Increased Access to Quality HIV/AIDS Prevention and Mitigation Services:

Care and Support Interventions, to include Counseling and Testing, Organizational Development and Monitoring and Evaluation, Democratic Republic of Congo (DRC)

" Réseau Santé Plus – RESA+ "

Cooperative Agreement, No 623-A-00-05-00343-00

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Increased Access to Quality HIV/AIDS Prevention and Mitigation Services:
" Réseau Santé Plus – RESA+ "

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ACRONYMS

AIDS	:	Acquired immunodeficiency syndrome
ACS/AMO-Congo	:	Actions SIDA / Avenir Meilleur pour les Orphelins au Congo
ART	:	Antiretroviral therapy
ARV	:	Antiretroviral
CHW	:	Community health worker
CRS	:	Catholic Relief Services
CSW	:	Commercial sex worker
DHMT	:	District Health Management Team
DRC	:	Democratic Republic of Congo
MCZ (DMOH)	:	District Medical Officer, Health
FP	:	Femme plus
FHI	:	Family Health International
HTC	:	HIV Testing and Counseling
HGR	:	General Referral Hospital
HIV	:	Human immunodeficiency virus
HMIS	:	Health Management Information System
HQ	:	Headquarters
IGA	:	Income-generating activities
IMPACT	:	Implementing AIDS Prevention and Care
IP	:	Implementing partner
GF	:	The Global Fund to Fight AIDS, Tuberculosis and Malaria
LNRS	:	National Referral AIDS Laboratory
LPRS	:	Provincial Referral AIDS Laboratory
MARP	:	Most at Risk Populations
M&E	:	Monitoring and evaluation
MoH	:	Ministry of Health
NGO	:	Non-governmental organization
OI	:	Opportunistic infections
OVC	:	Orphans & Vulnerable Children
PLWHA	:	Persons living with HIV and AIDS
PMTCT	:	Prevention of mother-to-child transmission
PNLS	:	National AIDS Control Program
PNMLS	:	Multisectoral National Program for the Response to HIV/AIDS
PSI	:	Population Services International
Q	:	Quarter
QA	:	Quality assurance
RESA+	:	Réseau Santé Plus
SNP	:	Strategic National Plan
TA	:	Technical assistance
TB	:	Tuberculosis
TOCAT	:	Technical and Organizational Capacity Assessment Tool
UNDP	:	United Nations Development Program
USAID	:	United States Agency for International Development

1. **EXECUTIVE SUMMARY**

a) Brief program description

Family Health International (FHI) received USD 4,200,000 from USAID funds to implement a part of a comprehensive HIV/AIDS Prevention, Care & Support Program covering the period from October 2005 to September 2009 in the Democratic Republic of Congo (DRC). As a member of a large team compounded of Population Services International (PSI), Catholic Relief Services (CRS), FHI has been accountable for implementing HIV Counseling & Testing (HTC) services in three USAID-supported interventions zones: Bas-Congo (Matadi), Katanga (Lubumbashi) and South Kivu (Bukavu & Nyantende).

In these settings, the FHI project named Réseau Santé Plus "RESA+" offered HIV quality services to vulnerable targeted populations such as truck-drivers, miners, military, women sex workers, youth and aimed building capacity of implementing agencies (IA). In the course of the project, USAID added money to extend HTC activities in new cities in Katanga (Kasumbalesa, Kipushi & Likasi) through End December 2009.

Within the framework of this project, FHI aimed 4 main objectives: 1) increase utilization of high-quality HTC services by most at risk populations (MARPs) in targeted geographical areas; 2) establish an effective referral network, linkages, and coordination between existing health system and community organizations providing multi-sectoral; 3) increase technical, organizational, and managerial capacity of new and existing Congolese organizations and networks to provide high quality prevention, care and support to PLWHA, OVC, and other vulnerable populations; and 4) ensure monitoring and evaluation of project activities.

To this end, FHI contracted with national and indigenous partners as Implementing partners (IP) through these geographic identified settings and collaborated with the following IAs : AMO-Congo (Matadi, Lubumbashi, Kasumbalesa), Fondation Femme Plus (Bukavu), World Production (Kipushi, Likasi), HGR Nyantende (Bukavu), HGR Kenya (Lubumbashi), CSR Mvuzi (Matadi), and HGR Panda (Likasi).

In addition, FHI upgraded its internal organization with two new field offices in Bukavu and Lubumbashi to ensure a closer activities' follow-up and increased collaboration with health district authorities for a high quality delivery services.

b) Achievements:

<u>Objective 1</u>.
According to the workplan and expected results, the project achieved significant results over the course of the 4 years:

- Sixteen HTC sites were established and operational in the six intervention sites. It was not the case at the end of the project as some of them were closed progressively over the time (depending the duration of each site. They provided various types of HTC services including stand alone & community-based (7), integrated into health structures providing TB services

(4), mobile (4) and a specific youth-targeted (1). One center of HTC training has been established and worked in Bukavu during 1 year and closed due to the change in the PNLS's guidelines on the training of providers.

- 180,900 clients have been counseled and tested for HIV (0.5% beyond the expected result); 98.7% out of them returned to get their HIV test results with a high acceptance rate (98.1%).
- With FHI's support, the 3 Provincial National AIDS Control Program (PNLS) Offices trained 317 persons in the following topics:
    - HIV counseling (131 counselors)
    - HIV rapid tests performance (59 lab technicians)
    - Peer education (125 Community Health Workers~CHW)
    - Monitoring and Evaluation (M & E) (2 staff of project were targeted and this training extended to personnel of Health district).

  For this performance, twenty different sessions have been held on counseling (8), laboratory performance (6), peer education (5) and one in M&E.

Objective 2.

FHI and the provincial PNLS offices jointly organized one referral workshop in each of the three provincial capitals (June-August 2006), during which HIV referral tools were standardized; referral guidebooks were subsequently produced, disseminated, and are now in active use in each city. At central level and during the first year, FHI initiated quarterly meetings for USAID partners involved in this project (PSI & CRS) to evaluate how really operational was the referral system. In the field similar meetings on referral activities monitoring have been delegated to IAs (AMO-Congo, FP, Kenya Hospital, Mvuzi Hospital, Midema CCLD[1], World Vision, PSI, ECC[2]) in the purpose to stimulate an ownership by the local health authorities in Matadi, Lubumbashi, and Bukavu. By the end of the project (December 31, 2009), the sites referred 9,239 clients to appropriate facilities for support, care and treatment, and 30,771 clients from USAID partners and others were received at FHI-supported sites.

Objective 3.

To systematically build partner capacity, FHI improved AMO-Congo and Femmes Plus staffs capacity in organizational and technical assessment approach based on a well-established and standardized internal FHI tool. To this end, a designated FHI CO staff used an appropriate tool named TOCAT (Technical and Organizational Capacity Assessment Tool). As results of these trainings, partners identified gaps in their organizational structures, tools and procedures that have been inserted in a clear workplan and tracked over the project for accomplishments: development of administrative and financial procedures manual. These workplan served also as advocacy tool for resources mobilization and increased consideration of these IAs towards others potential donors. With the support of other partners, the two IAs developed specific Strategic Plan.

[1] CCLD= Corporate Commitment for Local Development
[2] ECC= Eglise du Christ au Congo

2. COUNTRY CONTEXT

The Democratic Republic of Congo (DRC), with 65 million people, faces a generalized HIV epidemic with a prevalence of 4.3% among pregnant women[3] and 1.3% of general population have been found HIV(+)[4].All these infections particularly occurred among youth, women and in rural areas. Risk to contract HIV infection increased with a decade of conflicts and internal populations displacements in the country. However although many people (97%) are aware of HIV epidemic, few among them (<22%) its means of prevention and only less than 11% knows its HIV status [5].

Therefore, the Government of DRC has defined access to HIV/AIDS prevention, care, and treatment services as a priority within the framework of its national poverty-reduction strategy document (DSCRP) and clearly developed in the five-year HIV National Strategic Plan.

Established since 2002 in the country, FHI continued its partnership with USAID through the Réseau Santé Plus (RESA+) project, a component of USAID's overall response to HIV/AIDS in the DRC. Through RESA+, which ran from October 2005 through December 2009, FHI focused on delivering HIV/AIDS counseling and testing services. FHI worked in complementarity with PSI, which provided HIV/AIDS sensitization services, and CRS, which focused on HIV/AIDS mitigation.

3. OBJECTIVE AND METHODOLOGY

This report describes and provides results on the FHI four year RESA+ project and funded by the USAID.

It presents a detailed analysis of overall supervision reports and other pertinent information collected throughout the course of project.
This report will also:

- Analyze quantitative results obtained from each Implementing partner
- Evaluate the quality of services rendered throughout time
- share lessons learned for future interventions and national programs

[3] Biological surveillance report, PNLS 2008
[4] Demographic and Health Survey (DHS), Macro 2007, p.256
[5] DHS Report 2007, pages 208, 228, 229

4. IMPLEMENTATION Process and Timeline

RESA+ was an HTC-focused project implemented by FHI and seven implementing partners that entered into sub-agreements with FHI. The project supported the strengthening of the capacity of government and civil society partners to design, implement and monitor HTC activities, as well as to establish a continuum of care through an effective referral system. FHI has collaborated with the following IPs AMO-Congo and FP, which were part of the RESA+ consortium, along with five other partners selected in collaboration with provincial and district-level health managers following field assessments conducted by FHI.
FHI worked closely with the IPs to develop customized proposals assorted with detailed workplans, clear technical strategies. The sub-agreement signed between FHI and its IPs defined roles and responsibilities of each.

The activities were implemented as per the following timeline according to the USG fiscal year[6]:

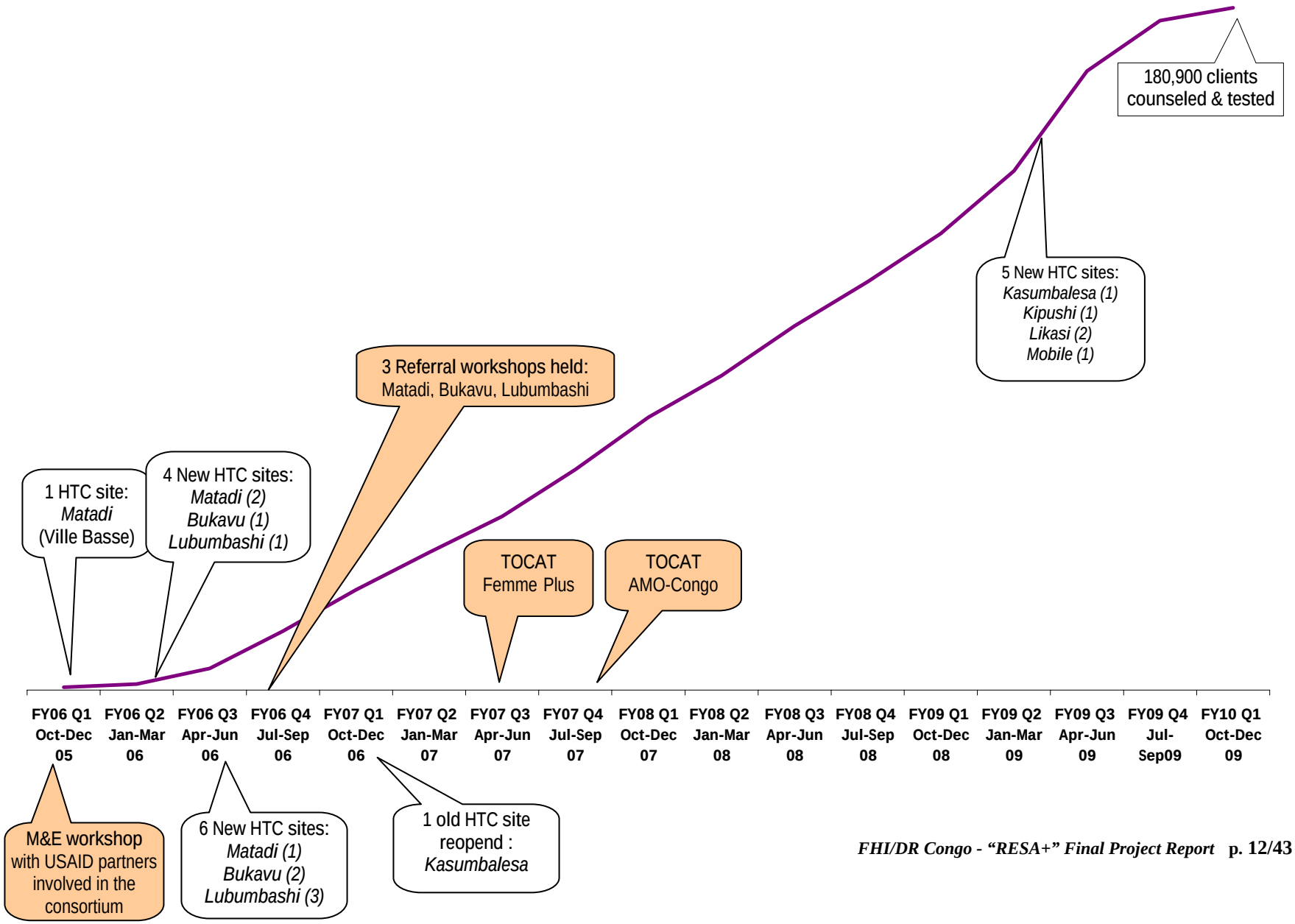
- Q1 and Q2 of FY06: FHI DRC conducted site assessments in Bukavu, Lubumbashi and Matadi with the support of two FHI Headquarter staff. This exercise resulted in IP selection. FHI completed its staff.
- Q1 of FY06 (October 2005): 1 HTC site from a previous project IMPACT (Ville Basse in Matadi) started its activities.
- Q2 of FY06: FHI opened its field offices in Bukavu and Lubumbashi.
- Q2 of FY06: FHI made 4 new HTC sites operational in Matadi, Bukavu, and Lubumbashi, which included Mobile HTC, and community-based activities in Bukavu.
- Q3 of FY06: FHI supported 7 other new HTC sites including 3 integrated TB/HIV CT sites in each town, 2 community stand alone (Bukavu and Lubumbashi), 1 youth CT site in Lubumbashi, and the training center (CFACD) in Bukavu.
- Q3-Q4 FY06: FHI brought full support to the provincial PNLS in each town to organize a referral workshop.
- Q1 of FY07: FHI assisted AMO-Congo to reopen its site in Kasumbalesa, which was funded previously by UNDP/Global Fund. Unfortunately, the activities in this site lasted one year due to a weak performance.
- Q3 and Q4 of FY07: FHI strengthened FP and AMO-Congo's technical and organizational capacities through TOCAT workshops that resulted in standing clear workplans.
- Q1 of FY08: the PNLS modified its guidelines on trainings, giving the MoH exclusive authority to do trainings, and consequently terminated the FP center activities in Bukavu. FHI solicited USAID involvement in the negotiation between FHI and PNLS.
- Q2 of FY09: under the USAID last demand and additional funding, FHI extended activities to 5 additional HTC sites in Katanga province located in Kipushi, Likasi and Kasumbalesa. These

[6] For US government and agencies, the fiscal year (FY) begins on October 1 and ends on September 30. Therefore, this calendar framework is executed per quarter: Quarter 1 (Oct-Dec), Quarter 2 (Jan-March), Quarter 3 (April- June) and Quarter 4 (July-Sept).

include 3 community stand alone HTC sites, 1 integrated HTC site in a General Hospital, and 1 Mobile HTC service.

- From FY09 Q3 till FY10 Q1: FHI started the process of progressive close-out of different sites according to its general workplan negotiated and approved by the donor. For this close-out, FHI developed a detailed plan of phase-out disengagement with local partners, which benefited from all acquired materials during the life of the project, so they will be able to continue their activities in a sustainability perspective.

Fig. 1. Implementation timeline and major achievements



5. PROGRAM IMPLEMENTATION

Introduction

Funded by USAID, FHI developed and implemented the RESA+, a four-year HIV/AIDS prevention and care project in three USAID-supported zones (Bas-Congo, Katanga, and Sud-Kivu provinces). This was the part of response to the DRC SNP in reducing HIV transmission and improving health of those affected and infected by HIV/AIDS. Specific objectives of the project were: 1) increase utilization of high-quality HTC services by high-risk and vulnerable populations in targeted geographical areas; 2) ensure an effective referral network, linkages, and coordination between existing primary health care system providers and community organizations providing multi-sectoral services in the targeted urban districts; 3) improve technical, organizational, and managerial capacity of new and existing Congolese organizations and networks to provide high quality prevention, care and support to PLWHA, OVC, and other vulnerable and high-risk populations; and 4) ensure the monitoring and evaluation of project activities.

FHI designed a customized program targeting the MARPs. FHI implemented this program in collaboration with PSI and CRS that together involved in a USAID 4-years comprehensive program. PSI ran community mobilization and HIV counseling and testing (HTC) promotion interventions. CRS developed a home-based care (HBC) and orphans/vulnerable children (OVC) program. As members of a team, FHI, PSI, and CRS together developed their respective programs to contribute to improving the breadth and quality of HIV/AIDS prevention and mitigation services available in the urban areas of Bukavu, Lubumbashi, and Matadi.

FHI's activities consisted in strengthening 1 existing community-based HTC site (Matadi), and opening an HTC training center in Bukavu to offer training to service providers. In addition, FHI deployed 3 mobile HTC units to reach transient populations such as female sex workers (FSWs), truckers, miners, youth, and current and demobilized military personnel in each city; and integrated HTC activities in 3 TB sites. Finally, FHI established 1 youth-friendly site to serve marginalized and most at risk youth specifically (Lubumbashi) and 4 HTC community-based services in these settings. Further, FHI added more sites in Katanga (5) while USAID increased funding during the life of project.

Management

An in-country management team conducted by the country director (CD) and assisted by its deputy (DCD) has local management responsibilities. The CD was responsible for supervising all technical assistance activities for FHI in the DRC, including the management of sub-grants to local implementing partners. He was supported by field office managers as well as by technical and program management personnel. The CD served as liaison with Headquarters and between FHI and donor and partners. Along with the CD, the DCD was responsible for coordinating partners, capacity building activities. He also had to provide programmatic, administrative and financial support to IP.

The managerial, technical and administrative national staff in Kinshasa provided technical assistance to FHI's field offices and implementing partners (IPs).

On a regular basis, a FHI team based in Headquarters brought consistent support to the field team.

Implementation strategies
FHI's guiding approach to program implementation focused on 1) field formative assessment, 2) strengthening institutional capacities (equipment, supplies and renovations) and 3) technical capacities (training, joint supervisions with health district authorities) of stakeholders and IPs.

6. RESULTS

Related to objective (1) **– *To increase utilization of high-quality HTC services by high-risk and vulnerable populations in targeted geographical areas.***

6.1. Overall Results

Over the four years of the project:

- 16 sites were operational (see table 1 below)
- 317 persons trained in following technical areas (HIV counseling, performing HIV rapid tests, HIV peer education)
- 180,900 clients (95,163 males and 85,737 females) were counseled and tested against an expected target of 180,000 (100.5%). 98.1% of the clients counseled and tested (177,461, including 93,555 males and 83,906 females) received their HIV results. 6.3% [11,346 (4,162 males and 6,890 females)] were HIV-positive and 2,826 (1.6%) were undetermined (see fig. 2 below).

In three towns of interventions (Matadi, Bukavu and Lubumbashi), the project covered nearly 30% of 2.5 M population targeted by the National Control AIDS Program (PNLS) as illustrated in the table 2 below[7].

Table 1: Overall results on counseled and tested clients aggregated by sex in the HTC sites.

Implementing Partners	Geographic Location	HTC Site Models	Tested for HIV			Tested HIV +		
			M	F	Tot	M	F	Tot
1. ACS/AMO-Congo	Matadi	Community stand alone	*6556*	*6986*	**13542**	*30*	*609*	**639**
		Community stand alone	*5537*	*5383*	**10920**	*112*	*223*	**335**
		Mobile	*7932*	*1856*	**9788**	*201*	*132*	**333**
	Lubumbashi	Community stand alone	*6930*	*7015*	**13945**	*555*	*788*	**1343**
		Youth	*5621*	*5091*	**10712**	*354*	*461*	**815**
		Mobile	*10618*	*10884*	**21502**	*805*	*1033*	**1838**
	Kasumbalesa[8]	Community stand alone	*1028*	*869*	**1897**	*150*	*139*	**289**
		Community stand alone	*1393*	*878*	**2271**	*114*	*129*	**237**
2. Femme Plus	Bukavu	Community stand alone	*17422*	*14020*	**31442**	*330*	*587*	**917**
		Mobile	*16961*	*13729*	**30690**	*171*	*327*	**498**

[7] The coverage result for these three towns has been specifically presented due to the long period (four years) of life of the project.
[8] Kasumbalesa site has been counted once as physically activities have been implemented on the same location (through two donors at two different periods)

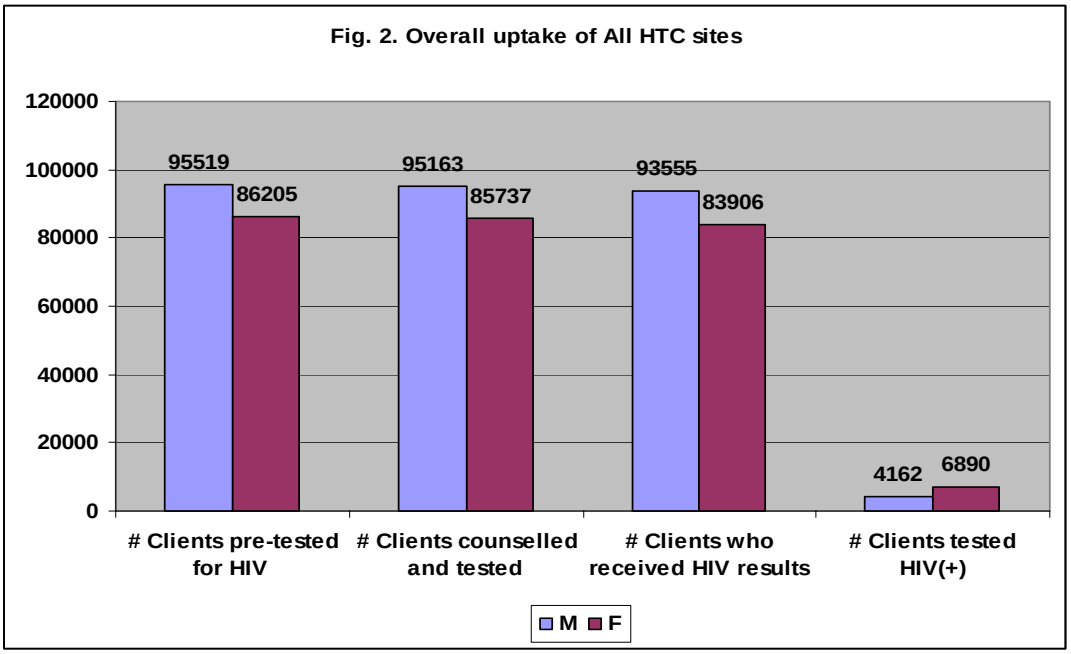
		CFACD*[9]	*99-*	*99-*	**198-**[10]**	-	-	-
3. World Production	Lubumbashi	Mobile	*2127*	*927*	**3054**	*45*	*63*	**108**
	Kipushi	Community stand alone	*1169*	*1280*	**2449**	*29*	*62*	**91**
	Likasi	Community stand alone	*1533*	*974*	**2507**	*32*	*51*	**83**
4. HGR Nyantende	Bukavu	TB/HIV integrated	*1633*	*3584*	**5217**	*76*	*103*	**179**
5. HGR Kenya	Lubumbashi	TB/HIV integrated	*3470*	*4967*	**8437**	*963*	*1680*	**2643**
6. CSR Mvuzi	Matadi	TB/HIV integrated	*3945*	*5444*	**9389**	*152*	*412*	**564**
7. HGR Panda	Likasi	Hospital stand alone	*1288*	*1850*	**3138**	*43*	*91*	**134**
Total			***95163***	***85737***	**180900**	***4162***	***6890***	**11052**

Table 2. Program coverage in FHI-supported zones in 2009

	Bukavu	Lubumbashi	Matadi	Total (3 towns)
Population in the intervention zone	592,674	1,501,501	212,306	2,306,481
% general coverage [ζ]	24	24	24	24
Expected Number in HTC services	142,242	360,360	50,953	553,555
Number of clients in FHI-supported zones	67,349	54,596	43,639	165,584
% FHI coverage program	47	15	85	29.9

[ζ] according to PNLS reference (PNLS, Annual report 2008)

Fig. 2. Overall uptake of All HTC sites

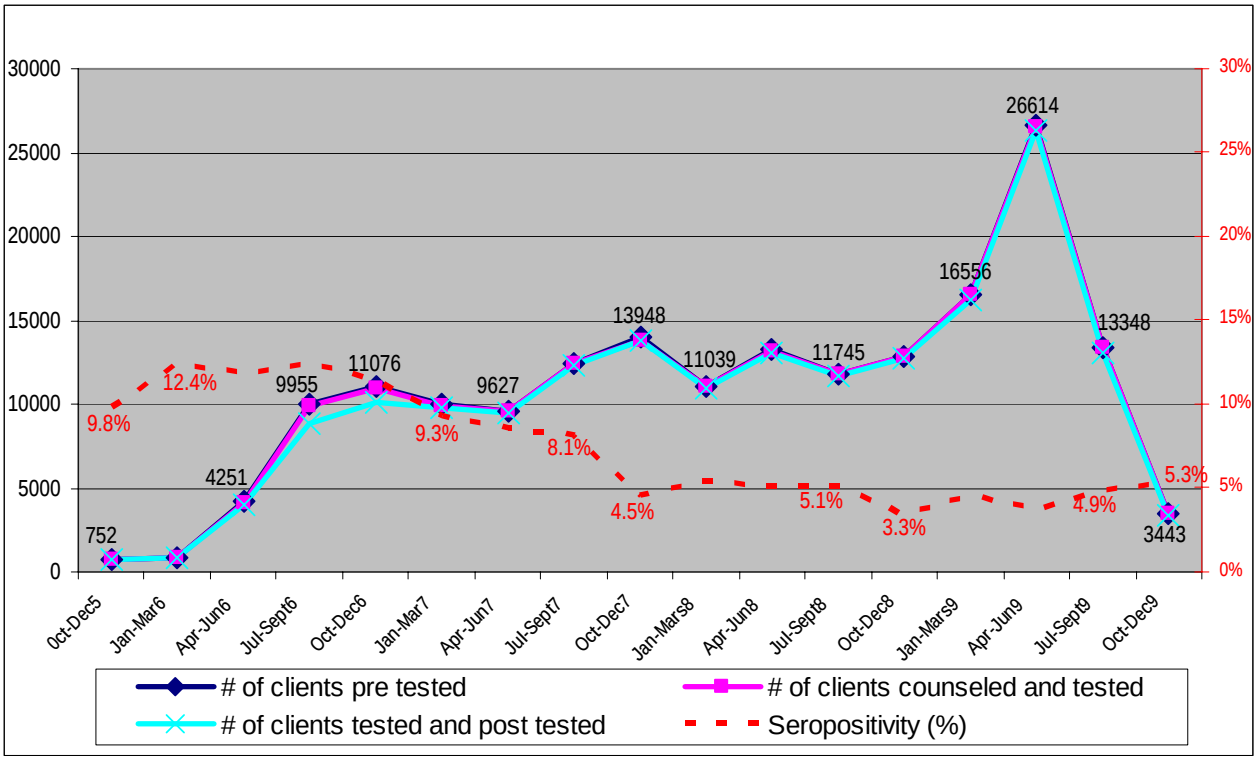


[9] * **CFACD** = Testing & Counseling Training & Learning Center

[10] ** During its short time of life, this center offered trainings in various areas: HTC, TB/HIV integration, PMTCT, Income Generative Activities (IGA)

The 16 HTC sites gradually started and progressively closed-out as mentioned in the summary of implementation process (see text page 10). The quarterly uptake of counseling and testing services rose progressively from 752 clients in October 2005 to 26,614 clients in June 2009 when the total of HTC sites was operational, with a quarterly uptake average of 10,688 (see fig. 3 below).

Fig.3. Quarterly uptake trend in all RESA+ HTC sites

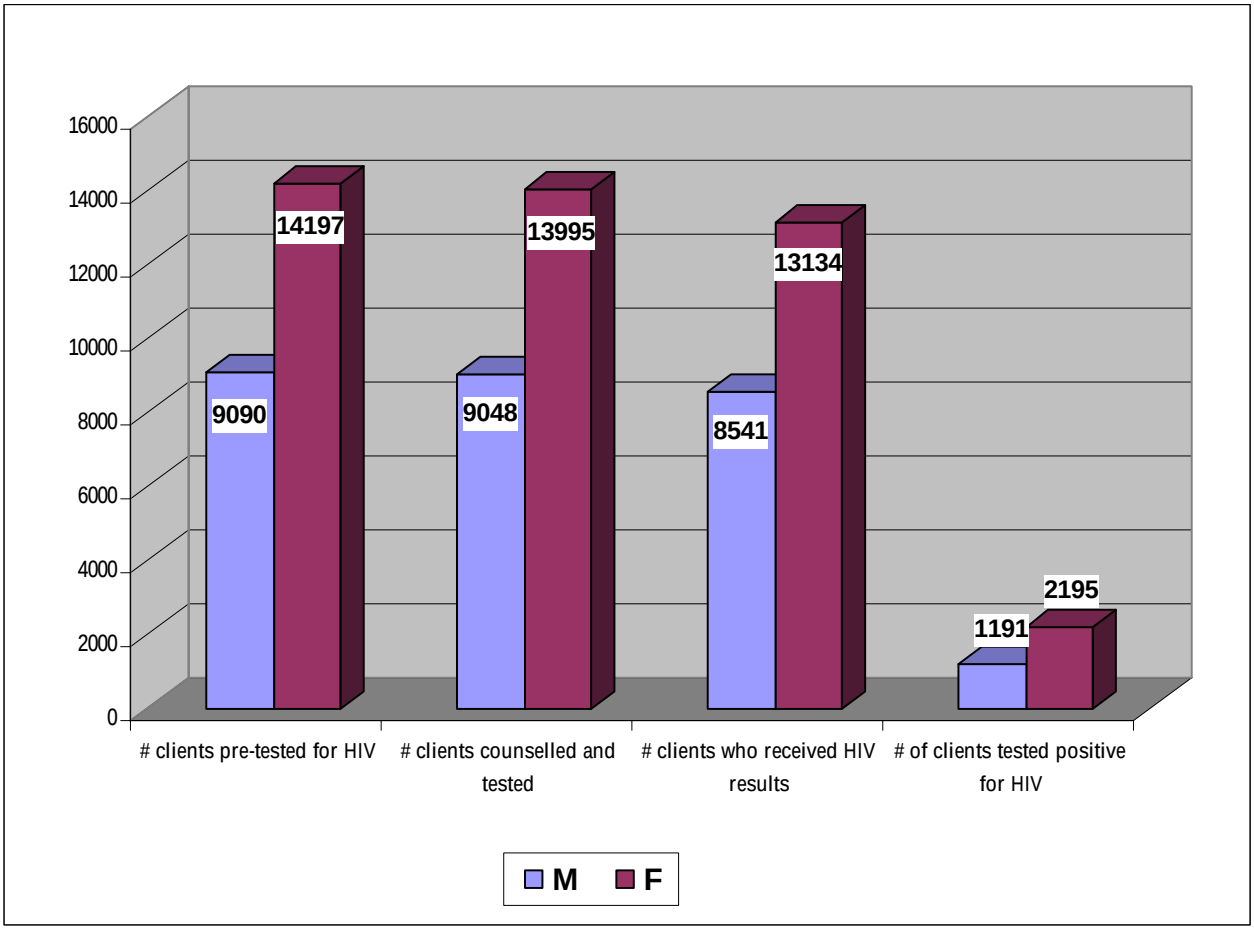


In the course of the project, almost clients counseled have been tested and received their results. The HIV positive rate declined over the time (from 9.8% to 5.3%) due probably to the presence of other HTC sites supported by other donors such as GF (fig.3).

6.2. Overall results of integrated sites (TB/HIV)

During the course of Project, FHI established 3 integrated HTC in TB health structures in each of the town (Matadi, Bukavu and Lubumbashi). A total of 23,287 (9,090 male and 14,197 female) clients, including TB patients (2,083) and members of the general population were counseled and tested by the end of the project. Among them 14.7% [3,386 (1,191 males and 2,195 females)] were tested HIV positive; of those tested, 94.1% [21,675 (8,541 males and 13,134 females)] received their HIV results (fig.4).

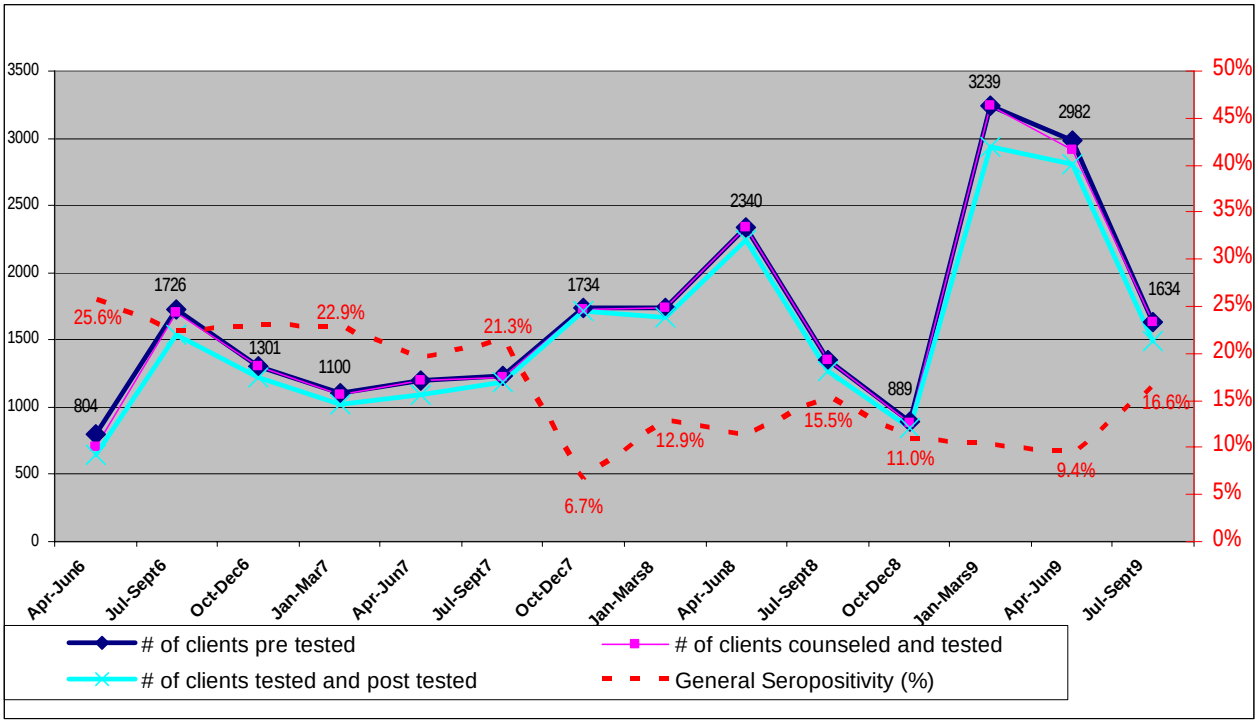
Fig.4. Overall uptake in the 3 Integrated TB/HIV sites



The 3 TB/HIV sites started HTC service delivery in June 2006. One of them was closed in June 2009 and the two others in September 2009 as shown in fig.5 below.

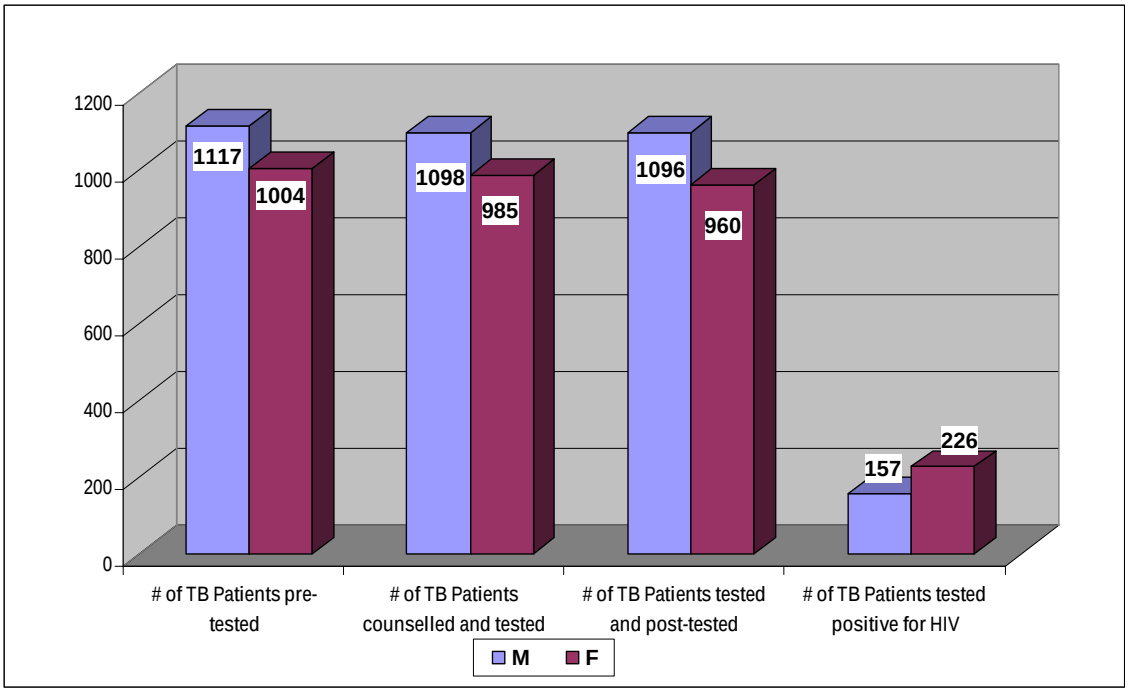
The quarterly uptake of counseling and testing services in these sites rose from 804 clients in June 2006 to 1,726 the following quarter, and declined slightly to 1,100 at the end of March 2007 ("start effect"), after which it significantly increased to 2,340 at the end of June 2008. After June 2008, the quarterly uptake drastically dropped and reached a minimum of 889 clients at the end of December 2008. This very low uptake was due to a 5-month-long nurses' strike between October and December 2008. Once they resumed work, the quarterly uptake quickly rose to 3,239 at the end of the next quarter in March 2009 before declining again to 1,634 in September 2009 with the closure of some sites. The HIV prevalence rate evolved from 25.6% to 16.6% with a minimum of 6.7% (?).

Fig.5. Quarterly uptake trend of Integrated TB/HIV sites



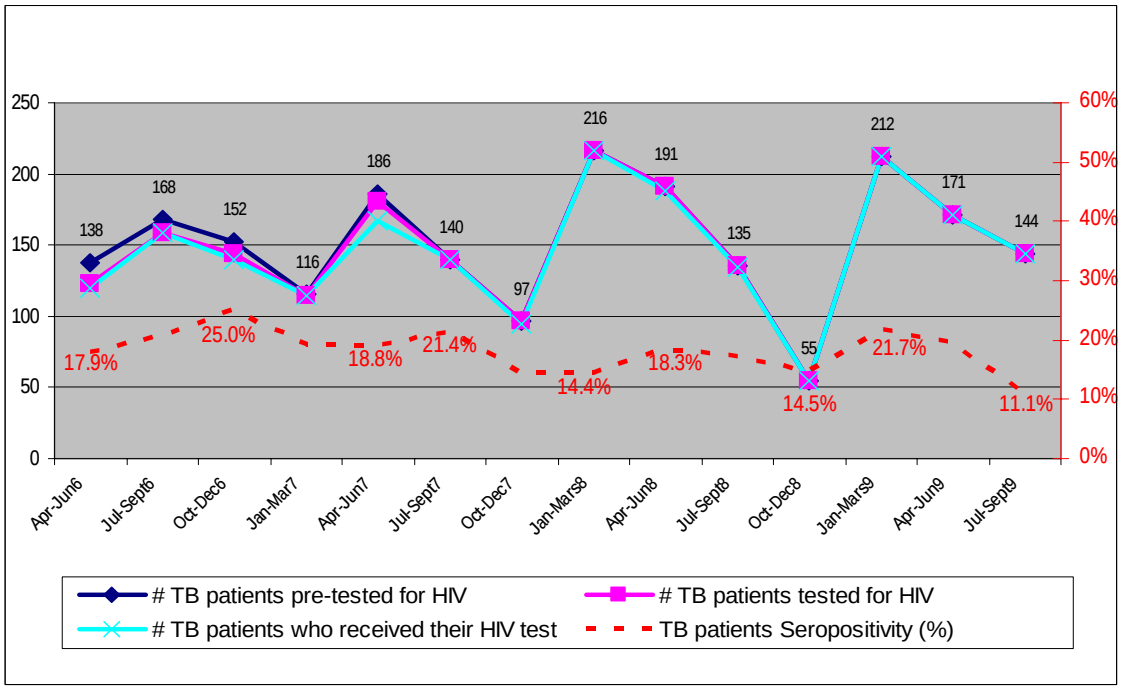
Out of the total 23,287 clients in the integrated TB/HIV sites, 9.1% of them [2121 (1117 males and 1004 females)] were TB patients. Among these TB patients, a total of 2,083 (1098 males and 985 females) were tested for HIV and 18.4% [383 (157 males and 226 females)] were HIV positive, thus co-infected with both TB and HIV. Among TB patients who were tested, 98.7% [2,056 (1,096 males and 960 females)] received their HIV results (see fig.6 on the next page).

Fig.6. overall uptake among TB patients in integrated TB/HIV sites



The quarterly service uptake by TB patients in the 3 integrated TB/HIV sites ranged between a minimum of 55 and a maximum of 216, with an average uptake of 152 TB patients per quarter. The minimum uptake of 55 was reached during the quarter October to December 2008 when the nurses' strike was at its height. The HIV prevalence rate oscillated between 11.1% and 25.0% with an average of 18.4% per quarter (fig.7 below).

Fig.7. Quarterly uptake trend among TB patients in 3 integrated TB/HIV sites

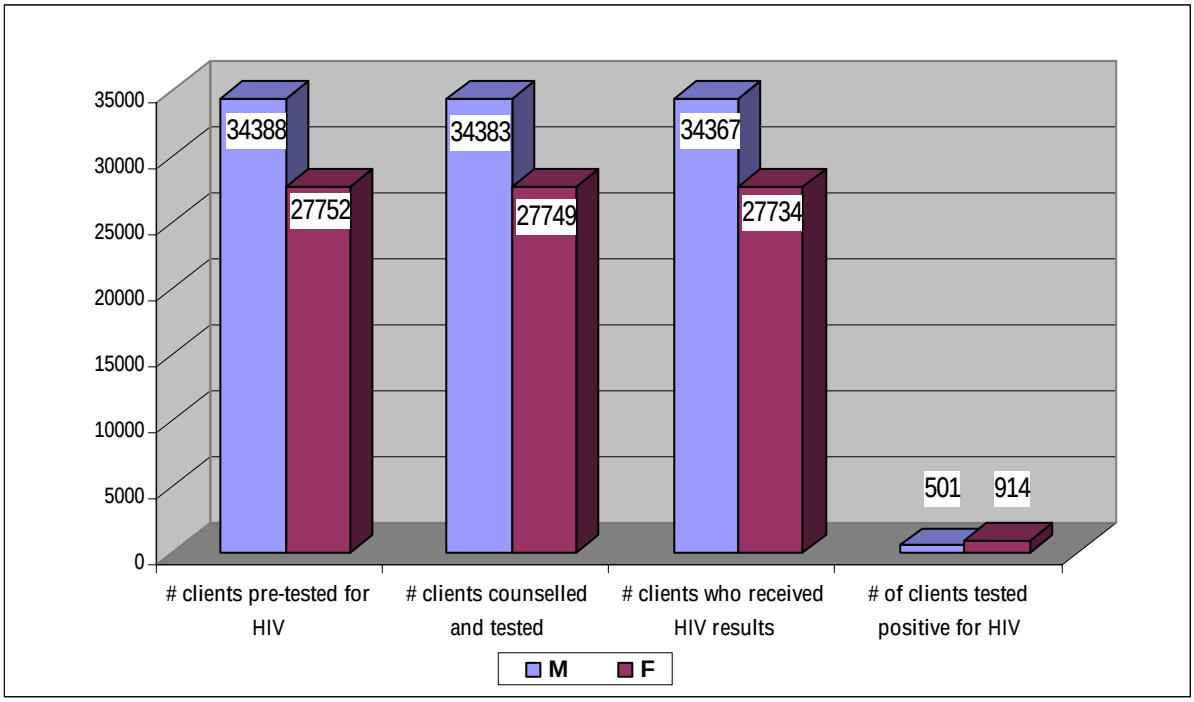


6.3. Implementing Partner Individual Results

6.3.1. Femme Plus Counseling and Testing sites

Fondation Femme Plus managed two HTC sites and the HTC training site, CFACD. These three sites were located in Bukavu. The training center was terminated prematurely in December 2007 as the PNLS changed its policy, making capacity building the exclusive preserve of the PNLS. The two other HTC sites were a community stand-alone site and a mobile HTC unit.
In total these two HTC sites (see fig.8 below) offered service to 62,132 clients (34,383 males and 27,749 females), among whom 2.3% [1,415 (501 males and 914)] were HIV positive and 99.9% [62,101 (34,367 males and 27,734 females)] received their HIV results.

Fig.8. Overall uptake in the 2 Femmes Plus HTC sites



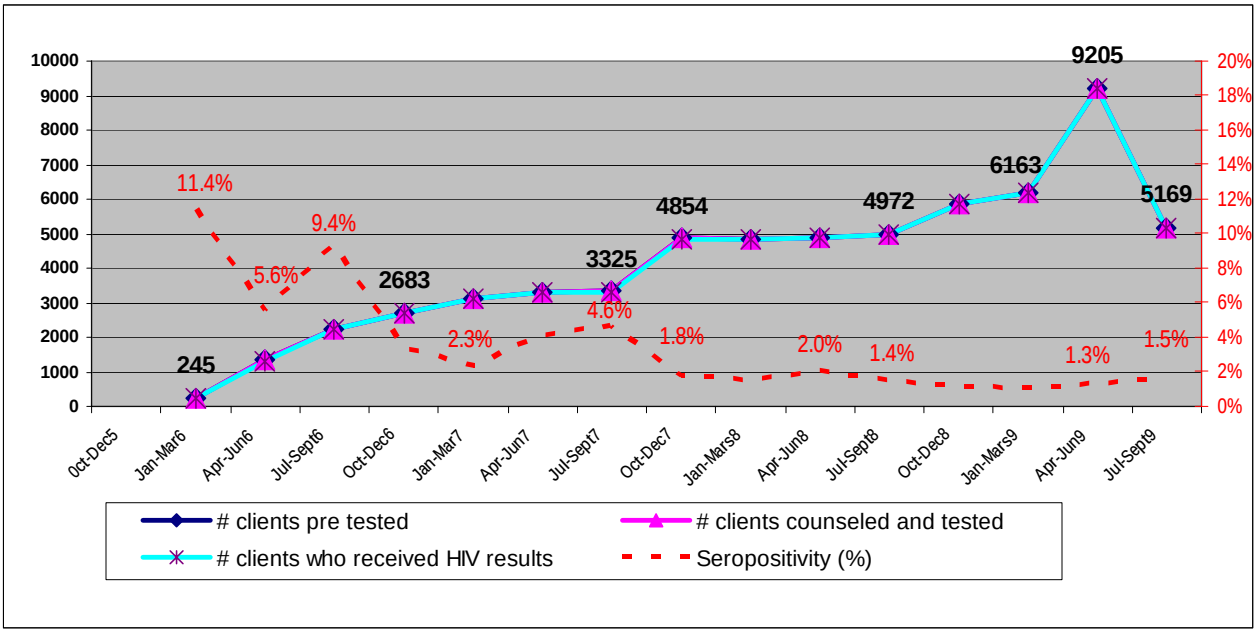
The table 3 (next page) shows the individual contribution of each FP HTC site, by sex.

Table 3. Contribution of each site in the overall result of Femmes Plus, by sex

		# clients pre-tested	# clients counseled & tested	# clients received HIV results-test counseled	# clients tested HIV positive	HIV positive rate (%)
Mobile HTC site	***M***	*16961*	*16961*	*16961*	*171*	*1.0%*
	F	*13729*	*13729*	*13728*	*327*	*2.4%*
	Tot	**30690**	**30690**	**30689**	**498**	**1.6%**
Community Stand alone HTC site	***M***	*17427*	*17422*	*17406*	*330*	*1.9%*
	F	*14023*	*14020*	*14006*	*587*	*4.2%*
	Tot	**31450**	**31442**	**31412**	**917**	**2.9%**
Total FP HTC sites	***M***	*34388*	*34383*	*34367*	*501*	*1.5%*
	F	*27752*	*27749*	*27734*	*914*	*3.3%*
	Tot	**62140**	**62132**	**62101**	**1415**	**2.3%**

The 2 FP HTC sites started in February and March 2006, respectively, and were closed in September 2009. The quarterly uptake rose from 245 clients in March 2006 to 9,205 clients in June 2009 and began to decline in July 2009 as shown in the figure 9 below. Only 5169 clients visited the sites over the course of the July-September 2009 quarter. The average quarterly uptake was 4,143 clients over the course of the entire project. The quarterly HIV positive rate varied between 1.5% and 11.4%, with an average of 2.3%. This resulted in presence of other HTC services in the province funded by GF as already mentioned above (see p.15).

Fig.9. Quarterly uptake trend in 2 Femmes Plus HTC sites



6.3.2. AMO-Congo Counseling and Testing sites

AMO-Congo managed seven HTC sites located in three cities, Matadi (Bas-Congo province), Lubumbashi and Kasumbalesa (both in Katanga province). These HTC sites were community stand alones (4), mobile HTC units (2) and a youth HTC site. The Kasumbalesa site was previously supported by funds from UNDP/The Global Fund. Because of funding difficulties, this site was shifted to RESA+ project for one year. It was finally closed for cost-efficiency reasons as it is located far away from Lubumbashi and the partner lost its well trained counselors due to a high competitive work environment ("Mining phenomenon"). Because Kasumbalesa is known to be a high HIV transmission area, FHI sourced for additional funds to continue support to this site. Later, FHI resumed its support to the Kasumbalesa site with additional fund that USAID provided for extension of HTC in the new sites (further explained below in the text).

In total, AMO-Congo HTC sites counseled and tested 84,577 clients (45,615 males and 38,962 females). Among them, 7.2% [6,129 (2621 males and 3508 females)] were tested HIV positive and 97.9% [82,779 (44,653 males and 38,126 females)] of these tested clients received their HIV results (see the figure 10 below).

Fig.10. Overall uptake in 7 AMO-Congo HTC sites

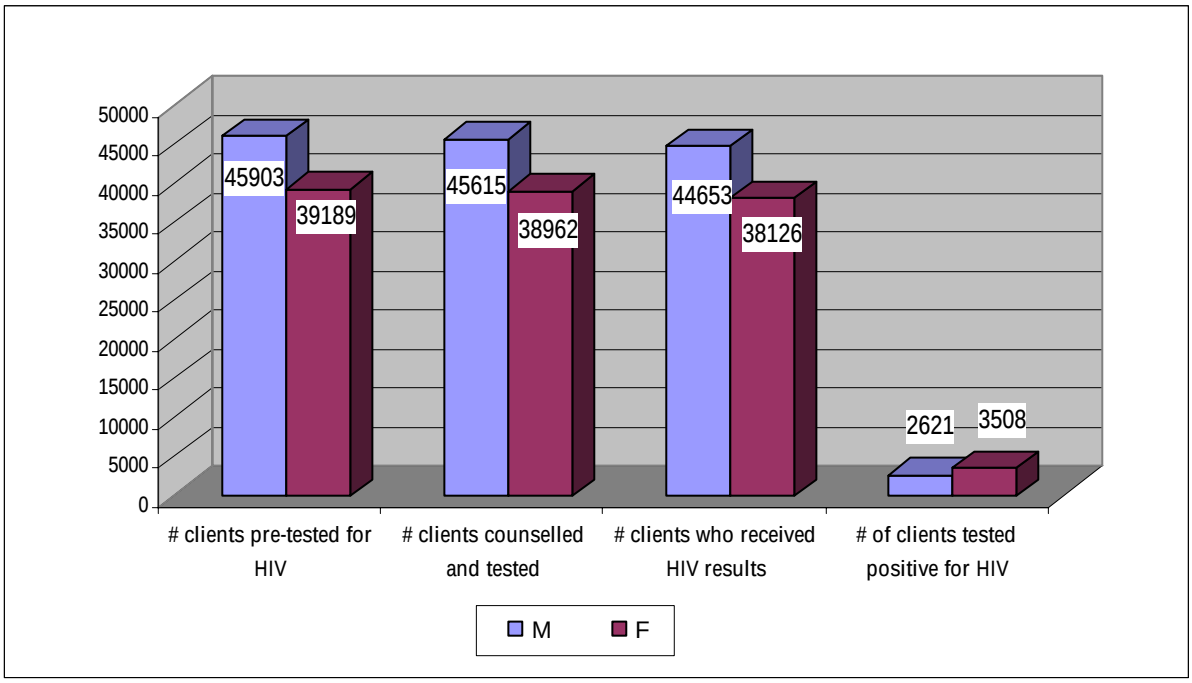


Table 4 (see next page) provides the individual contribution for each HTC site supported through AMO-Congo.

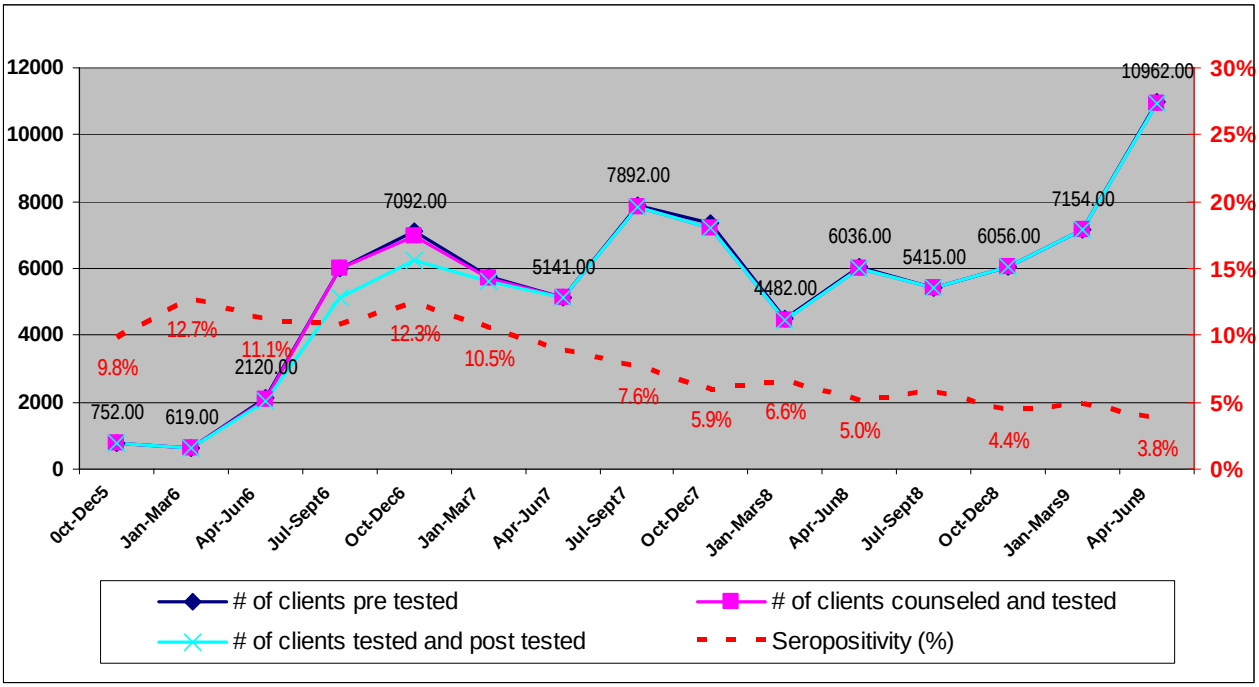
Table 4. Contribution of each site in the overall result of AMO-Congo, by sex

		# clients pre-test counseled	# clients counseled and tested	# clients who received HIV results	# clients tested HIV positive	HIV positive rate (%)
Mobile HTC site Matadi	***M***	*7932*	*7932*	*7932*	*201*	*2.5%*
	F	*1856*	*1856*	*1856*	*132*	*7.1%*
	Tot	**9788**	**9788**	**9788**	**333**	**3.4%**
Ville Basse HTC site	***M***	*6557*	*6556*	*6555*	*330*	*5.0%*
	F	*6987*	*6986*	*6986*	*609*	*8.7%*
	Tot	**13544**	**13542**	**13541**	**939**	**6.9%**
Chic-Chic HTC site	***M***	*5537*	*5537*	*5535*	*112*	*2.0%*
	F	*5385*	*5383*	*5381*	*223*	*4.1%*
	Tot	**10922**	**10920**	**10916**	**335**	**3.1%**
Mobile HTC site Lubumbashi	***M***	*10788*	*10618*	*10080*	*805*	*7.6%*
	F	*11014*	*10884*	*10493*	*1033*	*9.5%*
	Tot	**21802**	**21502**	**20573**	**1838**	**8.5%**
Tabac-Congo HTC site	***M***	*6982*	*6930*	*6662*	*555*	*8.0%*
	F	*7051*	*7015*	*6730*	*788*	*11.2%*
	Tot	**14033**	**13945**	**13392**	**1343**	**9.6%**
Youth HTC site	***M***	*5665*	*5621*	*5531*	*354*	*6.3%*
	F	*5127*	*5091*	*4986*	*461*	*9.1%*
	Tot	**10792**	**10712**	**10517**	**815**	**7.6%**
Kasumbalesa HTC site	***M***	*2442*	*2421*	*2358*	*264*	*10.9%*
	F	*1769*	*1747*	*1694*	*262*	*15.0%*
	Tot	**4211**	**4168**	**4052**	**526**	**12.6%**
Total AMO-Congo HTC sites	***M***	*45903*	*45615*	*44653*	*2621*	*5.7%*
	F	*39189*	*38962*	*38126*	*3508*	*9.0%*
	Tot	**85092**	**84577**	**82779**	**6129**	**7.2%**

Only 1 of the 7 AMO-Congo HTC sites started its activities during the period October-December 2005; the other 6 started their activities 12 months later due to difficulty to find available buildings to house these activities. Figure 11 (see next page) shows the quarterly uptake of HTC services in the 6 AMO-Congo HTC sites (till June 2009 except Kasumbalesa HTC site which continued to November 2009 with an average of 757 clients per quarter). The quarterly uptake of services in the 6 sites rose from 752 clients in December 2005 to a high of 10,962 clients at the end of the April-June 2009 quarter. Performance declined between December 2006 and June 2007, and between October 2007 and March 2008, possibly due to loss of trained counselors that moved to best paid mining enterprises.

The average quarterly uptake of services was 5,521 and the HIV prevalence rate ranged between 9.8% and 3.8%, with a quarterly average of 7.2%.

Fig.11. Quarterly uptake trend in 6 AMO-Congo HTC sites



6.3.3. Integrated TB/HIV Counseling and Testing Sites

In the course of the RESA+ project, FHI worked with the government health structures and the health districts authorities in the three cities to integrate HTC services into TB services to reach the TB patients who are at high risk to contract HIV. The overall objective of this integration was to primarily provide HIV screening to TB patients and secondarily provide similar HTC services to the general population. This integration consisted in training staff in HIV counseling and rapid tests performance, basic renovation to let operation well doing. In addition, FHI supplied with HIV kit tests, reagents and provided a closer monitoring to maintain high quality of HIV services.
TB tests and medicines were provided through another funding mechanism.

6.3.3.1. CSR MVUZI

The Reference Health Center (CSR) Mvuzi in Matadi houses a TB unit where FHI assisted to integrate HIV counseling and testing services into this existing TB unit. This site started services delivery in June 2006 and the support with the project stopped in September 2009 as per the established workplan and available funding. As shown in Figure 12 below, under this RESA+ project, this site provided HTC services to a total of 9,404 (3,949 males and 5,455) clients including the general population and TB patients. Among them 6.0% [564 (152 males and 412 females)] were tested HIV-positive and 3.0% were undetermined [283 (130 males and 153 females)]. Of the clients tested, 94.1% [9,331 (3,914 males and 5,417 females)] received their HIV results.

Fig.12. Overall uptake in CSR Mvuzi integrated TB/HIV site

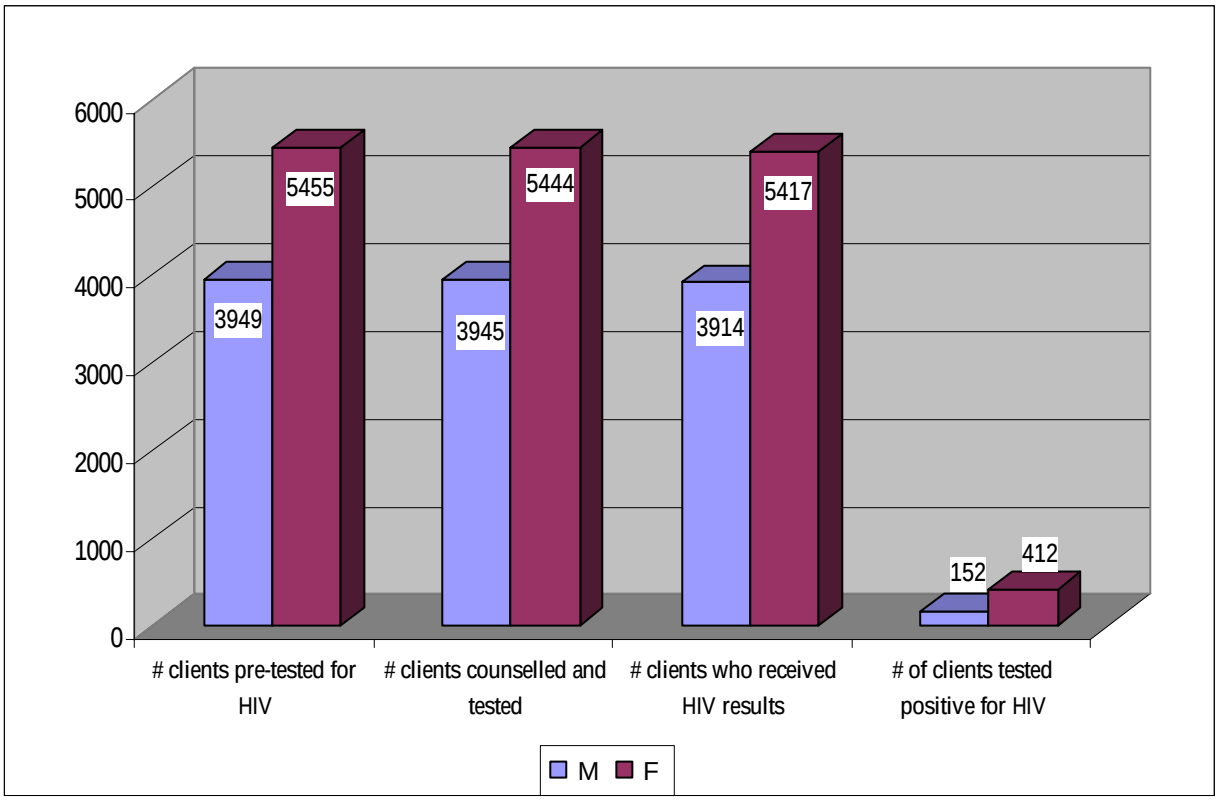


Figure 13 provides information on TB patients. Among 9,404 clients counseled and tested in the site, 7.3% [689 (332 males and 357 females)] were TB patients. Among these TB patients, 99% [682; (330 males and 352 females)] were counseled and tested for HIV and 12.6% [86 (21 males and 65 females)] were HIV positive and concurrently infected by TB and HIV. Among the TB patients tested HIV positive, there were three times more women than men (18.5% vs. 6.4% respectively). Of the TB patients tested, 96.5% received their HIV result.

Fig. 13. Overall uptake for TB patients in CSR Mvuzi integrated TB/HIV site

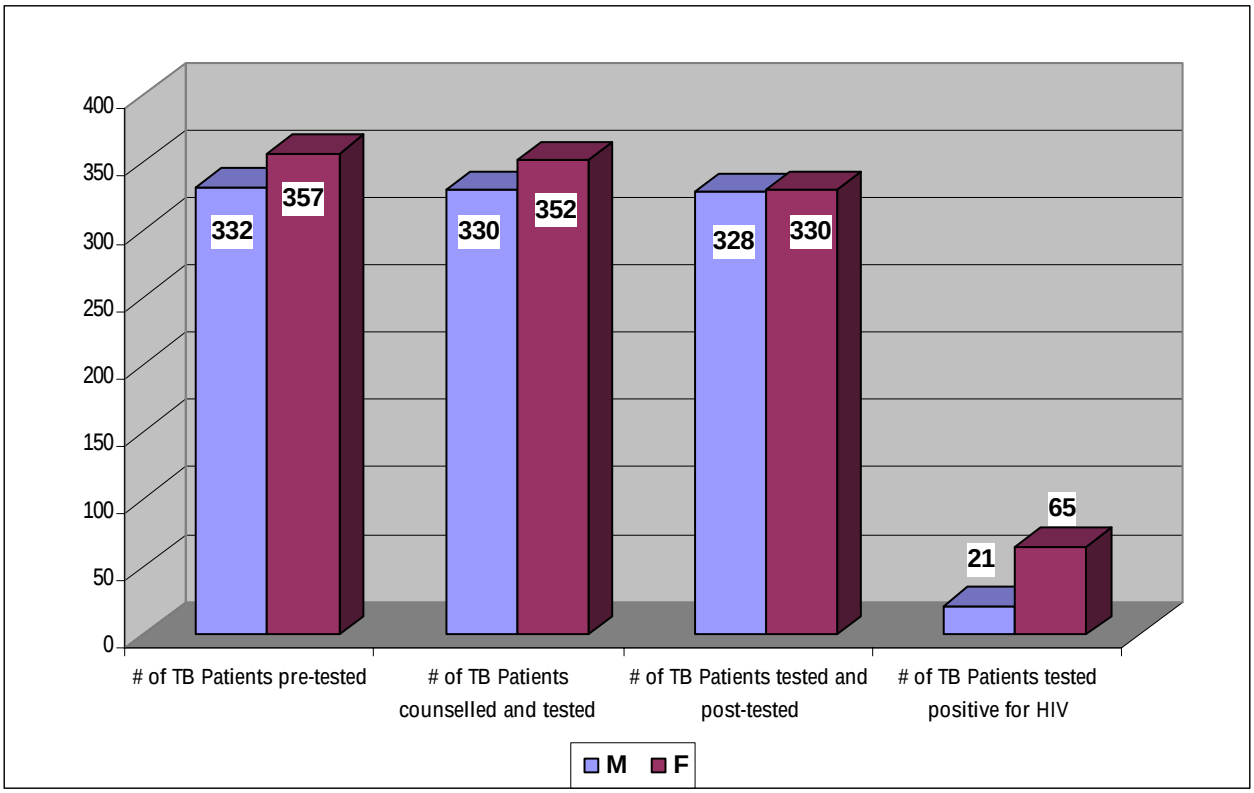
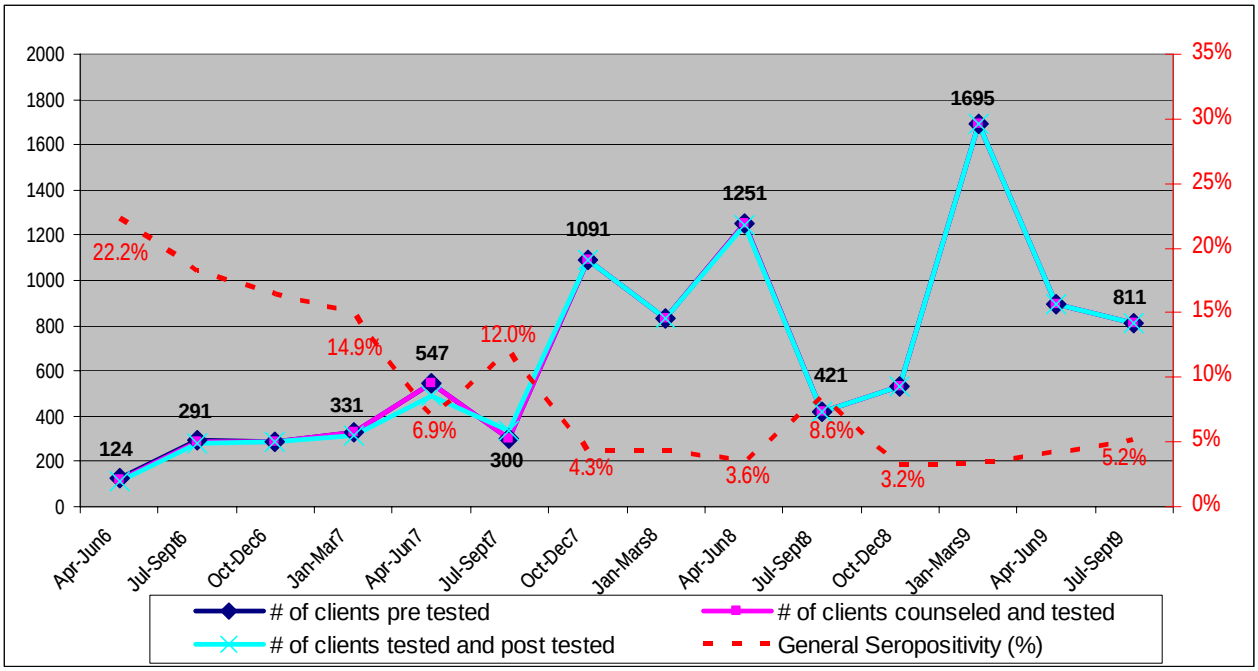


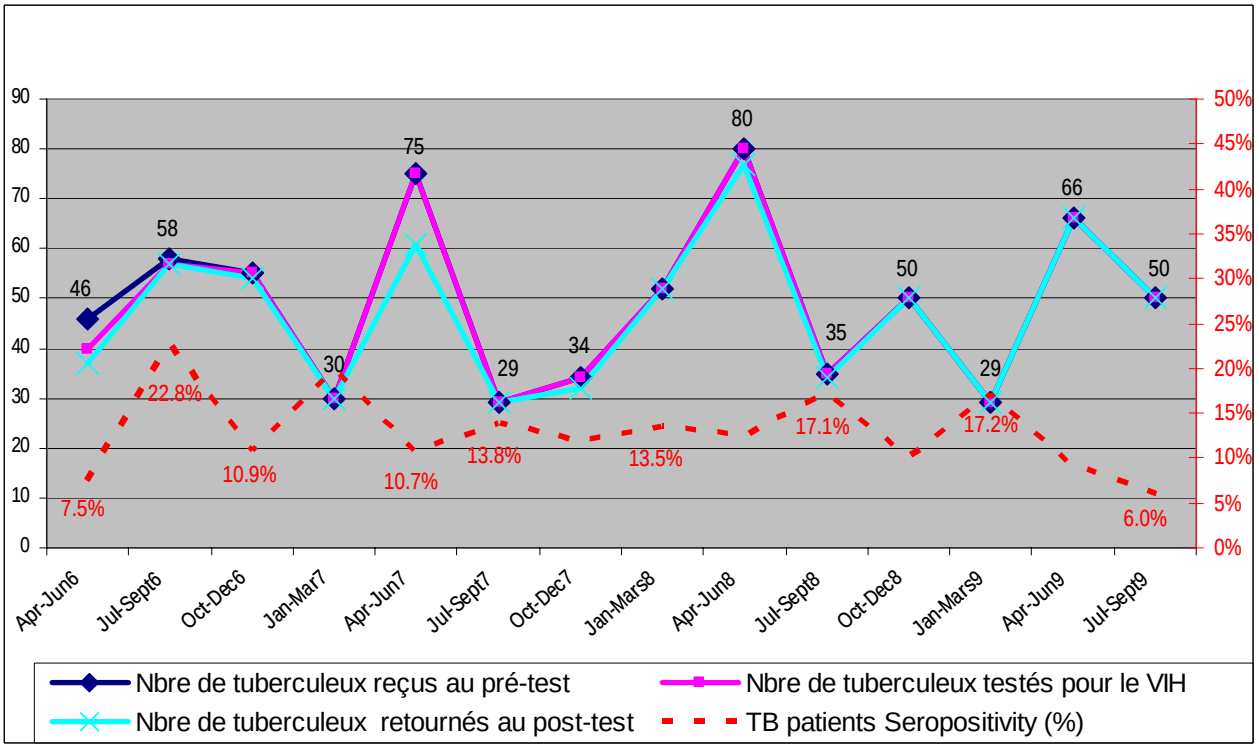
Figure 14 (see next page) provides more detailed information on progressive site uptake.
The quarterly uptake of services that started at 124 for the April-June 2006 quarter increased up to 547 by the end of the April-June 2007 quarter. From July 2007 through March 2009, uptake varied significantly from 1,251 to 421 during April 2008-March 2009 period because of repetitive nurses' strike. This site knew an overall HIV prevalence at 6.0%, range 5.2%-22.2%.

Fig.14. Quarterly uptake trend in CSR Mvuzi



This observed trend among general clients of the site was almost similar for TB patients for whom HIV prevalence was 12.6% (6%-22.8%) as shown in the figure 15 below.

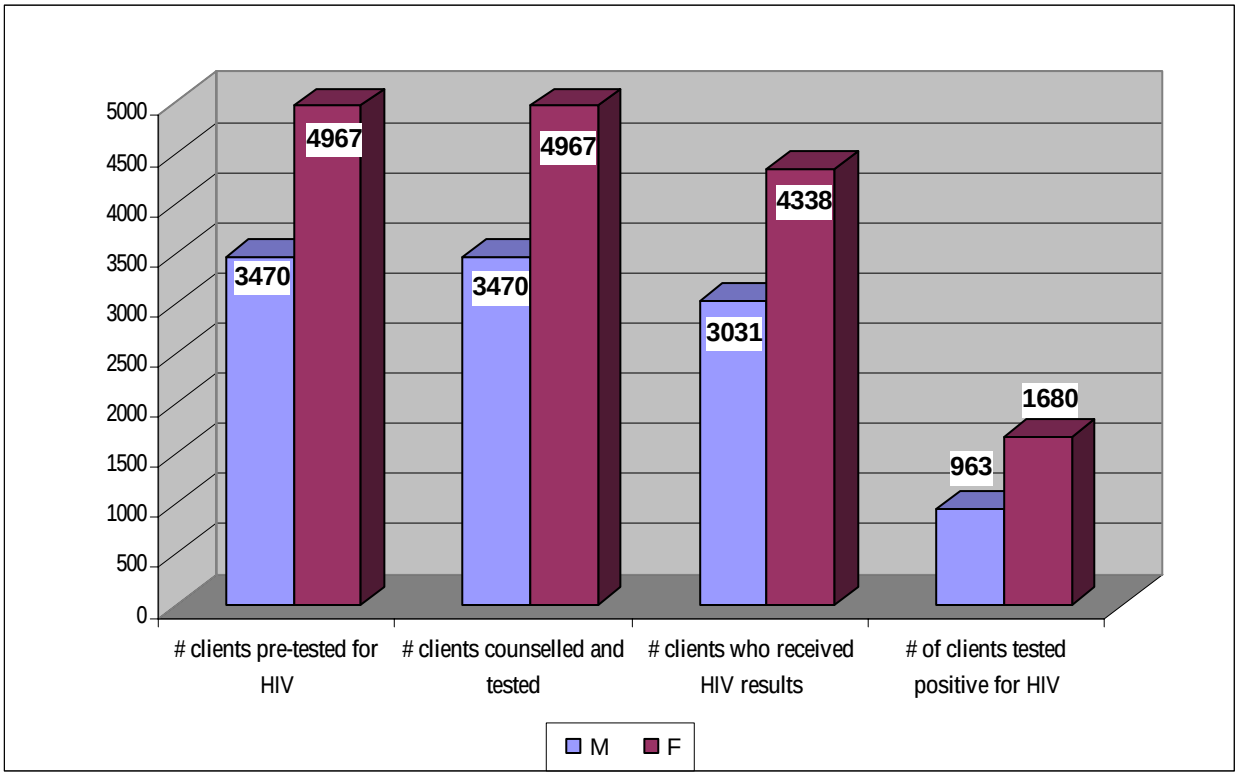
Fig. 15. Quarterly uptake trend among TB patients in CSR Mvuzi



6.3.3.2. HGR Kenya

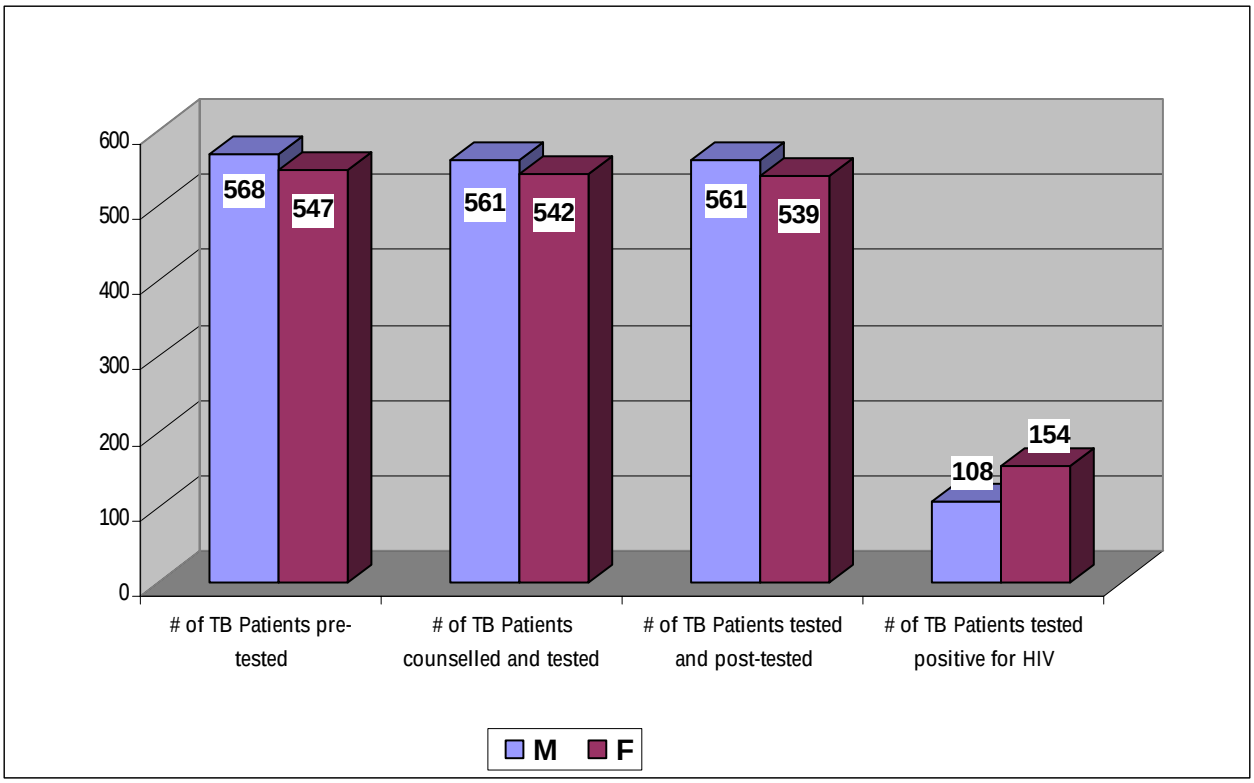
The Kenya General Reference Hospital (HGR) in Lubumbashi initiated HTC services in June 2006 and the support with this project stopped in September 2009 according to the workplan approved by the donor. Figure 16 below gives the global cumulative uptake of HTC services at this facility. A total of 8,437 clients (3,470 males and 4,967 females including 1.115 TB patients) were counseled and tested by the end of the project. Among them 31.3% [2,643 (963 males and 1680 females)] were tested HIV-positive and 2.4% were undetermined [205 (106 males and 99 females)]. Of those tested, 94.1% [7,369 (3,031 males and 4,338 females)] received their HIV results.

Fig.16. Overall uptake in HGR Kenya



Among the 1,115 TB patients (568 males and 547 females) seen in the site who represented 13.2% on total clients, 1,113 (561 males and 542 females) were counseled and tested for HIV and 23.8% [262 (108 males and 154 females)] were HIV positive. 96.5% [1100 (561 males and 539 females)] of tested TB patients received their HIV results (see figure 17 in the next page). These data showed that Females were more infected than males TB patients (28.4% vs. 19.3%).

Fig.17. Overall uptake for TB patients in HGR Kenya integrated TB/HIV site

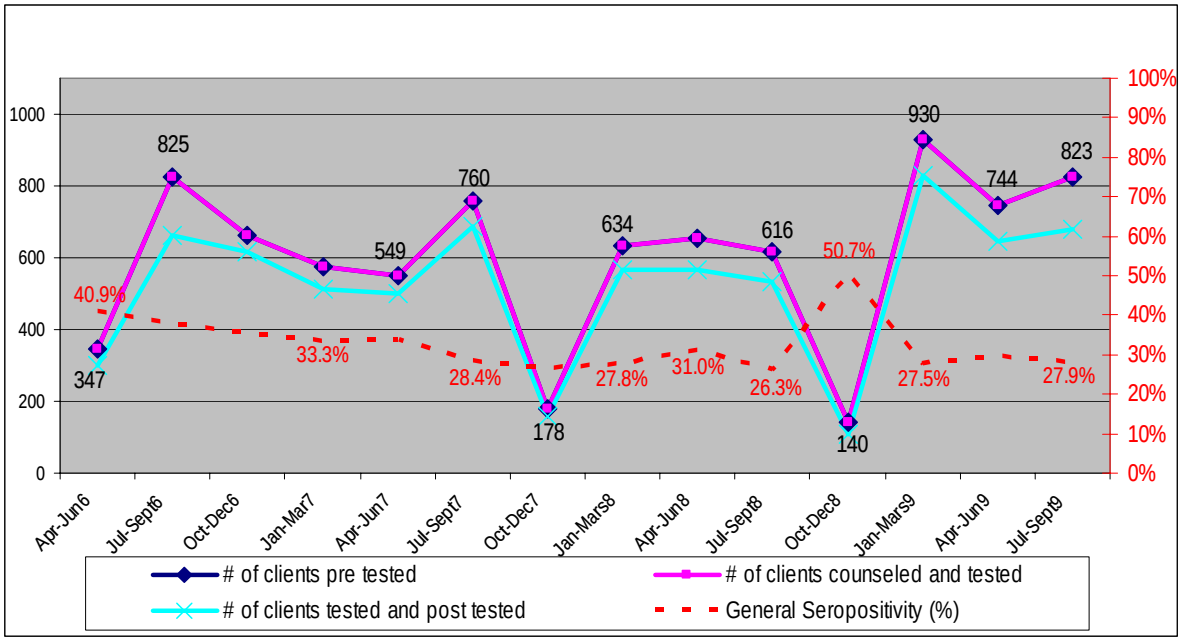


- **Overall quarterly uptake of HTC services at HGR Kenya**

Figure 18 shows that the quarterly uptake of HTC services at HGR Kenya fluctuated significantly, with low uptakes during the October-December 2007 quarter (178) and the October-December 2008 quarter (140), principally due to the nurses' strike. Maximum service uptake was registered during the January-March 2009 quarter (930). On average, 630 clients benefited from HTC services per quarter.

Quarterly HIV prevalence in this site varied between 27.5% and 40.9% with an average of 31.3%. This was due probably to the presence of ARV therapy that FHI brought (through GF mechanism) in the site. At this time, a free on charge ARV therapy was not commonly distributed in the town. In addition, FHI encouraged the PLWA seen in this site to set up a post test club for mutual assistance (psychological, material). This group evolved in the sensitization in their community and probably helped other patients to seek care.

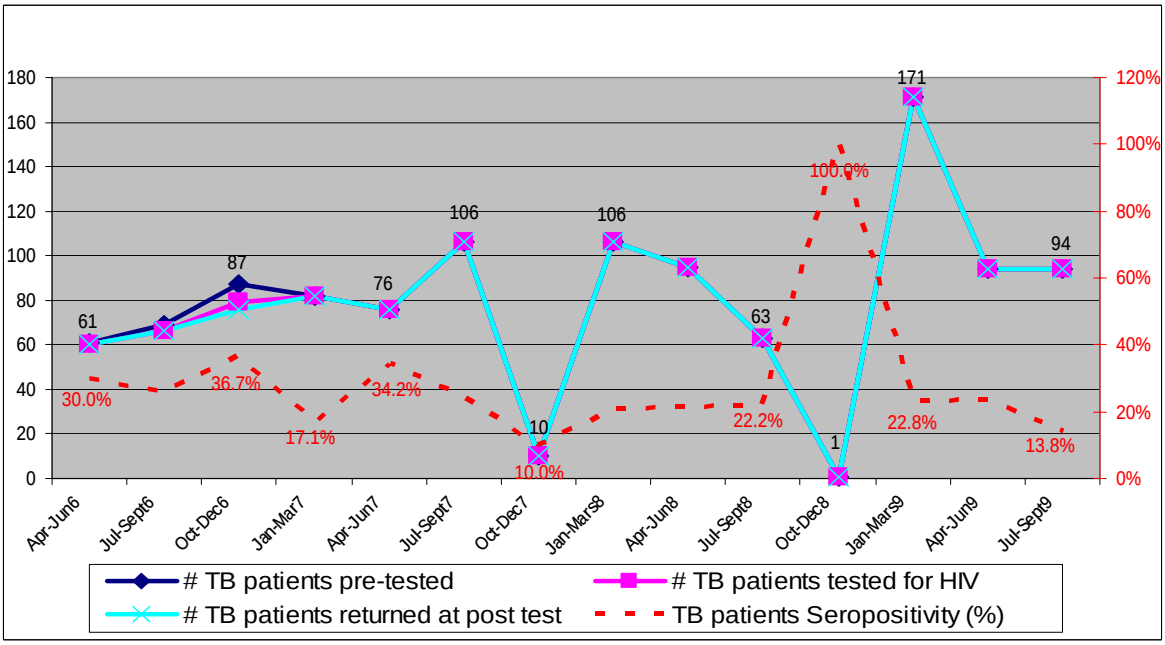
Fig.18. Quarterly uptake trend in HGR Kenya integrated TB/HIV site



- **Quarterly uptake of HTC services at HGR Kenya by TB patients**

Figure 19 below shows that quarterly uptake of HTC services by TB patients fluctuated from one quarter to another, from a low of 1 in the October-December 2008 quarter and a high of 171 in the January-March 2009 quarter. The average quarterly uptake was 80 TB patients. The lowest uptakes were registered during nurses' strikes. HIV quarterly prevalence rate varied between 13.80% and 36.7% with an average of 23.8%. This average HIV prevalence is lower than the global site's rate (31.3%). This resulted in PLWA participating in the sensitization process as explained in the paragraph above.

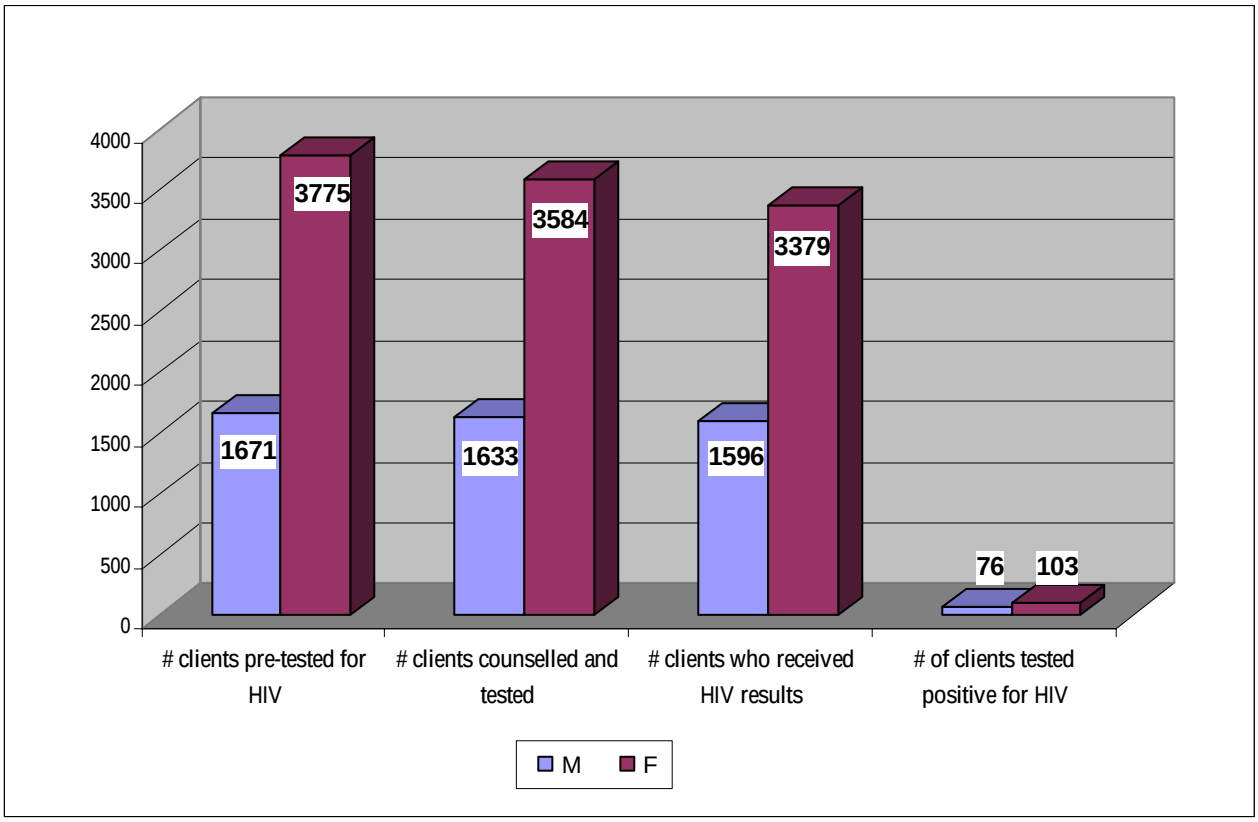
Fig. 19. Quarterly uptake among TB patients in HGR Kenya integrated TB/HIV site



HGR Nyantende integrated TB/HIV Counseling and Testing site

The Nyantende General Reference Hospital (HGR) in Bukavu is a referral hospital, operated by the BDOM, with a TB unit where HTC services were integrated. It is located 12 km out of the town in a sub-rural environment with some bit hard access during the raining season. This site was also open to the general population that benefited from counseling and testing services. This site started HTC services offer in June 2006 and was closed in June 2009 according to the workplan approved by the donor. Figure 20 below shows that a total of 5,217 (1,633 males and 3,584) clients (TB patients and general population) were counseled and tested over the course of the project. Among them 3.4% [179 (76 males and 103 females)] were HIV-positive and 0.8% were undetermined. Among those tested, 95.4% [4,975 (1,596 males and 3,379 females)] received their HIV results.

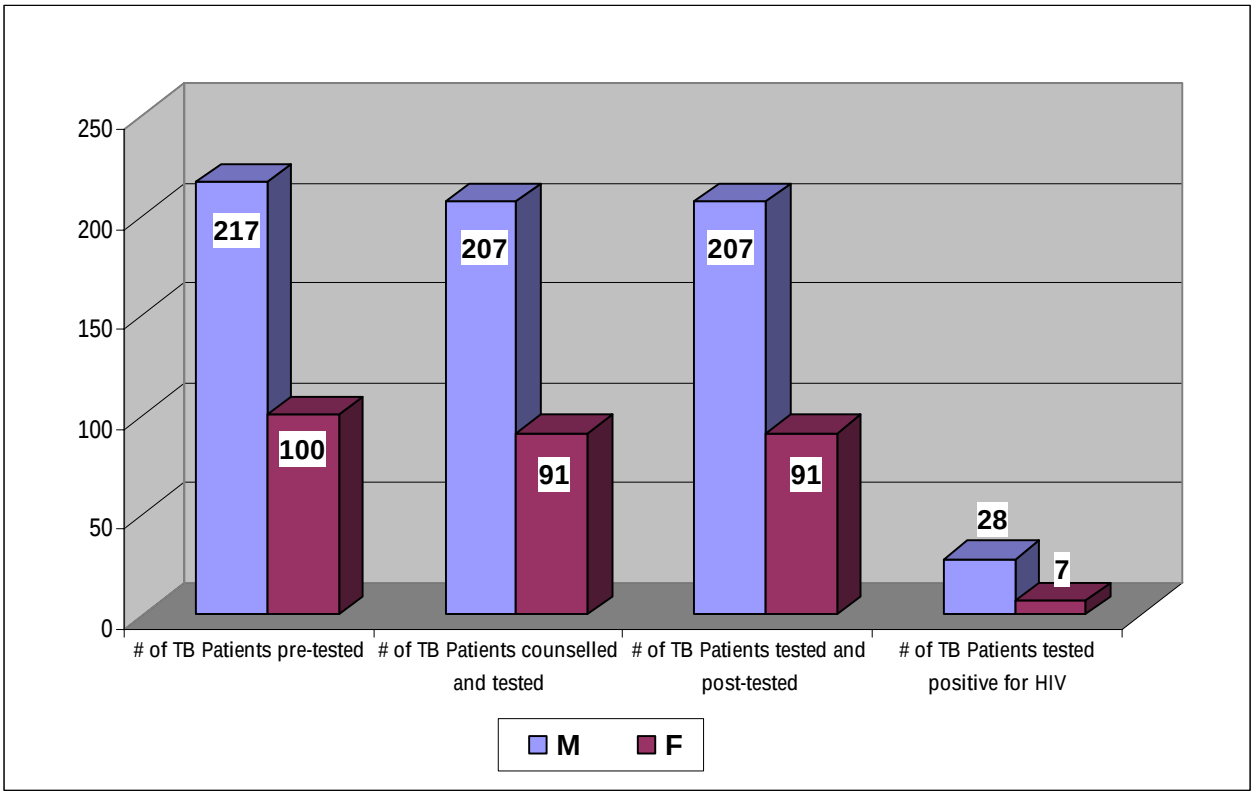
Fig. 20. Overall uptake in HGR Nyantende integrated TB/HIV site



As shown in the figure 21 (next page), 317 patients out of 5,446 (5.8%) had a TB diagnosis (217 males and 100 females). Among them, 298 (207 males and 91 females) were counseled and tested for HIV and 11.7% [35 (28 males and 7 females)] were HIV positive, thus co-infected with both TB and HIV. Here as opposed to the trends observed in other sites, males were proportionally twice as infected than females TB patients (13.5% vs. 7.7%)[11]. All tested TB patients received their HIV results.

[11] This is a small sample of TB patients to let drawing a solid conclusion in terms of gender-distribution.

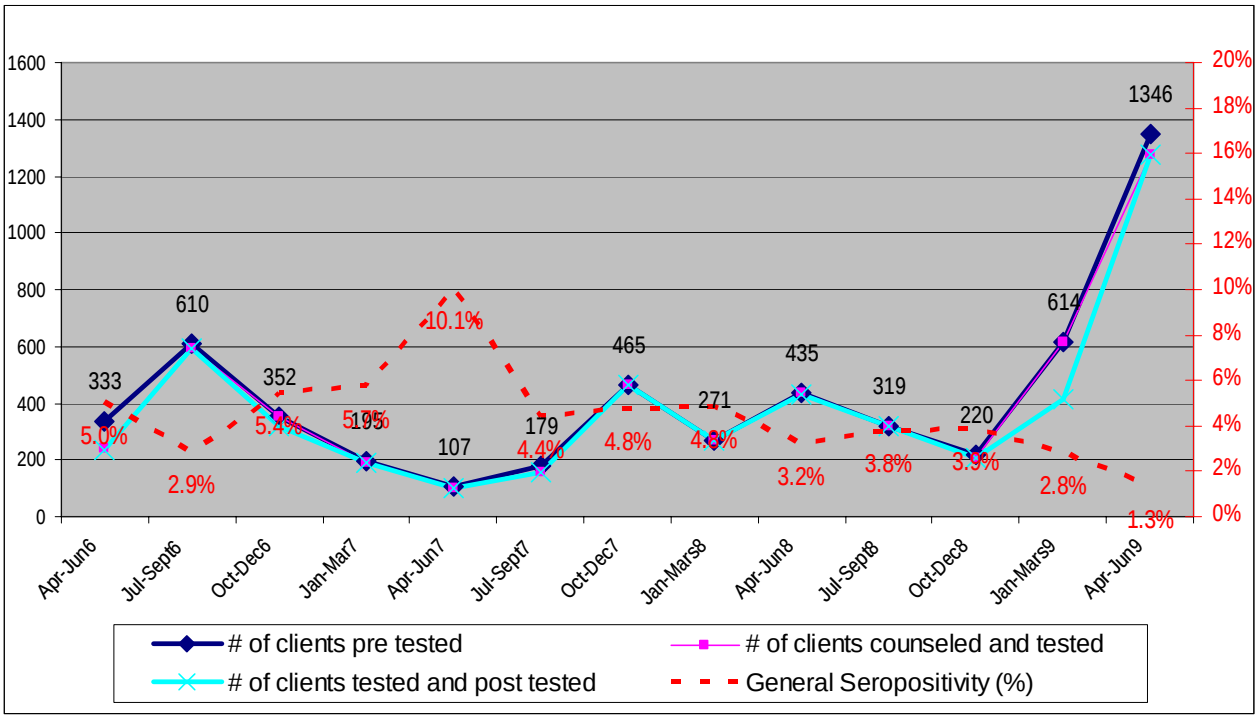
Fig. 21. Overall uptake for TB patients in HGR Nyantende integrated TB/HIV site



- **Overall quarterly uptake of HTC services at HGR Nyantende**

The figure 22 at the following page showed the quarterly uptake of HTC services at the HGR Nyantende fluctuated between 107 in the April-June 2007 quarter and 1,346 in the (final) April-June 2009 quarter. The high achievement in the last quarter of the project resulted in the strengthening of activities of the CHWs in the health zone starting in January 2009 and using a financing-based performance scheme. In this site, the average quarterly service uptake was 419. Quarterly HIV prevalence varied between 1.3% and 10.1% with an average of 3.4%.

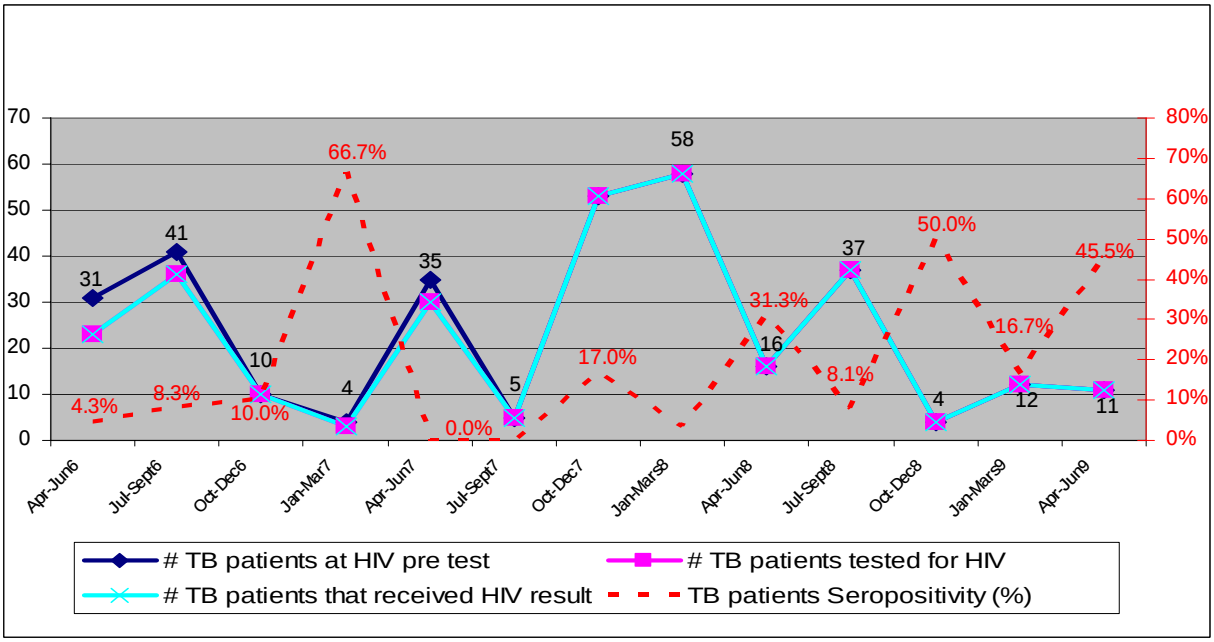
Fig.22. Quarterly uptake trend in HGR Nyantende integrated TB/HIV site



- **Quarterly uptake of HTC services at HGR Nyantende by TB patients**

Figure 23 below shows that the quarterly uptake of HTC services by TB patients fluctuated significantly, ranging between 4 in the October-December 2008 quarter and 58 in the January-March 2008 quarter, with an average of 24. Lowest HTC uptakes by TB patients were registered during the strike of nurses. The tested quarterly HIV rate varied from 0% to 66.7%, with an average of 11.7%. In general, this was the less performing site!

Fig.23,.Quarterly TB patients uptake trend in HGR Nyantende integrated TB/HIV site

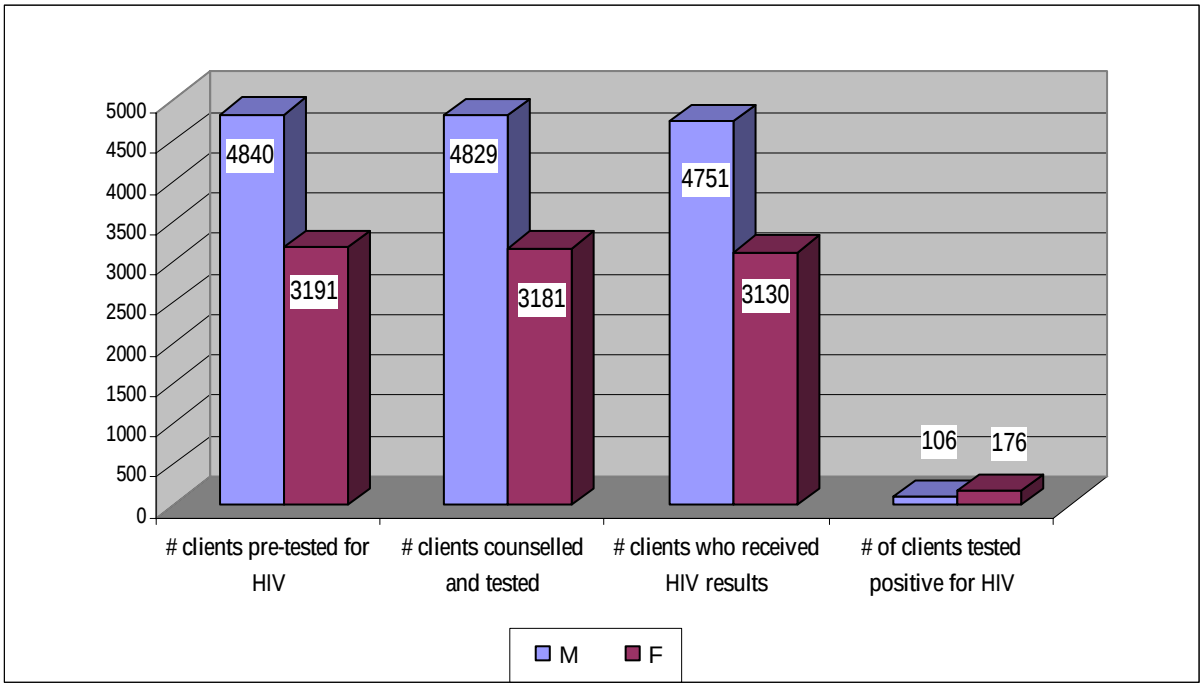


World Production (WP) Counseling and Testing sites

World Production managed three HTC sites: two community stand alone which were located in Likasi and Kipushi and one mobile HTC unit serving the route Kipushi-Lubumbashi-Likasi. These three sites were supported with supplementary funds provided by USAID and all started their activities in April 2009.

In total, these three HTC sites counseled and tested 8,010 (4,829 males and 3,181 females); among them 3.5% [282 (106 males and 176 females)] were tested HIV positive and 98.4% [7,881 (4,751 males and 3,130 females)] received their HIV results.

Fig.24. Overall uptake in 3 World Production HTC sites



- **Individual contributions of WP HTC sites**

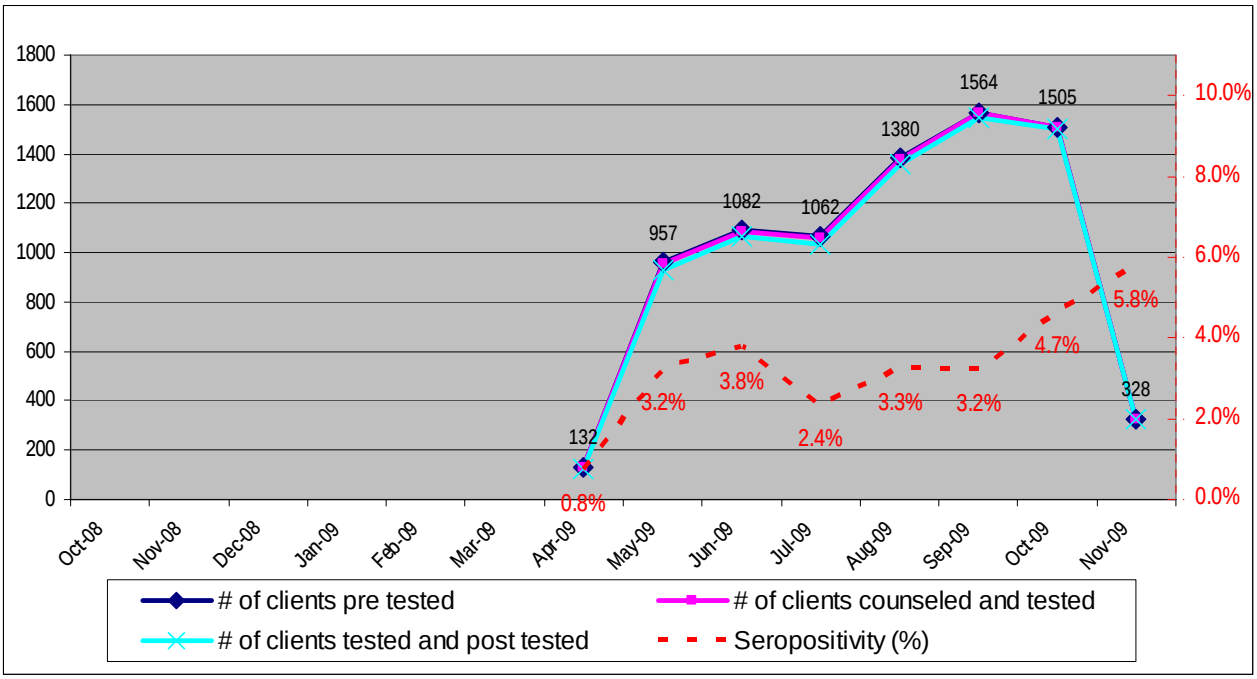
Table 4 below provides the cumulative uptake of HTC services at individual WP HTC sites during the program implementation period. Looking at the last column of this table, a quick conclusion is that female clients were three or two times more infected than males.

Table 5: Cumulative uptake of HTC services at WP HTC sites

		Number of clients at HIV pre-test	Number of clients counseled and tested	Number of clients received HIV results	Number of clients tested HIV positive	HIV rate (%)
Mobile HTC site WP	*M*	*2132*	*2127*	*2056*	*45*	*2,1%*
	F	*928*	*927*	*882*	*63*	*6,8%*
	Tot	**3060**	**3054**	**2938**	**108**	**3,5%**
Likasi HTC site	*M*	*1533*	*1533*	*1529*	*32*	*2,1%*
	F	*974*	*974*	*972*	*51*	*5,2%*
	Tot	**2507**	**2507**	**2501**	**83**	**3,3%**
Kipushi HTC site	*M*	*1175*	*1169*	*1166*	*29*	*2,5%*
	F	*1289*	*1280*	*1276*	*62*	*4,8%*
	Tot	**2464**	**2449**	**2442**	**91**	**3,7%**
Total WP HTC sites	*M*	*4840*	*4829*	*4751*	*106*	*2,2%*
	F	*3191*	*3181*	*3130*	*176*	*5,5%*
	Tot	*8031*	*8010*	*7881*	*282*	**3,5%**

The 3 WP HTC sites started operations in April 2009. Because of the short period of implementation (8 months in total), we chose to show the cumulative uptake by month instead of by quarter. Figure 25 shows that the monthly uptake of HTC services at the WP HTC sites consistently increased from 132 in April 2009 to 1505 in October 2009 before falling to 328 in November 2009 because of the closure of sites. The average monthly uptake of services was 1,004. The HIV monthly prevalence average rate in these sites was 3.5% (ranged from 0.8% and 5.8%).

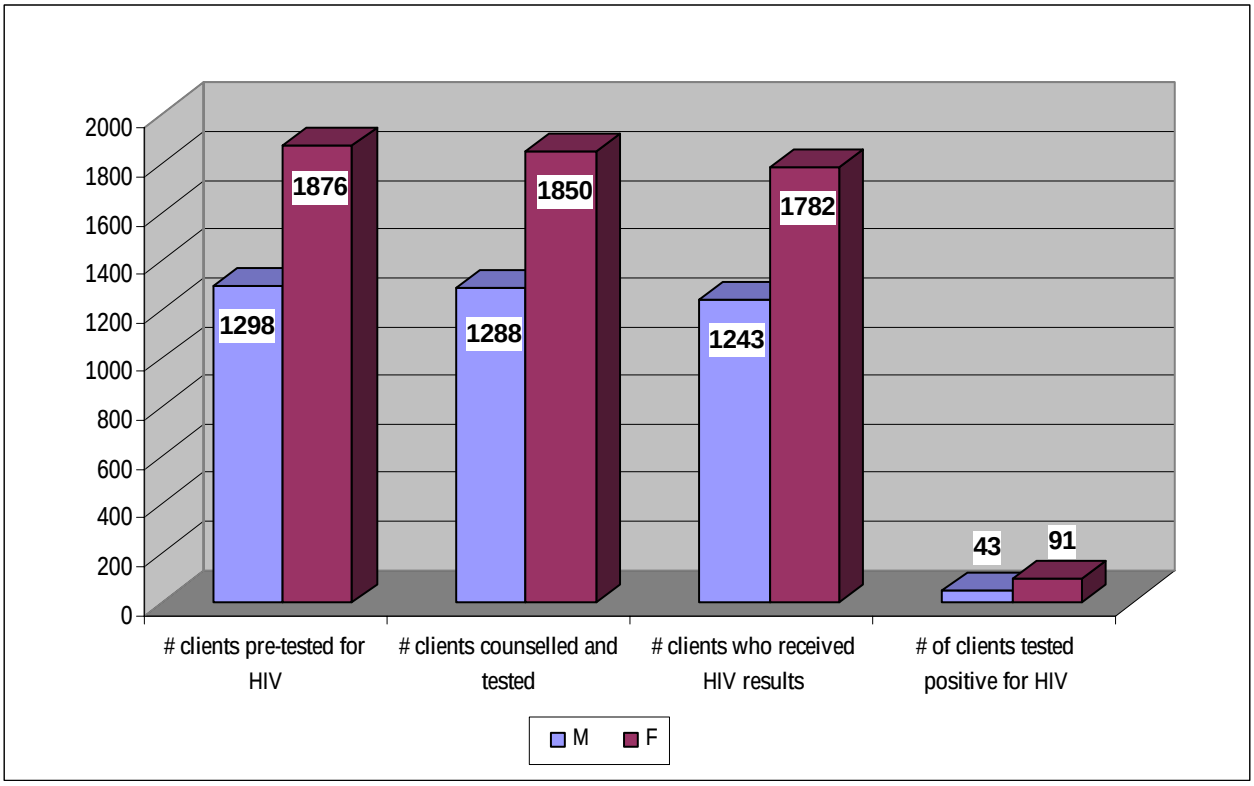
Fig. 25. Monthly uptake trend in the 3 World Production HTC sites



HGR Panda integrated HIV Counseling and Testing sites

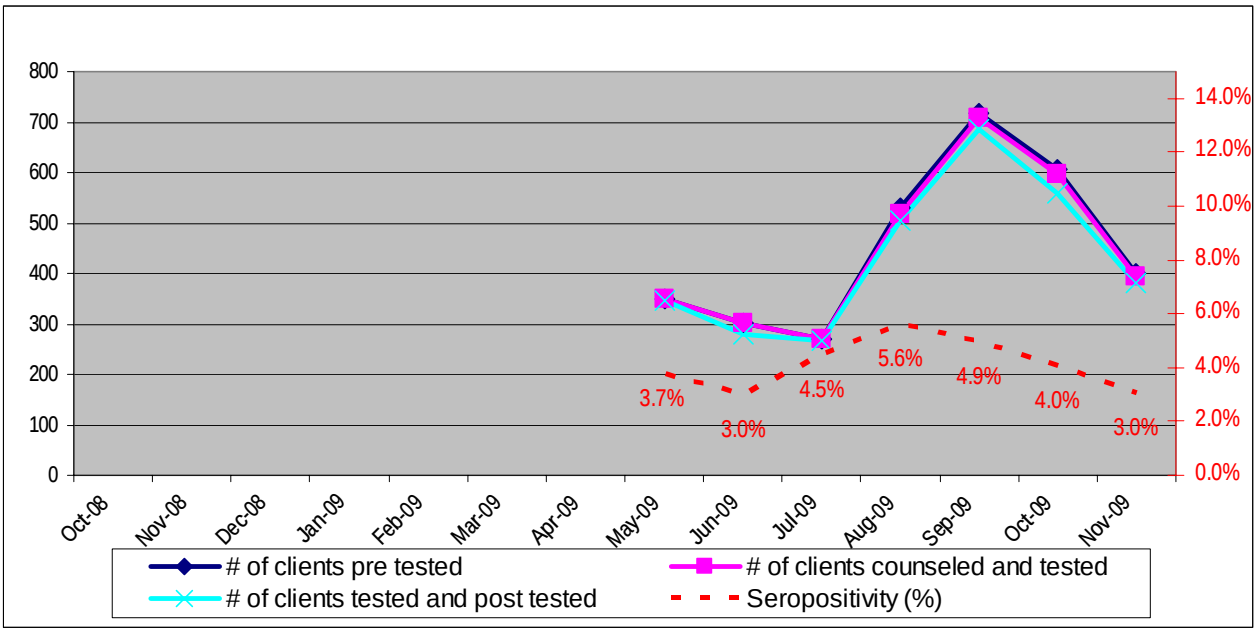
The Panda General Reference Hospital (HGR) is a privately-owned and maintained referral hospital and serves the employees and their families of a large mining company in Likasi city. It is also open to the surrounding general population. A HTC unit was integrated in this hospital to offer HIV counseling and testing services which started in April 2009 and was closed in November 2009 after counseling and testing a total of 3,138 (1,288 males and 1,850). Among them 4.3% [134 (43 males and 91 females)] were tested HIV-positive and 1.0% were undetermined. Among those tested, 96.4% [3,025 (1,243 males and 1,782 females)] received their HIV results (see figure 26 below).

Fig. 26. Overall uptake in HGR Panda integrated HTC site



As the previous sites (WP), uptake results are presented on a monthly basis. Due to administrative delay, this site began its activities in May 09 and reached a pick (717) in September before declined progressively due to close-out process (see fig. 27 on the next page). Rapidly the monthly average uptake was established at 453 while the HIV rate was quite stable around 4.3% (see fig. 27, next page).

Fig.27. Monthly uptake trend in HGR Panda integrated HTC site



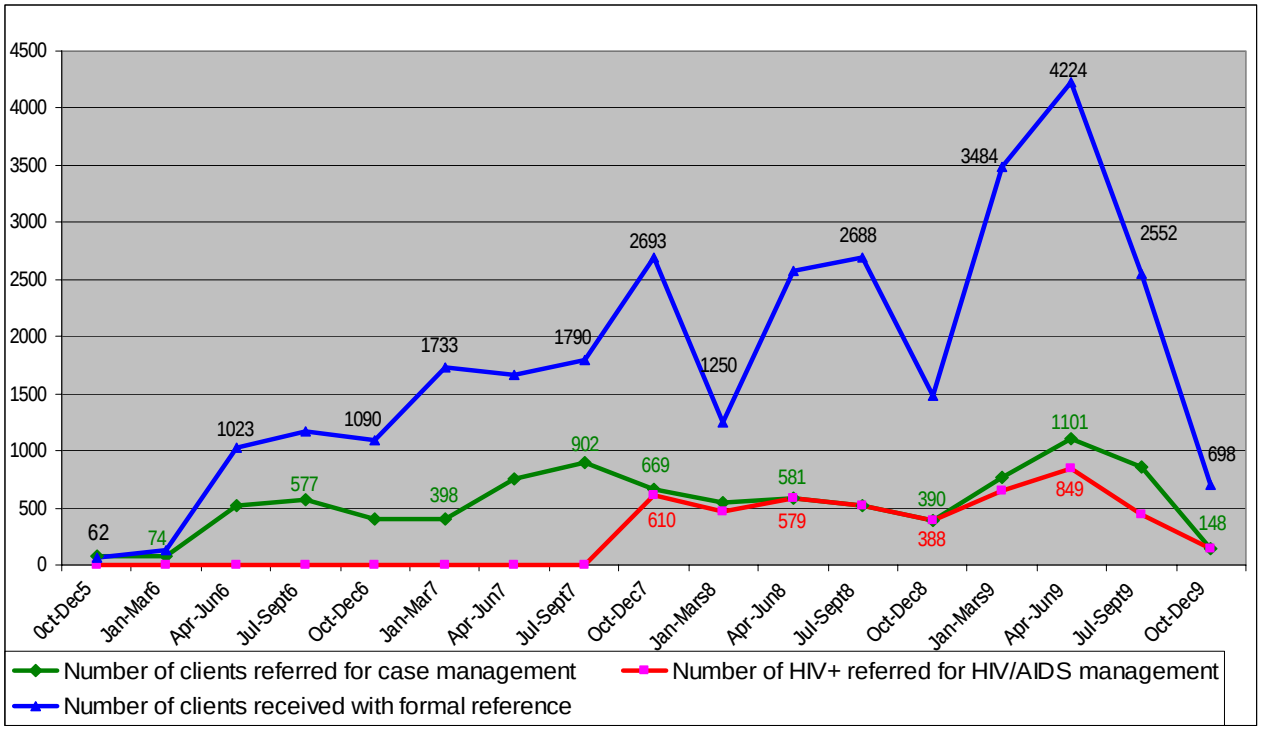
Related to objective (2) – ***To ensure an effective network, linkages, and coordination between existing primary health care system providers and community organizations providing multi-sectoral services in the targeted urban districts;***

To make easier a continuum of care, FHI worked with the Provincial Health Authorities (MoH, PNMLS, PNLS, Health district officers) in each town (Bukavu, Matadi and Lubumbashi) to produce and disseminate a specific referral guidebook.
By the end of the project (December 31, 2009), the sites referred 9,239 clients to appropriate facilities for support, care and treatment, and 30,771 clients from USAID partners and others were received at FHI-supported sites.

FHI initiated quarterly meetings for USAID partners involved in this project (PSI & CRS) to evaluate how really operational was the referral system. FHI housed these meetings in its national country office.
In the field similar meetings on referral activities monitoring have been delegated to IAs (AMO-Congo, FP, Kenya Hospital, Mvuzi Hospital, Midema CCLD[12], World Vision, PSI, ECC[13]) in the purpose to stimulate an ownership by the local health authorities in Matadi, Lubumbashi, and Bukavu. In addition, each involved site used a formal referral card for reference purpose.

As illustrated in Figure 28, the reference was not systematically used over the two first quarters of the project prior a formal referral system was put in place.
An average of 1,783 clients per quarter with a referral card obtained from FHI partners and 273 clients were referred after testing in supported HTC sites.

Fig.28. Quarterly reference trend



[12] CCLD= Corporate Commitment for Local Development
[13] ECC= Eglise du Christ au Congo

Related to objective (3) – ***To improve technical, organizational, and managerial capacity of new and existing Congolese organizations and networks to provide high quality prevention, care and support to PLWHA, OVC, and other vulnerable and high-risk populations;***

FHI implemented a variety of activities to strength IP involved in the implementation of RESA+. In addition to the traditional activities of regular trainings (starting training), supervision, coaching and feedback, FHI organized following activities:

- In December 13-16, 2005 in Kinshasa, FHI coordinated and facilitated an M&E Training and M&E system development workshop for 18 participants (from Bukavu, Lubumbashi, Matadi and Kinshasa), including key USAID partners (CRS, World Vision, AMO-Congo, ECC, and Foundation Femme Plus) and open to other stakeholders. The topics included the M&E concepts, development of indicators, developing and using data collection tools, data entry, data management, data quality, reporting and dissemination.

- In collaboration with the LNRS/PNLS, FHI organized a one-day technical session on HIV counseling and rapid tests quality control for AMO-Congo and FP staffs (in the FHI meeting room). Following issues have been discussed: revision on the HIV tests algorithms (September 2006).

- FHI associated its IPs staffs (AMO-Congo & FP) in the Commodities management training organized by Deliver, an international NGO, in Kinshasa (ECC Building).

- Using its specific tool (TOCAT), FHI worked with AMO-Congo and FP through a SWOT process to develop tailored workplan that help them to conduct their activities in clear vision.

  These workplans served to improve their capacity in commitment and resources mobilization. The following results have been registered through their different organization levels:
  - Development of Manual of financial and administrative procedures including operational guidelines for strong recruitment process
  - Improving archiving systems of files
  - Strengthening technical structure with qualified staff previously missed (such as pharmacist to ensure a high quality drugs/commodities management).

CHALLENGES

1) The RESA+ project has been developed in a global perspective of cost-sharing with other funding sources (Word Bank & UNDP Global Fund) that have not or not properly disbursed. FHI revised its initial plan in terms of creating provincial satellite offices, staffing, number of technical assistance expected.

2) The Testing & Counseling Training Center was closed prematurely following the change occurred in the PNLS management of the training in the HIV/AIDS which became an exclusivity of PNLS. This decision affected FHI initial plan to establish a sub regional HTC training that could deserve great lake region. FHI converted resources to train additional staff.

3) The project has been implemented in a context of weakness of health system where managing Medical waste was not properly established. To comply with the IEE regulations, FHI built some unplanned incinerators and increased in-site safety.

4) The lack of motivation of staff working in governmental organization conducted to multiple nurse strikes and several times paralyzed activities. Using a financing-based performance with staff, it was possible to get people motivated and obtain better performance (Nyantende health district, Bukavu). However, this was not initially clearly stated as strategy in the project and was used at a very small scale.

LESSONS LEARNED

Beyond the specific expected results of the project, the implementation of RESA+ helped to learn the following:

1. HTC services were welcomed by the population in the areas covered by the program. The mobile HTC strategy which was primarily planned to serve mobile and most-at-risk populations, were also used and accepted by the general population.

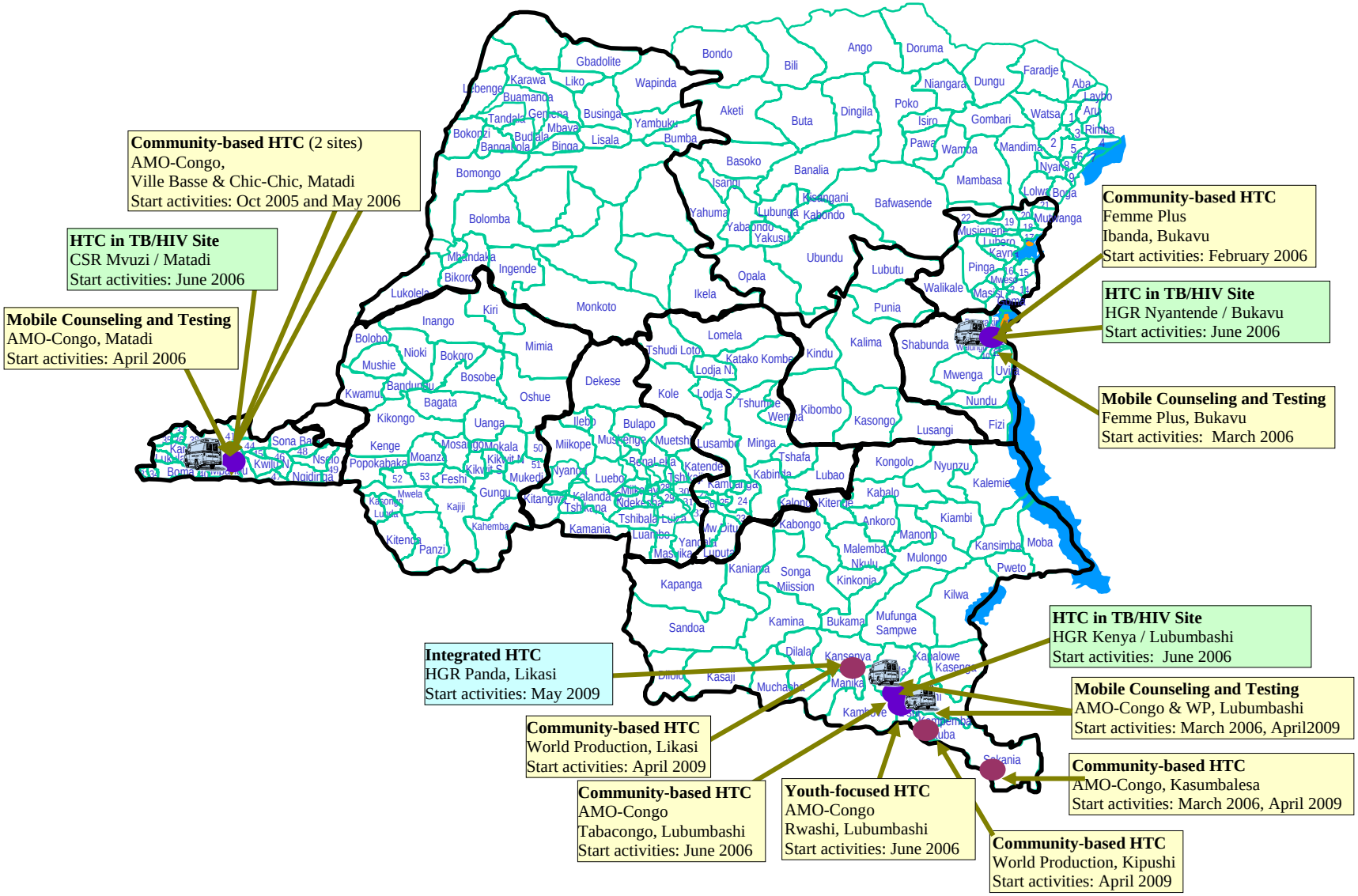
2. Use financing-based performance in large scale (already known elsewhere) is strategic approach to boost performance.

APPENDIX

Overall RESA+ Achievements

KEY INDICATORS	TOTAL		
	H	F	T
1. COUNSELING AND TESTING			
Number of service outlets providing counseling and testing according to national and international standards			16
Number of individuals pre tested	95,519	86,205	181,724
Number of individuals pretested and tested for HIV	95,163	85,737	180,900
Number of individuals who received counseling and received their test results	93,555	83,906	177,461
Number of individuals tested HIV positive	4,162	6,890	11,052
Number of individuals trained in counseling according to national and international standards			131
Number of individuals trained in testing to perform HIV rapid tests according to national and international standards			59
2. REFERRAL AND COUNTER REFERRAL SYSTEM			
Number of individuals referred from FHI supported sites to other partners for continuum care and support			9,239
Number of individuals received at FHI supported sites from other partners through formal referral system			30,771

Highlights of Implementing Partners Activities

Partner	Organizational Type	Number of HTC Sites	Geographic Location	HTC Site Types	Target Population	Project activity Dates Start - End
1. ACS/AMO-Congo	NGO	7	- Matadi - Lubumbashi - Kasumbalesa	- Stand alone - Mobile	- General population - CSW - Defense & Security Personnel - Truckers - Youth	Oct.2005 - Nov. 2009
2. Fondation Femme Plus (FP)	NGO	2	- Bukavu	- Stand alone - Mobile	- General population - CSW - Defense & Security Personnel Truckers - Miners - PLWHA	Oct.2005 - Sept. 2009
3. World Production (WP)	NGO	3	- Lubumbashi - Kipushi - Likasi	- Stand alone - Mobile	- General population - CSW - Defense & Security Personnel - Miners	Apr.2009 – Nov. 2009
4. HGR Nyantende	FBO Hospital	1	- Bukavu	- TB/HIV integrated	- TB patients - General population	June 2006 - June 2009
5. HGR Kenya	Governmental	1	- Lubumbashi	- TB/HIV integrated	- TB patients - General population	June 2006 - Sept 2009
6. CSR Mvuzi	Governmental	1	- Matadi	- TB/HIV integrated	- TB patients - General population	June 2006 - Sept 2009
7. HGR Panda	Private sector	1	- Likasi	- Integrated	- Out & In patients - General population	May.2009 – Nov. 2009

Cartography of FHI Interventions within USAID funds through RESA+ Project