

DRC-IHP Quarterly Report: January-March 2015

June 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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Cover photo: Community health workers in Mwene Ditu review health communication materials.

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ACRONYMS

ACT	Artemisinin-based Combination Therapy	FFSDP	Fully Functional Service Delivery Point (see FOSACOF)
AMTSL	Active Management of Third Stage Labor	FOSACOF	<i>Formation Sanitaire Complètement Fonctionnelle</i> (Fully Functional Service Delivery Point)
AOP	Annual Operational Plan	FP	Family Planning
ARV	Antiretroviral	GRH	General Referral Hospital
BCC	Behavior Change Communication	HBB	Helping Babies Breathe
CBD	Community-based distribution or community-based distributor	HPP	Health for Poorest Populations Project
CCM	Community Case Management	HIV	Human Immunodeficiency Virus
i-CCM	Integrated Community Case Management	IHP	Integrated Health Project
CHW	Community Health Worker	IMCI	Integrated Management of Childhood Illness
C-IMCI	Community Based Integrated Management of Childhood Illness	IPTp	Intermittent preventive treatment (of malaria) in pregnancy
CODESA	<i>Comité de Développement Sanitaire</i> (health development committee)	IRC	International Rescue Committee
CDR	<i>Centrale de Distribution Régionale</i> (regional distribution center)	KMC	Kangaroo Mother Care
CPA	Complementary Package of Activities	LDP	Leadership Development Program
CPCC	Champion Community Pilot Committee	LLIN	Long-lasting Insecticide-treated Net
CPLT	Provincial coordination unit for leprosy and TB	LMS	Leadership, Management, and Sustainability Program
CLTS	Community-Led Total Sanitation	MDR-TB	Multidrug-Resistant Tuberculosis
CST	<i>Centre de Santé de Traitement</i>	MOH	Ministry of Health
CSDT	<i>Centre de Santé de Diagnostic et Traitement</i>	MNCH	Maternal, Newborn and Child Health
CUG	Closed User Group	MIP	Provincial Medical Inspector
DTP	Diphtheria, Tetanus, Pertussis	MPA	Minimum Package of Activities
DPS	Division Provinciale de la Santé	MSH	Management Sciences for Health
DQS	Data Quality Self-Assessment	NGO	Non-Governmental Organization
DRC	Democratic Republic of the Congo	OSC	Overseas Strategic Consulting, Ltd.
ENA	Essential Nutrition Actions	PBF	Performance-Based Financing (see RBF)
ENP	<i>Encadreur National Polyvalent</i>	PEPFAR	President's Emergency Plan for AIDS Relief
EPI	Expanded Programme on Immunization (see PEV)	PEV	<i>Programme élargi de vaccination</i> (see EPI)
ETL	Education through Listening		

PICT	Provider-initiated HIV counseling and testing
PIP	Provincial Pharmaceutical Inspector
PIRTS	Performance Indicator Reference and Tracking Sheets
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-natal Consultation
PNDS	<i>Plan National de Développement Sanitaire</i> (National Health Development Plan)
PNLP	National Malaria Control Program
PNLS	National AIDS Program
PNLT	National TB Program
PNSR	National Reproductive Health Program
POC	Point of Care
PRONANUT	National Nutrition Program
RBF	Results-Based Financing
RDT	Rapid diagnostic tests
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SNIS	National health information system
SP	Sulfadoxine Pyrimethamine
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water /Sanitation/Hygiene
WFP	World Food Programme
WHO	World Health Organization

PROJECT BACKGROUND

This report covers the second quarter reporting period (January - March 2015) 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: Kasai Occidental, Kasai 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)

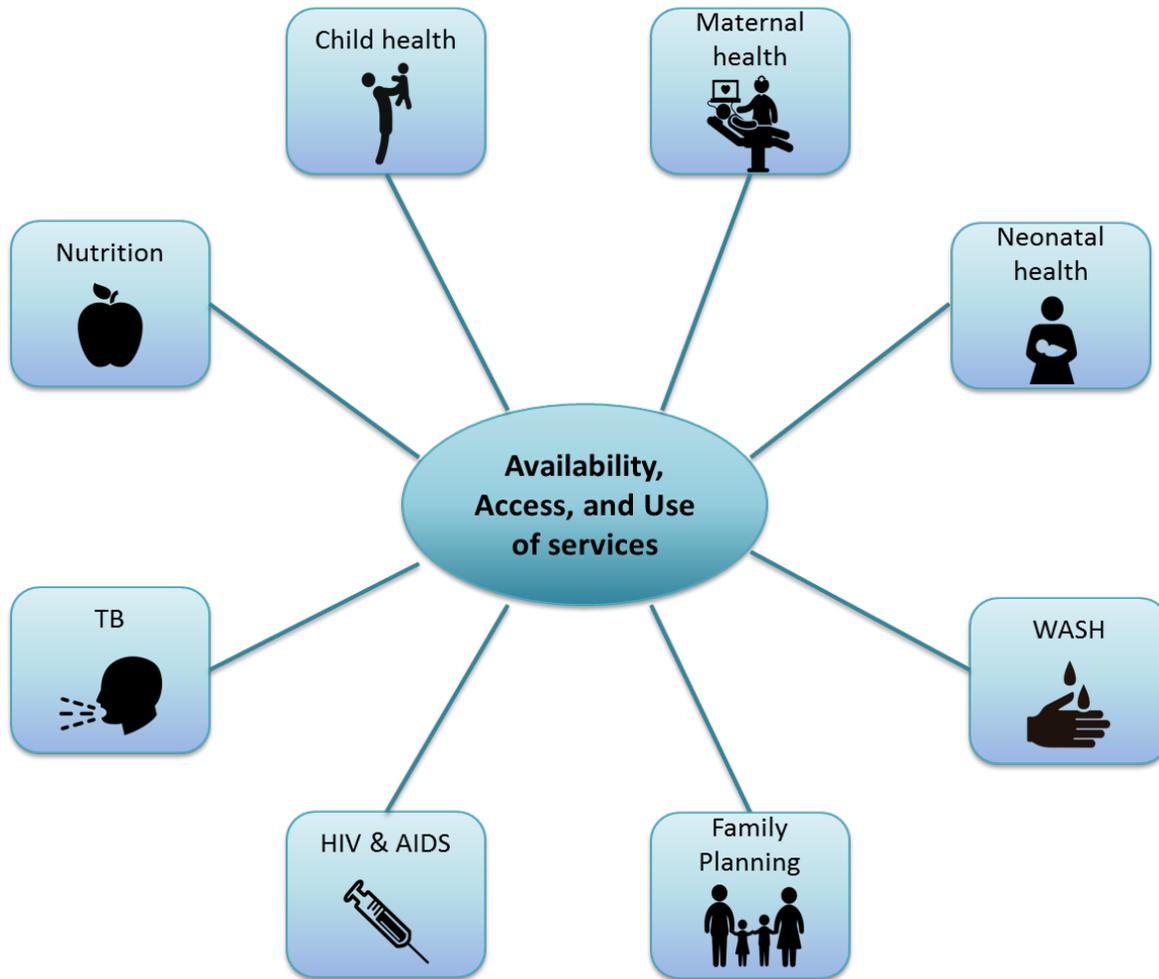
With the project entering its fifth and final year of implementation, **IHP’s vision** is that people in the 78 project health zones will participate more fully in determining their health outcomes by virtue of greater access to higher-quality comprehensive care; service delivery systems that are accountably 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 (Kasai 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 <ul style="list-style-type: none"> • Provide material/equipment • Provide drugs, commodities, and materials
	IR 1.2: Increased community-based health care services/products <ul style="list-style-type: none"> • i-CCM at Community treatment sites • CODESA - Collaborative strategy at the community level
	IR 1.3 Effectively engaged provincial management <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Training, supportive supervision
	IR 2.2: Minimum quality standards <ul style="list-style-type: none"> • 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 health-seeking behaviors increased in target health zones	IR 3.1: Health sector-community outreach linkages <ul style="list-style-type: none"> • CODESA • Youth outreach groups
	IR 3.2: Health advocacy/community mobilization organizations <ul style="list-style-type: none"> • Education Through Listening (ETL) • CODESA
	IR 3.3: Behavior change campaigns <ul style="list-style-type: none"> • 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 PERFORMANCE²

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

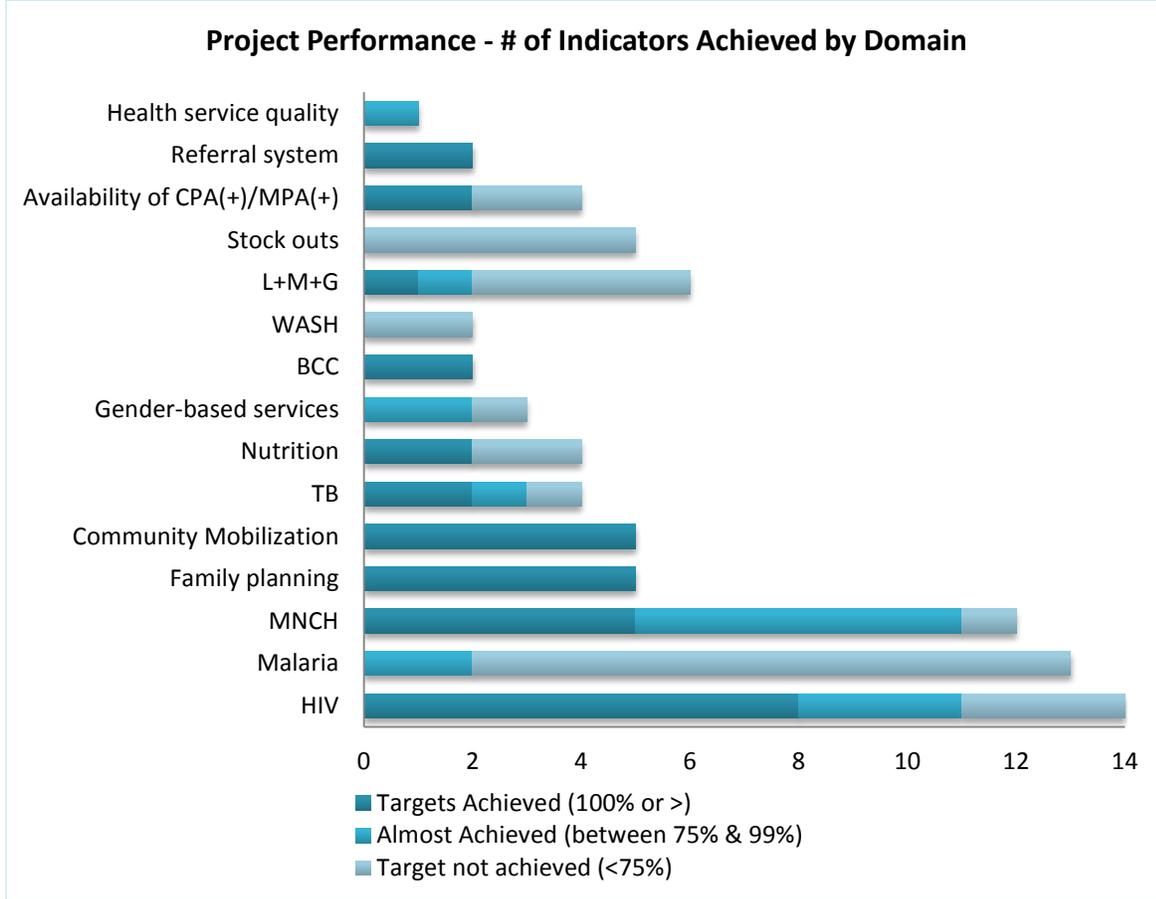
- Family planning (FP)
- Maternal, newborn and child health (MNCH);
- Nutrition
- Tuberculosis (TB)
- HIV and AIDS
- Malaria
- WASH
- Leadership, management and governance (L+M+G)
- Gender and gender-based violence (GBV)
- Referral systems
- Stock-outs
- Health service quality and availability
- Community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

For the second quarter of project year five (PY5Q2), DRC-IHP exceeded or almost met (75% or greater achievement) targets for more than half the indicators for these technical areas (50 out of 80 indicators). Results were slightly better than the previous quarter, with particularly strong results in family planning, HIV, MNCH, community mobilization, and referral systems (see Figure 2).

While performance continues to be weaker in some sectors such as TB, WASH, Malaria, and medicine stock-outs, more emphasis on grassroots initiatives such as Community-Led Total Sanitation (CLTS), supportive supervision, and collaborative working groups are leading to greater improvement. Details of these strategies are found later in the report. We look forward to adjusting targets to be more realistic given our resources and the realities of the context in DRC.

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.

Figure 2: Project performance overview, PY5Q2



KEY ACHIEVEMENTS

Uptake of curative services: The health services utilization rate in seven of the eight IHP coordination offices continued to increase, meeting or exceeding the 35% national average utilization rate. During this quarter utilization in the Luiza coordination area achieved the national average of 35%, up from 33% during the previous quarter, continuing its slow but steady progress since the beginning of the project. Only Uvira coordination office continues to show utilization rates just below the national average (33%).

Access and availability of MPA/CPA and MPA-plus/CPA-services: 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 70 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. CPA-plus and MPA-plus criteria 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 lower performing indicators are further discussed in the report. Key service delivery statistics are presented below in Figure 3.

Key Challenges and Way Forward

A number of challenges are discussed throughout this report, both technical and programmatic, with specific actions suggested to increase performance. Two specific challenges are worth mentioning in terms of the increased focus they will receive during the next reporting period.

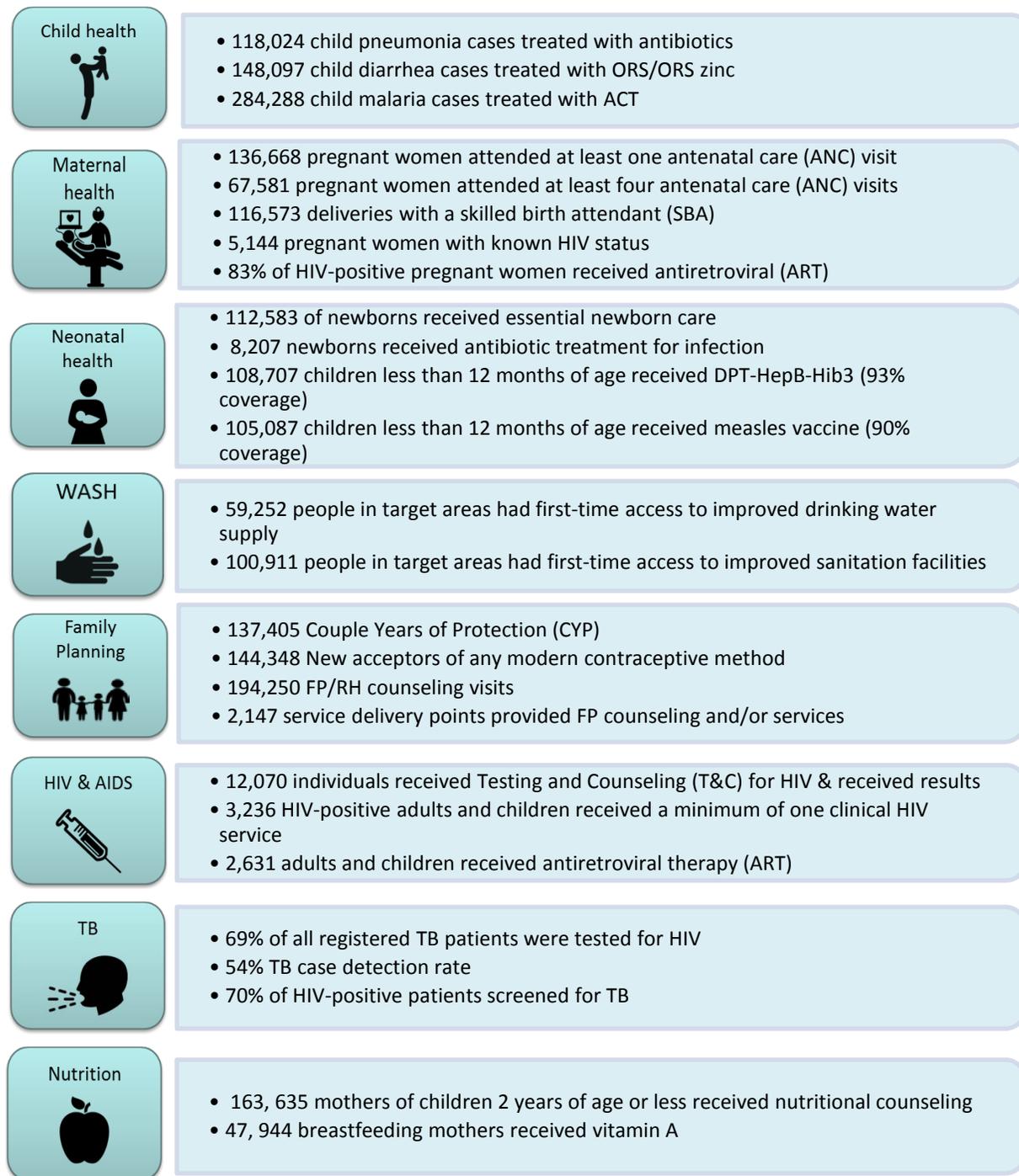
1. **Challenge:** The performance on indicators for the number of people who had access to drinking water for the first time (at 16%) and the number of people who had access for the first time to improved sanitation facilities (at 28%) remain low.

Way forward: Close monitoring of the rehabilitation of potable water sources is a priority for the next quarter, as this will improve the number of drinking water sources as well as the number of people who will have access to them. Community mobilization through awareness-raising campaigns, SMS messaging, and launching community-led total sanitation activities will encourage community ownership of these activities and improve coverage.

2. **Challenge:** Although overall stock-outs of pharmaceutical products have decreased, the frequency of stock-outs of drugs in health facilities remains unacceptably high, especially for folic acid (378 health facilities) and rifampicin/isoniazid (RH) (14 health facilities).

Way forward: During the next quarter, IHP and SIAPS will continue to work together to strengthen inventory control documents in the health facilities and revitalize and coach drug quantification committees and drug order validation committees. A landscape analysis must be conducted at the regional distribution centers (CDR) and drug depots in the health zones; frequently, medicines and other supplies are in the CDRs, but health facilities or the health zone management teams do not order on a timely and regular basis. There are more effective ways to deal with this challenge; for example, for the Kamina coordination area, plans were made to send health facility drug orders directly to the health zones to address the transportation issue during the rainy season when roads are flooded (due to nearby rivers and tributaries) and impassable. IHP also will continue to work with SIAPS moving into the bridge year 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 secure adequate supplies of medicines and commodities throughout the system.

Figure 3: In PY5Q2, 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, including 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 fertility rates, 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 in Table 2 below.

Table 2: PY5Q2 health service key activities at a glance

IR	Strategy	Key activities	Targeted zones
1	Provide drugs, commodities, products	• Monitor drug management in facilities	All coordination offices
		• Conduct health zone inventory data checks	All coordination offices
		• Support MEG quantification committees	Webonyama, Katako, Dikungu, Djalo, and Tshumbe health zones
		• Analyze purchase orders by quantification committee	Tshumbe, Wembonyama, and Dikungu health zones
		• Procure MEG, FP, PMI commodities	All coordination offices
		• Procure non-digital hydrometers	FODESA pharmaceutical warehouse in Lodja coordination office
		• Provide management tools	Kabongo, Kitenge, and Kayamba health zones
	Rehabilitate infrastructure & equipment	• Provide medical goods to health centers	Mwene Ditu health zones (with the exception of Wikong), and all Uvira health zones (5)
	Reinforce community care sites/ collaborative approach	• Provide MEG drugs (Ora-zinc, ACT, Paracetamol, Amoxicillin) and management tools to community care sites	All supported health zones except Shabunda, Kalole, Lulingu, and Mulungu health zones (Bukavu office) and the fluvial axis and Songa health zones (Kamina office)
		• Follow up on community health sites post training	Dibaya, Lubondaie, Ndekesha, Kalomba health zones (Luiza office), All health zones in Mwene Ditu office, all health zones in Tshumbe office
		• Follow up on MDR-TB post training	Bunyakiri, Ibanda, and Kadutu health zones (Bukavu office)
		• Follow up on MNCH post training	Kabongo health zone (Kamina office)
		• Provide on-site briefing for community health workers and licensed nurses on the new childhood diseases form (financed by HPP)	Luiza office
		• Supervise community health sites	Mwene Ditu, Kamiji, Kanda Kanda and Luputa health zones managed by Mwene Ditu coordination

	CLTS-WASH	<ul style="list-style-type: none"> Develop 37 new water sources and build 5 wells Construct 15,099 new latrines 	Katana, Walungu, Kole, Kanzenze, and Dikungu health zones All 9 health zones with WASH program
2	Clinical and managerial capacity building	Conduct on-site for health workers and licensed nurses on the new childhood diseases form (financed by HPP)	Luiza office
		Follow-up supervision	Luiza, Tshumbe, and Uvira offices
	Results-based financing	Conduct first annual review of RBF implementation	All 7 health zones with RBF programs
		Conduct data audit (October – December 2014)	Bibanga, Luiza, Wembonyama, and Lomela health zones
		Create a community-based organization	Bibanga health zone
3	BCC	Launch mini-campaign to advocate for sanitary and hygienic health facilities	Lodja, Kole, and Ototo health zones (Kole office), Manika health zones (Kolwezi office) and Ruzizi and Uvira health zones (Uvira office)
	Community mobilization	Support Champion Communities to construct family latrines	Health zones of Kanda Kanda (Mwene Ditu) and Kalomba (Luiza)
		Send 211,292 awareness text messages through Frontline	All health zones with cell network (46)

Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased

Key IHP performance results for IR1 during PY5Q2 are summarized in Table 3 below and discussed in detail in the following section. Reasons for the continued low performance of WASH and CPA+/MPA+ indicators are further discussed below.

Table 3: Summary of IR 1 key results for PY5Q2 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 & products	i-CCM – Pneumonia	🟡 Almost met targets
	i-CCM—Diarrhea	🟡 Almost met targets
	CLTS-WASH	🔴 Below targets
1.3 Leadership practices	LDP 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 PY5Q2, the health services utilization rate in seven of the eight IHP coordination offices increased again, meeting or exceeding the 35% national average. Utilization in the Luiza coordination achieved the national average of 35%, up from 33% during the previous quarter, continuing its slow but steady progress since the beginning of the project. Only the Uvira office still shows a utilization rate below the national average, but at 33%, it is now just 2% below the average. Luiza and Uvira, while improving, have struggled with utilization rates throughout the project. The low rate of utilization reported for Luiza may reflect the fact that some private sector facilities, particularly those not participating in the RBF activities, are not reporting their numbers to the project. Uvira, on the other hand, faces insecurity and difficult access in the mountains.

On average, the utilization rate for curative services in IHP-supported health zones remained at 45%, which is the same as last quarter. The project is still analyzing the data to examine what factors--aside from insecurity and infrastructure challenges--continue to hold performance back in Luiza and Uvira, so they can be addressed. Table 4 presents the utilization rate for this quarter, by month and by coordination.

Table 4: Curative services utilization by month and by coordination

Coordination office	Jan-15 (%)	Feb-15 (%)	Mar-15 (%)	PY5Q2 Average (%)
Bukavu	53	49	54	52
Kamina	39	45	43	43
Kole	43	42	46	44
Kolwezi	59	86	65	70
Luiza	36	33	35	35
Mwene Ditu	45	41	42	43
Tshumbe	39	38	40	39
Uvira	32	32	35	33
Average				45

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 4 and Tables 5 and 6). This is a significant achievement, especially since less than 10% of hospitals and health centers provided these services before the project.

Figure 4: Percentage of general referral hospitals offering CPA and MPA by project year

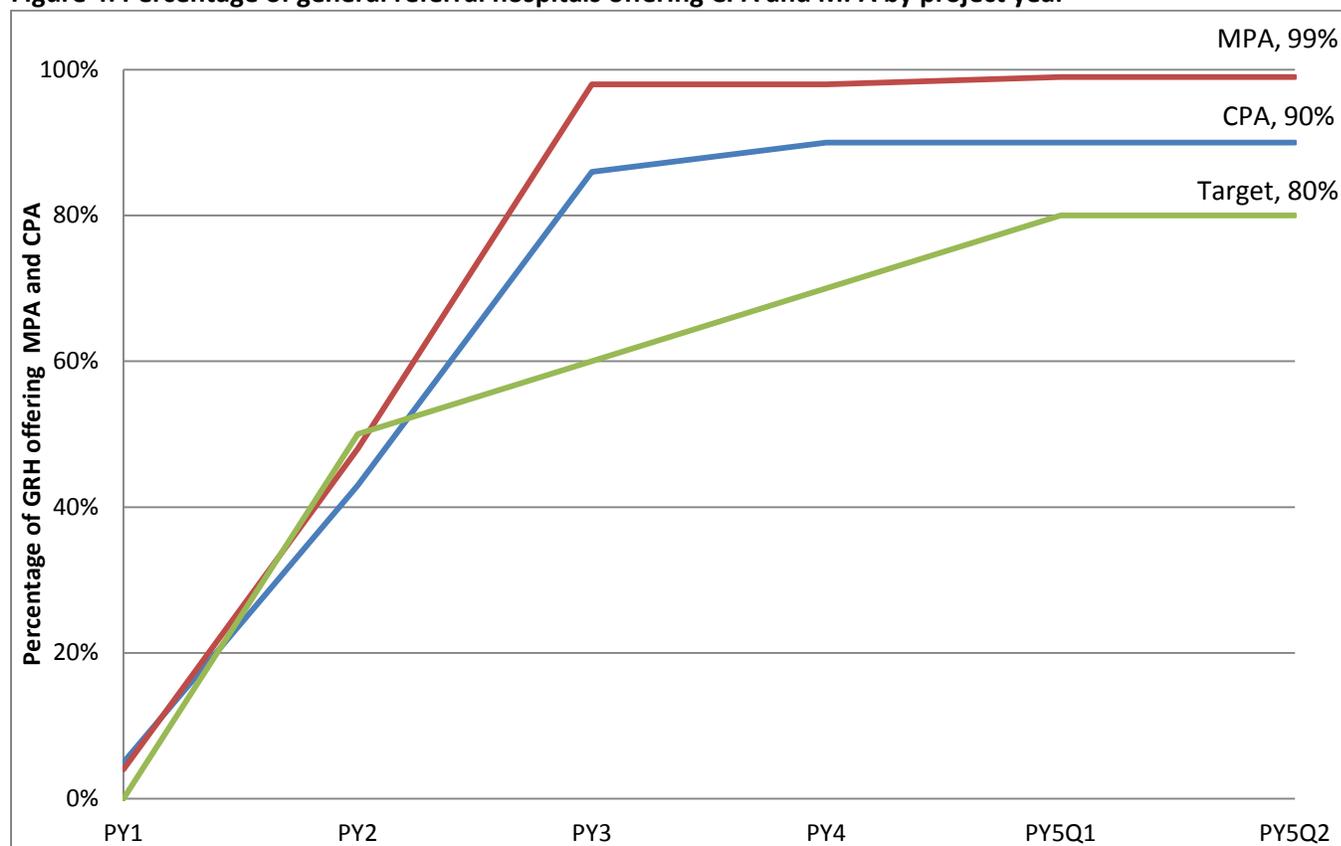


Table 5: Number of general referral hospitals (GRH) implementing a complementary package of activities (CPA) by coordination office

Coordination	Jan	Feb	Mar	Target	PY5Q2 % of target achieved
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 (HC) implementing a minimum package of activities (MPA) by coordination office

Coordination	Jan	Feb	Mar	Target	PY5Q2 % of target achieved
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: The CPA-plus and MPA-plus services were estimated based on the agreed calculation form included in the last IHP modification related to the revised content and revised calculation target of MPA-plus and CPA-plus. For this quarter, as summarized in Table 7 below, 794 health centers of 1,382 that offer MPA also offered MPA-plus services (57%) and 51 hospitals of 77 that offer CPA also offered CPA-plus services (66%).

Table 7: Hospitals and health centers offering CPA-plus and MPA-plus services

Description	Denominator	Numerator	Achievement
Hospitals without IHP HIV and WASH supported activities	45	28	62%
Hospitals with IHP HIV supported activities	13	9	69%
Hospitals with IHP WASH supported activities	9	7	78%
Hospitals with PMI-supported activities	10	7	70%
Total hospitals offering CPA-plus services	77	51	66%
Health centers without IHP HIV, malaria and WASH supported activities	1002	561	58%
Health centers with IHP HIV supported activities	56	31	55%
Health centers with IHP WASH supported activities	164	92	56%
Health centers with PMI-supported activities	160	90	58%
Total health centers offering MPA-plus services	1,382	794	57%

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 PY5Q2.

At the beginning of PY5Q2, SIAPS received the additional import permits for PY4 drug procurement. This order was expected to be completely delivered to DRC by the end of April 2015, but due to the delayed receipt of customs clearance documents (*notes verbales*), the delivery dates were revised. The elements of the whole order left their respective places of origin, and most shipments that do not have the *notes verbales* are the port in Dar es Salaam awaiting proper documentation to be released. Table 8 presents a revised timeline for delivery. Appendix 2 presents the tracking sheet for the customs clearance of each container.

Table 8: Status of PY4 pharmaceutical order

Pharmaceutical for PY4	Agreed -upon date	Delivery date (to CDR/warehouse)
Air shipment no. 1 of normal goods from Amsterdam	11/19/2014	Completed 11/11/2014
Air shipment no. 1 of dangerous goods from Amsterdam	11/19/2014	Completed 11/11/2014
Direct shipment from Chennai	01/07/2015	Completed 12/03/2014
Direct shipment from Mumbai	12/17/2014	Completed 12/15/2014
Singapore sea shipment no. 1	01/14/2015	Completed 01/13/2015
Air shipment no. 2 from Amsterdam ("keep cool items")	01/14/2015	Ready for pick-up since 01/26/2015, but still pending emergency removal
Air shipment no. 2 from Amsterdam Air (PT items + Ketamine and Ephedrine)	02/28/2015	Ready for pick-up since 02/28/2015, awaiting <i>note verbale</i> (Update: released 05/06/2015)
Sea shipment no. 2 from Singapore	02/25/2015	Pending <i>note verbale</i> since 03/04/2015
Air shipment no. 1 from Amsterdam ("keep cool")	11/19/2014	Completed 11/11/2014
Direct shipment from Shanghai	11/12/2014	Completed 10/28/2014

The first shipments to regional distribution centers (CDR) and partner warehouses started in February 2015 and included 8.7% of the total order as indicated in Table 9 below:

Table 9: Status of delivery of IHP PY4 order to CDRs

Province	Warehouse or CDR	Order value (USD)	Delivery value as of December 31, 2014 (USD)	% delivered	Value of remaining deliveries	% of remaining deliveries
Sud Kivu	APAMESK, DCMP, CEPAC and BDOM	1,243,630	119,048	10	1,124,582	90
Katanga	CEDIMEK	599,135	34,095	6	565,040	94
	Kolwezi	261,713	53,300	20	208,413	80
Kasaï Occidental	CADIMEK	430,625	26,617	6	404,008	94
Kasaï Oriental	CADMEKO	719,109	46,420	7	672,689	94
	FODESA	581,820	22,510	4	559,310	96
Total order/delivery		3,836,032	301,991	9	3,534,041	91

*Figures may not add up exactly due to rounding

According to a late April update from COMEXAS (the subcontracted freight forwarder), 31 containers of the 46 expected had arrived in DRC (13 from the Bukavu border point and 18 from Lubumbashi). We are expecting the proof of delivery of these containers from the CDRs during the next quarter.

MSH held a meeting with COMEXAS on April 29, 2015, to address the delays in delivering the IHP PY4 order, including the lengthy amount of time it has taken to obtain the *note verbale*.

Regarding the emergency order intended to partially cover PY5 pharmaceutical needs, production is underway by both suppliers, IDA and IMRES. However, no delivery planning has been communicated yet with the project. MSH is waiting for the supplier to send documentation in order to begin the importation request and follow up on the rest of the delivery process.

In support of the delivery of essential medicines, SIAPS conducted the following activities:

- SIAPS provincial representatives, while waiting for the PY4 delivery to be completed, updated the PY4 new lines of credit and shared the information with supported health zones;
- In March 2015, SIAPS coordinated the shipment of family planning commodities from the Kinshasa warehouse to supported provinces;
- SIAPS continued to support partner CDRs to draft and implement distribution plans and to analyze drug requisitions to meet the quarterly needs of the supported health facilities. This support was provided for drugs supplied/purchased with IHP funds as well as for those provided by PMI (including long-lasting insecticide-treated nets-LLIN);
- During routine inventory verification led by SIAPS in the Kolwezi warehouse (CEDIMEK), the project discovered a theft of 16,700 LLINs in Kolwezi, valued at \$50,100. IHP is waiting to receive a detailed audit report following the investigation conducted in April 2015 in the field.

Strengthen the management of essential medicines and medical consumables: During March 2011, a delegation comprised of staff from USAID, IHP, and SIAPS carried out a monitoring mission to contribute to improving the availability of family planning commodities in the provinces of Kasai Oriental and Kasai Occidental. During the mission, the delegation noted a stock of 3,000 units of Microgynon at risk of expiring in the health zone central office of Bilomba. The same risk was noted with contraceptives in a number of health facilities.

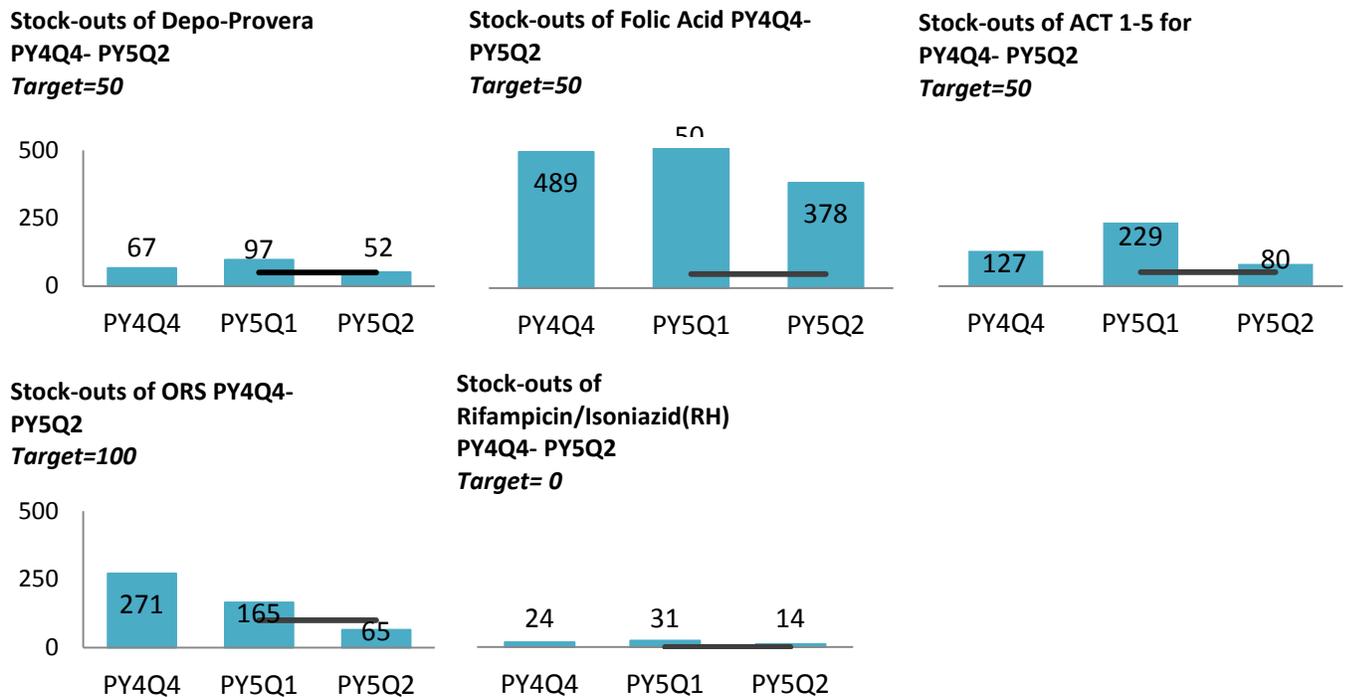
To respond to this situation, SIAPS initiated the following action steps: raised awareness among administrative authorities (provincial and *Inspection Provinciale de la Santé* [IPS] levels) on the situation of contraceptives in Kasai Occidental, met with the health zone management teams, visited drug warehouses in health zones and hospitals to brief relevant staff on stock management, and agreed to the following next steps with the stakeholders:

- Identify all contraceptives that are about to expire or that are overstocked in the health zones outside E2A intervention areas;
- Redistribute contraceptives at risk of expiring to health zones supported by E2A, Luiza health zone, and the national reproductive health program (PNSR) to deploy supplies to other USG-supported health zones;
- Closely monitor stock management of contraceptives in Kasai Occidental;
- Closely monitor the provincial-level management of contraceptives;
- Closely monitor the distribution of chlorhexidine digluconate 7.1%;
- Verify contraceptive data reported by health facilities.

SIAPS contributed to documenting 72,284 doses of ACT at risk of expiring in Lubumbashi in collaboration with PMI and its implementing partners. The overstock was redistributed to Kolwezi and Katanga to the 44 PMI sites. At the time of the publication of this report, the redistributed ACT stocks have been used.

Tracer drug stock-outs: Stock-outs have decreased throughout the project, with the exception of folic acid. However, longstanding supply chain issues (insufficient quantity ordered and extended delivery period) continue to contribute to stock-outs, as illustrated in Figure 5.

Figure 5: Stock-outs of tracer drugs



A few areas, such as Kolwezi, Uvira and Kole, have reduced stock-outs of tracer drugs and continue to perform better on this indicator. To do so, they either use their drug reserve fund from IHP, access other donors, or have recourse to fundraising (especially through religious congregations). However, these results need to be further explored; the RDQA survey led in March 2015 revealed that all health facilities may not report their stock-outs, as was the case for Kolwezi, Kamina, and Luiza during the previous quarter. Table 10 illustrates the current stock-out situation of tracer drugs in each coordination office.

Table 10: Stock-outs of tracer drugs by coordination

	Depo-Provera			Folic Acid			ORS			ACT 1-5			RH		
	PY4 Q4	PY5 Q1	PY5 Q2	PY4 Q4	PY5 Q1	PY5 Q2	PY4 Q4	PY5 Q1	PY5 Q2	PY4 Q4	PY5 Q1	PY5 Q2	PY4 Q4	PY5 Q1	PY5 Q2
Bukavu	12	9	38	56	75	93	4	22	45	13	27	24	2	19	2
Kamina	20	49	4	120	135	118	38	53	17	26	106	43	18	7	6
Kole	29	35	1	92	83	38	44	39	1	1	53	5	3	1	0
Kolwezi	0	0	0	0	0	10	0	4	0	1	7	4	0	0	0
Luiza	0	0	5	67	87	19	13	0	0	40	21	1	1	2	1
Mwene Ditu	0	0	0	24	13	15	76	5	1	22	0	0	0	0	0
Tshumbe	6	4	4	48	40	28	93	41	0	15	14	1	0	2	5
Uvira	0	0	0	82	69	57	3	1	1	9	1	2	0	0	0
Total	67	97	52	489	502	378	271	165	65	127	229	80	24	31	14

IHP will continue to work with SIAPS moving into the bridge year 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 secure adequate supplies of medicines and commodities throughout the system.

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

Malaria, diarrhea, and pneumonia are the three main killers of children under five in DRC. For this reason, the Congolese MOH adopted the Strategy for the Integrated Management of Childhood Illnesses (IMCI) as the main approach to reduce the child mortality rate. The USAID-funded IHP and UNICEF-funded Health for Poorest Populations (HPP) are both supporting the MOH to implement this strategy, at both the clinical and community levels.

Integrated Community Case Management (i-CCM)/A Promise Renewed

Integrated community case management (i-CCM) is an equity-based strategy to increase access to effective case management for children suffering from malaria, pneumonia, and diarrhea, especially in hard-to reach areas and amongst vulnerable populations; through i-CCM, community health workers are equipped, trained, supported and supervised to deliver life-saving treatments to improve outcomes for children in communities that lack access to health facilities.

IHP and HPP together now implement 589 i-CCM sites in 39 health zones. This quarter, these projects assisted the diarrheal disease program of the MOH to map all i-CCM projects nationwide, not just those of MSH, to assist the MOH in planning.

Community health workers at i-CCM sites treat childhood illnesses including pneumonia, diarrhea, and malaria (see Figure 6).

Figure 6: i-CCM cases treated of pneumonia, diarrhea, and malaria PY4Q1-PY5Q2

Note: This is only i-CCM-based treatment



During this quarter, IHP distributed 370,000 co-packs of oral rehydration salts (ORS) and zinc supplements in all supported health zones, in agreement with the national protocol on diarrhea case management. This contributed to an increase in the quality and utilization of health services for diarrhea treatment, leading to a 75% achievement of the quarter’s target, up from 70% last quarter. The number of children under five with diarrhea treated with oral rehydration solution (ORS) or ORS plus zinc supplements in USG-supported facilities reached 148,097, an increase of 10,638 cases over last quarter. Ten percent of these cases were treated in their community through i-CCM sites (see Table 11).

The Kole coordination office reported impressive results in i-CCM, achieving 118% of the target for diarrhea case management (3,899 in i-CCM sites and 12,339 in health facilities) and 111% for pneumonia (2,883 in i-CCM sites and 8,543 in health facilities). Kole also treated 3,150 episodes of malaria in i-CCM sites and 21,208 in health facilities). This overall high performance can be attributed to several actions taken by the coordination office:

- Procured pneumonia, diarrhea, and malaria commodities for all health facilities and community care sites;
- Organized “open house” consultation days in Lomela health zone;
- Conducted post-training monitoring visits to i-CMM sites;
- Implemented health zone management team monthly supervision visits to care sites in Vangakete, Lodja, and Bena Dibebe; and
- Implemented new community care sites in Tshudi Loto health zone.

Table 11: Number of children under five years old with diarrhea treated with oral rehydration solution (ORS) or ORS plus zinc supplements in USG-supported facilities in PY5Q2

Coordination Office	Jan-15	Feb-15	Mar-15	PY5Q2			PY5Q2 Target	% of target achieved
				Health facilities	i-CCM sites	Total		
Bukavu	12,421	13,385	11,757	36,667	896	37,563	57,076	66
Kamina	8,103	8,706	9,058	22,511	3,356	25,867	31,490	82
Kole	5,384	4,786	6,068	12,339	3,899	16,238	13,777	118
Kolwezi	1,669	1,834	1,881	5,151	233	5,384	13,777	39
Luiza	7,630	4,797	4,776	15,317	1,886	17,203	21,649	79
Mwene Ditu	5,639	5,495	6,884	16,654	1,364	18,018	31,490	57
Tshumbe	4,050	4,088	4,088	8,707	3,519	12,226	13,777	89
Uvira	5,020	4,728	5,850	15,258	340	15,598	13,777	113
Total	49,916	47,819	50,362	132,604	15,493	148,097	196,812	75

*Numbers may not add exactly due to rounding.

Childhood disease management at the clinic level

In prior years, IHP had trained health workers in facilities, and distributed care flowcharts to all health facilities as well as i-CCM sites. During this quarter, HPP organized refresher training for health providers from four Mwene Ditu health zones (Luputa, Mpokolo, Kamiji, and Mwene Ditu) and five health zones managed by the Luiza coordination office (Dibaya, Kalomba, Lubondaie, Luiza, and Yangala).

Fewer diarrhea cases were treated at health facilities and at the i-CCM level this quarter; more cases of simple diarrhea may be managed at home, due to the distribution in Dibaya, Ndekesh, and Kanda Kanda of IMCI family kits, which contain ORS, sulfate, and zinc. Data on home treatment is not yet collected by health centers. HPP carried out a study on the effectiveness of diarrhea management at home using the family kits; results of the study will be shared during the next reporting period.

In the Kolwezi coordination area, the rate of treatment of childhood illnesses remains low. IHP has launched various activities to improve the treatment rate, such as follow-up coaching for community health workers in Dilala, Fungurume, and Kanzenze health zones. In addition, the project has highlighted the significance and legitimacy of i-CCM by inviting the head doctor of the health zone--who usually only visits facilities--to make monitoring visits to community i-CCM sites each quarter. We expect these activities to improve results over the next quarter, and we also plan to extend these efforts to another three health zones.

Over the course of PY5Q2, health workers at community sites treated 10,428 cases of childhood pneumonia, up from 6,900 the previous quarter (see Table 12).

Table 12: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs

Coordination Office	Jan-15	Feb-15	Mar-15	PY5Q2			PMP target PY5Q2	% of target achieved
				Health facilities	i-CCM sites	Total		
Bukavu	12,946	11,610	11,208	34,764	1,000	35,764	42,806	84
Kamina	7,102	5,612	5,616	16,884	1,446	18,330	23,617	78
Kole	3,556	3,705	4,165	8,543	2,883	11,426	10,333	111
Kolwezi	1,504	1,462	1,496	4,308	154	4,462	10,333	43
Luiza	4,453	4,141	4,260	11,883	971	12,854	16,237	79
Mwene Ditu	7,036	6,746	7,209	19,426	1,565	20,991	23,617	89
Tshumbe	2,600	3,030	3,196	6,610	2,216	8,826	10,333	85
Uvira	1,808	1,789	1,774	5,178	193	5,371	10,333	52
Total	41,005	38,095	38,924	107,596	10,428	118,024	147,607	80

Relatively low performance in Uvira appears to relate to less frequent monitoring by community health workers due to local insecurity. There is a progressive decrease of pneumonia cases reported in Bukavu. Since it is among the first areas to introduce the pneumococcal conjugate vaccine (PCV13), it may be instructive to analyze the vaccine's impact.

Project sites treated 24% more malaria cases compared to last quarter (see Table 13). We attribute this significant improvement to the timely provision of drugs as well as post-training coaching for community health workers and i-CCM supervision by the health zone management team.

Table 13: Number of child malaria cases treated with ACT by trained facility or community health workers in USG-supported programs

Coordination Office	Jan-15	Feb-15	Mar-15	PY5Q2		
				Health facilities	i-CCM sites	Total
Bukavu	44,617	18,598	16,438	77,706	1,947	79,653
Kamina	15,845	15,786	13,991	40,567	5,055	45,622
Kole	7,913	6,821	9,624	21,208	3,150	24,358
Kolwezi	6,032	6,489	4,938	16,668	791	17,459
Luiza	15,826	11,408	8,899	35,484	649	36,133
Mwene Ditu	13,226	12,550	19,756	42,006	3,526	45,532
Tshumbe	6,094	5,255	10,091	19,275	2,165	21,440
Uvira	4,667	3,845	5,579	13,563	528	14,091
TOTAL PY5Q2	114,220	80,752	89,316	266,477	17,811	284,288

Challenges: The following challenges were encountered during PY5Q2:

- Staff is struggling with how to improve the reporting of diarrhea cases treated at home, now that IMCI family kits have been distributed in Mwene Ditu and Luiza health zones;
- Ongoing security issues have been delaying drug procurement in three health zones of Bukavu (Shabunda, Lulingu, and Kalole) and two in Kamina (Lwamba and Mulongo).

Action items for next quarter

- Ensure procurement of ORS-zinc and amoxicillin for diarrhea in health zones that have not yet been supplied in Kamina and Bukavu;
- Conduct monitoring visits on i-CCM in Lubudi, Bunkeya, and Mutshatsha health zones;
- Conduct drug management monitoring visits in Kolwezi and Kamina coordination offices;
- Identify ways to improve the qualitative and quantitative reporting of experience with family kits;
- Lead an evaluation to compare the pneumonia prevalence in health zones where PCV-13 was introduced in 2013 (and which achieved 80% vaccination coverage) with health zones not using PCV-13.

A Promise Renewed

IHP’s work with health facilities and i-CCM 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 partners, the DRC government developed an Action Framework to address constraints in the health system. 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 HPP³). In 25 zones, IHP is the primary provider of support.

LESSONS LEARNED

The co-pack formulation of ORS and zinc contributed to fulfilling the national diarrhea management protocol, improving the quality of care, and increasing service utilization.

Helping Babies Breathe: Although the reporting template for neonatal resuscitation has not yet been integrated into the SNIS, examination of the data that we do have for PY5Q1 and PY5Q2 from data collection, as presented in Table 14, reveals a high rate--between 90% and 92% on average--of 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. In order to improve timeliness of HBB data availability, the reporting template for neonatal resuscitation will be merged in the IHP master database through which the IHP field offices report on a monthly basis.

³ HPP is financed by UNICEF and implemented by MSH.

Table 14: Number of babies resuscitated during PY5Q1 and PY5Q2

Coordination Office	Period	Number of babies with neonatal asphyxia	Number of babies resuscitated after neonatal intensive care	% of babies resuscitated after neonatal intensive care
Bukavu	PY5Q1	265	237	89
	PY5Q2	322	302	94
Kamina	PY5Q1	40	33	83
	PY5Q2	30	24	80
Kole	PY5Q1	28	26	93
	PY5Q2	54	50	93
Kolwezi	PY5Q1	111	88	79
	PY5Q2	107	96	90
Luiza	PY5Q1	169	156	92
	PY5Q2	168	150	89
Mwene Ditu	PY5Q1	74	73	99
	PY5Q2	171	168	98
Tshumbe	PY5Q1	36	36	100
	PY5Q2	34	27	79
Uvira	PY5Q1	94	87	93
	PY5Q2	98	93	95
Total	PY5Q1	817	736	90
	PY5Q2	984	910	92

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

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 this reporting period, IHP/HPP distributed 5,922 IMCI kits in the four health areas of Fungurume health zone (Kolwezi coordination). In Vangakete health zone, IHP/HPP distributed 79 IMCI kits, 678 fever replenishment kits, and 293 diarrhea replenishment kits.

In the Kolwezi coordination office, IHP launched various activities to improve the treatment rate, such as follow-up coaching for community health workers in Dilala, Fungurume, and Kanzenze health zones.

Strategy 2: Support for health services at the peripheral level including reference facilities: The peripheral level benefited from supportive supervision and follow-up visits by the central and intermediate levels of services. To further support the health centers and i-CCM sites, the project supplied these sites with case management and referral tools.

Strategy 3: Improve health zone governance and management: A research study on the adoption and utilization of family kits is in progress at the Pharmacovigilance National Center at Kinshasa University. The results should be published shortly and will be presented in the next quarterly report.

Strategy 4: Strengthen human resources (health facility service providers: staff motivation, quality training): To ensure that patients receive the best care possible when visiting health facilities, IHP provided training this quarter on Integrated Management of Childhood Illnesses to 235 nurses and 36 members of the health zone management team in nine health zones: Luputa, Mpokolo, Kamiji, Mwene Ditu, Dibaya, Kalomba, Lubondaie, Luiza, and Yangala. In i-CCM sites, IHP conducted post-training follow-up for 252 community health workers, 153 licensed nurses, and 46 members of the health zone management team.

Strategy 5: Communication for Development: Mobile phone information campaigns diffused information via SMS messages in project-supported communities across field offices, targeting households with children under the age of 5 and pregnant women. During this quarter, 177,320 SMS messages were sent by the project and 11,120 by project-supported health zone authorities. See Table 34 in the IR 3 section of this report for more details.

Strategy 6: Community Mobilization: In order to better prepare for the next distribution of family kits, IHP/HPP trained 1,500 community health workers and 480 community facilitators. In addition, IHP/HPP also supported 145 active community-based youth organizations during their action planning sessions. One of the main actions was the organization of group facilitation and awareness-raising sessions on reproductive health, body hygiene, and sexually transmitted infections.

CODESA (Health Development Committees)

To date, IHP is supporting 1,396 health development committees (CODESA) which are actively promoting the use of health services and products in their community. Of these, 1,258 have developed action plans, designed to provide local solutions to local health problems, such as designing and building latrines, refurbishing health centers, forming WASH committees, and hosting information sessions on disease prevention. The CODESAs contribute to health behavior change through home visits, health education sessions, and development activities. Implemented by stakeholders and local leaders, these activities encourage communities to take ownership of public health, ensuring the sustainability of these activities following the end of IHP. Health development committees also systematically refer cases to health facilities.

To promote community participation, IHP has encouraged CODESA members and CHWs to be integrated into Champion Community groups with a possibility that these group will become officially recognized as a non-governmental organization (NGO). With this recognition comes various possibilities of resource mobilization and applying for grants.

This quarter, IHP supported CODESA activities in Mwene Ditu, Luiza, and Kole, where 4,325 families learned about malaria prevention and treatment and 1,207 cases were referred to health centers.

Challenges: CODESA members and CHWs are integral players in terms of community outreach and increasing coverage of services; therefore, frequent turnover, due in part to lack of monetary compensation, is negatively affecting program implementation and flow of activities. Project staff has been told that lack of salary is demotivating. Publicity materials (T-shirt, hats) that they are entitled to keep are not enough to encourage them to stay. The form of remuneration that the project has provided—per diem when attending meetings, bicycles to be used for their IHP-related work, and, in the case of CHWs, a 10% share of funds received by high-performing health centers under the RBF program—helps increase motivation but does not entirely stop the frequent turnover.

Next steps: To address these challenges, IHP will focus on the following during the next quarter:

- Reinforce joint supportive supervision visits with provincial health management teams, specifically the behavior change communications and social mobilization unit, and health central offices;
- Support the organization of monthly and quarterly meetings with health development committees for data evaluation and analysis;
- Work with health development committees on the use of management tools;
- Reinforce support of health central offices and other community-based organizations to health development committee activities;
- Encourage disease prevention and health promotion activities planned by health development committees.

Evidence-based WASH Activities

Within the context of the fight against infectious and parasitic diseases, IHP used the Community-Led Total Sanitation approach in nine health zones, with a cumulative target of reaching 80% of the population within these health zones. This approach helped to mobilize and engage communities to focus on self-reliance and was reinforced by champion communities.

During this quarter, IHP worked hand-in-hand with the communities to build 42 new clean water sources and 15,099 new latrines. As a result, 59,252 people can now enjoy safe drinking water, and 100,911 have access to improved sanitation facilities (see Table 15).

Table 15: Number of people in target areas with first-time access to improved drinking water supply and improved sanitation facilities

	# of people in target areas	First-time access to improved drinking water supply as a result of USG support in target area		First-time access to improved sanitation facilities as a result of USG support in target area	
		#	%	#	%
Bukavu	87,503	29,764	34	26,964	30
Kamina	33,454	0	0	945	3
Kole	37,472	1,410	4	14,476	39
Kolwezi	18,039	11,846	66	24,178	134
Luiza	50,075	0	0	8,309	17
Mwene Ditu	80,670	0	0	2,521	3
Tshumbe	27,367	16,232	59	19,717	72
Uvira	28,021	0	0	3,801	14
Total PY5Q2	362,601	59,252	16	100,911	28

In Kolwezi, the target population was underestimated. The population was larger than expected, and activities served more people than anticipated. In Tshumbe, work has not been completed, but we expect to meet the target in the next quarter. In Kamina, work began late; we also expect to meet the target in the next quarter.

The total sanitation approach used by IHP fully engages the community in the construction of improved latrines using local resources and materials. This approach produced a slight increase in the combined proportion of people with first time access to improved sanitation facilities between PY5Q1 and PY5Q2, from 23% to 25%.

The rehabilitation of water sources is more complex than latrine construction as it generally requires expensive materials and advanced knowledge and technology in some regions with complex geology such as Katanga, where the water table is very low. Therefore, from now until the end of the project, IHP will focus on finalizing the construction sites in progress in Bilomba (10), Kole (16), Wikong (22), and Dikungu (9) health zones. In addition, IHP will continue to support health zones to raise community awareness on sanitation, hygiene, and water-borne disease prevention.

Based on results to date, IHP recommends reducing the coverage target of 80% by half. Considering the geographical, logistical, and cultural barriers encountered, the original target was over-ambitious; 40% would be more realistic.

Community-based Nutrition Activities

Number of mothers of children 2 years of age or less who have received nutritional counseling for their children

During this quarter, 163,635 mothers of children aged two years or less have received nutritional counseling for their toddlers. Since the expected number of mothers was 105,530, IHP achieved 155% of its target. (These results are slightly lower compared to last quarter, when 166,966 mothers were advised on proper infant nutrition.)

We attribute this achievement in part to the fact that IHP has helped develop 1,080 fully-functioning Infant and Young Child Feeding support groups. These groups have a synergistic effect with health-center activities such as antenatal consultation, pre-school consultation, postnatal consultation and treatment.

However, the Infant and Young Child feeding groups are currently limited to 261 health areas in 45 health zones. The main constraint is budgetary: funding for nutrition activities does not allow for the approach to be scaled up to all 78 health zones.

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 other stakeholders that have major roles in health zones. The LDP helps health workers face and address challenges, create an environment that motivates staff, and promote teamwork, transparency, and accountability. LDP teams select leadership projects, which they carry out over four to six months in collaboration with stakeholders at all levels to address real challenges to improve services and the work environment.

A total of 48 LDP projects have been implemented since August 2014. Most of the LDP projects this quarter focused on improving maternal and child health services. Of those, 41 teams achieved their expected results by March 2015 (see Table 16). By comparison, during the previous quarter, the project supported more LDP projects [54], but fewer teams [24] achieved their target results.

Table 16: LDP projects per technical area during PY5Q2

Focus areas	# of projects implemented	# of projects achieving expected results	Achievement rate (%)
MNCH	32	29	91
GBV/Gender	1	0	0
TB	6	5	83
HIV	1	0	0
Leadership, management, and governance	2	1	50
Utilization of services	6	6	100
Total	48	41	85

A number of LDP teams from the health zones this quarter focused on improving maternal and child health indicators (see Table 17). The effort has borne fruit: ANC-4 attendance rates increased by a factor of ten: ranging from an increase of 2% (in Dibindi) to 21% (in Lubudi) during this quarter. Note that these results refer to achievements in the LDP projects, not to overall achievements of all health zones for ANC-4.

Other areas of focus included TB and health services utilization. For curative services, the performance reported by health zones rose an average of 7% from the previous quarter.⁴ The most significant progress was accomplished by the Wembonyama health zone, with a reported increase of 18%. The RBF implementation in this health zone contributed to this increase.

However, project staff faced similar challenges as in the prior quarter. The teams either set unrealistic targets (Lodja and Miti Murhesa health zones) or they did not ensure consistent and proper monitoring of their LDP implementation (Mutshatsha, Katana, and Miti Murhesa health zones). Some encountered difficulties in mobilizing their stakeholders (Kabongo health zone).

Table 17: LDP indicators

Health zone	Indicators by LDP project	Status of indicator after 8 months			
		Baseline	Expected result	Achieved result	Variance
Manika	Coverage for DTP3 vaccinations of children under one year (%)	69	85	68	-17
Mutshatsha	Dropout rate for Pentavalent 1-3 immunization (%)	5	3	8	-5
Lodja	Number of GBV survivors referred from health centers to GRH (#)	10	40	10	-30
Katana	Referral rate (%)	7	10	6	-4
Miti Murhesa	TB detection rate (%)	18	30	12	-18
Kabongo	TPI2 pregnant women coverage rate (%)	68	75	49	-26

⁴ This average is based on an increase of 8% for Ruzizi, 5% for Lemera, 18% for Wembonyama, 6% for Djalo Djeka, 3% for Kalomba, and 2% for Dibaya, or 42/6=7%.

Based on this quarter's results, IHP will increase its efforts to ensure that health zone management teams:

- Follow SMART guidelines when setting their target indicators;
- Are supported by the coordination offices in each step of their LDP implementation (monthly check-ins);
- Fully understand and integrate the LDP approach.

Intermediate Result 2: Quality of key family health care services in target health zones increased

Increasing access to quality health services is a key objective of the IHP project. Over the course of the project, access to and quality of several important services such as family planning, MNCH, nutrition, referrals, and gender-based care have increased tremendously since the PY1 baseline. While the project continues to struggle with some indicators--such as malaria and TB--progress is being made in HIV services and quality of care. Details are discussed by sector in Table 18 below.

Table 18: Summary of Key IR 2 Results for PY5Q2 by Sub-IR

Sub-IR	Key Indicators	Results
2.1 Clinical & Management Capacity		
Maternal Health	• Service delivery (ANC 1, SBA)	● Exceeded targets
	• Service delivery (ANC 4)	● Below 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	• 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 (T&C, HIV services, ART, New enrollees, TB ART, Lab)	● Exceeded targets
	• Service delivery & prevention (known status, PMTCT, TB screen)	● Almost met targets
	• Service delivery & prevention (% ART, key populations reached)	● Below targets
Tuberculosis	• Quality services	● Below targets
	• TB case detection rate	● Almost met targets

	<ul style="list-style-type: none"> MDR TB cases detected 	<ul style="list-style-type: none"> Below targets
Gender-based Violence	<ul style="list-style-type: none"> Health care workers trained in GBV service 	<ul style="list-style-type: none"> Below targets
	<ul style="list-style-type: none"> GBV service delivery 	<ul style="list-style-type: none"> Exceeded targets
	<ul style="list-style-type: none"> GBV BCC campaigns 	<ul style="list-style-type: none"> Exceeded targets
2.2 Minimum Quality	<ul style="list-style-type: none"> HC meeting minimum FOSACOF standards 	<ul style="list-style-type: none"> Almost met targets
	<ul style="list-style-type: none"> GRH meeting minimum FOSACOF standards 	<ul style="list-style-type: none"> Almost met targets
2.3 Referral Systems	<ul style="list-style-type: none"> Patients referred to HC 	<ul style="list-style-type: none"> Exceeded targets
	<ul style="list-style-type: none"> Patients referred to GRH 	<ul style="list-style-type: none"> Exceeded targets

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

Maternal, Newborn and Child Health (MNCH)

Number/percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities: In terms of the number of pregnant women attending at least one antenatal care visit (ANC), six of the eight coordinations exceeded the quarterly target rate of 95%, which led to the project's overall 108% achievement. This result is due mainly to the following reasons:

- The distribution of LLINs, iron folate, and SP during ANC
- Competency-based training of health providers on MNCH in the health zones of Bibanga, Dibindi, Mpokolo, Luputa, Mwene Ditu, Kanda Kanda , Ndekesha, Dibaya, Lubondaie, Lodja, Vangakete , Dilala, Manika, Fungurume, Kikondja, Malemba Nkulu, Uvira, and Nundu.

Specifically in Uvira, international NGO ADRA provided support by broadcasting radio publicity spots to raise awareness on ANC and training CHWs on community-level MNCH.

The implementation of RBF and competency-based training of health personnel in MNCH contributed to the improvement of the ANC 4 coverage in four health zones. However, delayed ANC first visits still occur in some health zones. Note that for the coordination of Uvira in the health zone of Haut Plateaux d'Uvira, data are provided only for the 10 days of the month following a nurses' strike in the health zones where coverage is low (Nundu, Uvira, and Haut Plateaux d'Uvira).

In the Lomela and Lodja health zones in Kole, due to efforts of CHWs awareness-raising campaigns on the importance of frequent ANC visits among pregnant women, the project surpassed targets as demonstrated in Table 19 and Figure 7 below.

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

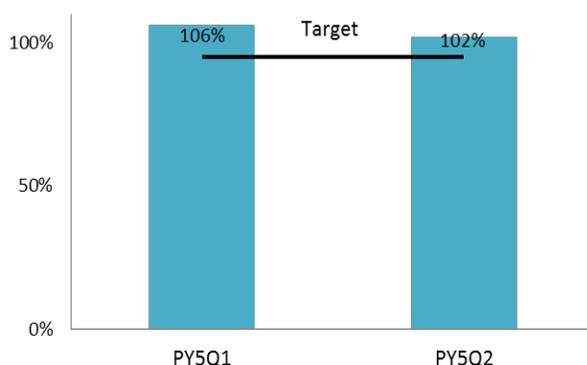
Note: Table presents percent achievement in USG-supported health facilities

	Number of pregnant women attending at least one ANC visit			Number of pregnant women attending at least four ANC visits		
	Total PY5Q2	Target PY5Q2	% Achievement	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	42,149	38,326	110	15,902	28,240	56
Kamina	19,195	21,145	91	8,443	15,581	54
Kole	10,612	9,251	115	7,229	6,817	106
Kolwezi	11,293	9,251	122	4,150	6,817	61
Luiza	14,058	14,537	97	8,792	10,712	82
Mwene Ditu	21,093	21,145	100	13,279	15,581	85
Tshumbe	8,720	9,251	94	5,345	6,817	78
Uvira	9,548	9,251	103	4,441	6,817	65
Total	136,668	132,157	108	67,581	97,379	72

Figure 7: Percent of pregnant women attending ANC visits by a skilled provider from a USG-supported health facility

Note: Table presents percent of women attending ANC as a proportion of expected pregnancies (4%) within the catchment area of the USG-supported health facilities

One ANC visit by a skilled provider
PY5Q2 Target= 95%



Four ANC visits by a skilled provider
PY5Q2 Target= 70%



Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities: Across the project, 99% of births were assisted by a skilled birth attendant (see Table 20), and 81% of postpartum and newborn visits were carried out within three days of birth (see Table 21). We note that Kamina and Uvira achieved the lower numbers of postpartum/newborn visits within 3 days of birth. The Uvira and Tshumbe coordinations, despite low coverage, were able to reach 15% of the target. These postnatal consultation (PNC) coverage results tell us that further capacity strengthening for health providers and more awareness-raising campaigns in the communities on the importance of PNC are needed in order to improve results in this area. In some places, in addition to the health benefits, postnatal visits also give mothers the chance to obtain birth certificates for their children since administrative authorities are present during these events.

It is worth noting that most private health facilities are under-equipped and often do not report to the health zone central office (specifically in the health zones of Uvira and Nundu). Training of health providers and CHWs in community-level MNCH on advocating for women to use services at the health centers contributed to the increase in coverage.

Next steps:

- Continue to ramp up advocacy efforts to use the maternity ward services in the integrated health facilities, especially for women about to deliver;
- Provide adequate equipment and supplies to maternity wards;
- Complete missing reports from the health areas;
- Organize post-training monitoring in health facilities;
- Strengthen close monitoring of health providers to improve MNCH-related skills.

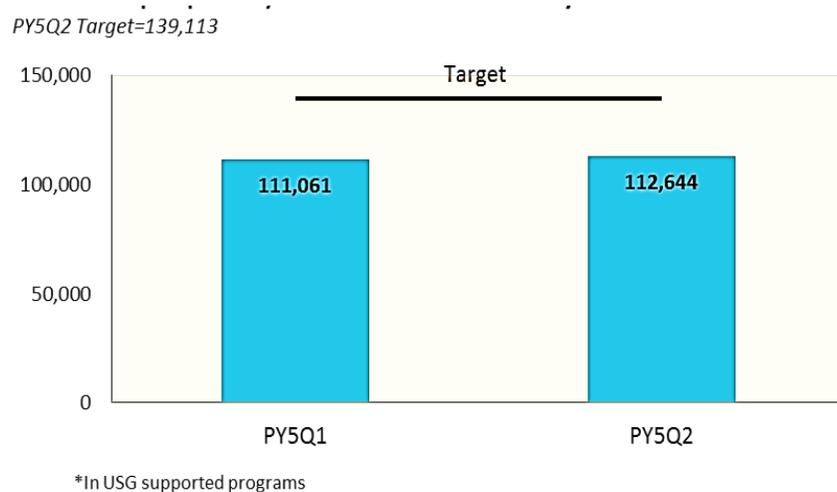
Table 20: Number of deliveries with a skilled birth attendant (SBA) in USG-supported facilities

Coordinations	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	11,347	10,774	11,767	33,888	34,291	99
Kamina	5,435	5,184	5,038	15,657	18,920	83
Kole	3,100	3,035	3,094	9,229	8,277	111
Kolwezi	3,354	3,349	3,489	10,192	8,277	123
Luiza	4,393	4,371	4,534	13,298	13,007	102
Mwene Ditu	6,472	6,584	6,603	19,659	18,919	104
Tshumbe	2,584	2,532	2,654	7,770	8,277	94
Uvira	2,148	2,246	2,486	6,880	8,277	83
Total	38,833	38,075	39,665	116,573	118,246	103

Table 21: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs

Coordinations	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	10,860	10,291	11,526	32,677	40,343	81
Kamina	5,361	5,106	4,876	15,343	22,258	69
Kole	2,664	2,735	2,707	8,106	9,738	83
Kolwezi	3,111	3,326	3,473	9,910	9,738	102
Luiza	4,390	4,204	4,480	13,074	15,303	85
Mwene Ditu	6,398	6,391	6,345	19,134	22,258	86
Tshumbe	2,542	2,556	2,638	7,736	9,738	79
Uvira	2,014	2,168	2,482	6,664	9,738	68
Total	37,340	36,777	38,527	112,644	139,113	81

Figure 8: Number of postpartum/newborn visits within three days of birth



Number of newborns receiving essential newborn care through USG-supported programs: The coordination of Kolwezi achieved 113% of the quarterly target in assisted births. Kole achieved 104% of the target in assisted births. Luiza and Mwene Ditu achieved similarly high numbers. The achievements may be attributed to trained and knowledgeable health providers who are able to properly care for newborns, the availability of drugs and essential newborn care supply, and close supervision by the health zone management team.

Underperformance in the other health zones is due in part to health providers not understanding or disregarding the components of newborn essential care, poor reporting due to lack of data collection tools in some health facilities, and stock out of supplies such as vitamin K3 and tetracycline. See Table 22 below for more data during PY5Q2.

Table 22: Number of newborns receiving essential newborn care through USG-supported programs

Coordination	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	10,858	10,454	11,286	32,598	34,147	95
Kamina	4,988	5,196	4,777	14,961	18,840	79
Kole	2,921	2,824	2,857	8,602	8,242	104
Kolwezi	2,836	3,054	3,396	9,286	8,242	113
Luiza	4,362	4,284	4,485	13,131	12,952	101
Mwene Ditu	6,449	6,596	6,596	19,641	18,840	104
Tshumbe	2,489	2,547	2,549	7,585	8,242	92
Uvira	2,099	2,219	2,461	6,779	8,242	82
Total	37,002	37,174	38,407	112,583	117,747	96
Expected	44,560	44,560	44,560	133,680		
% Achieved	83	83	86	84	100	84

Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs: Four coordination offices (Kole, Kolwezi, Uvira, and Luiza) out of eight surpassed the quarterly target due in part to the regular utilization of care flow charts and manuals on integrated management of childhood illnesses (IMCI) and availability of necessary supplies and pharmaceuticals such as antibiotics. Meanwhile, the coordination offices of Tshumbe, Mwene Ditu, and Kamina were not able to correctly treat 50% of sick newborns; reasons for this underperformance include misunderstanding of this indicator by health providers. The project plans to provide stronger supportive supervision to strengthen the capacity of health providers.

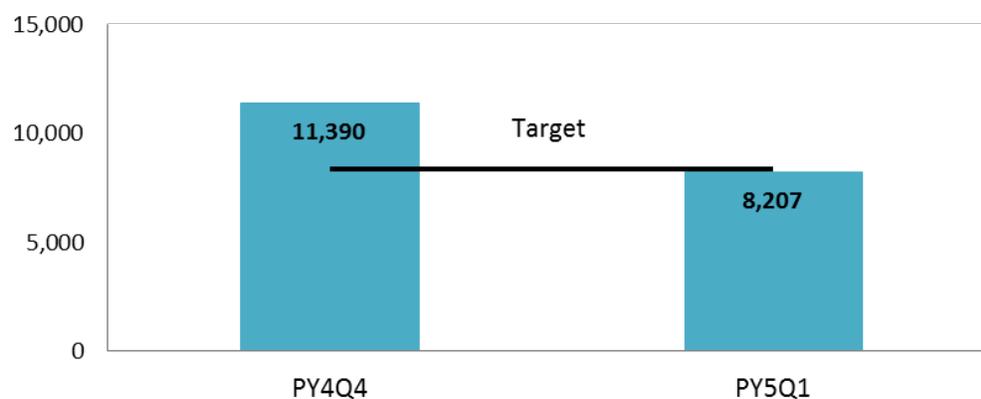
Additional data is presented in Table 23 and Figure 9 below.

Table 23: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs

Coordinations	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	568	443	665	1,676	2,421	69
Kamina	382	98	186	666	1,336	50
Kole	246	303	250	799	584	137
Kolwezi	539	988	489	2,016	584	345
Luiza	261	509	576	1,346	918	147
Mwene Ditu	126	142	262	530	1,336	40
Tshumbe	63	28	53	144	584	25
Uvira	399	318	313	1,030	584	176
Total	2,584	2,829	2,794	8,207	8,347	98

Figure 9: Number of newborns receiving antibiotic treatment for infection from appropriate health workers

PY5Q2 Target=8,347



*In USG supported programs

Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs: Efforts to reduce stock-outs of tracer medicines such as oxytocin were observed in Kolwezi, Uvira, and Kole; however, the coverage rate for AMTSL is weak (e.g., 78% in Kamina and 77% in Uvira; see Table 24 below). These two coordinations also recorded low coverage in deliveries assisted by a skilled birth attendant (both 83%). The project will further strengthen campaigns advocating for the services offered in maternity wards in integrated health facilities.

Table 24: Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs

Coordination	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	10,561	9,650	10,891	31,102	34,291	91
Kamina	5,042	4,998	4,743	14,783	18,920	78
Kole	2,487	2,339	3,012	7,838	8,277	95
Kolwezi	3,167	3,175	3,370	9,712	8,277	117
Luiza	4,384	4,258	4,499	13,141	13,007	101
Mwene Ditu	6,411	6,539	6,557	19,507	18,919	103
Tshumbe	2,481	2,488	2,471	7,440	8,277	90
Uvira	1,986	2,085	2,302	6,373	8,277	77
Total	36,519	35,532	37,845	109,896	118,246	94

Expanded Program on Immunization (EPI)

The project continued to achieve impressive vaccination coverage rates (see Table 25) that exceeded the PMP target of 90%. Project achievements in vaccinating children against preventable diseases contributed to the decrease of overall number of reported epidemics in project-supported health zones. This is particularly noticeable for pneumonia caused by pneumococcus bacterium, measles, and poliomyelitis; for example, the last case of wild poliovirus was reported on December 20, 2011, in Maniema province.

These impressive results are directly traceable to IHP's LDP, vaccine procurement, and cold-chain system strengthening. However, poor availability of certain vaccines at the national level remains a major challenge. Some are either unavailable or stock runs out quickly, forcing health zones to temporarily halt their immunization activities. For instance, in Lodja health zone, the EPI program lacked four vaccines (BCG, DTP HepB-Hib, VAR, and PCV13-3) at the time activities were scheduled to begin. As explained in last quarter's report, PCV13-3 is relatively new to DRC, and there was a national shortage. Weak performance in meeting targets for PCV13-3 can be explained by frequent stock-outs, due in turn to the government's difficulty in making its funding contribution available to procure the product in a timely manner.

Table 25: Immunization coverage by coordination and vaccination type for PY5Q2 (in percentages)

Coordination office	Tetanus vaccine 2+	BCG	DTP HepB-Hib1	DTP HepB-Hib3	OPV 3	Measles
Bukavu	92	68	109	104	103	98
Kamina	97	88	91	84	95	98
Kole	60	3	89	85	91	62
Kolwezi	122	174	146	135	134	120
Luiza	106	96	100	96	95	98
Mwene Ditu	100	100	97	92	91	93
Tshumbe	65	39	78	70	76	67
Uvira	81	64	100	94	93	79
PY5Q2 coverage (%)	90	77	99	93	95	90

Overall immunization coverage shows continuous improvement in performance throughout the life of project. BCG has previously exceeded the PMP target of 90%. However, it dropped to 77% this quarter, due to a shortage of both the vaccine and the 0.05 ml self-blocking syringe in Bukavu, Uvira, and Lodja health zones.

In general, IHP immunization strategies have proven successful. They consist of continuous support for the cold chain, organization of regular monitoring and evaluation visits to EPI sites, organizational development through LDP training, and community capacity building through Results-based Financing implementation.

Vaccination coverage for the Kolwezi coordination office has long exceeded 100% due to the influx of population related to the mining boom in this area, particularly in the health zones of Fungurume, Dilala, Manika, and Lualaba. These health zones rely on population projections rather than census information, creating a distortion in the denominator (underestimated) and the numerator (inflated to include old projections plus additional population coming to work in the mines).

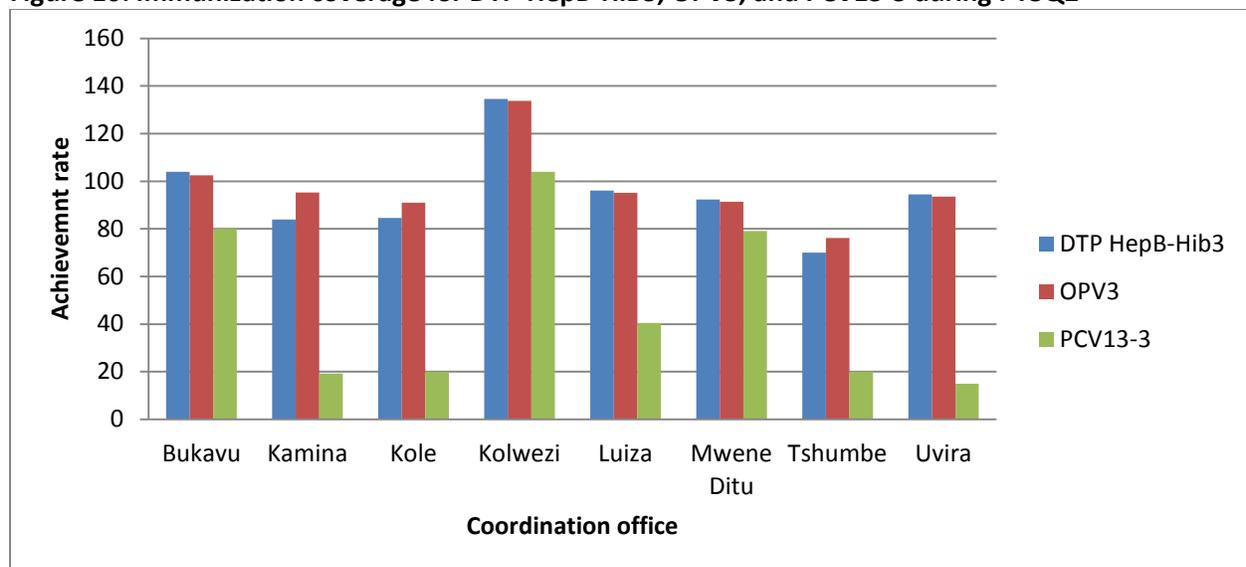
Lessons learned and way forward: By increasing the availability of vaccines through better management of secondary storage sites (geographically located closer to targeted populations) and engaging the community health workers, IHP was able to maintain excellent immunization coverage for children and reach the expected number of children for the third dose of Diphtheria, Tetanus, Pertussis (DTP).

As explained earlier, immunization-related performances for this quarter are satisfactory since a majority of indicators have either reached or exceeded the PMP target of 90%. The underperforming indicators are related to two of the four vaccines (BCG, DTP HepB-Hib, VAR, and PCV13) that were not procured on time/or in sufficient quantity due to the delayed availability of the Government of DRC's funding contribution. Immunization coverage for BCG reached only 77%, while PCV13-3 reached only 53%. The achievement was affected by the very low performance of Kole (3% for BCG) and Tshumbe (39% for BCG) health zones, the latter depending on Lodja EPI antenna for vaccine procurement. . The PCV13-3 shortage was national and affected all supported health zones, with the exception of Kolwezi, which already had a reserve stock.

Overall, the challenge lies in the poor availability of certain types of vaccines and 0.05ml self-blocking syringes, among other immunization materials, which negatively impact the project’s performance on vaccinations. There are a number of negative consequences: early stock-out, client dissatisfaction when vaccines are not available, and decrease of health service utilization, among others. Despite the challenges, the immunization dropout rate remained acceptable, with an average ratio of 5% among all supported health zones. None of them went above 10%.

According to the national immunization calendar, children should receive the DTP-HepB-Hib3, OPV3, and PCV13-3 vaccines at the same time; therefore their performance data should be identical. However, only DTP-HepB-Hib3 and OPV3 seem to have a similar coverage rate (see Figure 10). PCV13-3, on the contrary, reflects large disparities with the two others (between 10 to 90%) and has a very low coverage rate, mainly due to the poor availability of the vaccine at the Extended Immunization Program National Directorate.

Figure 10: Immunization coverage for DTP-HepB-Hib3, OPV3, and PCV13-3 during PY5Q2



As noted above, the last case of wild poliovirus in DRC was reported on December 20, 2011, in Lusangi health zone, located in Maniema Province. The certification of polio eradication is conditioned to three major criteria: (1) the country needs to demonstrate the absence of wild poliovirus transmission for at least three consecutive years; (2) the country needs to do so in the presence of certification standard surveillance; and (3) all facilities holding wild poliovirus infectious and potentially infectious materials must have implemented bio-containment measures according to the WHO global action plan for laboratory containment of wild poliovirus (2003). Based on these criteria, DRC is well on its way to receive polio eradication certification. Since the beginning of the project year, 27 health zones collected and notified at least one case of acute flaccid paralysis (AFP) to a laboratory, which is equivalent to a 35% performance rate. Most of the health zones that have not reported any cases have a population of less than 200,000. Normally, we expect 2 to 3 cases of AFP to be reported for a population of 200,000 children under 15 years of age (WHO). An area of improvement for health zones that are not reporting is to strengthen their monitoring system in order for DRC to fill the criteria related to the existence of a reliable standard surveillance.

In order for the project to build on its strong performance in this area, the team will have to keep supporting the health zones through data quality audit visits (DQS/RDQA), monitoring and evaluation support, vaccines and vaccination materials procurement, maintenance of the cold chain, and strengthening of the disease surveillance system.

Family Planning

Couple Years of Protection: All of the coordination offices, except Uvira (90%), surpassed the quarterly target. The total couple years of protection (CYP), at 137,405, is slightly lower than results from PY5Q1 (149,051), but it surpassed the quarterly target of 112,500, for an achievement of 122% (see Table 26).

Table 26: Couple Years of Protection for PY5Q2

Coordination office	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	Achievement (%)
Bukavu	12,520	11,536	11,452	35,507	32,625	109
Kamina	6,704	7,116	6,801	20,622	18,000	115
Kole	3,197	3,332	4,148	10,677	7,875	136
Kolwezi	3,761	4,165	3,812	11,738	7,875	149
Luiza	5,774	4,441	4,808	15,024	12,375	121
Mwene Ditu	8,734	8,167	8,309	25,209	18,000	140
Tshumbe	3,912	3,674	3,929	11,515	7,875	146
Uvira	2,316	2,395	2,401	7,113	7,875	90

Next steps include the following:

- Continue to strengthen interpersonal communication among health providers and their clients, and community health workers and community leaders
- Brief health providers, community-based distributors (CBD), and CHWs on family planning
- Organize a routine data quality assessment (RDQA) on family planning
- Organize awareness-raising campaigns in the health zones of Lemera and Ruzizi.

These results were reached due to:

- Frequent supply of long-term family planning methods
- Support to awareness-raising campaigns in the health zones
- Training of 50 CBDs in the health zones of Bunkeya and Kolwezi
- Integration of non-clinical family planning services in community care sites and family planning counseling in maternity units
- Availability of family planning products.

Modern Methods of Contraception

The number of individuals who adopted a modern contraceptive method dropped from 208,900 in PY5Q1 to 194,250 during this reporting period. Nevertheless, the project surpassed the quarterly target coverage of 128,058 by 13% (see Table 27).

Table 27: Number of new acceptors of any modern contraceptive method in USG-supported family planning service delivery points

Coordination office	Jan-15	Feb-15	Mar-15	Total PY5Q2	Target PY5Q2	% Achievement
Bukavu	10,134	8,994	9,299	28,427	37,137	77
Kamina	6,591	6,987	6,929	20,507	20,489	100
Kole	4,670	4,366	4,745	13,781	8,964	154
Kolwezi	2,999	5,031	3,343	11,373	8,964	127
Luiza	6,940	5,541	5,743	18,224	14,087	129
Mwene Ditu	9,261	12,547	9,006	30,814	20,489	150
Tshumbe	3,944	4,220	5,068	13,232	8,964	148
Uvira	2,589	2,627	2,774	7,990	8,964	89
Total	47,128	50,313	46,907	144,348	128,058	113

The results are due in part to the availability of contraceptives, the quality of care offered by qualified health providers, as well as the implication of political and administrative leaders in the advocacy efforts targeting women of reproductive age. The involvement of community-based organizations (CBOs) and community leaders in awareness-raising activities on family planning also contributed to the increase of new acceptors of modern methods.

In order to improve and increase the number of new acceptors of modern methods, IHP plans to:

- Work in synergy with peer educators and women leaders trained by other family planning implementing partners who live in the same health zones supported by IHP;
- Review communication techniques with trained CBDs and health providers;
- Organize a debriefing of CHWs in the nine new community care sites in Mwene Ditu;
- Support the health zone management teams to regularly oversee the management of supplies in order to avoid stock-outs and expiration of products.

Malaria

Pregnant women who received at least two doses of Sulfadoxine-Pyrimethamine (SP) during ANC visits: During this period, 85,920 pregnant women received two doses of SP--representing 64% of all pregnant women in the project zones. The target is 70% of pregnant women. The health zones managed by the offices in Kamina (67%), Kole (71%), Tshumbe (65%) and Mwene Ditu (67%) performed better than others. These results in part reflect stock-outs of SP. The last delivery of SP occurred in May 2014, and the supply covered only three months. Uvira (42%) and Bukavu (53%) bring the average down due women starting ANC later in pregnancy. The Uvira and Bukavu coordination offices organized awareness-raising sessions to encourage women to visit the clinic earlier in their pregnancy.

Number of ITNs purchased and distributed with USG funds: The quantity of long-lasting insecticide-treated nets (LLIN) distributed during the first ANC visit and preschool consultations increased to 31,913 from 18,948 in the last reporting period, for an increase of 28 percent. However, Kamina, Kolwezi, and Kole did not distribute LLINs during the reporting period due to a delay in finalizing the contracts with the CDRs to reflect new storage fees.

During the next reporting period, a catch-up distribution will be carried out for pregnant women who attended their first ANC session without receiving a bed net and also for children that have received VAR vaccination since the start of PY5. The health zones of Kamina and Kole will create distribution plans in coordination with the province and SIAPS. The project will also work with the CDRs to arrange the transport of LLINs to the health zones. The Kolwezi coordination restarted distribution during April 2015 after resolving an internal conflict at the CDR.

Number of ACT treatments purchased and distributed with USG funds: IHP partners distributed 594,409 doses of ACT, compared to 424,739 during the previous quarter. With a target of 625,000, this represents a 95% achievement rate. Performance was affected by stock-outs of ACTs for children one to five years old in the health zones of Bukavu (Mulungu, Kaniola, and Kamituga).

Of the total ACT doses distributed, 284,288 doses were for children under five, with 17,811 distributed at i-CCM sites. This is an improvement from last quarter, when 221,016 doses were distributed. Some community care sites under the management of HPP also received ACT from PMI, hence the improvement in results. IHP continued to provide transportation of supplies from the health zone central office to health facilities to avoid stock-outs.

Figure 11: Number of USG-funded malaria-rapid diagnostic tests (malaria-RDTs) purchased and distributed



*In USG supported programs

Despite efforts to strengthen capacities of health providers in the application of rapid diagnostic tests (RDT)—through training sessions, supportive supervision, and post-training monitoring—the project has seen a decrease in the number of RDTs distributed in recent months—from 381,154 in PY4Q4 to 347,496 in PY5Q1, and to 319,956 in PY5Q2, representing a 51% achievement rate (see Figure 11). The coordinations of Mwene Ditu (from 39,784 to 27,070 RDTs) and Luiza (from 24,772 to 17,302 RDTs) registered the greatest reductions. The CDRs in Mbuji Mayi and Kananga were out of stock during PY4Q4 but subsequently received more RDTs in December 2014, and the health zones received their supplies in the beginning of February 2015. Due to logistics challenges, the health zones of Dekese and Yangala did not receive any supplies and therefore did not report this quarter.

The current ratio of use of 2 ACT for 1 RDT is still far from the expected PNL/ MOH norm of 1 ACT to 2 RDTs. This data is not consistent with the 89% of children under five correctly treated with ACT. The

reason appears to be financial incentive: some health providers continue to use the thick blood smear to test rather than the RDT for uncomplicated cases because they can charge a fee; others say they do not trust RDT results. Project staff are discussing with the PNLP to encourage the use of RDT, but the lack of financial incentives is a challenge.

In terms of monitoring, the provincial-level PNLP joined supervision missions and post-training monitoring that focused on following the national protocol for the management of uncomplicated malaria. IHP also conducted post-training monitoring missions on prevention and management of malaria cases in ten health zones of Bukavu (Walungi, Nyangezi, Mwana, Mubumbano, Miti Murhesa, Minova, Kaziba, Katana, Kaniola, and Kalonge).

Based on the positive results of a feasibility study we had conducted, IHP began to train community health workers in the use of rectal artesunate as an initial treatment for children with severe malaria, before they arrive at a health center. Health zone central office supervisors and IHP point persons for the study were also briefed and a draft job aid on the use of rectal artesunate was proposed to the PNLP for validation. Refresher training for CHWs and the start-up of the pilot phase are scheduled for April 2015.

In preparation for the MOH 2016 workplan, IHP participated in field visits with the PMI team in Bukavu and Kananga to monitor the management and quantification of malaria products for 2017.

HIV and AIDS

By the beginning of the reporting period, IHP had 41 PMTCT sites in Kolwezi and 28 sites in Kamina, for a total of 69 sites. However, per PEPFAR recommendations, the project worked with USAID to reduce the number of sites in order to introduce Option B+ at all PMTCT sites. PEPFAR has also recommended prioritizing high-prevalence sites to detect more seropositive individuals who could benefit from ARVs.

All HIV sites supported by the project provide counseling and testing services through the provider-initiated counseling and testing (PICT) strategy, wherein the counseling is initiated by the provider. The transition from Option A to Option B+ is underway at the PMTCT sites. In Kolwezi, all sites now have integrated Option B+, with 14 sites having transitioned during this quarter (compared to 27 during the last quarter). However, in Kamina, where sites are more isolated due to impassable roads, especially during the rainy season, the transition to Option B+ is planned for the next quarter when roads will be in better condition during the dry season.

The project will also work with the national AIDS program (PNLS) to brief health providers at the 41 sites in Kolwezi on Option B+ and clinical monitoring of HIV patients to ensure sustainability of the initiative.

Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women:

During the current reporting period, 15 sites (2 in Kamina and 13 in Kolwezi) reached their targets, an increase from six sites last quarter, due in part to the transition to Option B+ treatment. Nevertheless, a follow-up briefing is needed to ensure the correct application of Option B+. The transition to Option B+ should be completed by June 2015 in Kamina.

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 reporting period, 5,144, or 78%, pregnant women knew their HIV status among the 6,608 tested. This proportion shows a slight increase from the previous

quarter (75%). Kolwezi zones rose from 81% the previous quarter to 83% during the reporting period, and Kamina zones from 65% to 70%.

Two factors account for under-performance in Kamina. First, in the health zone of Songa, a conflict among the health zone management team delayed activities; pregnant women received counseling but not testing for HIV during the month of March 2015 since the test kits were not released for use until the conflict was resolved. The provincial health officials in Katanga have been alerted to the internal conflict in Songa. In addition, in the health zone of Kabongo, providers at the PMTCT sites have not yet been trained on completing the cycle of counseling, testing, and results the same day. IHP plans to provide the appropriate training for health providers at all PMTCT sites, scheduling it during the dry season in Kamina, so roads will be in better condition and all the sites reachable.

Percentage of HIV-positive pregnant women who received antiretroviral to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery: This indicator increased dramatically from 36% last quarter to 83% (153/184) during the reporting period. In Kolwezi, IHP staff and MOH partners carried out Option B+ monitoring and coached health providers, thus helping raise results from 37% during Q1 to 87% (151/173) during this quarter. Because training has not been carried out for Option B+ in Kamina, coverage there remains low at 18% (2/11). As mentioned above, training and follow-up have been scheduled for PY5Q3 to increase coverage in these sites.

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: During this quarter, 78 female sex workers were reached individually or in small groups, compared to 82 in the previous quarter. In Kamina, local organization Batwa Bemba helped reach 46 female sex workers in the health zone of Mulongo; CHWs and health providers reached 15 in the health zone of Kitenge. In Kolwezi, health providers reached 17 female sex workers in the health zones of Dilala and Manika. HIV IHP-supported health facilities provided tests and treatment.

Number of individuals who received testing and counseling (T&C) services for HIV and received their test results: A total of 12,070 individuals (compared to 15,695 last quarter) were counseled and tested, and received their results. Kamina showed a slight rise: 8,698 individuals compared to 8,607 the previous quarter. Kolwezi saw a significant drop: 3,372 individuals compared to last quarter's 7,088. Awareness-raising activities were carried out at all sites but a lack of rapid screening tests (some of which went toward blood safety activities) in Kolwezi did not allow all individuals who had been counseled to be tested.

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: During this quarter, 2,571 HIV positive adults and children received at least one clinical evaluation (according to WHO staging) on the progression of the infection. This represents a slight increase from the 2,566 patients evaluated last quarter. Last quarter, however, there may have been some double counting in Kolwezi. In Kamina, health providers continue to report solely on PLWHA evaluated through CD4 count, while the clinical evaluation has not been reported.

Close supervision of service providers to be trained in PY5Q3 should improve this indicator. While IHP has supplied Pima CD4 cartridges, kits and equipment for the determination of viral load are not available.

Number of HIV-positive adults and children receiving a minimum of one clinical service: During the quarter, 3,236 HIV-positive adults and children received a minimum of one clinical service--a slight drop from the 3,384 PLWHA during the previous quarter. Similar to the previous quarter, in Kolwezi, this result is due to the availability of cotrimoxazole and other HIV products (i.e., iron sulfate and folic acid, mebendazole, and multivitamins) thanks to the partnership with public mining groups. Kamina does not have such a partnership. In addition, health providers tend to find this indicator confusing. In response, IHP plans additional training during the next quarter, as well as close joint supervision of health providers on HIV care by the MOH and IHP in order for health providers to better understand all HIV indicators.

TB/HIV: Percent of HIV-positive patients screened for TB in HIV care or treatment setting: This indicator saw a dramatic jump: 70% (379 out of 542) of PLWHA were tested for TB, an increase from the previous quarter's coverage of 9%. This significant increase can be attributed to a boost in supportive supervision provided to health providers by the health zone management teams, coupled with the availability of TB screening tools.

Results varied widely by region, however: in Kolwezi, 85% (378 out of 445) PLWHA were tested for TB, while in Kamina, only one in 97 (1%) was tested. This low performance reflects a lack of understanding of how to use the screening tool. IHP staff will provide more coaching, training, and post-training supportive supervision so that coverage expands in Kamina. TB screening tools will also be provided.

Number of adults and children receiving antiretroviral therapy (ART) (current): During the quarter, 2,631 PLWHA (51 in Kamina and 2,580 in Kolwezi) received ART, a drop from the previous quarter when 2,848 PLWHA went on ART. However, in Kolwezi during the previous quarter, the health zone management teams may have double-counted patients under the care of the Global Fund. IHP and the Global Fund both support sites across four health zones (Manika, Dilala, Lubudi, and Lualaba). IHP plans a field visit with the health zone management teams to verify data reported at different periods.

Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and receiving at least one of the following at enrollment: clinical assessment (WHO staging), or CD4 count or viral load: During this quarter, 608 PLWHA (597 in Kolwezi and 11 in Kamina) received at least one clinical evaluation (either the WHO Clinical Staging and Disease Classification System⁵ or CD4/viral load count) to see the progression of the virus. During the previous quarter, the 394 PLWHA (378 in Kolwezi and six in Kamina) received at least one clinical evaluation.

The results are due to the availability of Pima and close coaching by health providers trained by health zone management teams. Nevertheless, we note that there has been a series of Pima equipment breaking down in the Mutshatsha and Kanzenze health zones, and process for obtaining repairs is complex. Since Pima is necessary for Option B+, the project will prioritize repair of the equipment.

⁵ This disease classification system can be used readily in resource-constrained settings without access to CD4 cell count measurements or other diagnostic and laboratory testing methods. The WHO system classifies HIV disease on the basis of clinical manifestations that can be recognized and treated by clinicians in diverse settings, including resource-constrained settings, and by clinicians with varying levels of HIV expertise and training (World Health Organization, 2007).

Proportion of registered TB cases that are HIV-positive who are on ART: During this quarter, 353 out of the anticipated target of 356 (99%) TB patients registered that are also HIV positive were placed on ART, an improvement from last quarter when only 23% (194 out of 869) of TB patients that were also HIV positive were put on treatment. The improvement is due to a better understanding of this indicator by IHP staff, the local MOH supervisors, and service providers. TB screening tools also are available.

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 (17 in Kolwezi and one in Kamina) 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: One laboratory in Kolwezi meets the minimum criteria.

Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services: Sixty-nine PMTCT sites systematically provide family planning and maternity services and products. Health providers at these sites were trained to offer counseling and modern methods of family planning. Health zone management teams regularly carry out supervisory missions.

Tuberculosis

TB detection rate by coordination for PY5Q2: During PY5Q2, a total of 3,015 new sputum positive pulmonary tuberculosis cases (MPT+) patients were diagnosed, and the TB detection rate reached 64%. Compared to PY5Q1 (66%), there is a slight decrease. The overall IHP performance reported is influenced by the highest achievement in Kamina (103%) and the lowest achievement by Uvira (35%). Performance in two other coordination offices exceeded the 70% WHO target: Kole with 100% and Kolwezi with 83%. On the contrary, three other coordination offices underperformed: Bukavu with 38%, Tshumbe with 52%, and Luiza with 55%. The low performance has been mainly driven by the decrease of the number of TB cases reported in both Kamina and Uvira, for which there are two reasons: (1) the population is not exposed sufficiently to key TB messages; and (2) drug stock outs have been reported in 16 health facilities located in Kamina, Tshumbe, and Bukavu health zones, discouraging people from getting treatment there.

During the next quarter, IHP will address the stock-out challenge by supporting the transportation of TB drugs provided by the Provincial Coordination Unit for TB (CPLT in French acronym) to the health zones. IHP will continue to reinforce the capacity of trained CHWs and health providers to detect TB, including provision of awareness kits, and organizing awareness and door-to-door campaigns to inform the public about TB care and treatment, especially in areas where CHWs have been trained, such as Bukavu, Uvira, Luiza, and Tshumbe.

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 decreased to 95%, compared to PY5Q1 (99%). This result is still close to the National Tuberculosis Program average of 97/100,000 people; however, the IHP performance against the PMP target (214/100,000) is as low as 44/100,000.

IHP will continue to work with the PNLT to improve more complete reporting and to advocate for ongoing availability of mini-lab kits and DOT kits for sputum sample collection at the TB treatment health center level and support samples shipment to the diagnostic and treatment centers (CSDT).

TB patients who are tested for HIV through USG-supported programs: This quarter, IHP was able to meet its PMP target with a performance rate of 100%. Indeed, 62% of MPT+ patients were counseled and tested for HIV across all 78 health zones.

The fight against multi-drug resistant tuberculosis (MDR-TB): The total number of MDR-TB cases detected in PY5Q2 was 39, or 195% of the target (20). This represents a slight decrease from PY5Q1 (which was 45), but is still a great achievement when compared to PY4Q4 (15). The coordination office of Mwene Ditu is the greatest contributor to these good results with 21 MDR-TB cases, followed by Luiza with six and Kolwezi with five.

IHP identified the following combination of success 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 supportive supervision of providers for MDR-TB patients (health zone management teams and nurses and lab technicians in Uvira, Bukavu, and Luiza).

In order to keep improving the management of MDR-TB performance, the project plans to conduct the following activities:

- Assist with the transport of MDR-TB commodities from provincial level to the health zone;
- Support the installation of USAID-donated GenExpert equipment and provide required supplies to Kamina, Kolwezi, Tshikapa, and Kananga;
- Fund the collection and transportation of sputum samples from MDR-TB 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.

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

The number of facilities that experienced stock-outs of RH decreased by nearly half, from 31 health facilities in PY5Q1 to 16 in PY5Q2. The coordinations of Bukavu, Kamina, and Tshumbe reported the largest number of health facilities experiencing stock-outs.

Nutrition

The three nutrition indicators reported and analyzed in the report (number of children under 5 years who received vitamin A supplements, number of pregnant women who received iron and folic acid supplements, number of breastfeeding women who received vitamin A supplements) are related to nutritional commodities procurement, capacity building, monitoring and community strengthening. Two indicators have exceeded their quarterly set targets: the number of pregnant women who received iron and folic acid supplements (125% achievement rate) and the number of mothers of children 2 years or less receiving nutritional counseling for their children (155% achievement rate). The integration of the nutrition support group approach, Infant and Young Child Feeding (IYCF), and culinary demonstrations contributed to the improvement of the number of mothers and children under two years receiving nutritional support. In Luiza, the integration of IYCF during PY4 in the health zones of Dibaya, Bilomba, Kalomba, Luiza, and Ndeksha also contributed to the improvement of the indicator.

One area for improvement remains for the indicator related to breastfeeding mothers receiving vitamin A. IHP reached only 52% of the target, which is an improvement compared to last quarter (44%). See Table 28 for more data.

Table 28: Nutrition indicators by coordination for PY5Q2

Coordination office	# of children under 5 years who received vitamin A supplements (campaign)	# of pregnant women who received iron and folic acid supplements	# of breastfeeding women who received vitamin A supplements
Bukavu	0	46,670	19,103
Kamina	0	8,421	5,445
Kole	0	10,648	3,421
Kolwezi	0	14,436	2,861
Luiza	0	15,135	4,231
Mwene Ditu	0	32,769	8,975
Tshumbe	0	8,266	524
Uvira	0	4,244	3,384
PY52Q	0	140,589	47,944
Target	573,987	112,500	92,971
% target achieved	0	125	52

Number of children under 5 years of age who received vitamin A: IHP did not plan any activities related to providing vitamin A to children under 5 years of age during the MOH mass campaign. IHP will support technically and logistically the MOH during its next vitamin A mass supplementation campaign planned for PY5Q3. Vitamin A procurement for mass campaigns is not the responsibility of IHP.

IHP continued to improve its performance this quarter on iron-folate distribution to pregnant women to prevent anemia, with an overall achievement rate of 125% (see Figure 12). The number of recipients increased from 126,515 to 140,589 between PY5Q1 and PY5Q2. Important influencing factors were the sufficient provision of iron-folate to health facilities and its efficient use by the latter coupled with good data reporting. However, 378 facilities (a great deal more than the target of 50) reported “false” stock-outs, mainly due to the health zone central offices not procuring the needed products. A “false” stock out can be described as a situation where the health facility is running out of a specific product even when the product is available in the regional distribution center.

Figure 12: Proportion of pregnant women who received iron-folate to prevent anemia

Note: Chart includes percent of women attending ANC as a proportion of expected pregnancies (4%) within the catchment area of the USG supported health facilities

PY5Q2 Target= 81%



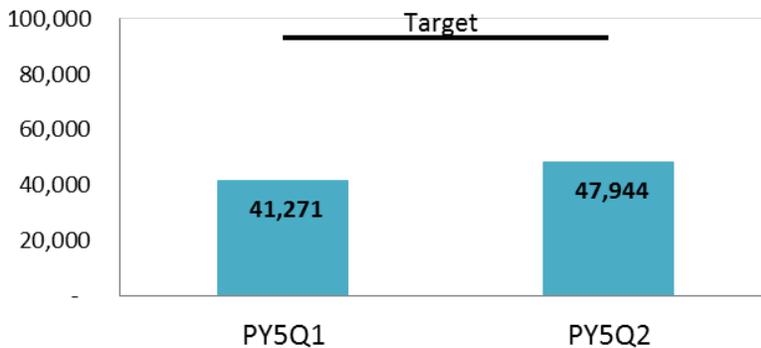
*USG-supported service delivery points

One of the root causes for this situation is that health zones do not plan enough time when they order iron-folate (or other products) from CDRs to avoid stock-outs, taking into account possible delays due to bad road conditions. The same situation occurs between the CDRs and health zone central offices. For example, the Wikong health zone did not order in a timely manner that would have allowed ample time for delivery, taking into consideration road conditions during the rainy season. By the time the health zone ordered from CADMEKO, the roads had become impassable to Wikong and trucks were not able to pass safely. Wikong suffered from stock-outs while waiting for road conditions to improve.

In Mutshatsha, Manika, and Dilala health zones, the organization of a mini-prenatal consultation awareness campaign played an active role in motivating more expecting mothers to seek maternal health services and therefore receive iron-folate. The continuous distribution of iron-folate during prenatal consultation also increased the use of maternal health services by women, attracted by the promise of receiving free drugs to assist them during their pregnancy.

Figure 13: Number of breastfeeding mothers receiving vitamin A

PY5Q2 Target= 92,971



*USG-supported service delivery points

The number of breastfeeding mothers receiving vitamin A increased by 16%, from 41,271 to 47,944 between PY5Q1 and PY5Q2 (see Figure 13). However, this number remains below the quarterly target of 92,971, with an achievement rate of 52%. Nevertheless, for the first time since the launch of the project, the achievement rate for this indicator is above 50%. To achieve this, the project provided sufficient vitamin A to the health facilities through the CDRs; helped organize with the CDRs an information campaign targeting health facilities to inform them about vitamin A availability; and supported the health zone central offices to distribute vitamin A to health facilities. However, some health areas did not receive enough vitamin A or did not receive it at all, because the informational message from the CDR either did not reach them at all, or too late.

Another positive factor was the good management and use of vitamin A stock by the health facilities, which helped them supplement more breastfeeding women this quarter while avoiding stock-outs.

Challenges: The project must continue to support health facilities to better manage their drug inventories so they can request the essential generic medicine package (including vitamin A and folic acid) on time to avoid stock-outs. It is important to extend the infant and young child feeding approach in all health areas, ensuring the sustainability of infant and young child feeding support groups within supported communities. IHP must also work on a higher level with regional distribution centers and health zone central offices to ensure the regular procurement of essential generic medicine in sufficient quantity.

IHP is planning the following activities to increase performance on the indicators:

- Ensure monitoring and management of vitamin A and folic acid stocks in health facilities;
- Continue drug procurement to health facilities, support the vitamin A and folic acid supplementation awareness sessions and the ones on infant and young child feeding;
- Make the infant and young child feeding data collection tools available at all levels (health facilities, the health zone central offices and the infant and young child feeding support groups);
- Organize follow up visits with infant and young child feeding support groups;
- continue to raise awareness with health facilities on routine provision of vitamin A.

Sexual and Gender-Based Violence

Sud Kivu is the province of DRC with the highest prevalence of gender-based violence (GBV), due to ongoing armed conflict. This quarter, the Bukavu office reported a total of 497 GBV cases, all against women except one. Of the survivors that sought care at a USG-supported clinic, 55% (271) arrived within the 72 hours following the attack and 45% (225) between 72 hours and 120 hours (see Table 29). In terms of age, 91% (450) were over 18 years; 7% (36) were between 10 to 17; 2% (11) were under 10 years old.

Table 29: Number of people impacted by GBV services funded by the U.S. Government, disaggregated by sex and period of arrival at a health facility

	Number of people reporting:					
	Sexual violence by sex		Sexual violence within 72 hours	Sexual violence between 72 and 120 hours	Sexual violence given ARVs	Sexual violence given emergency contraceptive
	Females	Males				
Bukavu	496	1	271	226	277	308
Kamina	27	1	26	2	2	2
Kole	29	1	26	4	16	9
Kolwezi	0	0	0	0	0	0
Luiza	2	0	2	0	0	0
Mwene Ditu	0	0	0	0	0	0
Tshumbe	4	0	2	2	2	1
Uvira	65	0	58	7	57	57
Total	623	3	385	241	354	377

The number of reported cases in Uvira (which were all women) decreased from 102 in PY5Q1 to 65 cases in PY5Q2. This reduction in reported cases may be due at least in part to awareness campaigns by the project and health zone management teams. IHP also provided supportive supervision, and post-exposure prophylaxis (PEP) kits were available in most health zones.

In Kamina, where two local NGOs receive a grant from IHP to monitor GBV cases, 28 survivors registered reports, due in part to the supportive supervision and awareness-raising activities organized by IHP in the health zones of Malemba, Kabongo, and Kitenge.

In Kasaï Oriental, the Kole and Tshumbe coordinations reported 34 cases of GBV, including one male. Twenty-seven survivors (79%) arrived at a USG-supported health clinic to seek care within the 72 hours following the attack; 21% (6) arrived between 72 hours and 120 hours following the attack. In terms of age, 18% were 18 years and older; 62% were between 10 and 17; 20% of the survivors were 10 years or younger. All of the 34 survivors received counseling and GBV services. However, in Sankuru, only the health zone of Kole had PEP kits available for GBV survivors.

Fistula

With IHP support, the Kaziba GRH fulfilled its contractual obligation and repaired 60 vesico-vaginal fistulas. Women in the age group of 20-34 years were most frequently affected and treated at the hospital. However, we also noted a slight increase of fistula patients of 45 years and older during the month of March. The recovery rate for this quarter (87%) decreased slightly compared to last quarter (90%), because the number of relapses slightly increased (10 versus 8).

Prolonged and/or obstructed labor accounts for 80% of vesico-vaginal fistulas in the Kaziba health zone. These fistulas are therefore preventable. IHP will intensify community mobilization to promote the use of maternal health services and prenatal consultation, with a focus on the fourth ANC visit as well as correct use of the partograph by birth attendants for an early identification of obstructed labor and prompt referral for timely/high quality C-sections. When high-risk pregnancies are detected, women can be referred to appropriate facilities in a timely fashion and receive the care they need. Addressing contextual factors, such as early marriage, will also be useful.

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

FOSACOF approach

IHP's *fully functional service delivery point* (FOSACOF is its French acronym) approach gives health centers standards and tools to improve services. The nine criteria of FOSACOF (see box) reflect norms established by the MOH to improve the quality and availability of services.

Since 2012, IHP has assisted 731 health facilities to implement the FOSACOF system of scoring and improvement. This quarter, we evaluated 309 of them using the nine criteria of FOSACOF--comparing those that have also integrated RBF with those that have not yet done so (see Table 30).

The results are remarkable. More than 20% of the centers with RBF are highly functioning compared to only 1% of those without. Only 16% of RBF centers score as weak, compared to 47% of those without RBF.

To improve FOSACOF implementation, IHP will ensure that health zone management teams evaluate the approach quarterly (especially in Uvira and Kamina) as well as implement improvement plans quarterly.

During the next quarter, IHP will monitor facilities using FOSACOF, especially coaching of IHP staff and health workers from facilities in Kamina, where 15 out of 18 health facilities evaluated were assessed as non-functional. In addition, IHP needs to ascertain that health facilities are reaching out to the communities they serve when designing and implementing improvement plans.

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

Table 30: FOSACOF evaluation of facilities

Coordination	Number of facilities evaluated		Class C : weak (score of < 50%)		Class B: moderately functioning (50<80%)		Class A: high functioning (≥ 80%)	
	Facilities using RBF	Facilities without RBF	With RBF	Without RBF	With RBF	Without RBF	With RBF	Without RBF
Bukavu	0	15	0	3	0	12	0	0
Kamina	14	18	0	15	11	3	2	0
Kole	20	26	13	24	6	2	0	0
Kolwezi	16	9	2	6	4	3	9	0
Luiza	19	45	0	22	12	23	6	0
Mwene Ditu	18	69	1	12	14	55	2	2
Tshumbe	16	9	0	8	12	1	3	0
Uvira	0	15	0	6	0	9	0	0
Total	103	206	16	96	59	108	22	2
Proportion (%)	33%	67%	16%	47%	57%	52%	21%	1%

Results-based Financing (RBF)

During this quarter, IHP/DRC focused on the performance review of the first year of RBF implementation, presenting the results to the MOH and investigators at the Kinshasa School of Public Health, and data verification.

All stakeholders in the implementation of RBF were represented at the annual review, where data verified during the first year were presented. The team discussed challenges as well as strategies to address them, which will be applied during the second year of implementation. The review took into account observations of the MOH plus the external evaluation firm IBTCI. Quantitative indicators regarding GRHs and new indicators for health centers and health zone management teams were clarified and calculated with the support of the National Health Information Unit (SNIS) of the MOH. Orientations towards the new structure of RBF implementation were also provided.

Enthusiastic testimonials came from a wide variety of stakeholders, community leaders, representatives from local NGOs, *Association pour le développement intégré et intégral de Fizi* (ADIF) and *Action des Femmes pour le Développement et la Protection de l'Enfant* (AFEDEPE), health zone teams, a head nurse, chief physicians, and a chief medical officer.

Before RBF was introduced, staff didn't show up on time but they left early. Neither the structure nor the staff were welcoming to patients. But after the RBF approach was implemented, I saw people start to come on time. When people arrived at the hospital, health staff welcomed them well. The place was clean and repainted and the odors had gone. Because of the enormity of the changes, one of the missionaries of the congregation spontaneously gave \$30,000 to the hospital to encourage them to keep up the progress.

-- Reverend **Pastor Jean François Kalombo Elunga**, Methodist Church of Wembonyama

Overall, results during the first year of implementation of RBF demonstrated the following:

- Service utilization rates in those facilities using RBF rose from 21% to 32%;
- ANC coverage increased from 79% to 87%;
- ANC 4 coverage rose from 14% to 35%;
- Referral rates of at-risk pregnancies went from 58% to 98%;
- Assisted birth increased from 63% to 69%;
- Second postnatal consultations (PNC 2) increased from 49 to 67%.

The quality of service, as measured by the FOSACOF tool, increased from 33% to 61% in the health centers and from 42% to 75% in the GRHs. For example, the RBF health zone of Luiza more than doubled its overall FOSACOF score, increasing from 26% to 65% (the higher percentage reflecting better performance). Bilomba, which is not participating in RBF, showed improvements as well, but far less, increasing its FOSCAOF score from 27% to 37%.

The greatest differences between RBF and non-RBF zones showed in specific criteria such as the following, again from Luiza and Bilomba:

- A functioning CODESA (score of 60% in Luiza versus 30% in the non-RBF health zone of Bilomba);
- CHW participation in activities (rated at 66% with RBF versus 18% without);
- Dealing with preventable deaths (66% in the RBF zone compared to 15% in non-RBF);
- Referral systems, which rated 65% in the RBF health zone against 15% in the non-RBF zone;
- Utilization rate is now 47% in Luiza, against 23% in Bilomba;
- ANC 1 coverage went from 82% to 93% in Luiza as compared to the drop from 91% to 88% in Bilomba; and
- Rate of referral for high-risk pregnancies referred tripled in Luiza-- from 31% to 98%--while it dropped from 33% to 30% in Bilomba.

The second study focused on improving quality of health information by looking at unreported data from the health facilities and verified data after the first year of implementation in the health zone of Bibanga. In data quality, too, RBF centers excelled over the non-RBF facilities.

With the MOH, IHP performed data verification in the health zones of Bibanga, Lomela, Luiza, and Wembonyama, visiting 69 health centers out of 118 (59%), four out of seven (57%) GRHs, and four out of seven (57%) health zone management teams. Three health zones were not verified following the restructuring of health districts into provinces. This issue will be addressed in the next reporting period.

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

For this quarter, the percentage of patients referred to a GRH continued to exceed the project target, with an achievement almost triple the target (3.8% compared to 1.3%). This result is consistent with the coverage for last quarter (4%). Considering the achievement rate reported up to this point, the target set may be underestimated in comparison with the 5% target norm used by SNIS (see Table 31).

Table 31: Number and percentage of patients referred to GRHs

	Jan-15		Feb-15		Mar-15		PY5Q2		Rate (%)
	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	Patients referred to GHR	Patients seen by a CHW or health care provider	
Bukavu	6,985	165,938	6,473	152,087	7,304	168,606	20,762	486,631	4.3
Kamina	1,102	67,361	896	77,708	912	74,206	2,910	219,275	1.3
Kole	2,052	34,766	2,124	33,838	2,189	36,720	6,365	105,324	6.0
Kolwezi	685	42,634	566	62,052	900	46,674	2,151	151,360	1.4
Luiza	103	43,117	128	39,854	325	42,555	556	125,526	0.4
Mwene Ditu	4,233	78,995	4,364	73,041	4,408	74,035	13,005	226,071	5.8
Tshumbe	2,161	28,581	1,990	27,897	2,118	29,627	6,269	86,105	7.3
Uvira	1,300	25,072	1,233	25,245	1,428	27,493	3,961	77,810	5.1
PY5Q2 Total	18,621	486,464	17,774	491,722	19,584	499,916	55,979	1,478,102	3.8

The lowest performance was reported by the Luiza coordination, with an achievement rate of 0.4%, due mainly to the withdrawal of private facilities in health areas where the RBF approach was introduced under the 9th European Development Fund (FED 9).

Table 32: Number and percentage of patients referred to health centers

	Jan-15		Feb-15		Mar-15		PY5Q2		Rate (%)
	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center by a CHW	Patients seen by a CHW	Patients referred to health center	Patients seen by a CHW	
Bukavu	204	4,636	97	946	108	899	409	6,481	6.3
Kamina	569	1,798	235	1,526	358	1,648	1,162	4,972	23.4
Kole	139	3,862	262	4,255	212	4,162	613	12,279	5.0
Kolwezi	47	313	67	469	61	437	175	1,219	14.4
Luiza	199	2,185	43	1,459	265	1,565	507	5,209	9.7
Mwene Ditu	524	1,387	356	1,694	803	2,337	1,683	5,418	31.1
Tshumbe	497	1,081	436	1,135	514	1,007	1,447	3,223	44.9
Uvira	75	380	61	269	28	347	164	996	16.5
PY5Q2 Total	2,254	15,642	1,557	11,753	2,349	12,402	6,160	39,797	15.5

As presented in Table 32, in general, the referral rate towards health centers during this quarter reached 310% against the target (15.5%/5%). Almost all coordination offices reported surpassing the target of 5%. This high coverage in referral is due mainly to the following:

- Functioning i-CCM sites (Uvira, Mwene Ditu, Kolwezi, and Bukavu) refer patients frequently;
- Availability of care management tools and referral notes;
- Timely detection of danger signs by CHWs.

Monitoring of curative care activities in the i-CCM sites and timely detection of danger signs by CHWs in those sites contributes to improved referral of community members to health centers.

Intermediate Result 3: Knowledge, Attitudes, and Practices to Support Health-Seeking Behaviors Increased in Target Health Zones

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 linkages, foster health advocacy and community mobilization, and facilitate behavior change communications (BCC) (see Table 33).

Table 33: Summary of IR 3 Key Results for PY5Q2 by Sub-IR

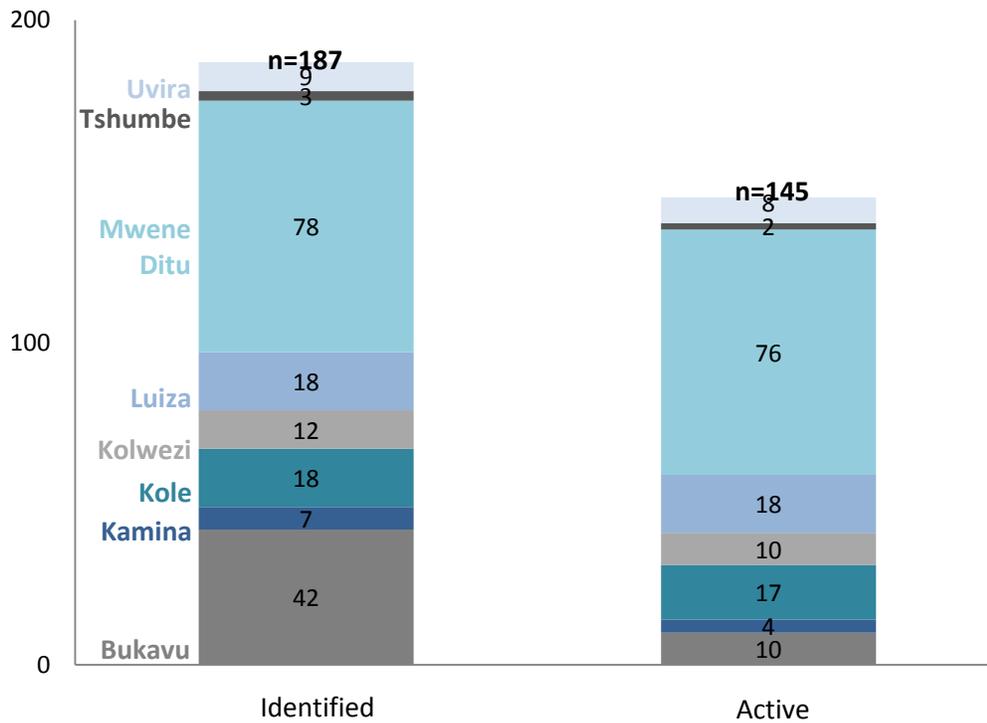
Sub-IR	Key Indicators	Results
3.1 Health sector-community outreach linkages	Youth and vulnerable group NGO participation	● Exceeded targets
	Active Champion Communities	● Exceeded targets
3.2 Health advocacy and community mobilization	Rehabilitated CODESAs	● Almost met targets
3.3 Behavior Change Communication	Functional CODESAs with communication action plans	● Exceeded targets
	mHealth text messaging	● Exceeded targets

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

Youth Associations

Youth are an important target group for IHP, particularly concerning the promotion of responsible sexual and reproductive health practices such as the prevention of HIV and AIDS, STIs, and unplanned pregnancy. IHP conducts outreach campaigns to youth in its target areas, and also partners with youth organizations to promote health messages among peers. Engaging youth organizations as equal partners in community health has been effective in reaching young people at a sensitive age as they begin the transition to adulthood. During this quarter, the number of youth organizations we worked with remained stable, with an increase of one active youth organization in Kolwezi (see Figure 14).

Figure 14: Number of youth organizations completing youth awareness raising activities



The project supported 145 youth associations across all field offices to plan and conduct group discussions and awareness-raising campaigns on reproductive health--especially the spread of STIs--and personal hygiene. Examples of IHP’s capacity building activities with youth associations are presented in the text box below:

IHP CAPACITY BUILDING AND SUPPORT TO YOUTH ASSOCIATIONS

RACOI/SIDA Youth Association

IHP trained and prepared a youth organization from the Mwene Ditu coordination area to lead a Performance-based Financing evaluation of health services utilization in the Bibanga health zone to be completed in PY5Q3.

Uvira Youth Associations

IHP supported youth associations in organizing a three-day outreach campaign in the Ruzizi, Uvira, and Lemera health zones, targeting women and youth, using the new theme “Zero infections on Valentine’s Day and proper family planning for a prosperous Congo”.

A list of key PY5Q2 activities and target populations reached can be found in table 34 below:

Table 34: Youth Association Activities PY5Q2

Activities	Location	Targets	Population Reached
Organized a quiz game on HIV and AIDS knowledge and family planning in three schools	Uvira, Sange, Luvungi	High school students	20 students participants per quiz game, 3 audiences totaling 1,386 students
Held group discussions on HIV awareness and prevention and family planning	Uvira, Sange, Luvungi	Students, women's group, youth and churches	3 group discussions with 156 students and 240 church members participating
Provided orientation to token distribution to health centers for STI screening and testing and family planning services	Uvira, Sange, Luvungi	Youth and Women	250 youth and women
Distributed condoms in bars and hotels	Sange, Uvira, Luvungi	Youth, adults frequenting hotels /pubs	2,858 youth and women
Organized radio broadcasts on HIV awareness and prevention and family planning	Uvira, Sange	Youth and Women	Approximately 100,000 community members
Supported theater productions (popular theater) on HIV awareness and prevention and family planning	Uvira, Sange Luvungi	Youth	6 theater productions, approximately 200 youth attending
Supported popular concerts (youth orchestras) on HIV awareness and prevention and family planning	Uvira	Youth	2 concerts, approximately 400 youth attending

Challenges: Although IHP staff provide technical guidance to youth organizations in the implementation of their activities, the biggest obstacle to youth organizations effectively engaging their communities in the promotion of healthy practices remains a lack of funding and management capabilities.

Next Steps: In order to address the challenges of this quarter, IHP staff will build the managerial and operational capacity of youth organizations in Uvira, Lemera, and Ruzizi by conducting supervisory training sessions in the field and assist with quarterly meetings for planning, implementation, and monitoring and evaluation of activities. IHP staff will also encourage project-supported youth organizations to share their experiences with other youth organizations, both IHP-supported and others not supported by the project, in an effort to promote the exchange of experiences and lessons learned and to develop solutions to collective financial and operational problems.

IR 3.2: Health advocacy and community mobilization organizations strengthened

CODESA: health advocacy and community mobilization

Among IHP's local implementing partners, CODESAs play an important role in promoting community health, especially in encouraging health care seeking activities and the use of health products. CODESAs are an integral part of their communities across IHP's target health zones, and members are often

leaders that are well known and respected by their peers. As such, CODESA members are able to effectively mobilize the communities to increase their use of health services and adoption of healthy practices.

IHP provides technical and managerial support by assisting CODESAs in developing and implementing community action plans, designed to provide local solutions to local health problems, such as designing and building latrines, refurbishing health centers, forming WASH committees, and hosting information sessions on prevention of disease. These action plans, implemented by stakeholders and local leaders, encourage communities to take ownership of public health, ensuring the sustainability of these activities following the end of IHP.

This quarter, the number of active CODESAs and CODESAs with finalized action plans remained stable from the last quarter, with the project supporting a total of 1,306 CODESAs, of which 93% are implementing action plans (see Table 35 below).

Table 35: Number of revitalized and functional CODESAs during PY5Q2

Coordination Office	Number of revitalized CODESAs PY5Q2	Number of CODESAs with an action plan	% CODESAs with an action plan
Bukavu	396	380	96
Kamina	195	191	98
Kole	129	129	100
Kolwezi	99	99	100
Luiza	147	137	93
Mwene Ditu	168	168	100
Tshumbe	92	83	90
Uvira	80	71	88
Total	1,306	1,258	96

As noted elsewhere in the report, CODESAs contribute to the increased use of community health care services by initiating and leading group discussions about health issues, conducting household visits, and disseminating health information via group educational sessions, where CODESA members give public presentations on disease prevention and healthy behaviors. IHP supports these efforts with CODESAs and community health workers by training them in the Champion Community approach, integrating this community mobilization technique with the CODESA’s traditional interpersonal communication activities. Highlights for this quarter include the following: CODESAs conducted 4,325 household visits in Mwene Ditu, Luiza, and Kole, and referred 1,207 individuals to health centers.

Challenges: Despite the effectiveness of CODESA activities, particularly household visits, it is difficult to incentivize individuals to become CODESA members or community health volunteers. Lack of incentives also discourages current CODESA members and community health volunteers.

Next Steps: In order to improve CODESA capacity to carry out their functions effectively, the project will continue to conduct joint supportive supervisory sessions with the health communication and social mobilization unit of the DPS, and the central health zone office. These training sessions will assist CODESAs in holding monthly and quarterly planning meetings, among other management techniques. IHP will continue to support the implementation of CODESA community health awareness information and disease prevention activities.

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

IHP works closely with local organizations such as youth associations, women's associations, and CODESAs, building their managerial and organizational capacity, as well as their technical capacity in BCC. To complement efforts by local partners, IHP has implemented several innovative BCC and community mobilization approaches, including Champion Communities, Education Through Listening (ETL), and mHealth.

Behavior Change Communication (BCC)

Awareness-Raising Campaign

The project organized community mobilization activities and mini-BCC campaigns in health areas where monitoring and evaluation indicators did not demonstrate a sufficient rise in the adoption of healthy behaviors in the Kole and Lodja health zones. To achieve the desired results, local community and religious leaders and members of civil society organizations assisted in developing and implementing a total of 14 mini-BCC campaigns across the health areas. The mini-campaigns focused on sexual violence, WASH, exclusive breastfeeding, and prevention of diarrhea at the household level, targeting heads of households and young couples. Highlights from the mini-campaigns are presented below.

Kole and Lodja WASH campaigns

Objective: Construct latrines and hand washing units with local materials to prevent the spread of illness caused by not washing hands.

Towadje Tokadjimo Champion Community and *Synergie* (local NGO) completed 3 mini-BCC campaigns in two health zones with the following activities:

- *Developing a community action plan*
- *Conducting informational and advocacy visits with local political and administrative authorities in Kole to encourage their participation in the campaigns*
- *Managing informational meetings on the design and construction of the latrines (with local materials) and hand washing units (with bamboo)*
- *Drafting and disseminating WASH messages in churches*
- *Launching a mini-BCC campaign with the territory administrative authorities*
- *Sending SMS messages and organizing community discussions*
- *Developing a monitoring plan*

Populations reached:

- *531 household visits conducted to raise awareness about WASH, breastfeeding, and sexual violence (426 in Kole and 105 in Lodja)*
- *BCC messages disseminated in the churches (reaching approximately 9,000 individuals)*
- *63 community discussions organized in churches, schools, and local organizations in Lodja*
- *673 ETL sessions held (510 in Kole and 163 in Lodja)*
- *1,699 SMS messages sent in Lodja*

Results for the mini campaigns:

- *445 calls to the local health center for clarification regarding information in the SMS messages*
- *2,295 latrines built in Kole and 602 in Lodja*
- *911 bamboo hand washing units in Kole and 272 in Lodja*

Challenges: Despite traditional and innovative BCC initiatives to encourage individuals to seek health care services, the distance of certain villages and households from health centers remains an obstacle to seeking care. Traditional attitudes on the part of heads of households, as well as social stigma specifically surrounding HIV and AIDs, often prevent individuals from seeking health care services or advice.

Next Steps: To address this challenge, IHP will create and implement similar mini-BCC campaigns in other health areas and health zones, exploring new methods to engage male heads of households and spread accurate health information to combat social stigma.

mHealth

Mobile phone information campaigns diffused information via SMS messages in project supported communities across field offices, targeting households with children under the age of 5 and pregnant women. During this quarter, 177,320 SMS messages were sent by the project and 11,120 by project-supported health zone authorities (see Table 36 below).

Table 36: Number of SMS messages sent by health area and by field office during PY5Q2

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
TB	1,472	5,000	894	--	8,000	3,000	13,700	--	32,066
Malaria	2,400	10,000	2,928	5,667	4,100	6,454	1,700	4,500	37,749
Family planning	1,500		2,839	2,000	--	3,700	9,000	2,500	21,539
MNCH	1,060	8,000	4,990	11,200	12,500	9,450	--	2,500	49,700
WASH	1,200		2,199					2,122	5,521
Exclusive breastfeeding	200	--	--	--	--	2,000	---	4,500	6,700
Diarrhea/Cholera	--	778	1064	3,000	2,800	5,300	--	--	12,942
Pneumonia	--	--	--	3,700	--	4,403	3,000	--	11,103
Total	7,832	23,778	14,914	25,567	27,400	34,307	27,400	16,122	177,320

The targeted SMS campaigns have raised health issues as topics for discussion among community members in households and local organizations such as women's associations, youth associations and NGOs. Specifically, community discussions have increased the flow of health-related information to women which, in turn, has increased their interest in joining and/or creating women's associations in their villages. For example, in Kolwezi, in the Mutshatsha health zone, four women's groups with 22 participants met to share the content IHP SMS campaign messages and to advise other women about good health practices.

Due to group discussions led by women's community organizations in target communities, 238 women were exposed to IHP SMS campaign messages. Women frequently do not often have ready access to mobile phones, which has proved an obstacle to SMS campaign success in the past, so women's group discussions provide a great advantage by sharing SMS campaign information with women who otherwise would not be exposed to it. Following these group sessions, 47 of the participants began seeking antenatal care, while 127 others stated that they would adopt the use of a contraceptive method (specifically Depo-Provera and other injectable birth control methods, and the cycle beads method), and 64 participants committed to exclusively breastfeeding.

Of 1,319 individuals surveyed during household visits, in group discussions held in churches and women's organizations, and during visits to health centers in Kole, Luiza, Mwene Ditu and Uvira, 68% stated that of all BCC techniques, they prefer SMS campaigns. In the Bilomba, Bunkeya, and Kabongo health zones, town criers with megaphones in popular community locations (such as markets) make announcements at night and at dawn regarding the content of SMS campaign messages.

Challenges: Although SMS campaigns are a highly effective means of providing local populations with health information, frequent network disruptions, the increasing cost of SMS messages, and weak cell phone coverage in IHP health zones often prevent or delay campaigns. This quarter, cell phone networks were disrupted in January due to instability and riots, while 46 of the 78 health zones covered by IHP suffered regular coverage disruptions.

Next Steps: Going forward, IHP will continue to encourage community leaders to inform their populations about health issues, utilizing the content of SMS messages disseminated by the project. Given the success of women's groups in spreading SMS message content, IHP will build the managerial and organizational capacity of women's associations to ensure that information generated by project SMS campaigns are widely shared among women during their outreach sessions. IHP will also replicate the women's association model in other health zones to spread the content of SMS messages. In order to ensure that community members continue to receive messages from outreach campaigns, the project will update telephone directories used to send SMS messages. The project will also support the installation of Frontline software on project field office and central office computers and laptops, as well as on the computers and laptops of local partners at the health zone level.

Champion Communities and Champion Men Initiatives

During this quarter the project celebrated seven Champion Communities receiving official NGO status (six in Luiza and one in Kolwezi), and helped eight other Champion Communities (five in Uvira, two in Kole, and one in Kolwezi) develop six-month action plans (see Table 37). A mid-term evaluation of Champion Communities action plans in Tshumbe is scheduled for PY5Q3. In order to ensure the sustainability of Champion Community activities following the end of IHP, project staff accompanied members of Champion Community steering committee in advocacy visits to local political and administrative authorities to obtain necessary legal documentation to receive legal NGO status in DRC.

As NGOs, these Champion Communities are now officially recognized as independent organizations by the DRC government. This enables Champion Communities to sign partnerships with local and international organizations, and to apply for funding from local and national authorities.

Table 37: List of Champion Communities

Coordinations	Health zones with Champion Communities	Number of Champion Communities	Status		
			In process of obtaining NGO status	With operational authorization**	With NGO status*
Bukavu	Walungu	1		✓	
	Katana	2		✓	
	Mwana	1		✓	
Kamina	Kabongo	1	✓		
	Malemba	1	✓		
	Songa	1	✓		
Kole	Kole	2			✓
	Lomami	1		✓	
	Lodja	1		✓	
Luiza	Dibaya	2			✓✓
	Luiza	1			✓
	Kalomba	1			✓
	Bilomba	1		✓	
	Ndekesha	1			✓
Kolwezi	Dilala	1			✓
	Kanzenze	1	✓		
	Fungurume	3			
Mwene Ditu	Kalenda	1	✓		
	Kanda Kanda	1		✓	
	Bibanga	1	✓		
	Wikong	1	✓		
Tshumbe	Dikungu	1	✓		
	Djalo	1	✓		
	Minga	1	✓		
Uvira	Nundu	1	✓	✓	
	Ruzizi	2	✓✓	✓✓	
	Uvira	2	✓✓	✓✓	
Total		34	15	12	7

*Have obtained final documentation issued by the Ministry of Justice granting CCs legal status as an NGO

**Operational authorization is a provisional document signed by the territory administration enabling Champion Communities to operate as NGOs in their jurisdiction.

Results:

- Seven Champion Communities obtained the required legal documents to register as NGOs (one in Kole, one in Kolwezi and five in Luiza);
- Fourteen Champion Communities received operation approval to work in their respective territories pending the provision of legal NGO registration documents.

In light of their new status as NGOs, in March the project conducted a capacity building workshop for the pilot committee members of five Champion Communities in Uvira, training the members in project and conflict management.

Challenges: Champion Community Pilot Committee (CPCC) members often encounter difficulties with a lack of funds for transportation when implementing their action plans. This quarter, certain CPCC members also changed their addresses without notifying the project, resulting in IHP being unable to obtain updated information prior to their relocation. CPCCs also frequently did not receive adequate support from health zone officials in developing their action plans, overcoming operational difficulties, or interpreting health data indicators.

Lessons Learned: This quarter, many of the Champion Communities were officially recognized as NGOs. This recognition is a source of pride for CPCC members and members of the Champion Communities and has served as a motivation and encouragement to continue with their community outreach work.

Next steps: The project will continue to strengthen the capacity of CCPCs to create and manage community development projects, and will continue to assist remaining Champion Communities in obtaining required legal documentation to be registered as an NGO by the state. IHP will also assist active Champion Communities in sharing their experiences with other local partners such as women’s and youth associations.

COMPONENT 2: HEALTH SYSTEMS STRENGTHENING

IHP continued to provide financial and technical support for health system strengthening at DPS and health zone levels. IHP supported the DPS to organize annual operational plans (AOP) consolidation workshop; some coordination and review meetings and monitoring and supervision visits to health zones. The health zones continued receiving the usual support for monthly monitoring meetings, supervision visits to health areas and elaboration and review of AOPs. IHP conducted data quality assessment exercises with the select DPS and health zones. IHP worked with youth associations to strengthen their involvement in understanding and addressing their health issues.

Intermediate Result 4: Health sector leadership and governance in target provinces improved

Table 38: Summary of IR4 Key Results for PY5Q2 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 target
	Health zone management teams with appropriate management system tools	● Below target

IR 4.1: Provincial and national level health sector policies aligned

During the reporting period, the project continued to support through fixed amount awards the provincial and health zone levels, including meetings with the advisory board, monitoring meetings, supervision missions, health zone level operations, engine maintenance, donation of gasoline, and other supplies related to the cold chain for vaccine storage.

Annual Operational Plans (AOP): Out of 78 health zones, only 44 (56%) were able to develop their AOPs. Among those that were submitted, 27 plans (35%) were validated by the advisory board--16 in Bukavu coordination, 9 in Mwene Ditu coordination, and 2 in Kole coordination. For those that have not yet submitted their AOPs, they are either still working on it or waiting for the advisory board to meet to validate them. The reasons for the difference in their pace of development are mainly related to conflicting calendars; they attempt to juggle this work between mass immunization campaigns, reorganizing geographic districts and health zones, and annual reviews of the health system conducted by the MOH in all provinces. For some health zones, there is also a financial challenge regarding the organization of consolidation workshops since they are not funded by IHP. While the project financially and technically supports the health zones during their process of AOP development and validation, the MOH is responsible, at the national and provincial levels, to provide technical and financial support to health zones in the implementation of consolidation workshops, which are organized by the DPS, bringing together health zones and partners. However, this support is not being provided consistently.

AOP validation represents a financial challenge for DPS, as they need to organize consolidation workshops regrouping health zones without IHP support. Some DPS are able to use funds made available by other projects, while others have to request that other organizations to sponsor/fund them. As for health zones, conflicting calendars between different actions led by the DPS has also a negative impact on AOP validation.

IHP drew meaningful conclusions this quarter from the challenges encountered for the AOP validation, the most important being that granting funding to health zones for the organization of their advisory board meeting accelerates the validation process.

IHP will carry out the following activities to support the health zones in completing and validating their respective AOPs: continue to support the health zone management teams to harmonize calendars between counterparts to avoid calendar conflicts when planning advisory board meetings to validate the 2015 AOP; and provide financial and technical support for the organization of quarterly and bi-annual AOP evaluations.

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

During the reporting period, the project continued to provide fixed amount awards at the provincial and health zone levels to support meetings with the advisory board, monitoring meetings, supervision missions, health zone level operations, engine maintenance, donation of gasoline and other supplies related to the cold chain for vaccine storage.

Support to monitoring and evaluation systems and the national health information system (SNIS)

RDQA: During this quarter, a joint IHP-MOH team led Routine Data Quality Assessment (RDQA) in 3 coordinations (Kolwezi, Kamina, and Luiza). Their goal was to verify the data authenticity of 4 indicators (number of women attending at least four antenatal care visits, number of women receiving active management of third stage labor, new acceptors of modern method of family planning, and number of all disease cases treated) and the overall data reporting system evaluation.

Results:

- 6 members of the provincial management team and 36 members of the health zone management team were briefed on RDQA and took part in the audit;

- 60 health centers were audited;
- 6 health zone management team offices were audited;
- 100% of the June 2014 data audit recommendations were executed in Ndekesha health zone management team office.

Data quality challenges:

- Data inconsistency between the basic collecting tools (records) and reporting tools (SNIS framework);
- Faulty archiving of basic collecting tools (records) and reporting tools (SNIS framework)
- Lack of routine monitoring;
- Absence or low quality of feedback.

Next steps:

- Extend this assessment to other coordination, specially Bukavu, Uvira, and Mwene Ditu;
- Involve the MOH central level in this assessment;
- Provide management tools to health facilities on a regular basis;
- Based on this report, audit the good or low performing indicators.

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

During this reporting period, IHP supported 145 youth associations across all field offices to plan and conduct group discussions and awareness-raising campaigns on reproductive health--especially the spread of STIs--and personal hygiene.

Youth are an important target group for the project, particularly concerning the promotion of responsible sexual and reproductive health practices such as the prevention of HIV and AIDS, STIs, and unplanned pregnancy. IHP conducts outreach campaigns to youth in its target areas, and also partners with youth organizations to promote health messages among peers. Engaging youth organizations as equal partners in community health has been effective in reaching young people at the sensitive age as they begin the transition to adulthood.

PROJECT MANAGEMENT

Success stories: During this quarter, the project produced 8 success stories to contribute towards the annual target of 30 stories. They are found in the last section of the report. We are on track to produce at least one RBF program and at least one MNCH story each quarter. Consequently, the project aims to develop more success stories on the LDP and nutrition programming to ensure fair representation of each health topic across the project.

Cost share: As of March 31, 2015, IHP has booked \$4,085,298.60. At full obligation, the project is required to book a total of \$4,193,013.87, which means the project needs to book \$107,715.27 to meet its cost share requirement. During the next quarter, the project will be booking as cost share the amount of \$1,207,631.97 from the HPP project for technical support in 27 health zones shared with IHP. Once this is approved by the MSH Contracts Officer and is booked by the MSH accounting unit, the project will have surpassed its cost share requirement at full obligation.

Status of PY4 pharmaceutical order: The PY4 pharmaceutical order is fully delivered. Shipping is ongoing to final destinations by the global shipping and logistics firm Kuehne & Nagel (and its subcontractors). Two shipments are still pending with customs in Dar Es Salaam (“keep cool” from Amsterdam and general cargo from Singapore). Please see Table 9 for more details.

Status of PY5 Pharmaceutical Order: The PY5 pharmaceutical order was placed with Amsterdam-based vendors IDA Foundation and Imres Medical Solutions in December 2014. The import permits were obtained in May 2015, and the products will be shipped to final destination by an MSH-selected freight forwarder. Delivery to final destination is anticipated for the last week of May 2015.

Warehousing: IHP worked with SIAPS to stock the newly-delivered USAID shipments of family planning commodities in the new warehouse in Kinshasa. IHP and SIAPS are working with USAID to make sure that the huge stock of male condoms remaining in the PROCOKI warehouse will be distributed to institutions that need them in order to prevent them from expiring.

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 has been well prepared for closeout. IHP continued to communicate transparently with the project staff on closeout requirements, steps, and activities.
- **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 of three videos on KMC, HBB, and fistula treatment. They provide lively testimonies from the project beneficiaries and USAID.
- **Contracts management:** The contractual requirements with MSH partners and other sub-grantees are being regularly followed up.
- **Operations and logistics:** The draft inventory of IHP assets was completed; 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 continues to closely monitor its budget and finance: 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. The MSH Internal Audit Director will continue to communicate very promptly and transparently any fraud allegations, audit reports, and actions taken to USAID OIG, AO, and AOR.

FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

1. Family planning

During the reporting period, the main family planning compliance activities conducted included the following: ensuring contraceptive supplies so that clients can make an educated selection from a range of methods; monitoring of contraceptive supply chain management; and distribution of management tools.

With IHP staff who completed the Voluntary Family Planning course during PY5Q1 as required by the MSH Corporate Contracts Office, IHP continued assessing vulnerabilities that may lead to non-compliance and violation of the Tiahrt amendment through field visits for monitoring and follow-up of workplan activity implementation, supervision, as well as RBF monitoring and verification activities. As of end of PY5Q2, IHP had not identified any Tiahrt violations or vulnerabilities.

2. HIV and AIDS

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

In preparation to transitioning additional sites to the implementation of Option B+ in the care of patients living with HIV during next quarter, IHP conducted a field visit to assess specific needs of the target health zones of Lubudi, Bunkeya, Lualaba, and Fungurume.

During PY5Q2, IHP's order of cool items was delivered to the CDRs, including the tests needed to ensure safety of blood transfusion. The health zones started getting resupplied.

ENVIRONMENTAL MONITORING AND MITIGATION PLAN

The project monitored the environmental compliance, particularly medical waste management, during field visits for monitoring and follow-up of workplan activity implementation, supervision, as well as RBF monitoring and verification activities. IHP identified no environmental non-compliance issues in health facilities visited. Health facilities continued to invest their resources to further improve their FOSACOF score, which includes environmental compliance.

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 42 water sources. IHP provided technical support for WASH mini-campaigns to raise awareness on recommended hygiene and sanitation practices in the community and for establishment of WASH committees. The communities built 15,099 household ventilated improved pit (VIP) latrines, using locally available means, which respect the environmental compliance guidelines. IHP will continue providing technical support to the WASH committees in charge of their maintenance.

IHP will continue monitoring the quality of water, including the water testing for arsenic. The coliform tests are still in customs pending completion of the exoneration process that had to be reinitiated because of a 100 kg difference of the actual shipment weight and the weight mentioned in the paperwork used to obtain the canceled exoneration.

CHALLENGES ENCOUNTERED

The main challenges that the project experienced during PY5Q2 included the following:

Security: During this reporting period, a chronic situation of insecurity situation prevailed in almost all the same health zones reported in PY5Q1, including Uvira, Ruzizi, Haut Plateaux, Mwenga, Miti Murhesa, Mulungu, Lulingu, Nundu Mubumbano, Kaniola, Lemera, Bunyakiri, and Shabunda. As usual, the most vulnerable of the population, i.e., women and children, suffered most from this situation. The

negative impact on project activities included stopping or delaying activities, delays in data collection and reporting, inaccessibility of health facilities of concerned health zones, and inability to carry out planned supervision visits. IHP continues to work closely with the health zones and health authorities in the affected health zones to make sure that the basic support needed to health facilities (e.g., essential medicines, commodities for cold chain for vaccines) is still available.

Supply Chain System: The health zones' figures on average monthly consumption of many of the commodities (e.g., ACTs and RDTs, iron/folic acid, and ORS, contraceptives, etc.) still lack accuracy to produce reliable quantifications and calculation of the annual needs for health zones for a year of full coverage.

IHP will continue to work in close collaboration with SIAPS, USAID|DELIVER Project, and SCMS to build capacity throughout the supply chain levels, including CDRs, the Provincial Health Divisions and health zone management team members in charge of commodity management. The coordination meetings and joint monitoring visits with USAID supply chain implementing partners should have a great impact in the reduction of stock-outs and expiries in the next quarters.

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 its objectives. IHP requested USAID support to identify and implement short-(immediate), medium-, and long-term solutions to the chronic vaccine shortages.

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. In addition to continuously providing tools to all health facilities and support for monitoring meetings, IHP conducted data quality assessments (DQA) that identified the following challenges and supported health zones and DPS to develop action plans to address them:

- Data inconsistency between the basic collecting tools (records) and reporting tools (SNIS framework);
- Faulty archiving of basic data collection tools (records) and reporting tools (SNIS framework);
- Lack of monitoring at the health area level;
- Absence or low quality of feedback.

As a priority activity during the next quarters, the project plans to provide support to DSNIS to train the DPS on and accompany them in conducting DQA exercises on a regular basis.

Pharmaceutical orders: As of the end of PY5Q2, only 9% of the IHP order for PY4 (placed in August 2014 to IDA) was delivered to the CDRs; this percentage represents primarily the cool drug items that benefitted from the emergency removal waiver procedures. The emergency order for PY5 that was meant to close the gap between total consumption of PY3 drugs by health zones and the delivery of the PY4 order will not be delivered before end of May 2015. The main challenges include, but are not limited to, several breaks in communication, lack of clarity in the responsibilities from the vendor to the delivery points, and a number of errors in processing the needed paperwork for the exoneration issuance. IHP is reassessing the pharmaceuticals order process in order come up with recommendations for the IHPplus order.

WAY FORWARD: PLANNED ACTIVITIES FOR NEXT QUARTER

In the final year of the IHP, 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 PY5Q3 efforts:

IR 1

- ✓ Provide essential medicines and other specific commodities for family planning, HIV, TB, and malaria to supported health facilities, especially those in health zones located in Ouest Bukabu health district, those in Kamina coordination (Mukanga, Mulongo, Lwamba, Malemba Nkulu, Kinkondja, Songa) and Mwene Ditu (Wikong)
- ✓ Provide basic equipment and materials to health facilities, based on need, in the health zones supported by the eight coordination offices
- ✓ Continue to establish an efficient management system for drugs and commodities and work with health facilities staff on how to efficiently use it
- ✓ Provide technical support for quarterly FOSACOF evaluations as well as corrective measures plan for the 7 health zones where RBF have been implemented 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.
- ✓ 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

- ✓ Train health facilities staff and community health workers from 51 health facilities and i-CCM sites from 7 health zones (Fungurume, Lualaba, Bibanga, Kanda Kanda, Biloma, Ndekesha, and Dibaya) on using rectal artesunate for pre-referral for children under 5

- ✓ Organize a workshop/seminar on how to disseminate and socialize MNCH norms and directives and consolidate the knowledge through a competence-based training approach
- ✓ Conduct a workshop to adopt communication tools on preventing child (0-5 years) diarrhea
- ✓ Strengthen family planning activities through supportive supervision of service providers on clinical family planning methods, integration of community-based distribution (CBD) activities, integration of family planning 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 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, and AMTSL
- ✓ Ensure transition to Option 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
- ✓ 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
- ✓ 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

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 and celebrate Champion Communities
- ✓ Evaluate mHealth and Champion Community approaches

IR 4

- ✓ Strengthen the capacities of the newly-appointed Provincial Division of Health management teams in data quality audit
- ✓ 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, especially in Lualaba Provincial Division of Health
- ✓ 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
- ✓ Provide financial and technical support to health zones in getting their AOPs for 2015 adopted by their boards.

PM

- ✓ Continue the implementation of IHP close out plan
- ✓ Organize a RDQA training for Lomami and Kasai Oriental provincial health division management teams in collaboration with DSNIS

LIST OF APPENDICES

- Appendix 1: DRC-IHP Performance Monitoring Plan, PY5Q2
- Appendix 2: DRC-IHP PY4 Pharmaceutical Order Exoneration*
- Appendix 3: DRC-IHP International Travel/STTA Plan*
- Appendix 4: DRC-IHP Organizational Chart
- Appendix 5: DRC-IHP SF425 January to March 2015
- Appendix 6: DRC-IHP Accruals Report January to March 2015

*Appendices 2 and 3 are attached separately as Excel files

SUCCESS STORIES

The success stories are found in the following pages.



SUCCESS STORY

Love in the time of AIDS: Promoting safer sex and family planning on Valentine’s Day

“Zero infections on Valentine’s Day, and family planning for a prosperous Congo” was the hope and the slogan for the Valentine’s Day campaign in Sud Kivu, Democratic Republic of Congo



Photo: Overseas Strategic Consulting, Ltd.

Quiz bowl scene at a school in Ndekeshu, DRC, to test students’ knowledge on reproductive health issues

“The enthusiasm the youth organizations showed in promoting health during this campaign was truly impressive,”

**-Jean-Baptiste Mputu,
Senior Behavior Change
Communication Technical
Advisor for IHP.**

Valentine’s Day has caught on in the Democratic Republic of Congo (DRC) over the last few years, especially among young people. This year, with the support of the USAID-funded DRC Integrated Health Project (IHP), youth organizations and community health workers in Sud Kivu took advantage of the holiday to conduct a campaign to promote safer sex, family planning (FP), and awareness of gender-based violence (GBV) among residents aged 14 - 25.

The more than 100,000 youth in Uvira, Ruzizi, and Lemera health zones have shown a high incidence of risky sexual encounters. IHP staff worked with youth organizations and other partners to develop the slogan: “Zero infections on Valentine’s Day, and family planning for a prosperous Congo” as well as specific information for youth on HIV and AIDS prevention, FP and GBV.

The messages saturated the health zones--distributed through radio, churches, schools, and musical and theater performances. Organizers of the Valentine’s Day mini-campaign sent 3,334 SMS on HIV and AIDS prevention and FP messages and distributed 7,500 condoms. In addition, they emphasized peer education and distributed more than 3,000 tokens for free visits at the health center. Three schools hosted a competition to test the students’ knowledge of reproductive health issues: 20 students from each school competed in the “quiz bowl,” while the rest of the school attended.

During the mini-campaign, the local radio station invited members of local organization Youth Parliament to co-host a radio program. The program, in which peer counselors answered anonymous callers’ questions about HIV and AIDS and FP, was broadcast daily in all three health zones over Valentine’s Day weekend.

“The enthusiasm the youth organizations showed in promoting health during this campaign was truly impressive,” said Jean-Baptiste Mputu, Senior Behavior Change Communication Technical Advisor for IHP. “We’ll be working with them to develop ways to sustain those kinds of efforts over the long term.”

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SUCCESS STORY

Going to the People with Sustainable Community Health Committees in Mwene Ditu

Community health committees in Mwene Ditu strengthen long-term sustainability strategies in collaboration with IHP staff and health zone leadership



Photo: Overseas Strategic Consulting, Ltd.

CODESA meeting in progress in Mwene Ditu

“I am proud to be a CODESA member because the work we do saves lives. As a CODESA member, I am respected in my community.”

-Trodon Ngoie, CODESA member Mwene Ditu

In far-flung areas of the vast Democratic Republic of Congo (DRC), families often prefer to treat illnesses traditionally and at home. Visiting a clinic can be painfully long and expensive and provoke questions and stigma.

To expand health education and services, the Ministry of Health promotes the creation and training of community health committees (known by the French acronym “CODESA”) in local health zones. CODESA members are trained as community health workers, and spend 5 -10 hours a week or more volunteering on health-related projects.

In the Mwene Ditu area, the USAID-funded DRC Integrated Health Project (IHP) has collaborated with six health zone management teams to assist all 168 CODESAs to improve skills and develop strategies to sustain themselves. In particular, IHP has been building CODESA capacity in behavior change communication and in management skills, such as action planning.

In the first quarter of 2015, Mwene Ditu CODESAs conducted nearly 22,000 outreach activities on maternal and child health, hygiene and sanitation, and infant vaccination schedules. Their activities included household visits and discussions, reaching an estimated 386,000 people in the region.

In some cases, strengthening a CODESA involves helping them obtain a base of operations, as IHP did in Katabwa. As one member said, “Thanks to IHP, we finally have a dedicated space for meetings and other work.”

As part of efforts toward sustainability, IHP-DRC staff has been working with CODESA to get them legally registered, along with the “Champion Communities,” as official NGOs. The Champion Communities are IHP-trained community promotion groups, developed where IHP works.

As NGOs, CODESAs and Champion Communities will be able to apply for state funding for their activities, provide incentives for members to continue their efforts, and enter into formal partnerships with other local as well as international organizations.

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SUCCESS STORY

Overcoming the trauma of rape in the DRC: Valence’s story

With support from IHP, the Kavumu General Referral Hospital in Sud Kivu is providing physical and psychological support to rape survivors



Photo: Warren Zeilman for MSH

Rape has become a weapon of war in the decades-old armed conflict in Eastern DRC

“God bless the medical staff for taking such good care of my friends and me.... Even after our physical wounds faded, they stayed to care for the hurt that remained in our heads and hearts. We would not be here today if it was not for them.”

–Valence Heshima, rape survivor, Sud Kivu

U.S. Agency for International Development
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Valence Heshima, a 20-year-old mother of two, was walking home with a group of friends in Miti Murhesa, Sud Kivu, when they were robbed and raped by marauders. Nearby villagers, alerted by their screams, came to their rescue and took them to the closest health center. They were then immediately referred to the Kavumu General Referral Hospital (GRH). Being raped in Democratic Republic of Congo (DRC) is like a double sentence: not only must you live with indelible physical and psychological trauma, but your community and even family blame and ostracize you.

More than 23 years of conflict in Nord and Sud Kivu have resulted in death, displacement, and insecurity. In just the first four months of 2014, Miti Murhesa registered more than 30 cases of gender-based violence (GBV). This is likely underestimated since social stigma makes survivors reluctant to report attacks. Of reported cases, 60% victimized minors; 10% involved children under five.

Luckily for Valence and her friends, the Kavumu GRH is supported by the USAID-funded Integrated Health Project (IHP), which has been working with the Congolese Ministry of Health since 2011 to improve GBV care in Sud Kivu. IHP staff trained health care workers in 27 zones, worked with health zone management teams to improve GBV-related services, provided drugs and supplies such as Post-exposure Prophylaxis (PEP) kits to protect those who may have been exposed to HIV, and helped local organizations to raise awareness of GBV.

Through careful physical and mental care, the Kavumu GRH staff was able to help Valence and her friends recover from their trauma. The counseling sessions Valence and her husband both attended helped him learn to treat his wife as a survivor rather than as guilty.

“Sexual violence survivors are often brought to us in a critical condition, physically and mentally speaking,” said Pascal Muhogera, head nurse and GBV officer at Kavumu GRH. “But the project provided us with the necessary training and medical supplies, so we are able to provide the right care for these women and lead them towards a path to full recovery.”

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SUCCESS STORY

A neglected health center springs to life through results-based financing in the Congo

RBF approach makes it possible for health staff, CHWs, and a CODESA to work hand in hand to give a second life to a health center



Photo: Management Sciences for Health

Patients waiting to receive care at Lomela health center

“When I see everything we were able to accomplish in Lomela through the RBF program, I am speechless.”

***- Kimba Bofululu,
Government Administrator
of Lomela***

In November 2013, the Lomela health center was on the verge of closing. The community health committee (CODESA) and community health workers (CHW) were inactive. Visitors described substandard hygiene and safety conditions and visibly demotivated staff. Residents avoided the center, preferring to travel to another further away; the utilization rate had fallen to 10 percent.

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

Under the RBF program, the health zone management team revamped the Lomela health center by training the staff in management and leadership and meeting with the CODESA to set up achievable goals and identify indicators to measure progress. Then the health zone hired construction workers to refurbish the facility, including building toilets and an additional room to accommodate patients. Health staff and CODESA members also volunteered to help in the rebuilding. The CODESA procured medicines and other supplies to prevent stock-outs. Then the health center organized two open houses to welcome community members and authorities to the rebuilt, better managed facility.

By November 2014--within a year of the launch of the RBF program--the utilization rate had more than quadrupled, from 10 percent to 47 percent.

“When I see everything we were able to accomplish in Lomela through the RBF program, I am speechless,” said Kimba Bofululu, the Administrator of Lomela. “The program was useful and important, especially when you see how it affects peoples’ lives. The CODESA, community health workers, and health center staff joined forces not only to improve care for the sick but also to improve their working environment. [Today] they are proud to work in the Lomela health center and encourage everyone to seek care there.”

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SUCCESS STORY

Results-based financing inspires a youth group to rebuild a clinic in the Congo

Financial incentives improve performance of health workers in Tsheko Poto

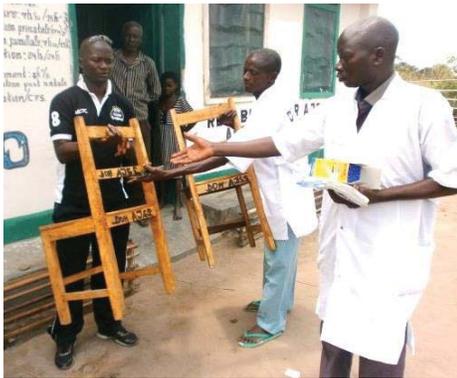


Photo: Management Sciences for Health

Clinic staff receiving necessary materials from AJSS (youth-oriented AIDS awareness group)

“We look forward to continuing to work with the RBF approach, as it has encouraged us and pushed us to be better. Funding allows us not only to pay our workers and invest in other aspects of health care—it helps us do our jobs better.”

***– Daniel Wutshu,
head nurse in Tsheko Poto***

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For years, the residents of Tsheko Poto mostly avoided their local health center, although no one seemed to know why.

To improve the utilization rate (then 36%) as well as general quality of service, the USAID-financed Integrated Health Project in the Democratic Republic of Congo (IHP-DRC) partnered with the Congolese Ministry of Health (MOH) to implement results-based financing (RBF)--a system of incentives for improved results in health facilities. The system works by providing management training as well as offering financial rewards to facilities that perform well according to a verification system of results: first, results are verified by IHP and the MOH, and then they are counter-verified by local organizations. By using double verification, health workers and community members feel confident that incentives are allocated fairly.

In Tsheko Poto, counter-verification was performed by *the Association des Jeunes du Sankuru Pour la Lutte Contre le SIDA* (AJSS), a youth-oriented AIDS awareness group. As they went about their evaluation, AJSS noticed that the building’s infrastructure was crumbling: the facility had no ceiling, paved flooring, or office furniture-- not even chairs. The building’s condition gave a clue as to why residents gave the clinic a cold shoulder.

The members of AJSS wanted to be part of the solution. So, in addition to verifying indicators, they helped renovate the clinic. The organization got to work repainting walls, installing window panes, and bringing in a slew of new office materials: chairs, notebooks and pens, and medical uniforms for health workers, who previously had none. Meanwhile, the center staff oversaw repairs of the pavement and built a new maternity ward.

“During my time as Head Nurse, I had never seen a community-based organization help renovate a health center,” said head nurse Daniel Wutshu.

The results of the RBF funding were striking: the overall score of the health center climbed to 75% from 54.8%, the utilization rate increased to 40%, and the assisted birth rate rose to 118% from 76%--indicating that the clinic was drawing people from other neighboring health area communities.

AJSS is now considering rehabilitating other structures. “When we first started, the only funding we received went to distributing condoms and spreading awareness about HIV and AIDS among youth,” said Olivier Odimba, AJSS President. “However, with IHP support, we were able to put funding toward renovating the Tsheko Poto Health Center. Now we’re thinking of doing the same for other health centers in our area.”

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SUCCESS STORY

House to house: Searching for and treating TB cases in the Democratic Republic of Congo

Awareness-raising campaigns and screening dramatically increase detection and treatment in Kamituga, Sud Kivu, DRC



Photo: Management Sciences for Health

A community health worker brings sputum samples she collected during her home visits for testing at a laboratory

“I thought my coughing was a curse or a spell that could be treated by healers. But thanks to community health workers, I discovered that it is a curable disease.”

***–Solange Bitondo,
Kinkindi resident and TB patient***

Solange Bitondo coughed for a year, but never sought treatment from the Kinkindi health center less than a kilometer from her home. Instead, the 37-year-old mother of three consulted traditional healers, prayed, and self-medicated with herbs and medicines she found in the market.

Tuberculosis (TB) is one of the leading causes of death and disability in the 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 expected cases. But in Solange Bitondo’s health zone of Kamituga in Sud Kivu, the detection rate until recently reached only 28 percent, due partly to the difficulty of mobilizing community volunteers for outreach, coupled with stigma about the disease.

To control the spread of TB, the Ministry of Health (MOH) is currently implementing—through its National Tuberculosis Program (PNLP)--the National Tuberculosis Strategic Plan for 2014-2017. The success of this plan 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 (i.e., people with a chronic cough). If a test comes back positive, the volunteer refers the individual to a local treatment center.

In February 2015, CHWs conducted a “mini-campaign”--visiting more than 5,000 households in the Kamituga health zone--with the support of the USAID-funded Integrated Health Project in the DRC (DRC-IHP). At the same time, awareness-raising through radio broadcasts and church announcements reached more than 45,000 people.

The door-to-door campaign tested 321 people; 30 of them were found to have TB, compared with an expected 24 for the month. Solange was among those visited by a health worker and given a rapid diagnostic test. After she tested positive and was counseled by a CHW, Solange sought treatment from the Kamituga General Referral Hospital.

“I thought my coughing was a curse or a spell that could be treated by healers, but thanks to community health workers, I discovered that it is a curable disease,” said Solange. “Thank you to the health zone team and to IHP for their support. Now I have to convince my brother, who has also been coughing, to get tested for TB.”

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SUCCESS STORY

Water at last: Access to drinking water is changing lives in a Congolese village

A rehabilitated water system decreases illness and more in Kimuka, Sud Kivu, DRC



Alice Nalukogo rejoicing for finally having easy access to safe drinking water.

Photo: International Rescue Committee

“Hallelujah! I don’t have to wake up at 5 am anymore and risk my life and health for water that was making my family and me sick.”

***– Alice Nalukogo,
Kimuka resident***

Alice Nalukogo used to rise before dawn and walk for an hour to collect water from the river. On her way, there was always a risk of rape: Sud Kivu in the Democratic Republic of Congo (DRC) has suffered decades of civil war--and rape is a common weapon. On top of that, Alice’s family and others in her village of Kimuka would often fall sick from diarrhea due to the unsafe drinking water she laboriously carried home each morning.

Like 50% of the Congolese rural population, the Kimuka community had not enjoyed a functioning water system for a decade. It reported 35 cases of diarrhea a month.

As part of its mission to improve health in the DRC, the USAID-funded Integrated Health Project (IHP), working alongside the Ministry of Health, has been increasing access to safe drinking water by rehabilitating existing water points in three health zones in Sud Kivu.

To promote ownership and sustainability of the water project, IHP mobilized the community to establish a water, sanitation, and hygiene (WASH) committee to manage and maintain the water system in Kimuka. The committee also raises awareness on sanitation and hygiene in the community.

For three months, Kimuka villagers dug ditches for water pipes, collected building supplies such as sand and rocks, and helped workers finish building the water system--which includes eight water points where people can easily fill their containers.

As a result, 574 families in Kimuka (4,019 people) now have access to safe drinking water. Diarrhea cases have dropped to five a month.

“Hallelujah! I don’t have to wake up at 5 am anymore and risk my life and health for water that was making me and my family sick,” says Alice. “I can’t contain my joy! IHP was able to remove the thorn from our foot and God only knows how much we needed this!”

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SUCCESS STORY

A life saved at the 11th hour: Training and doing in Ndekeshia, DRC

Newly-trained maternity team helps mothers with high-risk pregnancies to deliver their babies safely



Photo: Overseas Strategic Consulting, Ltd.

Ngalula Ndunga with her baby delivered by the newly-trained Ndekeshia maternity team

“I thank the Lord and the caregivers at Ndekeshia who helped me. Today, my tears of sadness and humiliation were transformed into a joyful smile for my whole family.”

-- Ngalula Ndunga, new mother and patient at the Ndekeshia maternity clinic

In the Democratic Republic of Congo (DRC), birth rates are high, with pressure to bear children even higher. In Kasaï Occidental, women on average give birth to eight; a childless woman is vulnerable to abuse and abandonment.

No one knows these pressures better than Ngalula Ndunga. Married at 18, she got pregnant ten times in ten years, but miscarried each time. As a result, her parents-in-law accused her of sorcery and her husband took a second wife, with whom he has two children. Determined to have a child, Ngalula, who was four months pregnant, scheduled a prenatal consultation during a training that the USAID-funded Integrated Health Project (DRC-IHP) had organized for providers at the local Mombela Health Center. The training team diagnosed her with cervical insufficiency and promptly transferred her to the Ndekeshia General Referral Hospital, 35 kilometers away, for a simple surgery, while the facilitators of the training also taught local health personnel the procedure.

Three months later, Ngalula gave birth for the first time. However, her baby girl was dangerously small, weighing only 2,100 grams (about 4.6 pounds). The Ndekeshia maternity team responded quickly by teaching Ngalula the Kangaroo Mother Care method: Ngalula wrapped her daughter close to her body, providing warmth, security, and increased immunity. In less than two weeks, Ngalula’s daughter had gained an additional 400 grams.

Dr. Clement Mukendi, director of Ndekeshia Hospital, praised the IHP trainers for their dedication to Ngalula’s care as well as their focus on training. “This situation happened during training, and the trainers helped us care for Ngalula during her entire birth,” he said. “This was a success for us as well as the family.”

After so many years of struggle and disappointment, Ngalula was overjoyed. “I thank the Lord and the caregivers at Ndekeshia who helped me,” she said. “Today, my tears of sadness and humiliation were transformed into a joyful smile for my whole family.”

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

APPENDIX 1: DRC-IHP Performance Management Plan, January to March 2015		Definition		Jan-15		Feb-15		Mar-15		PY5Q2		
Indicateur										Achievement	Target	Achievement Rate (%)
USAID/DRC/IHP Objective: Increase use of high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, TB, HIV&AIDS, and WASH in target health zones												
1	FP: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	46,919	44,826	45,660	137,405	112,500	122				
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	18,039	17,204	18,308	53,551	41,250	130				
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	47,128	50,313	46,907	144,348	128,058	113				
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	64,448	68,031	61,771	194,250	164,890	118				
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	2,148	2,146	2,147	2,147	2,000	107				
	Disaggregated by type of service delivery:		1,543	1,543	1,543	1,543	1,600	96				
	(a) Health facility based		605	603	604	604	400	151				
	(b) Community-level based		56	64	52	52	50	104				
5	FP: Number of USG-assisted health facilities experiencing stock-outs of Depo-Provera	Maximum number of USG-supported health facilities experiencing stock-outs of Depo-Provera	45,817	45,339	45,512	136,668	132,157					
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 Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population) Numerator/ Denominator (in percentage)	44,560	44,560	44,560	133,680	139,113					
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 Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population) Numerator/Denominator (in percentage)	22,332	22,209	23,040	67,581	97,379					
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 Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop) Numerator/ Denominator (in percentage)	38,833	38,075	39,665	116,573	118,246					
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 Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	36,519	35,532	37,845	109,896	118,246					
			38,833	38,075	39,665	116,573	118,246	103				

		Numerator/ Denominator (in percentage)	94.0%	93.3%	95.4%	94.3%	100%	94
10	MNCH: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs	Number of postpartum/newborn visits within 3 days of birth (includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery) (4% Tot Pop)	37,340	36,777	38,527	112,644	139,113	81
11	MNCH: Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area Denominator: # of newborns delivered in the IHP target areas (4% of total population)	37,002	37,174	38,407	112,583	117,747	
12	MNCH: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Numerator/ Denominator (in percentage) 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)	83.0%	83.4%	86.2%	84.2%	100%	84
13	MNCH: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	2,584	2,829	2,794	8,207	8,347		98
14	MNCH: Number of cases of child diarrhea treated in USG-supported programs	41,005	38,095	38,924	118,024	147,607		80
15	MNCH: Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs =	49,916	47,819	50,362	148,097	196,812		75
16	MNCH: Drop-out rate in DPT-HepB-Hib3 among children less than 12 months of age	Rehydration Therapy (ORT) or ORT plus zinc supplements in USG-support programs/IHP target area (20% Tot Pop *18% infection rate-MICS 2010) 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 Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI) Numerator/ Denominator (in percentage)	37,662	34,716	36,329	108,707	108,655	
17	MNCH: Percent of children less than 12 months of age who received measles vaccine from USG-supported programs	38,879	38,879	38,879	116,636	121,376		
18	MNCH: Number of USG-assisted health facilities experiencing stock-outs of ORS	96.9%	89.3%	93.4%	93%	90%		104
		Numerator: Number of children less than 12 months who did not complete the full regimen of DPT-HepB-Hib1-3 vaccination Denominator: All children less than 12 months who received DPT-HepB-Hib1	1,472	2,487	2,614	6,573	5,433	
		Numerator/ Denominator (in percentage)	39,134	37,203	38,943	115,280	108,655	
		Numerator: Number of children less than 12 months of age who received measles vaccine from USG-supported programs/IHP target area Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI) Numerator/ Denominator (in percentage)	3.8%	6.7%	6.7%	5.7%	5%	114
		35,700	34,565	34,822	105,087	108,655		
		38,879	38,879	38,879	116,636	121,376		
		91.8%	88.9%	89.6%	90%	90%		101
		143	112	65	65	50		130

19	NUTRITION: Number of children under 5 years of age who received vitamin A	Number of children under 5 years of age who received vitamin A from USG-supported programs/IHP target area	0	0	0	0	0	0	573,987	0	0
20	NUTRITION: Proportion of pregnant women who received iron-folate to prevent anemia	Numerator: Number of pregnant women who have received iron-folate tablets to prevent anemia during the last five months of pregnancy Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop) Numerator/ Denominator (in percentage)	45,281	44,560	45,204	44,560	101%	102%	112,500	139,113	81%
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)	54,205	50,072	50,072	59,358			105,530	155	
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	16,442	16,340	16,340	15,162			92,971	52	
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	489	499	499	378			50	756	
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) Denominator: Total population in the specified geographical area Numerator/ Denominator (per 100,000 population)	772	1,114,003	921	1,322			7,226		
25	TB: Percent of all registered TB patients who are tested for HIV through USG-supported programs	Number of TB patients who are tested for HIV	520	662	662	680			4,480		
26	TB: Case detection rate	Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing Numerator/ Denominator (in percentage)	772	72	921	1,322			7,226	100	
27	TB: Number of multi-drug resistant (MDR) TB cases detected	Number of new smear positive TB cases detected	772	921	921	1,322			3,652		
28	TB: Number of USG-assisted service delivery points experiencing stock-outs of RH (rifampicin, isoniazid) combination	Estimated number of TB cases expected	1,671	1,671	1,671	1,671			5,217		
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 Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	7	69	8	69			69	69	

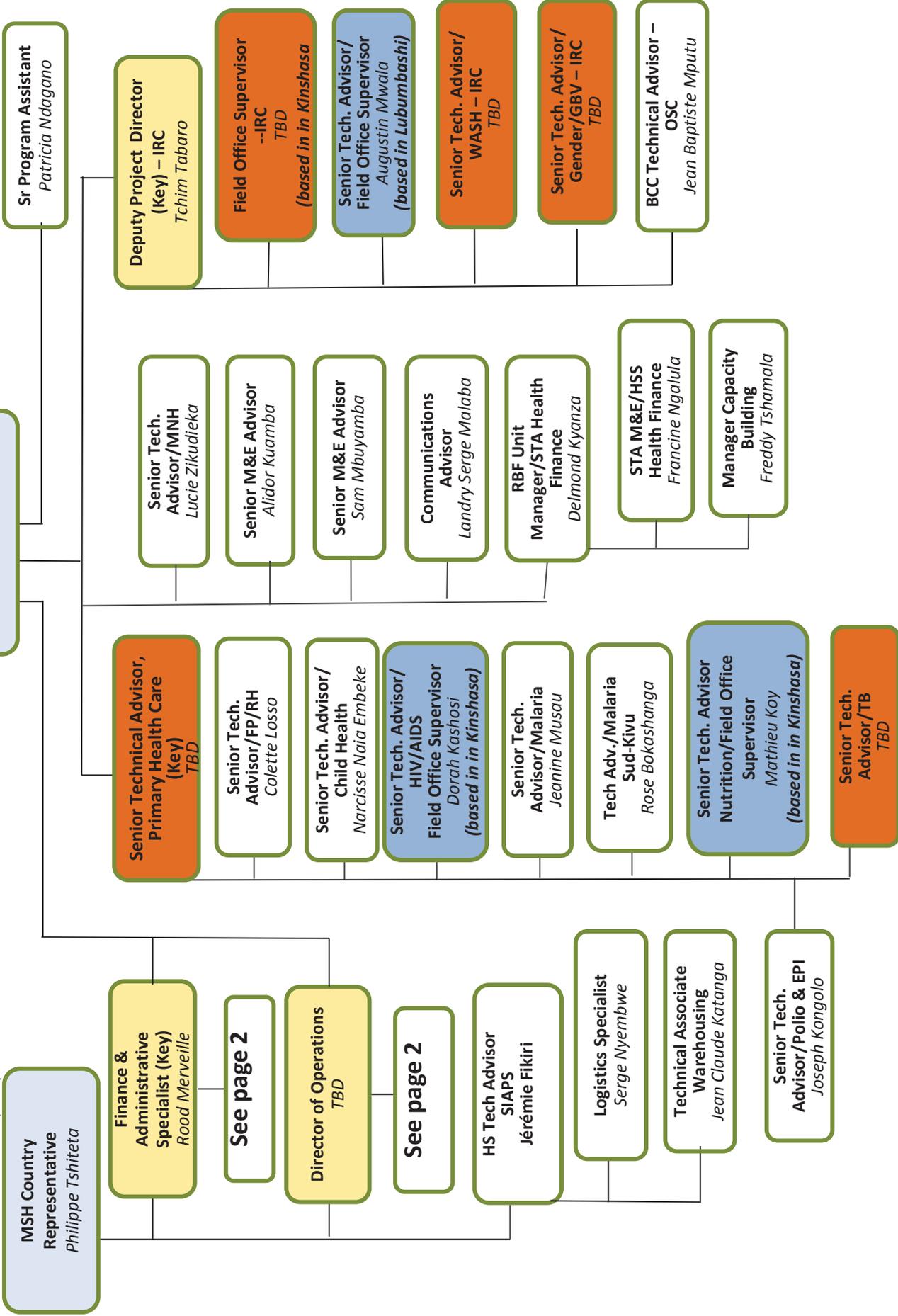
	visits	Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	44,560	44,560	44,560	44,560	133,680	139,113	
		Numerator/ Denominator (in percentage)	67%	63%	63%	64%	85%	76	
48	MALARIA: Number of USG-supported service delivery points experiencing stock-outs 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	82	75	80	80	50	160	
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	10,709	8,301	12,903	31,913	113,750	28	
50.1		(a) through campaigns	0	0	0	0	0	#DIV/0!	
50.2		(b) through health facilities	10,709	8,301	12,903	31,913	113,750	28	
50.3		(c) through the private/commercial sector	0	0	0	0	0	#DIV/0!	
50.4		(d) through other distribution channels	0	0	0	0	0	#DIV/0!	
50.5		(e) through voucher schemes	0	0	0	0	0	#DIV/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	0	0	0	0	219	0	
		Male	0	0	0	0	146	0	
		Female	0	0	0	0	73	0	
52	MALARIA: Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	63,915	58,454	55,420	177,789	750,000	24	
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	#DIV/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)	116,546	106,621	99,479	322,646	750,000	43	
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	9,011	43,889	41,348	94,248	875,000	11	
57	MALARIA: Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	213,902	177,866	202,641	594,409	625,000	95	
		(a) to health facilities	206,966	172,350	197,282	576,598	610,051	95	
		(b) to community health workers (HBMF, CCM)	6,936	5,516	5,359	17,811	14,949	119	
		(c) to the private/commercial sector	0	0	0	0	0	#DIV/0!	
58	MALARIA: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds Disaggregate in 3	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	0	0	0	0	300	0	

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	2	2	27	27	78	78	
		Denominator: Total # HZs in IHP target area	78	78	78	78	78	78	
		Numerator/ Denominator (in percentage)	3%	3%	35%	35%	100%	100%	35
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)	1,058	1,036	1,006	1,033	1,398	1,398	
		Denominator: Total number of health centers in IHP areas	1,398	1,398	1,398	1,398	1,398	1,398	
		Numerator/ Denominator (in percentage)	75.7%	74.1%	72.0%	73.9%	100%	100%	74
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)	66	61	60	62	78	78	
		Denominator: Total number of hospitals in IHP areas	78	78	78	78	78	78	
		Numerator/ Denominator (in percentage)	84.6%	78.2%	76.9%	79.9%	100%	100%	80
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	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	218	222	186	626	500	500	125
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	3	3	6	2	2	400
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	571	560	553	553	700	700	
		Denominator: Total # of facilities	1,476	1,476	1,476	1,476	1,398	1,398	
		Numerator/ Denominator (in percentage)	39%	38%	37%	37%	50%	50%	75
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	2,254	1,557	2,349	6,160	10,881	10,881	
		Denominator: Total # of patients seen by a CHW	15,642	11,753	12,402	39,797	217,620	217,620	
		Numerator/ Denominator (in percentage)	14%	13%	19%	15%	5%	5%	310

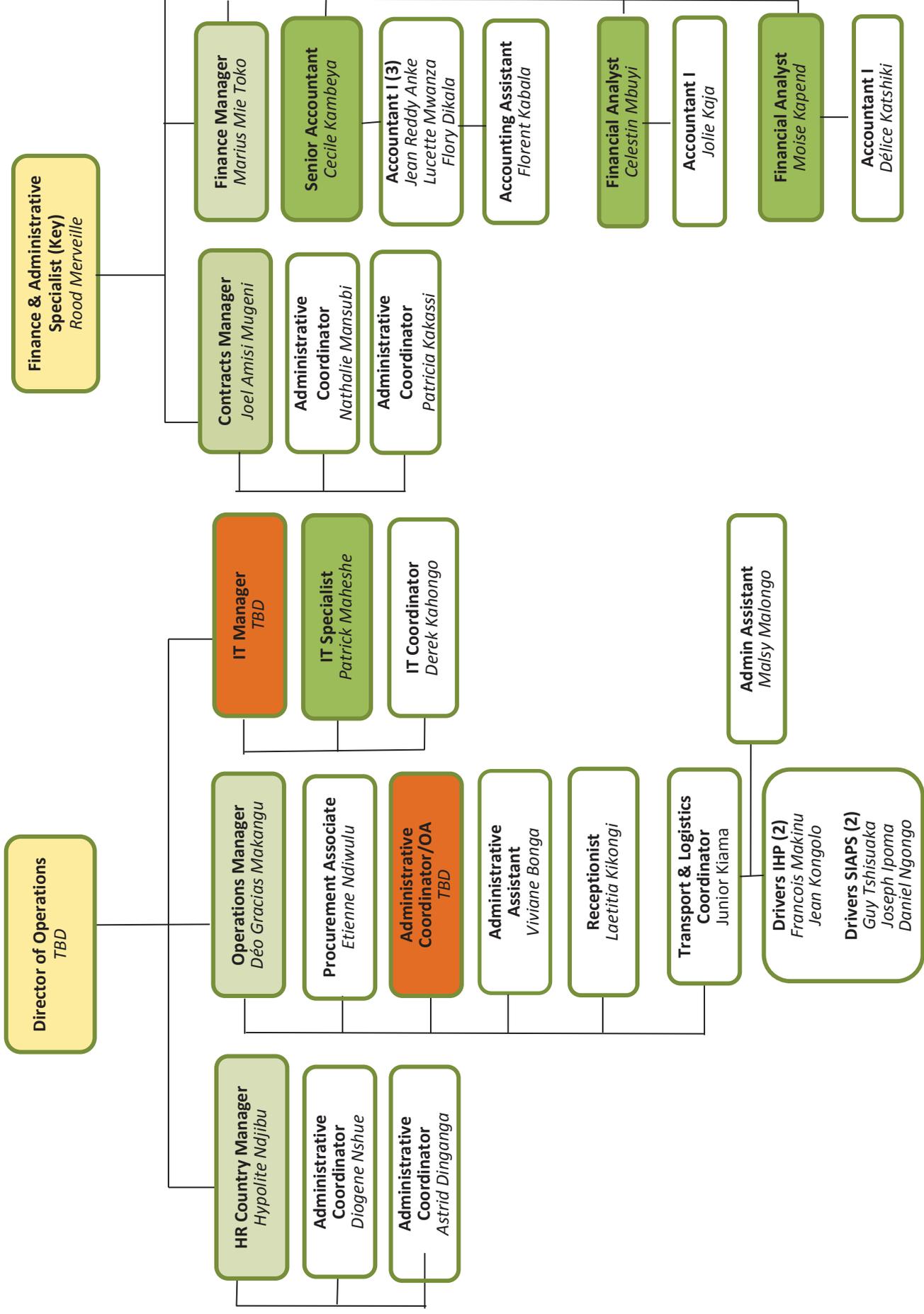
71	% of patients referred to GRHs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to GRHs by a CHW or health care provider Denominator: Total number of patients seen by a CHW or health care provider Numerator/ Denominator (in percentage)	18,621 486,464 3.8%	17,774 491,722 3.6%	19,584 499,916 3.9%	55,979 1,478,102 4%	11197 862,117 1.3%	
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased (Component 1)								
IR 3.1: Evidence-based health sector-community outreach linkages –especially for women, youth and vulnerable populations– established								
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 Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC Numerator/ Denominator (in percentage)	248 350 71%	252 347 73%	250 345 72%	250 345 72%	15 25 60%	121
73	***L+M+G: # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	34	34	34	34	7	523
74	***L+M+G: # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	34	34	34	34	7	523
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	148	147	146	147	30	490
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influencers (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	1,256	1,269	1,249	1,258	1,060	119
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)	30,845	79,981	66,494	177,320	125,000	142
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") Denominator: Total # of health zones Numerator/ Denominator (in percentage)	30 78 38%	35 78 45%	44 78 56%	44 78 56%	78 78 100%	56
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 Denominator: Total # of health zones Numerator/ Denominator (in percentage)	48 78 62%	46 78 59%	46 78 59%	46 78 59%	78 78 100%	59

Appendix 4: Organizational Chart

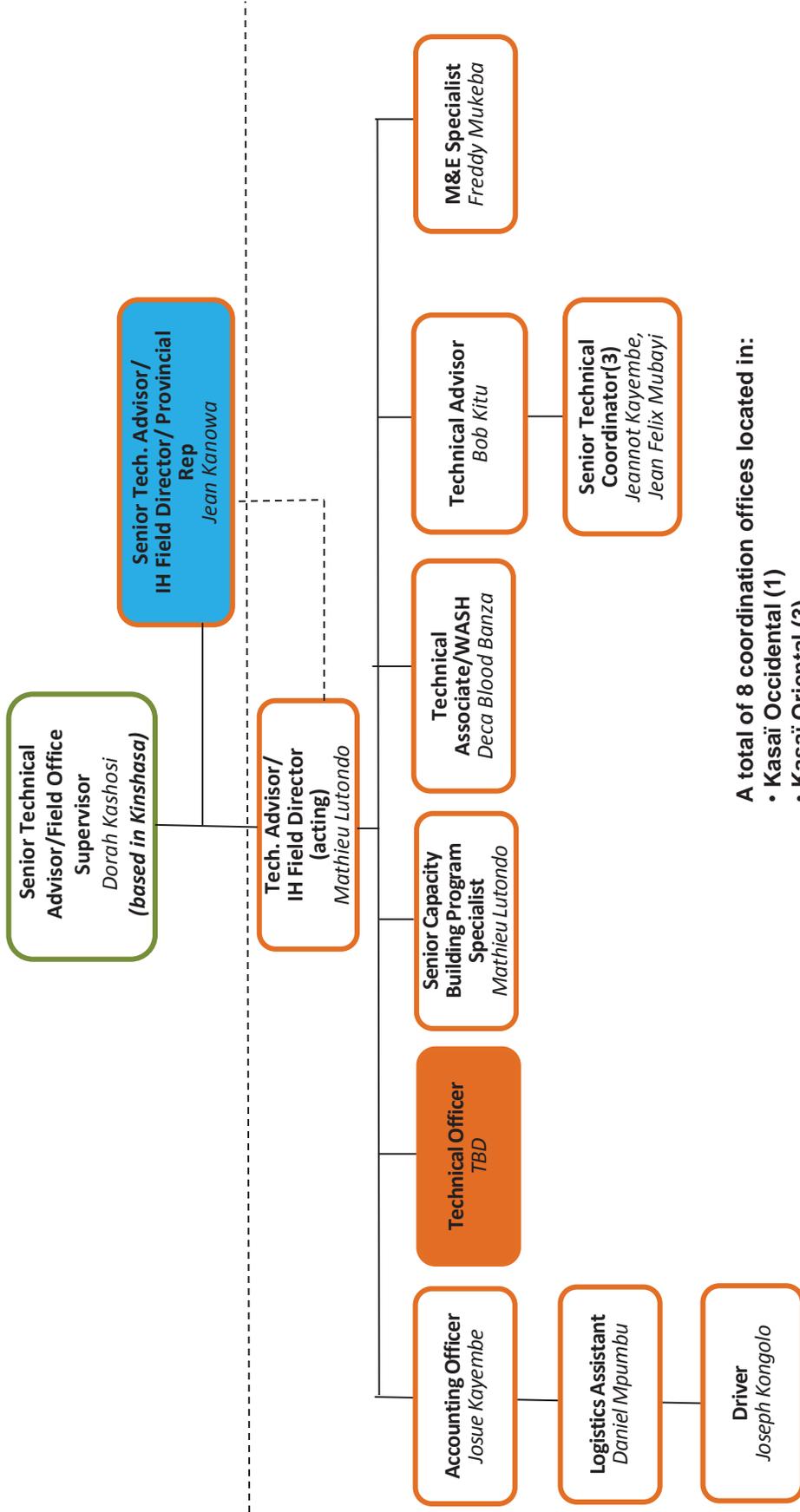
Kinshasa Office (HQ)



Kinshasa Office (HQ – page 2)



IHP Field Office: Luiza, Kasai Occidental

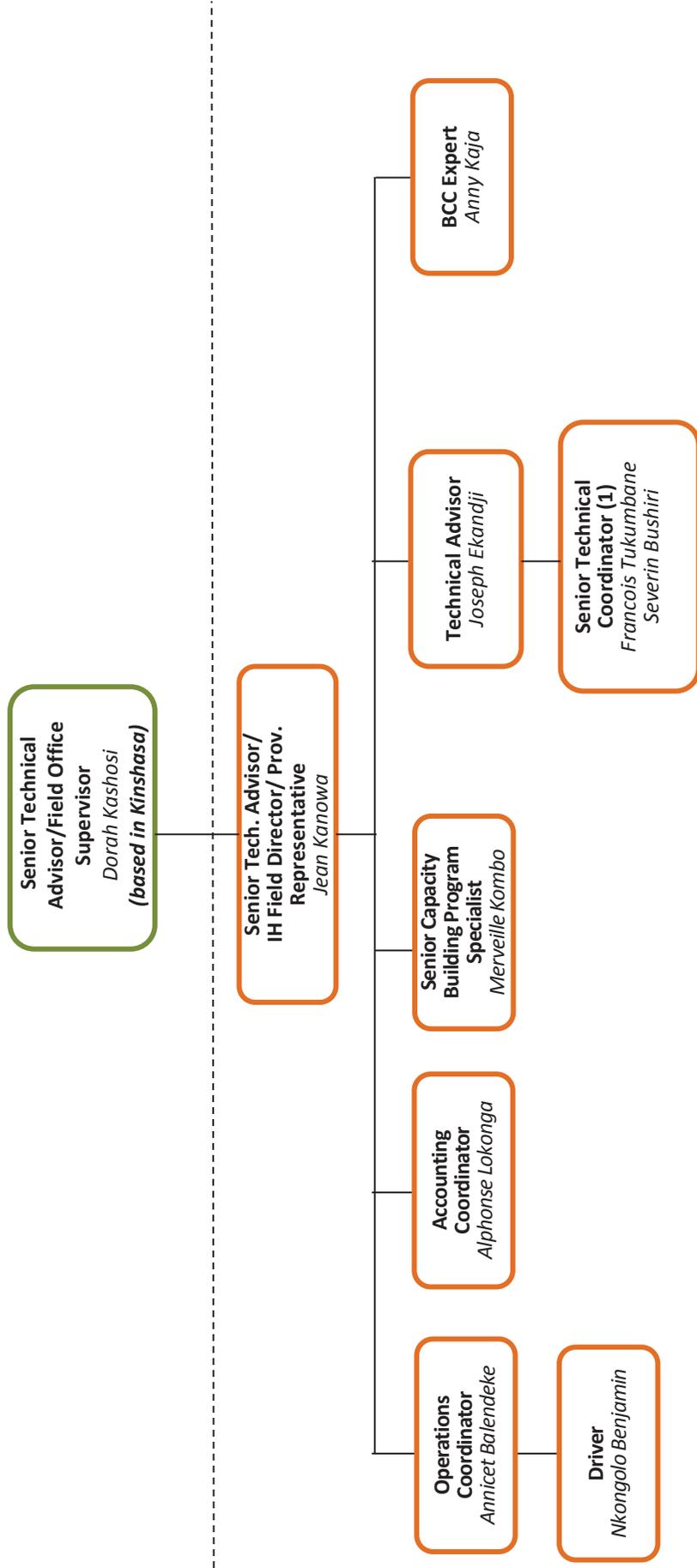


A total of 8 coordination offices located in:

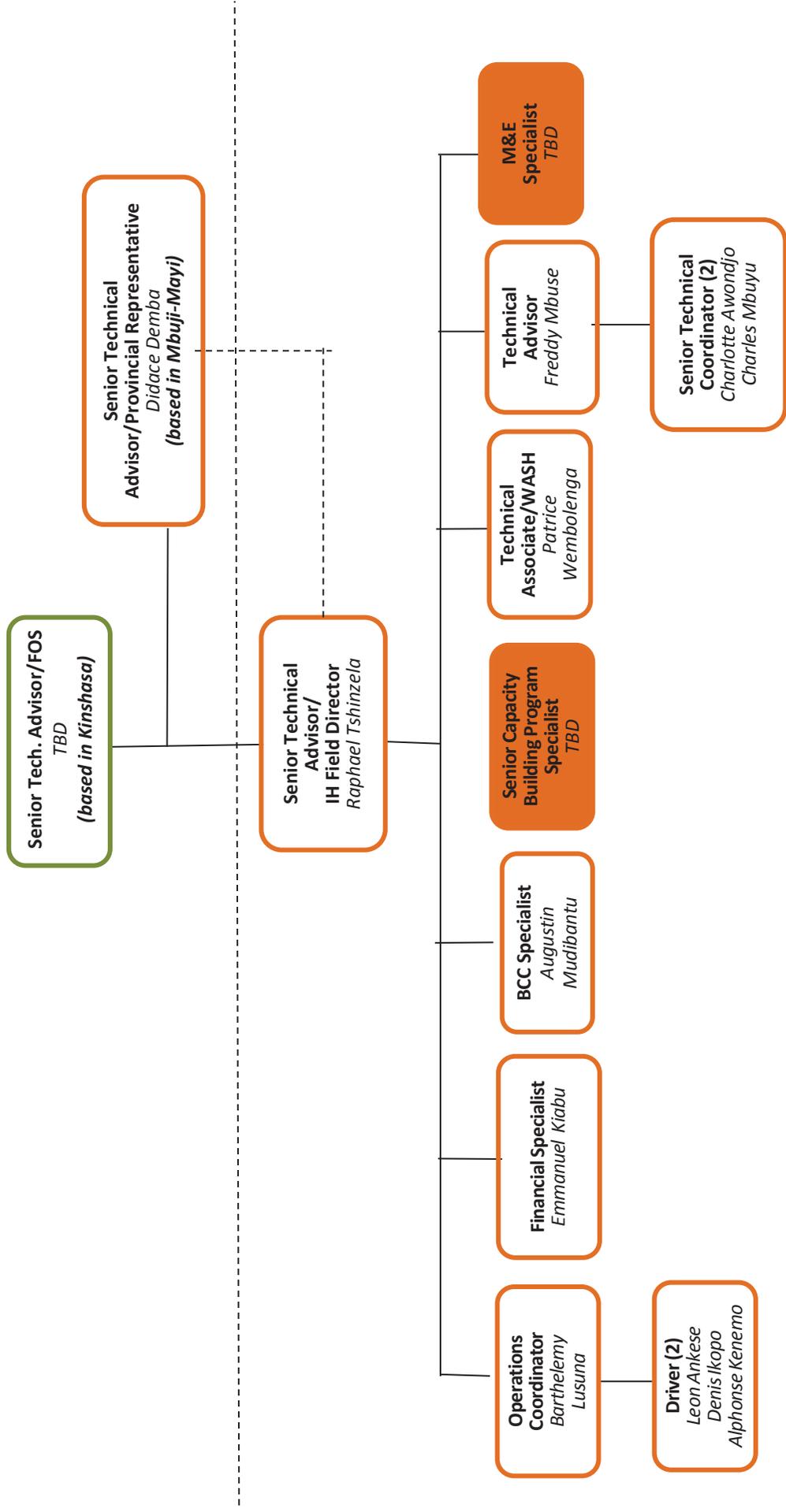
- Kasai Occidental (1)
- Kasai Oriental (3)
- Katanga (2)
- Sud Kivu (2)

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.

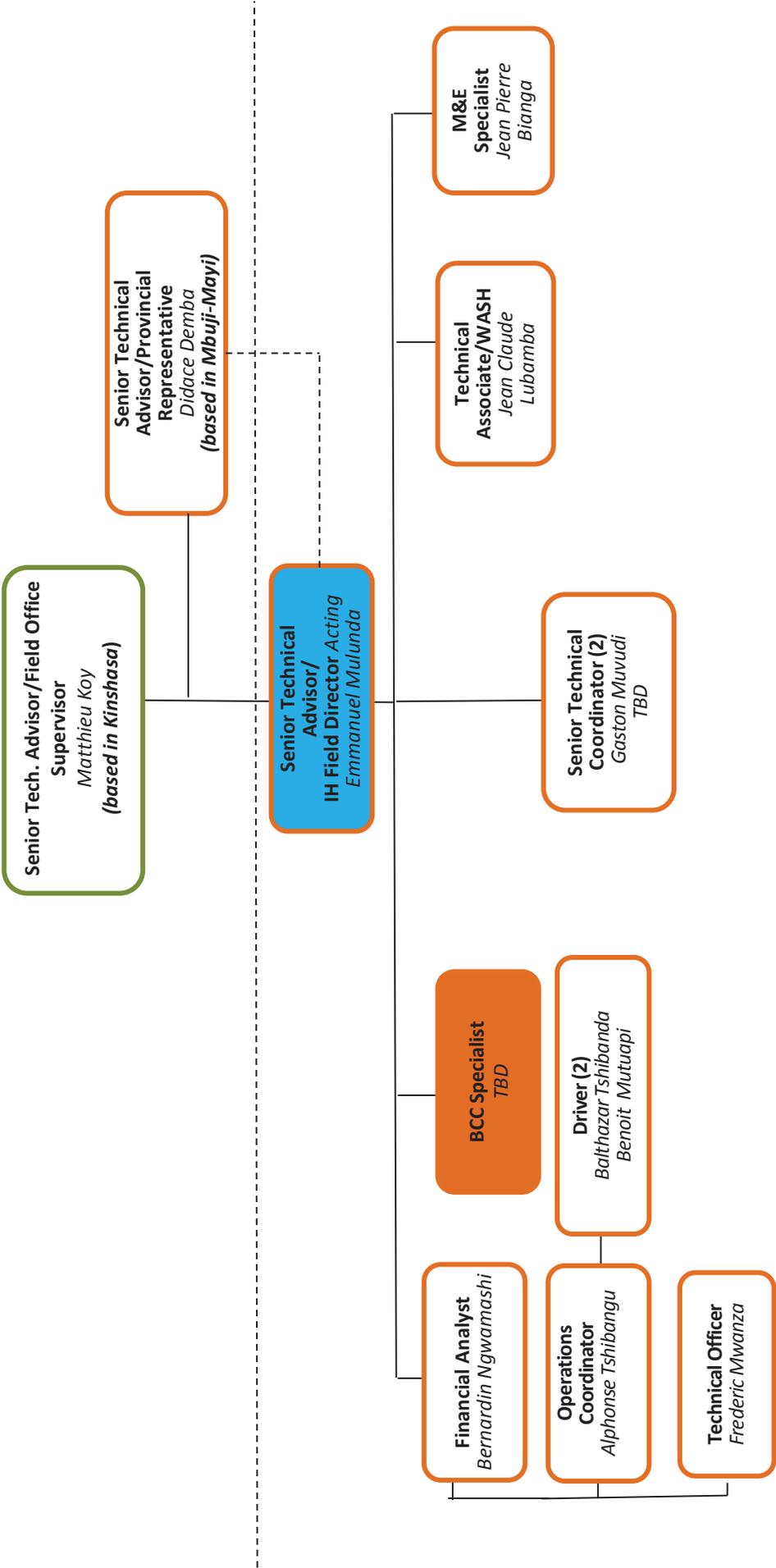
IHP Field Office: Kananga, Kasai Occidental



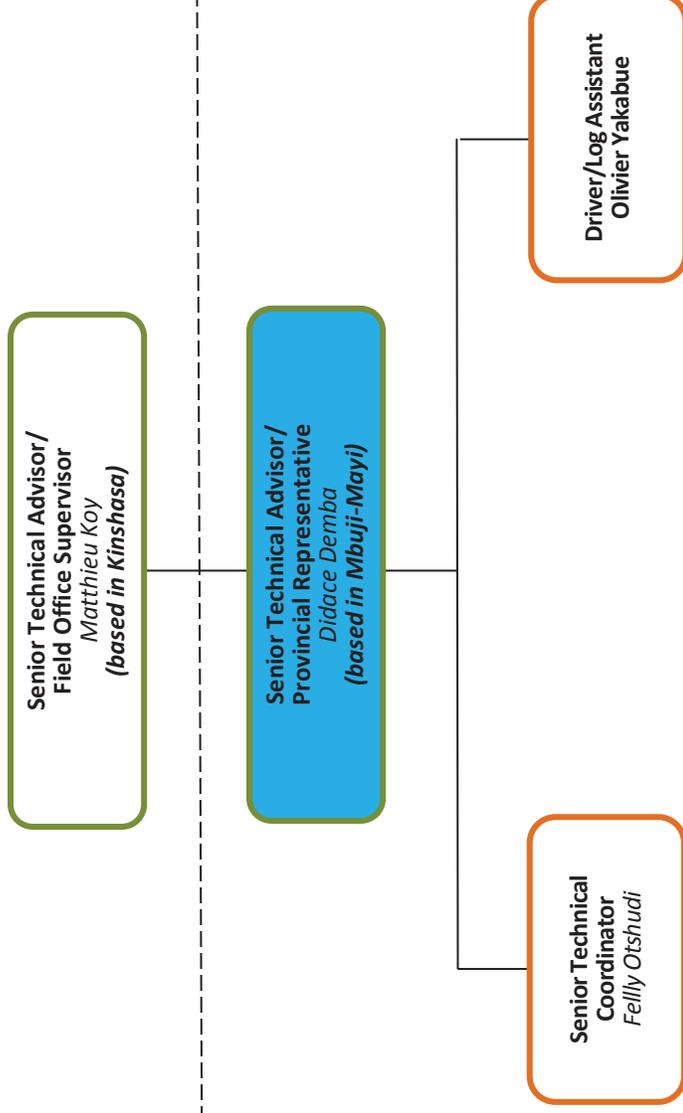
IHP Field Office: Kole (Lodja), Kasai Oriental



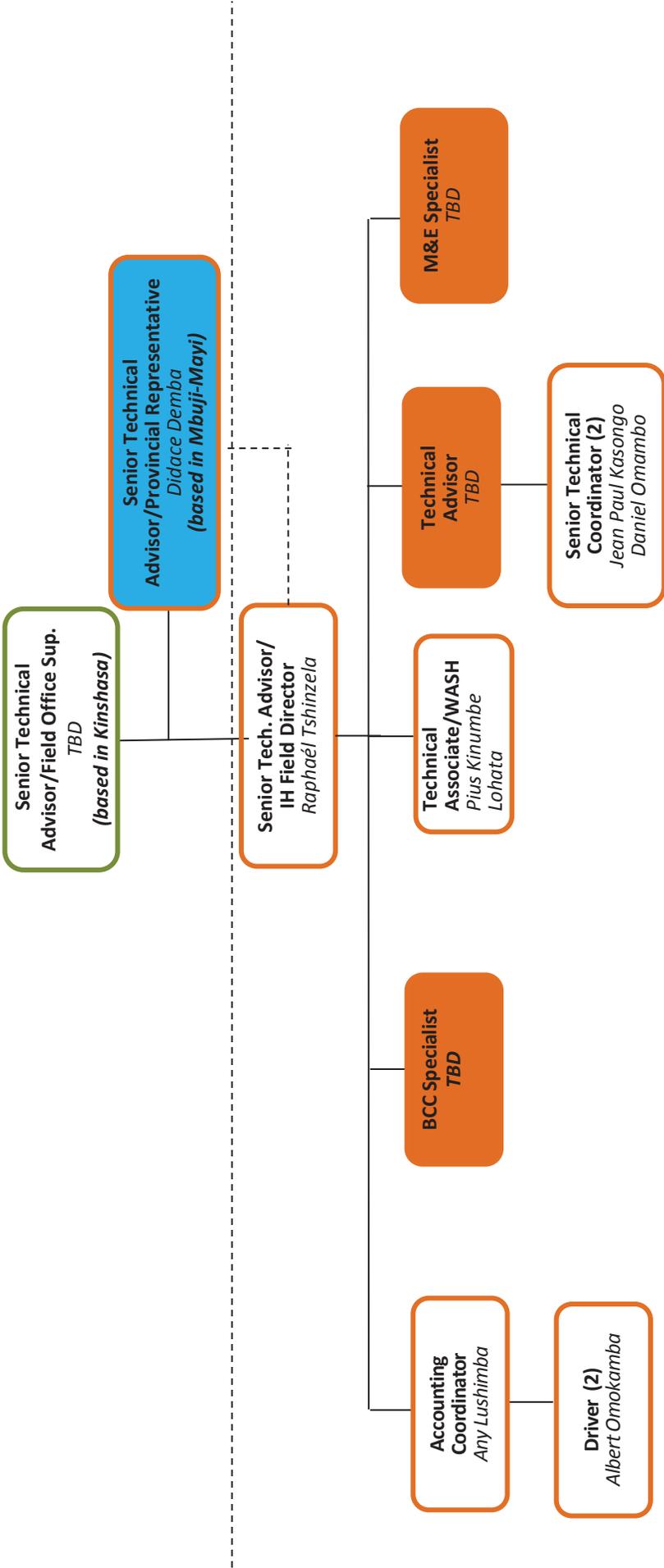
IHP Field Office: Mwene-Ditu, Kasai Oriental



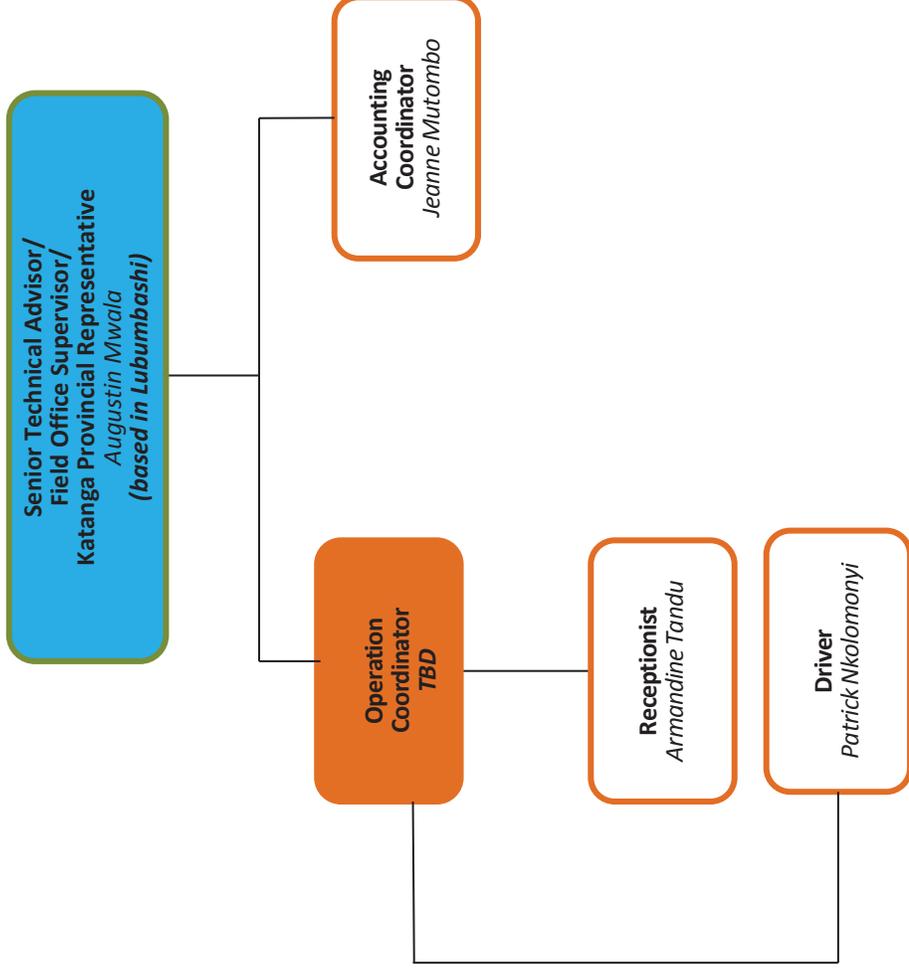
IHP Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



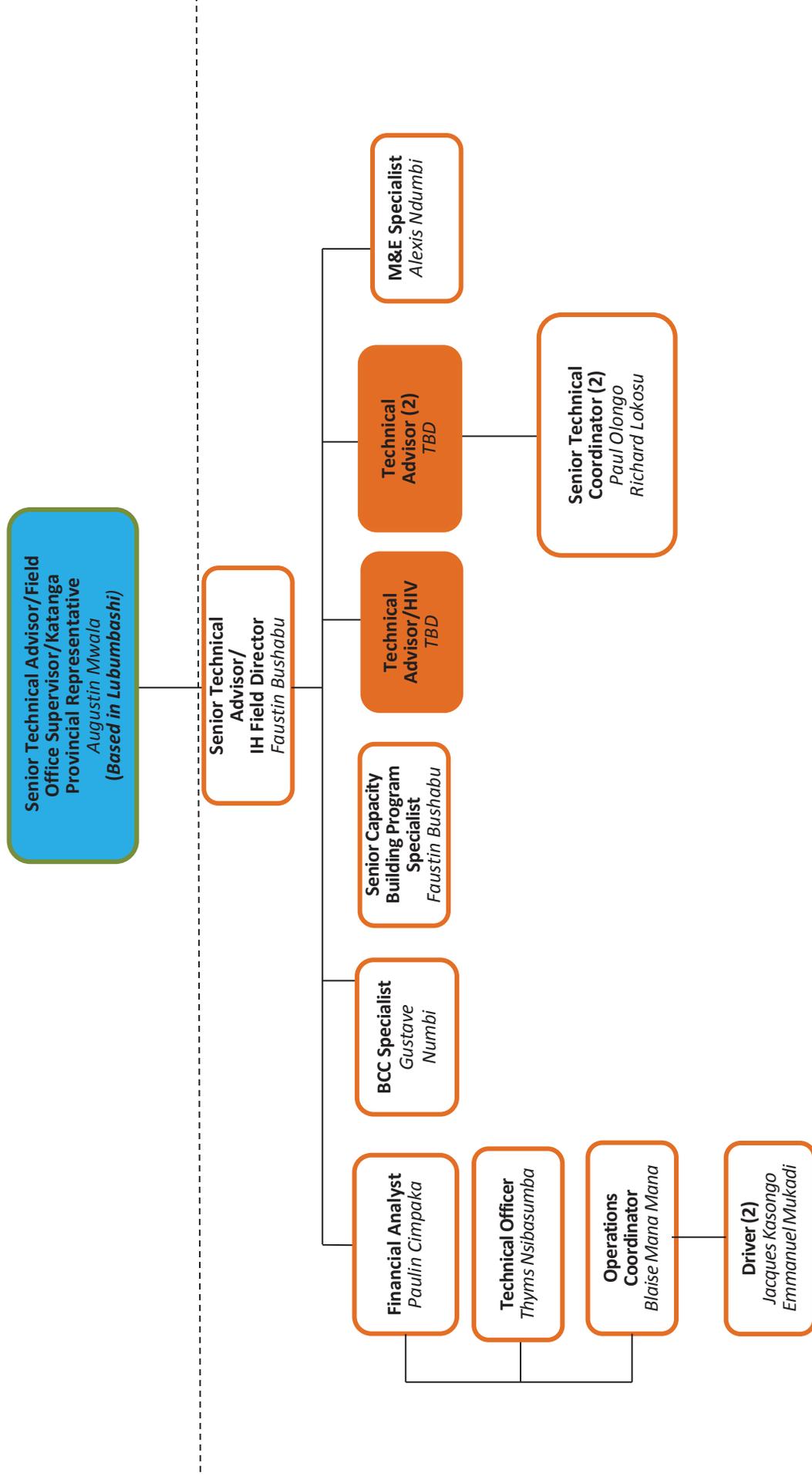
IHP Field Office: Tshumbe, Kasai Oriental



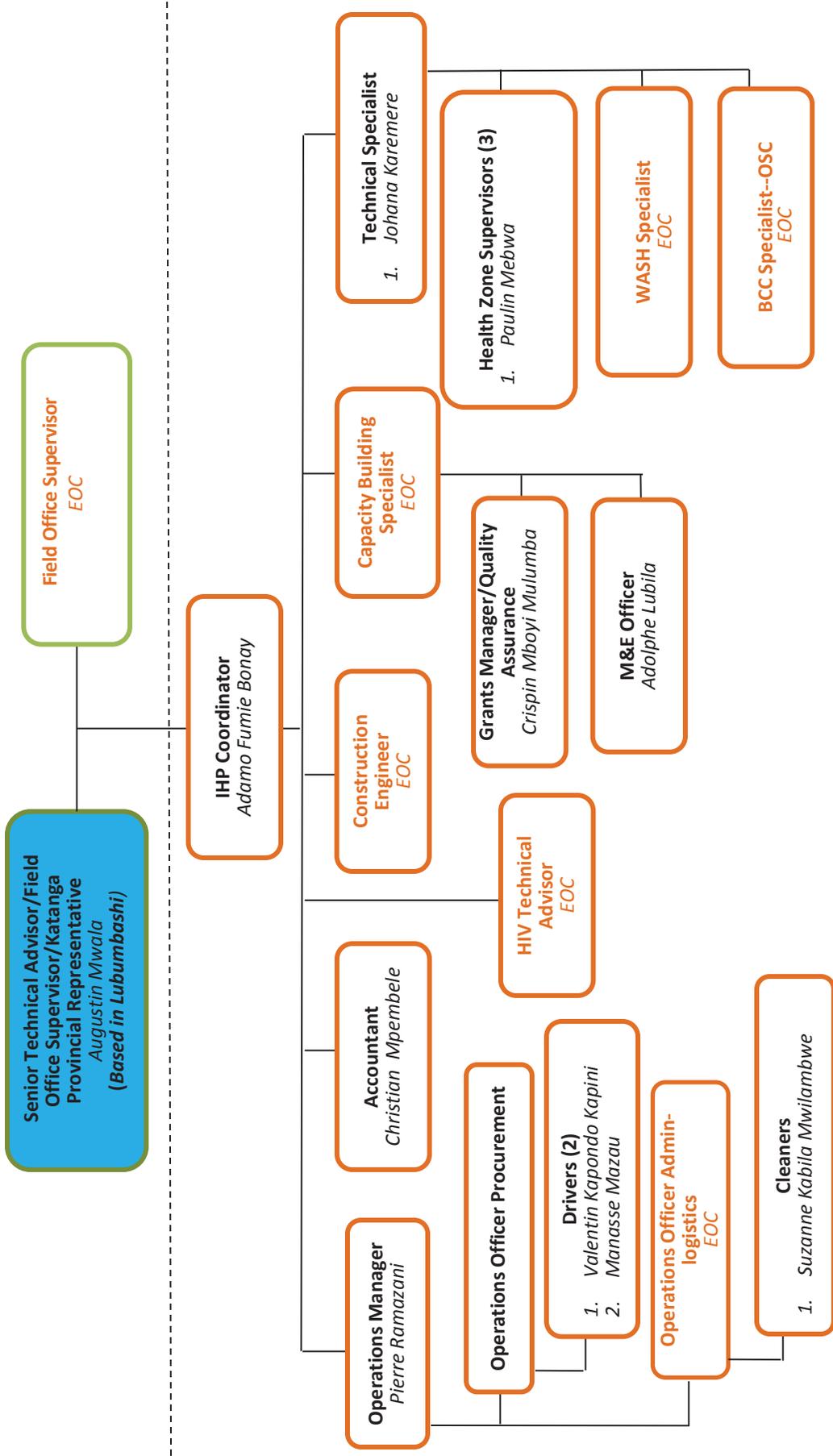
IHP Field Satellite Office: Lubumbashi, Katanga



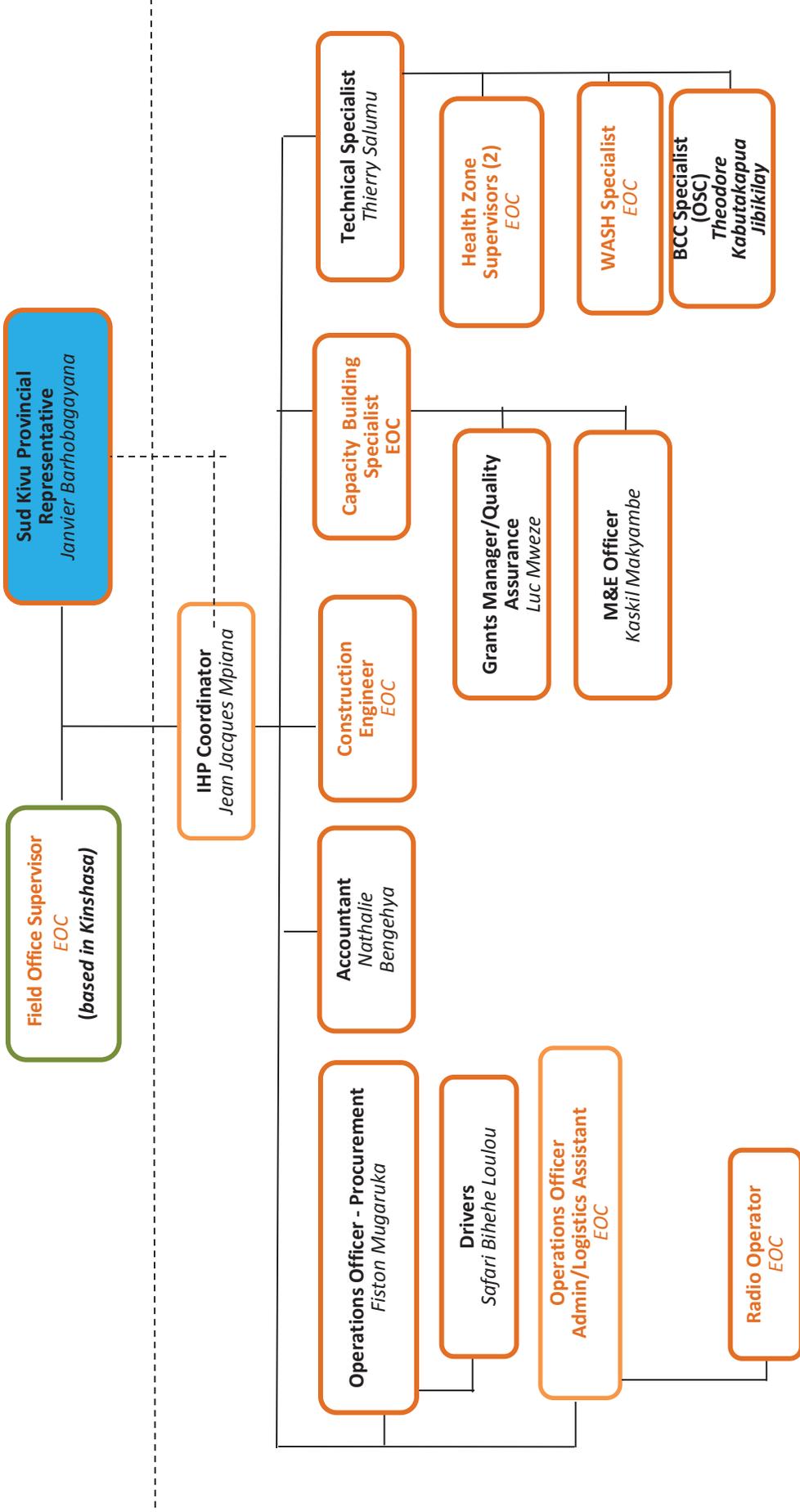
IHP Field Office: Kamina, Katanga



IHP Field Office: Kolwezi, Katanga



IHP Field Office: Uvira, Sud Kivu

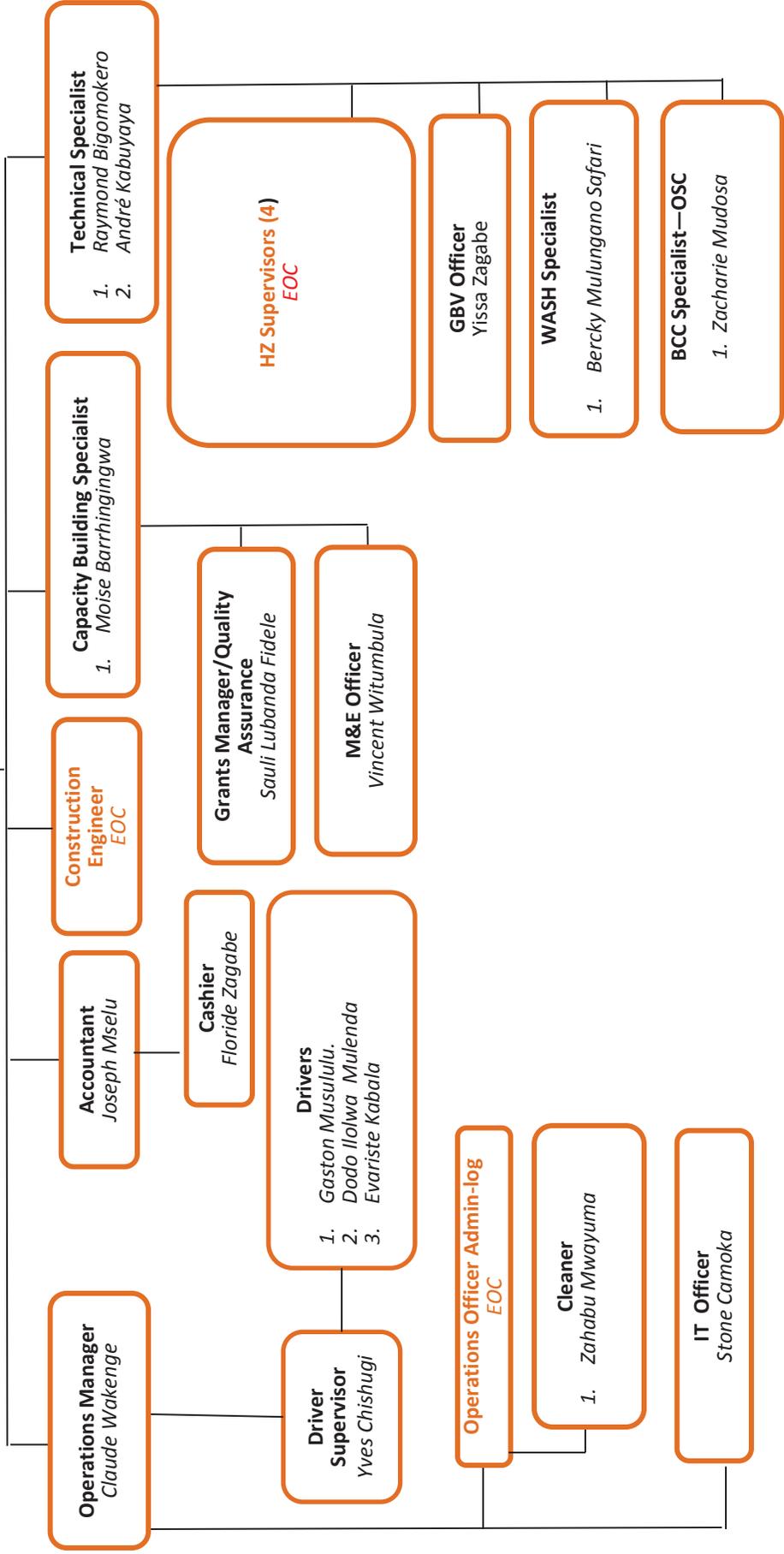


IHP Field Office: Bukavu, Sud Kivu

Field Office Supervisor
EOC
(based in Kinshasa)

Sud Kivu Provincial Representative
Janvier Barhobagayana

IHP Coordinator
Janvier Barhobagayana



EOC: End of Contract



USAID/Democratic Republic of Congo
 198 Isiro Avenue
 Kinshasa / Gombe
 DRC

Contract: DRC Integrated Health Project
 Contract # : AID-OAA-A-10-00054
 MSH Project # : A083
 Billing Period: Jan-March 2015
 Start Date: 09/30/2010
 Ending date: 09/29/2015

CATEGORY	Budget (\$)	Billed Prior Period (\$)	Costs Incurred This Period (\$)	Billed To Date (\$)
Total Costs	139,767,129.00	109,446,285.84	5,996,306.47	115,442,592.31
Unallowable Costs**	-	-	(328,078.00)	(328,078.00)
Total Costs	139,767,129.00	109,446,285.84	5,668,228.47	115,114,514.31

The undersigned hereby certifies that (1) the fiscal report and any attachments have been prepared from the books and records of the contractor in accordance with the terms of this contract, and to the best of my knowledge and belief, that they are correct, that the sum claimed under this contract is proper and due, that all the costs of contract performance (except as herewith reported in writing) have been paid or will be paid currently by the contractor when due in the ordinary course of business, that the work reflected by the costs above has been performed, that the quantities and amounts involved are consistent with the requirements of this contract, that all required Contracting Officer approvals have been obtained, and (2) appropriate refund to USAID will be made promptly upon request in the event of disallowance of costs not reimbursable under the terms of this contract.

By: *Patricia Barros-Smith*
 Patricia Barros-Smith
 Sr Treasury Manager

Date: 04/30/2015

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted USAID/OFM		2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) AID-OAA-A-10-00054			Page 1	of pages
3. Recipient Organization (Name and complete address including Zip code) Management Sciences for Health, Inc. 200 Rivers Edge Drive, Medford, MA 02155 United States						
4a. DUNS Number 071713085	4b. EIN 04-2482188	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment) FRLC 72 00 1329			6. Report Type <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual
8. Project/Grant Period From: (Month, Day, Year) 09/30/2010		To: (Month, Day, Year) 09/29/2015		9. Reporting Period End Date (Month, Day, Year) 03/31/2015		
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	\$113,570,189.00
b. Cash Disbursements	\$115,114,514.31
c. Cash on Hand (line a minus b)	(\$1,544,325.31)

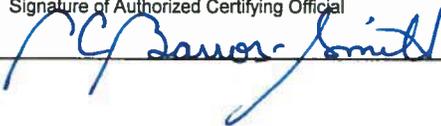
(Use lines d-o for single grant reporting)

Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	\$139,767,129.00
e. Federal share of expenditures	\$115,114,514.31
f. Federal share of unliquidated obligations	\$0.00
g. Total Federal share (sum of lines e and f)	\$115,114,514.31
h. Unobligated balance of Federal funds (line d minus g)	\$24,652,614.69
Recipient Share:	
i. Total recipient share required	\$4,193,013.88
j. Recipient share of expenditures	\$4,085,298.60
k. Remaining recipient share to be provided (line i minus j)	\$107,715.28
Program Income:	
l. Total Federal program income earned	
m. Program income expended in accordance with the deduction alternative	
n. Program income expended in accordance with the addition alternative	
o. Unexpended program income (line l minus line m or line n)	

11a. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
	Salaries	81%	01/01/2015	03/31/2015	145,786.79	118,087.30	100%
	Local Prof	40%	01/01/2015	03/31/2015	1,090,077.56	436,031.02	100%
	Consultants	40%	01/01/2015	03/31/2015	15,390.00	6,156.00	100%
g. Totals:					\$ 1,811,528.67		

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

13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official Patricia Barros-Smith, Sr Treasury Mgr		c. Telephone (Area code, number and extension) 617-250-9214
b. Signature of Authorized Certifying Official 		d. Email address pbarrossmith@msh.org
		e. Date Report Submitted (Month, Day, Year) 04/30/2015
14. Agency use only:		

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

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

USAID/DRC
Financial Management Office
Accruals Worksheet for the period
Jan 1, 2015 - Mar 31, 2015

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

Program Area	Program Element	BFY Fund	A	B	C	D	E	F= (C + D+ E)	G = B - F
			Estimated LOP Budget	Obligations	Disbursements (Oct 2010 - Dec 2014)	Quarter 2 - Disbursement (Jan-Feb 2015)	Quarter 2 Accruals and Estimated (March 2015)	Project Total to Date (Including accrual)	Obligations remaining (Pipeline)
A11	A047- HIV/AIDS	GH-AIDS/2010/201	\$ 14,743,405.00	\$ 9,183,113.00	\$ 7,190,944.09	\$ 210,154.66	\$ 832,288.32	\$ 8,233,387.07	\$ 949,725.93
A11	A048- TB	GH-C/2010/2011	\$ 17,286,763.00	\$ 14,158,910.82	\$ 11,087,300.80	\$ 296,627.53	\$ 1,283,257.23	\$ 12,667,185.56	\$ 1,491,725.26
A11	A049 - Malaria	GH-C/20102011	\$ 20,245,000.00	\$ 18,940,982.33	\$ 14,831,957.85	\$ 495,754.25	\$ 1,716,668.24	\$ 17,044,380.34	\$ 1,896,601.99
A11	A052- MCH	GH-C/20102011	\$ 45,731,306.00	\$ 60,010,131.38	\$ 46,991,635.58	\$ 1,529,329.09	\$ 5,438,867.16	\$ 53,959,831.83	\$ 6,050,299.55
A11	A053 - FP/RH	GH-C-POP/2010/201	\$ 20,625,615.00	\$ 17,897,315.00	\$ 14,014,701.94	\$ 380,229.59	\$ 1,622,078.08	\$ 16,017,009.61	\$ 1,880,305.39
A11	A054 - WASH	ES/2010/2011	\$ 12,610,800.00	\$ 13,178,793.67	\$ 10,319,808.59	\$ 308,718.82	\$ 1,194,426.78	\$ 11,822,954.19	\$ 1,355,839.48
A11	A142- Nutrition	GH-C-GFS/2010/201	\$ 8,524,240.00	\$ 6,397,882.80	\$ 5,009,936.99	\$ 136,550.61	\$ 579,856.00	\$ 5,726,343.60	\$ 671,539.20
Grand Total			\$ 139,767,129.00	\$ 139,767,129.00	\$ 109,446,285.84	\$ 3,357,364.54	\$ 12,667,441.82	\$ 125,471,092.20	\$ 14,296,036.80

*** Note : Data contained in this report may change since accounting has not closed the books for the months of February and march 2015

Breakdown of column E: Quarter 2 Accruals and estimates March 2015

	Expected to be paid by March 2015
Estimates March 2015	\$ 2,300,000.00
Accruals	\$ 2,300,000.00
Staff	\$ 214,421.29
Travel and Transportation	\$ 310,659.53
Training	\$ 277,873.99
Pharmaceuticals Purchase and Shipment cost (suppliers to Warehouse-CDRs)*	\$ 6,883,466.97
Shipment of equipment and commodities and received from USAID (PML,PF,TB)	\$ -
Equipment purchase (vehicles, solar fridge, motorcycles)	\$ 205,427.89
Subcontracts	\$ 1,149,980.48
Support to HZ others	\$ 770,398.11
	\$ 555,213.56
Subtotal Accruals	\$ 10,367,441.82
TOTAL	\$ 12,667,441.82

* Pharmaceutical cost includes remaining payment of Year 3 order and order for Year 4 purchase and shipment cost thru CDRs (Warehouses in provinces)