Les conférences de restitution, sont une série de conférence tenue au niveau provincial où il s'agira de montrer l'appui de PROSANI au niveau provincial durant les cinq années d'intervention. Ce sera un cadre idéal d'échanges avec toutes les parties prenantes et elles seront organisées par PROSANI sous l'égide des autorités de la santé au niveau Provincial.
La Conférence de Presse, qui se fera au niveau national en équipe mixte MSP-USAID-PROSANI, reste privilégiée pour faire valoir l'appropriation des résultats et les leçons apprises. MSH a produit un documentaire vidéo qui sera utilisé pour illustrer les réalisations du projet au cours de différentes présentations.

4. Messages clés

Dans le cadre de son appui au Ministère de la Santé Publique à travers les PNDS : :

- PROSANI a renforcé des capacités du système de santé pour augmenter l'accès et la disponibilité de produits et services essentiels de santé dans les zones de santé ciblées du projet.
- PROSANI a renforcé les capacités cliniques et de gestion des prestataires de santé en RDC pour améliorer les prestations de services de santé offertes à la population congolaise.
- PROSANI a travaillé conjointement avec la population congolaise pour développer des pratiques positives de santé et des comportements à intégrer dans la vie quotidienne.

- PROSANI a renforcé le leadership et la gouvernance dans le secteur de la santé pour promouvoir des améliorations durables de la qualité des prestations de services de santé qu'il faille pérenniser.

5. Cibles et Moyens techniques

5.1 Cibles Primaires

Les principaux publics visés par ce plan communication de ce projet sont ses partenaires clés, notamment le Gouvernement de la RDC à travers le Ministère de la Santé Publique, l'USAID/RDC, les partenaires de mise en œuvre et la population congolaise.

5.2 Cibles secondaire

Le public secondaire est le peuple américain, notamment les personnes qui œuvrent dans le domaine du développement et de la santé publique, l'USAID dans le monde et ses organismes partenaires.

Public Cible:	**Moyens techniques:**
Bailleur:	Rapport trimestriel. Success stories. Factsheets. Newsletter USAID, Medias sociaux (Facebook)
Ministère de la Santé Publique:	Conférences de restitution sur les résultats et les leçons apprises de PROSANI aux niveaux central et Provincial. Factsheet mis à jour. Feuillet à quatre pages. Visite de terrain Documentaire sur les succès du Projet Conférences-déjeuner Voyage de Presse Conférence de Presse Rapport Final Compendium
Les institutions partenaires du projet:	Réunions et Note d'information

Partenaires en santé publique:	Conférence de restitution
Staff PROSANI	Note d'étape

5. Rôles et Responsabilités

Le Directeur PROSANI est le principal responsable de ce plan de communication dont il coordonnera la mise en œuvre tout en assurant une collaboration étroite avec l'USAID. Il s'appuiera sur les membres de l'équipe de PROSANI à différents niveaux.

6. Chronogramme

Activités	TRIMESTRE 1			TRIMESTRE 2			TRIMESTRE 3			
Conference de Restitution Provinciale	Janv	Fév.	Mars	Avril	Mai	Juin	Juillet	Août	Sept.	
• Katanga: Lubumbashi										
• Sud Kivu: Bukavu										
• Kasaï Oriental: Mbuji Mayi										
• Kasaï Occidental: Kananga										
• Kinshasa: Gombe										
Conférence Thématique										
• Université Notre Dame Kananga										
• Université de Mbuji Mayi										
• Université de Bukavu										
• Université de Lubumbashi										
• Université de Kinshasa										
Jeu Concours HIV										
• Kolwezi										
• Kamina										
Autres										
• Voyage de Presse [Bilomba et Kanzenze]										
• Conférence-déjeuner										
• Rapport Final et Conférence de Presse										
• Note d'information	TBD			TBD			TBD			
COUT TOTAL										**225.000$**

Chronogramme des conférences de restitution et vies sauvées, Juin- Août 2015

Provinces	Période	Lieu	Types d'activités
Kasaï Occidental	22 au 27 juin	Kananga	Conférences de restitution et vies sauvées, Conférence de Presse et visite de site. Pas de lancement CDCS
Katanga	13 au 18 juillet	Lubumbashi	Conférences de restitution et vies sauvées, CDCS, Conférence de Presse et visite de site.
Kasaï Oriental	27 au 31 juillet	Mbuji- Mayi	Conférences de restitution et vies sauvées, CDCS, Conférence de Presse et visite de site.
Sud Kivu	10 au 15 août	Bukavu	Conférences de restitution et vies sauvées, CDCS, Conférence de Presse et visite de site.
Kinshasa	13 au 18 août	Kinshasa	Conférences de restitution et vies sauvées, Conférence de Presse et visite de site. Pas de lancement CDCS

Appendix 5: DRC-IHP Accruals Report, October to December 2014

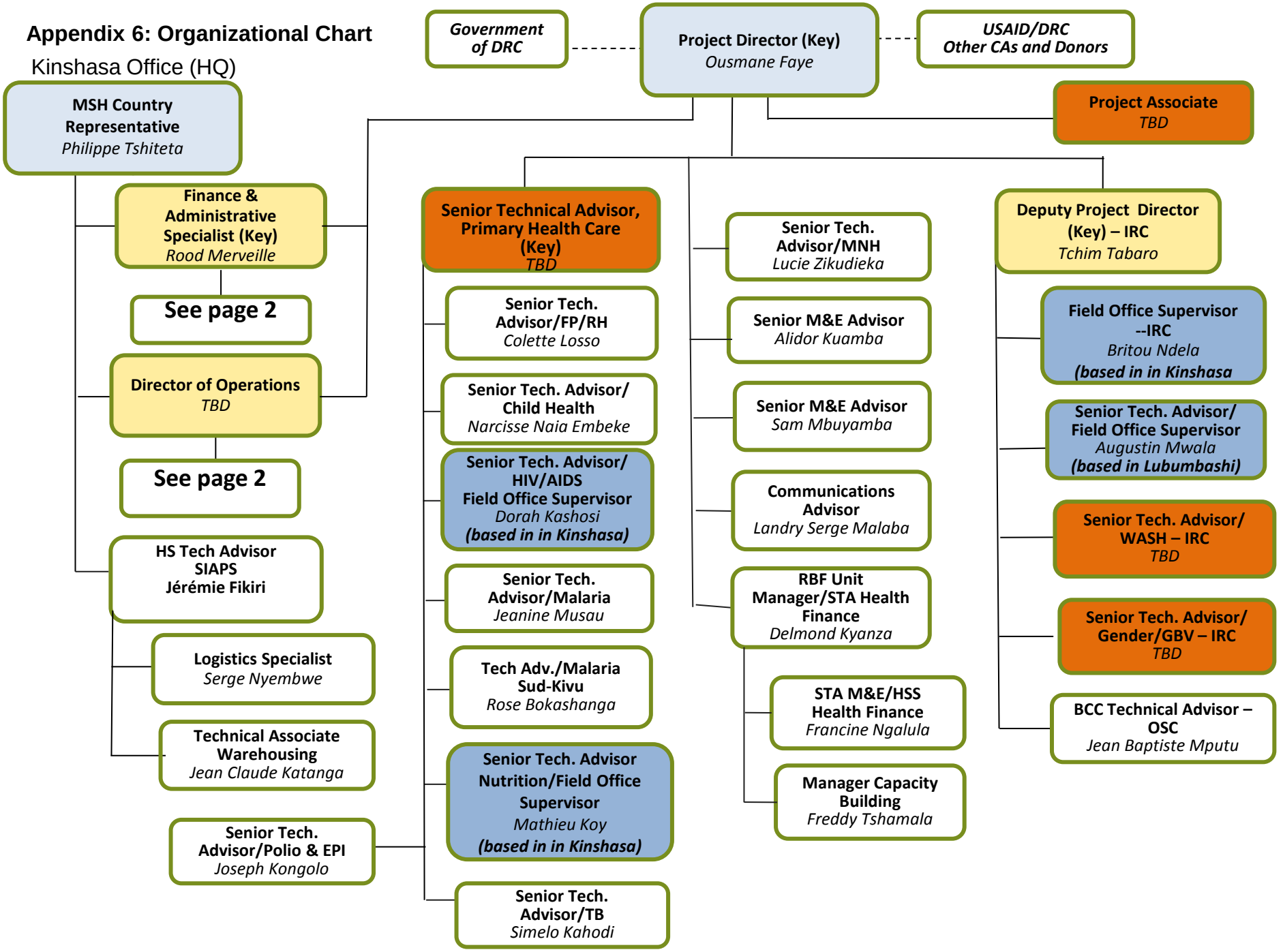
USAID/DRC
Financial Management Office
Accruals Worksheet for the period
Oct 1, 2014 - Dec 31, 2014

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

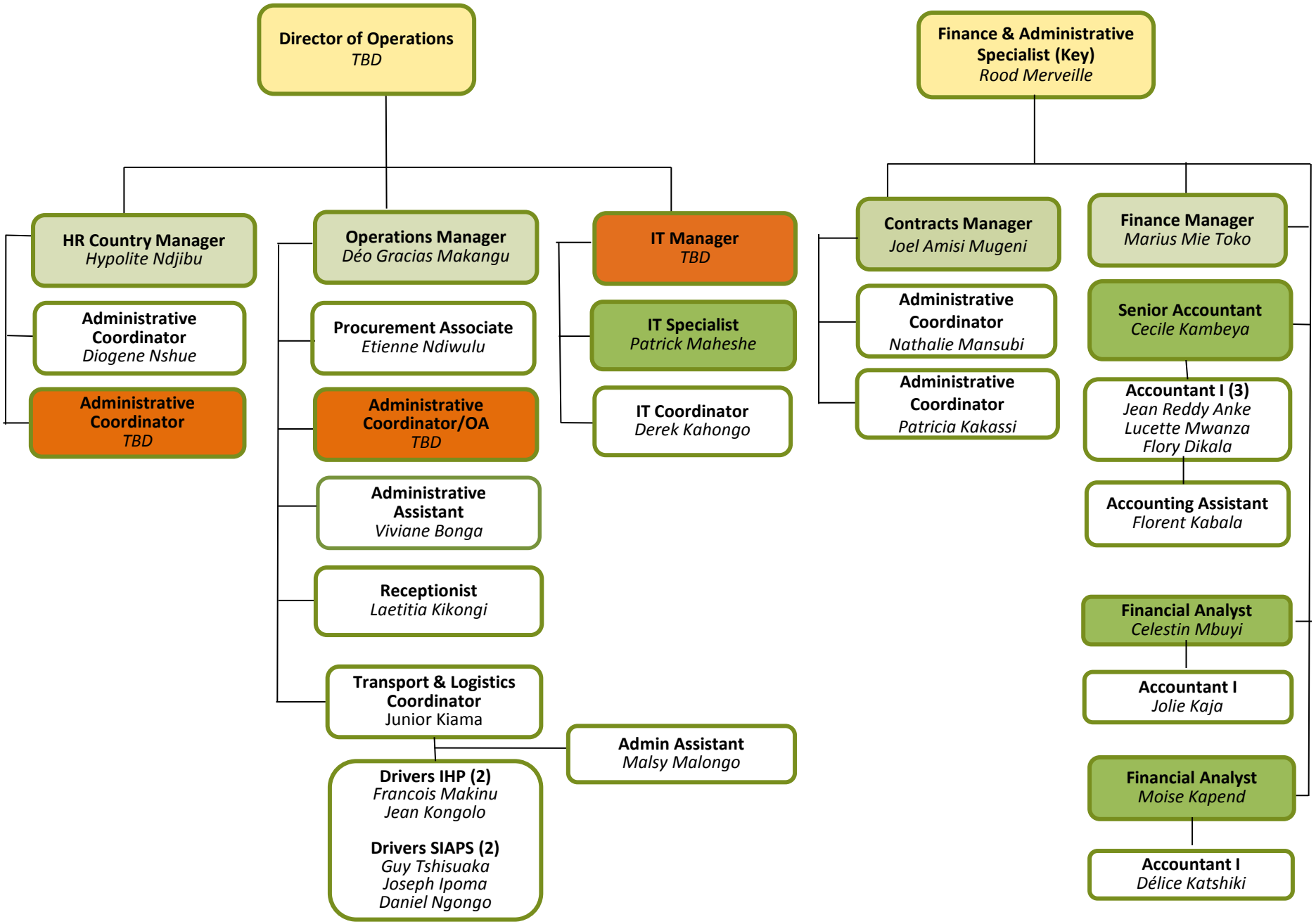
			A	B	C	D	E	F= (C + D+ E)	G = B - F	K = A - F
Program Area	**Program Element**	**BFY Fund**	**Estimated LOP Budget**	**Obligations**	**Disbursements (Oct 2010 - Sept 2014)**	**Quarter 1 - Disbursement (Oct-Dec 2014)**	**Quarter 1 Accruals (Dec 2014)**	**Project Total to Date (including accrual)**	**Obligations remaining (Pipeline)**	**Estimated Balance**
A11	A047- HIV/AIDS	GH-AIDS/2010/201	$ 14,743,405.00	$ 9,183,113.00	$ 7,257,107.09	$ 532,373.32	$ 724,559.45	$ 8,514,039.85	$ 669,073.15	$ 6,229,365.15
A11	A048 - TB	GH-C/2010/2011	$ 17,286,763.00	$ 13,366,723.67	$ 10,563,274.68	$ 681,954.05	$ 1,054,651.72	$ 12,299,880.45	$ 1,066,843.22	$ 4,986,882.55
A11	A049 - Malaria	GH-C/20102011	$ 20,245,000.00	$ 18,344,982.33	$ 14,497,426.01	$ 978,883.57	$ 1,447,442.74	$ 16,923,752.32	$ 1,421,230.01	$ 3,321,247.68
A11	A052- MCH	GH-C/20102011	$ 45,731,306.00	$ 53,058,614.83	$ 41,930,448.82	$ 2,867,710.18	$ 4,186,393.06	$ 48,984,552.06	$ 4,074,062.77	$ (3,253,246.06)
A11	A053 - FP/RH	GH-C-POP/2010/201	$ 20,625,615.00	$ 16,958,948.00	$ 13,402,089.43	$ 828,602.43	$ 1,338,082.84	$ 15,568,774.71	$ 1,390,173.29	$ 5,056,840.29
A11	A054 - WASH	ES/2010/2011	$ 12,610,800.00	$ 13,178,793.67	$ 10,414,759.89	$ 723,852.12	$ 1,039,823.80	$ 12,178,435.80	$ 1,000,357.87	$ 432,364.20
A11	A142- Nutrition	GH-C-GFSI/2010/201	$ 8,524,240.00	$ 5,642,844.80	$ 4,459,351.53	$ 292,828.62	$ 445,227.72	$ 5,197,407.87	$ 445,436.93	$ 3,326,832.13
Grand Total			$ 139,767,129.00	$ 129,734,020.30	$ 102,524,457.45	$ 6,906,204.29	$ 10,236,181.33	$ 119,666,843.07	$ 10,067,177.23	$ 20,100,285.93

Appendix 6: Organizational Chart

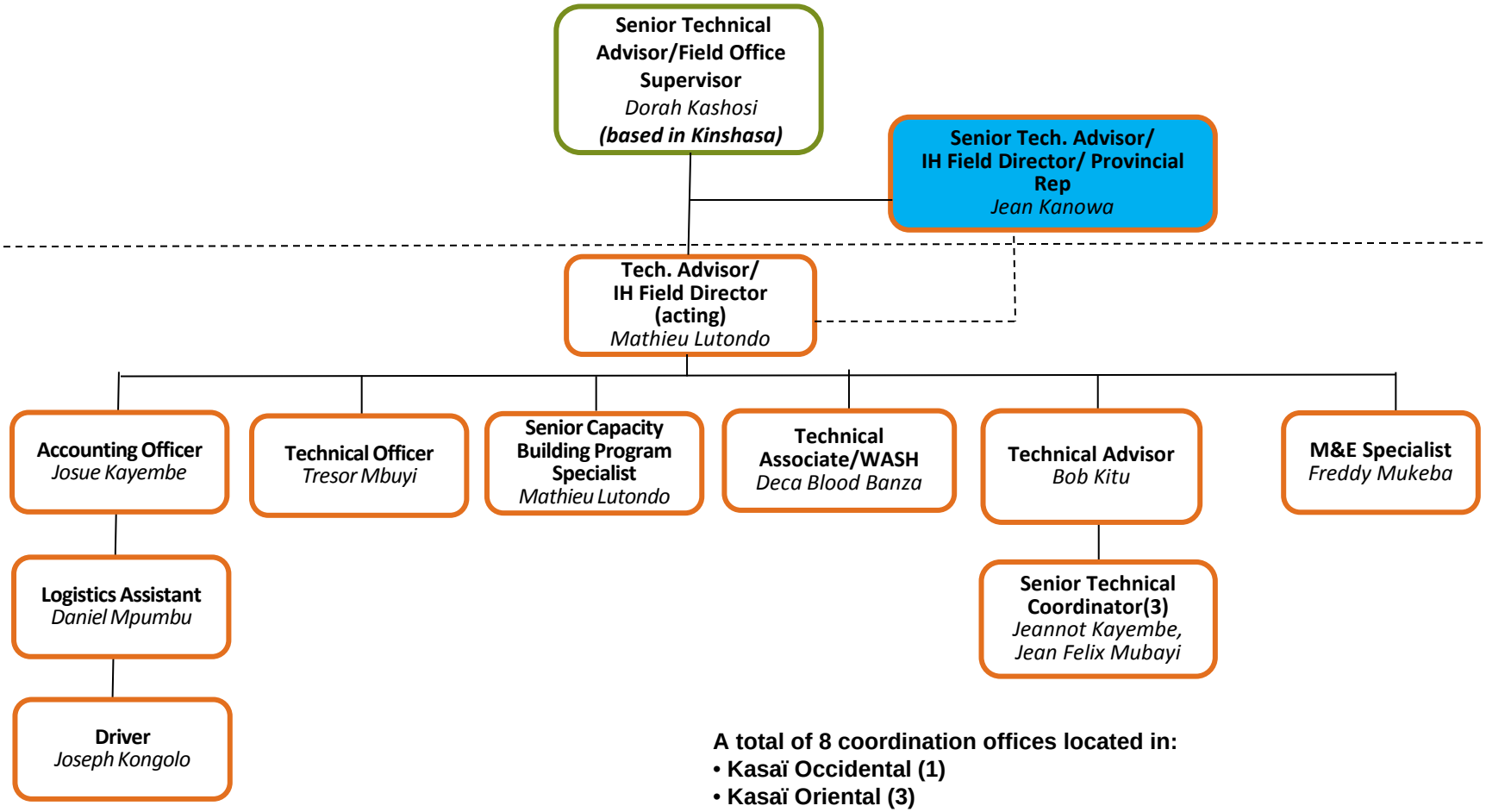
Kinshasa Office (HQ)



Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasaï Occidental

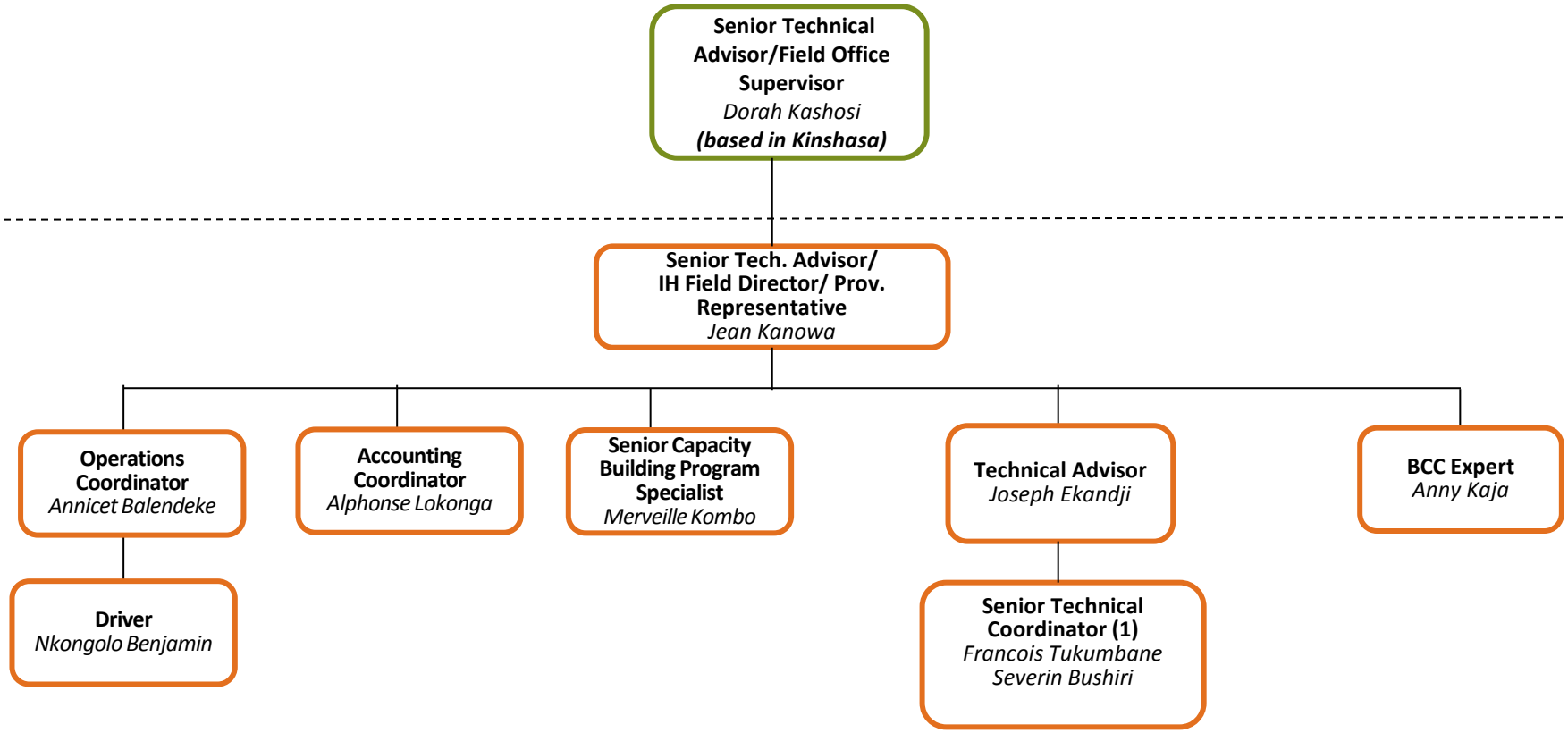


A total of 8 coordination offices located in:

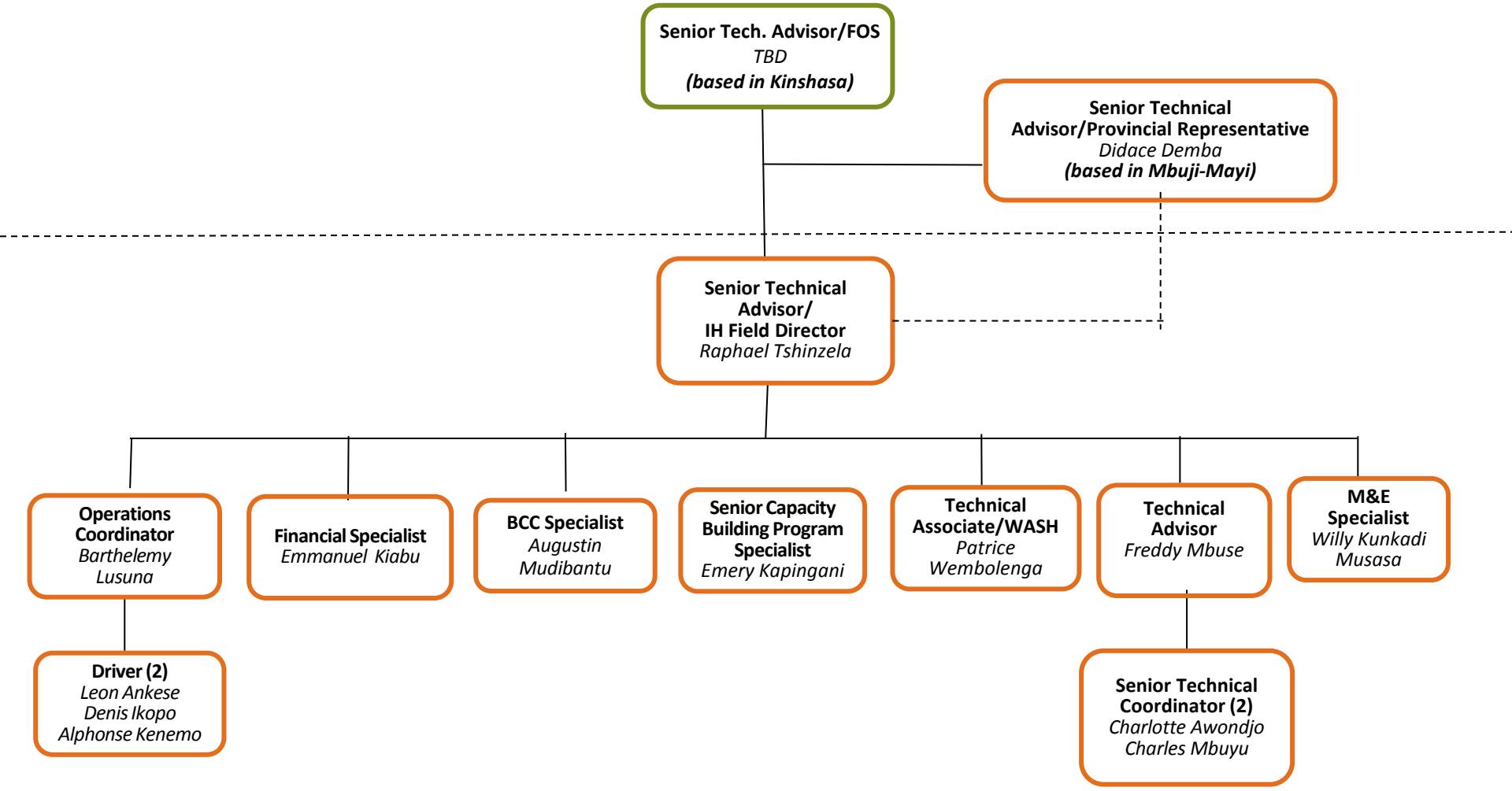
- **Kasaï Occidental (1)**
- **Kasaï Oriental (3)**
- **Katanga (2)**
- **Sud Kivu (2)**

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.

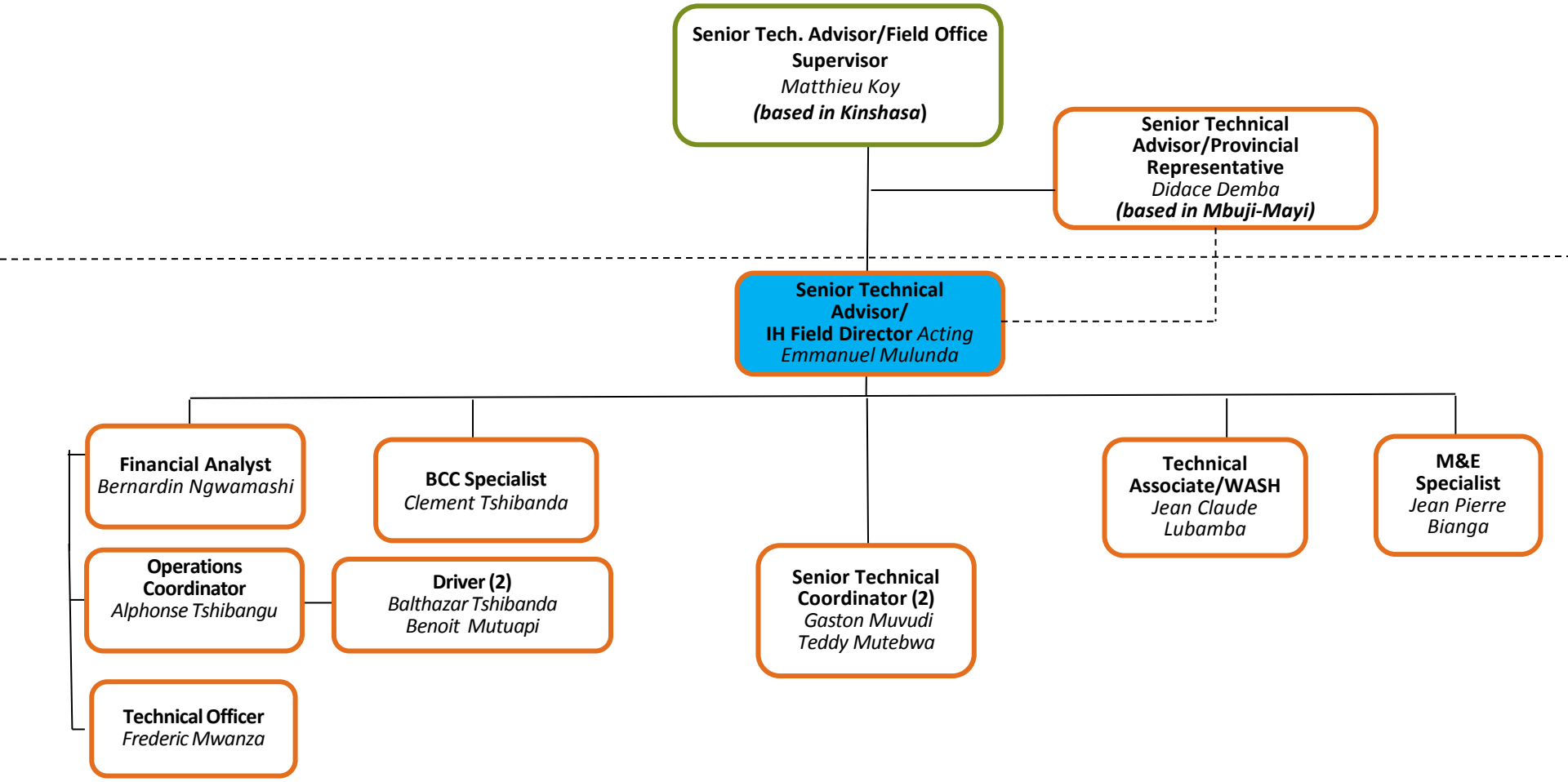
IHP Field Office: Kananga, Kasaï Occidental



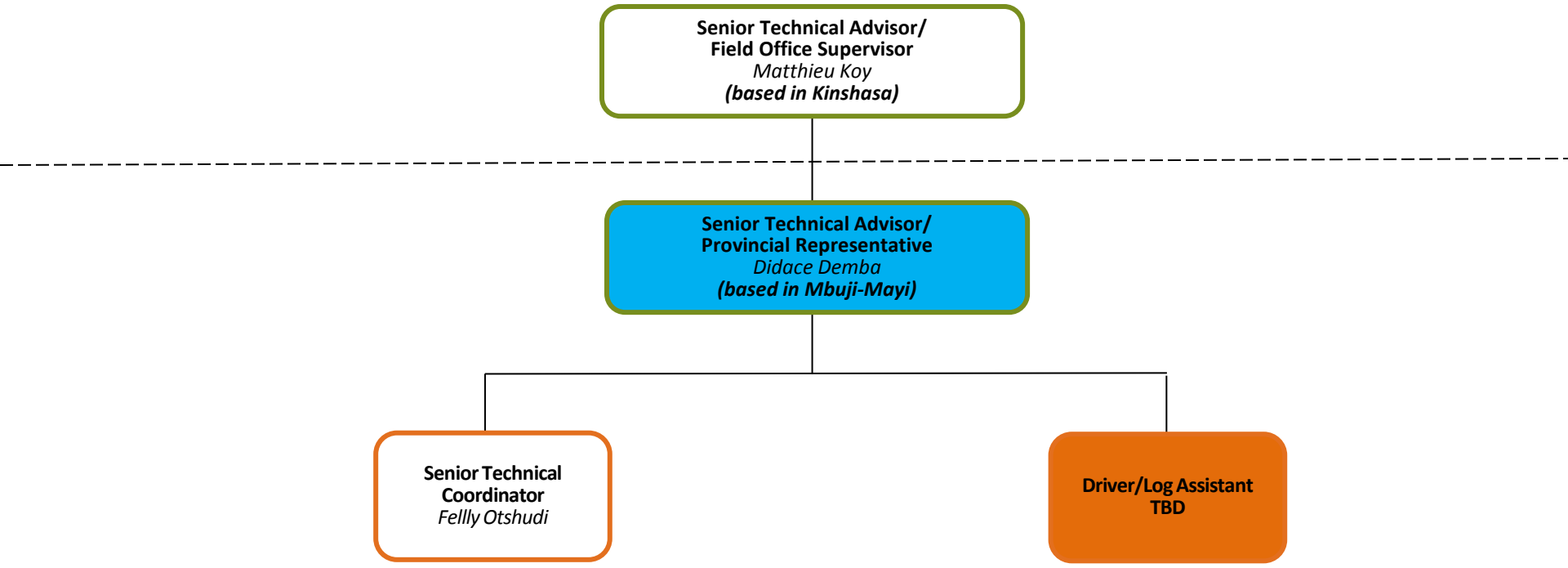
IHP Field Office: Kole (Lodja), Kasaï Oriental



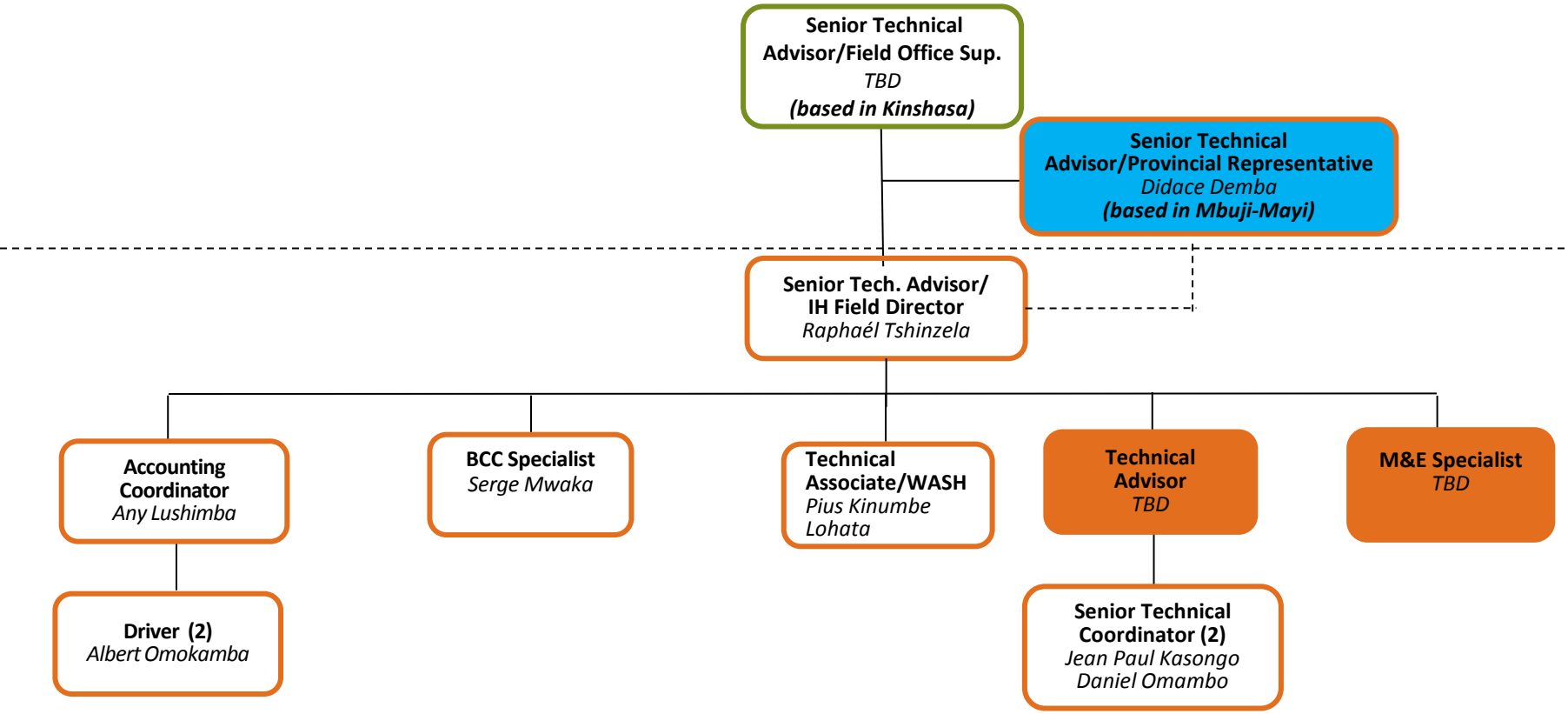
IHP Field Office: Mwene-Ditu, Kasaï Oriental



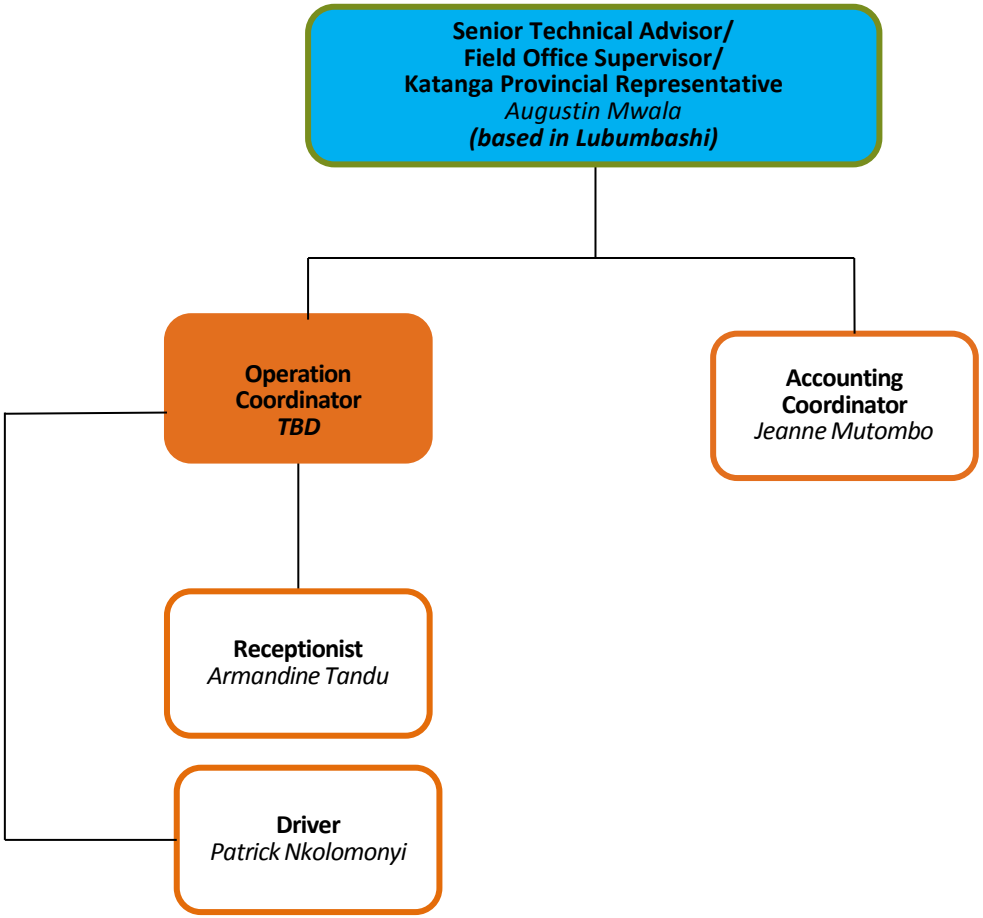
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



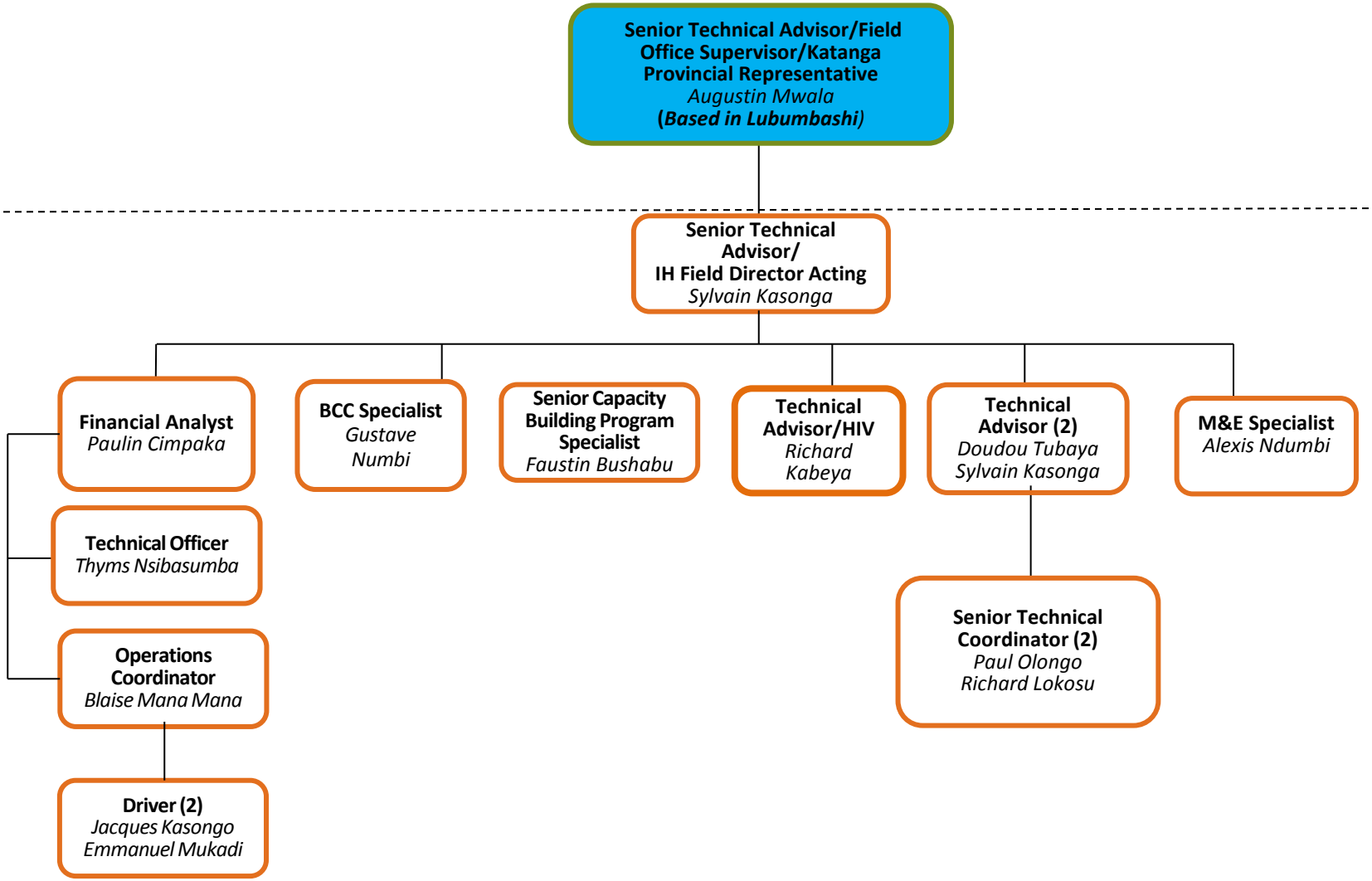
IHP Field Office: Tshumbe, Kasaï Oriental



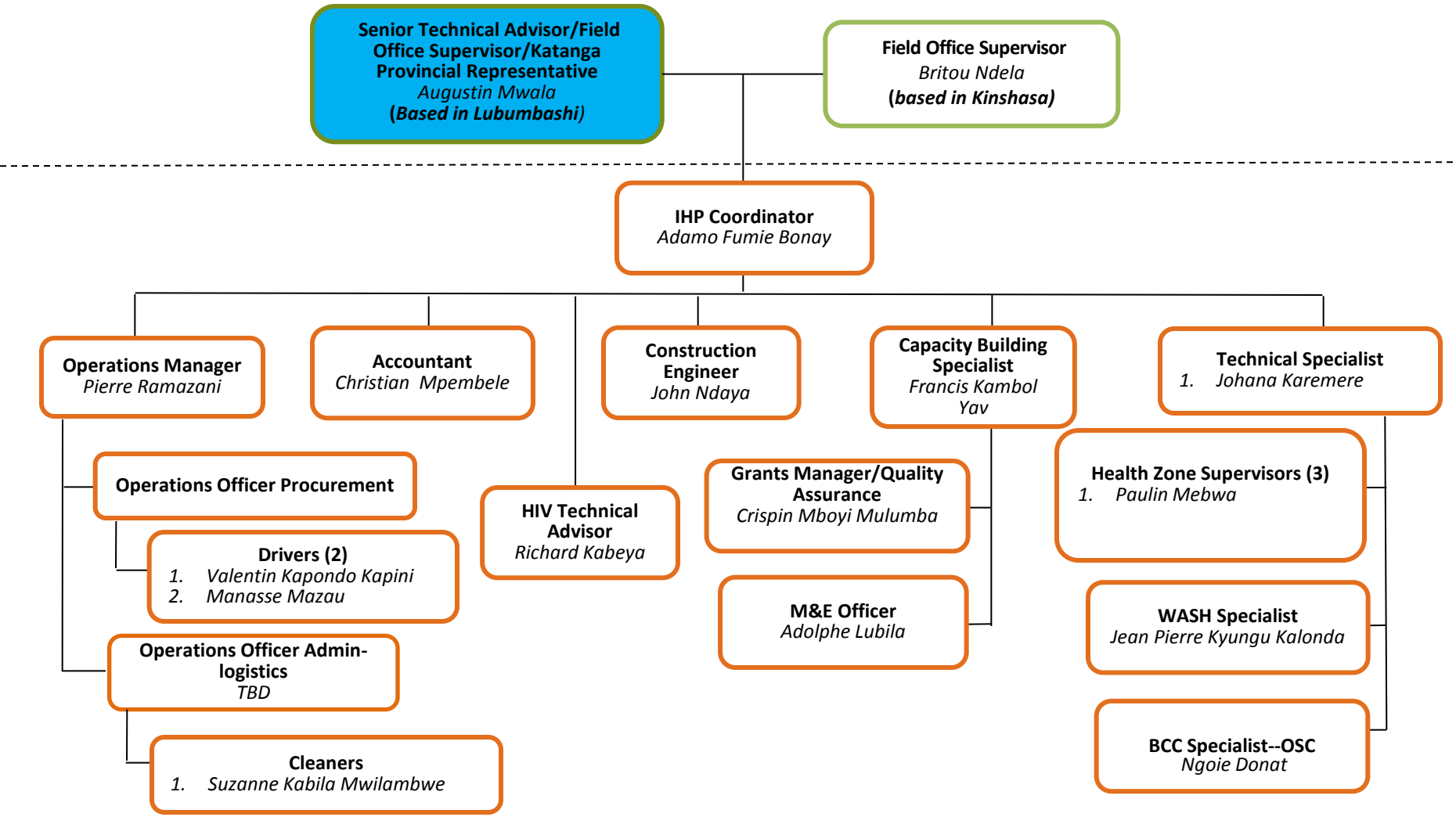
IHP Field Satellite Office: Lubumbashi, Katanga



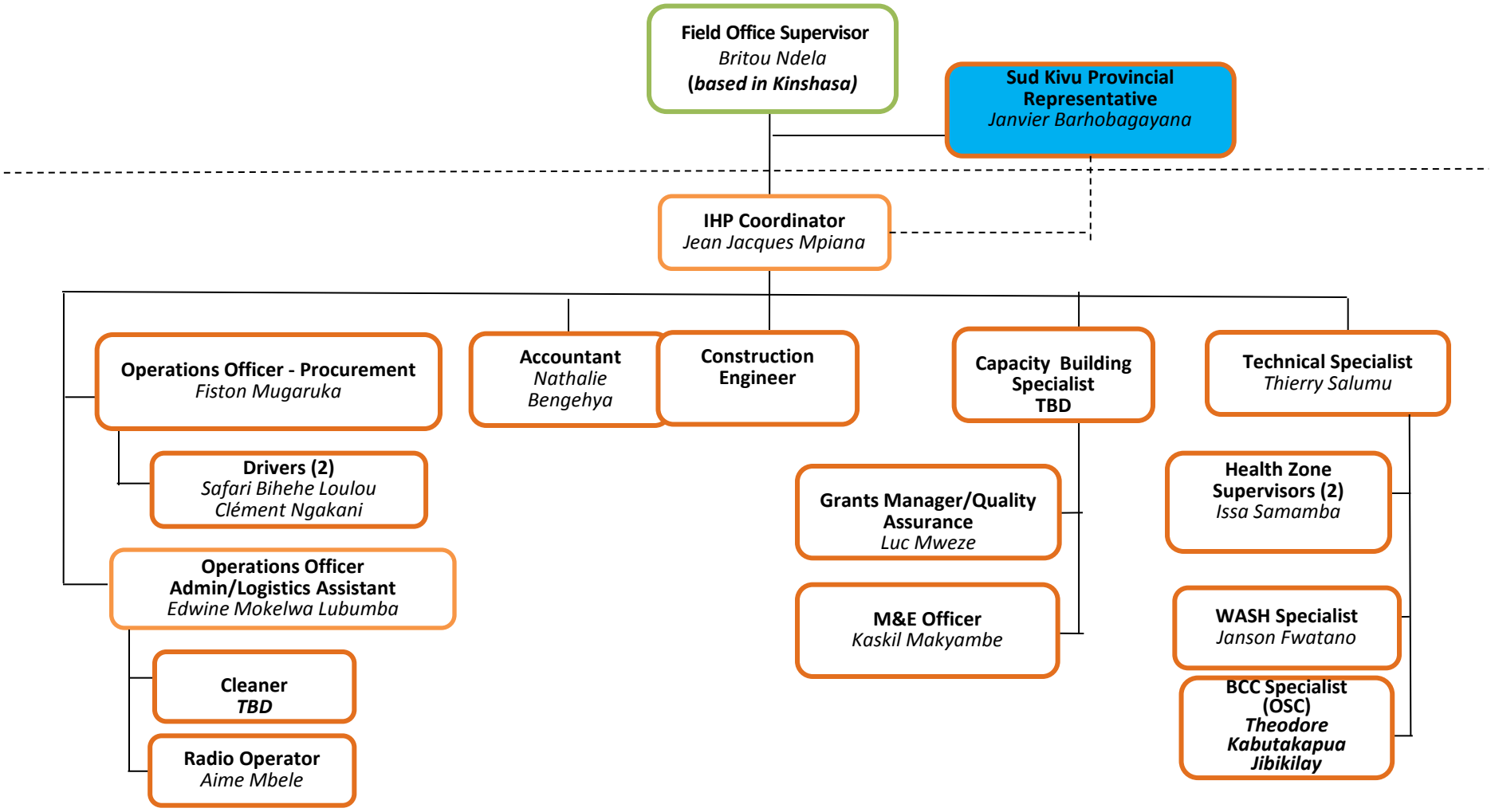
IHP Field Office: Kamina, Katanga



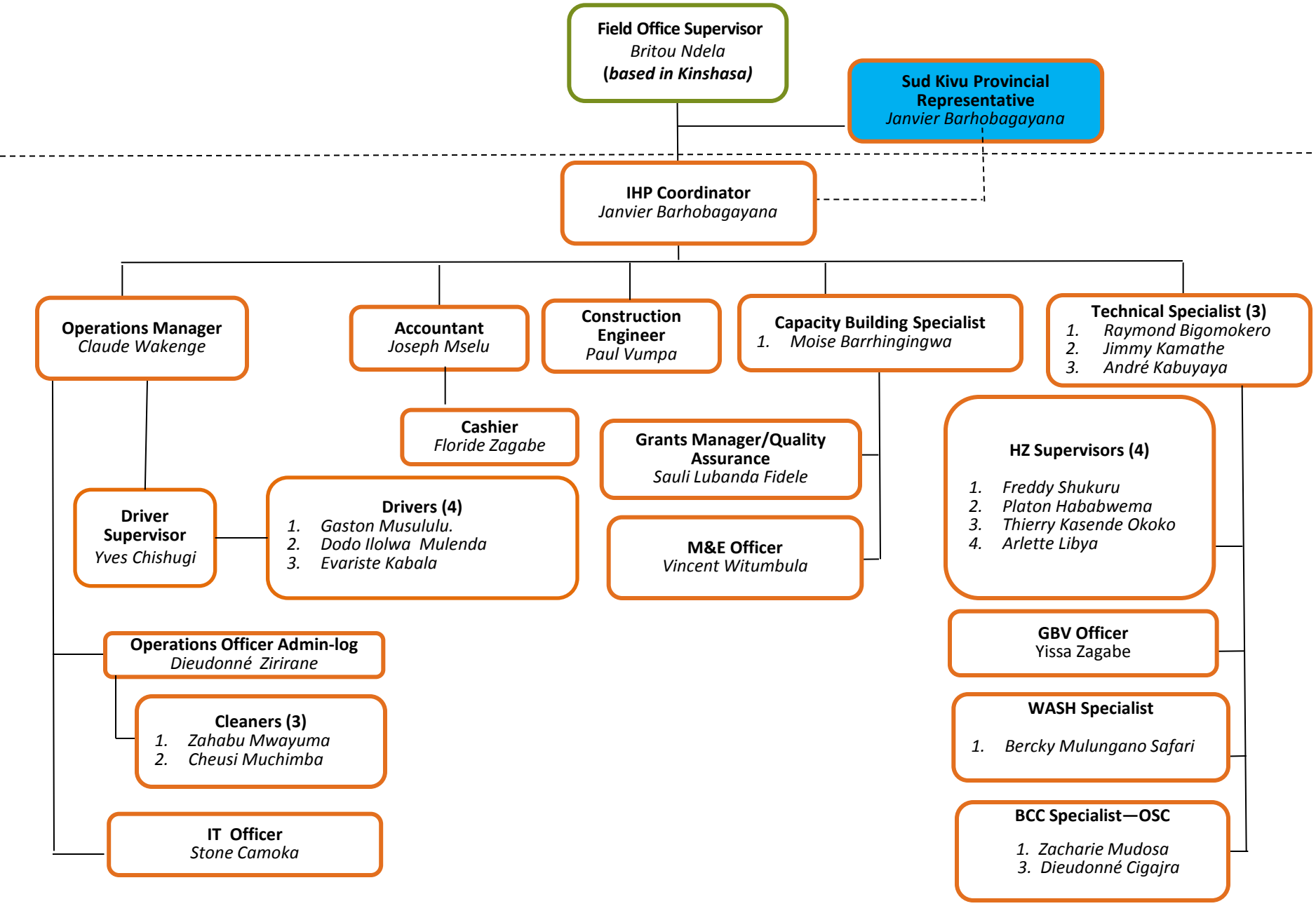
IHP Field Office: Kolwezi, Katanga



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	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)	Page	of
USAID/OFM	AID-OAA-A-10-00054	1	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	12/31/2014

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	$107,817,189.00
b. Cash Disbursements	$109,446,285.84
c. Cash on Hand (line a minus b)	($1,629,096.84)
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	$129,734,020.30
e. Federal share of expenditures	$109,446,285.84
f. Federal share of unliquidated obligations	$0.00
g. Total Federal share (sum of lines e and f)	$109,446,285.84
h. Unobligated balance of Federal funds (line d minus g)	$20,287,734.46
Recipient Share:	
i. Total recipient share required	$4,193,013.88
j. Recipient share of expenditures	$3,232,241.15
k. Remaining recipient share to be provided (line i minus j)	$960,772.73
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%	10/01/2014	12/31/2014	193,061.95	156,380.18	100%
	Local Proff	40%	10/01/2014	12/31/2014	838,009.53	335,203.81	100%
	Consultants	40%	10/01/2014	12/31/2014	39,739.67	15,895.87	100%
				g. Totals:	$ 1,578,291.01		

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	c. Telephone (Area code, number and extension)
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	d. Email address: pbarrossmith@msh.org
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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