



Angelique (left) and her husband happily present the appointment card that they no more need to consult to check dates for DMPA injections. They are now engaged in the use of the *Jadelle* implant, a long term method, proposed by one of the USAID-supported clinics.

**Advancing Social Marketing for Health in the Democratic Republic of Congo  
Task Order # GHH-I-05-07-00062-00**

**Final Narrative Report  
October 2009 – September 2013**

**Submitted by:  
Population Services International  
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## I. EXECUTIVE SUMMARY

By the end of September 2009, Population Services International (PSI) was awarded a contract of \$22,779,101 by USAID under the contract number GHH-I-00-07-00062-00 task order 05, to implement a 4-year integrated social marketing project (from October 2009 to September 2013) named *Advancing Social Marketing for Health in the Democratic Republic of Congo* through its local partner in DRC, the Association de Santé Familiale (ASF). The project primarily focused in provincial capitals and most of the 80 USAID priority health zones. In December 2011, the estimated cost of the contract was increased by \$3,365,748 to include expansion of project's HIV activities to Kisangani and in Kinshasa. The new total estimated cost became \$26,144,849. USAID actually obligated \$25,956,248, that needed to reduce the contract cost by \$188 thousands down to the obligated amount.

The program goal was to improve the health status of the people of the Democratic Republic of the Congo. Therefore, PSI proposed to expand and build upon the achievements of USAID's previous social marketing programs in DRC by increasing the use of effective health products, services, and behaviors in the areas of HIV/AIDS/STI, family planning and reproductive health (FP/RH), maternal and child health (MCH) and water and sanitation. In order to achieve this purpose, the program had four main objectives: (1) Increase the supply and diversity of health products and services; (2) Increase awareness of and demand for health products and services; (3) Develop and/or enhance the ability of commercial/private sector entities to socially market health products and services; and (4) Integrate service delivery and other activities, emphasizing prevention, at all levels through joint planning with the GDRC, other United States Government (USG), and non-USG partners.

By the end of the project, this USAID-funded program significantly contributed to improve Congolese people's health by averting 594,449 unintended pregnancies, 58,207 diarrhea cases among children under five<sup>1</sup>, 14,451 HIV infections<sup>2</sup> and 1,912 maternal deaths<sup>3</sup> through specific achievements:

*Distribution of:* 3,304,456 COC (83% of the target), 870,163 injectables (116%), 36,431 CycleBeads (164%), 11,959 IUDs (117%) and 7,378 *Jadelle* implants (117%); 515,571,540 liters of water disinfected with point-of-use home water treatment solutions (240%); 120,333,586 male (104%) and 4,273,979 female condoms (118%); 50,896 clean delivery kits (102%);

*Behavior Change Communication:* 106,006 individuals referred to HCT services (373%); 66,961 individuals reached through interpersonal communication (IPC) activities promoting abstinence and/or being faithful (101%); 86,240 MARPs reached through IPC (159%); 1,223,571 people reached through HIV/AIDS community-wide events (122%); 1,268,528 people reached during outreach activities promoting the use of water purifier products (159%);

*Building Capacity of:* ASF and 20 other local NGOs in institutional development and social marketing;

*Partnership / Coordination:* by attending 383 external, technical or coordination meetings at the national, provincial and district levels with other stakeholders (103%).

PSI is grateful for the support of USAID and is enthusiastic about the continuing collaboration with the USG, the GDRC, ASF, and other partners to improve the health of Congolese people.

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<sup>1</sup> Calculated by using PSI DALY Calculator, a scientific converter of products and services provided into health impact. It calculates several indicators, including DALY (Disability Adjusted Life Year) which is an indicator used by WHO and the World Bank to evaluate the impact of health interventions. One DALY equals one year of life lost due to illness or death. When PSI averts one DALY, it means one year of healthy life would have been lost without PSI's intervention.

<sup>2</sup> Idem.

<sup>3</sup> Ibidem.

## II. PROGRAM BACKGROUND

### DRC Context

*Demographics and Overall Health Situation:* At the beginning of the program, the Democratic Republic of the Congo was home to nearly 70 million people. For almost 20 years, DRC has had some of the worst health indicators and performance on human development and governance scales. According to the 2008 U.N. Human Development Index, DRC ranked 168 out of 177 countries with data; the Human Poverty Index for developing countries (HPI-1) placed DRC well below Sub-Saharan Africa averages<sup>4</sup>.

The leading causes of death and disability included malaria, diarrheal diseases, respiratory infections, violence and road collisions<sup>5</sup>. At 1.3% DRC's adult HIV prevalence was lower than that of many of its neighbors which had some of the highest HIV prevalence figures in the world. Despite this low reported prevalence, HIV prevention and testing activities were essential for the general population, and women, urban, and eastern populations in particular, due to movement across borders by mobile and other most-at-risk populations as well as the influx of people into DRC for economic reasons. DRC's maternal mortality rate was 549 per 100,000 live births, and under-five mortality also remained extremely high at 148 per 1000 live births.<sup>6</sup> DRC's total fertility rate was 6.3 children per woman, contraceptive prevalence rate was only 6%, and unmet need for family planning was estimated at over 24%. Health-care seeking behavior was uneven, with fewer than 45% of children with fever receiving any care from a trained professional yet 72% of women giving birth reporting receiving assistance from a trained person.<sup>7</sup> Due to long periods without rigorous data collection, the country lacked reliable markers by which to accurately gauge trends. Infant, child and maternal mortality increased between 2002 and 2007. Only 48% of the population had access to an improved drinking water source, and less than 18% to adequate sanitation; over 16% of children under five experienced an episode of diarrhea in the two weeks preceding the survey. According to the 2007 DHS, up to 45% of DRC's population lives in urban areas; the DRC's rate of urbanization was increasing each year due to insecurity in many rural areas and the promise of better economic opportunities<sup>8</sup>.

*Government Response:* The Government of the Democratic Republic of the Congo (GDRC) is devoted to improving the health of its citizens, but is still in the process of recovering from years of instability. The GDRC has expressed its support of achieving progress toward the United Nations Millennium Development Goals (MDGs), but the country is unlikely to meet most of these goals without drastic investment and change. Less than 25% of health care is currently delivered through the public sector.<sup>9</sup>

The Ministry of Health (MOH) has developed a National Strategic Health Plan (NSHP) that identifies child health, integrated reproductive health, STI/HIV/AIDS, and malaria as the four main public health priorities. DRC's National Multisectoral AIDS Commission (PNMLS) includes representatives from government ministries and civil society, and is designed to address the HIV crisis across sectors with the National HIV/AIDS/STI Program (PNLS) situated under the MOH. The National Malaria Control Program (PNLP) coordinates malaria activities in close collaboration with the Global Fund Country Coordinating Mechanism (CCM).

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<sup>4</sup>UNDP 2007-8. [http://hdrstats.undp.org/countries/country\\_fact\\_sheets/cty\\_fs\\_COD.html](http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_COD.html)

<sup>5</sup>MOH 2005 estimates

<sup>6</sup>2007 DRC DHS

<sup>7</sup>Idem

<sup>8</sup>2008 CIA World Factbook. <https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html>; 2007 DHS

<sup>9</sup>2007 DRC DHS

*Private Sector Response:* The private sector for health care is relatively small in the DRC, but growing. From 2002 to 2009 in particular, private clinics and pharmacies multiplied in urban and peri-urban areas, and drug vendors increasingly played a role in supplying more rural areas and in filling gaps at the HZ level. The private sector also supports the distribution of PSI/ASF socially marketed health products through over 78 private clinics, 277 pharmacies, and additional sales points throughout the country.

*Civil Society Response:* International and local non-governmental organizations (NGOs) as well as outreach and clinics associated with particular religions or churches (known in DRC as *les confessions religieuses*) have also played a large role in the delivery of health services throughout DRC, particularly in providing virtually uninterrupted (if limited) care and treatment services throughout the country's periods of conflict.

### PSI

Population Services International (PSI) is an international, non-profit organization dedicated to improving the health of low-income and vulnerable populations through social marketing, which utilizes commercial and public channels to deliver needed health products at affordable prices while creating informed demand for practicing healthier behaviors. With more than 40-year experience and programs (HIV, FP, MCH, malaria, water and sanitation) in more than 60 countries, PSI is one of the largest social marketing organizations in the world. PSI has signed an agreement with ASF to implement in DRC its programs supported by necessary technical assistance.

### ASF

Association de Santé Familiale (ASF) is one of the western and central Africa's social marketing associations, members of the PSI network. ASF is one of the largest locally registered non-governmental organizations in the country working to address a range of public health priorities. First established in 1987, ASF has activities in almost all of DRC's provinces. With a talented and experienced staff of more than 160 Congolese trained in public health, marketing, research, communications and supply chain management, ASF distributes and promotes a range of high-quality reproductive and maternal and child health products, services and related behaviors to prevent the leading causes of disease and disability in the DRC. ASF's continuous commitment to the Congolese population over the past 25 years has enabled this project to achieve significant results in increasing access to high quality health products and services by benefiting from its existing relationships with important provincial health authorities and distribution networks developed under PSI/ASF's malaria prevention, HIV prevention or safe water programs.

### USAID-funded *Advancing Social Marketing for Health in DRC*<sup>10</sup>

In September 2009, Population Services International (PSI) was granted USAID's funding to implement a 4-year integrated social marketing project *Advancing Social Marketing for Health in the Democratic Republic of Congo* through its local partner in DRC, the Association de Santé Familiale (ASF). This project was implemented in DRC's provincial capitals (Kinshasa, Lubumbashi, Kisangani, Mbuji-Mayi, Kananga, Matadi, Bukavu, Mbandaka, Goma), some urban cities (Kikwit, Boma, Likasi, Kolwezi, Kipushi, Kasumbalesa, Kalemie, Uvira, Mweneditu...) and most of the 80 USAID priority health zones in the provinces of Kasai Oriental, Kasai Occidental, Katanga and Sud-Kivu.

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<sup>10</sup>This project is also named AIDSTAR project in reference to the global USAID-funded PSI program.

This program promoted and distributed health products and services related to HIV, family planning (FP), mother and child health (MCH) and water. The AIDSTAR program leveraged on previous PSI's USAID-funded HIV (Number 623-A-00-05-00341-00) and FP (Number GHS-A-00-04-00009-00) cooperative agreements' equipments, achievements, challenges, lessons learned and best practices.

### III. TARGET GROUPS

#### *HIV/AIDS/STI*

The following groups were targeted under this HIV program:

*Youth:* This group included young boys and girls aged 10-24 living in communities in urban and peri-urban program-targeted areas; they were reached at school, church and youth associations.

*Female sex workers (FSWs), their regular partners and other clients:* The female sex workers were women earning their lives from their sex work. They were reached in their work sites (night clubs, bars, closed houses, hotels, streets, mines...) and living sites, in all the program-targeted provinces. Some of them were mobile inside and between cities looking for more opportunities and revenues. Regular partners (named *loves*) were men who live with FSWs as a family with children most of the time, taking up the FSWs' security in FSWs' community or with their clients. They are considered as the FSWs' trust partners with whom they have unsafe sexual intercourses, and their behavior is mostly characterized by sexual multi – partnership, constituting a permanent risk for FSWs. Clients were any person attending FSWs' work sites and living sites and had paid sexual intercourse with FSWs.

*Men who have sex with men (MSM):* These were men who have paid or unpaid sexual intercourse with other men in sites such as bars, night clubs, hotels... They were targeted in Kinshasa only as a pilot project.

*Truckers:* This group included commercial drivers of long-distance vehicles (from cars to trucks), their accompanying staff and parking staff. They were mostly reached at bus stations. They were regularly far from their home and their mate / spouse, with unsafe sexual relations with regular partners in most of their major stops including in DRC's neighboring cities. They were also FSWs' clients.

*Uniformed Personnel (military and police):* They were men and women working as Congolese army and police staff living in program-targeted sites (in and around military / police camps and schools). Their dependents were also targeted as part of a more comprehensive targeted population. Uniformed personnel are often mobile and spend long period of time away from their mate / spouse. Military were targeted in Bas-Congo and Kasai Occidental provinces as other provinces were already covered by other PSI's USG-funded projects such as DoD. Specific behaviors increase their vulnerability to HIV infection as sexual multi-partnership, gender based-violence, and weak condom use.

*Miners:* These were artisanal workers operating in mining sites in Katanga and Kasai Occidental provinces, having many artisanal mining sites easy to access. They spend long period of time away from their mate / spouse seeking the fortune. Their daily revenue is spent in bars and with FSWs in and around mining sites. They attract FSWs because of their capacity to earn easily and frequently money, and can propose unsafe sexual relations when they pay more.

*People living with HIV/AIDS (PLWHA):* They were HIV+ men and women members of a PLWHA's association in Kinshasa as a pilot project. Unsafe sexual relations and lack of HIV status notification highly increase the risk of infection of their partners and the surinfection of the HIV+.

*General Population:* They were sexually active men and women in general, living in program-targeted provinces. Their behaviors exposed them to HIV infection.

### **FAMILY PLANNING**

The target group was constituted with women of reproductive age (WRA). They were women aged 15-49 living with mates or not, living in urban program-targeted sites and at risk of having unwanted pregnancies in their reproductive lives. They were reached in the vicinity of partner clinics, in public places (markets, churches ...), in their associations and in mother and child health services (ante-, post-natal and preschool consultations). Their partners were also reached as they could influence their adoption of family planning.

### **MCH**

The following groups were targeted under this MCH program:

*Pregnant Women:* They were pregnant women aged 15-49 living in urban program-targeted sites at risk of giving birth in unsafe environment resulting in potential infectious conditions for delivery. They were reached in the vicinity of partner clinics and maternity services.

*Mothers and caregivers of children under five:* They were persons living in both urban and rural program-targeted settings in charge of children under five who were at risk of contracting diarrhea. They were reached in the vicinity of partner clinics, in public places (markets, churches ...), in their associations and in mother and child health services (ante-, post-natal and preschool consultations).

### **WATER**

The target group was constituted with *mothers and caregivers of children under five*. They were persons living in both urban and rural program-targeted settings in charge of children under five who were at risk of contracting diarrhea. They were reached in the vicinity of partner clinics, in public places (markets, churches ...), in their associations and in mother and child health services (ante-, post-natal and preschool consultations).

## **IV. ACTIVITIES PERFORMED BY PROGRAM'S OBJECTIVE**

The program goal was to improve the health status of the people of the Democratic Republic of the Congo through the following objectives:

1. Increase the supply and diversity of health products and services that are to be distributed and delivered through the private sector, in conjunction with the public sector, for disease prevention and control as well as integrated health service delivery.
2. Increase awareness of and demand for health products and services to emphasize prevention of childhood illnesses, unintended and unsafe pregnancies, HIV infection and STIs, and to build an informed, sustainable consumer base.

3. Develop and/or enhance the ability of commercial/private sector entities to socially market health products and services including behavior change communication activities.
4. Integrate service delivery and other activities, emphasizing prevention, at national, provincial, district, facility, and community levels through joint planning with the GDRC, other United States Government (USG), and non-USG partners.

The description below presents the approaches used and results obtained by objective and health component.

**OBJECTIVE 1: Increase the supply and diversity of health products and services that are to be distributed and delivered through the private sector, in conjunction with the public sector, for disease prevention and control as well as integrated health service delivery.**

### **Approaches of intervention**

The AIDSTAR program was based on social marketing strategies addressing the products / services to be distributed / provided (P-Product), prices to be applied on different stages of the distribution from PSI's warehouses to final beneficiaries (P-Price), the distribution networks and channels to be used to ensure adequate geographical access and coverage for the targeted populations (P-Place), and the behavior change communication (BCC) promoting the adoption of products / services for healthier life (P-Promo). Approaches related to P-Promo are presented under Objective 2.

#### ***P-Product and P-Price***

##### *HIV*

The *Advancing Social Marketing for Health in the DRC* program inherited PSI's previous USAID-funded HIV program two branded condoms: one male (*Prudence*) and one female (*Prudence femme*).

**2009-2010:** PSI/AS's condom packaging were produced according to USAID policy, only USAID, PEPFAR and PNMLS logos were present on PSI/ASF's condoms packaging.

**2011-2012:** Previous studies conducted among youth on condom use in DRC and other countries showed their consumption rate of condom depended on the attractiveness of the product. Thus, a Flash FoQus study was conducted in Kinshasa to determine the color and scent of the new male condoms to be launched. The preferred flavors of the interviewed target groups were banana and strawberry, and they recommended keeping the existing translucent color. The interviewees also proposed orientations for the foil of the condoms. The results of this study were sent to USAID and this triggered the new condom order process by USAID.

**2012-2013:** The results of the 2012 study enabled the creative development to take place for outer packaging of the scented male condoms. The pretest of this packaging was conducted among target groups. The Prudence products range (*Prudence Classic*, *Prudence Sensuel fraise*, *Prudence Sensuel banane*, *Prudence femme*) was developed to have the products evolved.

PSI/ASF applied for the AMM for *Prudence Sensuel* to the MoH in December 2012. It was only in late June 2013 that the MoH informed PSI/ASF that it was found eligible to get the AMM provided that it submits additional information about the product beyond usually required information. PSI/ASF obtained the AMM delivered by the MoH.

PSI/ASF sold male condom (pack of tree) to wholesalers at \$0.027 and the consumer bought it at \$0.109. As for the female condom, it was sold (pack of two) to wholesalers at \$0.030 and the consumer bought it at \$0.109.



*Prudence* (left) and *Prudence femme* (right) are respectively the male and female branded condoms distributed during the AIDSTAR program.



The new range of branded male and female condoms:  
*Prudence femme* (on top) *Prudence Sensuel fraise* (bottom, left)  
*Prudence Classic* (bottom, center) *Prudence Sensuel banane* (bottom, right)

### FP

The *Advancing Social Marketing for Health in the DRC* program inherited PSI's previous USAID-funded FP program types of products overbranded with the *Confiance* label: oral contraceptives (Duofem and Ovrette), 3-month injectables, CycleBeads and IUD.

**2009-2010:** PSI/ASF was actively engaged with Bayer-Schering to facilitate the registration in DRC of the *Jadelle* implant. Although Bayer was responsible for the registration of *Jadelle* under the PSI/ASF's Dutch-funded project, SALIN, PSI/ASF provided guidance on necessary documents and points of contact in DRC. PSI/ASF also renewed the market entry authorization (AMM) documents for *Microlut* and *Jadelle*. The latter which was produced by Bayer-Schering was not granted the manufacturer's approval for overbranding under *Confiance*. In the same time, PSI/ASF continued the registration process for Petogen (another brand name of the 3-months injectable contraceptive) in DRC under the SALIN project. Packaging for all *Confiance* products was updated, based on the recommendation of USAID to remove all other logos (including PSI and ASF) on the packaging, and leave the USAID logo. The updated packaging was reviewed and approved by USAID.

**2010-2011:** *Duofem* oral combined contraceptive had to be replaced by Combination 3 which was effectively registered on the list of essential medicines in DRC and obtained its AMM in Q4 FY11 by Bayer Schering Pharma. In Q1 FY12, PSI/ASF obtained the overbranding authorization of Combination 3 under the *Confiance* brand from the MoH's 3rd Directorate. Ovrette oral progestative contraceptive had to be replaced by *Microlut* for which the registration process was under the supervision of Bayer Schering's focal point based in Kinshasa (Ethica) for both forms of the product, specifically the 28-tablet blister packs (available at PSI/ASF) and 35-tablet blister packs (not available, but announced by USAID).

**2012-2013:** In December 2012, the MoH granted the AMM for 35-pill *Microlut*. Unfortunately, there was no product in stock.

Not only does the *Confiance* brand signal high quality contraceptives, but all products are packaged with branded inserts which provide detailed information on correct product usage and potential side effects, which do not accompany the generic contraceptives distributed at other points of sale.

All the FP products distributed in the AIDSTAR program were directly purchased by USAID and donated to PSI/ASF for distribution in the *Confiance* network. Income generated by those sales was saved in a bank account until further notice from USAID.

PSI/ASF sold the following products to wholesalers at: \$0,068 for pills (one blister), \$0,163 for injectables, \$0.380 for IUD, \$0.217 for CycleBeads and \$5 for *Jadelle*. The consumer bought them at: \$0,163 for pills (one blister), \$0,435 for injectables, \$1.304 for IUD, \$0.543 for CycleBeads and \$10 for *Jadelle*. The latter was distributed at five (5) US\$ in all the provinces of intervention and its price was fixed after a "willingness to pay" survey conducted by PSI/ASF Monitoring and Evaluation Department.



The range of branded FP products *Confiance* (from left to right, from top to bottom): implant, IUD, injectable, pills, and cyclebeads.

## *MCH*

The *Advancing Social Marketing for Health in the DRC* program selected two health issues to be addressed. The first issue was to improve delivery conditions and the second one was to reduce diarrhea episodes, one of the three top children killers in DRC, among children under five. Two products were selected through this project in order to address these issues.

### Clean Delivery Kit (CDK)

With its own funding, PSI/ASF locally purchased CDK components including soap, gauze, gloves, sheet, etc., which were validated by PNSR. This *Delivrans*-branded product was distributed by PSI/ASF since 2007. The product was assembled in PSI/ASF's main warehouse of Kinshasa by trained and experienced manufacturers. PSI/ASF sold this product to wholesalers at \$2.2 and the consumer bought it at \$2.5. The income generated by the sales of CDK were used by PSI to resupply stocks.



*Delivrans*, the branded CDK

### Diarrhea Treatment Kit (DTK)

DTK is constituted of 2 oral rehydration salt (ORS) sachets and 10-tablet strip of zinc. According to WHO's latest recommendations, ORS is combined with Zinc to reduce the acuity of diarrhea, shorten diarrhea episodes and provide immunity to treated children. Production and packaging costs were reduced by having the two components in one kit.

**2010-2011:** In Q1 FY11, DTK package and instructions leaflets were designed after the PSI Washington-funded visit to PSI Benin by PSI/ASF's MCH staff to learn from their experience with their DTK program. In Q2 FY11, the design of DTK package and instructions leaflet was completed through workshops with MoH (PNLMD, 3<sup>rd</sup> Directorate, Training Directorate, Family and Specific Groups Directorate) and technical assistance from PSI's Global Social Marketing and Communication Department and Malaria & Child Survival Department. Brand name (*Ora-Zinc*) and flavor (ORANGE) were chosen after pretest with targeted groups from populous health centers, with prior approval of USAID and MoH. ORS package was also designed and developed in the PSI/ASF studio. The DTK was planned to be pre-packaged by the selected firm to simplify and speed up the procurement process. The DTK manufacturer was selected after a bidding process. Before starting production, PSI submitted the source/origin and pharmaceutical waiver to USAID. The DTK providers' training curriculum was designed and developed during Q2 FY11 and presented to the MoH during a workshop in July 2011.

**2011-2012:** USAID granted the waiver for the procurement of *Ora-Zinc* in Q3FY12. The new manufacturer, FDC Limited from India, was then selected, and an order for 700,000 kits was placed.

**2012-2013:** During the second quarter, samples of low-osmolarity ORS 1-liter packets and packs of ten 20-mg Zinc tablets as well as technical documents were received from the manufacturer and sent to the Third Directorate of the Ministry of Health in Q3. The manufacturer packaged DTKs in units of 20 pieces each. In Q3, the Third Directorate of the Ministry of Public Health granted the market entry authorization for DTKs. The DTKs' manufacturer shipped the products to DRC only in Q4 because of the BIVAC issue (please refer to the Challenges section) but they did not arrive by the end of the project.



Ora-Zinc, the branded diarrhea treatment kit developed under the AIDTSAR program

## **WATER**

The *Advancing Social Marketing for Health in the DRC* program selected PSI/ASF's two existing points of use chlorine-based water treatment products: *Pur* and *Aquatabs*. These products were promoted and distributed under this project in order to prevent diarrhea among children under five, this sickness being the second killer of children in DRC.

### Point of use water treatment products *Pur* and *Aquatabs*

*Pur* is a prepacked sachet of chlorine powder treating 10 liters of turbid water. Such water is commonly found in rural areas of DRC. *Aquatabs* is a chlorine-based tablet treating 20 liters of clear water. Such water is mostly found in urban areas of the country. *Pur* and *Aquatabs* were purchased by PSI/ASF's several donors (MCHIP - Mother and Child Health Integrated Program – USAID, UNICEF, UNDP Pooled Fund, and Procter and Gamble). USAID funding supported their distribution and demand creation. *Pur* was pre-packed at reception while PSI/ASF had to proceed with *Aquatabs* packaging before distribution. PSI/ASF sold *Pur* to wholesalers at \$0.042 a sachet and the consumer bought it at \$0.088, whereas *Aquatabs* was sold to wholesalers at \$0.200 a tablet and \$0.444 for the consumer. The income generated by the sales of these two water purifiers was used to re-supply stocks.



POU water purifiers *PUR* (left) and *Aquatabs* (right)

## *P-Place*

### *Cross-cutting*

Two main distribution channels were used, depending mostly on where they were authorized to be distributed. “Ethical” products had to be distributed in the pharmaceutical sector and included all the FP products, except oral contraceptives and cyclebeads that were eligible to community-based distribution. “Non ethical” (or Over The Counter – OTC) products included condoms, CDK, and water purifiers and were also allowed to be distributed in the fast moving consumer goods (FMCG) channels. In some provinces (Kasaï Occidental, Kasaï Oriental, Sud-Kivu and Kinshasa), the distribution network was expanded to fast moving consumer goods distributors and their networks.

**2009-2010:** A method of selection of wholesalers and intermediaries was formalized, based on criteria (such as conformity to laws, frequency of products purchase, and quantities of purchases) set up and validated in coordination with PSI provincial leaders, based on field experiences and technical support. Updated information about validated wholesalers for distribution networks was shared between field teams and programs on a monthly basis.

Two planning workshops for provincial leaders were held in Kinshasa, with the participation of all provincial leaders from USAID health zones and the backstopping teams of the national headquarters (Chief of Party, programmatic, administrative and finance departments). The first workshop focused on capacity building and planning activity included integrating social marketing strategies, AIDSTAR project rules and requirements related to administrative management, finance, stock management and procurement, project goal, objectives and targets while the second workshop targeted sharing experiences, challenges and lessons learned during implementation among provinces, updating charts, reviewing achievements and indicators and planning.

Based on lessons learned during distribution of all its products and MIS assessment in all provinces and at the national level, PSI/ASF put in place a triangulation system to reconcile products stock, sales and income. To avoid losses or thefts, reality and veracity of documents and products stock were monthly checked. This control also allowed the evaluation of the distribution channels and pricing structure. The restructuring of product supply system to provinces started with the revision of human resources charts in provinces to reinforce and integrate promotion, communication and distribution activities for all socially marketed health areas and products.

The list of air and road transporters was renewed after completion of a transparent tender; new contracts were signed to establish strong collaboration for a one year period with these key partners for products shipping to intervention provinces.

**2010-2011:** A national workshop was held in Kinshasa with the participation of programmatic teams at PSI/ASF headquarters, and provincial technical representative to discuss overview of year 1 project implementation, presentation and validation of year 2 objectives and strategies by province and specific domains, strengthening of the collaboration between programmatic departments and provincial teams, updating of data collection tools and procedures in order to improve data quality.

The wholesaler evaluation was completed and the final list of those which would directly collaborate with PSI/ASF as distributors was established. In order to strengthen the distribution network, the other wholesalers were linked to the selected distributors for their orders.

A total of 42 USAID-targeted rural health zones were visited at the end of FY11. In these zones, “junction points” (which were mostly semi wholesalers where existing commercial bikers would be supplied) were identified to extend the distribution network by supplying rural and underserved areas. A policy was written to standardize how the provinces with rural targeted zones (Kasaï Occidental, Kasaï Oriental, Sud-Kivu and Katanga) would identify bikers and work with semi wholesalers and commercial bikers (as mobile points of sale) to increase the availability of social marketed products.

As a component of the routine project activities, the sales team continued to create retail points of sale. This activity was also carried out in rural health zones in Katanga, Kasaï Oriental, Kasaï Occidental, and Sud-Kivu.



Commercial bikers are the main distributors of FMCG products in rural and underserved zones (before the training)



USAID supported the training of commercial bikers (including women) in socially marketed health products and the distribution of the non ethical products

The number of commercial bikers recruited went up to more than 3,000. This activity generated such an enthusiasm among the population that even non bikers were interested in becoming mobile points of sales as an opportunity for an income generating activity

**2011-2012:** Training workshops were held in Kinshasa for the benefit of communication, clinics network, sales and M&E managers from all the provincial offices. According to the recipients, the skills they acquired through this training have helped them organize their work in the field.

The distribution network was expanded to fast moving consumer goods distributors and their networks in Kasai Occidental, Kasai Oriental, Sud-Kivu and Kinshasa.

Pharmacies were removed from the *Confiance* social franchising network in order to expand distribution outlets in basic communities. These retail pharmacies were replenishing their stocks with pharmaceutical wholesalers. Since only partner clinics remain in the network, PSI/ASF staff focused its efforts on activities related to maintaining the quality-assurance of service provided through the network.

Commercial wholesalers effectively distributed products in Kinshasa, as well as in provinces, since all of them continued to order products and had a significant stock rotation. The number of sales force teams increased. PSI/ASF's visibility in the field was thus improved, points of sale that were not operating were replaced in distribution sites, and coverage was expanded.

**2012-2013:** The collaboration with wholesalers / distributors continued in all the project-targeted provinces in order to reach distribution indicators and strengthen partnership with the private sector. Sales forces visited points of sales to ensure that they meet MAP (measuring access and performance) criteria, which are: lack of stock-out, visibility of products, presence of promotional materials, compliance with the recommended price, and absence of expired products.

The inventory of all rural strategy materials in provinces was completed and the rural strategy continued to be successfully implemented in Kasai Oriental Province (especially in Mweneditu, Ngandajika and Kabinda), in Katanga (especially in Kolwezi and Kamina), and in Province Orientale (especially in Kisangani and its surroundings).

#### ***HIV/AIDS/STI***

To boost condom distribution, several strategies were set up, including regular meetings with PSI/ASF's approved wholesalers, condom promotion with wholesalers, community outreach activities to stimulate informed demand, etc. Sales teams created retail points of sales. The rural strategy, consisting in mobile points of sale by commercial bikers, was put in place to make social market health products available in USAID-targeted rural health zones.

**2009-2010:** A total of 40,254,000 male condoms and 500,000 female condoms were received from USAID both under previous USAID-funded cooperative agreement # 623-A-00-05-00341-00 and year one of the current contract. All quantities received from USAID were sampled, tested, packaged, shipped to provinces and distributed. It should be noted that no stock of female condoms was available at the end of September 2010 in PSI/ASF's central and provincial warehouses.

During the first quarter of this project (Q1 FY10), the previous USAID-funded cooperative agreement # 623-A-00-05-00341-00 benefited of an extension of its term from September to December 2009; sales realized during this period were reported under this cooperative agreement.

The sales agents (PSI/ASF's teams and community-based distributors) continued to expand the distribution system in order to increase access to condoms and reach new clients groups by using multiple distribution channels especially nontraditional outlets, increasing the number and types of outlets supplying condoms, and matching those outlets to clients' needs.

To intensify distribution results several strategies have been set up:

- regular meetings with PSI/ASF's approved wholesalers and their sales clerks to explain PSI/ASF's health products prices and new discount policies focusing on condoms margin of profit; to systematically track their condoms stock level and record new orders; to discuss and find solutions to the issues raised; and to ensure that those "alternative condom providers" had positive attitudes, accurate knowledge, and counseling skills because they had direct interaction with consumers;
- regular meetings with local partners organizations, especially Women's associations (for female condoms); to explain PSI/ASF's distribution network focusing on approved wholesalers; present PSI/ASF's health products donated by USAID (especially male and female condoms); prices and discount policies; to record new orders; and refer them to PSI/ASF's approved wholesalers for purchase;
- condoms promotion with wholesalers in order to stimulate retailer level purchase orders;
- community outreach activities to stimulate informed demand by giving condom clients essential information on how to use condoms correctly, to display and distribute educational materials;
- multiple distribution channels including nontraditional outlets by using trained community-based distributors and the PSI/ASF BCC and sales agents.

**2010-2011:** A total of 27,003,000 male condoms and 700,000 female condoms were received, tested, packaged and shipped to provinces. It should be noted that 4,000,000 male condoms were given with USAID/DRC's approval to DoD/DRC for its HIV prevention program among the military. At the end of FY11, there were stock-outs of male condoms in Kinshasa and Katanga provinces with the highest distribution level.

Based on the market evolution, the need for price adjustment for all the social-marketed products was identified as a priority to assess. PSI/ASF postponed the evaluation of current male condom price and price grid to project year 3 in order to extend to all HIV, FP, MCH and water products.

In the sales outlets that were created for condom sale throughout all targeted provinces by sales teams, their owners benefited from capacity building in stock management, respect of price structure, social marketing, as well as the sensitization of their customers on HIV and its prevention.

**2011-2012:** PSI/ASF received 89,997,000 male condoms. It should be noted that 2,500,000 were given out with USAID/DRC's approval to DoD/DRC for its HIV prevention program targeting the military. PSI/ASF also received 1,662,900 female condoms.

A comparison of Q4FY11 and Q1FY12 distribution figures of *Prudence* male and female condoms revealed a large decrease, mainly due to the following reasons:

- Small quantity of stock available at the end of FY11 in provinces, and some provinces such as Kinshasa, Katanga and Bas-Congo had a complete stock out of *Prudence* male and/or female condoms during Q1 FY12.
- The political situation, specifically the organization of presidential and parliamentary elections, did not facilitate the achievement of the objectives during FY11's last quarter. Indeed, because of socio-political instability, access to intervention areas was difficult as there was confrontation between partisans of some political parties and the police, and gatherings were prohibited during and after the election period.

With regard to the rural strategy, some additional points of junction were identified, and PSI/ASF distributed kits (containing condoms and water purifiers) to mobile sales outlets during Q2FY12.

**2012-2013:** From the existing stock, 550,000 *Prudence* male condoms were given out with USAID/DRC's approval to DoD/DRC for its HIV prevention program targeting the military. PSI/ASF received 14,568,000 *Prudence Sensuel* male condoms and 1,450,000 female condoms.

Male and female condoms were distributed in the private sector through pharmaceutical and non-pharmaceutical wholesalers as well as sales outlets. The sales force backed this distribution and enhanced the visibility of sales outlets.

In Q1, in partnership with PNMLS and the Ministry of Tourism, the launch of condom distribution in hotels took place in the presence of the Kinshasa Province's Minister of Tourism, the Provincial Executive Secretary of PNMLS and managers of 236 hotels located in Kinshasa.

**Distribution results :**The following tables highlight the distribution of male and female condoms by province from October 2009 to September 2013:

Table 1: Male condoms distribution by province from October 2009 to September 2013

Provinces	PRUDENCE HOMME YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	7 334 289	12 818 483	11 068 965	8 756 988	39 978 725
KATANGA	2 540 160	6 750 000	5 758 185	5 662 450	20 710 795
BAS CONGO	517 860	1 978 155	2 609 640	1 759 860	6 865 515
SUD KIVU/NORD KIVU	1 538 550	4 267 530	4 224 159	3 390 600	13 420 839
PROVINCE ORIENTALE	0	403 200	1 630 710	4 063 852	6 097 762
EQUATEUR	0	29 700	447 930	0	477 630
KASAI ORIENTAL/KASAI OCCIDENTAL	2 356 170	6 407 044	9 232 052	14 787 054	32 782 320
<b>TOTAL</b>	<b>14 287 029</b>	<b>32 654 112</b>	<b>34 971 641</b>	<b>38 420 804</b>	<b>120 333 586</b>

Table 2: Female condoms distribution by province from October 2009 to September 2013

Provinces	PRUDENCE FEMME 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	283 736	319 430	1 061 205	523 642	2 188 013
KATANGA	51 820	50 400	78 016	248 354	428 590
BAS CONGO	27 400	38 400	89 880	39 120	194 800
SUD KIVU/NORD KIVU	22 304	30 240	124 501	48 881	225 926
PROVINCE ORIENTALE	0	0	3 982	93 618	97 600
EQUATEUR	214	400	8 200	5 800	14 614
KASAI ORIENTAL/KASAI OCCIDENTAL	120 036	38 090	453 910	512 400	1 124 436
<b>TOTAL</b>	<b>505 510</b>	<b>476 960</b>	<b>1 819 694</b>	<b>1 471 815</b>	<b>4 273 979</b>

## *Family Planning*

PSI/ASF's FP program had a specific urban focus, but this should not be confused with an urban bias, as FP products and services are severely limited even in DRC's largest cities. Consequently, DRC's urban populations do not have a substantial advantage over rural populations regarding access to FP provisions. Rather, rebuilding family planning programs and capacity in urban areas has allowed FP products and services to return quickly and efficiently to areas where the demand for FP was highest (in absolute numbers) and where product distribution faced the least amount of obstacles. This fact is extremely relevant in a country where the costs and logistics of distribution can cripple a FP program.

An increasing proportion of DRC's population is found in urban areas, as the country is urbanizing at an astonishing rate, with the 2007 DHS estimating DRC to be 40-45% urban, coupled with an estimated annual urban growth rate of 5.1% (CIA World Factbook), one of the highest in Africa. Kinshasa, currently Africa's third most populous city, is also its fastest growing and is projected to become Africa's largest urban area by 2025 (UN HABITAT 2008). Most of the population growth in DRC's cities will be among the urban poor, a group with high unmet need for FP. Even though DRC's urban MCPR is higher than rural (9.5% vs. 3.3%), unmet need in urban areas is still slightly higher than in rural (24.9% vs. 24%) (DHS 2007).

Neglecting FP programming in DRC's urban would leave millions of Congolese women in the cities without access to products or services. In fact, ensuring broad access to FP in DRC's urban areas must be part of the national strategy for FP and fertility decline, as "urban places have been at the forefront of fertility decline in sub-Saharan Africa" (Shapiro and Tambashe, 1991), and positive trends in FP uptake tend to spread from urban to rural areas. Additionally, most private clinics and pharmacies are found in and around the urban centers. Furthermore, the commercial distribution channels, considerably diminished during the wars, recovered more quickly in cities following the conflict, allowing for a more sustainable flow of products into urban areas where there is a large, concentrated population of women with an unmet need for FP.

**2009-2010:** The *Confiance* network continued its FP IEC, service delivery and product distribution activities started under the 5-year CA GHS-A-00-04-00009-00, implemented in 8 provinces (Kinshasa, Katanga, Bas Congo, Sud Kivu, Nord Kivu, Province Oriental, Equateur and Kasai Occidental). The *Confiance* network was a network of 78 private clinics and 277 pharmacies that provided quality FP services and information, and distributed *Confiance* branded contraceptives.

Providers at partner sites received comprehensive FP training, on-going supportive supervision, and a guaranteed supply of *Confiance* contraceptives. Five contraceptive products (two oral pills, injectable, IUD and CycleBeads) were socially marketed through the network partners.

The *Confiance* network was expanded in Kinshasa with complementary Dutch SALIN funds. Twenty new partner clinics and 39 new partner pharmacies were added to the network, in addition to the 15 clinics and 45 pharmacies added in Mbuji-Mayi and Kindu using Dutch SALIN funds. Partners were pre-selected using minimum standard criteria, and two clinicians and one pharmacy worker were trained for each selected site.

Training was done using the PNSR National FP Training Module for clinicians and a PNSR-approved pharmacy training module designed by ASF/PSI. Partners were given theory and practical training in FP counseling, products, secondary effects and communication. The training covered short-term methods, as the equipment for long-term methods (IUDs and implants) were not cleared by customs at that time. All activities at the expansion sites were covered under Dutch SALIN funding until December 2010. The

expansion of the *Confiance* network increased coverage and visibility of FP activities throughout the DRC's capital.

Quarterly meetings were held in each of the eight FP provinces (Kinshasa, Katanga, Bas Congo, Sud Kivu, Nord Kivu, Province Orientale, Equateur, Kasai Occidental) with partner clinicians and mobile educators and bi-annual meetings with pharmacists were held with network partners. These meetings provided an opportunity for PSI/ASF trained clinicians and mobile educators to meet together to discuss lessons learned, present successes and difficulties, share ideas and receive technical updates from PSI/ASF staff. These meetings ensured that previously trained partners have up-to-date information on FP products and services and that information given to clients was standardized throughout the *Confiance* network.

**2010-2011 :** In December 2010, the complementary backing of the Dutch SALIN funds that allowed the expansion of the *Confiance* network ended. Hence, in Q2 FY11, some of the Dutch SALIN project's clinics and pharmacies in Kasai Oriental (8 clinics and 30 pharmacies), Kinshasa (20 clinics and 39 pharmacies) and Bas-Congo (2 clinics in Boma) were incorporated in the AIDSTAR project. As part of the *Confiance* network expansion planned for this second year of project implementation, the new health facilities (25 clinics and 75 pharmacies) selection process started in collaboration with the respective Health Zones' Chief Medical Officers and PNSR's coordinator in the provinces of Kinshasa, Katanga, Bas Congo, Sud Kivu, Kasai Occidental and Kasai Oriental. PSI/ASF, backed by PSI's office in Washington, finalized the updated version of the memorandum of understanding for these new network partners before starting their FP basic training (2 service providers per clinic and one per pharmacy) which was jointly conducted with the National Program for Reproductive Health (PNSR).

In order to insert USAID's implants into the existing *Confiance* network, the implant training funded by the Dutch SALIN project for all *Confiance* sites was completed. After obtaining the AMM (authorizing the product distribution in the country), the *Jadelle* implant was successfully introduced in the *Confiance* distribution network.

To further assure clients' safety during FP consultations, PSI/ASF distributed FP medical equipment to its network clinics. The materials in the kit include the following items: gynecological bed, examination lamp, bin for disposal of waste generated, IUD and implant's insertion kit, sterilizer (pressure cooker), stainless tray, blood pressure monitor, white jacket and other delivery tools for data collection.

During the second part of FY11, the distribution of contraceptive methods was limited to a range of only 4 methods due to the stock out of Duofem and Ovrette, which would be replaced respectively by Combination 3 and Microlut.

**2011-2012 :** The distribution of combination oral contraceptive pills started in December 2011 after receiving the overbranding authorization for Combination 3 in mid-Q1FY12. At the beginning, Combination-3 pills were distributed as generic products. Afterwards, in Q3FY12, these pills were distributed under the *Confiance* brand. The Microlut's registration was pending at the MoH's 3<sup>rd</sup> Directorate. Consequently, there was no distribution of progestin-only pills.

A programmatic workshop was held in Kinshasa for building field teams' capacities. At this workshop, sales teams were instructed to introduce *Confiance* contraceptives through pharmaceutical wholesalers as described in the Year 3 USAID-approved project priorities.

It should be mentioned that a pilot phase was launched with five health facilities in Kinshasa for post partum IUD (PPIUD) insertions.

In Q3FY12, the number of community-based educators was increased from 45 to 145 to reinforce FP activities and boost indicators.

**2012-2013 :** FP products (COC, DMPA, IUD, CycleBeads, and Implants) were distributed through social marketing in partner clinics and by distributors. Information sessions were conducted to ensure that clinics restocked from distributors.

**Distribution results :** The following tables highlight the distribution of FP products by province from October 2009 to September 2013:

Table 3: COC (Duofem) distribution by province from October 2009 to September 2013

Provinces	COC (Duofem) YEAR 4 DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	430 175	255 408	653 946	452 547	1 792 076
KATANGA	82 470	42 450	140 844	91 675	357 439
BAS CONGO	33 765	33 915	52 508	54 280	174 468
SUD KIVU/NORD KIVU	56 454	34 735	170 330	95 470	356 989
PROVINCE ORIENTALE	7 680	2 400	12 360	42 575	65 015
EQUATEUR	8 999	9 000	12 600	4 040	34 639
KASAI ORIENTAL/KASAI OCCIDENTAL	21 320	21 510	106 865	374 135	523 830
<b>TOTAL</b>	<b>640 863</b>	<b>399 418</b>	<b>1 149 453</b>	<b>1 114 722</b>	<b>3 304 456</b>

Table 4: Injectables (DMPA) distribution by province from October 2009 to September 2013

Provinces	INJECTABLE (DMPA) 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	89 990	70 144	141 602	149 132	450 868
KATANGA	31 310	30 580	18 890	33 748	114 528
BAS CONGO	17 080	18 770	15 130	23 200	74 180
SUD KIVU/NORD KIVU	17 530	35 590	19 310	30 208	102 638
PROVINCE ORIENTALE	3 770	6 330	6 930	18 907	35 937
EQUATEUR	5 240	7 480	5 842	2 530	21 092
KASAI ORIENTAL/KASAI OCCIDENTAL	6 650	13 146	25 902	25 222	70 920
<b>TOTAL</b>	<b>171 570</b>	<b>182 040</b>	<b>233 606</b>	<b>282 947</b>	<b>870 163</b>

Table 5: IUD distribution by province from October 2009 to September 2013

Provinces	IUD 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	672	1 557	745	1 838	4 812
KATANGA	349	249	327	188	1 113
BAS CONGO	207	217	220	138	782
SUD KIVU/NORD KIVU	477	970	820	795	3 062
PROVINCE ORIENTALE	160	69	83	120	432
EQUATEUR	60	42	76	15	193
KASAI ORIENTAL/KASAI OCCIDENTAL	215	257	767	326	1 565
<b>TOTAL</b>	<b>2 140</b>	<b>3 361</b>	<b>3 038</b>	<b>3 420</b>	<b>11 959</b>

Table 6: CycleBeads distribution by province from October 2009 to September 2013

Provinces	CYCLE BEADS 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	615	3 416	2 514	3 384	9 929
KATANGA	1 258	1 064	800	1 546	4 668
BAS CONGO	460	630	549	540	2 179
SUD KIVU/NORD KIVU	1 324	1 012	7 945	2 694	12 975
PROVINCE ORIENTALE	208	187	253	500	1 148
EQUATEUR	299	201	400	66	966
KASAI ORIENTAL/KASAI OCCIDENTAL	736	1 000	1 430	1 400	4 566
<b>TOTAL</b>	<b>4 900</b>	<b>7 510</b>	<b>13 891</b>	<b>10 130</b>	<b>36 431</b>

Table 7: Jadelle (Implants) distribution by province from October 2009 to September 2013

Provinces	JADELLE (IMPLANTS) 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	0	344	1 153	287	1 784
KATANGA	0	200	172	170	542
BAS CONGO	0	99	149	179	427
SUD KIVU/NORD KIVU	0	500	1 652	495	2 647
PROVINCE ORIENTALE	0	0	0	300	300
EQUATEUR	0	0	0	0	0
KASAI ORIENTAL/KASAI OCCIDENTAL	0	165	900	613	1 678
<b>TOTAL</b>	<b>0</b>	<b>1 308</b>	<b>4 026</b>	<b>2 044</b>	<b>7 378</b>

## Maternal & Child Health

**2009-2010 :** CDKs are produced with local components paid by other source of funding. They are promoted and distributed with USAID funds.

**2010-2011 :** The DTK providers' training curriculum was designed, developed and presented to the MoH during a workshop.

**Distribution results :** The following table highlights the distribution of *Delivrans* by province from October 2009 to September 2013.

Table 8: Clean Delivery Kits distribution by province from October 2009 to September 2013

Provinces	CLEAN DELIVERY KITS 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	15 816	79	1 312	0	17 207
KATANGA	1 116	865	4 123	572	6 676
BAS CONGO	253	228	969	217	1 667
SUD KIVU/NORD KIVU	2 605	3 398	6 598	421	13 022
PROVINCE ORIENTALE	178	1	299	166	644
EQUATEUR	333	174	342	121	970
KASAI OCCIDENTAL	250	4 300	1 900	260	6 710
KASAI ORIENTAL	13	2 947	1 040	0	4 000
<b>TOTAL</b>	<b>20 564</b>	<b>11 992</b>	<b>16 583</b>	<b>1 757</b>	<b>50 896</b>

## Water and Sanitation

**2009-2010 :** 4.4 million sachets of *PUR* were purchased by Procter & Gamble. For household distribution, PSI/ASF sales agents created demand and direct populations to existing points of sale for replenishment. A significant amount of POU products were distributed in emergency situations (cholera outbreaks, floods, etc.) by NGOs (CRS, UNC) and UN agencies as during cholera outbreak in Sud Kivu, Nord Kivu, Katanga and Kinshasa.

**2010-2011:** *PUR* and *Aquatabs* were distributed to health centers, pharmacies, retailers, wholesalers, NGOs and households. PSI/ASF's sale agents continued to create demand and directed populations to existing and new points of sale. And important amount of POU products were distributed in emergency situations by NGOs and Unicef during cholera outbreaks along the Congo River including Katanga, Sud-Kivu and Kinshasa, and significantly pushed demand and distribution beyond the FY11 targets.

PSI/ASF worked with FH (Food for the Hungry), an international NGO working with Community Based Distribution Agents (CBDAs) in Kalemie to provide *PUR* to vulnerable people in Kalemie, one of the cholera-endemic cities in Katanga. PSI/ASF's BCC sales agents provided water treatment and training on key hygienic behaviors to FH providers.

6.6 million *Aquatabs* tablets were cleared, tested and shipped to the field. In addition, a quantity of 5,969,312 *Aquatabs* tablets was received during Q4 FY11.

The WATSAN marketing plan was completed at the end of July during the STTA provided by the PSI child survival technical team based in Nairobi. It equipped the PSI/ASF team with marketing strategies in order to perform distribution and promotion interventions in the field.

**2011-2012:** Unfortunately, in Q4, a total of 5,550 sachets of PUR and 42,400 tablets of *Aquatabs* were stolen during a burglary of the PSI/ASF office in Mbandaka. Security measures were identified to minimize such risks in the future, such as adding another security guard and reinforcing the office fence. In addition, 30,720 tablets of *Aquatabs* were lost in Kisangani due to a vehicle accident.

**2012-2013:** The distribution of these water purifiers went beyond the FY13 targets mainly because of emergency situations related to cholera outbreaks in Katanga (for instance in Mura and Kikula, Likasi medical district), Bas-Congo, Bandundu (Bolobo), in Sud-Kivu (Uvira, Kamituga, Rutshuru). UNICEF and NGOs such as World Vision and Oxfam played a key role in that distribution activity.

From September 2012 to late Q3, there was a stock-out of *Aquatabs* in PSI/ASF's main warehouse due to the customs clearance issue that remained pending since last year.

**Distribution results :** The following table highlights the distribution of *Pur* and *Aquatabs* by province from October 2009 to September 2013:

Table 9: PUR distribution by province from October 2009 to September 2013

Provinces	PUR 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	735 952	1 174 200	1 219 321	807 237	3 936 710
KATANGA	313 884	547 849	499 848	612 124	1 973 705
BAS CONGO	76 217	78 623	173 760	102 240	430 840
SUD KIVU/NORD KIVU	532 640	875 161	473 316	2 092 324	3 973 441
PROVINCE ORIENTALE	0	132 000	114 816	320 160	566 976
EQUATEUR	0	63 384	666 012	12 972	742 368
KASAI ORIENTAL/KASAI OCCIDENTAL	301 750	404 906	583 364	158 800	1 448 820
<b>TOTAL</b>	<b>1 960 443</b>	<b>3 276 123</b>	<b>3 730 437</b>	<b>4 105 857</b>	<b>13 072 860</b>

Table 10: AQUATABS distribution by province from October 2009 to September 2013

Provinces	AQUATABS 4 YEAR DISTRIBUTION				TOTAL 4 YEAR
	FY10	FY11	FY12	FY13	
KINSHASA	343 624	2 384 304	5 032 808	1 262 409	9 023 145
KATANGA	635 692	571 526	526 080	847 200	2 580 498
BAS CONGO	69 632	122 552	281 184	99 840	573 208
SUD KIVU/NORD KIVU	647 820	890 344	1 300 597	355 840	3 194 601
PROVINCE ORIENTALE	0	239 040	193 440	155 680	588 160
EQUATEUR	0	398 794	1 017 000	960	1 416 754
KASAI ORIENTAL/KASAI OCCIDENTAL	234 253	430 208	492 840	708 480	1 865 781
<b>TOTAL</b>	<b>1 931 021</b>	<b>5 036 768</b>	<b>8 843 949</b>	<b>3 430 409</b>	<b>19 242 147</b>

**OBJECTIVE 2: Increase awareness of and demand for health products and services to emphasize prevention of childhood illnesses, unintended and unsafe pregnancies, HIV infection and STIs, and to build an informed, sustainable consumer base.**

### *Cross cuttings*

**2009-2010:** Meetings were held with USAID-funded project, PROVIC (HIV Integrated Program in Congo), which is composed of 5 USAID-funded partners: Chemonix, EGPAF, CRS, IHAA and PATH. In order to avoid efforts duplication and maximize resources use among USAID-funded partners, mechanisms of collaboration and coordination were discussed relatively to selection and adaptation of communication materials, audio and visual production through the use of PSI/ASF production studio and comprehensive communication campaign's development.

**2010-2011:** In order to get the general population and women in particular to know about the female condom, a transparent and open bidding process was launched and an agency to create the *Prudence* female condom campaign was identified and the contract signed. Moreover, in order to better position the *Prudence* male condom, distinguish it from other condoms and increase its sales in different points of sale throughout DRC, another agency was preparing a new branded campaign.

Due to the delay in producing the new *Prudence* male and female condoms TV/radio spots by selected advertizing agencies, the existing branded spots were aired on 39 TV and radio channels in USAID-targeted provinces. The advertizing agencies revised the new spots based on feedback from the PSI/ASF marketing team and the recommendations of the communication materials pretest. Consultants were hired in all the provinces to monitor the effective broadcasting of these spots by local channels.

PSI/ASF headquarters was actively implicated in the 2010 World AIDS Day celebration (December 1st), for which several meetings were held with the Government of the DRC (MoH, Gender Ministry, etc.) and partners to harmonize and finalize activities planning. Thus, decentralized activities were conducted by PSI/ASF provincial offices in coordination with local partners and politico-administrative authorities, including community mobilization (motorized caravans, MVUs), promotion of condoms and VCT use, communication materials distribution.

In Q2 FY11, PSI/ASF, through its provincial teams in charge of its FP program, joined international and local NGOs in celebrating the International Women's Day 2011 (IWD 2011). The national theme was: "Equal access to training for men and women as well as boys and girls, equal access to same opportunities for an equally representative Congo". The celebration of this day lasted all of March and was marked by several FP-related awareness activities that were mainly oriented to women of reproductive age and associations so as to create demand and direct them towards partner structures for receiving FP services. An estimated total of over 5,000 women were informed on the importance of FP on health and on the location of the *Confiance* network partners.

Under the AIDSTAR project, PSI/ASF celebrated the World Population Day on July 11<sup>th</sup> with the theme: "*It is high time to involve men in family planning discussions*", in coordination with MoH, UNFPA, ABEF, etc.

In partnership with the MoH, UNICEF, and other partner members of the Watsan Cluster, PSI/ASF organized the World Toilets Day (November 19th) under the theme “We deserve better”. Sensitizations in markets, schools, churches and health centers were carried out by PSI/ASF’s communication agents, in collaboration with local NGOs and community-based educators.

**2011-2012:** The World AIDS Day (December 1<sup>st</sup>) was not commemorated as usual because of the political situation around presidential elections in the country. Neither PNMLS nor PNLN organized activities during the month of December 2011.

The World Toilets Day (November 19th) was celebrated with the same theme as the previous year. On October 15<sup>th</sup>, PSI/ASF shared in activities related to the celebration of the Global Hand washing Day.

In Q2 FY12, PSI/ASF, alongside government partners organized the celebration of International Women’s Day. The theme chosen in DRC was: “Invest in Rural Woman and Young Girls for the Best Future”. During this event, PSI/ASF raised women’s awareness on a range of PSI/ASF’s socially marketed products.

In Q3 FY12, PSI/ASF obtained USAID’s approval for its new media campaigns consisting of Prudence male (“Vrai Djo”) and female (“Protection au féminin”) condoms radio and TV spots, and *PUR* and *Aquatabs* radio and TV spots. The same was done with posters.

PSI/ASF was among the participants in the 2012 International Fair of Kinshasa (FIKIN). This was a highly visible opportunity to exhibit PSI/ASF’s products and services, promoted and distributed with USAID funding.

In order to support behavior change communication efforts of other partners, reinforce collaboration and coordination, and prevent duplication of activities, PSI/ASF sent various communication materials produced under the AIDSTAR program (leaflets, posters, radio/TV spots and magazines) to the following programs of GDRC’s Ministry of Health (MoH): Programme National Multisectoriel de Lutte contre le SIDA (PNMLS), Programme National de la Santé de la Reproduction (PNSR), Programme National de Lutte contre les Maladies Diarrhéiques (PNLMD), Programme National de la Santé des Adolescents (PNSA).

**2012-2013:** Communication materials developed on CD and DVD and approved by the Ministry of Health were shared in Kinshasa with governmental partners (PNMLS, PNSR, and PNLMD) and partner implementing NGOs.

The script of the documentary on the AIDSTAR project was validated internally and externally by USAID. Then the film was edited and a final draft was presented to USAID in mid-September for feedback that was integrated for the finalization of the documentary.

## ***HIV/AIDS/STI***

The selection of local NGOs was done by Social Impact, one of the PSI&ASF’s subcontractors, according to their viability and capacity to implement project activities. A collaboration agreement was then signed with each of them and allowed the integration of the project activities in those NGOs programs. At the end of peer educators’ training session, the best peer educators were selected by trainers according to performance and trained as supervisors, so that there was one supervisor for 5

peer educators. These supervisors were in charge of supervising peer educators and reporting to local NGO's coordination.

A recruitment test was administered to preselected NGOs members by the PNLs and the PNMLS at provincial level. Qualified candidates were trained as peer educators by the PNLs and PNMLS. After training session, trained peer educators received materials for field activities (images, sensitization guide, fiche technique, etc.) and went on conducting 30 to 45-minute interpersonal communication sessions. Each peer educator had to sensitize 10 to 15 persons from her/his specific target group a month in four different sessions with different subjects. In order to be considered as reached by the message of sensitization, one had to assist to the four IPC sessions.

The peer educator data collection register was systematically filled with all the information at each session. At the end of the month, the monthly data collection form was filled and submitted to the supervisor who in turn compiled data from all the peer educators and submitted to the NGO's coordination. With all data collection forms received from supervisors, the coordination elaborated the local NGO's monthly report that was submitted to PSI/ASF. In addition to the interpersonal communication sessions, local NGOs organized monthly mass communication sessions for its specific target group. Other sensitization activities were organized by local NGOs during special events such as World AIDS day.

Specific approaches were used to address the different target groups.

#### *Youth aged 10-24*

Partnerships were made with local NGOs targeting youth in each project targeted province. Activities were implemented by peer educators selected among their NGOs' youth members and trained by the Government staff of the National Program for fight against HIV/AIDS at provincial level. Interpersonal communication sessions were held in schools and churches, with distribution of 100% *Jeune* magazine. During these sessions, peer educators' messages focused abstinence for youth not yet sexually active or return to abstinence for those who were already sexually active.

#### *FSWs and their clients*

The intervention for female commercial workers and their clients started with the identification and selection of local NGOs targeting female sex workers in the project targeted provinces. The selection of these partners took into account their experience in working with FSW and capacity to successfully implement the project. Interpersonal communication sessions were conducted at FSWs living and working sites. Peer educators' messages during these interpersonal communication sessions focused on correct and consistent use of condom, negotiation skills to convince the clients to use condoms. Other subjects developed during these sessions included STI contamination and prevention modes, HIV/AIDS contamination and prevention mode, voluntary counseling and testing, etc.

#### *Men who have sex with men (MSM)*

The intervention for men who have sex with other men (MSM) took place in Kinshasa as pilot. It started with the identification of this vulnerable group meeting sites and leader, holding meetings with MSM in site, identification of MSM candidates for peer education and selection of MSM peer educators. Before training, since this population was not organized in group, a local NGO was selected and asked to integrate MSM among its targets groups. Peer educators' messages during these interpersonal communication sessions were similar to IPC sessions targeting FSWs (messages to MARPs). Sometimes, lesbians participated to IP'C sessions.

### *Truckers*

The intervention for truckers started by making a partnership and signing a collaboration agreement with the “Association des Chauffeurs du Congo (ACCO)/Congo’s truck drivers Association” in all intervention sites except in Bukavu where the collaboration agreement was signed with “Transporteurs Arrêtent Sida” TRASI, a truck drivers association for fight against HIV/AIDS in Sud Kivu province. Peer educators’ messages during these interpersonal communication sessions focused messages to MARPs.

### *Military*

The intervention for military started by the collaboration agreement signed with the provincial coordination of PALS (Programme de l'Armée de Lutte contre le VIH/SIDA) and took place in two provinces: Bas Congo and Kasai Occidental because the other provinces targeted by the AIDSTAR program were already covered by the PSI&ASF's DoD-funded project. The selection of military peer educators' supervisors was done according to their performance and position in the army so that a supervisor should be among the military with the highest grade in the group. Next they were trained as supervisors, in charge of supervising peer educators and reporting to the PALS provincial coordination. Peer educators activities(IPC, mobile and forum video) in the field and data collection and reporting channel was the same as for other target groups.

### *Police*

The intervention for policemen started by making a partnership and signing a collaboration agreement with PMILS (Programme du Ministere de l'Interieur de Lutte contre le Sida). Peer educators activities (IPC, mobile and forum video) in the field and data collection and reporting channel was the same as for other target groups.

A post training supervision program was set up and implemented in collaboration with the Ministry of Health specialized programs (PNLS and PNMLS) and health zones. Conducted on a quarterly basis, the post training supervision program aimed at identifying field actors' (peer educators, supervisors and coordination) weakness at the level of theory and practice, and bringing technical support in order to improve the quality of our intervention for the benefit of Congolese communities.

**2009-2010:** No interpersonal communication activities were held in all targeted USAID provinces, as there was no budget allocated to these activities. Nevertheless, in all targeted provinces, sessions of mass communication activities were held using the mobile video for projections of film at night related to HIV/AIDS prevention. During these sessions, themes included safer sex behaviors, correct and consistent use of condoms and promotion of VCT were presented using participative approaches. Participants were encouraged to ask questions and obtain correct information about all topics cited above. They were also referred for STIs and to VCT health facilities.

**2010-2011:** After his recruitment in Q1 FY11, the technical representative from Social Impact traveled in Q2 to six USAID-intervention provinces to identify local NGOs using the developed and validated criteria. Based on the contract targets, 20 local NGOs were selected, among which 10 signed collaboration agreement with PSI/ASF. Thanks to the contribution of these newly selected NGOs, trained PEs’ conducted awareness activities, targeting the following groups: youth, police, military, miners, sex workers, and truckers.

A portion of the materials related to the advanced-strategy condoms distribution (*rural strategy*) including hats, bags for bikers to carry commodities, bibs for bikers were ordered and delivered during Q3 FY11.

PSI/ASF participated in the GDRC Fair “FIKIN 2011” with the following activities:

- Raising small groups awareness on HIV prevention
- Mass awareness campaigns through mobile video
- Demonstration of male and female condoms use
- Free distribution of *Prudence* male and female condoms

PSI/ASF completed the production of the first issue of the *100%Jeune* magazine after review and approval from USAID/DRC and MoH.



The first issue had a circulation of 7,000 copies and its main theme was about youth sexuality and abstinence tips. *100%Jeune* magazine was sold at \$1.09 to wholesalers and \$1.65 to final beneficiary. The price was on based on a willingness to pay survey.

The front page of the first issue of the *100%Jeune* magazine

**2011-2012:** After pretesting, *Prudence* male and female condoms’ new TV and radio spots, respectively named “Vrai Djo” and “Protection au féminin”, have been broadcast.

The film *Amah Dja Foule* (which raises CSWs awareness on condom use, VCT uptaking, and, if possible, quitting prostitution for other income-generating activities), produced by PSI Côte d’Ivoire and translated in four local languages (Lingala, Swahili, Tshiluba, and Kikongo), has been broadcast on national and local broadcasting channels.

Due to budget constraints, the short film to be screened outdoors for truckers was not produced.

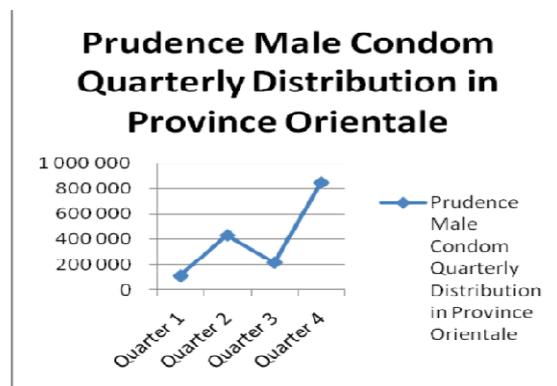
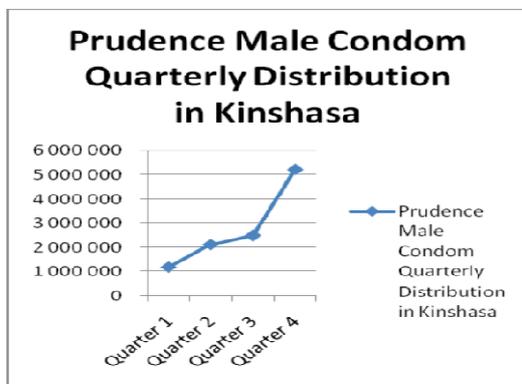
Billboards advertising the new *Prudence* condom and targeting the general population have been used in Kinshasa and Province Orientale. To reach truckers, billboards were placed on the following roads: Kinshasa/Bas-Congo, Lubumbashi/Kasumbalesa, Mbuji-Mayi/Kananga and Bukavu/Uvira.

*Prudence* male and female condoms’ new TV and radio spots, respectively named “Vrai Djo” and “Protection au féminin”, were developed and broadcast. Apart from radio and TV media, billboards were also used to increase the impact of this new campaign. As the graphs show below, the use of billboards, which started in Q3, had significantly increased male condom distribution both in Kinshasa and in Province Orientale.



Billboards promoting Prudence female (left) and Prudence male (right) were used to support communications efforts

**Graph 1: Influence of the use of billboards on *Prudence* male condom distribution**



### 100%Jeune

The launch ceremony of the *100%Jeune* magazine took place in Q2 FY12 in the presence of about 500 young people, as well as USAID’s representatives and other partners including youth opinion leaders. During this fiscal year, three issues were released.

The *100%Jeune* TV spot was broadcast on local and national TV channels to inform the public about the existence of the magazine as well as the release of the latest issue. This strategy helped to enhance the profile of this youth-focused magazine.

Youth clubs were set up in each province (Kinshasa, Katanga and Sud-Kivu) to ensure that after special events were held, there was ongoing awareness-raising through peer education.

Special youth-friendly activities were conducted such as “Génies en herbe” contest to test students’ general knowledge and the level of their knowledge of HIV and AIDS (in Sud Kivu), concerts (in Kinshasa and Lubumbashi), a big soccer game for pupils (in Katanga). This was done to educate youth through entertainment during the summer holidays, often an idle period for many of them. Youth were sensitized through the *100%Jeune* magazine and various talks on HIV prevention. Partner NGOs (AJIS, RACON), which target youth, and the city departments in charge of youth (Division urbaine de la jeunesse) were involved in the organization of these events.

## *IPC*

During this fiscal year, PSI/ASF organized refresher trainings for all the 10 NGOs it collaborates with in order to increase their capacity to conduct IPC sessions. Furthermore, seven other partner organizations were trained in Bukavu, Lubumbashi, Kananga, Mbuji-Mayi and Boma to continue awareness-raising campaign activities through IPC. Peer educators, who are members of partner NGOs, continued to conduct IPC sessions with project-targeted groups and mobile video sessions. They also consistently refer their peers to existing VCT centers in project-targeted provinces. A significant number of people were referred during PSI/ASF and ProVIC joint activities, since the presence of ProVIC's mobile VCT unit attracted more candidates to testing.

365 new PEs were selected and trained in collaboration with PNLS and local partner NGOs in 7 provinces (Bas-Congo, Kasai Oriental, Kasai Occidental, Katanga, Kinshasa, Province Orientale, and Sud-Kivu).

In collaboration with PNLS, PSI/ASF retrained 197 existing PEs out of the 200 who were scheduled to be trained, including 120 males and 77 females for gender purpose, to enhance the strategy of the delivery of prevention messages to target groups (youth, CSWs, truckers and uniformed personnel) in accordance with national standards. The 3 remaining PEs who were not available during the retraining period were trained by their supervisors.

During this fiscal year, refresher and training modules for PEs were updated thanks to the technical assistance provided by PSI/Rwanda. This update was also done in collaboration with the PNLS.

**2012-2013:** All the provinces had the reminder spots of the “Vrai Djo” and “La protection au féminin” Prudence campaigns broadcast on partner local and national channels to support Prudence products' sales activities.

The leaflet containing integrated HIV and FP messages was developed and distributed to targeted communities to counteract false beliefs regarding condoms and contraceptive methods.

Interpersonal and mass communication sessions with local implementing NGOs were conducted in project-targeted provinces. BCC activities coupled with mobile VCT in collaboration with ProVIC continued as a successful strategy and reach and test more people. Lessons learnt from each activity were used to address challenges during the service delivery.

As part of the *Prudence* product's life cycle, consumer studies were conducted and these revealed the need to have the brand evolve to a more comprehensive range in order to offer a variety of products that meet the evolving needs of target populations. However, given the short project's remaining time and the lack of guarantee that social marketing would continue after the AIDSTAR project, USAID recommended that PSI/ASF stop the launch of the *Prudence* range, consisting in current male and female condoms with an uplifted packaging and the scented male condoms. Indeed, it was deemed better not to create a demand that would not be met thereafter. USAID gave its consent only for the uplifting of the current packaging, not for the launch of new product (*Prudence Sensuel*). The production of the *Prudence* range packaging, communication/promotional materials and the launch were canceled and replaced by the production of packaging of the current *Prudence* in order to achieve the targets of project's condom social marketing. The existing stock of *Prudence Sensuel* is kept in PSI/ASF's main warehouse.

## *100%Jeune*

The implementation of the *100%Jeune* project revealed that most of the targeted youth (aged 14-25) were already sexually active. So, the best way of raising their awareness was to integrate reproductive health with HIV in the contents of the magazine. In addition, various testimonies gathered and published in 2012 indicated that young girls were vulnerable and exposed to risk. Thus, the magazine examined the dangers of early pregnancies and clandestine abortion. During this fiscal year, two issues were released.

PSI/ASF's team explored the feasibility of an electronic edition of the *100%Jeune* magazine taking into account some practical data. After analyzing the pros and cons, it was decided to continue releasing the paper magazine as downloading the entire magazine would be difficult in light of the limited technical possibilities working-class areas' cybercafés offer. Yet, PSI/ASF took full advantage of new communication technologies to promote the magazine via such tools as Facebook.

The number of followers on the Facebook profile of the magazine increased from 150 at the beginning of the fiscal year to 597 at the end of the project. PSI/ASF greatly used Facebook during activities such as the organization of the second edition of the Dictation Contest and the concert for closing all the activities in connection with that contest.



Pupils from Kinshasa's schools are passing the dictation contest organized by the *100%Jeune* team with USAID support

## ***Family Planning***

**2009-2010:** Messaging regarding HIV/STI prevention was always a core part of PSI/ASF's FP messaging and training. The dual protection of condoms (against unwanted pregnancies and HIV) was promoted by both the FP and HIV programs. Additionally, FP messaging (on product packaging, in provider trainings and IEC messages) clearly stated that all non-condom contraceptives do not protect against HIV/STIs.

Given the increasing popularity of the Zain carrier across DRC, PSI/ASF added it as a second carrier and second line to the FP hotline. The first successful calls were made on the hotline in June 2010 and the new number (099 300 30 01) was included, along with the existing Vodacom number (081 080 00 00) on all new IEC and provider materials being produced in Q3 2010. In addition, PSI/ASF tracks call levels to see if, as suspected, certain networks are more dominant in different parts of the country and that this will impact call levels per carrier.



The trained operators of the two FP hotlines used a dedicated software to computerize data related to calls received (socio demographic characteristics of callers, type of requests, etc) and spoke different local languages, depending on the one of the callers.

New materials for FP promotion were produced and distributed to health service providers in clinics and pharmacies of *Confiance* network.

In Q3 2010, the Family Planning program held its annual national retreat. The members of the family planning program in ten provinces (except Bandundu) attended the retreat. The retreat was co-funded with USAID and Dutch SALIN funds, and covered all aspects of the FP program. The retreat offered an important opportunity to reinforce the technical and administrative capacity of all FP team members, as well to share experiences and strategies for improved program implementation. During the four-day retreat, a number of crucial themes were presented and debated, including reminders of donor rules and regulations, including the Thiart Amendment and IEE regulations, the strategies for responding to rumors and for managing secondary effects from products and the presentation on the relationship between FP and Millennium Development Goals #4 and #5.

A total of 11 trainers (from PSI/ASF, the National Program for Reproductive Health (PNSR) and the 3rd Directory – Pharmacy and Drugs) and 63 health services providers and supervisors (from respective health zones and PNSR) for FP in both USAID and SALIN provinces were trained with Dutch SALIN funds for *Jadelle* insertion. Thus, the USAID-funded project didn't need to train providers for *Jadelle* insertion as they were already trained with Dutch SALIN funds.

**2010-2011:** During BCC activities, meetings with the *Confiance* network partners and FP training in all the targeted provinces, PSI/ASF-FP staff and community-based educators continued, promoting messages regarding the dual protection of condoms (against unwanted pregnancies and HIV/STI prevention). These messages were also included in some printed media, such as the flipchart, and in the training module.

Two TV spots (generic and branded) promoting FP, based on previous research results for evidence-based communication campaign, were developed with the Dutch SALIN funding after the PNSR approval.

In the reporting period, PSI/ASF translated a short-length film on FP with the Dutch SALIN funding in Swahili, which already existed in two languages (French and Lingala).

In order to support communication activities and make FP messages permanent in partner clinics, PSI/ASF provided them with TV sets with DVD players along with other necessary materials to continue broadcasting of the *Confiance* spot and the existing short film on FP for clients, patients or any other person waiting for any service. The clinics continued to play FP spots in their waiting rooms, promoting the adoption of modern and long-term FP methods.

IPC activities were conducted with the support of community-based educators, promoting the importance of FP on health, the location of service delivery points, the promotion of the hotline for questions related to clients care and the promotion of all methods including long-term methods. These activities were conducted during home visits and educational talks in local communities. Monthly analysis of the questions asked by the target populations continued to be carried out to improve IPC activities.

Counseling sessions, organized for couples or individuals of reproductive age in network clinics, created a framework for conversations on FP, its importance on health and on the available contraceptive methods including condoms, which offer dual protection, and long-term methods.

**2011-2012:** The *Confiance* products marketing plan was finalized with an emphasis on marketing strategies in order to improve the quality of services, the quality of supervisions, the demand creation, the increase of modern contraception methods utilization rate, the promotion of long-term methods as a cost-efficient strategy, the expansion of the *Confiance* network with recruitment of new clinics and the distribution to *Confiance*-labeled pharmacies via wholesalers. The *Confiance* marketing plan benefited from the technical assistance of PSI's Sexual Reproductive Health department.

The FP flipchart was revised during this fiscal year in collaboration with PNSR.

Existing FP generic spots were broadcast, and two radio programs that were recorded to leverage users' testimonials and correct false beliefs were aired in Kinshasa. PSI/ASF's provincial offices produced radio programs with different radio stations in their respective provinces in order to facilitate communication (spoken language and interactivity with listeners). The following themes were discussed during these programs: correcting false beliefs and addressing rumors, promoting FP and the *Confiance* range of FP products, involving men in FP, and testimonies from users of contraceptive methods.

**2012-2013:** To address frequently asked questions, PSI/ASF produced information leaflets addressing false beliefs related to various FP methods, including condoms. These leaflets were distributed to service providers and recipients.

The FP flipchart was developed, produced and distributed to all partner clinics of the *Confiance* network so that they can continue to educate women who attend ante-natal and preschool consultations.

Five posters on quality assurance protocols, which serve as reminders to FP providers, were produced and posted in partner clinics throughout project-targeted provinces. These posters deal with: 1) stages of infection control; 2) protocols for IUD insertion; 3) protocols for *Jadelle* insertion; 4) questions FP service providers can ask to rule out pregnancy; 5) protocols for post-partum IUD insertion. These posters were distributed to USAID- and CDC-supported e-MTCT health facilities and to PNSR.

Community-based educators were active in all the project-targeted areas. They conducted home visits, educational chats and participated in the community-based distribution of some FP methods such as oral contraceptives, CycleBeads, and condoms.

## Results

Due to IPC activities conducted with the support of community-based educators, a total of 1,947,587 persons were reached with the message about the importance of FP in health, the location of service delivery points, the promotion of the hotline for questions related to clients care and the promotion of all the methods including long-term ones. These activities were conducted during home visits and educational talks in local communities.

Table 11: Number of people reached through FP interpersonal communication, by province from October 2009 to September 2013

Provinces	Number of people reached through FP interpersonal communication										TOTAL
	FY10		FY 11		FY 12		FY 13		Total		
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	
KINSHASA	65 309	157 002	51360	147151	38983	99440	79310	173390	234 962	576 983	811 945
KATANGA	13 602	110 864	18668	107733	6413	43717	8820	50453	47 503	312 767	360 270
BAS CONGO	13 771	18 658	5 572	16 443	3 546	17 400	2 361	10 554	25 250	63 055	88 305
SUD KIVU	1 721	65 248	1 839	51 479	3 196	19 909	2 656	42 792	9 412	179 428	188 840
NORD KIVU	15 144	61 228	4 950	15 354	1 019	7 419	4 522	24 815	25 635	108 816	134 451
PROVINCE ORIENTALE	5 831	12 989	3 606	9275	3 413	11228	3 737	12885	16 587	46 377	62 964
EQUATEUR	4 897	17 169	2666	15502	1383	6564	525	2867	9 471	42 102	51 573
KASAI OCCIDENTAL	17 129	47 106	11 744	36 943	7 165	21 005	6 407	24 226	42 445	129 280	171 725
KASAI ORIENTAL			4 198	13 548	4 608	21 501	7 741	25 918	16 547	60 967	77 514
TOTAL PER SEX	137 404	490 264	104 603	413 428	69 726	248 183	116 079	367 900	427 812	1 519 775	
TOTAL	627 668		518 031		317 909		483 979		1 947 587		1 947 587

The PSI/ASF's field staff, the partners in the *Confiance* network, and the trained community-based educators promoted the two hotline numbers (+243 81 080 00 00 and +243 99 300 30 01) and distributed printed communication materials listing these hotline numbers so as to extend access to FP information to the targeted groups. They also referred potential users to the *Confiance* network's clinics and pharmacies for adequate support. A monthly analysis of the questions asked was carried out to improve IPC activities.

Table 12: Number of calls received by FP hotlines from October 2009 to September 2013

Number of calls received by FP hotline,											
Provinces	FY10		FY 11		FY 12		FY 13		Total		TOTAL
	Men	Women									
KINSHASA	1 491	849	1766	2052	2087	2555	1985	2878	7 329	8 334	15 663
KATANGA	4 920	438	3642	540	2751	427	2927	701	14 240	2 106	16 346
BAS CONGO	366	123	570	343	380	277	461	394	1 777	1 137	2 914
SUD KIVU	322	92	327	122	291	99	284	171	1 224	484	1 708
NORD KIVU	332	80	368	151	168	75	206	204	1 074	510	1 584
PROVINCE ORIENTALE	724	159	573	148	398	112	308	165	2 003	584	2 587
EQUATEUR	845	180	896	273	461	163	389	243	2 591	859	3 450
KASAI OCCIDENTAL	923	123	952	247	777	210	691	299	3 343	879	4 222
KASAI ORIENTAL			645	149	559	138	741	286	1 945	573	2 518
MANIEMA			1 131	165	444	46	264	72	1 839	283	2 122
BANDUNDU			637	189	623	220	701	292	1 961	701	2 662
OTHERS	1 394	274	0	0	1	1	0	0	1 395	275	1 670
TOTAL PER SEX	11 317	2 318	11 507	4 379	8 940	4 323	8 957	5 705	40 721	16 725	
TOTAL	13 635		15 886		13 263		14 662		57 446		57 446

Counseling sessions, organized for couples or individuals of reproductive age in network clinics, created a framework for extensive exchanges on FP, its importance in health and the available contraceptive methods including condoms, which offer dual protection. As shown in the following table, 401,010 people benefited from this service thanks to FP providers, indicating men's interest (15.5%) in birth spacing and prevention of unwanted pregnancies.

Table 13: Number of people reached through FP counseling activities, by province from October 2009 to September 2013

Number of people reached through FP counseling activities											
Provinces	FY10		FY 11		FY 12		FY 13		Total		TOTAL
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	
KINSHASA	6 617	33 238	3762	31261	5500	31055	8248	76927	24 127	172 481	196 608
KATANGA	759	11 336	1494	11259	1784	8094	1141	8269	5 178	38 958	44 136
BAS CONGO	775	6 112	1 183	5 796	1 108	3 071	142	482	3 208	15 461	18 669
SUD KIVU	223	5 743	207	5 903	2 162	2 787	216	5 193	2 808	19 626	22 434
NORD KIVU	192	8 202	1 031	2 244	135	2 022	240	3 528	1 598	15 996	17 594
PROVINCE ORIENTALE	540	1 472	667	1997	625	2198	604	3180	2 436	8 847	11 283
EQUATEUR	935	2 461	128	779	103	333	40	129	1 206	3 702	4 908
KASAI OCCIDENTAL	1 867	9 857	2 988	16 364	3 122	8 745	4 334	7 505	12 311	42 471	54 782
KASAI ORIENTAL			1 283	1 656	3 737	7 629	4 077	12 214	9 097	21 499	30 596
TOTAL PER SEX	11 908	78 421	12 743	77 259	18 276	65 934	19 042	117 427	61 969	339 041	
TOTAL	90 329		90 002		84 210		136 469		401 010		401 010

Of all clients who received care in partner service delivery points during this year, there were 183,289 new FP clients for modern contraceptive methods.

Table 14: Number of new FP clients, by province, from October 2009 to September 2013

Number of new FP clients											
Provinces	FY10		FY 11		FY 12		FY 13		Total		TOTAL
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	
KINSHASA	236	36 515	158	22440		9924		33984	394	102 863	103 257
KATANGA	374	3 020	662	2975		3462		3221	1 036	12 678	13 714
BAS CONGO	721	5 570	291	1 332		1 536		483	1 012	8 921	9 933
SUD KIVU	480	2 307	608	2 089		2 171		1 714	1 088	8 281	9 369
NORD KIVU	748	3 660	264	1 993		493		714	1 012	6 860	7 872
PROVINCE ORIENTALE	22	526	216	944		831		1720	238	4 021	4 259
EQUATEUR	60	1 491	0	6300		1257		484	60	9 532	9 592
KASAI OCCIDENTAL	93	2 562	1 525	5 987		4 031		4 137	1 618	16 717	18 335
KASAI ORIENTAL			333	1 344		2 454		2 827	333	6 625	6 958
TOTAL PER SEX	2 734	55 651	4 057	45 404		26 159		49 284	6 791	176 498	
TOTAL	58 385		49 461		26 159		49 284		183 289		183 289

## ***Maternal & Child Health***

**2009-2010:** Additional funds were leveraged with UNICEF (\$266,000), Procter and Gamble (\$372,000) and Pooled Fund (\$256,000) to respectively distribute 1 million tablets of *Aquatabs* in Nord Kivu, 4.4 million sachets of *PUR* nationwide, and 475,000 tablets of *Aquatabs* and 565,000 sachets of *PUR* in the province of Maniema.

Interpersonal communication sessions were performed in schools, churches, markets, health centers (during ante and post-natal sessions), to reach mothers of children under five, community leaders, students women associations.

World Water Day was celebrated in Kinshasa, Katanga, Bas Congo, Sud Kivu, Kasai Oriental and Kasai Occidental, on March 22nd in partnership with the Ministry of Health and UNICEF. Sensitizations focused on the safe drinking water to avoid waterborne disease. *PUR* and *Aquatabs* were proposed as the affordable short and midterm solution while infrastructures were considered long-term one.

Radio spots with messages related to safe drinking water, hygiene and sanitation promotion were aired through both rural and urban radio stations.

### **2010-2011:**

*CDK:* The short film for MVU and production of the new posters were completed and approved by USAID and the MoH.

*DTK (Ora-Zinc):* An experience-sharing visit to PSI/Benin was done in October 2010, funded by PSI Washington, to share lessons learned about promotional and communication activities, and tools during their DTK project implementation some years ago.

The *Ora-Zinc* marketing plan was completed thanks to the technical assistance of the PSI/Rwanda MCH team in Kigali, and had strategic priorities focusing on building the *Ora-Zinc* notoriety among the targeted population and the providers, its quality perception, and its coverage and access.

The community-based educators (CBE) training curriculum on diarrhea treatment, water, and sanitation was produced.

The generic “Diarrhea care communication campaign” concept creation, which would lead to the production of providers’ flipcharts, radio/TV spot, etc. was under development.

### **2011-2012:**

The CDK short film for MVU produced during FY11 was broadcast to increase communication impact and create demand.

*Ora-Zinc* and diarrhea radio/TV spots were produced. Communication materials (posters, leaflets, flipcharts, etc.) for the launch of the *Ora-Zinc*<sup>®</sup> campaign were finalized and produced.

### **2012-2013:**

The flipchart on diarrhea management was developed in collaboration with PNLMD and produced. It was not distributed during the life of the project as it was tied to the launch of *Ora-Zinc*.

The marketing plan, the communication plan and the materials related to the Ora-Zinc campaign were developed and produced. However, they were not used since the product was not received by PSI/ASF by the end of the project.

### ***Water and Sanitation***

**2010-2011:** Thanks to a Pooled Fund project in 3 rural health zones in Maniema (Lubutu, Obokote and Salamabila), IPC activities and radio spots broadcasting were done to expand household water treatment activities. It is the same situation in Mbandaka with P&G funding in 2 health zones (Wangata and Mbandaka). In Goma (Kiroche Health Zone), BCC activities were held in January and February when the UNICEF project closed.

A total of 1,634 interpersonal communication (IPC) sessions were conducted by communication agents in local markets, mobile video units, health clinics (during ante and post-natal sessions), churches and schools; and by community volunteers, with door to door awareness raising activities. A total of 308,719 people, including mothers and caregivers with children under five, students, etc., were reached.

Radio and TV spots with messages promoting safe drinking water, hygiene and sanitation were respectively aired 4,066 and 1,575 times through both rural and urban radio stations for behavior change communication and demand creation. In addition, 92 radio talks were organized by PSI/ASF provincial offices.

There was still a cholera outbreak in Equateur, Bandundu and Kinshasa. PSI/ASF, in partnership with the MoH and other partners involved in the WATSAN field (Unicef, MSF, WHO, Red Cross, etc.) conducted outreach activities with the community leaders (churches' leaders, ports' leaders, markets' leaders, etc.) in exposed and affected health zones. Cholera prevention messages (hand washing, water treatment before drinking, safe water storage, latrine use and cleaning and other hygienic behaviors) and treatment messages (directing identified and suspected patients to the treatment centers, rehydration, etc.) were selected for and used during awareness activities.

**2011-2012:** The training manual for community-based distribution agents was finalized with experts from the National Program for Diarrheal Diseases Control (PNLMD) and those from the MoH's General Secretariat and approved by the MoH.

In FY12, a total of 13,390 interpersonal communication (IPC) sessions were conducted by communication agents in local markets, mobile video units, health clinics (during ante and post-natal sessions), churches and schools; and by community volunteers, with door to door awareness raising activities. A total of 571,522 people, including mothers and caregivers with children under five, students, etc., were reached with messages on: household water treatment, water and diseases, drink potable water, protecting our children, safe water storage, healthy environment, etc.

Radio and TV spots with messages promoting safe drinking water, hygiene and sanitation were aired 405 and 270 times, respectively, on both rural and urban radio stations for behavior change communication and demand creation.

The broadcasting of the *PUR* children cartoon, produced with P&G funding and approved by the MoH during a workshop held at PSI/ASF's national office, was aired in December during the Christmas holidays so as to reach as many children as possible. The existing *PUR* TV spot was aired during the summer holidays.

New communication campaigns for *PUR* and *Aquatabs* were finalized and broadcast.

In October 2011 during a cholera outbreak, and in partnership with the MoH, PSI/ASF launched a free distribution campaign of about 600,000 sachets of *PUR* and heightened awareness in Kinshasa. This was done through a special activity, named "*12 jours avec l'eau potable*" (12 days with drinking water), for preventing cholera. All the households were targeted.

**2012-2013:** Communication activities regarding water treatment were organized. They were coupled with family planning communication activities as both of them have the same target, women. During these sessions, community-based educators reached these women, who are mostly mothers of children under five, with water-related messages.

A total of 207,606 people, including mothers and caregivers with children under five, students, etc., were reached with messages on: household water treatment, water and diseases, drink potable water, protecting our children, safe water storage, healthy environment, etc.

**OBJECTIVE 3: Develop and/or enhance the ability of commercial/private sector entities to socially market health products and services including behavior change communication activities.**

### *Cross-cutting*

**2009-2010 :** An ASF board of directors meeting was held with the participation of PSI Executive President, and led to the signature of the memorandum of understanding between PSI and ASF.

ASF benefited from six external financial audits: 4 for specific projects with other donor funds, the external inventory audit and the external global financial audit.

In order to reinforce provincial systems, ASF offices of Kinshasa and Bas Congo benefited from an assessment visit of systems (sales, inventory and finance) and key recommendations were identified to strengthen procedures and policies.

The subcontract of Social Impact (SI) and other work documents, such as the scope of work and work plans, were signed and agreed upon during the first year. The SI's Senior Organizational Development (OD) Specialist to deal with this capacity building in DRC was identified.

**2010-2011 :**The annual financial assessment and technical assistance was conducted by PSI's financial specialists (OFOG). Administrative, financial and managerial skills were reinforced for both PSI/ASF national and provincial levels. Also, the 2010 external financial audit was completed.

Preparation by SI of the questionnaire and the workshop methodology to be used during the missions to the provinces to assess selected NGOs' organizational capacity needs, and validated the needs identified in the questionnaire at a feedback workshop for their NGO. The feedback workshops also served as a mechanism for formulating the organizational capacity building plans (PARESCOs).

The selection of 10 NGOs in FY11 was successfully conducted with the collaboration of our partner, Social Impact. The following organizations were selected and trained, continued to conduct outreach activities in the field.

- For Katanga province: Dynamique des Femmes pour le Développement du Congo (DFDC) and Association des Jeunes Intellectuels Solidaires (AJIS)
- For Kasai Oriental province : Centre Féminin de Formation and d'Information pour le Développement (CEFIDE)
- For Kasai Occidental province : Women's Muakaji
- For Sud-Kivu province : Umoja Wa Manawake Wakulima Ya Kusini (UWAKI) and TRASI
- For Bas-Congo province : Bureau Femmes et Familles de l'Eglise du Christ au Congo-Bas Congo (BFF/ECC), Association pour la Promotion des Vulnérables, and Appui à la Mobilisation des Actions Communautaires (APROVEMAC)
- For the province capital city of Kinshasa : Réseau National des ONG pour le Développement de la Femme en RDC (RENADEF) and Centre de Développement et d'Appui à la Formation Professionnelle (CEDAPRO).

**2011-2012 :** All NGOs that received refresher training from PSI/ASF, and those that received in-service training, continued to conduct communication activities (IPC and MVU sessions) under the supervision of PSI/ASF communication staff.

During the second quarter, SI's activities were primarily focused on organizing and implementing feedback workshops to foster institutional buy-in among the nine NGOs of the Cohort 1, streamlining the results from the feedback workshops into a short-list of common organizational needs (Strategic planning, Results based management, Financial and administrative procedural manuals, Family planning and reproductive health, HIV prevention, advocacy and communication and Gender) and on drafting modules and tools for capacity building. During the third quarter SI focused on organizational capacity building, via Strategic Planning and Results Based Management (RBM) workshops for the nine partner NGOs of Cohort 1. Finally, in the fourth quarter the focus was primarily on completing and reviewing strategic plans and results frameworks from the nine ASF/PSI partner NGOs in Cohort 1 and planning for the second round of capacity building for the 11 NGOs in Cohort 2.

The ten additional local NGOs selected to implement activities of the AIDSTAR program were:

- For Katanga province: Réseau des Femmes pour le Développement (REFED) and Jeunes Anti Maladies Sexuellement Transmissibles (JAMST)
- For Kasai Oriental province :Confédération congolaise pour le Développement Intégral en faveur de la Femme et des enfants (CODIFE)
- For Kasai Occidental province : Femme Plus
- For Sud-Kivu province : Solidarité des Femmes pour le Développement Intégré (SOFEDI) and Fondation Solidarité des Femmes (FSH)
- For the province capital city of Kinshasa : HALT SIDA and Ensemble Luttons Contre le SIDA (ELCOS)
- For Province Orientale: Parlons SIDA and Equipe d'Urgence pour la Biodiversité (EUB).

At the request of USAID, PSI/ASF contributed to the implementation of the “FP capacity building for PMTCT acceleration plan” by providing FP training to 456 providers and supervisors, from USAID's partner (ProVIC) and CDC's partners (UNC, EGPAF and ICAP). Moreover, the supervisors received

additional training on facilitative supervision and training techniques to ensure continued skill-strengthening of their partners who implement FP activities.

**2012-2013 :** In collaboration with PNLS, PNMLS and HZs, technical meetings for validating data were held each month with 20 partner NGOs and 12 associations that implement communication activities in Kinshasa, Katanga, Province Orientale, Sud-Kivu, Bas-Congo and Kasai Oriental.

In collaboration with PNLS, PNMLS and HZs, post-training sessions with trained PEs and supervisors, implementing partner NGOs members, etc. were held on integrated communication techniques and data quality assurance in all six provinces: Lubumbashi (Katanga), Kinshasa, Kisangani (Province Orientale), Bukavu (Sud-Kivu), Mbuji-Mayi (Kasai Oriental), Matadi and Boma (Bas-Congo).

Technical meetings with CBEs and FP service providers from *Confiance* network clinics were held in various locations for their continuous capacity building and improvement of services they deliver. The following topics were discussed: management of waste generated by FP service delivery, from the FP counseling room to the site of destruction (incinerator or pits); operation of the communication tree for the management of major complications resulting from the administration of long-acting contraceptive methods; persistence of free-distribution stocks of generic contraceptive products in the network's clinics, these products from some public-sector FP stakeholders were found in PSI/ASF's partner clinics as a result of the campaign for the celebration of the 2012 World Contraception Day; and overlapping in the supply of contraceptives in some network's clinics that were targeted by PMTCT partners, such as the case of ICAP in Kinshasa.

The Post-partum IUD (PPIUD) insertions pilot phase got started. First, five public-sector health facilities in Kinshasa (Hôpital Roi Baudouin, Maternité de Kintambo, and Mother and Child centers in Ngaba, Barumbu and Bumbu) were identified as PPIUD clinics in collaboration with the Provincial Inspection of the MoH and PNSR's Provincial Coordination. Then, thanks to the technical support from the PPIUD trainers who were trained in September 2012, 10 FP clinic providers were trained on techniques of post partum IUD insertion started delivering this service. PSI/ASF's clinic managers from the Kinshasa office conducted post-training follow up targeting the newly trained providers to ensure that they complied with protocols of caring for women who are eligible for this method.

With the technical support of PNSR and SCOGO, the FP basic training which started during project's Year 3, continued for the capacity building of 380 providers from clinics supported by UNC, EGPAF, ICAP and ProVIC. Sessions took place in Kinshasa, Katanga, Province Orientale, Bas-Congo and Sud-Kivu.

The 2013-2017 ASF's strategic plan, which was developed during a four-day workshop held in November with the technical assistance of PSI, was approved by ASF's Board at its April 2013's meeting. This plan identifies the strategic direction for ASF over the next five years. It is based on an analysis of the internal and external environment of ASF, results of a stakeholder survey and a review of the PSI global strategic plan.

In the first quarter, SI's activities were primarily focused on designing financial and administrative procedural manuals with four Cohort 1 NGOs, preparing for the Training of Trainers (TOT) - to equip SI consultants and ASF staff members to be organizational coaches based in the provinces and launching the second round of organizational capacity building for 11 partner NGOs. During the second and the third quarters, SI's main activities were to complete financial and administrative procedure manuals with remaining Cohort 1 NGOs, carry out the coaching TOT workshop, design and

test out the website that was created to help maintain contact between NGOs in the different provinces even after the project ends. In the last quarter, the focus was mainly on finalizing strategic plans and carrying out closeout activities.

The capacity building activity took place in Kinshasa, Katanga, Kasai Occidental, Kasai Oriental, Sud-Kivu, Bas-Congo and Province Orientale, and below are its main accomplishments:

- The SI team engaged more than 600 NGO participants in its capacity building activities, including organizational diagnoses, designing capacity development plans, developing strategic plans, writing administrative and financial procedure manuals, and publicly receiving an oath from the NGO's management team to service their respective communities according to the approved manual.
- 12 provincial coaches and 16 ASF staff were trained in coaching to assist NGOs in programmatic and financial management and coach them according their organizational mandate and objectives.
- A "Training of Trainers" coaching curriculum was designed and written to be distributed via the project designed website to partner NGOs.
- A website was developed to keep partner NGOs linked together and all them to exchange experiences as continue to partner with ASF.

Partner NGOs are now distributing ASF products and receiving resources from this activity.

### ***HIV/AIDS/STI***

**2009-2010 :**The ASF's sales agents continued to conduct visits to wholesalers and points of sales to check product availability and merchandising, to verify the respect of price structure, and to train new clients on-site.

35 meetings were held with wholesalers and local partner organizations throughout all the six USAID-targeted sites. These meetings offered opportunities to strengthen capacities in social marketing.

**2010-2011 :**PSI/ASF's sale agents continued carrying out visits to wholesalers and points of sale and extended these visits to rural areas, checking product availability and merchandising as well as verifying the respect of the price structure and informing new clients on site.

PSI/ASF continued to maintain the new distribution approach, taking into account wholesalers, semi wholesalers and retailers, following the fast moving consumer goods channel, with targeted promotion and advertising.

US Ambassador in DRC visited USG-funded activities in Bas-Congo province, including PSI/ASF and ProVIC and especially collaboration between the two organizations and coordination of their activities in the field. Happy with the visit, he encouraged both teams to closely work together for the province population's well being.

As part of PSI/ASF's staff capacity building, scheduled in the project, an STTA was conducted in June for HIV and Marketing departments. This capacity building focused on the following points: review the DELTA marketing process for both male and female condoms and contribute to completing the marketing plan ; reinforce the HIV department strategies and interventions in liaison with new HIV priorities, high quality IPC activities, and training curriculum ; and assess existing training modules for peer educators/community-based agents and supervisors and give clear recommendations to improve these documents, in liaison with project objectives and logical framework

## ***Maternal & Child Health***

**2009-2010:** Final detailed scope of work and operational plan for CDK spin-off was discussed and validated with PSI/ASF's sub contractor, Hope Consulting, prior to their arrival in the DRC to conduct the survey on the situational analysis of the Fast Moving Commercial Goods distribution network and CDK spin off.

**2010-2011:** A willingness to pay survey for CDKs was conducted by HOPE Consulting, one of PSI/ASF subcontractors under this project. The results showed that:

- Use of health services drops off significantly when service fees rise above \$1.50 per consultation;
- If we assume that individuals will not want to pay more for products that are used during health services than for the health services themselves, the average Congolese is not likely to be willing to pay \$2.50 per CDK.

In addition, the assessment conducted by Hope Consulting revealed that no private company would be interested in taking up the CDK distribution because of its low profit margin. Based on these findings, PSI/ASF sent a letter to the COTR in late 2011, explaining that CDK's spinning off will not be possible even if it was a strategy chosen under the AIDSTAR contract. PSI/ASF abandoned the spin off strategy and continued to distribute the remaining stocks of CDK.

## ***Water and Sanitation***

**2009-2010:** PSI/ASF continued to maintain the new distribution approach, taking into account wholesalers, semi wholesalers and retailers, following the fast consuming goods channel, with targeted promotion and advertising.

**OBJECTIVE 4: Integrate service delivery and other activities, emphasizing prevention, at national, provincial, district, facility, and community levels through joint planning with the GDRC, other United States Government (USG), and non-USG partners.**

## ***Cross-Cutting***

During the life of the project, technical meetings were held with the USAID/DRC specialists and the COTR on specific topics such as AIDSTAR kick-off meeting, commodities planning, introduction for COP, project monitoring, project achievements, review PEPFAR audit's recommendations, and address commodities issues, specific challenges encountered during project implementation and solutions, etc.

**2009-2010 :** Discussions were performed with team partners (Hope Consultancy, Social Impact and QED) to finalize sub contracts scopes of work, budgets and work plans, and provide technical assistance.

During the provincial leaders workshop held in November 2009, strategies to integrate activities at the provincial level were raised. Based on experiences cumulated and lessons learned shared between provinces during the implementation of HIV (# 623-A-00-05-00341- 00) and FP (GHS-A-00-04-00009-00) previous cooperative agreements, field roll out was planned with all programs technical advisors, head of administration and finance, project COP and PSI Country Representative. This opportunity was seized to discuss selection criteria for NGOs which will be reinforced by Hope Consulting under this program. A list of potential NGOs was selected.

PSI FP technical team participated in early December 2009 in a national conference held in Kinshasa, under the leadership of the Reproductive Health National Program in coordination (PNRS) with USAID and UNFPA, for FP repositioning in DRC. Accordingly to Millennium Objectives, advocacy was made to policy makers and donors to revitalize FP interventions.

PSI/ASF attended actively five meetings organized by the PNMLS in Kinshasa in the framework of “condoms panel” to improve coordination of condoms distribution between stakeholders in DRC. These meetings gathered many organizations including USAID, UNFPA, SANRU, CORDAID.

In addition, quarterly meetings including provincial condoms panels and M&E panels were held in all the 6 USAID targeted provinces under the leadership of PNMLS to reinforce partnership and to follow up improving of coordination of HIV interventions.

Lessons learned from previous USAID-funded HIV/AIDS and Family Planning projects were gathered, discussed with field teams and integrated in strategies during FY10.

In order to update the FP interventions in DRC, PSI/ASF attended a USAID-funded training held by C-Change and targeting journalists about FP communication methods. Management and Leadership was another training theme developed by C-Change to which PSI/ASF attended too. This latter training led to the proposals how to implement the recommendations of the FP Repositioning National Conference held in December 2009.

Four PSI/ASF program managers and researchers attended the « Monitoring and Evaluation » workshop held by the PSI Western and Central Africa Regional Research & Metrics department in Abidjan during August 2010. This workshop provided tools to both researchers and programmatic key persons to improve project monitoring and evaluation.

PSI/ASF attended the Comité Intersectoriel de Lutte contre le Choléra (CILC) weekly meetings, along with the Comité National d’Action Eau et Assainissement (CNAEA), the Ministry of Health (4th Directorate – Diseases Directorate), UNICEF. Strategic plan against ongoing cholera outbreaks was discussed.

Meetings with ORS/Zinc task force partners (UNICEF, MCHIP, PNLMD, WHO, Kinshasa University Clinics, ...) were held in Q4 to schedule the DTK launch during the FY11 project implementation taking into account the existing on field.

ASF attended the cluster watsan monthly meeting lead by UNICEF with the other watsan partners. The watsan humanitarian strategic plan for 2011 and the 2010 second round of Pooled Fund funding were discussed. No fund for POU product distribution was scheduled for July to December 2010 period by Pooled Fund. The selected projects targeted infrastructures activities such as wells, sources, latrines, etc.

**2010-2011 :** In December 2010, in order to contribute to the RH/FP interventions in DRC, PSI/ASF attended a workshop led by MoH to validate the strategic plan and the waybill to speed up the reduction of the maternal, neonatal and infantile mortality in DRC.

At the national level, PSI/ASF attended meetings of the Monitoring and Evaluation Task Force under the coordination of PNMLS, so as to improve HIV data collection and transmission in accordance to national needs.

PSI/ASF attended the Comité Intersectoriel de Lutte contre le Choléra (CILC) weekly meetings. A strategic plan against ongoing cholera outbreaks, the CILC Regulation, the CILC 2011 Work Plan, and the global 2010 cholera epidemiology were part of the discussions.

PSI/ASF attended the cluster WATSAN monthly meetings for water and sanitation activities' coordination at national and provincial levels with other WATSAN partners and some of the Pooled Fund donors' representatives (ECHO, UNDP).

In order to contribute to the RH/FP interventions in DRC, PSI/ASF's staff attended the meeting on the development of FP stakeholders and interventions mapping which was held in March 2011 under the PNSR lead.

As part of the collaboration with partners intervening in the FP field, PSI/ASF attended a workshop that C-Change organized in Kisantu, Bas Congo, in March 2011 on the development of the communication strategic plan for social and behavior changes in connection with RH/FP. This workshop, which benefited from the participation of the majority of partners who were active in the RH/FP field, is part of the donor's vision to develop a collaborative mechanism for the implementation of USAID-funded activities.

PSI/ASF attended two meetings with the IHP implementing partners, C-Change and OSC about communication tools sharing and setting up a common communication strategy that will take into account the specificity of each of the partners so as to increase the impact.

PSI/ASF attended the CNAEA "Water and Sanitation Open Days" 2011 to monitor the achievement of the WATSAN MDG in DRC as of 2015. It was concluded that DRC still had a long way to go before achieving the water and sanitation MDG which is 49% of 2015 because only 26% of Congolese had access to safe drinking water and 14% to sanitation, leading to the spreading of waterborne diseases including cholera.

In June 2011, PSI/ASF was part of a joint mission to Kisangani by PEPFAR- USG implementing partners to analyze gaps so as to coordinate HIV project expansion activities. Following this mission, a joint action plan was developed and presented it to GDRC and USAID/DRC.

PSI/ASF attended the IMCI experience workshop in DRC organized by WHO in partnership with health sector NGOs and UN agencies.

**2011-2012 :** In April 2012, a delegation from USAID carried out a supervision visit of activities implemented in Kolwezi and Kasumbalesa by its partners (IHP, ProVIC and PSI/ASF). The delegation recommended that PSI/ASF's provincial office speed up the implementation of the rural strategy and make necessary efforts to catch up the delay in achieving project indicators' targets. They also encouraged close collaboration with other partners.

PSI/ASF organized workshops with the MoH and other partners involved in child survival interventions to develop a strategic plan to scale-up effective treatment of pneumonia, diarrhea and malaria, focusing specifically on pneumonia and diarrhea, because there was less funding available for their treatment. The scale-up was scheduled to take place through both the public and private sector and at the community level. This initiative (named Essential Medicines Initiative) was supported by a high-level working group under the leadership of UNICEF and with participation from the Bill and Melinda Gates Foundation (BMGF), the Clinton Health Access Initiative (CHAI), the United Nations Secretary

General Special Envoy for malaria (UNSE), Population Services International (PSI), John Snow, Inc, (JSI), Management Sciences for Health (MSH) and other partners. The main goal of the initiative is to achieve the Millennium Development Goals 4 (MDG 4) consisting in reducing child mortality to 66/1,000. Ten high-burden countries (India, Nigeria, The Democratic Republic of Congo, Pakistan, Ethiopia, Tanzania, Uganda, Bangladesh, Kenya and Niger) with around 60% of child mortality are targeted by this initiative. In DRC, PSI/ASF was chosen by the international working group as the focal point to lead the discussion and develop the nationwide distribution plan.

The Minister of Health sent a letter to Katanga's mining companies to encourage them to collaborate with PSI/ASF to conduct activities that will improve their populations' health. Some of them expressed their interest after receiving a concept note from PSI/ASF.

PSI/ASF held one Board of Directors' meeting during which the list of the members was revised in order to have a more representative and open board, and the achievements of ASF's institutional development were presented. This took place in October 2011 during the visit of PSI CEO to DRC. He also visited the USAID/DRC mission.

PSI/ASF participated in different workshops organized in provinces under PNLMS' coordination to evaluate HIV activities and to prepare the operational plan for 2012.

Coordination meetings were held with PNMLS, PNLs and other partner NGOs in Lubumbashi, Mbuji-Mayi, Matadi and Bukavu to ensure post-training follow-up of partner NGOs' peer educators. The aim was to assess the implementation of recommendations from post-training supervision.

PSI/ASF and ProVIC held joint activities during the PEPFAR Deputy Principals' site visits in January 2012 and at the Kinshasa International Fair, in August 2012.

PSI/ASF's FP staff attended meetings of the Permanent Multisectoral Technical Committee, which was established for advocating the repositioning of FP in DRC. This indicated that PSI/ASF contributes to GDRC's efforts in that matter. One of the items on the agenda of the Committee's meeting in August 2012 was the debriefing on the joint business trip (PSI/ASF, PNSR and SCOGO) made at PSI/Zambia early August 2012 to get informed about PPIUD success factors in Zambia.

PSI/ASF attended the October WATSAN cluster monthly meetings under UNICEF's lead. These meetings were mainly focused on the cholera outbreak in DRC.

**2012-2013:** In May 2013, the COR made a supervision trip in Kisangani including a visit to one of PSI/ASF's partner FP clinics, the attendance of an IPC session conducted by one of PSI/ASF's local partner NGOs targeting youth and a meeting with the coordinating committee of a local partner NGO targeting CSWs.

PSI/ASF's offices in Kinshasa, Province Orientale, Kasai Oriental and Katanga participated in their respective provinces in meetings for the development of HZs operational action plans. During these meetings, PSI/ASF's data were also taken into account.

PSI/ASF participated in HZs periodic reviews, shared its achievements to harmonize data generated by PSI/ASF in the HZ's database and for the presentation of the HZs' operational action plan by the management committee.

Coordination meetings with other USAID partners were held in Province Orientale, Katanga and Bas-Congo. The discussions were about activities implementation, supervision and coordination of activities with a visiting USAID team in these provinces.

This year, PSI/ASF's participation to international health days offered opportunities to coordinate with the MoH and other partners for advocacy and behavior change communication.

During this year, PSI/ASF participated in various thematic meetings and workshops both at the national and the provincial levels: WASH cluster meetings, workshops on development of the "Action Plan for Eliminating Bottlenecks to Access to Thirteen Life-Saving Commodities for Women and Children" in DRC, the 2011-2012 workshop for the evaluation of the fight against cholera, the sub-regional workshop on the development of 2013-2017 strategic plan for eliminating cholera in DRC, meeting organized by PNLS about the analysis of HIV epidemiologic data for developing DRC's HIV profile, meeting organized by PNMLS for reviewing the national HIV multi-sectorial strategic plan, workshop for writing the DRC's FP multi-sectorial strategic plan, the meeting of the coalition of FP stakeholders operating in Kinshasa, etc.

## V. RESEARCH, MONITORING AND EVALUATION

### Research

During the life of the project, PSI/ASF based its interventions upon evidence resulting from research findings. These research activities enabled programs to continually adjust what needed to in order to achieve initially set results and objectives and, most importantly, improve their interventions by making evidence-based decisions.

Indeed, several qualitative and quantitative surveys were conducted, and the information they generated helped decision-makers grasp the perception of target groups about the quality of project's products and services, identify factors associated with the use of products and services, measure at what level target groups are exposed to project's interventions in order to develop/adjust strategies, actions and messages that fit their real needs. All surveys requiring human participants obtained prior approval from the DRC Ethics Board. All communication materials produced and / or used under this program were first pre-tested with different target groups and adapted according to their feedback.

These are some of the *qualitative surveys* that were conducted:

- Evaluation of service quality in the *Confiance* network's clinics located in Kinshasa and Mbuji-Mayi (FP Exit Interview), 2012: this survey had to determine FP clients' perception of service quality in 58 clinics that deliver family planning service with the support of the AIDSTAR (44 in Kinshasa and 14 in Mbuji-Mayi). The main findings of the survey show that globally the service quality was considered good by FP clients who were interviewed. About 90% of them were satisfied with their reception at clinics, privacy during consultation, interaction with and explanations from service providers. In addition, more than 80% of them were also satisfied with the billing rate and the waiting time. These results suggest that if these clinics are still supported, they will further improve the quality of their services.

- Perception of male condom brand by urban population aged 25-45 in Kinshasa and Lubumbashi (FoQus on Marketing Planning), 2012: The survey consisted in collecting useful information for evolving the positioning of *Prudence* male condom so that it can be perfectly in line with current aspirations and expectations of consumers, thereby promoting this condom brand. According to the findings of the survey, most of the interviewees felt that *Prudence* male condom is a good quality brand and it is effective not only in protecting against HIV/AIDS, but also in preventing unwanted pregnancies. However, interviewees suggested that the improvement of *Prudence* male condom requires a reduction of its lubricant quantity and of the thickness of the rubber.
- Motivation to use female condom by women inhabiting Kinshasa, Lubumbashi and Mbuji - Mayi (FoQus on Segmentation), 2013: The goal of this study was to understand the real reasons of female condom use by women aged 18-45 in PSI/ASF's intervention areas to better understand their needs. Results show that many participants agreed that they buy female condoms to protect against STIs, including HIV/AIDS, and to prevent unwanted pregnancies. They also claimed that this condom provides more pleasure, does not tear during sexual intercourse and makes you feel body contact. However, some interviewees reported that the condom is difficult to use, its ring hurts during sexual intercourse and that women who use it are considered as less serious (thus, there was a problem of stigma that PSI/ASF's Marketing Department addressed through actions and awareness messages for the adoption of healthy behavior).

As for *quantitative surveys* that were conducted, the following ones can be mentioned:

- Survey on the willingness to pay *Prudence* male condom in sales outlets (Experimental approach on prices), December 2012- March 2013: The information from this research had to help PSI/ASF's authorities to review the price of *Prudence* male condom based on a reliable method of forecasting the effects of price changes on product demand by final consumers. Data were collected in Kinshasa at 463 pharmacies and in Lubumbashi at 265 pharmacies, which means that a total of 728 pharmacies participated in the survey. Main findings indicate that most (88.6%) of pharmacies in Kinshasa and Lubumbashi sell *Prudence* male condom at 100 Congolese Francs (CDF), i.e. US\$ 0.104. During the experimental phase, sales outlets were divided in three groups that were assigned each the following prices: 100 CDF, 200 CDF and 300 CDF. After this phase, it was found that selling *Prudence* male condom at 200 CDF did not affect condom demand in sales outlets that were assigned that price. However, the demand for *Prudence* male condom significantly decreased in the 300 CDF group. Basically, these results suggest that if the price is to be increased, that should not exceed 200 CDF, because beyond this price the demand significantly declined.
- Survey on measuring access and performance (MAP) in Democratic Republic of the Congo, 2013: This MAP survey aimed at evaluating the access and availability of social marketing products which are distributed by PSI/ASF, namely *Prudence* male and female condoms, *Confiance* contraceptives and water purifiers (Pur and Aquatabs). Findings indicate that *Prudence* male and female condoms are available and accessible in sales outlets of the provinces that were visited. *Prudence* male condom was found in over 60% of outlets visited, and *Prudence* female condom in 13% of them. In addition, *Confiance* products, such as IUD, CycleBeads and Jadelle, are found more in PSI/ASF's partner pharmacies, at drug sellers' and public health centers than at sales outlets. It is so because these products are considered "ethical" as one needs a medical prescription or a recommendation from qualified health staff to

acquire them. At last, water purifiers are present with a penetration rate (i.e. ratio of number of sales outlets that usually sell the product and the number of sales outlets visited during the survey) at the national level of 10.3% for *PUR* and 18% for *Aquatabs*. It should be mentioned that *Aquatabs* is mostly sold by drugs sellers and PSI/ASF's partner pharmacies whereas *Pur* is sold in great quantities by pharmacies (PSI/ASF's partner pharmacies on top) and street vendors.

## **Monitoring and Evaluation (M&E)**

In order to measure the progress achieved in implementing the AIDSTAR program, PSI/ASF set up a monitoring and evaluation system that involves PSI/ASF staff and all the program stakeholders at all levels. Supervision trips were conducted at three levels for continuous capacity building and project monitoring: 1.) short term technical assistance by PSI experts from various PSI countries and PSI Headquarters to DRC platform, 2.) by PSI DRC national level to provinces, and 3.) by provincial technical teams to field actors.

QED, a US-based business, was subcontracted to provide technical assistance for performance monitoring and evaluation plan (PMEP) development, during development and implementation of baseline data collection and a mid-term project evaluation in project's Year 3. QED reviewed and evaluated project indicators and the M&E plan, providing written feedback and technical guidance. Projects indicators and PMEP were revised accordingly, before submission to USAID mission.

PSI/ASF's M&E staff, namely the M&E Specialist and his deputy participated in a regional research training organized by PSI in Douala – Cameroon at the beginning of the program. Training consisted in building capacity in data quality insurance, protocol writing and data analysis methods. PSI/ASF also built M&E provincial managers capacity to improve their skills in monitoring-evaluation of distribution and communication activities carried out by local NGOs and partner clinics that worked with PSI/ASF in the implementation of project's activities. This training offered a good opportunity to harmonize and understand indicators that are used and reported against as well as standardizing tools for collecting and reporting data.

The Research Department developed the integrated supervisory and reporting tool. This tool was used during several supervision trips which were conducted at three levels for continuous capacity building and project monitoring such as short term technical assistances by PSI experts from various PSI countries, PSI Headquarters to DRC platform, by PSI/ASF national level to provinces and by provincial technical teams to field actors.

In that vein, regular supervisions were carried out by PSI/ASF staff in USAID-supported sites with focus on IEE regulations, quality insurance of counseling and FP care given to clients in the *Confiance* network partner clinics and pharmacies. These regular visits, with particular emphasis on micro trainings, helped to improve the capacity of PSI/ASF-trained providers. They also served to regularly supply network members in order to ensure contraceptive methods availability. Apart from frequent visits to partner service delivery points (and trained providers) conducted by PSI/ASF's provincial staff in the areas of intervention, satisfactory national supervision visits took place in Kinshasa, Katanga, Bas-Congo, Sud-Kivu and both Kasais to ensure the smooth running of activities at the operational level. Their goal was not only to support trained providers in their daily activities, but also to strengthen the existing collaboration with the government in order to achieve the assigned objectives to benefit the target population. Recommendations made were shared with field staff and monitored for improvement of performance. In addition, an internal audit was conducted in Sud-Kivu in the last

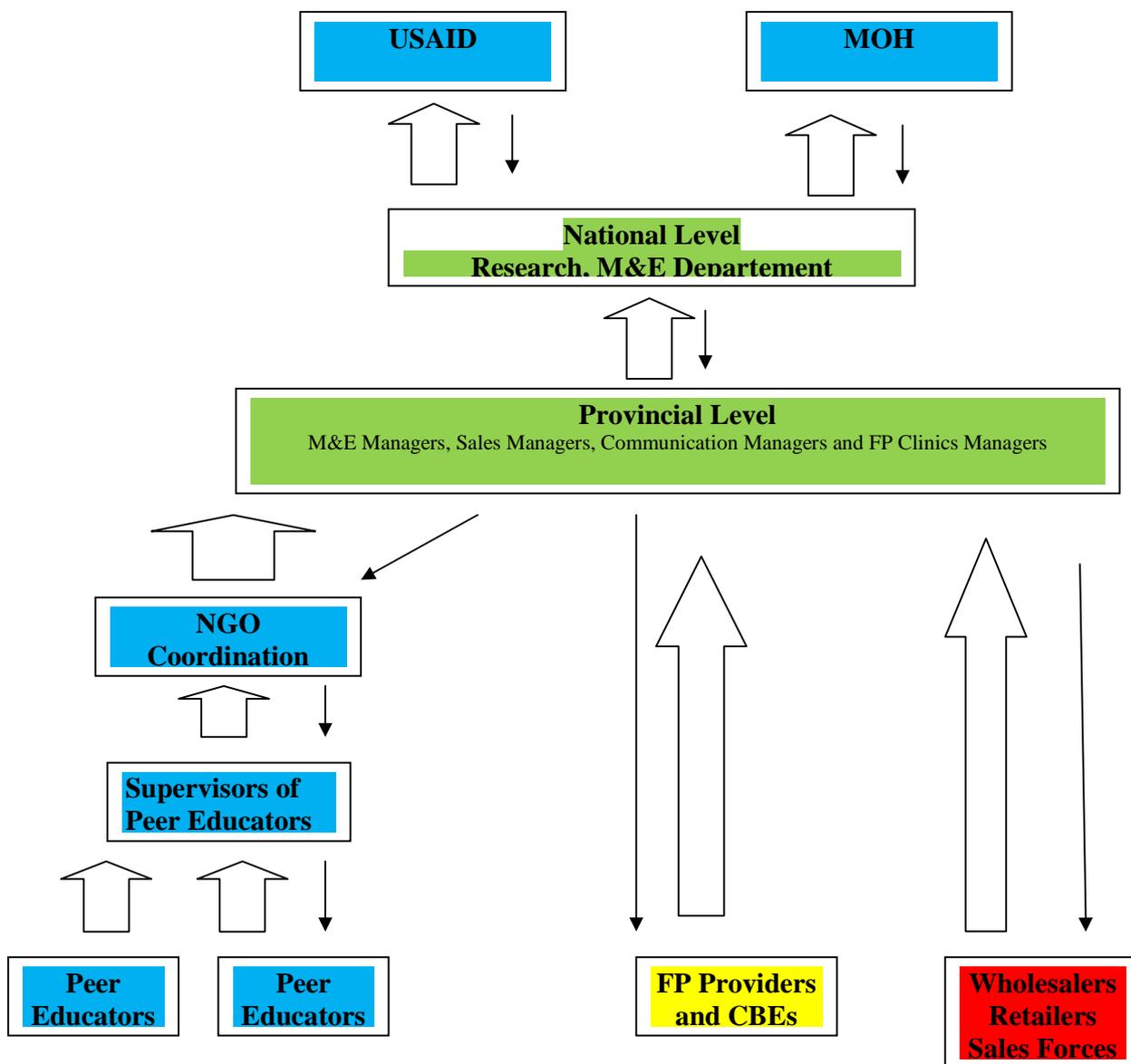
quarter of FY13 by PSI/ASF's technical staff from Kinshasa. Its findings revealed a satisfactory level of partnership with the clinics that were visited, the interest of the clinics' managers to continue offering FP service for the benefit of clients, and the compliance with standards of quality service.

Joint supervisions were conducted in all project-targeted provinces with the MoH's specialized programs including PNLS, PNMLS, PNSR, PNLMD, the involved HZ's management teams, coordinating teams of and supervisors from local NGOs in charge of implementing BCC activities and partner clinics. The purpose was to improve the quality of interventions, share new guidelines regarding the participatory approach, techniques and principles of IPC in peer education and community-based educators, make sure national health policies are adhered to, etc.

In order to evaluate the quality of FP service in the *Confiance* network's clinics, an internal audit was conducted in Sud-Kivu by PSI/ASF's technical staff from Kinshasa. Its findings revealed a satisfactory level of partnership with the clinics that were visited, the interest of the clinics' managers to continue offering FP service for the benefit of clients, and the compliance with standards of quality service. The most important areas for improvement were related to the management of biomedical waste and the good use of data collection tools.

It should be noted that an *external evaluation* (mid-term evaluation) of the project was conducted in project's Year 3 to systematically and objectively assess progress made in achieving the objectives that were assigned to this social marketing project in DRC. QED was initially subcontracted to perform, among its expected deliverables, this evaluation but could not because of a conflict of interest after being awarded with an IQC with USAID (as stated in Amendment 3 of the USAID Global Health Technical Assistance RFP, solicitation number SOL-OAA-12-000025). Thus, USAID recruited a team of three evaluators: an international consultant and two local consultants to conduct the mid-term evaluation. They used a qualitative approach to collect data relevant to this evaluation. To this end, they conducted 30 focus groups in 4 project-targeted provinces (Kinshasa, Bas-Congo, Katanga and Kasai Oriental); they also conducted extensive consultations with key individuals as well as documentary reviews. Their findings showed that PSI/ASF adequately achieved the objectives of this social marketing project. However, they found that, given PSI/ASF's comparative advantage in terms of experience in social marketing and its control of the Congolese market, PSI/ASF could do or go beyond its accomplishments. And that is what PSI/ASF endeavored to do after the mid-term evaluation.

As regards reporting, data collection frequency varied according to program, type of report and level of reporting on the information channel. In general, programs data were transmitted on a weekly and monthly basis by field actors to provincial M&E managers. After compiling and analyzing these data, these managers transmitted them to the national level M&E specialist. The latter treated them and shared his report with USAID on a quarterly and annual basis, and with MoH. Below is the internal data collection chart:



AIDSTAR program's data collection chart

CAPTION : \*Large Arrow : Data Transmission from the field to provincial and national levels ;  
 \*Thin Arrow : Feedback.

## VI. PROJECT MANAGEMENT

The AIDSTAR was constituted of four years of planning and budgeting exercises. Prior to the implementation of each fiscal year's activities, work plans and budgets obtained USAID approval. So each planning process took into account the deliverables included in the contract for the period, the national strategic priorities and evidence-based information collected after surveys and lessons learned from preceding periods of the program. Deliverables were yearly updated based on previous achievements, and the final version of the indicators was included in the last modification of the contract.

During the life of the project, PSI Executive Team from Washington conducted field visits to attend several meetings with USAID/DRC mission and key partners such as Ministry of Health, UNICEF, UNDP/Global Fund and Pooled Fund for partnership strengthening, along with ASF institutional development, field activities monitoring, review of project's implementation and achievements, and strategies to reinforce activities and capacities to deliver the expected results in a timely manner. Also, several short term technical assistance (STTA) trips from both Washington and PSI Regional Offices were conducted to the profit of PSI/ASF.

Regular supervisions visits were conducted by the USAID/DRC mission representatives (Head of Mission, Health Department Officers and technical teams, COTR) in the different targeted provinces to evaluate the progress of USAID-funded activities implemented by PSI/ASF, to monitor technical aspects of implemented activities, and provide appropriate recommendations for improving performance.

Ten success stories were written during the implementation of the program and submitted to USAID related to :

- HIV prevention (*Youth and Faith: A Conviction against HIV Infection; Talking about sexuality with adults is easier thanks to 100%Jeune; and Female condom, an efficient option for commercial sex workers*);
- Family Planning (*Implant provides quiet mind; and Long term FP method saves a marriage*);
- Water (*Water purifiers save lives; and Schoolchildren empowered to champion home water treatment*);
- Product distribution (*Bikers Make Health Commodities Available in Rural Areas*);
- Capacity building (*A Local Non-Governmental Organization Better Equipped To Address Community Concerns*); and
- Testimonies of acceptors of the health solutions provided by the AIDSTAR program (*Words that touch hearts*).

### 2009-2010

In March 2010, PSI/ASF was invited to participate in a regional USAID FP meeting in Kigali, Rwanda, which included USAID and partner representatives from 12 sub-Saharan African countries. PSI/ASF's FP National Manager represented the PSI/ASF program and gave a presentation to all conference participants titled: "The *Confiance* Family Planning Network: leveraging the private sector to re-establish FP post-conflict in the Democratic Republic of Congo". The conference was designed to offer a forum for sharing experiences and lessons learned among different USAID-funded FP programs. Many of the different approaches and strategies discussed at the conference are included in

PSI/ASF's FP programming and PSI/ASF's FP National Manager played an active role in the elaboration of the DRC national FP strategy.

In Q2 2010, the George Washington University's peer-reviewed, on-line journal on public health communication and marketing, Cases Proceedings, published an article on PSI/ASF's toll-free family planning hotline. The article, "Ligne Verte Toll-Free Hotline: Using Cell Phones to Increase Access to Family Planning Information in the Democratic Republic of Congo." The article explains that the FP project and hotline are funded by USAID and can be accessed at:

[http://www.gwumc.edu/sphhs/departments/pch/phcm/casesjournal/volume4/cases\\_4\\_03.pdf](http://www.gwumc.edu/sphhs/departments/pch/phcm/casesjournal/volume4/cases_4_03.pdf)

Approvals were obtained from the Contracting Officer to subcontract with three US small businesses. Hope Consulting was in charge of conducting a situation analysis and ensuring a successful spin-off of clean delivery kits (CDKs) to a private sector entity. Social Impact was responsible for working with 20 local organizations over the life of the project to build their operational capabilities in areas such as strategy and planning, finance and administration and key skills. QED was in charge of providing technical assistance with PMEP development, during development and implementation of baseline data collection, and a mid-term project evaluation in project year 3. QED subcontract was signed in November 2009; Social Impact in March 2010; and Hope Consulting in Sept 2010 after obtaining USAID approval for the subcontracts.

Before starting the procurement process for furniture/equipment in Yr 2, PSI/ASF completed the inventory assessment to verify what PSI has on hand in all offices and its condition. An annual audit of all PSI equipment in its national office in Kinshasa and all its provincial offices was completed at the end of the year 2009, with other donor funding. The report allowed updating assets list, prioritizing needs and planning furniture/equipment for project year 2.

PSI/ASF completed year 1 work plan, revised year 1 budget based on funding sources per health area and get approval by USAID, submitted TCN waivers & international travel request and participated in meeting on project commodities. PSI/ASF also prepared the year 2 project budget, finalized list and characteristics of equipment and material to be purchased during FY11.

ASF's programmatic (HIV, FP, MCH and WATER, M&E) and financial (Deputy Director and accountants) staff was trained on budgeting, budget tracking and PSI annual budgeting in Q4 FY10.

PSI/DRC met the Task Order Contracting Officer on a regular basis to discuss key achievements and major challenges concerning requests approval, program income generated during previous cooperative agreement use and project launch.

A marketing training was organized by PSI/ASF for 16 of its personnel in June 2010 under the technical assistance of PSI Global Social Marketing Advisor based in Benin. The marketing plan produced was presented to USAID.

A rural assessment was completed in May-June 2010 to identify keys strategies for the expansion of the integrated social marketing project in rural underserved areas. Two technical advisors (from PSI/India and PSI/Cameroon) conducted site visits in villages in the provinces of Katanga and Kasai Oriental. During this mission, several meetings with USAID-funded (such as AXxes) and non USAID-funded partners and GRDC representatives (Heads of Health Zones and Districts, Health Provincial Inspectors) were held. Concrete recommendations were discussed with PSI/ASF teams at both central and provincial levels to strengthen distribution network for « ethical » and « non ethical » products, to

use existing commercial bikers to distribute and promote social marketing products in all rural USAID-targeted health zones. The final plan was presented to USAID team in June 2010.

The AIDSTAR's COP participated with other USG-funded partners in the visit in Kinshasa of PEPFAR Director of Gender Initiatives to share on vision/objectives, targets, approaches and accomplishments of the project.

#### **2010-2011 :**

PSI/ASF's Finance Manager and Internal Auditor attended a financial training organized by PSI Washington in DC in December 2010. This important workshop offered them the opportunity to share with other PSI platforms technical persons and PSI Washington experts their experience in USAID rules and procedures, risk management and fraud prevention, and financial reporting.

PSI/ASF's Human Resources Manager and Waterborne Diseases Project Coordinator attended a training workshop organized by PSI Washington in Mali in November 2010. As Capacity Building Champions, they were provided with adults training skills so as to elaborate, implement and monitor a training plan for PSI/ASF national and provincial staff's capacity building.

Most of equipment was purchased locally to avoid long time for delivery due to exoneration pending issues with the GDRC administration.

ASF's Executive Director attended a management and leadership training in Benin with other western and central Africa PSI Country Representatives to select with PSI headquarters top priorities for improving governance, reducing risk management, and increase the platform teams' involvement in achievements.

An Inspector General audit on HIV data was conducted in April 2011 in Kinshasa and Matadi. The recommendations were shared by USAID/DRC, most of them have been implemented within the FY11 and the remaining actions were monitored with the COTR.

In June, PSI/ASF benefited from one-week technical assistance from PSI/W HIV Department. Key accomplishments were the completion of the HIV marketing plan, the training of PSI/ASF HIV team in new BCC techniques and the review of existing communication tools.

#### **2011-2012 :**

PSI/ASF's M&E Director attended the PSI/WCA workshop for new Research and M&E Directors in Benin. PSI's research methods (quantitative and qualitative with emphasis on research ethics) were discussed and helped him oversee various studies planned within the framework of this project.

The project manager for Social Impact's subcontract with PSI/ASF, visited Kinshasa in order to: (1) provide supervision and technical assistance to the Social Impact (SI) team to ensure quality in SI's capacity building services, (2) strengthen the relationship between SI and PSI/ASF so as to more effectively coordinate SI's role on the project, (3) better understand the needs of the SI team, in order to provide more effective and efficient management and project backstopping from SI HQ in Washington, DC, (4) make contact with other local organizations, individuals and structures that can collaborate with SI on capacity building services and (5) more deeply understand the local NGOs that are being supported through SI capacity building to become PSI/ASF's service delivery partners.

In July, PSI/ASF organized a capacity building workshop for the benefit of its administration, finance and audit staff. The focus was on tools for inventory management and finance, ethics-related issues, procedures for managing human resources, issues in connection with audit and/or control of management, leadership, as well as discussions on the strengths, weaknesses, and recommendations from provinces.

An international consultant, hired by USAID, conducted the mid-term evaluation of the AIDSTAR project to assess the status of contractual indicators, and to provide guidance to the project for the remaining year.

### ***HIV***

PSI/ASF received an STTA from PSI/Rwanda to update the HIV prevention training modules for PEs, facilitate a TOT workshop, and provide the new HIV/TB Director an overview of PSI's approaches for implementing HIV programs.

The Head of PSI/Cameroon HIV-TB Department provided a technical assistance to the DRC's *100%Jeune* team. Since PSI/Cameroon's *100%Jeune* has many years of experience, it was fitting to learn from their experience in targeting youth with appropriate and innovative approaches.

In September 2012, the AIDSTAR's COP, attended the meeting PEPFAR/DRC organized with its implementing partners in Kisangani, with the Provincial Minister of Health, representatives from various government health programs (PNLS, PNMLS, PNSR, PNT, etc.) and CORDAID (Global Fund's sub recipient). During this meeting, an update on progress in Kisangani, an analysis of existing gaps in HIV services provided versus need, and a review of PEPFAR's implementing partners' portfolio were presented. The meeting re-affirmed that a coordinated approach between these partners and Global Fund's principal recipients was essential.

### ***Family Planning***

To improve program management and quality of FP service delivery, PSI/ASF's FP team attended the FP International Conference held in Dakar in Q1, and the subsequent technical meeting organized by PSI/Washington for PSI staff present in Senegal, that helped identify best practices which are applicable to the country context, such as conducting IPC sessions targeting clinical providers to increase the distribution of long-acting methods, the improvement of FP service Quality-Assurance (a factor that increases FP service attendance), etc.

In order to revitalize the *Confiance* network, which includes partner clinics, PSI/ASF's FP staff made an exchange visit to PSI/Mali in Q2 since this platform is experienced in organizing and maintaining a social franchise network. Lessons learned from this mission aimed to help increase the FP services attendance rate and improve FP products distribution system through the existing network.

In Q2, PSI/ASF's FP technical staff made an exchange visit to PSI/Benin. That visit focused on the process of improving the quality of FP services and products by complying with the 5 quality-assurance standards, namely: technical competence, client satisfaction, informed choice, privacy/confidentiality and continuity of care. Additional lessons learned included points to take into account when organizing a programmatic audit of FP activities, and facilitative supervision also directed at other categories of clinics personnel (logisticians, cleaners, etc.) who were involved in the safety and satisfaction of clients.

In the same quarter, PSI/ASF's provincial clinic managers in the *Confiance* network attended a capacity building workshop held in Kinshasa in order to promote FP in accordance with quality-assurance standards. The workshop focused on two aspects: training of trainers, including notions on supervision of FP activities, and discussions on best practices and lessons learned about the process of improving quality in FP. Other workshops were held in Q2 to build provincial sales managers' and monitoring and evaluation managers' capacity.

PSI/ASF's FP technical staff satisfactorily completed the online course "USAID FP Legislative and Policy Requirements" on regulations related to the delivery of FP service/products to target groups. Certificates of completion of the course were transmitted to USAID/DRC in Q3. Lessons learned were continuously shared with PSI/ASF's provincial teams, CBEs and service providers to comply with the donor's FP requirements.

In April 2012, PSI/ASF received the first quality-assurance (QA) audit of FP service carried out by PSI/Washington technical team. They visited some network clinics in Kinshasa and Bas-Congo in order to assess compliance with five standards of service quality delivered to women of reproductive age, namely: technical competence, client safety, informed choice, privacy/confidentiality and continuity of care. In order to implement audit recommendations, which is part of QA improvement; joint supervisions of the network clinics were organized and actually conducted with PNSR and project-targeted health zones in nine provinces. The analysis of various reports revealed some weaknesses as to the compliance with the five standards mentioned above that required an action plan in order to maintain and improve service quality in the upcoming months. PSI/ASF developed its plan and monitored progress the year after.

In June 2012, PSI/ASF participated in an advocacy meeting for funding family planning in DRC. This meeting, held for donors and technical partners, was marked by discussions about the theme developed by PSI/ASF: "The FP *Confiance* Network: Experience with Pharmacies and Clinics." Apart from this presentation, PSI/ASF exhibited its products and conducted IPC sessions for participants who visited its stand. These FP promotion activities demonstrate PSI/ASF's commitment to contribute to the efforts of the GDRC that listed FP as one of the priorities of its program as indicated in the Growth and Poverty Reduction Strategy Paper 2 (GPRSP-2).

A delegation composed of representatives from PSI/ASF, PNSR and SCOGO made an exchange visit to PSI/Zambia in August 2012 to learn about the post partum IUD (PPIUD) insertion approach, so as to adapt it to the DRC context. Lessons from this exchange visit were highlighted in a debriefing at the Permanent Multisectoral Technical Committee for FP repositioning meeting the same month.

### ***MCH***

In Q3 FY2012, PSI/Washington organized the Leadership in Reproductive Health training for the benefit of concerned program managers from ten French-speaking countries. Thanks to SIFPO funding, PSI/ASF was represented by its MCH Director and MCH Deputy Director in charge of FP. The nature of knowledge imparted (basic essentials on management and leadership, strategic vision, performance improvement process, specific and practical issues related to reproductive health, design and use of marketing plan, and compliance) boosted participants' capacities in program management in general and reproductive health programs in particular.

### ***WATER***

PSI/ASF received an STTA from PSI/Nairobi to strengthen its partnership with the 9<sup>th</sup> Directorate of the MoH regarding the integration of point-of-use water treatment in its 2012 annual action plan. This important aspect of hygiene was barely mentioned as a simple prevention method in the national policy

on fighting diarrheal diseases. However, it was included in the training guide on diarrhea treatment using ORS and Zinc.

## 2012-2013

Alongside other USAID's partners and MoH's representatives, PSI/ASF attended the international conference on the *Use of Mobile Technology to Improve FP and RH* in Dar es Salaam, Tanzania. This conference allowed countries to share their experiences in using the mobile technology through its available functions (voice, SMS, Internet, money transfer, etc.) to improve vulnerable populations' health. At the end of the conference, the DRC team proposed the vision of the "rational integration of mHealth in the national health system to improve coordination, use of services and program management", to be submitted by the MoH's representatives (PNSR and PNSA) to government health officials in order to define the next steps.

### AIDSTAR Project's Closeout:

- The equipment acquired for the project was inventoried.
- The termination of project's staff was gradually conducted as the project reached its end. Therefore, project's activities went gradually down during the last quarter.
- PSI/ASF submitted to USAID its proposed closeout plan in early September 2013 along with "equipment inventory and disposition plan" and "status of stocks as of July 2013".
- On September 26<sup>th</sup>, 2013, PSI/ASF organized a closeout workshop with USG partners, national programs officials (PNLS, PNMLS, PNSR, PNLMD, PNSA, etc.) to share lessons learned and factors of success. Attendees followed presentations and testimonies that highlighted for each area of intervention (HIV, FP, MCH, Water) project's main achievements, lessons learned, and partnerships that were set up with public and private sectors. The MoH was represented by its Secretary General and the USAID mission by its Director. Testimonies of actors from public and private sectors, as well as from direct beneficiaries of the project, highlighted project's success and impact on the community.



September 26, 2013: Mrs. Diana Putman, USAID/DRC Director, and Dr. Blanchard Mukengeshayi, Secretary General a.i. at the DRC Ministry of Health; ready to open the one-day AIDSTAR project's closeout workshop

## **VII. ENVIRONMENTAL MITIGATION (IEE)**

Needles from injectables: Part of the pre-selection criteria for partner clinics was that they had, at the time of selection, a place established where hazardous waste, including needles, was burned and safely disposed of. This is also a requirement of the MOH for all clinics/health centers. Verification of proper procedures for disposing of hazardous waste at clinics was added to all clinic supervisions. Used contraceptive injectables needles bins were shipped to the provinces in order to collect them before burning in all the *Confiance* network clinics.

Condoms: Proper disposal of condoms, in a designated garbage can or latrine, was included in all community-based actors' trainings and condom messaging, including IEC and condom packaging.

Packaging and materials: PSI/ASF did all it can to ensure that product packaging and IEC materials were properly disposed of. This is particularly true following events where samples, brochures, stickers or other promotional and IEC, where materials were often discarded or left lying around.

IEE regulations were recalled to the *Confiance* network providers during ongoing long lasting FP methods training. Guidelines for assuring IEE requirements are met in *Confiance* clinics was also added to newly revised Quality Assurance checklists to be used by FP staff for partner site visits.

The promoted POU products PUR and Aquatabs, are harmless. During sensitizations, people were taught how to discard the packaging so as to avoid their littering. Packaging were gathered and burnt at the nearest health center along with other hospital or household wastes.

## **VIII. FP AND HIV POLICY COMPLIANCE**

As for HIV, to ensure that all FP program activities adhere to the Tiahrt Amendment requirements, all FP staff were continuously briefed and reminded on the Tiahrt requirements and given examples of hypothetical situations to determine whether they are in compliance with Tiahrt. Provincial Leaders (LPs) were also briefed and continuously reminded on Tiahrt at the bi-annual LP retreats, to ensure that understanding of the Tiahrt Amendment was at all levels and not restricted only to FP staff, as LPs and other staff often work with FP activities

## **IX. PROBLEMS /CHALLENGES FACED DURING THE LIFE OF THE PROJECT**

During the life of the project, the project faced the following challenges:

### **2009-2010:**

Communication activities in connection with correct and consistent use of condom by targeted populations were not conducted for lack of budget. In fact, a request to use revenue generated during previous cooperative agreement #623-A-00-05-00341-00 from condom sales was not approved by USAID because the two projects had different funding mechanisms (cooperative agreement vs. contract);

Delayed approval of branding and marking plan, indicators, logframes and PMEP, which were submitted early, delayed the start of project's activities;

## **2010-2011:**

Delays in products arrival in DRC (e.g. condoms) caused delays in achieving some of the project's objectives, this led even to a stock-out of female condoms; because of that stock-out the launch of the female condom promotion campaign was postponed to avoid reinforcing demand during that period;

New branded male condom, *OK*, distributed by DKT, appeared in the market. They distributed their product only in points of sale created by PSI/ASF sales teams, instead of creating new ones. A meeting was held with DKT representatives to discuss how to better coordinate and maximize efforts to increase the accessibility and availability for targeted populations;

Based on HOPE Consulting's conclusions, the spinning-off of the CDK to a private company or another NGO was not considered as a good option. Also, the insufficient internal funding to produce CDK delayed the achievement of CDK distribution target. Based on these findings, PSI/ASF wrote USAID explaining that CDK's spinning off would not be possible even if it was a strategy chosen under the AIDSTAR contract, and the remaining year 2 target was postponed in year 3;

Long delay to obtain the approval from the local ethical committee in FY10 impacted the completion of the TRaC survey and the availability of the results to initiate evidence-based communication. This situation delayed the production of specific messages addressing key determinants of behavior and the airing of new HIV communication campaigns for male and female condoms;

Suspension of all exonerations for NGOs as of November 2009 significantly undermined PSI/ASF's activities, including the introduction of the *Jadelle* implant under this project and the replacement of FP equipment in many USAID-supported clinics. The exoneration issue persisted for three years and impacted the clearance process for point of use water purifier *Aquatabs* (for a quantity of 6 million tablets) which was purchased by other donors and to be distributed under this USAID-funded project. In addition, there was an increase of vehicle rental costs in order to achieve project's targets because the 3 newly purchased vehicles could not be used due to issues of exoneration and temporary license (IT) plates.

Stock-out of Duofem (COC) and Ovrette (POP) and the delay in the registration process of their replacements, respectively Combination 3 and Microlut limited clients in their free and informed choice of modern contraceptive methods in the *Confiance* network. The complete stock-out of POP (Ovrette) persisted till the end of the project.

Communication activities that had to be implemented by selected local NGOs were delayed due to the tragic air crash which caused the death of the Kinshasa-based Social Impact Senior Organizational Development Specialist.

## **2011-2012:**

Delayed production of *Combination 3*'s appropriate packaging due to Bayer Schering (its manufacturer)'s slowness to provide its concurrence for the overbranding of this FP product delayed the distribution of this new product;

*Ora-Zinc* was not launched during the life of the project because of (i) the delay in receiving the waiver from USAID (granted in June 2012); (ii) the slowness of the process for obtaining the market entry authorization (AMM); indeed, it was only by the end of Q3 FY13 that PSI/ASF received the invitation to pay fees for obtaining the AMM; and (iii) the difficulty to obtain the BIVAC to authorize the shipment of the *Ora-Zinc* kits already manufactured/ For the latter, the manufactured product had not the required minimum shelf life of two years at the entry port in DRC, special permission from the Ministry of Health (through the 3<sup>rd</sup> Directorate) was obtained so as to get from the manufacturer's country the authorization of shipping the product to DRC. PSI/ASF has now settled the issue;

The production of high quality communication materials (radio/TV spots) in connection with the AIDSTAR logframes objectives (for HIV, MCH and Water programs) was delayed because of the lack of local advertizing agencies familiar with social marketing media campaigns;

The implementation of the rural strategy was delayed due to the inability of local suppliers, selected after a transparent bidding process, to deliver the needed materials on time for the scaling up of communication and distribution activities to rural areas;

There was an increase of vehicle rental costs in order to achieve project's targets because the 3 newly purchased vehicles could not be used due to issues of exoneration and temporary license (IT) plates.

### **2012-2013:**

Two different approaches for the distribution of contraceptives were coexisting in some *Confiance* network clinics: social marketing by PSI/ASF and free distribution by USAID's and CDC's PMTCT partners. This reduced social marketing FP products distribution in Kinshasa, Katanga, Bas-Congo, Province Orientale and Sud-Kivu;

In some provinces, such as Kinshasa and Katanga, the momentum of socially marketed FP products in *Confiance* network's clinics was broken by contraceptives freely distributed by some FP partners during the World Contraception Day celebrated in DRC in October 2012;

PSI/ASF could not meet the consumers' evolving needs and get the opportunity of readjusting condom price according to the findings of the Willingness to Pay study because of the cancellation of the process of launching the campaign on the *Prudence* range awaited by the community resulting from the constraint related to the closure of the project in September 2013;

Stock-out of more than 6 months for *Aquatabs* at PSI/ASF's main warehouse due to customs clearance issue disrupted the distribution of this product and reduced its health impact;

PSI/ASF's teams could not cover all the project-targeted areas due to insecurity in some provinces, namely Katanga and Sud-Kivu.

The funding was insufficient to keep all PSI/ASF provincial offices opened till the end of the project, and limited interventions in some targeted provinces with the reduction of staff and closure of provincial offices.

## **X. LESSONS LEARNED**

- Organization of joint planning and activities in the field among partners increased synergy and impact of each activity, maximized the use of funds and reduced risk of duplication;
- Integration of health services increased the cost effectiveness of interventions and the access for the targeted populations, and provided holistic health response to common targeted population health needs.
- Combination of marketing strategies (mix marketing) increased exposure of targeted populations to promotion and behavior change communications and the opportunity to adopt safer behaviors;
- Involvement of GDRC representatives and MoH programs at all level facilitated the planning and the implantation of the program, according to national priorities and standards, and the sustainability of the interventions.
- Commodities stock outs broke the confidence private sector's distribution actors (from wholesalers to retailers) have in the implementing partner and it costs a lot (human and financial resources, time) to rebuilt a sustainable partnership.

### ***HIV/AIDS/STI***

- Involving targeted populations as actors in program planning and implementation (youth, sex workers, MSM; uniformed personnel, truckers) ensured their buy-in and significantly contributed to the success of the AIDSTAR program's interventions;
- Participatory peer education made interpersonal communication more convenient and efficient ; a peer is considered sensitized if and only if he was exposed four times to different themes in connection with prevention against HIV and STIs;
- Partnership with local implementing NGOs contributes to ownership and sustainability of Behavior Change Communication (BCC) activities;
- Zonal approach based on the implication of health zones in the program planning and implementation strengthened identification and reporting of data ;
- Condom distribution coupled with awareness-raising messages increased chances of getting protected against HIV, STIs and unwanted pregnancies.

### ***Family Planning***

- Involvement of governmental partners in FP interventions strengthened the coordination of private sector's activities;

- Involvement of the private sector in promoting FP increased access to information as well as to contraceptive services and products;
- Availability of a wide range of products ensured continuity of service by clients and had a direct impact on the contraceptive prevalence;
- Regular monitoring of the family planning service quality improved providers' technical competence;
- Use of the toll-free hotline contributed to improving men's involvement in family planning and increased equity access of women to FP information and services;
- Raising men awareness of family planning made it easier for marriage mates to talk about reproductive health;
- Free distribution of FP products in private clinics lessened the impact of social marketing.

## ***MCH***

### ***CDK***

- PNSR's involvement in determining the kit's contents and price allowed its adoption by implementing partners and its insertion in the approach of family kits;
- The availability of the kit's components in the local market made its local production easier and faster.

### ***ORA-ZINC***

- The involvement of PNLMD in the development of the training module and in the design of communication materials, and the consideration of Ora-Zinc in the operational action plan of the Ministry of Health eased the adoption of the product in the country's priorities;
- The presentation of the product as a kit containing ORS and Zinc will ease the access of Zinc in diarrhea management.

## ***WATER***

- The social marketing of water purifiers contributed to their penetration into the community;
- Social marketing was an efficient means that can serve as a bridge between emergency situations and development;
- Water purifiers found a favorable environment for their consumption. Home water treatment is still an alternative to the gap resulting from low water coverage.

## **XI. RECOMMENDATIONS**

PSI/ASF recommends that:

- Legal environment be adapted to promote a large range of family planning products in community-based distribution
- The donor's supply chain management system take into consideration key constraints of the local context (including exoneration issues, ability of the supplier to deliver commodities according to the projects' validated work plan) and be improved in order to avoid delays in commodities delivery, resulting in stock-outs during the life of the project;
- Necessary exonerations be available for the institution that imports commodities or equipment for the purpose of any health project to avoid delays in product distribution to targeted populations and program implementation;
- GDRC and donors coordinate projects implementing partners to avoid overlapping in their activities and have them comply with the mapping of interventions in the field;
- Local partner NGOs and organizations whose institutional and technical capacity was built under this program be recommended by USAID to its other implementing partners or other USG health agencies' implementing partners for their expertise in health behavior change communication, especially in HIV, FP, MCH and water areas;
- The HIV/AIDS national program involve most-at-risk targets (sex workers, MSM, etc.) in planning activities and raising their peers awareness for a strong mobilization and adherence of recipients for the success of programs;
- The HIV/AIDS national program buy in peer education based on participatory approach to make IPC more practical and effective;
- The Ministry of Health, through PNLs, PNSR, PNSA, PNLMD and health zones, continue to supervise the activities of the AIDSTAR program's NGOs and structures;
- 7.1% chlorhexidine (an approach of umbilical care which is part of the 13 life-saving commodities for women and children) be integrated in the delivery kit to increase the kit's health impact;
- The PNSR and the FP project implementing partners promote the use of the FP toll-free hotline as a successful solution to offer interactive communication with targeted population, including men.

## XII. CONCLUSION

Through the support of the American People provided by USAID under the contract number GHH-I-00-07-00062-00 task order 05, PSI has successfully implemented a 4-year integrated social marketing project (from October 2009 to September 2013) named *Advancing Social Marketing for Health in the Democratic Republic of Congo* through its local partner, ASF.

This program has significantly contributed to the efforts of the GDRC to improve the health status of Congolese people by promoting and distributing quality health products and services in HIV, Family Planning, Mother and Child Health, and Water. In capitals and major cities of the provinces of Kinshasa, Katanga, Bas Congo, Sud Kivu, Nord Kivu, Province Orientale, Equateur, Kasai Occidental and Kasai Oriental and most of the 80 USAID priority health zones, this USAID-funded program significantly contributed to improve Congolese people's health by averting 594,449 unintended pregnancies, 58,207 diarrhea cases among children under five, 14,451 HIV infections and 1,912 maternal deaths<sup>11</sup> by the end of the project.

Through this project, PSI has built the capacity of ASF's senior and mid-level staff, developed ASF's strategic vision and plan for 2013-2017 and reinforce the ASF Board of Directors with additional high value members. Also, the AIDSTAR program has ensured an appropriation of the program by the beneficiaries through the capacity building and institutional development of a network of 20 other local NGOs, working on a daily basis in the different targeted provinces with vulnerable target groups including youth, female sex workers, men who have sex with men, truckers, military and police officers. Their activities continue after the end of the AIDSTAR program.

With the support of the AIDSTAR program, PSI/ASF has strengthened the network of trainers as well as service providers available at both national and provincial levels for all implementing partners in HIV and FP/RH. With the support provided by this contract, PSI/ASF has reinforced the private sector actors in social marketing, develop new quality products to increase the health impact, and extend the coverage of products distribution and the distribution channels in pharmaceutical and FMCG networks in urban areas, but also in remote and underserved rural areas with innovative approaches. New technologies such as Facebook have been used to increase awareness of the targeted population and engage open communication among people from target groups and between target groups and PSI/ASF experts. The program has contributed to e-MTCT national efforts and contributed to improving the gender equity with an increased access of women and girls to health information and health services delivery and an increased number of trained women and girls to be actors in the empowerment and behavior change of their peers.

With the closing of the AIDSTAR program, PSI and its local partner, ASF, take the opportunity to thank the American People and USAID for their contribution to the improvement of the Congolese people's health with the different resources made available (human, financial and material). PSI/ASF also thanks the GDRC and its specialized programs (PNLS, PNSR, PNSA, PNLMD, etc) and the PNMLS for their administrative and technical support that made this program a success. Last but not least, PSI/ASF thanks the health sector partners, all the execution partners and all the field actors for their collaboration and their commitments to be dedicated to the Congolese people we all serve.

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<sup>11</sup> Calculated by using PSI DALY Calculator, a scientific converter of products and services provided into health impact. It calculates several indicators, including DALY (Disability Adjusted Life Year) which is an indicator used by WHO and the World Bank to evaluate the impact of health interventions. One DALY equals one year of life lost due to illness or death. When PSI averts one DALY, it means one year of healthy life would have been lost without PSI's intervention.

### XIII. ANNEXES

#### 1- Project indicators

##### Annex A: Product Distribution Targets

<b>Annex A: Product Distribution Revised Targets</b>						
	PRODUCTS	YEARS				TOTAL
		1	2	3	4	
HIV	Male Condoms	20,000,000	25,000,000	34,000,000	36,500,000	115,500,000
	Female Condoms	500,000	700,000	1,100,000	1,310,000	3,610,000
FP	Oral Contraceptives	700,000	1,000,000	1,200,000	1,500,000	4,400,000
	Depo-Provera (3-month)	100,000	200,000	200,000	250,000	750,000
	IUD	2,000	2,500	2,750	3,000	10,250
	Cycle Beads	4,000	6,000	6,000	6,200	22,200
	Implants	500	800	2,500	2,500	6,300
MCH / WS	Clean Delivery Kits	20,000	30,000	0	0	50,000
	ORS+Zinc Diarrhea Treatment Kit	0	0	0	100,000	100,000
	PUR	1,000,000	2,000,000	2,000,000	2,200,000	7,200,000
	Aquatabs	1,150,000	2,000,000	2,000,000	2,000,000	7,150,000

## Annex B: Annual Performance Milestones

INDICATORS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL	Comments/Assumptions	
<b>Task 1: Increase supply and diversity of health services and products</b>							
1	Number of male condoms distributed through the USG funded social marketing programs	20 000 000	25 000 000	34 000 000	36 500 000	<b>115 500 000</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (30,000,000+4,000,000). Year 4 target is increased by adding Kinshasa-Kisangani extension (32,000,000+4,500,000).
2	Number of female condoms distributed through the USG funded social marketing programs	500 000	700 000	1 100 000	1 310 000	<b>3 610 000</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (1,000,000+100,000). Year 4 target is increased by adding Kinshasa-Kisangani extension (1,200,000+110,000).
3	Liters of water disinfected with point of use home water treatment solution to the USG funded social marketing programs	33 000 000	60 000 000	60 000 000	62 000 000	<b>215 000 000</b>	Based on quantities planned. Year 1 target is based on previous project last year achievement. Year 2, 3 and 4 targets have been updated, based on year 1 achievements. Expected results are based on other donors supplying products. Year 3 and 4 targets cannot be increased, as cholera outbreaks are not included in the calculation as they cannot be planned.
4	Number of Diarrhea Treatment Kits containing 2 low-osmolarity flavored ORS sachets plus a 10-blister pack of zinc distributed through the USG funded social marketing programs	0	0	0	100 000	<b>100 000</b>	Due to the late approval of the waiver for purchasing ORAZINC (Orasel+Zinc) by USAID, and the consecutive need to initiate a new international tender, the arrival of the product in DRC is expected in May 2013. Thus, the distribution will certainly not start before June 2013. Consequently, only 100,000 DTKs are expected to be distributed late FY2013.
5	Number of clean delivery kits distributed through the USG funded social marketing programs	20 000	30 000	0	0	<b>50 000</b>	Based on quantities planned. Based on Hope Consulting's assessment, transfer of CDK's distribution and promotion to a private company is not feasible.
6	Number of cycles of oral contraceptives distributed through the USG funded social marketing programs	700 000	1 000 000	1 020 000	1 275 000	<b>3 995 000</b>	Year 1 and 2 targets remain the same. Year 3 & 4 targets are decreased by the number of POP to be distributed (respectively 180,000 and 225,000) because of stock out of Ovrette since FY10 and lack of approval for distribution (Autorisation de mise sur le Marche) of Microlut).
7	Number of injectable contraceptives distributed through the USG funded social marketing programs	100 000	200 000	200 000	250 000	<b>750 000</b>	Based on universe of needs calculation (including baseline percentage of targeted people using the product, estimated impact of the project on product used-related behavior change) and previous project achievements. Year 2 target has been updated, based on year 1 achievements.
8	Number of IUDs distributed through the USG funded social marketing programs	2 000	2 500	2 750	3 000	<b>10 250</b>	Based on universe of needs calculation (including baseline percentage of targeted people using the product, estimated impact of the project on product used-related behavior change) and previous project achievements.
9	Number of cyclebeads distributed through the USG funded social marketing programs	4 000	6 000	6 000	6 200	<b>22 200</b>	Based on universe of needs calculation (including baseline percentage of targeted people using the product, estimated impact of the project on product used-related behavior change) and previous project achievements. Year 2 target has been updated, based on year 1 achievements.
10	Number of implants distributed through the USG funded social marketing programs	0	1 300	2 500	2 500	<b>6 300</b>	Based on universe of needs calculation (including estimated impact of the project on product used-related behavior change). Year 2 target has been updated, as there was no distribution in year 1 due to registration issue. Year 3 and 4 targets have been updated, based on year 2 achievement.
11	Couple-years of protection (CYP) in USG-supported programs	88 867	145 107	152 150	183 200	<b>569 323</b>	Based on the revised distribution targets above and the new USAID's CYP conversion factors, the calculation of CYPs is updated.

INDICATORS		YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL	Comments/Assumptions
<b>Task 2: Increase the awareness of and demand for health products and services</b>							
12	Number of people reached during HIV/AIDS activities who are oriented to a VCT site	0	4 364	11 252	12 817	<b>28 433</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (10,952+300). Year 4 target is increased by adding Kinshasa-Kisangani extension (11,617+1200).
13	Number of individuals reached with individuals/small group preventive interventions primarily focused on abstinence and/or being faithful that are based on evidence and/or meet the minimum standards	0	17 717	23 442	25 337	<b>66 496</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (19,942+3,500). Year 4 target is increased by adding Kinshasa-Kisangani extension (21,437+3,900).
14	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	0	14 286	19 666	20 386	<b>54 338</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (16,566+3,100). Year 4 target is increased by adding Kinshasa-Kisangani extension (17,286+3,100).
15	Number of targeted condom service outlets	1 800	6 000	7 952	8 852	<b>8 852</b>	Year 1 and 2 targets remain the same. As this indicator is cumulative from one year to the following, Year 3 & 4 targets are increased by adding Kinshasa-Kisangani extension (respectively 800 and 900).
16	Number of individuals participated in community-wide event focused on HIV/AIDS	0	200 000	340 000	460 000	<b>1 000 000</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (300,000+40,000). Year 4 target is increased by adding Kinshasa-Kisangani extension (400,000+60,000).
17	Number of media outlets including HIV/AIDS messages in their programs	0	48	30	25	<b>48</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (27+3). Year 4 target is increased by adding Kinshasa-Kisangani extension (15+10).
18	Number of media broadcasts that promote responsible sexual behavior	0	20 160	12 986	2 350	<b>35 496</b>	Year 1 and 2 targets remain the same. Year 3 target is increased by adding Kinshasa-Kisangani extension (5,400+7,586). Year 4 target is increased by adding Kinshasa-Kisangani extension (1,350+1,000).
19	Number of peer educators who successfully completed an in-service training program	0	300	365	0	<b>665</b>	No change
20	Number of FP service delivery points (pharmacies and clinics) added to the <i>Confiance</i> FP network with USG assistance	0	199	5	0	<b>204</b>	No change
21	Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (depo provera)	100	68	45	45	<b>45</b>	Contingent upon consistent product supply from the donor.
22	Number of people reached during outreach activities promoting the use of water purifier products	50 000	300 000	250 000	200 000	<b>800 000</b>	No change
23	Number of people reached during outreach activities promoting the use of ORS sachets to treat diarrhea	0	0	0	20 000	<b>20 000</b>	Due to the late approval of the waiver for purchasing ORAZINC (Orasel+Zinc) by USAID, and the consecutive need to initiate a new international tender, the arrival of the product in DRC is expected in May 2013. Thus, the distribution will certainly not start before June 2013. Consequently, only 20,000 people are expected to be reached late FY2013.
24	Number of service delivery points social marketing delivery kits	200	400	0	0	<b>400</b>	No change. Non cumulative indicator.
25	Percentage of service delivery points reporting stock out of water purifier at any time	40%	30%	20%	15%	<b>15%</b>	Based on anticipated project efforts. In year 1, wholesalers were considered as service delivery points. For years 2, 3 and 4, the indicator is corrected: service delivery points are retailers. No change.
26	Percentage of service delivery points reporting stockouts of ORS/zinc tablets at any time	-	-	-	-	-	Due to the late approval of the waiver for purchasing ORAZINC (Orasel+Zinc) by USAID, and the consecutive need to initiate a new international tender, the arrival of the product in DRC is expected in May 2013. Thus, the distribution will certainly not start before June 2013. Consequently, we believe that it will be difficult to measure this indicator.

INDICATORS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL	Comments/Assumptions	
<b>Task 3: Develop and/or enhance the ability of commercial/private sector entities to social market health products and services including behavior change communication activities</b>							
27	Number of socially marketed health products or services transitioned to the private sector	0	0	0	0	0	Based on Hope Consulting's assessment, transfer of CDK's distribution and promotion to a private company is not feasible. Thus, the indicator for year 3 was zeroed out.
28	Number of trained/refreshed private sector distributors, NGOs, associations and community health workers trained in social marketing and/or BCC techniques	0	10	10	0	20	Years 2 and 3 are cumulative.
<b>Task 4: Integrate service delivery and other activities, emphasizing prevention, at national, provincial, district, facility, and community level through joint planning with GDRC, other USG and non-USG partners</b>							
29	Number of external technical/coordination meetings attended at national/provincial/district levels with stakeholders	60	93	110	110	373	Based on budget available, and past experience in coordination. No change.

## 2- Achievement of Project Indicators up to the end of the project\*

### Objective 1 Indicators: Situation as of end of project \*

#	INDICATORS	TARGETS					ACHIEVEMENTS	
		Year 1	Year 2	Year 3	Year 4	TOTAL	Numbers	%
1	Number of male condoms distributed through the USG funded social marketing programs	20 000 000	25 000 000	34 000 000	36 500 000	115 500 000	120 333 586	104%
2	Number of female condoms distributed through the USG funded social marketing programs	500 000	700 000	1 100 000	1 310 000	3 610 000	4 273 979	118%
3	Liters of water disinfected with point of use home water treatment solution to the USG funded social marketing programs	33 000 000	60 000 000	60 000 000	62 000 000	215 000 000	515 571 540	240%
4	Number of Diarrhea Treatment Kits containing 2 low-osmolarity flavored ORS sachets plus a 10-blister pack of zinc distributed through the USG funded social marketing programs	0	0	0	100 000	100 000	0	0%
5	Number of clean delivery kits distributed through the USG funded social marketing programs	20 000	30 000	0	0	50 000	50 896	102%
6	Number of cycles of oral contraceptives distributed through the USG funded social marketing programs	700 000	1 000 000	1 020 000	1 275 000	3 995 000	3 304 469	83%
7	Number of injectable contraceptives distributed through the USG funded social marketing programs	100 000	200 000	200 000	250 000	750 000	870 163	116%
8	Number of IUDs distributed through the USG funded social marketing programs	2 000	2 500	2 750	3 000	10 250	11 959	117%
9	Number of Cycle Beads distributed through the USG funded social marketing programs	4 000	6 000	6 000	6 200	22 200	36 431	164%
10	Number of implants distributed through the USG funded social marketing programs	0	1 300	2 500	2 500	6 300	7 378	117%
11	Couple-years of protection (CYP) in USG-supported programs	88 867	145 107	152 150	183 200	569 324	594 449	104%

#### Comments on achievements:

Indicator #3: Due to cholera outbreaks, distribution went beyond the target.

Indicator #4: As described in the above section IX. PROBLEMS /CHALLENGES FACED DURING THE LIFE OF THE PROJECT , *Ora-Zinc* was not distributed during the life of the project and its arrival is expected after the end of the project.

Indicator #9: As the action of community-based educators was stepped up, the demand for Cycle Beads increased.

\* This is an updated version of tables found in Q4 FY13 and FY13 reports, with final numbers.

**Objective 2 Indicators: Situation as of end of project**

#	INDICATORS	TARGETS					ACHIEVEMENTS	
		Year 1	Year 2	Year 3	Year 4	TOTAL	Numbers	%
12	Number of people reached during HIV/AIDS activities who are oriented to VCT site	0	4 364	11 252	12 817	28 433	106 006	373%
13	Number of individuals reached with individual and/or small group preventive interventions primarily focused on abstinence and/or being faithful that are based on evidence and/or meet the minimum standards	0	17 717	23 442	25 337	66 496	66 961	101%
14	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	0	14 286	19 666	20 386	54 338	86 240	159%
15	Number of targeted condom service outlets	1 800	6 000	7 952	8 852	8 852	9 285	105%
16	Number of individuals who participated in communitywide event focused on HIV/AIDS	0	200 000	340 000	460 000	1 000 000	1 223 571	122%
17	Number of media outlets including HIV/AIDS messages in their program	0	48	30	25	48	48	100%
18	Number of media broadcasts that promote responsible sexual behavior	0	20 160	12 986	2 350	35 496	36 647	103%
19	Number of peer educators who successfully completed an in-service training program	0	300	365	0	665	665	100%
20	Number of FP service delivery points (pharmacies and clinics) added to the <i>Confiance</i> FP network with USG assistance	0	199	5	0	204	204	100%
21	Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (Depo provera)	100	68	45	45	45	0	100%
22	Numbers of people reached during outreach activities promoting the use of water purifier products	50 000	300 000	250 000	200 000	800 000	1 268 528	159%
23	Number of people reached during outreach activities promoting the use of ORS sachets to treat diarrhea	0	0	0	20 000	20 000	0	0%
24	Numbers of service delivery points for social marketing delivery kits	200	400	0	0	400	400	100%
25	Percentage of delivery points reporting stock-out of water purifier at any time	40%	30%	20%	15%	15%	0%	100%
26	Percentage of service delivery points reporting stockouts of ORS/zinc tablets at any time	0	0	0	0	0	0	-

**Comments on achievements:**

Indicator #12: Combined mass communication actions with ProVIC contributed to the increased number of persons referred to VCT services.

Indicator #14: Due to interest manifested by target population and buy-in of the activities by trained NGOs' members, partner NGOs conducted more sensitization sessions than planned.

Indicator #22: Due to cholera outbreaks, more outreach activities were conducted.

Indicator #23: As described in the above section IX. PROBLEMS /CHALLENGES FACED DURING THE LIFE OF THE PROJECT , Ora-Zinc was not distributed during the life of the project and its arrival is expected after the end of the project.

Indicator #26: same comment as for indicator #23.

**Objective 3 Indicators: Situation as of end of project**

#	INDICATORS	TARGETS					ACHIEVEMENTS	
		Year 1	Year 2	Year 3	Year 4	TOTAL	Numbers	%
27	Number of socially marketed health products or services transitioned to the private sector	0	0	0	0	0	0	-
28	Number of trained/refreshed private sector distributors, NGOs, associations and community health workers trained in social marketing and/or BCC techniques	0	10	10	0	20	20	100%

**Comments on achievements:**

Indicator #27: Based on Hope Consulting's assessment, transfer of CDK's distribution and promotion to a private company is not feasible. Thus, the indicator for year 3 was zeroed out.

**Objective 4 Indicator: Situation as of end of project**

#	INDICATORS	TARGETS					ACHIEVEMENTS	
		Year 1	Year 2	Year 3	Year 4	TOTAL	Numbers	%
29	Number of external technical/coordination meetings attended at national/provincial/district	60	93	110	110	373	383	103%

### 3- Inventory on hand: stock

The table below highlights PSI/ASF's current stock levels for each product in each targeted province of the project.

Provinces	HIV Products		FP Products					WatSan Products	
	Prudence Male	Prudence Female	Combi 3	Injectable	IUD	Cycle Beads	Jadelle	PUR	AQUATABS
KINSHASA	15 971 096	7 151	758 127	38 331	31	74 231	568	2 006 968	20 100 943
KATANGA	1 445	24 000	77 985	0	60	254	30	366 240	1 203 200
BAS CONGO	0	0	0	0	0	0	0	0	0
SUD KIVU/NORD KIVU	551 949	4 775	0	0	50	0	274	1 620 000	668 160
PROVINCE ORIENTALE	0	8 000	5 050	3	0	0	0	0	41
KASAI ORIENTAL/KASAI OCCIDENTAL	114 398	0	0	0	0	0	0	0	0
<b>TOTAL</b>	<b>16 638 888</b>	<b>43 926</b>	<b>841 162</b>	<b>38 334</b>	<b>141</b>	<b>74 485</b>	<b>872</b>	<b>3 993 208</b>	<b>21 972 344</b>

It should be noted that there are additional 14,557,876 *Prudence Sensuel* ("fraise" and "banane") male condoms in PSI/ASF's main warehouse in Kinshasa.

#### 4- List of Acronyms

AIDS	: Acquired Immune Deficiency Syndrome
AMM	: Autorisation de Mise sur le Marché
ASF	: Association de Santé Familiale
BCC	: Behavior Change Communication
CA	: Cooperative Agreement
CBDA	: Community-Based Distribution Agent
CBE	: Community-Based Educator
CCP	: Comprehensive Condom Programming
CCM	: Country Coordinating Mechanism
CDK	: Clean Delivery Kit
CDF	: Congolese Francs
CILC	: Comité Intersectoriel de Lutte contre le Cholera
CNAEA	: Comité National d'Action Eau et Assainissement
COC	: Combined Oral Contraceptive
COP	: Chief of Party
COTR	: Contracting Officer's Technical Representative
CR	: Country Representative
CSW	: Commercial Sex Worker
CYP	: Couple Years of Protection
DALY	: Disability Adjusted Life Year
DoD	: United States Department of Defense
DHS	: Demographic and Health Survey
DTK	: Diarrhea Treatment Kit
DRC	: Democratic Republic of Congo
e-MTCT	: Elimination of Mother To Child HIV Transmission
EGPAF	: Elisabeth Glazer Pediatric Aids Foundation
FH	: Food for the Hungry
FMCG	: Fast Moving Consumer Goods
FoQuS	: Focus on Qualitative Survey
FP/RH	: Family Planning / Reproductive Health
FSWs	: Female Sex Workers
FY	: Fiscal Year
GDRC	: Government of DRC
HCT	: HIV Counseling and Testing
HIV	: Human Immune deficiency Virus
HQ	: Headquarters
HZ	: Health Zone
IEC	: Information, Education and Communication
IHP	: Integrated Health Project
IPC	: Interpersonal Communication
IQC	: Indefinite Quantitative Contract
IUD	: Intra Uterine Device
M&E	: Monitoring and Evaluation
MAP	: Mesure de l'Accès et de la Performance
MARPs	: Most At Risk Populations
MCH	: Maternal and Child Health
MCHIP	: Maternal and Child Health Integrated Project
MCSA	: Marketing, Communication and Sales Department
MDGs	: Millenium Development Goals
MIS	: Management Information System
MoH	: Ministry of Health

MSF	: Médecins Sans Frontières
MSM	: Men having Sex with Men
MVU	: Mobile Video Unit
No	: Number
NGO	: Non-Governmental Organization
NSHP	: National Strategic Health Plan
OC	: Oral Contraceptive
OFOG	: Overseas Financial Operations Group
ORS	: Oral Rehydration Solution
P&G	: Procter and Gamble
PEC-D	: Prise en Charge Correcte de la Diarrhée
PEPFAR	: (US) President's Emergency Plan for AIDS Relief
PLWHA	: People Living With HIV/AIDS
PMTCT	: Prevention of Mother To Child Transmission
PMEP	: Performance Monitoring and Evaluation Plan
PNLMD	: Programme National de Lutte contre les Maladies Diarrhéiques
PNLP	: Programme National de Lutte contre le Paludisme
PNLS	: Programme National de Lutte contre le Sida
PNMLS	: Programme National Multisectoriel de Lutte contre le Sida
PNSA	: Programme National de la Santé des Adolescents
PNSR	: Programme National de Santé de la Reproduction
POP	: Progestin-Only Pill
POU	: Point of Use
PPIUD	: Postpartum Intra Uterine Device
ProVIC	: Projet de lutte contre le VIH Intégré au Congo
PSI	: Population Services International
Q	: Quarter
RH	: Reproductive Health
SCOGO	: Société COngolaise de Gynéco-Obstétrique
SI	: Social Impact
STIs	: Sexually Transmitted Infections
STTA	: Short Term Technical Assistance
TOT	: Training Of Trainer
TRaC	: Tracking Results Continuously
TV	: Television
UN	: United Nations
UNDP	: United Nations Development Program
UNICEF	: United Nations Children's Fund
UNFPA	: United Nations Population Fund
USAID	: United States Agency for International Development
USG	: United States Government
VCT	: Voluntary Counseling and Testing
W	: Week
WATSAN	: Water and Sanitation
WCA	: West and Central Africa
WHO	: World Health Organization