Integrated Health Project in Burundi (IHPB)

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Table of Contents

Introduction 7

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels 10

Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household and community levels 10

Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and households 14

Sub-CLIN 1.3: Strengthened support for positive gender norms and behavior and increased access to GBV services 18

CLIN 2: Increased Use of Quality Integrated Health and Support Services 26

Sub-CLIN 2.1: Increased access to health and support services within communities 26

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services 30

Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services 35

CLIN 3: Strengthened Health Systems and Capacity 38

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas 38

Sub-CLIN 3.2: Strengthen M&E and data management systems at the facility and community levels 44

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated services 47

Priority Health Domain Strategies 49

Malaria Strategy 49

Child Health Strategy 54

Maternal and Newborn Health Strategy 56

Reproductive Health Strategy 60

HIV/AIDS Strategy 65

Innovation study: Pilot of Integration of Prevention of Mother-to-Child Transmission (PMTCT) and Early Infant Diagnosis (EID) of HIV into Routine Newborn and Child Health Care 88

Implement learning, documentation and dissemination activities 90

Program Monitoring & Evaluation 92

Program Management 94

Annex I: Change package of Muyinga health province 98

Annex II: Preliminary results of the assessment of the supervision system 100

Annex III: Success stories 107

Men`s involvement and investment celebrated as good examples for good health of families 107

Reaching the Positives from the general population: Successful Experience of Integrated Health Project in Burundi 108

Life of 3 triplets saved thanks to IJHPB donated incubators 109

Annex IV: IHPB Indicators – Achievements for the period April 1, 2017 – June 30, 2017 111

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ABUBEF	*Association Burundaise pour le Bien Etre Familial*
ACTs	Artemisinin-based Combination Therapy
ADBC	*Agent Distributeur à Base Communautaire* (Community Based Distributor of Contraceptives)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ANSS	*Association Nationale de Soutien aux Séropositifs et aux Sidéens*
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BDS	*Bureau du District Sanitaire* (District Health Bureau)
BEmONC	Basic Emergency Obstetric and Neonatal Care
BMCHP	Burundi Maternal and Child Health Project
BPS	*Bureau Provincial de la Santé* (Provincial Health Bureau)
BRAVI	Burundians Responding Against Violence and Inequality
BTC	Belgian Technical Cooperation
CAM	*Carte d'Assistance Médicale* (Health Assistance Card)
CBO	Community-Based Organization
C-Change	Communication for Change
CCM	Community case management
CCT	Community Conversation Toolkit
CFR/OMB	Code of Federal Regulations/Office of Management and Budget
CHW	Community Health Worker
CLA	Collaborating, Learning and Adapting
COP	Chief of Party
COSA	*Comité de Santé*
CPSD	*Cadre de Concertation pour la Santé et le Développement*
CPVV	*Comité Provincial de Vérification et de Validation*
CS	Capacity Strengthening
CSO	Civil Society Organization
CTN	*Cellule Technique Nationale*
CT FBP	*Cellule technique du Financement Basé sur la Performance*
DATIM	Data for Accountability, Transparency and Impact
DBS	Dried Blood Samples
DCOP	Deputy Chief of Party
DHE	District Health Educator
DHIS	District Health Information System
DHS	Demographic and Health Survey
DHT	District Health Team

DPE	*Direction Provinciale de l'Enseignement*
DPSHA	*Département de Promotion de la Santé, Hygiène et Assainissement*
DQA	Data Quality Assurance
EC	Emergency Contraception
EID	Early Infant Diagnostic
EONC	Essential Obstetric and Neonatal Care
ENA	Emergency Nutrition Assessment
FAB	Formative Analysis and Baseline Assessment
FGD	Focus Group Discussion
FHI 360	Family Health International
FFP	Flexible Family Planning Project
FP	Family Planning
FQA	Facility Qualitative Assessment
FTO	Field Technical Officer
FSW	Female Sex Worker
GASC	Groupement d'Agents de Santé communautaire
GBV	Gender Based Violence
GoB	Government of Burundi
HBC	Home-Based Care
HD	Health District
HealthNet TPO	Dutch aid agency – merger between HealthNet International and Transcultural Psychosocial Organization
HH	Household
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Technician
HIS	Health Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
iCCM	Integrated Community Case Management
IDI	In-Depth Interview
IHPB	Integrated Health Project in Burundi
INGO	International Non-Governmental Organizations
IP	Implementing Partner
IIP	Institutional Improvement Plan
IPC	Inter Personal Communication
IKG	In-Kind Grants
IPTp	Intermittent Preventive Treatment of malaria during Pregnancy
IPC	Interpersonal Communication
IRB	Institutional Review Board

ISTEEBU	*Institut de Statistiques et d'Etudes Economiques du Burundi*
ITN	Insecticide-Treated Net
IYCF	Infant Young Child Feeding
JICA	Japanese International Cooperation Agency
Kfw	Kreditanstalt für Wiederaufbau (Établissement de crédit pour la reconstruction) Allemand (German Development Bank)
KII	Key Informant Interview
LLIN	Long Lasting Insecticide-treated Nets
LMIS	Logistics Management Information System
LOE	Level of Effort
LOP	Life of Project
LPT	Local Partner Transition
LS	Learning Session
MAP	Men As Partners
M&E	Monitoring and Evaluation
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MoU	Memorandum of Understanding
MPHFA	Ministry of Public Health and the Fight against AIDS
MSH	Management Sciences for Health
MSM	Men who have Sex with Men
MUAC	Mid-Upper Arm Circumference
NHIS	National Health Information System
NPAC	National Program for AIDS/STIs Control
NMCP	National Malaria Control Program
NGO	Non-Governmental Organization
OASIs	OASIs (*"Outil d'amélioration des services intégrés"*
OIRE	Office of International Research Ethics
ORS	Oral Rehydration Salts
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PCR	Polymerase Chain Reaction
PECADOM	*Prise en Charge à domicile* (Community case Management)
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PIRS	Performance Indicator Reference Sheet
PLHIV	People Living with HIV
PMEP	Performance Monitoring & Evaluation Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNILP	*Programme National Intégré de Lutte contre le Paludisme*
PNSR	*Programme National de Santé de la Reproduction*

PPP	Public-Private Partnership
PSA	Public Service Announcement
PTO	Program Technical Officer
QA/QI	Quality Assurance/Quality Improvement
QA	Quality Assurance
QI	Quality Improvement
RBP+	*Réseau Burundais des Personnes vivant avec le VIH*
RDTs	Rapid Diagnostic Tests
RH	Reproductive Health
ROADS II	Roads to a Healthy Future
SARA	Services Availability and Readiness Assessment
SDPs	Service Delivery Points
SBC	Strategic Behavior Change
SBCC	Social and Behavior Change Communication
SCM	Supply Chain Management
SCMS	Supply Chain Management System
SDA	Small Doable Action
SIAPS	System for Improved Access to Pharmaceuticals and Services
SIMS	Site Improvement through Monitoring System
SLT	Senior Leadership Team
SMS	Short Message Service
SOP	Standard Operating Procedures
STA	Senior Technical Advisor
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
SWAA	Society for Women against AIDS in Africa
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TOR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
URC	University Research Corporation
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WP	Work Plan
Y4	Project Year 4

Introduction

The *Integrated Health Project in Burundi* (IHPB) is a five-year project (December 23, 2013 to December 22, 2018) funded by the United States Agency for International Development (USAID). IHPB builds on USAID's legacy of support to the health sector in Burundi and FHI 360 and Pathfinder's successes in assisting the Government of Burundi (GoB) to expand and integrate essential services for HIV/AIDS; maternal, neonatal and child health (MNCH); malaria; family planning (FP); and reproductive health (RH).

The Ministry of Public Health and Fight against AIDS (MPHFA) is a major partner that is involved at every step throughout project planning and implementation. IHPB's goal is to assist the GoB, communities, and civil society organizations (CSOs) to improve the health status of populations in 12 health districts (HDs) located in the provinces of Karusi, Kayanza, and Kirundo, and Muyinga. IHPB's expected results are:

1) Increased positive behaviors at the individual and household levels;
2) Increased use of quality integrated health and support services; and
3) Strengthened health system and civil society capacity.

Highlights for this quarter

This quarterly report details program activities and results during the period from April 1, 2017 to June 30, 2017. Highlights of activities and achievements during the quarter are presented below:

- In collaboration with Karusi province health authorities, IHPB identified six families in Gihogazi commune who have achieved nine key actions from ante-natal care (ANC) to post-natal care (PNC). In a ceremony attended by community members, the six families were awarded certificates of recognition and will serve as role models.
- Conducted, in collaboration with the Information, Education and Communication (IEC) Unit of the MPHFA, 12 sessions of mobile cinema in the three provinces (Karusi, Kirundo and Muyinga), with a focus on malaria prevention messages during the ongoing malaria epidemic. The sessions reached an estimated population of 8,523.
- Produced six radio programs and three public service announcements (PSAs) aired two times on National Radio (RTNB) - reached an estimated 109,230 household in the four IHPB provinces - RTNB constitutes 22% of audience radio exposure in the country.
- In response to needs expressed by districts, during the reporting quarter, IHPB rented trucks 40 times for the transport of essential health products from the central level to districts, facilities, and communities across the 12 IHPB health districts.
- Through the 14 trained Health Promotion Technicians (HPTs) as master trainers on Men As Partners (MAP) approach, IHPB trained 517 Community Health Workers (CHWs) who got skills to counsel community members and to engage young men to critically question male gender norms that reinforce unhealthy behaviors as well as gender-based violence (GBV) by providing examples of alternative ways that men can express their masculinity.
- Conducted a one-day training of 299 new members of Comités de Santé (COSAs) (107 female and 192 male) from Karusi province on their scope of work. The training aimed to help COSAs play fully their roles in overseeing the health center management.
- IHPB partnered with Muyinga provincial health authorities to organize the third Quality Improvement (QI) learning session (LS), on integration of malaria prevention into ANC services.

Change package and extension strategy were designed and implementation started in 37 additional facilities.

- Outil d'Amélioration des Services Integrés de Santé (OASIS), developed under the Open Data Kit (ODK) Collect electronic model, was deployed for the first time in June in 13 health centers in the provinces of Muyinga and Kirundo. It is currently used by IHPB supervisors and program managers in districts.
- Using IHPB-designed district supervision assessment tool, continued to assess the supervision system in the 12 HDs and preliminary data that was collected, is being analyzed.
- IHPB provided technical and financial support to organize eight joint data review/use and quarterly coordination meetings in the provinces of Karusi (2), Kayanza (3) and Muyinga (3).
- IHPB in partnership with respective provincial health information system (HIS) in-charges, conducted data quality assessment (DQA) exercises in 54 health centers: Kirundo (15), Karusi (10), , Kayanza (14) and Muyinga (15).
- IHPB, in collaboration with partners (NMCP, UNICEF, USAID, Medecins Sans Frontières/Belgique, World Vision), took the lead and developed a flipchart on malaria prevention and a poster on maintenance and use of long-lasting insecticide treated nets (LLINs) that will be used by CHWs during and after mass distribution of LLINs planned for August 2017.
- As part of the response of the ongoing malaria epidemic, IHPB provided financial and technical support to develop district-level micro-plans across the 12 IHPB districts. In addition, interactive theatres were organized in seven communities that reached an estimated 19,890 people (8,820 male and 11,070 female).
- A post training follow up was conducted to 17 CHWs from 15 HCs in Giteranyi health district to reinforce their skills. CHWs were refreshed on the vaccination schedule and were reminded to fill in the immunization surveillance notebooks; health center staffs were involved in the activity to get their commitment.
- 10 maternal death audit sessions were held – 60 % of deaths were due to direct causes with postpartum hemorrhage as leading direct cause (50 % of all causes and 83 % of the direct causes) and malaria was the main indirect cause of death (30 % of all causes and 75 % of the indirect causes). It was noticed that 80 % of recommendations that were made to prevent future deaths were executed.
- Continuous joint (IHPB and HD staff) supervisions (with a focus on maternal and neonatal health) contributed to achieving 87 % of women receiving uterotonic in the third stage of labor for the prevention of postpartum hemorrhage.
- Provided technical and financial support to the first Mother and Child Week of 2017 through participation in the national commission in charge of the preparation of the week and the community mobilization - a total of 2,078 people (504 female and 1,574 male) were reached.
- Conducted integrated outreach team activities in 18 sites from Musema, Mukenke, and Busoni health district. 386 new acceptors for FP methods (injectable: 175, Pills: 80, Condoms: 42, implants: 89) received commodities at the sites, 12 clients referred for IUD and contraception surgery at facility level, 1,026 tested and treated for malaria.
- Conducted a three-day sensitization workshop for 40 pupils (20 male and 20 female) from Rugari secondary school in Muyinga as peer educator team. 498 young people received contraceptive methods at youth friendly health centers. .
- Conducted a 5-day training session on vasectomy for six medical doctors and six operation room nurses (nine male and three female). 50 men received vasectomies during the practical component of the training.
- By implementing targeted outreach HIV Testing and Counseling (HTC) sessions, index testing for household of People Living with HIV (PLHIV) and Provider-Initiated Testing and Counseling (PITC)

in outpatients and inpatients, of the 14,816 individuals (5,992 male and 8,824 female) who volunteered to be tested 408 (174 male and 234 female) who were found positive were referred to care and enrolled on ART.

- Mentor visits conducted to sensitize and enable healthcare providers -nurses for prescribing and following up antiretroviral therapy in 72 decentralized ART sites resulted in. 416 (176 male and 240 female) new PLHIV enrolled on ART.
- Support groups were organized for 443 PLHIV (175 male and 268 female) with detectable Viral Load (VL) with focus on adherence to ARV and positive-prevention.
- 137 Dried Blood Samples and 685 VL examined for PLHIVs Samples were collected and transported from health facilities to specialized laboratories and, test results have been given.
- Upon the end of its enrollment period on 31 May 2017, the pilot study for the integration of PMTCT and EID of HIV into routine newborn and child health care reached a total cohort of 66 HIV+ mother/ baby pairs for follow-up.

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels

Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household and community levels

Planned for April-June 2017	Achievement and Results	Comments
Conduct regular monitoring visits to Community Health Workers (CHW)	Ongoing	6 families have been identified and awarded certificates for having completed the nine key actions for pregnant women.
Continue production, and monitoring of radio drama and expand programming to include public service announcements	Ongoing	Through a competitive process, IHPB has identified a local company that will produce a serial radio drama of 24 episodes with messages targeting parents of children under five
Continue production of weekly radio programs to reinforce community mobilization efforts	6 radio programs and 3 public service announcements (PSAs) produced and aired 3 times each on the National Radio Station (RTNB)	20 radio programs are planned for this fiscal year. The project has already produced 18 radio programs. The 2 remaining will be finalized next quarter
Develop and produce trigger video on 3 life stages	Achieved	Trigger videos available but have yet to be used, as more focus was made toward malaria prevention during this period of malaria epidemic
Conduct mobile cinema on the 4 life stages	12 sessions of mobile cinema conducted.	22 sessions out of 24 planned for this fiscal year have been conducted.
Conduct mobilization campaign using roadshow as a communication tool	Ongoing	IHPB has identified a service provider.

During quarter April- June 2017, the SBCC team continued carrying out activities in line with IHPB's strategic framework. The main activities were:

Conduct regular monitoring visits to community health workers

During the quarter, April to June 2017, with the assistance of trained supervisors and Health Promotion Technician (HPT), IHPB conducted joint supervision visits to support the Community Health Workers (CHW) in their daily health promotion tasks. It was an opportunity to identify families who completed the nine key actions we are promoting toward pregnant women.

IHPB, in collaboration with Karusi province, identified six families in Gihogazi commune who achieved the nine key actions targeting pregnant women. On 8thJune 2017 Provincial Health authorities, HPTs, CHWs invited community in ceremony and awarded families with certificates. The ceremony was attended by nearly 305 (206 females and 99 males) community members. Ceremony was enlightened with dancing performers that entertain audiences with songs that focus on how to better help pregnant women to give birth to healthy babies.

Role model families shared their testimonies on how they performed the nine key actions for pregnant women. They narrated how CHWs are doing a better job to counsel couple to overcome barriers to adopting healthy behaviors. Now, according to community members and CHWs men are more and more involved in health of their families and pregnant spouses. They accompany their spouse during Ante Natal Care (ANC), help them to reduce heavy workloads in the field and buy supplement foods (proteins).

Continue production, and monitoring of radio drama and expand programming to include public service announcements

IHPB had advertised for a local company that will produce a serial radio drama of 24 episodes that will focus on messages for caretakers of children under five. Contract is being finalized and the company will start the work next quarter.

Continue production of weekly radio programs to reinforce community mobilization efforts

In close collaboration with the Information, Education and Communication(IEC) unit of the MPHFA, IHPB aired a total of 6 radio programs and 3 PSAs. Each radio program was aired 2 times on the National radio and each public service announcement 3 times on the same radio station.

The two first programs focused on the importance of sleeping under long-lasting insecticide treated net as well as the importance of intermittent preventive treatment during pregnancy (IPTp). The first one was aired through "Irondoka rijanye n'amagara meza" (reproductive health) radio program on April 9th and rebroadcast on April 16th. The second, on the importance of Intermittent Preventive Treatment of malaria in pregnancy (IPTp), was aired on "Intungamagara" radio program on April 11th and rebroadcast on April 18th. The two radio programs were followed by public service announcements (on the same theme) aired three times during the month.

A program (Irondoka rijanye n'amagara meza) on the importance of washing and repair of long-lasting insecticide treated nets (LLINs) to enhance their effectiveness and a second on the importance of intermittent preventive treatment of malaria during pregnancy (IPTp) were produced and aired respectively on 14th and 16th May 2017. A radio program on importance of Program for Mother to Child transmission of HIV/AIDS (PMTCT) was aired on Sunday 21st of May 2017 and the second (Intungamagara) on importance and barriers of post-natal care on Tuesday 23rd May 2017 followed by a service public announcement aired three times during that week.

A program was also produced and aired on prompt care seeking during the first symptoms on 29th May to 2nd June 2017 and was aired on the following week. At the same time a public service announcement was produced on the malaria prevention messages and aired three times during the same week on the National Radio (RTNB)

Develop and produce trigger videos on the three life stages

During this quarter, IHPB signed a contract with Papy Jamaica Production to produce 3 trigger videos on adolescents, young adults and parents of under five children. Papy Jamaica Production's first activity was to conduct field research in Kayanza, Kirundo and Muyinga to understand more about promoting positive

behaviors at individual and household levels. After the field research, the production house organized the filming schedule and gathered footage between March 16 - 25 in Muyinga, for the young adult video, in Kirundo for the parents of children of under-five video and finally Kayanza for the video targeting adolescents. For the period under reporting, Papy Jamaica has submitted final 3 videos: Melissa (23 minutes) with key messages on maternal new born and child health, Fidelité (19 minutes) targeting young adult with key messages on Sexual Reproductive Health and HIV/AIDS and temptation (24 minutes) targeting adolescent with key messages on HIV/AIDS and sexual and Reproductive Health. Those videos will be used for projection during mobile cinema activities.

Conduct mobile cinema on the four life stages

During the reporting period, the Social Behaviour Change Communication (SBCC) unit strengthened community mobilization using mobile cinema in Kirundo and Muyinga provinces. This activity is prepared and conducted with close participation of the Information, Education and Communication unit of the MPHFA/IEC. While targeting pregnant women in the community to adopt healthy behaviors, a strong focus was placed on malaria prevention in response to the outbreak of malaria in program regions. The mobile cinema vehicle visited 3 Health Provinces:

In April 2017, SBCC in collaboration with the MPHFA/IEC Unit continued the community mobilization through mobile cinema to address malaria outbreak in the Project area. The mobile cinema activity focused on the use of long-lasting insecticide mosquito net in malaria prevention. In the period of 3rd through 6th of April, the activity was conducted in the Province of Muyinga, in Gashoho HD. The malaria prevention messages reached 400 people (220 male and 180 female) in Muyinga site. In Mwakiro commune, the same messages reached 620 people (380 males and 240 females) and 250 people (170 males and 80 females) inBuhinyuza commune.

In Kayanza Province, mobile cinema was conducted in 4 sites during the period of 10-14th April 2017. Malaria prevention messages were delivered to 540 people (180 males and 360 females) in Butaganzwa site. In the commune of Rango, Musema HD mobile cinema gathered 800 people (300 male and 500 male). In Matongo commune, Musema HD the messages reached 300 people (100 male and 200 female). In the period of 17th through 21st April 2017, the same activity was carried out in Gahombo HD. It reached 574 people (308 males and 266 females) in Gahombo, 592 people (276 male and 316 female), 574 people in Gatara (300 male and 274 female) in Kavuvuma site. From 24 through 27th, 1825 people (799 male and 1026 female) were reached with malaria prevention messages from 3 sites (Murago, Sovu and Muvumu) in the Kayanza HD.

In May, the mobile cinema vehicle visited three communities of Buhiga HD (Gisenyi, Teme, and Mugende), IHPB organized community awareness raising activities to encourage the community members to adopt positive behavior in malaria prevention. The sessions were attended by 2,156 (899 male and 1,257 female) participants

In June, community mobilization efforts through mobile cinema was conducted in Karusi Province, Nyabikere and Buhiga Health Districts where community gatherings reached an estimate of 1717 participants (993 female and 724 male) with specific messages on malaria prevention.

In addition to planned activities, IHPB conducted the following activities:

Train HPTs as trainers on IPC (Interpersonal Communication)

IHPB developed a 1-day Training of Trainers (TOT) refresher module on interpersonal communication. The module is centered on nine key actions for caretakers of children under five. During this quarter, SBCC conducted 1-day TOT to strengthen the capacity of 42 out of 65 health promotion technicians (HPTs) from Kirundo, Kayanza, Kirundo, and Karusi in interpersonal communication. The newly trained HPTs started a cascade training in their catchment areas and will finalize the training in the project provinces next quarter.

Refresher Training of CHW's on IPC techniques using caretakers of children under five materials

After the TOT conducted in June, 10 HPTs from Buhiga and Nyabikere Health Districts conducted the training of 513 (282 male and 231 female) community health workers (CHWs) on interpersonal communication skills with an emphasis on how to use communication materials to promote the 9 key actions caretakers for children under five. It was a great opportunity to evaluate how best we can increase the quality of CHW's home visit and community gatherings.

Participation in subcommittee of community mobilization and communication of the response to malaria epidemic

IHPB participated 8 times in the weekly meetings to share ideas and strategic planning and implementation of activities related to the response against the malaria epidemic. The subcommittee is composed of various stakeholders, NGO's, USAID and chaired by PNLIP representatives. Among other activities, IHPB took the lead to develop a flip chart and poster that will be used by CHWs across the country. The flip chart has specific key messages on LLIN use, Malaria symptoms, full medicine uptake, prompt care seeking in the first symptoms, washing and repair the nets and vector control options for preventions of malaria.

The posters focused on the proper hanging and repair and washing of the mosquito nets.

The 2 communication materials were pre-tested with male and female caretakers of children in Kabezi Health District on 4th July 2017. The committee planned a quick qualitative assessment on behavior determinants to mosquito net use.

Progress and discussion on SBCC indicators

Indicator	**Target End of Project**	**Achieved to date**			
		October-December	**January-March**	**April-June**	**TOTAL**
1.0.1. Percent of the targeted audiences who report practicing positive behaviors at the					

Indicator	Target End of Project	Achieved to date			
individual and household levels [Mandatory Result]					
1.1.1. Percent of the targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels [Mandatory Result]					
1.1.2. Percent of targeted population who correctly report causes of specific illness (e.g. HIV/AIDS; malaria; diarrhea) [Mandatory Result]	+10%	Outcome indictors will be measured via end of project survey			
1.1.3. Percent of the target population who recall hearing or seeing or reading a specific HC message					
	Target for 2017				
1.1.4 Number of health communication materials developed, field tested, and disseminated for use	8	0	5	3	8

1.1.4. Number of health communication materials developed, field tested and disseminated

The target for Y4 is 8 communication materials. During the quarter, January – March 2017, IHPB produced 5 communication materials (2 posters, 1 flipchart, 1 invitation card and 1 leaflet) for parents of children under five life stages. The five materials have been reviewed and approved by the Health Communication Technical Working Group.

In June, in close collaboration with the Communication and Community Mobilization Committee of the response to malaria epidemic subcommittee, IHPB developed a flip chart on LLIN use, Malaria symptoms, full medicine uptake, prompt care seeking in the first symptoms, washing and repair the nets and vector control options for preventions of malaria and 2 posters that focused on the proper hanging and repair and washing of the mosquito nets.

Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and households

Planned for April-June 2017	Achievement and results	Comments
Support Program Technical Officers (PTOs) to deploy the SCM module of the integrated instrument and conduct monthly supervision visits to strengthen Supply Chain Management to priority districts, facilities and communities as identified through the integrated instrument	Partially achieved (10/12 health districts)	The deployment of the SCM module of Outil d'Amélioration des Services Integrés de Santé (OASIS) was done in 10 districts. The deployment in the remaining 2 [Giteranyi and Gahombo] will be done in August. Supervision visits were based on supply chain bottlenecks identified in preparation of the visits.
Collect through supportive supervision visits in health facilities, compile, analyze and share data from integrated instrument tool SCM during	Not achieved	Postponed until OASIS is fully deployed in August.

Planned for April-June 2017	Achievement and results	Comments
quarterly coordination meetings for district health data analysis.		
Develop a list of available and approved private transport providers and update it at mid-way through Y4	Achieved	A list of 10 truckers updated
Develop and pilot SCM module for the integrated instrument for SCM support at facility level	Ongoing	SCM module developed, and available for PTO pilot and not fully deployed.
Deliver and replenish pharmaceutical products (purchased by UNICEF), including amoxicillin, ORS and zinc; provide and replenish non-pharmaceutical products for complete iCCM kits for CHWs in focus areas	Achieved	741 CHWs (242 in Gahombo, 205 in Musema, 77 in Kirundo,118 in Giteranyi,99 in Gashoho) have received iCCM kits.
Avail and track project-supported vehicles for timely delivery of commodities to health facilities per districts' requests	Ongoing	Trucks have been rented in response to gaps in vehicle availability at district level 40 times during the reporting period
Requisition and quantification of HIV commodities and reagents	Ongoing	HIV commodities requisitions integrated in routine requisitions

More detailed descriptions of the activities and analysis of results achieved from April to June are:

Support PTOs to deploy the SCM module of the integrated instrument and conduct monthly supervision visits
SCM specialist supported the PTOs of the project in the deployment of the SCM module of the integrated instrument in Kirundo, Muyinga, and Kayanza health provinces through a training session that targeted both PTOs and the district supervisors of the three provinces.

After the training, participants conducted 3 days of supervisions visits to Gashoho and Muyinga health facilities. The health facilities visited have been identified based on data collected in DHIS2 on stock out for essentials medicines (mandatory indicator 1.2.1: percent of supported facilities that experience a stock out at any time during the last three months). Those stock outs were related to the lack of products at the central stores for the ACT commodities and Rapid Diagnostic test of Malaria within the first and second quarter.

In Musema and Busoni health districts, the supervisions focused on malaria health commodities (4 ACTs and Rapid diagnostic tests) and IHPB staff demonstrated how to adapt average monthly consumption for each health facility after a period of stock out and how to resupply according to National Malaria Program new supply plan in collaboration with partners and new stock available at central level.

For family planning products for which Musema health district experienced stock out during last quarter, IHPB identified the cause of stock out as high consumption and proposed an adapted average monthly consumption for each health facility and reminded the health facilities to resupply as soon as possible.

In Mukenke and Busoni health facilities where Dipstick Statpak HIV ½ stock-out were due to misinformation on the availability of the stock at national level since April. IHPB informed health districts and availed a vehicle to transport the commodity.

Develop a list of available and approved private transport providers and update it at mid-way through Y4

The IHPB project has set up a database of truckers to help the project better coordinate support and promote timeliness and efficiency of transporting the drugs to the districts.

A total of 10 trucks readily available contracted and supporting documents were entered in the IHPB health commodity leasing database with an average of 2 days of rent per district at an average cost of 350.000 Bu Francs per day per truck (6 tons).

Deliver and replenish pharmaceutical products (purchased by UNICEF), including amoxicillin, ORS and zinc; provide and replenish non-pharmaceutical products for complete iCCM kits for CHWs in focus areas

To further support the implementation of ICCM in Musema, Gahombo, Gashoho , Giteranyi and Kirundo health districts, IHPB distributed some tools and materials as detailed in the table below:

CHW iCCM Kit items	Musema	Gahombo	Gashoho	Giteranyi	Kirundo
Individual tracking record for the sick child	205	0	100	120	0
Register of cases	205	0	100	120	0
Transfer book	205	242	0	0	0
Requisition cards	205	242	0	0	0
Algorithm	205	0	0	0	77
Electronic timers	205	0	0	0	77

Avail project vehicles (upon need basis) for timely delivery of commodities to health facilities per districts' requests

In response to needs expressed by districts, within the 3rd quarter of Year 4, IHPB rented trucks 40 times for the transport of essential health products from the central level to districts, facilities, and communities – Busoni (4), Mukenke (4), Kayanza (4), Vumbi (3) ,Buhiga (3) ,Nyabikere(3), Gashoho (3), Gahombo(3), Kirundo(2) , Muyinga(2), Giteranyi(2), and Musema (3).

Note that the trucks rented for health districts were also used to support maternal and child health commodities transport within the maternal and child health week.

Requisition and quantification of HIV commodities and reagents

IHPB facilitated the transport of blood samples from Kirundo (140) and Kayanza (96) for viral road analysis from Ngozi's reference laboratory to CRDBi private laboratory (Centre de Recherche de Virologie et de diagnostic Biologique).

The requisition of HIV has been integrated in the normal supply circuit.
In addition, as a member of the National Quantification Committee for HIV/STI, IHPB Supply Chain Specialist participated in a 1-day meeting organized by Global-Fund which aimed to the strategic investment for viral road machine by Global Fund which aimed to identify the needs of viral roads machines by analyzing the capacity of existing machines, the requirement of additional machines and the strategies for improving viral road performance.

The global fund has agreed to make available three Roche-branded machines for viral load analysis and Early Infant diagnostic test, one of which will be affected in Bujumbura to serve as a back-up, another in Gitega to serve the central-east region and another machine in Makamba province to serve the southern region of Burundi.

Discussion and analysis of the SCM results indicators

Indicator	**Target FY2017**	**Oct-Dec**	**Jan-March**	**Achieved to date October-December**			
				April	May	June	Average
% of supported facilities that experience a stock-out at any time during the last three months [MR][1]	55%	70.9%	40.7%	33%	32%	Not available[2]	
% of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptive method that the SDP is expected to provide at any time during the reporting period[3]	10%	3.4%	10.7%	Not available	Not available	Not available	
% of health centers that meet minimum SCM standards[4]	88%						

% of supported facilities that experience a stock-out at any time during the last three months [MR]

	Number of products stocked out						
	0	1	2	3	4	5 or more	Average # days of stock-outs
April	121	20	13	10	11	6	15
May	123	26	8	11	8	5	15

[1] Data collected from DHIS2
[2] Data will be available in August
[3] Data collected from family planning commodities monthly management report and data for Q3 will be available in August
[4] This indicator is measured once a year, from PBF database – data will be available in December 2017

In April: (a) Mebendazole tablet 100 mg: 25 health facilities (CDS) were stocked out. This can be explained by a period of stock-out at districts level caused by stock-out at central warehouse and lack of enough financial means to resupply from private pharmacy wholesalers. (b) Fer/Folic Acid: 21 CDS experienced stock out due to stock out in some health districts also. The cause of stock out was also the lack of product at central warehouse. (c) Oxytocin which was the most stocked out product during the 1st Quarter with an average of 60 days is now at 13 days of stock out due the availability of oxytocin at the central warehouse since October 2016. (c) SRO sachets – 25 CDS. This product was at the central warehouse and some health facilities didn't get enough funding for replenishment from private sector (private pharmacy).
(d). ACT (1-5 years): The number of days of stock out have been reduced from 56 days during Q1, 15 days during Q2 and now stock out have experienced by 2 health facilities due to unrespect lead time by health facilities when ordering.

In May: (a) Mebendazole tablet 100 mg ,24 health facilities (CDS) were stocked out. This can be explained by a period of stock-out at districts level caused by stock-out at central warehouse and lack of enough financial means to resupply from private pharmacy wholesalers. (b) Iron/Folic Acid: 19 CDS experienced stock out due to stock out in some health districts also. The cause of stock out was also the lack of product at central warehouse.

Note that since April, Mebendazole tablets 100 mg and Iron/Folic Acid are not available at the central warehouse and their stock out is observed at peripheral levels. The stock outs were reduced from 70.9% during quarter 1 to 40.7% during quarter 2 and 33% within the last 2 months, due to the strengthening of the SCM in IHPB intervention zone.
IHPB fixed these challenges by availing trucks for transport commodity to address on delivery time and supervision visits to show how to calculate the average monthly distribution/consumption specially at health facility level.

Sub-CLIN 1.3: Strengthened support for positive gender norms and behavior and increased access to GBV services

1.3. a.: Strengthened support for positive gender norms and behavior

Planned for April-June 2017	Achievements and results	Comments
Convene stakeholders' meeting on gender through the Ministry of Health's Technical Working Group (TWG)	Contacts made with the main partners targeting the meeting	Postponed for implementation in July-August September quarter due to the need to prioritize the malaria epidemic response
Expand IHPB field office staff's capacity in gender integration through training (4 Fields Managers, 12 program Technical Officers, 4 Community Mobilizers and 12 Health District staff)	The training module and tools adapted to the target audience	Postponed for implementation in July-August September quarter due to the need to prioritize the malaria epidemic response

Planned for April-June 2017	Achievements and results	Comments
Reduce gender-based stigma towards Men having Sex with Men (MSM) and Female Sex Workers (FSW) by training HIV service providers	Activity canceled	Local authorities' resistance to the training and the targeted areas Karusi and Muyinga are no longer PEFPAR priorities for implementation. The partner project LINKAGES which specializes in gender integration for key population will continue to advocate with local authorities for the training.
Implement Men As Partners (MAP) intervention	517 CHWs were trained in Buhiga (333) and Nyabikere (184) districts of Karusi	These CHWs are supervised by the Health Promotion Technicians (HPTs) and they will identify 200 men participating in MAP Intervention.
Promote positive gender norms through SBCC mass media activities including the serial drama, radio programs and PSAs	Gender integrated into materials radio programs especially on importance of male involvement during antenatal care	This is an ongoing activity so gender integration will continue to be considered as more mass media materials are produced
ANC outreach strategy that includes male engagement	Tentative plans were made before activity had to be postponed	Postponed for implementation in Quarter 4 (July-August-September) due to the MOH prioritizing the response to malaria epidemic
Conduct mobilization campaign to promote positive gender norms	Not achieved	The CSO recruited and the CSO approval request sent to USAID

Convene stakeholder meeting on gender through the Technical Work Group (TWG)

The stakeholder meeting is an advocacy activity intended to promote gender integration into policy and practice with two key Ministries by sharing new findings about gender and discussing ways in which partners who are working to end GBV and support gender integration could be better supported and connected. The ministries targeted are the Ministry of Public Health and the Fight against AIDS and the Ministry of Rights of Human Person, Social Affairs and Gender. IHPB made progress on this activity by contacting staff from several organizations involved in the TWG including UNFPA, UN Women (who co-chairs the TWG), Engender Health and the National Reproductive Health Program (PNSR) to secure their commitment to attend the meeting and discuss the purpose and plan for it.

However, the TWG was postponed by the two ministries in order to focus on responding to a malaria epidemic and finalize a review of various policy documents that have been pending including the National Work Plan of the Resolution 1325 of the United Nations Security Council; the National Gender Policy; National GBV Strategy; and a GBV specific law. As such, this meeting will be rescheduled for Quarter 4 according to the two ministries' schedules. IHPB has asked to participate in the meetings to validate these new policies and laws and has been told the project staff will be invited to contribute when the meetings are held.

Reduce gender-based stigma towards MSM and FSW through training of HIV service providers

Gender social norms are strong in Burundian society so people such as female sex workers (FSW) and men having sex with men (MSM) who transgress these norms like are often stigmatized, discriminated against and ostracized in their communities including by health providers. FSW and MSM's social isolation also deeply affects their risk of violence and HIV acquisition, as well as their desire and ability to access health services, test for HIV and access and adhere to HIV treatment. To reduce this stigma IHPB partnered with the LINKAGES project and planned a training for 90 HIV service providers from Muyinga and Karusi to reduce gender-based stigma towards MSM and FSW. However, the LINKAGES project reported strong resistance from local administrative authorities who are against any programs targeting these key populations and would not approve IHPB and LINKAGES to conduct the training of HIV service providers. Continued advocacy is necessary to overcome their resistance and will be taken up on the LINKAGES project which specializes in improving HIV services for key populations and has experience dealing with such resistance.

Expand capacity development in gender integration training through training of IHPB field office and HD staff

Building upon the gender integration training provided to the district hospital team staff in Y3, the project planned to ensure basic gender competence of the entire staff by training new employees in gender 101 and gender integration. During the January - March quarter, the training module and tools were adapted for the target audience and the Bujumbura technical staffs have been trained. Twenty field staff including 4 Field Office Managers, 12 Program Technical Officers and 4 Community Mobilizers have been identified for the training. The Ministry of Health's request to focus on responding to the malaria epidemic caused staff to redirect their attention to malaria and the training intended for this quarter has been rescheduled for Quarter 4.

Implement MAP intervention

In order to support implementation of gender integrated activities across the project beginning in Karusi Province, IHPB set out to implement the Men as Partners (MAP) strategy which has been successfully used in Burundi previously. Through MAP, IHPB will increase both the adoption of healthy behaviors and use of services by men. The intervention will especially target young men who may be more receptive to new ways of thinking that promote greater equity between women and men, boys and young girls.

The first step in implementing the MAP intervention was to train the CHWs to deliver the program. During this quarter, in partnership with the Karusi provincial health bureau, IHPB organized and conducted 18 separate two-day-training sessions on gender equity and integration by engaging the community as a whole and men in particular. A total of 517 (278 male and 239 female) community health workers (CHWs) from seven communes of Karusi were trained by 14 health promotion technicians (HPTs). The CHWs were trained in 6 districts in this province including districts included Buhiga (138), Bugenyuzi (87), Gitaramuka (108), Gihogazi (50), Mutumba (32), Nyabikere (51), and Shombo (51). A training module entitled *"Impliquer les partenaires communautaires dans l'amelioration de la prise en charge des cas de la violence sexuelle au Burundi"* developed by Engender Health which has been

successfully implemented in other provinces was used. In addition, a draft leaflet has been edited and is the validation process to be used as a sensitization tool for the CHWs to use with community members.

The second step of MAP implementation which IHPB has begun but not yet completed is to identify community role models who will be champions for engaging men to critically question gender norms that reinforce unhealthy behaviors as well as GBV. During July – September, the CHWs, supervised by the HPTs will finish identifying 200 men as role models, who will provide examples of alternative ways that other men of their community to express their masculinity, such as non-violent responses to conflict, safety improvements for women in the community, and support of prompt care and treatment for GBV survivors.

Promote positive gender norms through SBCC mass media activities including the serial drama, radio programs and PSAs

Gender integration concerns different areas of life. For an effective change in norms and behavior, the gender program must work in synergy with SBCC to reach a maximum of community members. During the April - June quarter, the gender program continued to integrate gender into the SBCC activities through two radio programs highlighting the importance of male involvement during antenatal care (ANC).

Conduct mobilization campaign to promote positive gender norms

Community mobilization to promote positive gender norms more broadly will be conducted by a CSO. The Burundi Red Cross was recruited as the appropriate CSO and the approval request have been submitted to USAID.

Discussion and analysis on the Gender results indicators

Indicators	Target FY 2017	Achieved to date FY 2017					
		Oct-Dec 2016	January-March 2017	April 2017	May 2017	June 2017	Total
1.3.1. Number of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalance within the household)	5	1	6	0	1	0	8
1.3.3. Percent of target population reporting agreement with the concept that males and females should have equal access to social, economic, and political opportunities		Indicator will be measured through end of project survey					

The target for Y4 is to achieve 5 project interventions that address at least one gender theme. The interventions can be classified into two main categories: a) training or b)

sensitization/mobilization. During the quarter, 18 training sessions were provided to 517 CHWs on the Men As Partners program.

1.3. b.: Expand access to high quality and comprehensive services for GBV survivors

Plans for April - June	Achievements and Results	Comments
Conduct SGBV landscape mapping exercise	In progress	Data collected Review and analysis underway.
Train 86 providers on GBV case management	Achieved	43 providers trained in the quarter from April to June 2017; 45 providers trained in the quarter from January to March 2017
Support quarterly coordination meetings	Not achieved	Due to the accelerated response of the malaria epidemic
Disseminate job aids on clinical management of SGBV, once adopted by PNSR	Validation meeting was held on June 30, 2017 and the tools were validated.	Tools will be multiplied and disseminated in July to September 2017 quarter
Follow-up supervisions	Not achieved	Health care providers were mobilized for the accelerated response to the malaria epidemic.
Develop CSO partnership for comprehensive package of services to GBV victims	Finalized the preparation of the selected CSO program description and translated the document into English	Approval request submitted to USAID in July 2017.
Train 521 CHWs from Buhiga and Nyabikere districts on GBV	517 CHWS trained	4 CHWs were not available
Train 122 health care providers on the psychological support methods of GBV victims.	Postponed for July to September quarter[5]	Conflict of agenda with the activities organized by the MPHFA.

During the April to June 2017 quarter, IHPB conducted the following activities to effectively fight against gender based violence and improve access to quality care for victims.

Conduct SGBV landscape mapping exercise

For the April to June 2017 quarter, information was collected from 48 health centers, 10 hospitals, 27 non-health institutions (Legal Institutions (Prosecutor's Office, High Courts, Judicial Police) CDFC, CSO) and 48 community leaders were consulted at the time of information gathering. We transcribed the information gathered to facilitate the analysis. Review and analysis is underway.

We noted that the information gathering activity did not follow the planned schedule because of the conflicting agenda of the other activities organized by the MPHFA (Ministry of Public Health and Fight against AIDS) and other challenges such as lack of fuel.

[5] IHPB met with the PNSR to plan postponed activity due to the accelerated response of the malaria epidemic

Train providers on GBV case management

In partnership with the PNSR, IHPB organized and conducted a 6-day training of health care providers from health districts of Kayanza and Gahombo in two consecutive sessions. A multidisciplinary team of five facilitators sent by the National Reproductive Health Program moderated these training sessions. The training module used is "Guide de Formation sur la Prise en Charge integree des Victimes de Violence Sexuelles et Basées sur le Genre" *(Training Guide for Integrated Case Management of Victims of SGBV)*. For this quarter, a total of 43 health care providers (25 male and 18 female) participated in the training. Of the 43 participants, 20 health care providers came from Gahombo HD and 23 from Kayanza HD (40 were nurses and 3 were medical doctors).

For WP Y4, IHPB set out to train 86 care providers from the health districts of Kirundo, Vumbi, Kayanza and Gahombo. 88 health care providers were trained, representing 102% of the Y4 target.

Support quarterly coordination meetings

For the April to June 2017 quarter, IHPB had planned to organize a quarterly coordination meeting for stakeholders in the SGBV and victim care component. The meeting did not take place due to other events[6] organized by the MPHFA and the accelerated response of the malaria epidemic. This quarterly coordination meeting was postponed for the quarter of July to September 2017

Disseminate job aids on clinical management of SGBV once adopted by PNSR

During the last quarter, a meeting of the GBV stakeholders was chaired by the PNSR to review and modify the document, including the tools, which will be multiplied. On June 30, 2017, the PNSR organized a meeting of all stakeholders in the SGBV component to verify whether the comments made for the first draft were incorporated and then validate the document.

Indeed, the document *"Manuel du prestataire de soins sur la prise en charge intégrée des victims de VSBG"* which contains the tools of medical care of the victims of the SGBV has been validated.

The tools identified with PNSR are:

- *Formulaire clinique sur la violence sexuelle et basée sur le genre*
- *Formulaire d'orientation vers d'autres services,*
- *Ordinogramme de prise en charge médicale des victimes de VSBG*
- *Pictogramme du corps,*
- *Protocole national de prise en charge médicale d'une victime de VSBG*
- *Fiche du patient*

These tools will be multiplied and disseminated in July to September 2017 quarter.

[6] For these events, we can report the mother-child health week, the African vaccination week and the accelerated response of the malaria epidemic.

Follow-up supervisions

This activity was not carried out because of a conflict of agenda with other activities organized by MPHFA. Thus, the week of maternal and child health, the week of African vaccination and the accelerated response of the malaria epidemic did not allow the realization of the activity. This activity postponed for July to September 2017 and 43 health facilities will be supervised.

Develop CSO partnership for comprehensive package of services to GBV victims

During the April to June 2017 quarter, program description of activities has already been completed and has been validated by the recruitment committee. The technical team finalized the translation of the document into English and an approval request was submitted to USAID in July 2017.

Train CHWs from Buhiga and Nyabikere health districts on GBV

During the April to June 2017 quarter, IHPB organized and conducted training for the CHWs of the Buhiga and Nyabikere health districts. The training was organized in 18 separate four-day-training sessions (first two days focused on men as partners and the second two days on comprehensive package for GBV victims) on gender-equality integration by engaging community especially men through Men As Partners (MAP) and community level comprehensive package for GBV victims.

A total of 517 (278 male and 239 female) community health workers (CHWs) from seven communes of Karusi were trained by multidisciplinary team of facilitators (health promotion technicians (HPTs), psychologists of specialized centers and magistrate focal points for gender and GBV): Buhiga (138), Bugenyuzi (87), Gitaramuka (108), Gihogazi (50), Mutumba (32), Nyabikere (51), and Shombo (51). A module entitled "Impliquer les partenaires communautaires dans l'amelioration de la prise en charge des cas de la violence sexuelle au Burundi" developed by Engender Health was used for the first two days while for the second two days, a draft training material on community level psychosocial and legal aspects of GBV care "Prise en charge communautaire des victimes de VBG: Aspects psychosociaux et juridiques" developed by the project was used.

In short, for Y4, IHPB planned to train 521 CHWs in the health districts of Buhiga and Nyabikere. Thus, out of 521 CHWs that should be trained, 517 CHWs are trained which represents 99% of the Y4 target

Train 122 health care providers on the psychological support methods of GBV victims

The activities (the mother-child health week, the African vaccination week and the accelerated response of the malaria epidemic) organized by the MPHFA did not allow the execution of the activity.
Indeed, since the target for indicator (1.3.2) has been reduced to 4 health districts where the program of comprehensive care of the victims of GBV must be initiated, during Y4, the project adopted a strategy to initiate this program in 2 health districts (Buhiga and Nyabikere) and two others for Y5. Therefore, in the quarter of July to September 2017, IHPB will train 74 health care providers from the Buhiga and Nyabikere health districts on the psychological support methods of GBV victims.

Progress and discussion on GBV indicators

Indicator	Target FY2017	Achieved to date					
		October-December	January - March	April	May	June	TOTAL
1.3.2. Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products	33% (4/12)	NA	NA	NA	NA	NA	0%
1.3.4. Number of people receiving post-GBV care (post-rape care, other post-GBV care, PEP)	170	44	68	8	10	4	90[7] (53%)
1.3.5. Number of facilities that provide PEP to GBV survivors	34	30	31	31	31	32	32 (94%)
# of people trained on GBV case management (Trainers, health care providers, and community health workers)	634	0	65 (20 trainers of providers and 45 providers)	43 providers	517 CHWs	0	625 (98%)

Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products

This indicator, to be reported annually, has an annual target of four health districts that must have one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products. For April to June 2017 quarter, activities were planned to implement in the two health districts, a comprehensive program for the care of GBV victims and a male participation initiative with referrals to health services and products.

Indeed, IHPB set up a male involvement initiative with referrals to health services in Buhiga and Nyabikere HD by training the CHWs of these districts on gender-equality integration by engaging community especially men through Men As Partners (MAP) and community level comprehensive package for GBV victims. During the quarter of July to September 2017, IHPB will train 74 health care providers in the health districts of Buhiga and Nyabikere on the listening and psychological support techniques of the victims of GBV and to set up listening centers on the health facilities. These counseling centers will assess with victims the needs and refer them to legal structures if the victim needs them. This will make it possible to set up a program of comprehensive care (medical, psychological and legal care) in the two health districts.

[7] DHIS2 provides data for the months of April and May: 30 survivors received post-GBV care in the two PEPFAR provinces (Kayanza and Kirundo) and 13 survivors in the other non-PEPFAR provinces (Muyinga and Karusi)

Number of people receiving post-GBV care (post-rape care, other post-GBV care, PEP)

During the quarter of April to May 2017, 22 survivors received post-GBV care in the two PEPFAR provinces. Thus, 90 people received post-GBV care, which represents 53% of the Y4 target for the two PEPFAR provinces. If we add the 13 survivors who received post-GBV care (in April and May 2017) in the non-PEPFAR area, a total of 103 people received post-GBV care, which represents 61% of the Y4 target.

Number of facilities that provide post-exposure prophylaxis (PEP) to GBV survivors

During this quarter, 32 facilities (representing 94%) in the two IHPB PEPFAR provinces reported on PEP provision to GBV survivors (20 from Kayanza and 12 from Kirundo).

Number of people trained on GBV case management

For this quarter, IHPB trained 43 healthcare providers in the health districts of Kayanza and Gahombo. In addition, the project also organized and conducted training for 517 CHWs in the health districts of Buhiga and Nyabikere. Thus, a total of 625 (trainers of providers, health care providers and CHWs) were trained on GBV case management.

CLIN 2: Increased Use of Quality Integrated Health and Support Services

Sub-CLIN 2.1: Increased access to health and support services within communities

Planned for April-June 2017	Achievement and results	Comments
Organize, at commune level, regular CHWs meeting to debate community health system matters including data analysis in four provinces.	Achieved	The meeting was organized in 9 communes in Kayanza province.
Pilot the CHWs peer supervision strategy in Vumbi health district	Ongoing	A one-day workshop was held with the peer-support group coordinators, the HPTs, a health district representative, and a provincial health office representative to assess the strategy.
Conduct one-day orientation for 164 nurses in-chief and 164 heads of *comité de santé* (COSA) from 12 HDs on community health system.	Achieved	A one-day orientation was conducted in Kayanza province with 36 heads of health centers and 40 heads of COSAs.
Conduct 2-day training of 110 trainers of COSAs from 12 health districts.	Partially achieved	20 were trained in Karusi; 25 will be trained in Kayanza to make a total of 45; Muyinga and Kirundo provinces will be covered with another partner, COPED.
Conduct one-day training for 1,674 members of COSA from 12 HDs on COSA scope of work.	Partially achieved	299 were trained in Karusi; 520 will be trained in Kayanza; Kirundo and Muyinga will be trained by COPED.

To strengthen the community health system, IHPB planned activities aimed to support the work of CHWs and COSAs. The following are activities carried out during the period April to June 2017.

Organize, at commune level, regular CHWs meeting to debate community health system matters including data analysis

In collaboration with the health district offices, CHWs quarterly meetings were held in Kayanza province, gathering CHWs, health center heads and health promotion technicians. The meetings were held in the nine communes (out of 9); 891 CHWs (out of 897), 16 HPTs, 42 health center heads, nine supervisors of district, three health district medical chief attended the meetings. The purpose of the meeting was to coach health centers and CHWs on correcting the monthly reports, analyzing community data, and making evidence-based decisions.

The points discussed were: completion of CHWs monthly reports, analysis of the data: activities not done and why, alarming figures, issues, and recommendations.

Pilot the CHWs peer supervision strategy in Vumbi health district

IHPB is testing the CHWs peer supervision strategy in Vumbi health district to supplement current forms of supervision undermined by the shortage in health promotion technicians. The strategy consists of grouping CHWs in small groups (peer-support groups) with four-eight members, headed by a support group coordinator selected among the CHWs. The CHWs in peer-support groups organize joint activities, conduct supervisory visits to one CHW, and hold two meetings per month.

During this quarter, a one-day workshop was held (report is available) with participants including peer-support group coordinators, the HPTs, a HD representative, and a provincial health office representative to assess the strategy. The objectives of the workshop, were to correct some errors noted in the monthly reports of peer support groups, monitor the strategy relevance (added value) perceived by the CHWs, address the challenges, and identify the successes stories. Pilot is ongoing, will be assessed again through a workshop with health system officials including health center heads, HPTs, health district office, and provincial health office representatives, and the community score card; results will be disseminated.

The strategy advantages perceived by CHWs are such: the strategy reinforces collaboration between CHWs; the strategy motivates CHWs; the strategy facilitates capacity-building; the strategy increases CHWs credibility. Examples of successes are: at Gatare-Canzikiro, a CHW failed to convince a pregnant adolescent to go for ANC services, but when four CHWs visited her, she finally accepted; at Nyamivuma, the CHWs group made possible a home visit in a household where one CHW could not go because he had a land conflict, they screened a child severely malnourished and referred him to the HC; at Nyamirembe, the CHWs group counseled a women with her 3rd pregnancy, two home deliveries, and she went to give birth at the health facility.

Challenges mentioned:

- Some CHWs were not trained on CBD: a training is planned for year five in RH section.
- Some CHWs have no working note-books: one note-book will be provided to each CHW

- Some peer support groups count two CHWs only, making difficult to conduct peer supervisory visits: It was decided to merge some groups.

Conduct one-day orientation for 164 C nurses in-chief and 164 COSA presidents from 12 HDs on community health system

While COSA (comité de santé) is in charge of overseeing the health center, it was noted that health center managers were not aware of the task of COSAs and this brought about mistrust between them. To bring health center heads and COSAs heads to have the same understanding of the community health system and improve collaboration between them, a one-day orientation was organized for them in Kayanza province. 36 out of 42 Health center heads (6 female and 30 male) and 40 out of 42 COSAs heads (14 female and 26 male) attended the session. The participants were divided into three groups, district by district, and discussions focused on the following themes: definition of some concepts, history and evolution of community health in the world and in Burundi, COSA scope of work, COSA versus CHW.

Along with the 35 health center heads and 35 COSA heads from Karusi reached with the orientation session in November 2016, the total makes 71 health center heads and 75 COSA heads. The remaining 87 HC heads and 87 COSA heads (from Kirundo and Muyinga) will be covered by another partner, COPED.

Conduct 2-day training of 110 trainers of COSAs from 12 HDs

IHPB offered to train the members of COSAs on their scope of work; the COSA being a committee of community members involved in HC management, community participation, and assure to the community access to health care. For that, a training of trainers is necessary, trainers who will train COSAs members. Thus, 19 trainers attended a two-day training in Karusi province (1 female, and 18 male) including 15 health promotion and four supervisors of district. The training had as objectives: inform the participants on the origins and the purpose of COSAs; train the participants on some components of HC management involving the COSA; make clear some barriers to health care that COSA is appealed to overcome; discuss on the COSA functionality indicators. The themes debated included: history and purpose of COSAs, organization et functions of COSAs, barriers to health care, human resources management in HC, finance management in health center, COSA functioning indicators.

The pre- and the post-test had the following scores: an average 57% in pre-test and 84% in post-test; a minimum of 20% in pre-test and 60% in post-test; a max of 77% in pre-test and 93% in post-test.

Conduct one-day training for 1,674 members of COSA from 12 HDs on COSA scope of work:

IHPB offered to strengthen the COSA, a committee of community members involved in HC management and community participation. Thus, in Karusi province, 299 members of COSAs (107 female and 192 male) attended a one-day training on their scope of work. The training encompassed the following themes: history and purpose of COSAs, organization and functions of COSAs, barriers to health care, and COSA functioning indicators.

Participants noted many tasks they were performing incorrectly and others they were not doing at all.

A pre- and a post-test framed the training with the following scores: an average score of 39% in pre-test and 78% in post-test; a minimum of 7% in pre-test and 27% in post-test; a max of 90% in pre-test and 100% in post-test.

Organize a semi-annual coordination meeting at province level:

This activity was planned for the quarter January-March 2017, but had been postponed because of malaria epidemic. The activity was finally reoriented to malaria response; mobile clinics and interactive community theaters were organized.

Discussion and analysis of the results

Indicator	Target FY2017	Achieved to date FY 2017					
		October-December 2016	January-March 2017	April 2017	May 2017	June 2017	Total
2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services[8]	36%	N/A	N/A	N/A	N/A	N/A	N/A (measured at endline)
2.1.2 Number of cases treated or referred by CHWs	80,000	53,296	62,374	13,414	13,118	(-)[9]	142,202
2.1.3 Percent of health facilities that have functional CHW systems[10]	25%	N/A	N/A	N/A	N/A	N/A	N/A (measured annually)
2.1.4 Percent of COSAs that meet defined functionality standards[11]	72%	N/A	N/A	N/A	N/A	N/A	N/A (measured at endline)

2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services

Since this indicator is informed by baseline, mid-term, and end -of-project surveys, IHPB did not establish FY 2017 target in the PIRS.

2.1.2 Number of cases treated or referred by CHWs

This information is extracted from CHWs monthly reports. While the 2017 annual target is 80,000, data up to May 2017 makes a total of 142,202 (177 % of the annual target). The annual target has been already exceeded; this is due to the fact that IHPB-target provinces were subject to malaria outbreak. In

[8] No monthly data available for this indicator which will be informed by end-of-project survey.
[9] Data for June are not yet available
[10] Data not available on monthly basis - indicator collected annually using PBF database.
[11] Data not available on a monthly basis; indicator will be informed by end-of-project survey.

addition, CHWs from four health districts (Gahombo, Gashoho, Musema, and Kirundo) were trained on diarrhea and pneumonia management extending the range of diseases managed and the number of children treated by CHWs. Moreover, the CHWs' reporting system follow-up was improved by regular monthly data analysis and report collection.

2.1.3 Percent of health facilities that have functional CHW systems

This indicator is collected annually using PBF mechanism, not supported by the IHPB. HCs that meet functionality standards are those that have always scored 50/50 at the PBF indicator on CHWs activities during the four successive quarterly quality evaluations. While the baseline for this indicator was 11% and the 2017 target set to 25%, the achievement for 2016 was 42%. Training on various health areas and CHWs supervision helped to achieve the result.

2.1.4 Percent of COSAs that meet defined functionality standards

Since this indicator is informed by baseline, mid-term, and end -of-project surveys IHPB used the mid-term target of 72% presented in the PIRS as the FY 2017.

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services

2.2. C: Support integration with a QI model and prepare districts for scale-up of best practices

From April to June 2017, Quality Improvement (QI) activities focused on developing the integration extension plan for Muyinga province, continuing the documentation of the QI work, coaching the extension teams and monitoring the extension of improvements in all 165 facilities of IHPB interventions.

The following table provides a summary update on the level of implementation against the planned activities described in the third quarter of Y4 work plan.

Planned activities April-June, 2017.	Achievements And results	Comments
Complete the QI demonstration phase in the 46 initial sites		
Identify and coach the Quality Improvement Teams (QIT) who have not achieved their integration objectives	Achieved	Conducted intensified coaching support in 12 sites with low performance in the four provinces.
Extend best practices to the remaining facilities within each province		
Organize the third Learning Session (LS) in Kayanza and Muyinga; identify the extension team and organize a two-day extension strategy workshop in Kayanza.	Achieved	Third LS in Muyinga was conducted, attended by 70 participants. In Kayanza, third LS was conducted in February.
Support and accompany the extension teams, monitor the extension and adjust the strategy accordingly.	Continuous	37 new QIT set up in extension sites in Muyinga province. Coaching visits continuing in Karusi, Kayanza and Kirundo.
Document the QI Initiative		
Collect the information and review draft	Achieved	First draft now complete.

Planned activities April-June, 2017.	Achievements And results	Comments
Produce short briefs on QI work	Achieved for the demonstration phase	Newsletter on demonstration phase produced.
Supporting activities		
Train 15 HIV providers in Kayanza province on contraceptive technology.	Achieved	15 health providers (7 males and 8 females) trained.

Identify and coach the QI teams who have not achieved their integration objectives

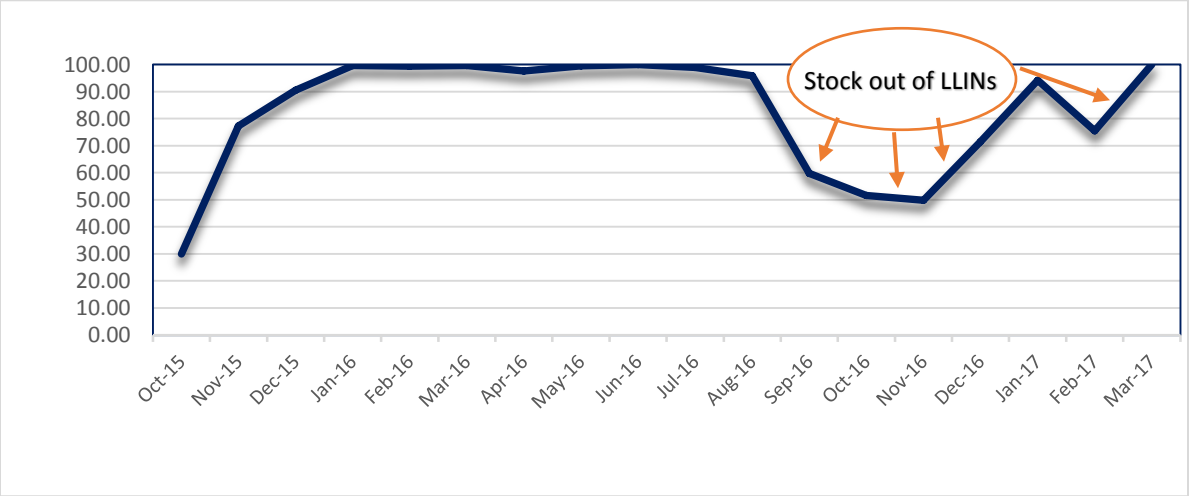
Two sites out of 11 facilities in Karusi, five out of 17 in Kirundo, four out of 15 in Kayanza and one out of 9 in Muyinga continued receiving intensified coaching support and have now improved their integration objectives.

Organize third learning session on the extension of improvements into 37 new health facilities in Muyinga province

In partnership with Muyinga province and districts health bureau, IHPB organized the third LS to develop the change package to extend to all facilities in the province for the integration of prevention of malaria into ANC services. The workshop gathered 33 participants for the first two days including a chairman of QIT per site, 4 HIS in charge, 3 district supervisors, 3 district coaches, 4 health district managers and the director of Muyinga health province. During the 3rd and 4th day, 37 participants in charge of new facilities joined to learn about the extension strategy. A total of 70 participants (10 females and 60 males) attended the workshop. By the end of the workshop, an extension charter/plan was developed and co-signed by partners and IHPB.

Following are some main achievements:

% of pregnant women seen in ANC1 who benefited from Long Lasting Insecticidal Nets (LLINs)

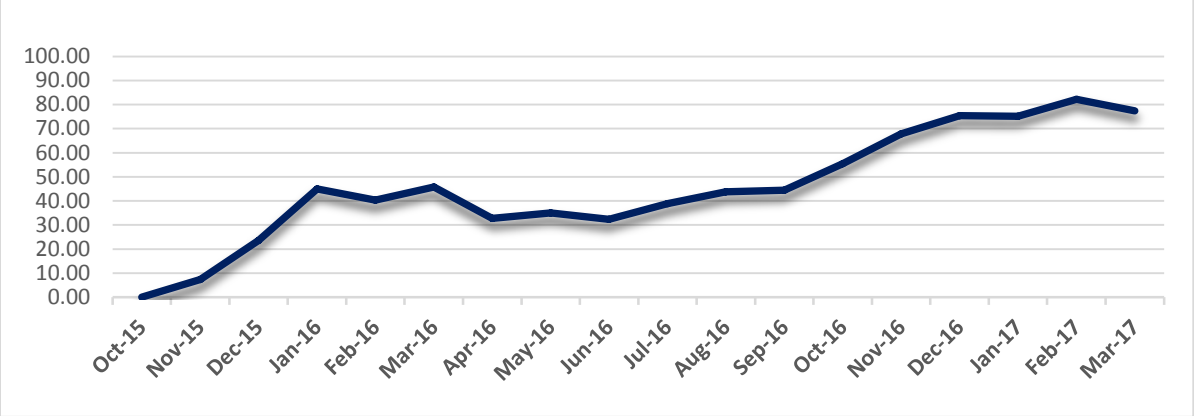


Since the introduction of the integrated services with QI approach, the percentage of pregnant women seen in ANC1 who have benefited from LLINs has increased from 30% before QI to stabilize at 100%.

However, stock-outs at the central level during the period between September-November 2016 and February 2017 interrupted the good progress on this indicator.
Some of changes tested that led to improvements:

- Offer the LLIN (Long Lasting Insecticidal Nets) in ANC services
- Set up a register of requisitioning and daily consumption of LLINs in the ANC service
- Record the LLIN offered in ANC register.

% of pregnant women seen in AN3 who received second dose of Intermittent Preventive Therapy in pregnancy (IPTp)



The percentage of pregnant women seen in ANC3 who received the second dose of IPTp gradually increased from 0% prior to the introduction of the changes, to 77% in March 2017.
Some of changes tested that led to improvements.

- Provide Fansidar (SP) in the ANC service by trained health providers and taken directly in the presence of the service provider.
- Follow up on a LLTN/SP requisition addressed to the Health District.

What worked well

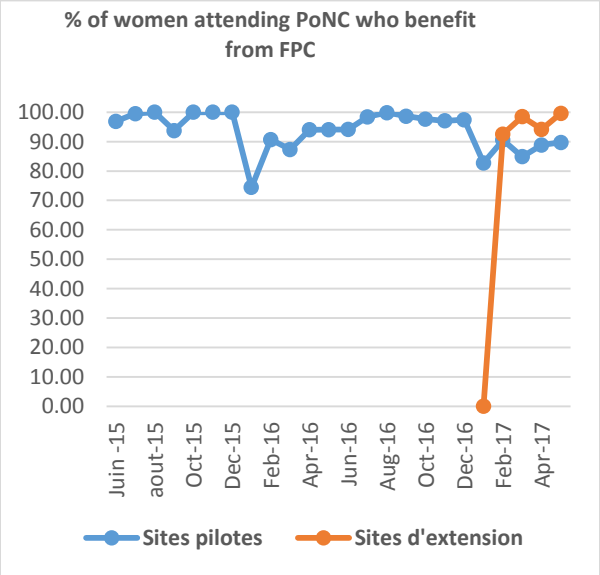
Sensitization meetings of CHWs in households about the benefits of IPTp and early ANC combined with spreading messages signed by the communal administrator across churches and mosques to raise public awareness about the benefits of early Ante Natal Care (ANC) resulted in the increase of women attending early ANC. This is shown by the fact that 85 % of pregnant women received the first dose of IPTp before the 15th week of amenorrhea.

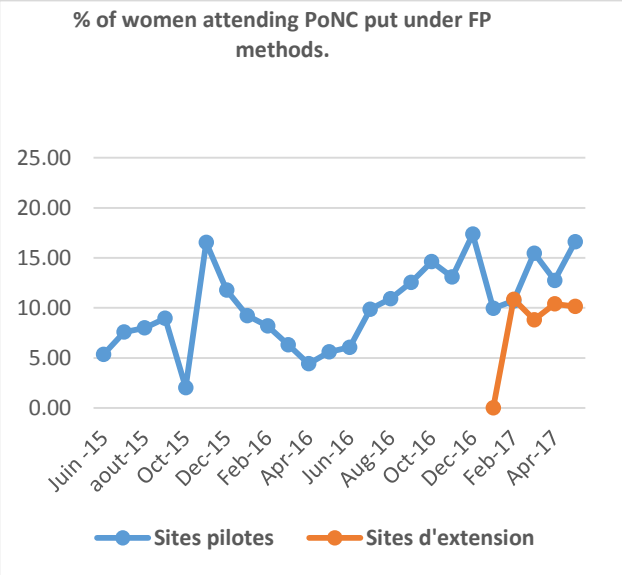
Support and accompany the extension teams, monitor the extension and adjust the strategy accordingly.
Organized four-days for jointly coaching visits in Karusi

In close collaboration with health districts bureaus, IHPB organized a) the second wave to introduce package change on the integration of Family Planning (FP) into MCH in 9 new extension sites, b) coaching visits on June,12-15,2017. Coaching visit focused on 4 HC in Buhiga Health District (HD): Rudaraza, Rutonganikwa, Cirambo and Kiranda and 5 Health Center (HC) in Nyabikere HD (Kivoga, Gikombe, Mazita, Rugwiza and Sagara). The purpose of this visit was to introduce and explain the change package.

For coaching visits, the purpose was to monitor the implementation of the package change in extension phase, document progress and data collection. Eight health facilities were coached respectively, 6 in Buhiga HD and 2 in Nyabikere.

The following two charts show the percentage of women attending Post Natal Care (PoNC) who benefited from Family Planning Counselling (FPC) on the left, and those put under FP methods on the right in pilot and extension sites in Karusi health province.



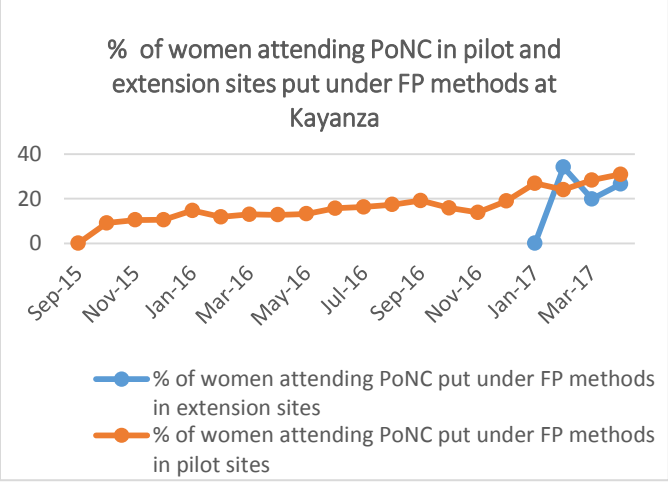


Note that in extension sites, some of counseled women were already under FP methods.

Organized joint coaching visits in Kayanza

In close collaboration with health districts bureaus, IHPB organized coaching visit to collect data and update the improvement database for April and provide technical assistance in the QI integration efforts

The following chart show the percentage of women attending Post Natal Care (PoNC) who benefited Family



Planning Counselling (FPC) in pilot and extension sites at Kayanza health province.

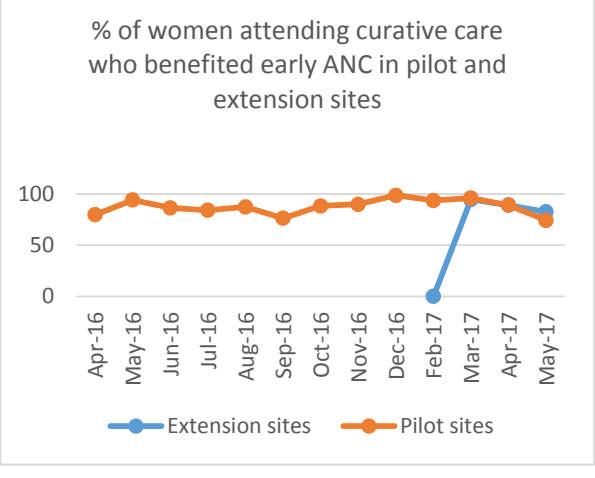
The rate of women attending PoNC put under FP methods is low in some identified extension sites due to turn over of key staff and conflict between QI teams some other sites of Musema health district in charge.

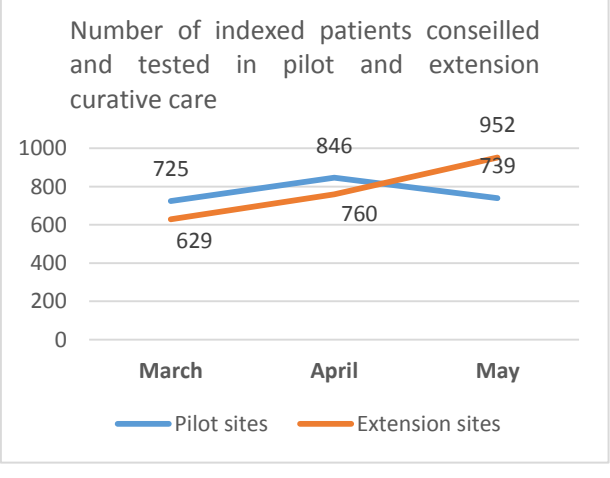
Organized joint coaching visits in Kirundo

During the period of May 2017, IHPB organized in partnership with health province, districts and health facilities, coaching visit in 29 health centers Kirundo health province, respectively; 6 in Kirundo; 7 in Vumbi ; 7 in Mukenke and 9 in Busoni health district.

The purpose was to document the functionality of the new QI teams, verify the consistency of the data collected and transmitted, and document progress of the QI teams and, check eventual challenges and provide a technical assistance to address to the challenges found.

Results





The run chart on the left shows the % of women attending curative care who benefited early ANC in pilot and extension sites. The one on the right shows the evolution of indexed patients counselled and tested in pilot and extension curative care.

Support and accompany the extension teams through coaching visit in Muyinga.

During the demonstration phase, many change ideas have been tested in selected pilot sites. At the end of the third learning session, participant identified effective changes which generated good results/best practices. Successful pilot teams were identified as champions/extension agent to extend the best practices to the remain facilities (extension sites) to cover the whole province.

Thus, health province of Muyinga in collaboration with IHPB, organized first wave extension visits in three HD from May 30 -13 June, 2017. Fifteen HC of Muyinga HD, 12 of Giteranyi HD, 10 of Gashoho HD were invited to their respective pilot sites for experience sharing.

Documentation of QI work

Produce short briefs on QI work

A newsletter has been produced for the demonstration phase and has been published.

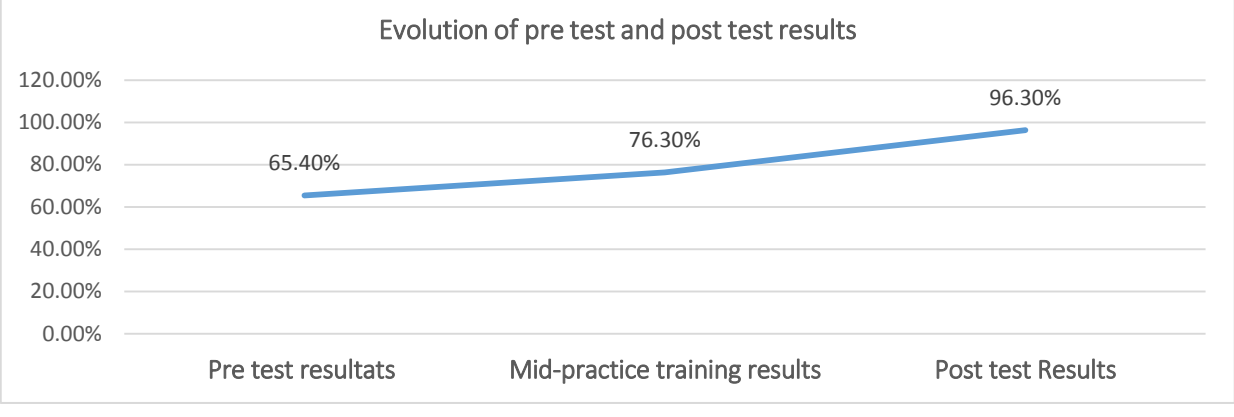
Collect the information and review QI draft

The first draft of the QI story is now complete and will be reviewed by FHI 360 TA provider.

Train 15 PF providers in Kayanza province on contraceptive technology.

Before this training, missed opportunities to provide FP methods to seropositive women were observed due to lack of capacity. Then, the health province of Kayanza in collaboration with the Reproductive Health Program; supported by the IHPB organized fourteen training days of 15 HIV service providers of Kayanza province in Contraceptive Technology from June 12th to 23th; 2017 at Muyinga province. This training session brought together 21 participants (12male, 9female) including 15 learner-participants (7male, 8female) and 6 trainers (5 male,1 female). The purpose was to provide participants with the clinical knowledge and skills needed to adequately deliver family planning services to women living with HIV. Specific objectives were to provide participants with decision making skills to adequately manage side effects and contraceptive rumors; Provide participants with interpersonal communication on FP counselling to respect the right of women to life, health, privacy, dignity and freedom of choice of the contraceptive method to be used; Integrate FP into other services.

Results on training of 15 health providers (of HIV services) of Kayanza province on contraceptive technology.



During the practice training, a total of 53 Intra Uterine Dispositive) IUD were inserted, 8 removed; 220 of implants inserted and 21 removed by participants themselves.

Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services

Planned for April-June 2017	Achievement and results	Comments
Develop and pilot OASIS modules through project-led, human-centered design, with support from Tech Lab.	Achieved	In order to deploy the Integrated Instrument, a user guide has been developed and finalized.
Continuously update the IHPB training database, including contribution to Standard operating procedures for M&E Officers and trainers and their role in collecting trainee data	Ongoing	221 health providers, 299 COSA members and 1,531 CHW were trained. The training database is updated accordingly.
Plan and coordinate supervision visits supported by IHPB and OASIS	Achieved	A post training-follow-up joint supervision was conducted (IHPB & Gashoho Health District)
Participate in national- and intermediate-level technical meetings and working groups on HRH and	Achieved	An orientation session of the staff of the "Direction de l'Offre et de la Demande de Soins"

Planned for April-June 2017	Achievement and results	Comments
iHRIS		(DODS) was conducted during three days from 03 to 05 May on the use of the integrated tool
HSS Officer contributes experiences, perspectives, and best practices to the FHI 360 Health Workforce Strengthening Task Force	Ongoing	A web-based collaborative platform (SharePoint) has been created and is used by IHPB staff; the Outil d'Amélioration des Services Integrés de Santé (OASIS) and user guide are regularly updated

During April-June 2017, the following Sub-CLIN 2.3 activities were conducted:

Develop and pilot OASIS modules through project-led, human-centered design, with support from Tech Lab.

At the Health ministry level, an orientation session of the use of the Integrated tool was conducted to the staff of the Direction de l'Offre et de la Demande de Soins (DODS) from 03 to 05 May. A total of 8 members of the staff including 5 women attended the session. A four-day training from 29th May to 1st June was organized by IHPB in collaboration with the DODS to 40 District supervisors and Program Technical Officers.

Subsequently, from June, as part of OASIS deployment, integrated supervisions were jointly conducted by the districts supervisors and the Program Technical Officers in 13 Health Center (HC) in Muyinga and Kirundo and the following services were supervised: Ante Natal Consultation in 2 Centers, Immunization in 2HC, Adult Curative Consultation in 3 HC, Infant Curative Consultation in 3 HC, HIV Test Counseling in 1 HC, Supply Chain Management in 2HC.

Operationalization of OASIS using tablets by TPOs and other project staff during project-supported and joint supervision visits

In order to deploy the Integrated Instrument, a user guide has been developed and finalized. This user guide describes the different stages of using the tablet containing the ÓASIS. Since the device is switched on to ODK Collect opening. Different steps of forms use are detailed from the backup to sending the finalized forms. By the end of June, eight modules out 12 ready to be deployed were downloaded to ODK Collect (Open Data Kit) on tablet.

Continuously update the IHPB training database

During this quarter, nine different trainings were conducted. A total of 2,051 learners were trained. Of these1,830 were trained at community level in which 577 were trained on nine key actions targeting parents of children under five years in Karusi province and 299 were COSA members. 221 were health care providers.

Plan and coordinate supervision visits supported by IHPB and the II-ARC

A post training-follow-up joint supervision was conducted (IHPB & Muyinga HD) Gashoho Health District: Mirwa health center, Musama health center, Gisabazuba health center, Nyagatovu health center, Gisanze health center, Bwasare health center. Those supervisions were conducted in frame of follow up TPIg training. Eight were assessed. In Kayanza Health district, 5 trainees on GATPA were followed up in following health centers: Nyabihogo, Gahahe, Kavoga, Murima, Kabuye.

Participate in national- and intermediate-level technical meetings and working groups on HRH and iHRIS

In partnership with MOPHFA, IHPB has financially and technically supported the Human Resources Department in the development of Human Resources in Health 2016 after 2013 Edition. A document was produced that will be printed by IHPB in the amount of 100 copies. These copies which will be printed this month of July will be diffused at all levels of the MOPHFA as well as its partners.

HSS Officer contributes experiences, perspectives, and best practices to the FHI 360 Health Workforce Strengthening Task Force

Share Point site created and used in which an OASIS user guide was shared. All the IHPB staff has an access to this documents. Eleven out of 13 modules all already uploaded on SharePoint IHPB site in their Excel version. We have already 8 modules in their XML version already ready to be uploaded in ODK Collect version on tablet.

Discussion and analysis of Sub CLIN 2.3 (HR)

Indicators	Target FY2017	October-December	January-March	Achieved to date April- June			
				April	May	June	Total
2.3.1. Percent of trained health providers, managers and CHWs who perform to a defined standard post-training [Mandatory Result]	95%	N/A	N/A	N/A	N/A	N/A	
2.3.2. Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [Mandatory Result]	90%	98,4%	94,7				84% (n=600)
2.3.3. Percent of trained health care staff who report positive attitudes (composite indicator) about work and the workplace [Mandatory Result]	69%	(79,2%[12])	N/A	N/A	N/A	N/A	
2.3.4. Percent of health facilities with at least 80% of clients reporting satisfaction with services received [MR]	100%[13]	N/A	N/A	N/A	N/A	N/A	
2.3.5. Number of health care workers who successfully completed an in-service training program	1,525	158	694	122	72	27	221
2.3.6. Number of community health/para-social workers who successfully completed a pre-service training program	6,558	1,716	2,682	299	517	793	1,830

% of trained health providers, managers and CHWs who perform to a defined standard post-training

Non-applicable. Data annually reported

% of supported health providers, managers and CHWs who have demonstrated improvement post-training

[12] Mid-term evaluation Result

[13] PBF source

Pre-and post-test are regularly given and results are collected and the progress by trainee is estimated. Out of 600 trainees assessed,84% have demonstrated improvement post training. Among 521 CHW trainees, 82% have demonstrated improvement while among 79 health provider's trainees, 96% showed a post training improvement.

% of trained health care staff who report positive attitudes (composite indicator) about work and the workplace

The target for positive health worker attitudes is set to 69%. This indicator was measured by mid-term evaluation through Facility Qualitative Assessment (FQA) - Health Provider Interviews. 79,2% of Health providers report positive attitudes about work and the workplace. 45 health facilities and 9 hospitals were assessed.

% of health facilities with at least 80% of clients reporting satisfaction with services received

This is a PBF indicator with a target of 100%.

Number of health care workers who successfully completed an in-service training program

As planned, 1,525 managers and health workers will be trained this year(FY17) and 221 were trained in this quarter (April-June). Out of people previously planned to be trained, 1,332 (87%) were trained end of third quarter.

Number of community health/para-social workers who successfully completed a pre-service training program

A total of 6,558 Community Health Workers are targeted to be trained by the end of FY 17; this quarter 1,830 were trained. Out of people previously planned to be trained, 5,852 (89%) were trained end of third quarter.

CLIN 3: Strengthened Health Systems and Capacity

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas

3.1. a.: Work with provincial and district health bureaus to progressively strengthen district-level capacity and performance in managing the decentralized health system

Planned for April-June 2017	Achievement and results	Comments
Plan and participate to joint data review/use & quarterly coordination meetings	Partially achieved (8/12 health districts)	IHPB supported and participated ~~to~~ in 8 quarterly data revue & coordination workshops
Assess the effectiveness of the coordination meetings	In progress	All eight previous coordination meetings were assessed
Continuous mentoring of lab technicians through IHPB technical officers	Continuous	IHPB Lab Technicians participated in formative supervision missions in 32 health facilities (27 health centers and 5 district hospitals out of 94)
Support inventory of equipment through supervision visits	Achieved	Equipment inventory done
Support inventory of documents and distribution through supervision visits	Achieved	Inventory of documents is done quarterly and distribution is done if necessary

Planned for April-June 2017	Achievement and results	Comments
Plan and conduct joint supervision visits	Continuous	54.1% of the joint supervision visits were conducted as planned by IHPB provincial staff in the 12 districts
Analyze the supervision system	In progress	The supervision system assessment tool was finalized and data is being collected across all 12 IHPB health districts

During the April-June 2017 quarter, IHPB continued to work collaboratively with provincial and district health bureaus to strengthen district health teams' capacity to perform priority functions that most affect the delivery of services.

Plan and participate to joint data review/use & quarterly coordination meetings

During the reporting period, IHPB provided technical and financial support to the organization and conduct of eight one day quarterly ~~one-day~~ health data analysis meetings followed by one-day coordination meetings in three HDs (Gashoho, Giteranyi and Muyinga) of Muyinga province, three HDs (Musema, Gahombo, and Kayanza) of Kayanza province and two HDs (Buhiga and Nyablkere) of Karusi province. For the 4 health districts of Kirundo province, these meetings were postponed due to malaria outbreak. They are planned to be conducted next quarter (July-September).

The joint data review/use & quarterly coordination meetings were attended by health care providers such as health facility staff, health promotion technicians, supervisors and health information system staff from the health district and health provinces office, the district chief medical officer, and the Manager of the province health office along with other various stakeholders. IHPB Senior Technical Advisor for Health Systems Strengthening participated to 3 meetings at Musema, Buhiga and Nyabikere health districts.

During these meetings, many topics relevant to IHPB were discussed: health problems in general, maternal deaths, stock-out of medicines and supply chain management issues; emergency malaria response and household visits to CHWs. Due to the malaria epidemic, the agenda was redirected on the following topics: follow up on malaria-specific recommendations of the previous meetings; presentation on the evolution of some indicators: evolution of malaria cases in every district, evolution of malnutrition, persistency of a relatively high number of home delivery case; low uptake of early ANC1, postnatal consultations and family planning.

The main recommendation from these meetings was to organize, with IHPB support, community awareness events to encourage the community to adopt positive behavior in malaria prevention, to analyze weekly the malaria situation during the period of active response to the malaria epidemic and to mobilize all partners in every health district to provide support in the active response to the malaria epidemic, combine efforts with partners and / or interveners to manage cases of malaria outbreaks and treatment of malaria cases, establish the stock record sheet for LLITN and record daily LLITN consumption in the requisition register. Others recommendations issued during data analysis and coordination meetings conducted with the 8 health districts, solutions/strategies were made: ensure, in collaboration with CHWs, pregnant women receive timely ANC; sensitize and encourage CHW and local administration authorities to jointly develop local strategies to increase early ANC1 and FP uptake in Kayanza health province; integrate in the supervisions the points related to the

implementation of the recommendations resulting from the SIS data analysis meetings. In Karusi health province, participants recommend to sensitize the population on the early consultation of the health centers in case of suspicion of any disease as well as the complete taking of the drugs received from the health centers to reduce the rate of death at home.

Assess the effectiveness of the coordination meetings

During the reporting quarter, a coordination meeting assessment tool was finalized and was used to measure the effectiveness of the coordination meetings by the IHPB field office and the HSS advisor during the eight previous coordination meetings. Findings include:

What is working well

Currently, all stakeholders know that coordination meetings are important:

- Health district teams consider that the meeting is a relevant activity where participants gather to perform work that requires a team effort;
- The meetings are now preceded by planning, characterized by focus well chosen, governed by structure, and there is always a budget. Before the IHPB support, many coordination meetings were postponed due to lack of budget.
- Health districts and their partners and other stakeholders know that during these meetings, the ultimate goals are agreements, decisions, or solutions.
- Jointly with districts, the agenda of the meetings are developed and include the issues related to the achievement of IHPB mandatory results;
- Every health district present the progress indicators (performance) for each health facility, strengths and weaknesses;
- Decision to develop joint schedule of supervision visits monthly has been taken in all the 12 supported districts;
- Meeting reports are always developed by IHPB and shared to health districts;

What are the weaknesses

- Health districts team don't produce the meeting reports but they receive them from PTOs;
- Presentations are not always prepared on time during these meetings.
- Lack of ownership of districts.

What do we do to improve the usefulness of these meetings?

- IHPB staff explain to the district team that it is better to spend a little time preparing for solutions than to spend a lot of time fixing problems;
- Sensitize health team districts to their ownership;
- IHPB sensitizes the districts so that these meetings take place on the scheduled dates;
- IHPB supports districts in evaluating the implementation of recommendations from the previous meeting.

Continuous mentoring of lab technicians through IHPB technical officers

IHPB Lab Technicians located in Kayanza and Kirundo provincial offices continued to support laboratories in these health provinces to conduct the routine tests.

From April to June, IHPB Lab Technicians participated in formative supervision missions (one supervision visit by health facility) in 32 health facilities (27 health centers and 5 district hospitals) with the objective to meet the standards of the SIMS tools, focusing on supply chain management system (reagents), HIV laboratory activities and HIV related services delivery. Two supervision visits by health facility in 17 HC and Mukenke DH and 15 HC and in Gahombo DH, Kayanza DH and in Musema DH of Kirundo and Kayanza health provinces have been conducted by Lab technicians during this quarter. IHPB's support enabled the health facilities to do quality laboratory tests and to remarkably strengthen the capacities of providers.

The objective of supervision visits is the following:

- ✓ Provide supervision on the quality control of the Tests of the basic tests offered by health facilities;
- ✓ Supervise the execution of HIV testing;
- ✓ Provide oversight on the quality of malaria diagnosis;
- ✓ Ensure that health facilities carry out quality control of each new reagent kit.
- ✓ Supervise the supply chain of HIV testing kits and other such as STI and malaria related reagents
- ✓ Appreciate the indeterminate rate for HIV test
- ✓ Supervise biomedical waste management.

Strengths

- Presence of qualified laboratory technicians (bachelor degree, A1 and A2).
- Presence of the quality control register.
- Paillasse and tiled floor.
- No shortage on the day of supervision.
- Undetermined rate of 0.03% (from October to December).
- Presence of safety boxes to ensure a good biomedical waste management.

Weaknesses

- Quality control log of each new kit of reagents
- Inventory records were out of date
- The procedures for the determines and start dipstick tests were not displayed on the day of the visits
- The injection needle of the Facs count CD4 dosing machine was in the open and therefore the machine was clogged
- Refrigerator temperature not recorded chronologically
- These visits enabled laboratories to perform quality control for each reagent batch, complete inventory sheets daily, conduct preventive maintenance before and after handling (daily clean) and then clean after one month or after measuring 500 samples, keep the slides for quality control, keep all HIV testing kit together and monitor the quality of each new kit of HIV testing reagents to avoid false result

Support inventory of equipment through supervision visits

In collaboration with district teams, IHPB reviewed equipment inventory system and its regular update through the supervision visits and address issues as needed. From now on, district supervisors who were initially doing the inventory hand in hand with the PTOs must perform this task on their own and submit reports to IHPB through the HSS Senior Technical Advisor with a copy to the Field Office Managers and the procurement Officer. On a need basis, verification visits may be conducted to ensure the reported equipment and status thereof reflect the reality.

IHPB signed a contract with Hospital Management Services (HMS), a private company for curative and preventive maintenance of the equipment. Technicians visited facilities that benefited equipment to repair unused equipment in the health facilities of Karusi, Kayanza, Kirundo and Muyinga health provinces.

HMS also repaired beds in Kirundo, Mukenke and Kayanza health districts, anesthesia machine, incubators, fridges, surgical bistoury and theater lamp in the 9 district hospitals and the gynecological examination tables, goose lamp for gynecological examination, scales adult, hemoglobin meters, table resuscitation of newborn in different health facilities of the twelve health districts.

The maintenance report shows that 98% of the equipment provided to health facilities is still functioning before maintenance. After the activity of repairing unused equipment, 100% of equipment are functioning.

Assess the supervision system

During the reporting quarter, a supervision system assessment tool was finalized and is presently being tested across all 12 IHPB health districts. Preliminary results are presented in Annex II.

Progress and discussion on the HSS (Sub CLIN 3.1) results indicators

Indicators	Target for FY 2017		Achieved to date				
		October-December 2016	January-March 2017	April	May	June	Q3
3.1.1 Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]	FP/RH: 24.4% ANC: 38% MH: 49% CH: 27% HIV:50% Malaria : 98% GBV : 33%						
3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result]	51.1%	51.1%		51.1%	51.1%	51.1%	51.1%
3.1.3 Number of supported testing facilities with capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	100% (5/5)	80%		80%	80%	80%	80%
3.1.4 (previously 2.2.4 in PIRS) Percent of supported facilities that receive supportive supervision on a regular basis [Mandatory Result]	100%	37%	73.7%	32.3%	21.8%		54.1%

Indicators	Target for FY 2017		Achieved to date				
		October-December 2016	January-March 2017	April	May	June	Q3
3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]	100%	100%		100%	100%	100%	100%

3.1.1 Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]

Since IHPB did not establish FY 2017 targets for tracking progress on this indicator, data the end of Y3 for FP/RH (24.4%), ANC (38%), MH (49%), CH (27%), Malaria (98%) and GBV (33%) is presented as FY 2017 targets while for HIV, the target of 50% that was set for FY 2016 is used as FY 2017 target.

3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result].

During this quarter, there has been no change in this indicator and IHPB is not planning to deliver more equipment because of budget restrictions. However, one must also notice that the LOP mandatory result (31.6%), established after the SARA baseline (26.6%), has already been exceeded.

3.1.3 Number of supported testing facilities with capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]

After the refocus of PEPFAR 3.0 on two provinces, the number of supported testing facilities with capacity to perform clinical laboratory tests supported with PEPFAR funding has decreased from 9 to 5 (3 at Kayanza and 2 at Kirundo health provinces). However, the Gahombo district hospital still needs a CD4 count machine. This means that 4/5 facilities have the capacity to perform all clinical laboratory testing.

2.2.4 Percent of supported facilities that receive supportive supervision on a regular basis [Mandatory Result]

This indicator measures only the supervision visits conducted by the district supervisors (not the IHPB staff) and is extracted from the GESIS/DHIS2 databases. From the table, above, 54.1% of the supervision visits were conducted as planned. This performance is explained by:

- Calendar conflict
- Lack of logistics: lack of vehicle supervision by the district.
- There has been an outbreak of malaria cases that kept district supervisors back from performing supervision visits as planned;
- The Maternal and Child Health Week suspended other activities for 2 weeks following involvement of partners in districts.

3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]

During the quarter, 8 health districts conducted quarterly resource coordination meetings. Only the 4 health districts of Kirundo health province (Busoni HD, Kirundo HD, Mukenke HD and Vumbi HD) didn't organize these meetings due to malaria outbreak. They have planned to onduct them next quarter (July-September).

Sub-CLIN 3.2: Strengthen M&E and data management systems at the facility and community levels

Planned for April-June 2017	Achievements and results	Comments
Conduct routine data quality assessments (DQAs)	54 out of 60 targeted (90%) DQA visits were conducted	Activities to support the fight against the malaria epidemic impeded conducting all of the planned visits
Strengthen capacity of district teams and facility managers on data use through quarterly workshops	7 out of 12 meetings planned (58.3%) were conducted	Data review meetings in Busoni, Kirundo, Mukenke, Gashoho and Muyinga HD were postponed due to the fight against the malaria epidemic; instead of separate district level meetings, a single provincial level data review workshop was organized in Muyinga to review the data form all these districts.
Develop and disseminate simple-to-use data visualization dashboards for use at the facility level	98 HFs out of 138 (71%) targeted benefited from coaching visits	The annual target of 138 HFs to be coached may not be achieved by the end of this fiscal year due to activities to support the fight against the malaria epidemic.
Support quarterly community data review meetings at the health facility level	10 meetings out of 30 planned have been completed	All meetings could not be organized due to the priority given to the fight of malaria epidemic. The annual target of 30 meeting may not be achieved by the end of this fiscal year

Conduct routine data quality assessments (DQAs)

During the quarter under review, IHPB in partnership with BPS and BDS HIS in-charges, conducted data quality assessment (DQA) exercises in 54 health centers (15 in Kirundo, 10 in Karusi, 14 in Kayanza, and 15 in Muyinga). The assessment team verified several indicators measuring especially IHPB supported services such as HIV testing and counseling, PMTCT services, ARV services, ANC services, Intermittent Preventive Treatment of malaria in pregnancy, Immunization services (DPT3, Measles), assisted delivery and Active Management of the Third Stage of Labor (AMTSL), as well as Family Planning (FP) data according to activities implemented in each province. The overall objective of routine data quality assessments is to improve the quality of data through data verifications activities. Specific objectives include: (1) identify opportunities for capacity strengthening; (2) involve provincial and district core teams in the integration of data quality aspects in their supervisions; (3) improve the quality of data for program use. At the same time, DQA exercises offer opportunities to identify opportunities for capacity strengthening whether through training or coaching.

Results of the DQAs conducted within the reporting period revealed that the average variance of reported data is 3.5% (-0.9-34.4), which falls below the targeted +/-5% variance considered as acceptable for high quality data. Results from this quarter shows improvement from Q1 and Q2, where average variance was 4.6% and 6.0% respectively. Nine (75%) of the 12 supported districts recorded good results (+/- 5%); two others (Gahombo and Kayanza) presented a variance of 6% due to one health facility, and indicators for which data source documents were not yet standardized (IPTp, AMTSL). In Vumbi district, the only one facility assessed experiences serious data quality issues, and specific agreed upon measure to address them were taken. The table below presents the details on numbers of facilities assessed by district and average variance observed.

Table 1: Average scores of DQAs covering the period January-March 2017 conducted during the Q3, FY 2017

Health District	# Health facilities	Average Variance (%)
Buhiga	5	-0.9% (-13.3% – 16.5%)
Nyabikere	5	4.0% (-20- 23)
Gahombo	3	6.1% (-19.8 - 22.7)
Kayanza	4	6.3% (-0.1 – 21.5)
Musema	7	1.5% (-4.1 – 5.5)
Busoni	5	3.5% (-3.1 – 23.3)
Kirundo	6	2.2% (-5.5 – 17.3)
Mukenke	3	1.7% (-0.7 - 8.1)
Vumbi	1	34.4 (-16.7-312.9)
Gashoho	5	4.7% (-3.6 -25.0)
Giteranyi	4	2.6% (-2.8 -16.7)
Muyinga	6	4.5% (-2.9 – 27.8)
Total/Average	**54 (90%)**	**3.5%**

Some root causes of poor data quality include: (1) absence of standard data collection tools (IPTp, AMTSL); (2) dispensation of insecticide treated nets in the pharmacy rather than in the ANC/EIP wards, (3) few human resources with multiple reports to aggregate within tight deadlines.

For all data quality issues identified (variance rate +/- 5%), specific improvement plans were developed. Key improvement actions taken include (1) data validation at the health facility level before monthly report submission; (2) Correction of data discrepancies observed and submission of updated data to hierarchal level; (3) Systematic notification of uterotonics administered on delivery registers and stock cards; (4) Regular notification of SP doses and ITNs provided to pregnant women in ANC register and ensure that they are not recorded in case of stock outs; and (5) Ensure that ITNs distribution to infants in EIP are registered as dispensed.

Strengthen capacity of district teams and facility managers on data use through quarterly workshops

On a quarterly basis, IHPB supported several quarterly data review workshops in order to foster quality of data, analyze program progress towards expected results, and improve data use in program management. These meetings bring together the core team of each district, a representative of each health facility, mostly the in-charge, health promotion technicians and partners involved in the implementation of health services, especially IHPB which supports financially and technically those workshops. This quarter, only seven (7) out of the 12 supported districts organized the activity: Buhiga, Nyabikere, Gahombo, Kayanza, Musema, Giteranyi and Vumbi due to the priority given to the fight against malaria epidemic. In Muyinga, it was decided to organize a provincial level data review workshop to allow analysis to be more inclusive. Topics covered include early ANC, assisted and home delivery rates, immunization and FP coverage, malaria outbreaks and its consequences, home deaths, distribution of ITNs, IPTp and AMTSL coverage, especially looking at data generated during the period of January-March 2017. Those meetings offered opportunity to discuss findings of data quality assessments conducted on data covering the same period.

During these meetings, iIt was found that some community indicators are revealing persistence of home births, low contraceptive coverage, and the recurring discrepancy of data. For the comparison, it was found that there is progress of some indicators compared to previous period, and a slight decrease in malaria deaths.

Appropriate actions agreed upon to improve limits observed include:

1) Review data at facility level before report submission
2) Improve completeness of data collection tools
3) Crosscheck data from different sources (maternity register, BCG, post-partum register, etc) to analyze correlation of data
4) Increase awareness of the importance of FP to increase the contraception rates
5) Work with the community health workers to increase early ANC and the rate of assisted delivery.

Develop and disseminate simple-to-use data visualization dashboards for use at the facility level

During the period under review, IHPB conducted coaching visits for data visualization dashboards in 35 health facilities (13 in Karusi, 14 in Muyinga and 8 in Kirundo). It was observed that update of data visualization is given priority for only indicators financed by the Performance-Based Financing system. Hence, dashboards related to antenatal care, delivery, immunization, family planning and curative consultations are displayed and regularly updated in most of facilities. Although other dashboards are displayed, they were not up-to-date. This was observed in Muyinga where despite 90% of health facilities having displayed dashboards, only 20% were updated the day of the visit, the main reason given being workload.. More efforts and especially advocacy at the district level will be made in forthcoming time.

Support quarterly community data review meetings at the health facility level

Community data review meetings is one of the ways set by IHPB to improve the quality of community driven data. However, these activities suffered somehow from the malaria epidemic which drove all the health sector attention during the second and third quarters of this current fiscal year.

In partnership with local health authorities, IHPB managed to conduct community data review meetings in the seven communes of Kayanza Province. Those meetings bring together all community health workers involved in the project supported activities, along with the health promotion technicians who supervise them. Discussions focused on experience sharing among CHWs, review and correction of data errors before report submission.

Kirundo field office conducted community data review meetings in Ntega commune. The objective was to refresh community health workers on use of data collection tools, analyze the data generated during the period under review and eventually correct their activity reports.

Progress and discussion on M&E indicators

Indicator	Target FY4 2017	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	EP Target
3.2.1 Percent of facilities that maintain timely reporting [MR]	97.8%	100%	65%	94%	+5%
3.2.2 Percent of districts and facilities that demonstrably use facility- and community-level data for timely decision making [MR]	Facility: 95% District: 90%	Facility:94% District:89%	Facility:94% District:89%	Facility: 94% District: 89%	+10%

There are two IHPB contractual indicators related to monitoring and Evaluation (M&E):

1) Percent of facilities that maintain timely reporting: this indicator already had a good baseline. For the quarter under review, 94% of timeliness was recorded. The slight drop is due to the newly introduced integrated reporting form which takes long time to complete.

2) Percent of provinces, districts and facilities that demonstrably use facility- and community-level data for timely decision making. To inform progress made on this indicator, in October IHPB actively collected data which showed improvements in both facility and district levels of data use for decision making, i.e. from 90 to 94% for facility and from 80 to 89% for districts.

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated services

Planned for April-June 2017	Achievements and Results	Comments
Conduct supportive supervisions focused on organizational activities	Ongoing	IHPB team conducted a supervision focused on monitoring the implementation of the sub-grant
Conduct at least semiannual joint supportive supervision (IHPB and BDS supervisors) focused on technical activities	Ongoing	
Recruit CSOs for non-HIV indicators followed by appropriate training including follow up	Procurement process is ongoing	Request submitted to USAID on July 5, 2017

In year 4, the IHPB project is strengthening the capacity of Civil Society Organizations (CSOs) in technical and organizational areas to contribute to the improvement of project indicators. To achieve this objective during this quarter (April-June 2017), the following activities were carried out:

Conduct supportive supervisions focused on organizational activities

A supervision visit focused mainly on monitoring the execution of the contract between FHI 360 and Association Nationale de Soutien aux Séropositifs et aux malades du SIDA (ANSS) was carried out by the IHPB staff composed of the Capacity Building Advisor and the Contracts and Grants Manager. The team reviewed staff management documents, annual leave tracking, payroll documents, timesheets, medical rests, anti-terrorism and debarment searches, and filing of accounting documents. The supervision team recommended that these documents be classified at the Kirundo clinic instead of classifying them at headquarters in Bujumbura. The team also recommended changing the clinic signal billboard to meet the requirements of the USAID marking and branding policy.

Conduct at least semiannual joint supportive supervision focused on technical activities

The supportive supervision visit with ANSS also examined technical performance. The technical reinforcement of the ANSS Kirundo Clinic to support equipment, staff and management of biomedical waste, was carried out as planned. Nevertheless, the supervisors recommended developing a plan for monitoring and preserving the environment around the clinic. ANSS Kirundo Clinic's performance in the areas of HTC, ARV therapy, PMTCT services, and positive prevention was found to be highly satisfactory. The few problems encountered are the temporary national stock out of testing kits for early infant diagnosis of HIV and the lack of a hematology device.

As illustrated in the table below, ANSS Kirundo has exceeded its targets except the number of pregnant seropositive women on ARV and participating in the PMTCT program:

	April	May	June	Total	Target	Percentage
HTC						
Number of persons tested	181	151	163	495	300	165%
Number of HIV seropositive	5	28	10	43	N/A	
Number of condoms distributed	2,372	2,282	1,940	6,594	N/A	
Treated						
Total number of PLHIV	1,023	1,036	1,036	1,036	N/A	
PLHIV on ART	1,022	1,031	1,034	1,034	985	104%
PLHIV on cotrimoxazole	995	1,006	1,007	1,007	870	115%
Number of viral load tests	118	0	0	118	75	157%
Number of CD4 analyses	77	122	74	273	N/A	
PMTCT						
Number of new pregnant seropositive women put on ARV and PMTCT program	5	0	4	9	12	75%
Number of pregnant seropositive women put on ARV and PMTCT program	48	43	57	57	N/A	
Children HIV exposed on cotrimoxazole	54	49	50	50	45	111%

Reestablish partnership with SWAA Burundi and RBP+

IHPB submitted requests to USAID on February 21, 2017 to re-establish partnerships with Society for Women Against AIDS in Africa (SWAA) Burundi and Réseau Burundais des Personnes vivant avec le VIH/SIDA (RBP+), including program description, budgets, time frames and targets. By the close of the reporting period, IHPB is still awaiting approval.

Recruit CSO for non-HIV indicators followed by appropriate training and follow-up

As was reported in the previous quarterly report, IHPB is recruiting a CSO expert in the area of SGBV. IHPB received nineteen applications in response to a solicitation released in December 2016. Burundi Red Cross was selected on a provisional basis by a procurement committee convened for this purpose. IHPB has developed an agreement package including program description and budget and completed its pre-award financial risk assessment. The award package was submitted to USAID on July 5, 2017 for concurrence. By the close of the reporting period, IHPB is still awaiting approval.

Priority Health Domain Strategies

Malaria Strategy

Planned for April-June 2017	Achievement and results	Comments
Conduct integrated training session on iCCM for 138 health providers	Ongoing	94 healthcare providers trained during October 2016 to February 2017 period .44 planned to be trained in August 2017
Training 622 CHWs on iCCM[14]: case management of diarrhea and pneumonia	622 CHWs trained on case management of diarrhea and 280 CHWs were trained on case management of pneumonia	343 planned to be trained on case management of pneumonia in July 2017
Supply equipment to CHWs for iCCM	425 registers, 447 transfers and requisition books, 282 electronic timers, 282 sheets of algorithm on pneumonia distributed	Activity done every three months
Conduct HH visits to CHWs involved in CCM of malaria	17 CHWs visited at their household in Giteranyi health district	Ongoing: activity planned each month at district level
Conduct supportive supervision visits at the facility level	6 health centers visited in Gashoho health district	Ongoing: activity planned each month at district level
Support information and micro-planning workshops on malaria response at district level	District-level micro-plans on Response of malaria epidemic developed and in implementation	Achieved
Provided technical and financial support to carry out mobile clinics activities during malaria epidemic period	Attended in 4 meetings on task force of malaria response epidemic and organized mobile clinics at district level.	mobile clinics ongoing
Conduct community interactive theater on malaria themes	19,890 community members reached (8,802 male and 11,070 female)	Activity done in the event of malaria epidemic period and ongoing
Conduct integrated training sessions on IPTp within ANC for 201 healthcare providers	60 healthcare providers from Kirundo province trained	148 healthcare providers trained during January-March 2017 period and the activity entirely achieved.
Partner with PNILP and DPSHA to adapt existing malaria messages, then produce and disseminate flipcharts	Flipchart and poster developed and validated	Printing and multiplication planned in July 2017

Conducted Integrated Training Sessions on iCCM for Health Providers

In the process of implementing iCCM in the four IHPB health district (Kirundo, Musema, Gahombo, Gashoho), 94 out of 138 healthcare providers benefited from training sessions (Gahombo: 33, Gashoho: 24, Musema: 17 and Kirundo: 37) on the all iCCM package. As expected in Y4 work plan, two healthcare workers per health center will being trained on iCCM. These training sessions were completed in Kirundo and Gahombo. Due to different activities planned by the Ministry of Health and Fight against AIDS (African Immunization week, mother-child health week in May and June 2017 and accelerating the response to the malaria epidemic period),

[14] Training on iCCM for CHWs is composed of 3 modules (malaria, diarrhea and pneumonia) and the trainings are conducted separately.

the remaining 44 health providers (Musema: 20 and Gashoho: 24) that were expected to be trained in April 2017, will be trained in August 2017.

Training CHWs on iCCM: Case management of Pneumonia

In coordination with Direction de l'Offre et de la Demande des Soins (DODS), with Gahombo and Kirundo Health District team, IHPB organized and conducted 12, two-day training sessions on case management of pneumonia for 77 Community Health Workers (CHWs) from Kirundo (39 female, 38 male) and 203 CHWs (130 female, 73 male) from Musema HD. All the 280 CHWs have completed the 3 modules of iCCM strategy. Using the training module developed by Ministry of Health, these trainings that last 2 days have been focused on how to count the number of respiratory movements which indicate that a child has or does not have pneumonia according to the number - more or less than 50 respiratory movements for children under 1 year and more or less than 40 respiratory movements for children between 12 to 59 months of age. In order to facilitate implementation of this strategy, algorithm of case management of pneumonia at community level has been distributed to CHWs.

Supply equipment to CHWs for iCCM

To further support iCCM implementation, IHPB provides a stock of material and tools for three months at the district level. During the period of April to June 2017, in Kirundo and Gashoho health districts, IHPB distributed the materials and tools detailed in the table below:

CHW iCCM Kit items	MUSEMA	Gahombo	Gashoho	Giteranyi	Kirundo
Individual tracking record for the sick child	205	0	100	120	0
Register of cases	205	0	100	120	0
Transfer book	205	242	0	0	0
Requisition cards	205	242	0	0	0
Taking algorithm managed at home with pneumonia	205	0	0	0	77
Electronic timers	205	0	0	0	77

Conduct household (HH) visits to CHWs involved in CCM of malaria

In coordination with healthcare providers and health promotion technicians, IHPB conducted joint household visits to 17 CHWs involved in iCCM in Giteranyi HD. The goal was to verify the storage conditions of malaria commodities and the quality of filling out registers of case management as well as the stock cards. Findings were that i) stock cards are not kept updated and ii) some CHWs experienced stock out of ACT within one and half (1 ½) months (March-April).

During these visits it was interesting to hear from community members their good appreciation of services offered by CHWs, but also their upset with stock-outs of iCCM commodities (Artemisinin Combined Therapeutic: ACT). The supervisor team took time to show to CHWs visited how to complete on a daily basis their stock cards, mention the expiration date and calculate the commodities ordered and even the number of cases treated. Other aspects related to diagnostic, treatment and referral of cases were well done.

Conduct supportive supervision visits at the facility level

Using the integrated supervision guide developed by the National Malaria Control Program, IHPB conducted a post-training follow-up visit on Intermittent Preventive Treatment during pregnancy (IPTp) in 6 health facilities

of Gashoho Health District: Mirwa, Musama, Gisabazuba, Nyagatovu, Gisanze and Bwasare health centers. These supervision visits were focused on integration of IPTp, LLINs in ANC, reporting and availability of Sulphadoxine Pyrimethamine (SP), and implementation of guidelines on malaria treatment. Constraints were related to discrepancies between the notified data (in the register) and the reported data (Gisabazuba) and poor reporting of doses of SP distributed. An improvement in reporting and recording on IPTp was seen in Gisanze and Mirwa that were visited in February 2017. In a restitution session, the health center team agreed to compile data weekly in order to minimize errors at the end of the month. The supervision team recommended that the healthcare provider be allowed to deliver antenatal care services and share roles in reporting of different data according to the competencies of health center staff.

Support information and micro-planning workshops on malaria response at district level

In collaboration with NMCP, IHPB organized and held workshops at district level to develop Micro-Plans on the response to the malaria epidemic in all 12 health districts. According to the National Plan on response to the malaria epidemic, health districts are required to identify effective and specific strategies to overcome the malaria epidemic through use of case management, prevention and social behavior change approaches. Then, IHPB provided technical and financial support to those micro-planning sessions. In the four provinces, a total of 447 participants (364M, 83F) that included Governors, communal administrators, health authorities, health care providers, health promotion technicians, and religious leaders attended. In Buhiga HD: 55**;** Nyabikere: 42; Musema: 36; Gahombo: 36; Kayanza: 44; Kirundo: 40; Vumbi: 32; Busoni: 28; Mukenke: 32; Gashoho: 29; Muyinga:40; and Giteranyi: 33 participants.

At the closure of the workshops, each health district has developed its own micro-plan to respond to the malaria epidemic that is used to reduce number of deaths related to malaria and will be used to implement indoor residual spraying (IRS) in some provinces including Karusi. This IRS is being supported by World Vision. IHPB is in charge of all activities related to mobile clinics and SBCC that are ongoing from June 2017 to date.

Provided technical and financial support to carry out mobile clinics/mass drug treatment activities during malaria epidemic period

From December 2016 until March 2017, IHPB provided financial and technical support to carry out mobile clinics and outreach treatment activities for the malaria epidemic response in its catchment districts.

In May 2017, implementing the micro-plans on the response to the malaria epidemic, IHPB staff coordinated with Kirundo, Kayanza, Muyinga and Karusi health districts and provincial offices to organize mobile clinics and outreach activities around health centres that recorded more than 700 cases of malaria per week.

IHPB represented by DCoP and Malaria Specialist participated in 4 meetings organized by NMCP. Two out of the four were focused on analyzing regularly the malaria situation and obtaining commitment of partners in malaria epidemic support for the coming period. Two others focused on developing monitoring-evaluation and supervision tools to be used in mobile clinics.

Conduct Community interactive theater on malaria themes

In coordination with health district team and NMCP, IHPB organized community awareness raising on malaria prevention, using community theater strategy, in different places (collines/sub-collines). A total of 19,890 participants (8,820 male and 11, 070 female) were reached with messages on early care seeking in case of malaria symptoms, use of LLIN[15] (showing how to extend ITN at the sleeping place) and environmental hygiene.

[15] LLIN: Long Lasting Insecticidal Nets

Priority to protect vulnerable people, transmission of malaria, avoiding self-medication, and IPTp were among talking points developed. In Musema HD (1,640); Gahombo (1,842); Gashoho (3,692); Nyabikere HD (4,050); Buhiga (6,833). In Gashoho HD, mobile cinema was an opportunity to collect blood that should be testing before donations: 165 bags collected.

Conduct integrated training sessions on IPTp within ANC

Indeed, IHPB planned to train 201 healthcare providers during Y4. 148 health care providers have been trained (77 female, 71 male) during January to March 2017 period. In April 2017, IHPB in coordination with Kirundo health district trainers on IPTp, conducted 2, 3-day training sessions on IPTp for 60 remaining additional healthcare providers (48 male and 12 female) from four health districts of Kirundo province: Busoni (10); Kirundo (20); Mukenke (14), and Vumbi HD (16). These trainings targeted one additional[16] health care provider per health facility including two from health district hospital.

Partner with PNILP and DPSHA to adapt existing malaria messages, then produce and disseminate flipcharts

As members of communication group for the response to the malaria epidemic, IHPB represented by the Malaria Specialist and the SBCC Program Officer participated in five technical meetings to develop communication material: flipcharts on fighting malaria and a poster on maintenance and use of LLIN that will be distributed to CHWs during the mass distribution of LLINs planned at the end of July 2017. The design of those communication materials is already finalized; thus, the printing and copying is ongoing. They will be used during and after the mass distribution campaign of LLINs for continuing to educate community members on the proper use of ITN and other methods of malaria prevention.

Progress and discussion on malaria indicators

Indicator	Target FY2017	Achieved to date FY4: October 2016-June 2017					
		Oct-Dec 2016	Jan-Mar 2017	April	May	June	Total
% of children under one year who had received LLINs through USG funds	97	62%	86.14%	87,2% (6322/7250)	90% (4483/4974)	-[17]	88%
% of pregnant women who had received LLINs during ANC through USG funds	96	59,6%	81.7%	81% (6825/8413)	80% (5913/7404)	-[18]	80,5%
% of children under five with fever who received ACT within	75	75%	77%	67.2% (10,021/14,909)	70.5% (9,561/13,570)	78.1% (13,899/17,797)	72.4%

[16] One health care provider per health facility in Kirundo province has been trained in 2015 at the beginning of the strategy.
[17] Data to be availed in August
[18] Data to be availed in August

Indicator	Target FY2017	Achieved to date FY4: October 2016-June 2017					
		Oct-Dec 2016	Jan-Mar 2017	April	May	June	Total
24 hours of onset of fever							
% of pregnant women who received IPTp2 during ANC visit	70	84%	83,7%	83,5% (6419/7684)	82,9% (5420/6540)	84,7% (5718/6754)	83,7% (17,557/20978)
Number of healthcare providers trained on iCCM	138	57	37	0	0	0	94
Number of community health workers trained on iCCM (case management of pneumonia at community level)	622	475	176	0	280	0	280
Number of healthcare providers trained on IPTp within ANC	201		148	60	0	0	208

% of children under one year who had received LLINs through USG funds

IHPB accessed this aggregated data from the national DHIS2 database. During October-December 2016 period, Burundi experienced stock out of LLINs for two months and this situation justifies the low rate of this indicator. Given that the level of achievement of this indicator up to date (April-May 2017) is 88% and the annual target is set at 97%.

% of pregnant women who had received LLINs during ANC through USG funds

IHPB accessed this aggregated data from the national DHIS2 database. These data concern all women that received LLINs during ANC in IHPB catchment health facilities. The level of achievement of the indicator to date (April-May 2017) is 80.5% and the target at the end of the year is estimated at 96%. IHPB has contributed to the awareness of use of LLINs and ANC service.

% of pregnant women who received IPTp during ANC visit

The indicator achieved during this quarter to date (April-June 2017): 83.7% is over the target of 70%. Sensitization sessions using community interactive theater and mobile cinema contributed to the increase of IPTp.

Number of community health workers trained on iCCM (case management of pneumonia at community level)

IHPB planned to train 621 CHWs on case management of pneumonia at the community level (203 from Musema, 77 from Kirundo, 99 from Gashoho and 242 from Gahombo). Then, 77 CHWs from Kirundo and 203

CHWs from Musema were trained in case management of pneumonia to complete the iCCM package. The other pools of CHWs from Gahombo and Gashoho are expected to be trained in July 2017.

Two important facts/activities have marked the period from April to June 2017

Develop the communication material for malaria prevention during and after mass distribution of LLINs

Flipchart on malaria prevention and poster on maintenance and use of LLINs. In order to support efforts on the use of LLINs and malaria prevention, IHPB in collaboration with partners (NMCP, UNICEF, USAID, Medecins Sans Frontières/Belgique, World Vision) developed flipchart on malaria prevention and poster on maintenance and use of LLNI that will be used by CHWs during and after mass distribution of LLIN in August 2017.Then, IHPB produced 3500 flipcharts and 4000 laminated copies of LLIN's poster.

Support information and micro-planning workshops on malaria response at district level

In response of malaria epidemic, IHPB provided financial and technical support to develop district-level micro-plans for response to malaria epidemics that include effective and specific strategies to respond to malaria epidemics and prevent deaths at district level. Mobile clinics that are ongoing and outreach activities gathered a total of 19,890 participants (8,820 male and 11, 070 female) in the four provinces.

Child Health Strategy

Planned for April-June 2017	Achievements and results	Comments
Train 46 health care providers from Kirundo and Mukenke HDs, on the management of acute malnutrition and IYCF	Postponed	The activities will be implemented during the quarter July-September 2017
Conduct a post training follow up in at least six health centers		
Work with the MPHFA to conduct supervision of 60 health centers on clinical IMCI	56 HC supervised during previous quarter	Four remaining HCs will be supervised during the quarter July-September 2017

During the quarter April-June 2017, IHPB had planned to conduct training of 46 health care providers from Kirundo and Mukenke HDs on the management of acute malnutrition and IYCF (Infant and Young Child Feeding) and a post training follow up, but these activities were not achieved because the Ministry of Public health and Fight against AIDS instructed to suspend all activities except those oriented to malaria epidemic response.
However, other activities were conducted such as: integrated supervision of health facilities, follow-up of CHWs trained on immunization surveillance, maintaining community-based activities, support to the African Vaccination Week, as described below.

Conduct integrated supervision of health facilities

Integrated supervision was conducted in health facilities by IHPB in collaboration with the health district offices; various health services were supervised including child health services. A total of 21 health centers were supervised (four in Giteranyi HD, eight in Muyinga HD, four in Nyabikere HD, five in Buhiga HD).
In child health area, main points noted are:

- All the visited HCs had functioning cold chain and had no stock out in vaccines.

- Discordance of data reported and those in the immunization book: it was recommended to the health care providers to analyze and discuss data before sending the monthly report.
- Some HCs did follow up children lost for immunization: discussions brought the health care providers to initiate a timetable to help them catch up children who missed a scheduled vaccine in collaboration with CHWs.
- In case management service, nutritional status was not systematically assessed in some health centers: health care providers were reminded the clinical IMCI protocol.

Post-training follow up of CHWs on the immunization surveillance in Muyinga

Following a one-day training of CHWs on the immunization surveillance that took place in February 2017, a post training follow up was conducted to 17 CHWs from 15 HCs in Giteranyi health district to reinforce their skills. The supervision was conducted jointly by a staff from IHPB, a supervisor of district, a HC-based health care provider, and the health promotion technician; and integrated three technical areas: ICCM, pregnancy follow up, and immunization surveillance. Main points noted in immunization surveillance: some CHWs did not register all children U2, others registered children U2, but do not register systematically all newborn, others did not master the vaccination schedule.

The results of the supervision were such:

- CHWs were refreshed on the vaccination schedule and were reminded to fill in the immunization surveillance notebooks
- Health center staff were involved in the activity to get their commitment

Maintaining community-based activities

In child health area, IHPB is supporting community-based activities such as malnutrition management (screening, referral, and education), and immunization surveillance. During this quarter, these activities were maintained through monthly report forms distribution, monthly report collection following the circuit CHWs-HC-HD-project, and CHWs meetings organized at commune level to debate community health data and other issues. Thus, the following data were achieved in April and May 2017 in the four IHPB provinces: 112,658 children under five were screened for malnutrition by CHWs among whom 89,504 (79.5%) were healthy, 17,081 (15%) had moderate acute malnutrition, 6,073 (5.4%) had severe acute malnutrition, 1,780 (29% of children with severe acute malnutrition) were referred to the HC (this issue will be discussed during the CHWs meeting organized at commune level); 1,941 children under two were reminded their vaccination date while 365 children who had dropped the vaccination schedule were retrieved.

Support to the African Vaccination Week (AVW)

Every year in April since 2011, the MPHFA celebrates an African vaccination week, aimed at keeping immunization rates high. A large-scale vaccination campaign is conducted and new vaccines are introduced. The 2017 session took place in May; a new vaccine combining measles and rubella was introduced and was provided to children aged 9 months to 14 years. IHPB provided technical and logistical support to conduct a mobilization at province and commune levels in its target provinces, and conducting supervision of field activities. In IHPB provinces 1,156,451 children were vaccinated (98% of the target). Then on, the measles-rubella combined vaccine will replace the single-measles vaccine in the vaccination schedule.

Discussion and analysis of the results

Indicator	Target FY2017	Achieved to date FY 2017					
		October-December 2016	January-March 2017	April 2017	May 2017	June 2017	Total
2.0.4 Number/percent of children who received DPT3 by 12 months of age	103,333	22,555	21,574	7,749	7,150	(-)[19]	59,028
2.0.6 Number/percent of women reached with education on exclusive breastfeeding	211,500	69,928	87,257	33,277	33,890	27,221	251,573

2.0.4 Number/percent of children who received DPT3 by 12 months of age

This information is extracted from the health centers' monthly report. While the annual target is 103,333, data up to May 2017 realized 59,028 (57% which represents 85% of pro-rated target for eight months). The annual target is not likely to be reached because IHPB target provinces were subject to a malaria outbreak. Based on the experience of Muyinga and Karusi provinces, the Immunization surveillance by CHWs strategy will be initiated in Kirundo province during year 5.

2.0.6 Number/percent of women reached with education on exclusive breastfeeding

This information is gathered from CHWs' monthly reports. While the 2017 annual target was set to 211,500, the available data up to May 2017 realized 251,573 (119% of the annual target). In nine months, we over-achieved the annual target. This is because the CHWs' reporting system follow-up was improved by regular monthly data analysis and report collection. In addition, CHWs from Karusi province were trained on the inter-personal communication involving nine actions of child health including the exclusive breastfeeding.

Maternal and Newborn Health Strategy

Planned for April – June 2017	Achievements and results	Comments
Organize maternal death audit sessions	Ongoing	10 sessions conducted
Conduct formative supervision	Ongoing	Integrated supervision conducted
Implement outreach strategy for ANC and SBA in Kayanza	Not achieved	Postponed due to malaria epidemic situation
Conduct training of trainers on EONC for Kirundo and Kayanza	Postponed for implementation in July 2017	The MPHFA postponed all activities due to the malaria outbreak
Equip Ngozi Nursing School for EONC and BEmONC	Anatomic models procured and administrative procedures underway for customs clearance. Room at the Nursing School renovated	Completion of renovation work and handing over planned for quarter July to September

[19] June data will be available in August 2017

Planned for April – June 2017	Achievements and results	Comments
Organize maternal death audit sessions	Ongoing	10 sessions conducted
Support the African immunization week and/or the mother and child health week	Achieved	IHPB supported the first Mother and Child Health Week of 2017.

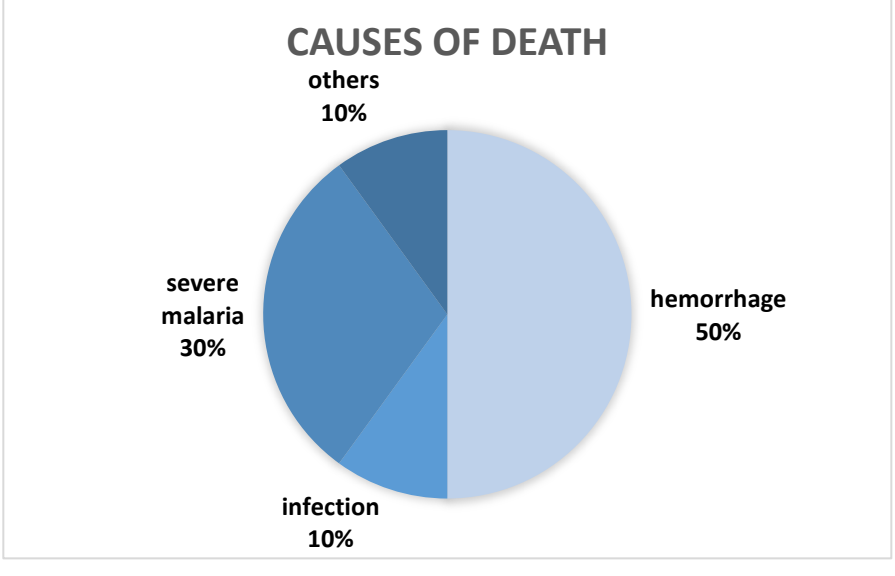
In partnership with partner health districts and the MPHFA, IHPB conducted the following activities during the quarter April – June 2017:

Support maternal death audits in hospital

During the quarter April – June 2017, seventeen maternal deaths were reported and 10 death audits conducted (2 for Muyinga hospital, 4 for Kayanza hospital, 2 for Kirundo hospital and 2 for Buhiga hospital). Per the national guidelines, each death must be audited within 30 days by participants that include district hospital staff from the maternity service and health center managers in the health district.

The causes identified were: postpartum hemorrhage (5), malaria [20](3), infection (1) and cholecystitis (1). An analysis of the data showed:

- The mean age of the women who died was 27.4 years and two were under 20 years old
- The median gravida was 2.7 (range 1-9) and the median parity 1.6 (range 0-6)
- 60% of deaths were directly related to postpartum hemorrhage as leading direct cause (50% of all causes and 83% of the direct causes) and malaria was the main indirect cause of death (30% of all causes and 75% of the indirect causes), as shown in the graph below.



During maternal death audits, participants begin by analyzing last recommendations and the level of implementation of recommendations for Kayanza hospital isin the table below:

Recommendations	Achievement
Ensure the completeness of referral sheets	80% of referral sheets were fully completed

[20] IHPB is supporting the response to the declared malaria epidemic situation in the 12 health districts

Recommendations	Achievement
Avoid delay for referral	90% of referrals were done without delay
Respect of the protocol for emergency case	100% of emergency cases per related protocol
Ensure the completeness of hospitalization sheets	80% of hospitalization sheets completed with all required elements

Conducted formative supervision: IHPB conducted integrated supervisions

During the quarter April - June 2017, a total of 35 health centers (Karusi: 8, Kayanza:13 and Muyinga:14) benefited from integrated supervisions during joint supervisions of health district supervisors and IHPB staff. The maternal services concerned were ANC, PNC, delivery, childbirth in the community and the other aspects of the supervision were immunization, community distribution of DMPA, data management, supply chain management. It was noticed that there is a need to increase early ANC and SBA; health centers will work with CHWs to sensitize community.

One of the issues in Karusi province was that the use of the uterotonics for the active management of the third stage of labor was not systematically registered for more than 50% of the file - it was recommended to always complete data for every woman who received uterotonic. The other issue was the use of partograph during delivery where 50% of deliveries did not have partograph and it was recommended that every delivery must have its partograph kept in folders.

Conduct training of trainers (ToT) on EONC for Kirundo and Kayanza

During the reporting quarter, IHPB continued to work and plan with PNSR to conduct the ToT that was postponed due to the ongoing malaria epidemic. In preparation for the training to take place from July 3, 2017 to July 12, 2017, invitations and necessary logistic arrangements were made.

Implement outreach strategy for ANC and SBAs in Kayanza

The activity planned to begin in April 2017 was postponed due to ongoing malaria epidemic and as Kayanza is one of the provinces concerned with high number of cases reported. IHPB will begin to implement the activity in the fourth quarter and continue in year five.

Equip Ngozi Nursing School for EONC and BEmONC

During the quarter April - June 2017, IHPB worked on the renovation of the room identified. After the anatomic models arrived in Burundi, Pathfinder began the administrative procedures for custom clearance including tax exemption letters from the Ministry of Foreign Affairs. It is anticipated that the anatomic models will be cleared in early July 2017. In addition, the service provider was contracted to make the minor renovations (painting and the replacement of broken windows) of the room designated for the training center. During the quarter July – September 2017, IHPB will officially hand over the center to the appropriate authorities.

Supported the first mother and child week of 2017 (June)

IHPB participated technically and financially in the first mother and child week of 2017, in June, through participation in the national commission in charge of the preparation of the week and the community mobilization. Technically, IHPB participated in five meetings of the commission designed to organize the event. The objective of these meetings was to identify and propose how and when the event could be organized. The commission elaborated the scope of work of the week and the budget necessary. Financially, IHPB supported the mobilization events organized at the communal level (for all the provinces). A total of 2,078 people (504

female, 1,574 male) participated in the events. In Muyinga for example, preliminary available data show that 89% of pregnant women were dewormed in Gashoho health district, 92.4% in Muyinga health district and 93.1% in Giteranyi health district

Progress and discussion on maternal and neonatal health indicators

Indicator	Target FY2017	Achieved to date					
		Oct- Dec 2016	January - March 2017	April	May	June	Total
2.0.5 Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs	80 %	91% (17,894 /19,627)	97% (21,826 /22,429)	87.8% (7471 /8511)	87.6% (7524 /8592)	85.7% (6719 /7839)	91.7% (62127 /67825)
Number of people trained in maternal/newborn through Burundi MCH supported programs	69	59/69 (86%)	0	0	0	0	59/69 (86%)
Number of USG-supported facilities that provide appropriate life-saving maternity care. (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC [21])	NA	NA					

Number of women giving birth who received uterotonics in the third stage of labor through USG supported programs

The above table shows that during the quarter April – June 2017, a total of 21,714 women (87% of women who delivered in health facilities) received uterotonics during the third phase of labor to prevent postpartum hemorrhage. There is a decrease observed from Q2 (97%) to Q3 (87%) due to the stock out reported in 23 health facilities (12% of health facilities) which is consequent to the stock out from the district pharmacies. The district pharmacies being still challenged to purchase needed commodities with limited resources.

Number of people trained in maternal /newborn through Burundi MCH supported programs

15 people from Kayanza (7) and Kirundo (8) are planned to be trained in July 2017. PNSR sent invitation to health district managers to identify 2 participants per district in Kayanza and Kirundo that will be trained. Once the training takes place, the Y4 target of 69 will be overachieved.

Number of USG-supported facilities that provide appropriate life-saving maternity care (defined as seven signal functions for BEmONC and nine signal functions for CEmONC)

The Service Availability and Readiness Assessment (SARA) identified 38 health facilities providing life-saving maternity care as defined by the seven signal functions for BEmONC and the nine functions for CEmONC. IHPB conducted training on BEmONC for a total of 86 health providers from 43 health facilities in Karusi, Kirundo, and Muyinga. From a small data collection conducted during Y3, it was noticed that 41.7% (15/36) of health facilities

[21] Reporting Frequency: Baseline, Mid-term, End-term

targeted are offering lifesaving maternity care as defined above. IHPB continues to conduct supervision for the 86 health providers trained in order make sure that quality services are available. The endline survey planned in year five will better inform our achievement on this indicator.

Reproductive Health Strategy

Planned for April - June 2017	Comments	Achievement and results
Conduct integrated supervision visit for family planning (FP) activities in 36 health facilities	Ongoing	Integrated supervision conducted in 33 health facilities from Muyinga, Kayanza and Karusi health provinces; Monitoring FP compliance visit was conducted in 147 HFs of Muyinga, Kayanza, Kirundo, Karusi provinces
Organizing supervision session of activities related to community based distribution	Ongoing	66 CHWs visited during their households visits
Conduct awareness sessions by theatre groups	Ongoing	8 sessions conducted in Gahombo, Kirundo, Muyinga, Mukenke, Gashoho, Busoni, Giteranyi and Vumbi HDs
Increase the contraceptive method mix counseled about/or provided by integrated mobile health teams	Ongoing	3 sessions conducted by integrated mobile health teams in 19 collines from Mukenke, Musema, and Busoni health districts
Identify the demand and the potential strategies for quality counseling and service delivery of male sterilization	Achieved	12 providers trained in vasectomy in Kayanza and 50 vasectomies performed during training session
Addition of evidence-based activities in existing youth-friendly health facilities	Ongoing	251 youth friendly networking committee members refreshed in 9 YF health facilities from Kirundo Province
Strengthen existing relationships for youth-friendly sensitization in secondary schools	Achieved	One sensitization workshop conducted for 40 pupils from Rugari secondary school.

Conduct integrated supervision visit for FP activities

During the April - June 2017 quarter, integrated supervisions have been conducted in 33 health facilities (23 from Kayanza province, six health facilities from Muyinga province and four from Karusi province). Different items were discussed and challenges revealed, including the conflict of agenda for the district team and the malaria outbreak time (for which supervisors reviewed the supervision calendar) and low contraceptive acceptance rate. To increase the contraceptive acceptance rate, the main recommendation made was to integrate the FP methods within the maternity service.

With the objective to monitoring and controlling FP compliance in health facilities under IHPB Support, IHPB technical staff visited health facilities (health centers and district hospitals) from Kirundo, Karusi, Kayanza and Muyinga provinces, using a French questionnaire.

147 Health facilities (8 District hospitals, 18 faith – based facilities, one Civil society organization called ANSS Kirundo and 120 public health facilities) were visited. Per the monitoring visits, recommendations have been made, including:

1. Conduct half – day training session on FP compliance to the health providers and district teams from the four provinces supported by IHPB and file training attendance sheets in facility and Pathfinder compliance folders;
2. Disseminate key compliance materials to all facilities, including the Pathfinder International Family Planning Regulations Reference Guide, voluntary sterilization consent forms, and Tiahrt posters (developed by the national program of reproductive health) where needed;
3. Make a comprehensible agreement with the faith – based facilities for displaying the Tiahrt poster;
4. Include compliance assessment in the health facilities' supervision agenda during supervisory activities by the PTOs and the district team to ensure the sustainability of the compliance requirements

Recommendation -2- has already been implemented and the -1- is expecting to be implemented soon in the august. 3 and 4 recommended will be implemented by the October 2017

Organizing quarterly supervision meeting of activities related to community-based distribution

During the April – June quarter, in collaboration with the health district offices, quarterly supervision meetings on CBD activities were held in Kayanza province, with the participation of health center heads and health promotion technicians (HPTs). The meetings were held at commune level 891 (419 male and 472 female) CHWs, 16 HPTs and 42 health center heads attended the meetings. The purpose of the meetings was to coach health centers and CHWs on correcting the monthly reports, analyzing community data, and making evidence-based decisions. The points discussed were: completion of CHWs monthly reports, analysis of the data: activities not done and why, alarming figures, issues, and recommendations.

In partnership with Mukenke, Vumbi, Busoni and Kirundo health district team, IHPB conducted supervision sessions at the hill level for 66 CHWs from Mukenke: (14), Vumbi: (32), Kirundo: (14) and Busoni: (6), targeting the constraints about the comprehensiveness of data collection tools, the regularity of the transmission of reports, requisition and storage of commodities, and households' visits with the possibility to bring solutions. 21 CHWs were followed during the households' visits, the sessions of sensitization of the community on the FP/RH, and others were observed during the community based distribution activity. The errors identified were discussed between members of supervision team after every session, and recommendations agreed upon. The supervision team recommendations were mainly to strengthen monthly CBD's activities assessment, to improve the community's reporting system, enhance youth knowledge in reproductive health and train the young Community Based Distribution to reach the youth within the overall entity.

Results related to CBD activities in the four provinces are as follows:

Raising awareness activities conducted	Kayanza	Muyinga	Karusi	Kirundo	Total
Households visited	19,738	9,132	16,180	6,692	**51,742**
People reached	143,455	41,101	49,481	34,495	**268,532**
FP commodities distributed					
Male Condoms	80,173	10,728	17,647	23,948	**132,496**
Female condoms	84	48	15	90	**237**
Pills	2,172	223	750	506	**3,651**
People referred to health facilities for	1,729	768	669	555	**3,721**

modern contraception					

Conduct awareness sessions by theater groups

During the April-June quarter, with the objective to address rumors affecting long-acting and short term family planning methods and to arouse the adherence to contraceptive methods, IHPB, in partnership with Mukenke, Gahombo, Vumbi, Gashoho, Kirundo , Muyinga and Busoni Health districts (HDs), conducted eight separate FP awareness sessions by using a local theatre group in nineteen collines that fall in the catchment areas of six public facilities (Tonga, Gitobe, Gahororo, Kiyanza, Mubogora, Marembo) and four faith-based health facilities (Gasorwe, Gisanze, Muhanga I and Ntega). These facilities were targeted because of low rates of adherence to FP methods: a total of 1,650 people (750 males and 900 females) in Kirundo HD, 1,300 people (500 males and 800 females) in BUSONI HD, 400 people (116 male and 284 female) in Gashoho HD, 901 people (543 males and 358 females) in Mukenke HD, 665 people (305 males and 360 females) in Gahombo HD, 1,500 people (550 males and 950 females) and 1,000 people (485 male and 515 female) in Muyinga HD attended the sensitization sessions and were reached with FP messages. The objective was to raise FP indicators in the respective health facilities by sensitizing community members on FP adherence through theatrical presentations, followed by an interactive discussion addressing rumors related to all FP methods. In all cases, local administration members attended and this enhanced the messages given during the theatrical presentation. In Gahombo HD, a competition game was organized after the presentation to test the message acquisition.

Increase the contraceptive method mix counseled about/or provided by integrated mobile health teams

During this quarter, IHPB, in partnership with Musema, Mukenke and Busoni HDs and the health facility teams, conducted integrated mobile team activities in nineteen collines (Gatare, Nyakizu and Kivoga collines in Busoni HD, Munyinya, Mutara and Kireka collines in Kirundo HD, Rusara, Baziro, Karambo and Kigarama collines in Mukenke HD and Camizi, Gasenyi, Kibavu, Gaheta, Muganza, Munyinya, Ruganza, Murehe in Musema HD (chosen because of low adherence on family planning methods). The all collines fall in the catchment areas of faith-based health facilities and public HFs with low rates of FP adherence. 2,591 (905 males and 1,686 females) attended the events and were reached with FP messages -, 387 people (39 males and 348 females) accepted methods among them 359 new acceptors. Of these, 348 females counseled accepted the family planning methods and received respectively: pills (80), condoms (4), implants (89) and injectable (175), while 38 males received condoms upon the sites. 1,575 people (615 males and 960 females) were tested for malaria and 1,026 people (380 males and 646 females) were tested malaria positive and received treatment. 361 people (184 males and 177 females) were tested for HIV with four positive cases. 514 children (220 males and 294 females) were screened for malnutrition and 63 (32 males and 31 females) were malnourished. All the malnourished children were referred to the health facilities with nutrition service for treatment.

District	Referred for method at HF	# people received Methods at the sites				Tested for HIV+	Screened to be malnourished	Tested positive for Malaria
		Pills	Injectable	condoms	Implants			
Musema	0	67	114	0	89	0	-	279
Mukenke	7	9	19	23	-	0	47	343
Kirundo	2	1	6	13	-	2	1	226
Busoni	3	3	38	6	-	2	16	178
Total	**12**	**80**	**177**	**42**	**89**	**4**	**64**	**1,026**

Identify the demand and the potential strategies for quality counseling and service delivery of male sterilization

Per the sensitization sessions made by both CHWs trained on CBD activity during households' visits and meetings and by health providers at the health facility level, couples are choosing contraceptive surgery methods (vasectomy and tubal ligation) as they do not want other children (89 in Kirundo, 60 in Muyinga, 100 in karusi).

To achieve the PNSR's aims which is to have a minimum of two doctors per district hospital trained in voluntary sterilization surgery, IHPB organized a second training session in Vasectomy.

In partnership with the PNSR, IHPB conducted a five-day training on no-scalpel vasectomy attended by 12 participants_ six medical doctors (five male and one female) and six operating room nurses (four males and two females) _ from the following provinces: Kayanza (6), Muyinga (4), and Kirundo (2). The training took place at Muyinga hospital and the health province, health District, CHWs and the administration team was working in leading and mobilizing volunteer's clients for practical component. During the practical component of the training, 50 men underwent voluntary sterilization.

An outreach strategy in vasectomy at the health center level has been discussed with the health province and district leaders as many cases have not been performed per the cause of long distance between community and District hospital. The proposal strategy was appreciated within Muyinga team and is waiting to be implemented in some HCs that have more advanced infrastructure and personnel in accordance with the PNSR.

Addition of evidence – based activities in existing youth friendly health facilities

During the April – June quarter, with the objective to address rumors related to use of contraceptive methods for young and adolescents and to increase reproductive and sexual health services in youth friendly health facilities and the community, in partnership with the Vumbi , Kirundo, Busoni, and Mukenke HDs team, IHPB conducted a two-day workshop to re-energize the system of networking from eight YF health facilities (Muramba, Mugendo and Vumbi in Vumbi HD, Burara and Marembo in Busoni HD, Gitobe and Buhoro in Mukenke HD and Ruhehe HF in Kirundo HD) for networking committee members. A total of 249 (171 males and 78 females) youth friendly HFs members attended the workshop representing various services and components involved in youth's health and well-being (secondary schools, health centers, centers for young, community development centers, associations of young people, religious and administration members). During the workshops, using the PNSR's module, many themes have been developed to clear the importance and the missions of the social network for young and adolescent health promotion. A quarterly work plan (roadmap) targeting new additional evidence based activities (which are expected to be implemented in next quarter and to boost the current activities) for every youth-friendly HC was developed and strategies for the sustainability of the network set up. Per using the acquired knowledge, 2,936 young were sensitized on SRH adapted to young during the reporting period.

Strengthen existing relationships for youth friendly sensitization in secondary schools

During the April – June Quarter, IHPB conducted a sensitization session in Rugari secondary schools with the objective to contribute to reduce unwanted pregnancies cases within the scholar areas. In partnership with the district and the MUYINGA provincial school authority, IHPB conducted a three-day sensitization session for 40 pupils (20 male and 20 female) from RUGARI secondary school (chosen for the high rate of unwanted pregnancy in the Muyinga commune) on the prevention of unwanted pregnancy, and the prevention of HIV and other sexual transmitted infections. The cohort was trained as a peer educator team for the sustainability of the activity and will continue sensitization activities within the school's clubs. From the sensitizations made by the peer educators, 498 young people received family planning methods at youth friendly health facilities and only

25 cases of unwanted pregnancies registered in the school's areas during the reporting period when 49 were reported in the previous quarter.

Progress and discussion on FP indicators

Indicator	Target FY 2017	Contribution of each method to couple years' protection with available data to date (from April 2017 to June 2017)					
		October to December 2016	January to March 2017	April	May	June[22]	Total
2.0.1. Couple Years Protection in USG supported programs (USAID 3.1.7.1-1)	153,795						
Pills		25,235	34,836	10,662	12,738		84,471
Injectable		53,633	53,850	19,412	18,823		145,718
Male Condom		50,005	87,917	32,400	29,341		199,663
Female		639	3,543	661	1,032		5,875
IUD		949	978	384	807		3,118
Implant (Jadelle)		5,778	6,567	2,926	3,273		18,544
Male sterilization		125	135	37	136		433
Female sterilization		101	70	13	22		206
2.2.2. Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (USAID 3.1.7.1-3)	100%	82%	150/183 (82%)	150/183 (82%)	154/183 (84,1%)		

Couple Years Protection in USG supported programs

This indicator is reported annually. Each method distributed is expected to contribute to increased couple years' protection with a specific coefficient.

All the strategies described above were being implemented in the community level to strengthen the community based distribution of contraceptives and through sensitizations meetings, households' visits and other approaches messages are given and more clients recruited for contraceptive methods. They will be enhancing for the next quarter to achieve the targets and will focus on awareness sessions by theatre groups, the integrated mobile team activities which combine counseling and family planning commodities provision, and information given by community health workers during household visits and meetings. Meanwhile, due to the data channel, we did not have data for June, and it will be available within the first week of the August.

Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services

This indicator is calculated considering health facilities that counsel on FP methods and/or distribute methods. We include faith-based facilities on the denominator, which do not offer modern FP methods. During the reporting period, based on April's achievements, 86.9% of supported facilities (public, private, and faith-based) delivered counseling and/or contraceptive methods.

[22] The June data will be available within the first week of August.

HIV/AIDS Strategy

The table below presents the implementation status of planned activities for the third quarter.

Planned for April-June 2017	Achievement	Comments
Organize 60 outreach HIV Testing and Counseling (HTC) sessions in hotspots	Achieved	571 outreach HTC sessions organized
Contract PLHIV networks to sensitize persons with high risk of HIV to HTC in hotspots, participate in HTC sessions, provide support to HIV infected persons and help their integration in care	On track	Awaiting USAID approval
Contract civil society organizations (CSO) to create multipoint HTC in popular and poor neighborhoods of Kayanza and Kirundo urban	On track	One CSO contracted in Kirundo (ANSS). For SWAA (Kayanza province), draft scope of work was developed and IHPB submitted to USAID a request for approval on July 14, 2016. Reminding e-mails have been sent on February 21, 2017 and recently on June 30, 2017 in a meeting with the new COR. Still pending.
Test for HIV a household of HIV positive patient (index-testing); 8 ART sites implement index-testing	Achieved	48 ART sites implemented index-testing
8 HTC services sites prioritize HIV test for TB and or suspicious TB infection patient, malnourished children, STI cases and all patients with HIV related signs in curative consultations;	Achieved	95 HTC services sites provide HTC services prioritizing of TB and or suspicious TB infection patient, malnourished children, STI cases and all patients with HIV related signs in curative consultations
Perform 88 formative supervision visits to sensitize and enable healthcare providers	Partially Achieved	83 formative supervision visits performed
Organize a five-day training session for 109 health care providers and supervisors on the new guidelines on ART	Partially achieved	A five-day training session was organized for 23 physicians in March 26-31, 2017. Remaining health providers will be trained in August 2017 if budget permit
Organize a five-day training session for 109 health care providers and supervisors on therapeutic education	Not achieved	The training is planned in August 2017 if budget permits
Support health facilities and districts through In-Kind Grants (IKGs) for running costs to provide quality and integrated HIV services	Achieved	Seven HDs and five hospitals benefited from In-Kind Grants (IKGs) to provide quality and integrated HIV services
Organize support groups to maintain adherence on ARV and promote positive prevention for PLHIV in 8 ART sites	Achieved	Support groups organized in 16 ART sites
Maintain the contract with the private laboratory for early diagnosis of HIV in	Achieved	Contract maintained and DBS and Viral load samples are examined by the “Centre de Recherche Virologique et de Diagnostic Biologique (CRDBi)” while public machines are

Planned for April-June 2017	Achievement	Comments
infant and viral measure		not functioning

Organize targeted outreach HTC sessions

In collaboration with the Kayanza provincial and district health offices, IHPB supported outreach HTC sessions targeting individuals at high risk of acquiring HIV such as single mothers, separated couples, men and women with multiple partners. Of the 10,909 individuals (4,323 male and 6,586 female) that volunteered to be tested through this outreach HTC, all 311 (121 male and 190 female) that were found positive were referred to an ART site for enrollment. This strategy permitted to reach a yield of 2.9% compared to the 1.4% prevalence in the general population. It is efficacious for finding People Living with HIV (PLHIV) who ignore yet their HIV status.

Test for HIV household of HIV positive patient (index-testing)

In collaboration with health facilities, IHPB supported index testing (among families of PLHIV) in 48 ART sites– (i) of the 338 partners that volunteered to be tested (155 male and 183 female), 32 (19 male and 13 female) tested positive?; (ii) of the 3,527 children that volunteered to be tested (1,282 male and 1,379 female), 49 (27 male and 22 female) were tested positive. All whotested positive were enrolled on ART; The index testing show a positivity yield of 9.5% among partners and 1.4% in children of PLHIV.

Prioritize HIV test for TB and or suspicious TB infection patient, malnourished children, STI cases and all patients with HIV related signs in curative consultations

In collaboration with health districts, IHPB supported Provider-Initiated Testing and Counseling (PITC) targeting TB and/or suspicious TB infection patients, malnourished children, STI cases, HIV-exposed infant and all patients with HIV related signs- of the 908 patients that volunteered to be tested (232 male and 676 female), the 16 that tested positive (7 male and 9 female) were referred to ART sites. The testing yield of 1.8% is over the national prevalence of 1.4%.

Perform formative supervision visits to sensitize and enable healthcare providers

In partnership with Health Districts, IHPB conducted 83 supervision visits in 65 ART sites. These include mentoring visits to enable nurses prescribing and following up antiretroviral therapy in decentralized ART sites and 457 new PLHIV (168 male and 289 female) have been enrolled on ART.

Organize a five-day training session for 109 health care providers and supervisors on the new guidelines on ART

In collaboration with the Kayanza and Kirundo provincial and district health offices, IHPB organized a five-day training session for 23 healthcare providers - doctors (21 male and 2 female) on new national guidelines for HIV care and prevention using anti-retrovirals. The training of remaining health providers has not been organized due to malaria outbreak and is tentatively planned for August 2017 if budget permits.

Support health facilities and districts through IKGs for running costs to provide quality and integrated HIV services;

In partnership with Health Districts and through IKGs, IHPB continued to support running costs by which 137 Dried Blood Samples (DBS) and 685 Viral load samples have been transported from health facilities to the National lab and Centre Recherche de Virologie et de Diagnostic Biologique (CRDBi).

Organize support groups to maintain adherence on ARV and promote positive prevention for PLHIV

In partnership with 16 ART sites, IHPB organized separate adherence counseling sessions for 443 PLHIV (175 males and 268 females) with the objective of improving ART adherence and follow up.

Maintain the contract with the private laboratory for early diagnosis of HIV in infant and viral measure

Thanks to the private laboratory CRDBi, 214 Viral Load and 34 DBS sample have been examined while National lab machines were broken.

1. Performance against PEPFAR targets (achievement versus target)

Every year, PEPFAR determines targets to be reached by the end of each fiscal year with the framework of the Country Operation Plan (COP). The table below presents the progress on the indicators over the period October 2016 – June 2017.

PEPFAR Indicators	Target FY 2017	Achievement				
		Oct- Dec 2016	Jan-Mar 2017	Apr- June 2017	Total	% Achieved
Number of individuals who received HTC services and their test results	155,008	85,830	81,314	72,828	239,972	155%
Number of HIV positive individuals	2,813	1189	1272	742	3,203	114%
Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	666	200	240	155	595	89%
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	666	161	299	57	517	78%
Number of people receiving post-GBV care	110	44	24	22	90	82%
Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load	2,813	928	978	666	2,572	91%
Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	10,212	8,580	8,938	8,972	8,9727	88%
Number of adults and children newly enrolled on ART	2,725	1114	1,047	647	2,808	103%
Number of adults and children receiving ART [current] (TA-only)	9,195	7284	8340	8,604	8,604	94%
Number of PLHIV followed up screened for tuberculosis (TB_SCREEN)	8,972	4,603	4,798	5,594	5,594	62%

PEPFAR Indicators	Target FY 2017	Achievement				
		Oct- Dec 2016	Jan-Mar 2017	Apr- June 2017	Total	% Achieved
Number of registered new and relapsed TB cases with documented HIV status, during the reporting period (TB_STAT)	852	205	158	210	573	67%
Number of patients with tuberculosis enrolled on ART (TB_ART)	68	17	9	9	35	51%

Number of individuals who received HTC services and their test results

Of the 155,008 targeted, individuals that received HTC services are 239,972(155%). Results are over expectations dueto acceptability and quality of HTC services.

Number of HIV positive individuals

Of the 2,813 targeted, individuals tested HIV positive are 3,203 (114%). Results are over expectations due to implementation of index testing and targeted outreach HTC strategies.

Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

Of the 666 targeted, HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery are 595 (89 %). Achievements by the Q3 are very good due to better scale-up of PMTCT services. To meet year 4 expectations, health providers coaching will continue.

Number of infants who had a virologic HIV test within 12 months of birth during the reporting period

Of the 666 targeted, HIV-exposed children whom a virologic HIV test have been done are 517 (78%). Achievements by the Q3 are good due to better follow up HIV- exposed infants and strengthened logistics for transportation of DBS samples and results returning between health facilities and specialized laboratories. To meet year 4 expectations, support will be continued.

Number of people receiving post-GBV care

The progress for this indicator is a bit less than expected 90/110 (82%). Facility- and community-based services will be strengthened through quality health services improvement and health services seeking sensitization.

Number of HIV-positive adults and children newly enrolled in clinical care

The FY 2017 target is 2,813 and achievements are 2,572 (91%) patients enrolled in clinical care. Results show that not all individuals tested HIV positive (3,203) are enrolled in care. Improving linkage between HTC services and HIV care through an escorting system and mentoring nurses to provide ART will be continued.

Number of HIV-positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD).

Of the 10,212 targeted, 8,972 (88%) HIV-positive adults and children are enrolled in care. Supportive supervision will be kept in supported health facilities to attain full results.

Number of adults and children newly enrolled on ART

Data indicate very good performance 2,808/2,725 (103 %) over the nine-months of implementation. This is because per the national new guidelines ART initiation is no longer dependent on CD4 counting. In addition, decentralization of ART in all health centers and mentoring nurses to prescribe ARVs have enhanced ART access.

Number of adults and children receiving ART [current] (TA-only)

Of the 9,195 targeted, 8,604 (94 %) of adults and children are receiving ART - this significant performance in Q3 is due to implementation of the test and treat strategy and ART decentralization in all health centers.

Number of PLHIV followed up screened for tuberculosis (TB_SCREEN)

Half of the 8,972 (5,594) PLHIV received in care have been screened for TB from April to June 2017. In partnership with health districts, IHPB will continue to sensitize health providers for TB screening at each medical visit of PLHIV.

Number of registered new and relapsed TB cases with documented HIV status, during the reporting period. of PLHIV treated for tuberculosis (TB_STAT)

Of 852 targeted, registered TB cases with documented HIV status are 573 (67%). Integrating HIV screening in TB clinics by increased awareness of health providers will improve results.

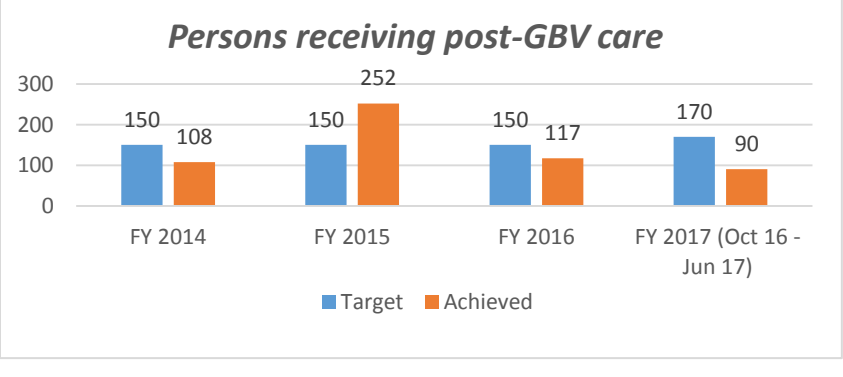
Number of patients with tuberculosis enrolled on ART (TB_ART)

Of the 68 targeted, PLHIV with tuberculosis enrolled on ART are 35 (51%). Improved screening of PLHIV for TB, testing all TB cases for HIV and decentralization of ART through awareness and task-shifting activities to health providers will lead to greater results.

2. Progress and discussions on HIV/AIDS indicators

This section states the progress on HIV indicators in IHPB to the Performance Monitoring and Evaluation Plan (PMEP).

Indicator 1.3.4: Number of persons receiving post-GBV care (PEP, Post-rape care, other post-GBV care) [GEND_GBV]



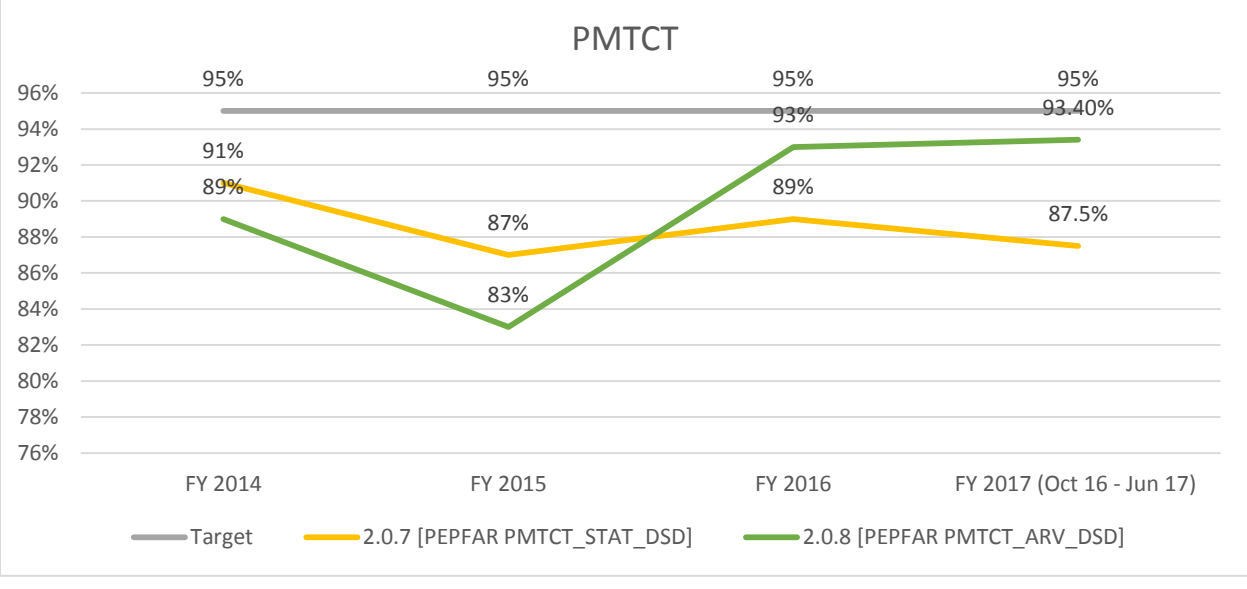
Yearly targets are not reached -except the FY 2015[23]. There is a poor seeking of health care by survivors of GBV because of stigmatization and discrimination.

[23] The FY 2015 achievements include four provinces (Karusi, Kayanza, Kirundo and Muyinga) whereas others (FY 2016 and FY 2017) counts for the only PEPFAR zone (Kayanza and Kirundo)

Continued community GBV-related activities and integration of GBV package of services in health centers will increase results by FY 2017 and beyond.

Indicator 2.0.7 & 2.0.8: Percent of pregnant women with known status [PEPFAR PMTCT_STAT_DSD] and Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV_DSD]

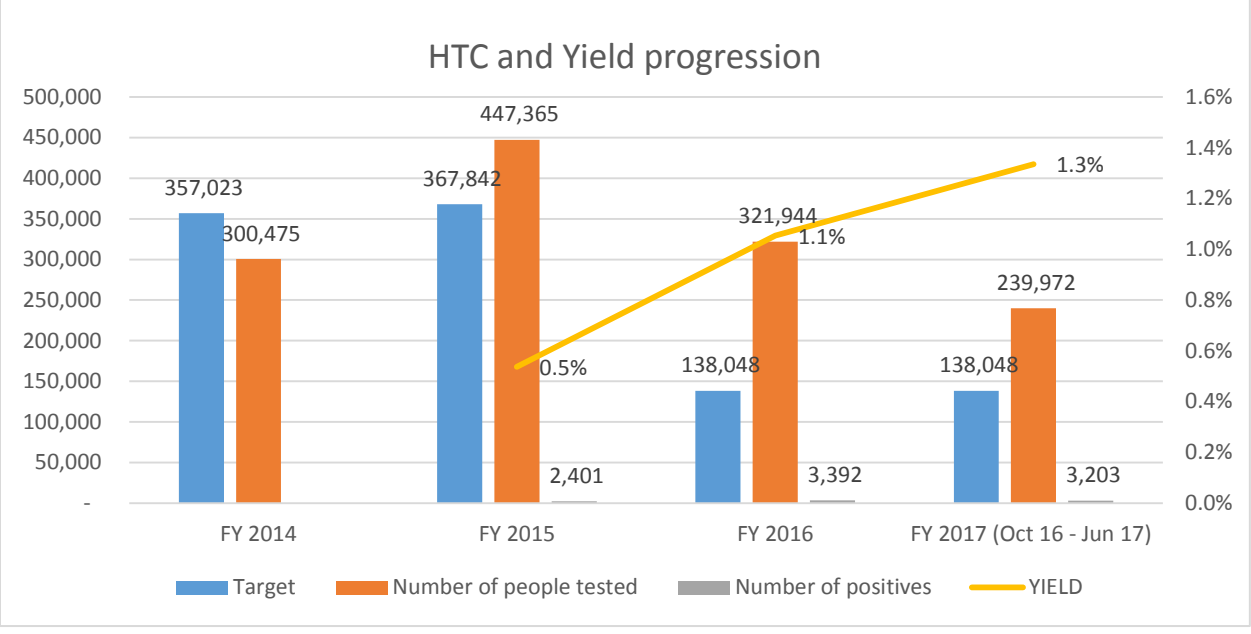
The proportions for both pregnant women knowing their HIV status and pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery are still under expectations over the fiscal years.



The lack of support by their partners and social discrimination results in refusing HIV test and or ARVs taking. Intensifying HIV awareness among partners is one of the strategies to enhance acceptance of HIV testing and ARV prophylaxis among pregnant women.

Indicator 2.0.9: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST_DSD]

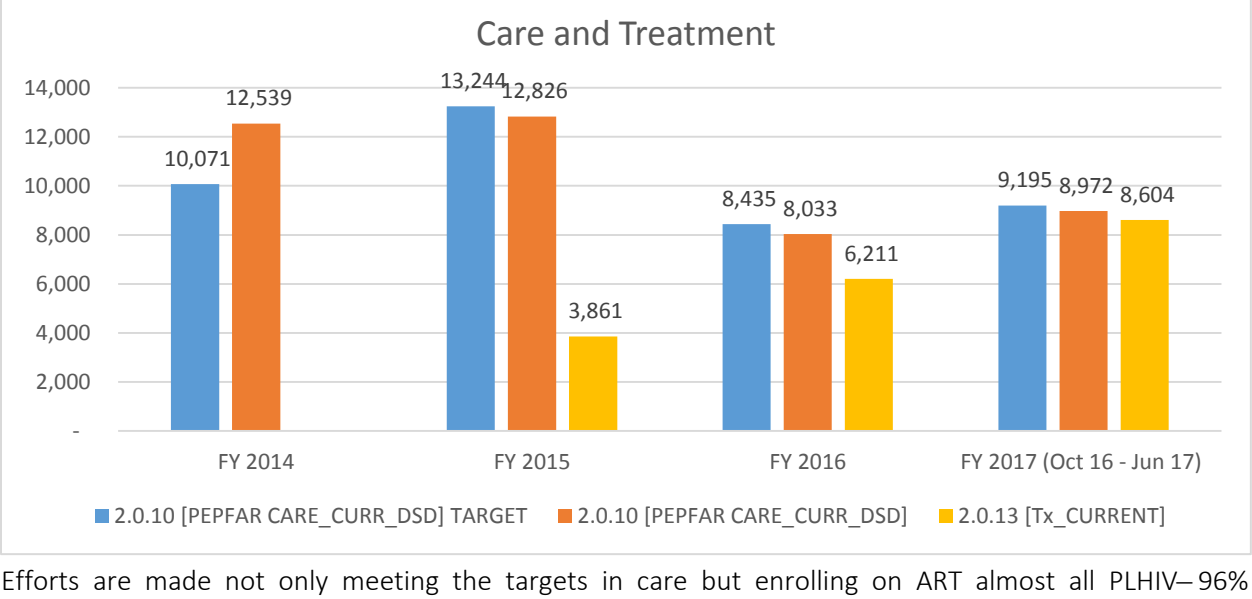
We have overall good utilization of HIV testing and counseling services – each FY targets have been overachieved- thanks to provider-initiated HIV testing and counseling. However, positivity rate was less than the national prevalence of HIV (0.5% vs 1.4%).



As of FY 2016, IHPB is focusing on testing of people at high risk of HIV infection /transmission. As a result, the testing yield has increased from 0.5% (2015) to 1.3% (2017). It is an effective strategy to achieve the 90, 90, 90 objectives by 2020.

Indicator 2.0.10 and 2.0.13: Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD] and Number of adults and children receiving ART (TA only) [PEPFAR TX_CURR_TA]

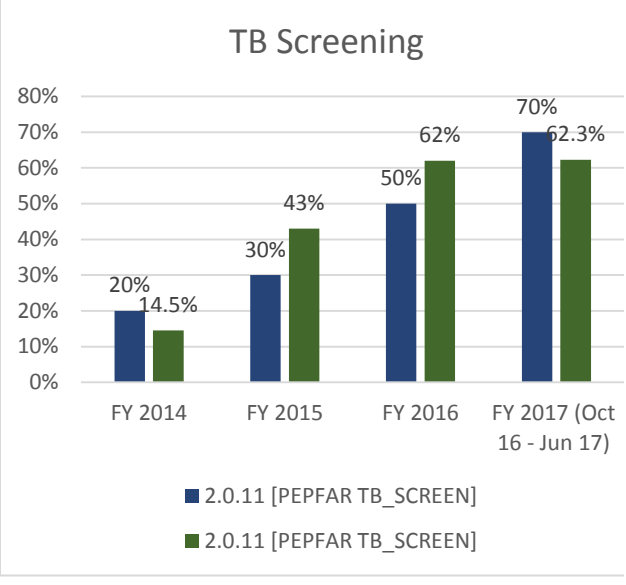
The indicators are related to care and treatment services. According to national guidelines -adopted in 2016, ART is initiated to every individual tested HIV positive regardless the number of CD4 count. Results are presented in the following graph.



Efforts are made not only meeting the targets in care but enrolling on ART almost all PLHIV– 96% (8,604/8,972). Strategies such as HTC services focused on individual at high risk of HIV in mobile and static

HTC approaches as well as mentoring health centers and performing task shifting for antiretroviral therapy are responsible for the success. IHPB hopes reaching the FY 2017 ART targets with maintained strategies

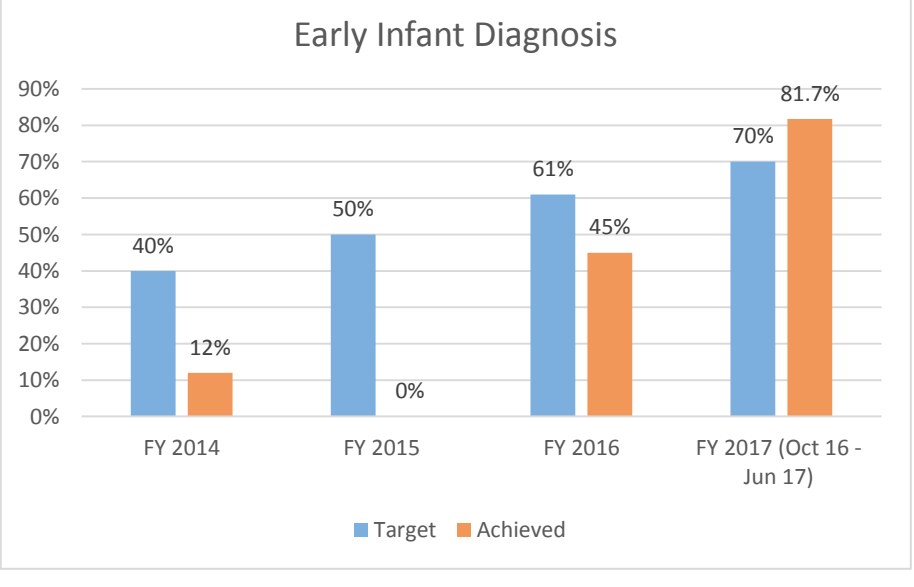
Indicator 2.0.11: Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]



IHPB supports increased screening TB symptoms awareness of personnel in clinical care centers. And the number of PLHIV in HIV clinical care screened for TB symptoms at the last clinical visit is ascending. Close supervision of health providers will permit the achievement of the target.

2.0.12 Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth [PEPFAR PMTCT_EID]

Poor achievements for FY2014 and FY 2015 are due to repetitive breakdowns of machine at national laboratory. The use of private laboratory as of FY 2016 while public ones are not functioning allows better results



Innovation study: Pilot of Integration of Prevention of Mother-to-Child Transmission (PMTCT) and Early Infant Diagnosis (EID) of HIV into Routine Newborn and Child Health Care

Planned for April-June 2017	Achievement and Results	Comments
Conduct meeting (quarterly) with the Technical Advisory Group (TAG)	Achieved	Quarterly meeting was conducted on June 15, 2017
Conduct meeting (quarterly) with BPS	Achieved	On April 13, 2017, the meeting for the January- March period was conducted
Conduct data collection and supervision	Ongoing	66 mother-child pairs already enrolled in 12 study intervention sites
Request approval for study period extension (one additional year) to the Burundi Ethics Committee	Achieved	Approval granted on April 12, 2017

During the quarter under review, activities implemented within the framework of the innovation study are detailed as follows:

Conduct meeting with the TAG

On June 15, 2017, the innovative study Technical Advisory Group held its third quarterly meeting.
Key points on the agenda were: Validation of the minutes of its previous meeting and brief description of the study progress.

The TAG recommended: 1) make PCR kits available for all infants enrolled in the study, 2) develop and distribute the dashboard for PCR tests follow-up to all study sites, 3) offer, at the Kayanza HC, the PCR test to the infants with mothers registered at Kayanza Hospital.

The next field-based implementing partner's meeting was scheduled for the end of July 2017.

Conduct meetings with provincial health bureau cadres

On April 13, 2017, in partnership with the Ministry of Public Health and Fight against AIDS (MPHFA), IHPB organized and conducted a one-day quarterly meeting for pilot study field-based implementing partners. At the meeting, the president (chairperson) of the TAG stressed the relevance of the pilot study as it was commanded by the MPHFA.

Based on discussions on the few persistent constraints related to lack of sufficient staff to ensure on-going permanent recruitment and no selecting of women targeted by the study by MNCH services, the TWG lead himself formulated strong and specific recommendations for each study site.

Regarding study sites' lack of sufficient staff, recommendations were made for improving work organization and services:

- Avoid compensatory leave to lessen the burden and allow sites to keep ongoing recruitment in MNCH services
- Extend working hours until noon on the day after for the nurse who has been on duty the previous day
- Provide HIV testing in all entry points and avoid refer targeted women for HIV lab testing,
- Ensure providing pre-and posttest counseling,
- Ensure providing HIV testing and its results in the same entry service and by the same health care provider.
- Assign more providers for study clients' recruitment and improve the triage of women targeted by the study will contribute to increase the number of HIV + mother/baby pair enrolled.

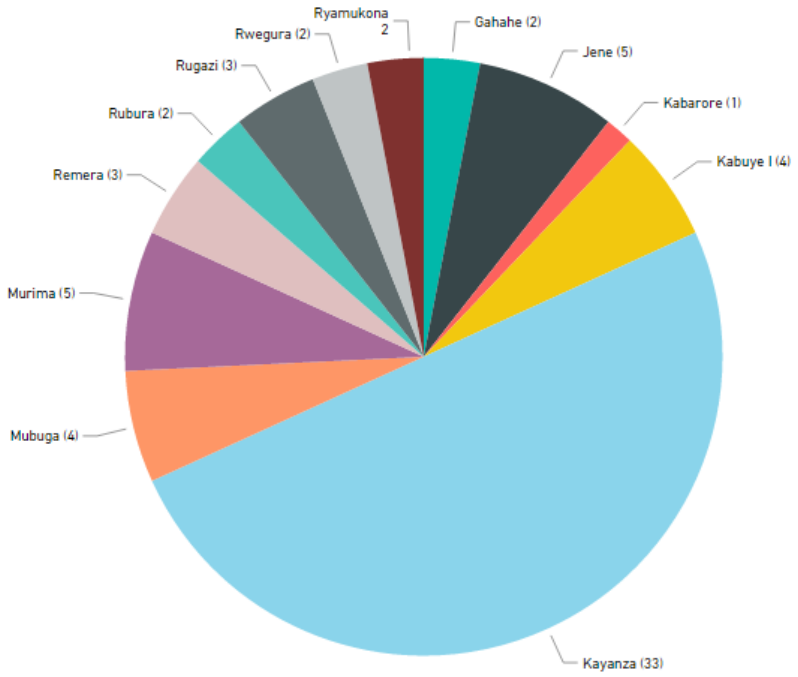
In addition, to allow all study sites to provide vaccinations which are the study's most frequent entry point, it was also agreed that IHBP will ensure the necessary logistic support on the day after the meeting to ship the new fridge to Ryamukona HC to allow the study site to resume vaccinations.
In order to improve the circuit of the women targeted by the study across the study sites' MNCH services, the participants drafted a Quality Assurance process diagram for each intervention site, under the guidance of the Quality Improvement (QI) officer and the BPS and BDS QI coaches.

Conduct data collection and supervision

A mixed team composed by the study data collection coordinator, the IHPB lab technician and two Kayanza health district supervisors conducted a monthly supervision visits in all fourteen intervention sites (April 25 – May 12).
The supervision aims were to: (1) to follow up on the implementation of recommendations agreed upon during the april field-based implementing partners meeting, (2) to collect data related to HIV+ mother/HIV-exposed baby pairs already enrolled by intervention sites, (3) to refresh health providers from study sites on DBS/PCR sampling site-based in PCR sampling and on the use of HIV rapid diagnostic tests, and (4) to finalize and display the customized QI process diagram in MNCH services rooms.
In general, the supervision provided the opportunity to highlight the lack of PCR test kits in nine study sites, to correct data errors within one site, and to display the QI process diagram in all study sites.

As of May 31, 2017, out of 14 interventions sites, 12 health centers were able to enroll a total number of 66 HIV+ mother/HIV-exposed baby pairs. (See figure below)

HIV+mother/HIV-exposed baby pairs enrolled by May 31, 2017 across 12 health centers



In conclusion, for the upcoming quarter (July-Sept 2017), activities planned are: (1) jointly monthly supervisions, (2) data collection and data entry in the study specific database, (3) field-based stakeholders meeting, and (4) Innovation study Technical Advisory Group fourth meeting.

Implement learning, documentation and dissemination activities

Planned for April-June 2017	Achievement and results	Comments
Organize and convene CLA mission	Ongoing	▪ Technical and logistical joint committee established ▪ Three committee meetings held between Apr-Jun ▪ CLA themes identified ▪ Discussions underway with Ministry of Public Health and Fight against HIV (MPHFA) and USAID to confirm a convenient date to hold the CLA
Draft and submit ≥4 abstracts and/or manuscripts	Ongoing	▪ Abstract for ICASA drafted and under revision by the Scientific Affairs unit of FHI360. Shall be submitted by July 28, 2017 ▪ QI abstract draft submitted for Uganda National QI Conference ▪ Two abstract drafted and submitted for International HRH Forum
Organize and convene national workshop on formatives analysis and baseline assessments (FABs)	Cancelled	Activity cancelled given the unavailability of key partners from the central level of the MPHFA and districts due to malaria outbreak and epidemic emergencies
Produce QI Technical Brief	Ongoing	▪ QI-focused edition of *IHPB News* published ▪ Inputs for future QI Technical Brief drafted

Planned for April-June 2017	Achievement and results	Comments
Produce ≥1 newsletter or success story per month	Achieved	▪ Success stories published on: MNCH in Kirundo; Community case management of malnutrition and pneumonia; Community role models for change ▪ Newsletters published on: QI; Celebration of success in Karusi; Community theater; IHPB response to malaria epidemic (in production) ▪ Factsheet issued on malaria situation and response in Muyinga ▪ Technical brief on Vasectomy drafted

Organize and convene a CLA Mission

In early 2017 IHPB finalized a scope-of-work for a collaborating, learning and adapting (CLA) mission, in partnership with the Ministry of Public Health and Fight Against HIV (MPHFA) and USAID. In April 2017 IHPB began convening a technical and logistical tripartite organizing committee, which met three times this quarter. The committee discussed the CLA mission's themes and agenda, and began preparing for the mission to take place on May 23-24, 2017. However, changes in the health team of USAID requested postponing this activity Discussions are underway with the Ministry of Public Health and Fight against HIV (MPHFA) and USAID to confirm a convenient date to hold the CLA, most likely in FY18.

Draft and submit ≥4 cumulative abstracts and/or manuscripts

The International Conference on AIDS and STIs in Africa is the continent's most significant HIV forum and a key opportunity to share program experiences and knowledge. IHPB is eager to contribute to this forum, and drafted an abstract which it will finalize and submit to the conference in late July. During the reporting period project staff also began developing three additional abstracts. The first of these focuses on QI and will be submitted to the Uganda National Conference on QI. The other two focus on the OASIS tool and HR mapping and were submitted on June 26, 2017 to the Fourth Global Forum on Human Resources for Health (HRH).

Organize and convene national workshop on FABs

IHPB is seeking opportunities to more readily share project outcomes and information with local partners. To this end, the project endeavored to finish formatting reports on FAB findings and translating them into French, convene a national meeting to disseminate FAB results, and generate French translations of recent progress reports. These activities were cancelled in lieu of competing priorities during the reporting period, including emergency response to a malaria outbreak that escalated into an epidemic by April.

Generate Knowledge Products

In May IHPB widely disseminated Issue 11 of *IHPB News* entitled "Supporting Integration with a Quality Improvement Model and Preparing Health Districts to Scale-up Best Practices." The document shares information on IHPB's processes for implementing the QI Model and several learned lessons from its demonstration phase. This resource provides a brief introduction on which IHPB will build through subsequent documentation. The project also drafted a technical brief on vasectomy which is under final review and revision before publication and dissemination.

Produce ≥1 newsletter or success story per month

Since April 2017 IHPB documented three success stories from the field. One of these illustrates the impact of IHPB equipment (especially incubators) and MNCH training in Kirundo Hospital, where triplets were recently born and nurtured. A second success story describes implementation and positive outcomes from community case management of malnutrition and pneumonia in Matongo Health Center. The third narrates changes to married couples' behavior in Karusi, following community mobilization for maternal and child health. In addition to its QI-focused issue, the project issued and disseminated a new edition of *IHPB News* highlighting community theaters. The project is currently developing two further newsletters, on community celebrations of success and IHPB responses to the malaria epidemic.

Additional activities

IHPB produced a fact-sheet on malaria for Karusi heath province and began drafting factsheets on additional health intervention areas. Discussions around the themes on which CLA should focus inspired IHPB to produce a video of partner and beneficiary feedback in the field. The project organized and executed a mission and captured the desired content for the video in May 2017. A draft of the video was shared with IHPB management and suggested edits are being made. This video will be shared during the CLA event and via all communication platforms available to the project.

Program Monitoring & Evaluation

Planned for April-June 2017	Achievements and results	Comments
Prepare end-of-project surveys to be conducted in Year 5	Ongoing	✓HHS protocol and questionnaire completed ✓SARA protocol and questionnaire updated and are under review ✓FQA protocol and questionnaires updated and under review
Train IHPB staff on intermediate research, evaluation, epidemiology and biostatistics	Postponed	Due to delay in STTA team travel approval, the training session was postponed to Q1 of FY18

Prepare end-of-project surveys to be conducted in year 5

End-of-project (EOP) studies planned include the Household Survey (HHS), the Services Availability and Readiness Assessment (SARA), the Facility Qualitative Study (FQA) and the Health District Systems Diagnostic. Studies may require three approval steps before implementation, i.e. FHI 360 PHSC, Burundi Ethics Committee and ISTEEBU approvals, although these approvals are anticipated to be quick as the EOP studies are basically repeats of the already approved baseline studies.

During quarter three, IHPB completed reviewing the HHS protocol and data collection form (questionnaire). The endline household survey protocol maintains the same study design, sample size, inclusion and exclusion criteria as at the baseline, of course with updated specific objectives and an updated data collection form (DCF). The tools are ready to be submitted to the Protection of Human Subjects Committee of FHI 360. It should be noted that the Ministry of Public Health and Fight against AIDS (MPHFA) conducted the 2016 Demographic and Health Survey (DHS) and the final report is expected

soon. This may answer some questions of the IHPB HHS and lead to reformulation of some survey questions and a further DCF review.

In addition, a draft of SARA protocol was prepared by the M&E team and submitted for review to the Services Integration Senior Advisor who conducted the baseline. Based on the findings generated by the 2014 SARA baseline and the October 2016 midterm evaluation, the development of the EOP SARA protocol includes a review of study objectives, considers a reduced sample size of health facilities instead of inclusion of all supported ones, and keeps the same study design. With the support of the World Health Organization (WHO), the MPHFA is conducting its first SARA nationwide. Therefore, it is possible that IHPB may have most of the end line SARA questions answered by the national assessment and limit its survey to address only those outstanding unanswered questions. The facility assessment tool used in 2014 baseline SARA was reviewed to update some questions.

The Services Quality Assessment tools were also updated by the IHPB M&E team and submitted for review to the QA/QI Senior Advisor for review, as he conducted the related baseline.

Train IHPB staff on research, evaluation, epidemiology and biostatistics

Following an introductory training conducted in the first quarter, another training session was planned for June 2017. Due to time constraints and delays on travel approvals, the training was postponed.

Other program M&E activities

IHPB has been supporting community health activities and worked at driving information from them as the national health information system (NHIS) is still working on ways to include community health data in the NHIS. IHPB had already developed a database for Community Case Management of Malaria (CCMM), but two new developments necessitated a review of the database: (1) the MPHFA, in particular the Department of Offer and Demand of Services (DODS), included pneumonia and diarrhea components on CCMM to complement the iCCM (integrated Community Case Management) package, and requested IHPB to support the development of a database; (2) the previous version of the CCMM database was capturing aggregated data instead of individual Community Health Worker (CHW) report data and hence limiting the diagnostics of data quality issues. Therefore, IHPB M&E team, jointly with the project Malaria Specialist, and in partnership with the DODS, developed an iCCM database incorporating the new program components and individual CHW report form.

With the objective to get project Program Technical Officers (PTO) and M&E Technical Officers (M&E TO) accustomed to the content of the CHW tool and the use of the iCCM database, IHPB conducted a training for them on the use of the database. The training team took that opportunity to train attendees on the database of Community-Based Distribution of FP commodities (CBD database), and the GASC database. A total of 14 project staff (7 PTOs and 7 M&E TOs) completed the training.

Nevertheless, the participants of the Muyinga field office expressed their concerns about the use of this iCCM database, since their workload increased with an additional iCCM district (Giteranyi) with a total of 217 CHW reports to capture, particularly since the Muyinga Field Office has only one M&E Technical Officer. The consensus reached is that they will meanwhile continue to use the aggregating tool until the

new CHW tool issue is resolved. One of the solutions suggested to resolving the issue was the recruitment of a temporary data entry clerk.

Program Management

Planned for April – June 2017	Achievement and results	Comments
Submit monthly, quarterly, and annual reports	Achieved	All deliverables were submitted on time
Bujumbura-based staff conduct support visits to sub-offices	Achieved	Muyinga, Karusi, Kayanza and Kirundo offices visited
Hold quarterly staff planning and management meetings	Achieved	Weekly meetings held during the months of April and May. Beginning June 5th, weekly meetings were replaced by bi-weekly meetings
Participate in collaboration, coordination and partnership-building meetings at the national and field office levels	Achieved	See details below
Perform modifications for grantees as needed and monitor grants implementation	9 in-kind modifications were performed	

Submit monthly, quarterly, and annual reports

During the reporting period, as required by the IHPB contract, FHI 360 submitted monthly progress reports for the months of April, May and June. The monthly reports present achievements during the report period.

Bujumbura-based staffs conduct support visits to sub-offices

Senior staff including the COP, DCOP, Senior Leadership Team members, and other technical specialists and advisors conducted support supervision visits while key project activities were underway.

Hold quarterly staff planning and management meetings

Under the leadership of the Chief of Party, the six-member Senior Leadership Team (COP, Deputy COP, Associate Director of Finance & Administration, Senior Technical Advisor of Health Systems Strengthening, Senior Technical Advisor of Monitoring and Evaluation, and the Integrated Services Advisor) held regular meetings to make strategic decisions and monitor program implementation including coordinating with USAID, GOB entities and other USG partners. Under the leadership of a Field Office Manager, technical teams also held regular meetings with their respective staff and in their respective offices.

Perform modifications for grantees as needed and monitor grants implementation

During the period from April to June, IHPB performed nine (9) In-Kind modifications for partner health districts (Giteranyi, Musema, Buhiga, Kayanza and Mukenke HDs) and hospitals (Kayanza, Mukenke, Gahombo and Buhiga Hospitals) in the intervention zone. All the modifications were aimed at increasing

the obligated amounts to allow activity continuity. The process consists in having modification budget prepared by the grantee hand in hand with the Field Office Managers, then reviewed by the Contracts and Grants manager who also prepares the modification document to be reviewed and partially executed by FHI's Contracts and Management Service and, finally, executed by the grantee.

Participate in collaboration, coordination, and partnership-building meetings at the national and field office levels

During the reporting period, IHPB fostered collaboration and coordination with USG-funded projects and organizations and MPHFA. The table below presents key events and meetings attended by project staff.

Date	Title of IHPB Staff Member	Theme of Meeting/Event
April 3, and 10, 2017	Maternal health specialist	Meeting of the committee in charge of the preparation of RH coordination workshop
April 14, and May 4, 2017		Meeting of the committee in charge of the preparation of the mother and child week
April 18, 2017	Malaria Specialist	Restitution meeting of the recommendations resulting from a joint field visit of WHO and NMCP on the task force for the Malaria Epidemic
April 19, 2017	COP, DCOP, M&E, HIV & HIS Advisor, FOM Kayanza et Kirundo	PEPFAR Implementing Partners meeting
April 20, 2017	Malaria Specialist	Preparation of celebration of the World Day dedicated to Malaria Fight
April 24, 2017	DCoP and Malaria Specialist	Accelerate the response of Malaria Epidemic based on district level micro-plans.
April 26,2017	Malaria Specialist	Analyze weekly malaria data (Working group in charge of monitoring and evaluation of the response of Malaria Epidemic)
April 28 to May 5, 2017	HIV and Integrated Health Services Advisor	Participating in a workshop on the designing of National HIV/AIDS Strategic Plan
May 5, 2017	MH and RH specialist	Restitution workshop on RH data from survey
May 8,11,18,25th, and	SBCC Program Officer and Malaria Specialist	Develop flipchart on malaria prevention and a poster on use and maintenance of LLNI(Working group in charge of communication and social mobilization for the response of Malaria Epidemic)
May 23, 2017	DCoP and Malaria Specialist	Analyze the epidemic situation of malaria (extended task force that includes provincial and district health authorities) and commitment of partners in implementation of response at Malaria Epidemic.
May 26, 31 and June 2, 2017	Maternal health specialist	Meeting of the committee in charge of the preparation of the mother and child week
June 1, 2, and 12, 2017	SBCC Program Officer and Malaria Specialist	Validation of flipchart on malaria prevention and poster on use and maintenance of LLIN
June 12, 2017	COP, Maternal health specialist, Communication and Documentation officer	Participate in the national mobilization workshop for the mother and child health week in Ngozi
June 19, 2017		Participate in the launching ceremonies for the mother and child health week in Rumonge
May 08, 2017	COP, Child Health Specialist	Participate in the launching ceremonies for the African Vaccination Week in Cibitoke.

Problems Encountered/Solved or Outstanding

Following the outbreak of malaria that affected 11 provinces including the four IHPB provinces, the MPHFA instructed that all activities other than the emergency malaria response be suspended and that all staff (at the central and peripheral levels) should support peripheral health care providers in diagnosing and treating malaria cases. This situation, coupled with preparations for the African Week for Immunization and Mother and Child Health Week, delayed implementation of certain planned activities

for the quarter - conducting integrated training sessions on iCCM for health providers from Musema and Gashoho HD and of CHWs on case management of pneumonia in Gahombo and Gashoho HD). Also, the stock shortage of injectable artesunate (since February 2017), used in pre-transfer and in the treatment of severe malaria, compromises the free management of severe malaria.

During the course of the 3rd year and since the start of October 2016 (Y4) IHPB, in partnership with respective health districts and provinces, has trained over 2,000 CHWs on community-based distribution and available methods of contraceptives. During regular meetings with CHWs, they expressed an unmet need related to male sterilization and tubal legation services i.e. when the CHWs conduct sensitization activities in the community, some men select male sterilization and women tubal ligation as their preferred FP method, but lack resources for transportation to district hospitals which are quite far from some communities. According to USAID PDC 3 (Policy Documentation), informed consent is required before sterilization procedure and must be documented. Also, incentive payments for sterilization are prohibited but under special situations, compensation may be permitted (determined by USAID Mission) for transportation, food during confinement, necessary medicines, surgical garments, and value of lost work time. Since there are men and women who expressed willingness to perform sterilization, with the objective to increase the contraceptive prevalence rate across the four IHPB provinces, IHPB sought USAID approval (not yet received) to pay each client, transportation of 20.000 BIF ($12) and 50.000 BIF ($30) for food and lost work time.

Annex I: Change package of Muyinga health province

Objectives of change	Changes to be implemented	Activities/best practices
At the health facility 1. Improve the package of malaria prevention services in ANC. a) Improve the LLIN (Long Lasting Insecticide Treated Nets) offer for women seen in ANC/AR	a.1. Offer the LLIN (Long Lasting Insecticide Treated Nets) in ANC service	a) Set up a register of requisitioning and daily consumption of LLINs in the ANC service. b) Set up' daily scoring record'' to check the LLIN distributed in the ANC service. c) Record the LLIN offered in ANC register.
	a.2. Follow the calendars of the refocused ANC.	a) Give appointments according to the calendar of refocused ANC: - 1rst ANC : 8 to 12 WA (week of amenorrhea) - 2nd ANC : 18 to 24 WA - 3rd ANC : 28 to 32 WA - 4th ANC : 36 to 38 WA b) Inform the client of the date of appointment and save it in her notebook.
b) Improving the availability of IPTP (Intermittent Preventive Treatment of malaria during Pregnancy) in pregnant women seen in ANC.	b.1. Provide Fansidar in the ANC service by trained health providers and directly observed by service provider.	a) Set up a clean water point (water filter) and a cup in the ANC service. b) Update the internal requisition register of ANC Inputs. c) Record requisitioned inputs on Fansidar daily stock record. d) Remind the pregnant woman of the importance of dose-taking (Fansidar) on site.
	b.2. Supply the HC in Fansidar according to the average monthly consumption (AMC)	a) Check the consumptions of the previous months on the stock cards. b) Calculate the number of expected pregnant women and make the requisition of the Fansidar according to the average monthly consumption (AMC). c) Use appropriate formula to calculate the average monthly consumption (AMC).
2. Improve notification of malaria prevention services for pregnant women in ANC.	2.a. Mark in the ANC register the number of the Fansidar dose.	a) Inform all providers of the ANC service on the recording of the dose of the IPTP in the appropriate column of the ANC register b) Designate a nurse to check at the end of the day if all items are filled in the ANC register.
	2.b. Analyze the data before transmitting it.	a) Collect and compile data b) Develop a calendar of data analysis meeting. c) Invite members of the QIT to analyze the data. d) Transmit the corrected report before the 25th day of the month following the month in question. e) Synthesize data from the ANC register at the end of the day.
	2.c. Record the LLIN offered in the ANC register.	a) Compare the number of tokens distributed and the number of pregnant women seen in the first ANC of responsibility area. b) Make the daily inventory of distributed LLIN.
3. Reduce the	3.a. Conduct a LLIN requirement in time, taking	a) Fill in the LLINs inventory sheets every day. b) Prepare a distribution report for LLINs at the end of

number of days of stock-outs in LLIN.	into account the average monthly consumption(AMC).	each day. c) Make the monthly inventory of LLINs. d) d) Update the average monthly consumption(AMC) every six months.
	3.b. Follow up on a LLITN requirement addressed to the HD.	a) Call the HD pharmacist to request the delivery date in LLITN before stocking out.
4. Reduce stock-outs of Fansidar	Conduct a SP requirement in time, taking into account the average monthly consumption(AMC).	a) Observe the AMC (average monthly consumption) formula while making requirement. b) Update the average monthly consumption(AMC) every six months. c) Respect the formula when establishing the requirement.
5. Increase early ANC Rate.	Introduce a theme on the importance of early ANC in morning health education sessions.	a) Develop a calendar of health education sessions. b) Prepare teaching materials for a Health Education session c) Set up a booklet to prepare key messages to be disseminated. d) Disseminating key messages.
6. **At the community level:** Increase early ANC rate through awareness of the population about the benefits of early ANC.	6.a) Spreading messages about the benefits of early ANC across churches and mosques.	a) Develop key messages to teach b) Contact the administration and religious leaders c) Disseminate messages.
	6.b) Conduct a joint filed visit (nurse, HTP, CHW) on the air of responsibility hills to educate community about the importance of early ANC.	a) Assign hills from HC to providers for follow-up. b) Identify key messages to be disseminated by Community Health Workers. d) Develop a sensitization calendar. e) Inform the local administration about the awareness calendar.
	6.c. Contact to pregnant women who have missed their appointment.	a) Identify pregnant women who have missed / delayed ANC appointments. c) Writing invitation letters
7. Increase the use of LLIN and IPTp through community sensitization.	Conduct a monthly CHW sensitization meeting on the importance /benefits of using LLIN and IPTP by pregnant women.	a) Develop themes on the importance /benefits of using LLIN and IPTP by pregnant women. b) Convene a meeting of the Community Health Workers by sending a letter of invitation to the meeting. c) Identify key messages to be disseminated by Community Health Workers. d) Develop a sensitization calendar.

Annex II: Preliminary results of the assessment of the supervision system

	Indicators/HD	Gahombo	Kayanza	Musema	Buhiga	Nyabikere	Busoni	Kirundo	Mukenke	Vumbi	Gashoho	Giteranyi	Muyinga
1	% of district supervisors that correctly prepared for the supervision visit per the MPHFA guidelines	100 %	100 %	100 %	75%	25%	100 %	100 %	100 %	50%	70%	70%	100 %
2	% of supervision visits that happen as planned	100 %	100 %	100 %	100 %	0%	50 %	0%	75 %	25%	50%	50%	0%
3	% of facilities that received the minimum required number of visits in the last quarter.	30 %	40%	60 %	100 %	75%	100 %	75 %	100 %	100%	100 %	100 %	100 %
4	% of supervision visits that were conducted per MPHFA Guidelines	12 %	10%	8%	50%	75%	75 %	100 %	90 %	100%	75%	75%	100 %
5	% of facility managers and supervisors that think the frequency of supervision is adequate to meet facility's needs.	50 %	16%	0%	83%	50%	100 %	100 %	100 %	100%	50%	50%	30%
6	% of supervision recommendations from the past 3 visits that have been implemented	72 %	67%	83 %	90%	50%	80 %	80 %	100 %	60-75%	75%	50%	85%
7	% of performance gap improved	33 %	30%	26 %	< 10%	< 50%	RAS	RAS	RAS	< 20%	50%	50%	73.4 %

Analysis of the preliminary results shows:

1. % of district supervisors that correctly prepared for the supervision visit per the MPHFA guidelines

In 58% (7/12) of the districts, the supervisors correctly prepare the supervisions with a score of 100%. 16.6% (2/12) of districts received a score of 50% and 25%, respectively. These are the districts of Vumbi and Nyabikere.

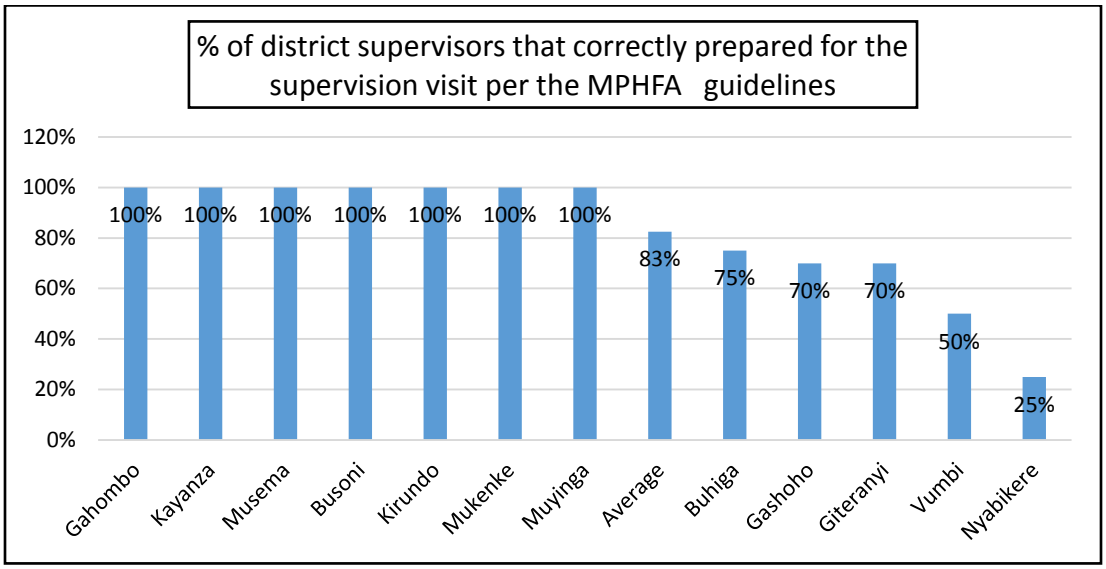
In Nyabikere HD, the performance is explained by:

- Supervisors don't review necessary documents to inform the supervision plan:
- They don't review facility indicators and performance
- They rarely analyze previous supervision reports before supervision visit
- They don't inform facilities of the visit at least 1 week in advance

In Vumbi HD, the performance is explained by:

- Supervisors don't review the annual action plan and objectives
- They don't review facility indicators and performance
- Supervisors don't develop a supervision plan.

The status of this indicator is shown in the following graph:

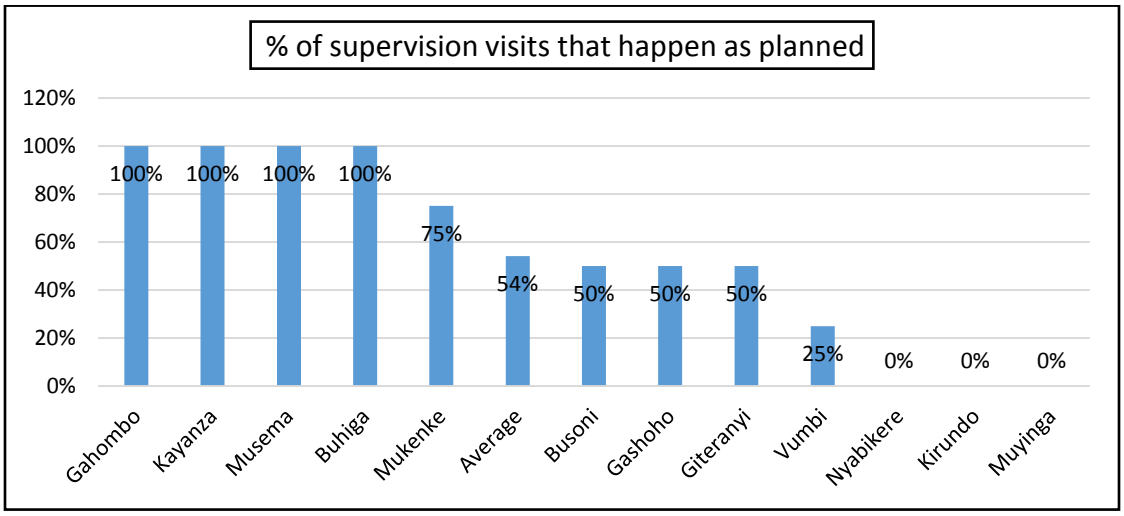


2. % of supervision visits that happen as planned

The analysis of this indicator shows that in 33.3% (4/12) districts, supervision visits happen as planned (Gahombo, Kayanza and Musema in Kayanza health province and Buhiga in Karusi health province. In Mukenke health district, 75% of supervision visits happen as planned. In 25% (3/12) of HD, 50% of visits happen as planned and in 25% (3/12) others, no supervision visits take place as scheduled. These are Nyabikere, Kirundo and Muyinga health districts. Main reason(s) why supervision visits were postponed or cancelled in the past quarter are:

- Conflict of agenda
- Lack of supervisors for health district
- Lack of supervision vehicle

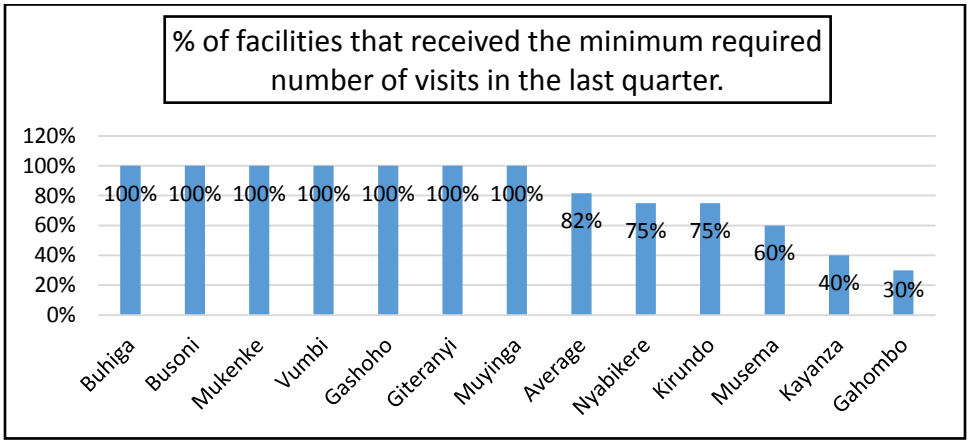
The status of this indicator is shown in the following graph:



3. % of facilities that received the minimum required number of visits in the last quarter.

In 58% (7/12) of the districts, facilities received the minimum required number of visits in the last quarter with a score of 100%. In 16.7% (2/12) of HD, facilities received the minimum required number of visits in the last quarter with a score of 50%. In 8.3% (1/12) of HD, the score was 25% and for 25% (3/12) had a score of 0%. The raisons are that supervision visits were postponed or cancelled.
During this period of report, there has been an outbreak of malaria cases that kept district supervisors back from performing supervision visits as planned and the Maternal and Child Health Week suspended other activities for 2 weeks following involvement of partners in districts.

The status of this indicator is shown in the following graph:

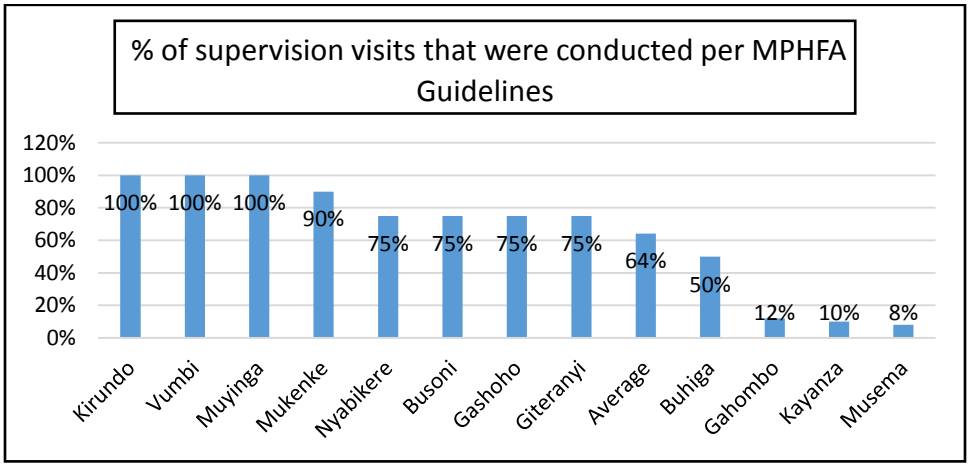


4. % of supervision visits that were conducted per MPHFA Guidelines

The analysis of this indicator shows that in 25% (3/12) districts, supervision visits that were conducted per MPHFA Guidelines with a score of 100%. These HD are Kirundo, Vumbi and Muyinga. In Mukenke HD, the score was 90% because the HD didn't share the supervision report with the health center. 41.7% (5/12) of health districts scored below average (64%). Main reasons are:

- The supervisors don't hold a brief meeting with facility staff before beginning supervision in some health centers,
- Some supervisors don't hold a joint meeting with staff to review findings of supervision and discuss problem solving,
- Some supervisors don't produce the supervision report.
- Some supervisors don't give a copy of the report to the facility manager.

The status of this indicator is shown in the following graph:



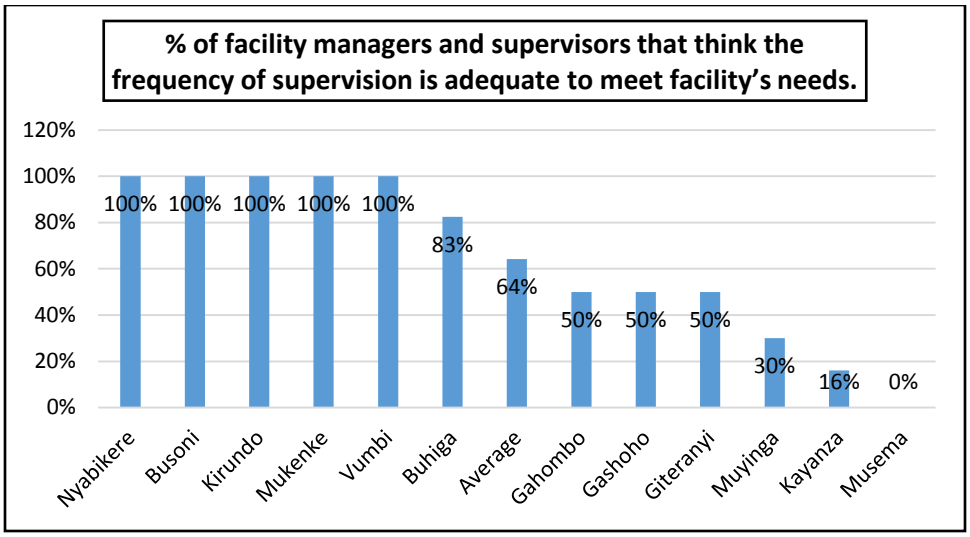
5. % of facility managers and supervisors that think the frequency of supervision is adequate to meet facility's needs.

The analysis of this indicator shows that in 41.7% (5/12) districts, 100% of facility managers and supervisors think that the frequency of supervision is adequate to meet facility's needs. In Buhiga HD, 83% of facility managers and supervisors think that the frequency of supervision is adequate to meet facility's needs. In 25% (3/12) of HD, 50% of facility managers and supervisors think that the frequency of supervision is adequate to meet facility's needs. These are Gahombo, Gashoho and Giteranyi HD. Other 30% or less of facility managers and supervisors think that the frequency of supervision is adequate to meet facility's needs in Muyinga, Kayanza and Musema health districts.

For the 3 last districts, the reasons are that:

- Lack of supervision vehicle for health district
- Many health facilities to supervise while each health district has only three supervisors;
- Many themes to supervise in 3 hours.

The status of this indicator is shown in the following graph:



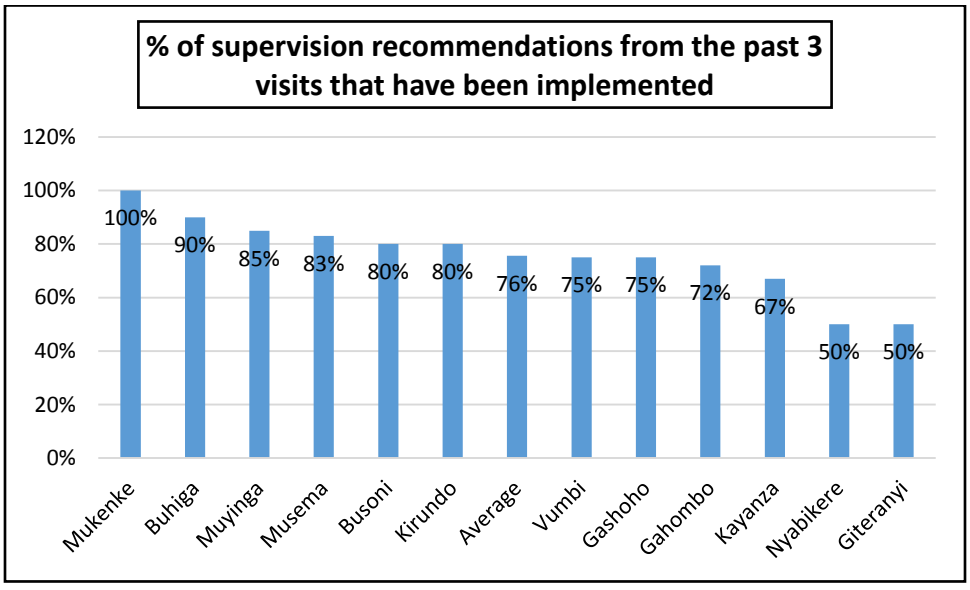
6. % of supervision recommendations from the past 3 visits that have been implemented

The analysis of this indicator shows that only in 8.3% (1/12) HD, all supervision recommendations from the past 3 visits have been implemented. In 75% (8/12) HD, 90 to 75% of supervision recommendations from the past 3 visits have been implemented and in 16.7 (2/12), the recommendations were implemented at 50%.

The main reasons of this situation for those districts are:

- Implementation whose executives have not been clearly identified or the timetable clearly established
- Factors exogenous or not vulnerable at the health facility level (stock out CAMEBU)
- Lack of an implementation plan.

The status of this indicator is shown in the following graph:



To improve the performance of the supervision system in problem districts, concrete actions to sensitize district supervisors to the supervisory stages will be carried out. There are also critical resources that need to be provided to strengthen low-performance supervision systems:

- The supervisions sessions remain the key strategy in strengthening the health system. It is important to focus on efforts for all phases of supervision.
- Evidence-based planning to address time and resource constraints by using available data to target health facilities to oversee
- To strengthen the staff supervisors: draw upon the resources already available (Manager, Information System Manager and Pharmacy)
- Develop plans to implement recommendations (follow-up)

A detailed analysis of the results of this evaluation will make it possible to make effective proposals to improve the supervision system in each health district.

Plan and conduct joint supervision visits

IHPB continued to provide technical and financial support to health district and PTOs participated in supervision activities. In the twelve districts of the 4 health provinces, IHPB Staff (PTO) and district supervisors developed joint schedules of supervision visits for April, May and June. The FOM shared the schedule of supervision visits with HSS advisor and all joint supervision visits were done as planned:

- 5 health centers (Buhindrye, Gitaramuka, Nyakabugu, Rudaraza and Rutonganikwa) from Buhiga HD,
- 3 health centers (Mugogo, Nyabibuye and Rusi) from Nyabikere HD,
- 3 health centers (Marembo, Bunyari and Nyagisozi) from Busoni HD,
- 6 health centers (Gaharo, Gakana, Kiyanza, Kiri, Rugasa and Rukuramigabo) from Kirundo HD,
- 2 health centers and 1 district hospital (Bucana, Kimeza and DH Mukenke) from Mukenke HD,
- 5 health centers (Gikomero, Mugendo, nyabikenke, Ntega and Vumbi) from Vumbi HD
- 6 health centers (Rukago, Nzewe, Kibaribari, Maramvya, Gakenke and Gatara) from Gahombo HD,
- 5 health centers (Nyabihogo, Gahahe, Kavoga, Murima and Kibuye) from Kayanza HD
  9 health centers and 1 district hospital (Burarana, Gaheta, Gasenyi, Gikomero, Karehe, Musagara, Musema HC, Musema DH, Ninga and Nyarumanga) from Musema HD,
- 4 health centers (Bwasare, Gasorwe, Nyungu and Rusimbuko) from Gashoho HD
- 10 health centers (Butihinda, Gahararo, Buhorana, Rabiro, Mugano, Mika, Mugano, Giteranyi, Kinyami and Kidasha) from Giteranyi HD,
- 8 health centers (Nyarunazi, Kibongera, Gitaramuka, Kayenzi, Muyinga, Kinazi, Rugari and Murama) from Muyinga,

Data from DHIS2 showed that during the reporting period of April and May, a total of 54.1% of supervisions visits planned by districts for the quarter have been conducted. This percent measures only the supervision visits conducted by the district supervisors (not the IHPB staff).

Districts	Number of planned supervision for April to June	Number of supervisions done from April to May	Number of supervisions done in April	Number of supervisions done in May	%ge of supervision visit done
Buhiga	32	22	14	8	68.8
Busoni	18	7	7	0	38.9
Gahombo	33	19	15	4	57.6
Gashoho	28	17	7	10	60.7
Giteranyi	32	16	9	7	50.0
Kayanza	56	34	21	13	60.7
Kirundo	38	15	8	7	39.5
Mukenke	22	17	9	8	77.3
Musema	30	17	10	7	56.7
Muyinga	52	30	14	16	57.7
Nyabikere	38	12	6	6	31.6
Vumbi	26	13	11	2	50.0
Total	**405**	**219**	**131**	**88**	**54.1**

The number/proportion of supervisions done each month shouldn't be calculated against the number of visits planned for that month because supervision visits are only quarterly planned.
The number of visits conducted by each district in June 2017 will be available in August 2017 and numbers will be adjusted accordingly. One of the factors that explain the difference between health district is that supervision schedule is rarely respected. This is generally due to the conflict of agenda observed within the members of the District Team. For Mukenke, the district Chief recommended to supervisors to respect schedule and their performance depends on the number of supervision done bye quarter. For Nyabikere district, supervisions have been postponed due to the situation of malaria.

The situation of the supervision visits during this reporting period of April and May is explained by these two main reasons:

- There has been an outbreak of malaria cases that kept district supervisors back from performing supervision visits as planned;
- The Maternal and Child Health Week suspended other activities for 2 weeks following involvement of partners in districts.

To address the issues and improve the performance to achieve/exceed the mandatory results during, main actions are planned for next quarter:

1. Strengthen the supervisory system by ensuring that supervisions are carried out in accordance with Ministry guidelines;

2. Ensure that the recommendations made during the supervisions are made;
3. Implement a plan for recommendations per each district,
4. Discuss this plan during the quarterly coordination meetings and assess the status of implementation of the recommendations.

Annex III: Success stories

Men`s *involvement and investment* celebrated as good examples for good health of families

"*Today, I am no longer ashamed to go and fetch water or seek for firewood for my family when my wife is pregnant. I do not also forget to escort her to the clinic because I understood that the good health of the mother takes precedence*"

GIHOGAZI, BURUNDI: Nteziyorirwa Paul and Nduwimana Prisca are one couple among others who were identified in the community by CHWs in collaboration with the hill leaders. This family was awarded with a *certificate of honor* by the IHPB project for recognition on adopting and observing positive behavior changes by putting into practice 9 essential actions for the pregnant woman[24].

It was during a community public session that Paul shared his experience and testimony of his ignorance before: "*I am a man married to one women and father of 2 children. I am a farmer and I also have a small business where I sell cassava flour. Normally I can say that I did not get on well with my wife because I did not help her enough in the daily work of the house; moreover, I never accompanied her to health center during the periods of pregnancy. I always told myself that it was only about her, and that I should rather take care of my business.* "

Paul revealed how his transformation started in his relationship: "*One day, a CHW known as Dieudonné Niyonzima came to visit me. It was very early in the morning. He started telling me about 9 essential actions of the pregnant woman. This was the first time I heard about this because I had never attended any of their community outreach meetings. I listened attentively and followed carefully the images on the bflipchart with images and a leaflet that he kept unrolling. I also asked him a lot of questions. At the end of his explanations, I finally convinced*. "

Paul listed few points that made him most convinced by the CHW's counselling: "*First, I [Paul] did not think it was important to escort my wife and attend together the antenatal or post-natal care. I considered it a waste of time, since I was a very busy man. I found logical that she would go alone and reports to me*

[24] IHPB has trained CHWs on interpersonal communication and provided material that enables them to sensitize and monitor behavioral changes in their communities. After one term, CHWs with hill authorities identify together couples who have followed the advice and encouraged them to continue to be a light for others in the community. This is done during a public event called “session of celebration of success "

later of what she had been told. I also did not know that a pregnant woman needs to eat special foods (such as eggs, fry or ndagala, etc.) to help her stay physically stronger during her pregnancy and for the baby to grow well in her womb. To say honestly, I was not lacking money to provide all this to her but my ignorance of all these things had a very bad impact on our family. The CHW has frankly opened my eyes: I realized with shame that my wife, even pregnant, has been working on digging the fields, going alone to fetch water … all of this until she delivered. I had the common mentality that a woman should take care of all the household work. I did not really know that I was endangering her life and that of our baby. "

Since the visit of that CHW, Paul resolved to be more concerned with his wife's health and pregnancy, and also to watch out danger signs of pregnancy as he was taught. He testified that the effect of these messages from the CHW on his behavior: "*Today, I am no longer ashamed to go and fetch water or seek for firewood for my family when my wife is pregnant. I do not also forget to escort her to the HC because I understood that the good health of the mother takes precedence*".

Currently, Paul is since forth volunteering and committed to supporting the efforts of CHWs in sensitizing male neighbors (especially husbands) to change behavior for a good health of mothers and children: *"I would advise all other husbands who are listening to take CHW teaching very seriously as they convey messages to improve the living conditions of their communities, especially on adoption of healthy practices*."

With a smile of satisfaction, Paul ended his story with an expression of sincere gratitude to CHWs and IHPB for having initiated, trained CHWs and organized the public certificate award session in Karusi.

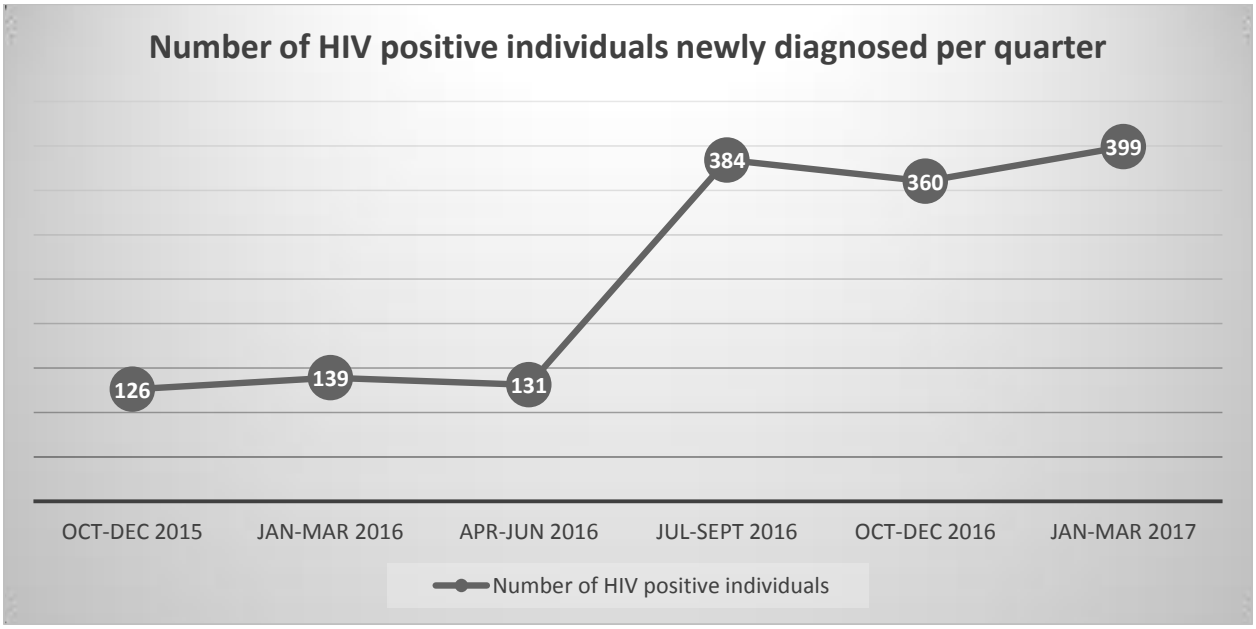
Reaching the Positives from the general population: Successful Experience of Integrated Health Project in Burundi

The Integrated Health Project- Burundi (IHPB) is a Health Systems Strengthening Project that trains health providers and supports commodity distribution throughout 12 health districts in Burundi. Originally, IHPB focused on facility-based HIV testing services (HTS) as the primary method to identify HIV positive people in the program areas. When analyzing HTS yield, IHPB's HIV positivity rate of 0.4% in Kayanza province was far lower than the national sero-prevalence rate of 1.4%. In response, IHPB initiates a targeted HIV outreach HTS strategy with the objective of increasing HTS yield.

To augment ongoing facility-based HTS, as of June 2016, IHPB introduced targeted HIV outreach testing through: (1) identification and targeting of geographic areas where there were high concentrations of PLHIV in care; (2) working with community health workers (CHWs) assigned in those areas to identify high-risk categories: single mothers, separated couples, and men and women with concurrent sexual partners; (3) conducting interpersonal counseling on HIV testing; (4) conducting mobile HTS in the catchment areas of IHPB-supported facilities.

Through the targeted HIV outreach testing model, selected people whose behavior is potentially exposing them to HIV infection receive HIV interpersonal counseling and are invited to HTS sessions organized within their community.

The number of newly diagnosed with HIV was fairly consistent from 2014 to June 2016; however, after introducing the enhanced targeted testing strategy, HTS output increased almost threefold: average numbers per quarter of newly diagnosed with HIV increased from 132 in October 2015 to June 2016 to 381 from July 2016 to March 2017. Additionally, the overall positivity rate doubled, from 0.4% to 0.9% for the same period.



The experience confirms that locally-specific, targeted outreach strategies are key to reach the positives in high prevalence areas. The approach is being scaled up in other provinces.

Life of 3 triplets saved thanks to IJHPB donated incubators

"*Without the incubators donated by IHPB to Kirundo Hospital, my 3 triplets would have died*" Said Eric Bashengezi.

KIRUNDO, BURUNDI: Eric Bashengezi and Harerimana Renate are from Kirundo. They are clients from Cumva health center in Kirundo health district. They are among happiest parents who have benefited from the neonatal services from Kirundo district hospital, one of the 9 hospitals supported and equipped with incubators by the Integrated Health Project in Burundi (IHPB).

Eric, the father of the triplets declared in May 2017 during a field visit of IHPB with district supervisor that without the incubators donated by IHPB to Kirundo Hospital his 3 triplets would have died. A feed-back from the Hospital management has reported to have been able to provide neonatal care to many other babies and, as well, has got 3 couples with triplets. They are all alive.

As featured within the poster below, Kirundo Hospital was not able to have enough room for the newborn babies and was obliged to use one incubator for the triplets. Even after IHPB ha provided another 4 incubators from Mukenke Hospital, the needs remained. But fortunately, these incubators are very helpful and help a lot to improve life and care of newborn babies.

USAID FROM THE AMERICAN PEOPLE

HISTOIRE DE SUCCES

IHPB INTEGRATED HEALTH PROJECT IN BURUNDI

Kirundo, Burundi: Eric Bashengezi et Harerimana Renate, du CDS Cumva dans le district sanitaire de Kirundo, ont eu la grace d`avoir la vie sauve de leurs triplets Iriho Fabrice, Abayisenga Joselyne et Ngabirano Jean Bosco. A une annee et demi de leur naissance, ce couple apprecie l`appuie d`IHPB aux formations sanitaires: ***"Sans les couveuses données par IHPB, nos enfants ne seraient pas en vie aujourd`hui"***

A la naissance

Février 2016, Hôpital de Kirundo: *les triplets dans les couveuses avec un poids moyen de 1,4 kg*

A 4 mois

Juin 2016 2016, Sur la Colline Mutumba du CDS Cumva (District Kirundo): *les triplets evoluent bien, sont suivis par les parents et l`agent de santee communautaire*

Mai 2017, Visite sur la Colline Mutumba du CDS Cumva (District Kirundo): *les parents se réjouissent du progrès et de la santé de leurs 6 enfants et particulierement de leur triplets*

Integrated Health Project in Burundi (IHPB) est un projet quinquennal (du 23 Décembre 2013 au 22 Décembre 2018) financé par l'Agence des Etats-Unis pour le Développement International (USAID). IHPB s'appuie sur l'héritage de l'USAID en matière de soutien au secteur de la santé au Burundi et sur les réussites de FHI 360 et Pathfinder pour aider le Gouvernement du Burundi à élargir et à intégrer les services essentiels pour le VIH/ SIDA, la santé maternelle, néonatale et infantile (SMNI), le paludisme, Le Planning Familial (PF) et la santé reproductive (SR). Les résultats escomptés de IHPB sont :

1. L`augmentation des comportements positifs au niveau individuel et des ménages ;
2. L`utilisation accrue de services de santé intégrée de qualité et des services d'appui ; et
3. Le renforcement du système de santé et des capacités de la société civile.

A une annee trois mois

Annex IV: IHPB Indicators – Achievements for the period April 1, 2017 – June 30, 2017

Indicator No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct-June 2017)		EOP	
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1.1.4	Number of health communication materials developed, field tested, and disseminated for use	Annually	N/A	2	0	8	1	4	21	8	8	30	
1.2.1 [MR]	Percent of supported facilities that experienced a stock-out at any point during the last three months	Quarterly	62%		87%		61%	65%	57%	50%[25]	45% (83/184)	-10%	
1.2.2	Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide [FP/RH 3.1.7.1-2]	Quarterly	37.6%	NA	38%	30%	0%	20%	14%	10%26	22% (33/150)	3%	
1.3.1 [MR]	Number of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalances within the household)	Annually	0	0	0	2	0	4	3	5	NA	5	
1.3.2 [MR]	Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products	Annually	0	0	0	0	0	1	0	4	NA	50% (6/12)	
1.3.4 (GEND_GBV)	Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)	Quarterly	102	150	108	150	252	150	117	170	90	860	
1.3.5	Number of facilities that provide PEP to GBV survivors	Quarterly	7	7	7	14	36	2727	26	34	32	34	

25 Performance will depend to availability of drugs at CAMEBU
26 Performance will depend on availability of contraceptives at the central level
27 Target is lower than achievement because PEPFAR support moved from four Provinces to two

Indicator No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct-June 2017)		EOP	
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
2.0.1 [MR]	Couple years of protection rate for family planning (3.1.7.1-1)	Annually	186,249		134,330	130,313	90,870[28]	136,828	132,567	150,511	NA	+5%	
2.0.3 [MR]	Number of individuals who were referred to and received other health and non-health services	Quarterly	7137		7262		18068	18200	20464	20500	17059	+5%	
2.0.4	Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs [3.1.6-61]	Quarterly	81.9%	82%	83%	83.7%	96%	85%	97%	98%	86.4% 52277/ 60532	+ 5% (86.9%)	
2.0.5	Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs [3.1.6-64]	Quarterly	8.8%	1000	8.8%	7765	15.6%	18%	77%	80%	90% 55238/ 61296	+10%	
2.0.6	Number/percent of women reached with education on exclusive breastfeeding	Quarterly	N/A	85000	110874	112000	88% (98612)	1150000	211286	211500	263001	+10% (212000)	
2.0.7 [MR]	Number and percent of pregnant women with known status (PEPFAR PMTCT_STAT_DSD)	Quarterly	94% (127,306/ 135626)	95%	91%	95%	87%	95%	89%	95%	88% 38591/ 44057	95%	
2.0.8 [MR]	Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery (PEPFAR PMTCT_ARV_DSD)	Quarterly	93%	95%	89%	95%	83%	95%	93%	95%	93% 595/636	95%	
2.0.9	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results (PEPFAR HTC_TST_DSD)	Quarterly	360446	357023	300475	367842	447365	138048[29]	321944	138048	237798	1139009	
2.0.10	Number of HIV-infected adults and children who received at least one of the following during the	Quarterly	10071	10071	12539	13244	12826	8435[4]	8,033	9,195	8929	13000	

28 CYP dropped due to 7,704 women who had implants removed while 1,732 had IUDs removed - removal out of these long acting methods contributed to reduction of CYP

29 Target reduces as PEPFAR strategically reduced support from 4 to 2 provinces.

Indicator No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct-June 2017)		EOP	
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
	reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD]												
2.0.11	Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]	Quarterly	12,8%	20%	14,5%	30%	43%	50%	62%	70%30	62% 5594/ 8972	95%	
2.0.12	Percent of infants born to HIV-positive women that receive a virological HIV test within 12 months of birth (PEPFAR PMTCT_EID)	Quarterly	31%	40%	12%	50%	0	61%	45%	70%	90% 574/636	95%	
2.0.13	Number of adults and children receiving ART (TA only) [PEPFAR TX_CURR_TA]	Quarterly	4996	6500	6025	7000	6510	7200	6211	919531	8604	10000	
2.0.14	Proportion of women attending antenatal clinics who receive IPTp2 under direct observation of a health worker[32]	Quarterly	0	-	0	50%	71%	60%	68%	80%	84% 56390/ 67130	90%	
2.0.15	Proportion of pregnant women attending ANC who received ITNs	Quarterly	80.3% (116160/144739)	80%	82 %	92%	79%	94%	81%	95%	82% 14074/ 17180	95%	
2.0.16	Proportion of children under five with fever who received ACT within 24 hours of onset of fever	Quarterly	66.6% (20666/ 31060)		76%	75%	65 %	75%	74%	85%	76% 125323/164377	90%	
2.1.2 [MR]	Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)	Quarterly	NA				61464	62000	93523	80000[33]	164380[34]	249464	
2.2.2	Percentage of HIV service delivery	Quarterly	26%		37%		59%	63%	75%	75%	84%	80%[35]	

30 Reduced from 80% to 70% based Y3 achievement
31 Target set in COP 2016
32 Assuming that SP would be available
33 Revised lower than FY2016 achievement due to unexpected stock outs of RDTs from time to times.
34 Cases outmatch the target due to the malaria epidemic

Indicator No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct-June 2017)		EOP	
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
	points supported by PEPFAR that are directly providing integrated voluntary family planning services [PEPFAR FPINT_STE]		45/173		(64/173)		(102/173)				(81/96)		
2.3.2 [MR]	Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training	Quarterly	N/A		89%	90%		90%	95%	95%	84% 504/600	95%	
2.3.5	Number of health care workers who successfully completed an in-service training program	Quarterly	NA		0		2100	1207	1372	593	918		
2.3.6	Number of community health/para-social workers who successfully completed a pre-service training program	Quarterly	NA		0		394	834	854	4295	7447		
3.1.3	Percent of supported facilities that have the capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	Annually	66.7% (6/9)		66.7% (6/9)		77.8% (7/9)	80% (4/5)	93%	100% (5/5)	80% (4/5)	100% (5/5)	
3.1.4 [MR]	Number of PBF indicators supported by the project	Annually		7	7	7	7	0	0	0	0	7	
3.1.5 [MR]	Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis	Annually	12	100%	100%	100%	100%	100%	100%	100%	100%	100%	
3.2.1 [MR]	Percent of facilities that maintain timely reporting	Quarterly	95% (165/173)		95% (165/173)	96.8%	94% (162/173)	97.8%	100%	100%[36]	94% 173/184	100% (+5%)	

35 Adjusted according to Y3 achievement

36 Adjusted to Y3 result