



EMPOWERMENT BUILDS CAPACITY FOR STRONGER, HEALTHIER COMMUNITIES

FINAL REPORT OF THE INTEGRATED HEALTH PROJECT PLUS IN THE DEMOCRATIC REPUBLIC OF CONGO 2015–2018

**Integrated Health
Project Plus**

in the Democratic Republic
of Congo



USAID
FROM THE AMERICAN PEOPLE



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ACRONYMS

ACT	Artemisinin-based combination therapy	E2A	Evidence to Action
ACZ	<i>Atteindre chaque zone</i> (or Reach Every Zone)	EGM	Essential generic medicines
AMTSL	Active management of third stage of labor	EID	Early infant diagnosis
ANC	Antenatal care	EMMP	Environmental Monitoring and Mitigation Plan
ART	Antiretroviral therapy	EmONC	Emergency obstetric and newborn care
AOP	Annual operational plan	EPI	Expanded Program on Immunization
APHA	American Public Health Association	FOS	Field office supervisors
ARV	Antiretroviral	FOSA	<i>Formation Sanitaire</i> (health facility)
BCG	Bacillus Calmette–Guérin	FOSACOF	<i>Formation Sanitaire Complètement Fonctionnelle</i> (Fully Functional Service Delivery Point)
CAD	<i>Club des Amis de Damien</i>	FP	Family planning
CBD	Community-based distribution or community-based distributor	GHSC-TA	Global Health Supply Chain Project-Technical Assistance
CDR	<i>Centrale de Distribution Régionale</i> (regional distribution center)	GHSC-PSM	Global Health Supply Chain Project-Procurement and Supply Management
CHW	Community health worker	GRH	General referral hospital
CLTS	Community-led total sanitation	HBB	Helping Babies Breathe
CODESA	<i>Comité de Développement Sanitaire</i> (Health Development Committee)	HIV	Human immunodeficiency virus
CPA	Complementary package of activities	HMS	Helping Mothers Survive
CPLT	<i>Coordination Provinciale lèpre et tuberculose</i> (Provincial Coordination Unit for Leprosy and TB)	HTC	HIV testing and counseling
CSO	Civil society organizations	HZMT	Health zone management teams
CTMP	<i>Comité Technique Multisectoriel Permanent</i>	i-CCM	Integrated community case management
cVDPV	Circulating Vaccine-Derived Poliovirus	IDP	Internally displaced person
CYP	Couple Years of Protection	IEP	<i>Initiative pour l'éradication de la polio</i>
DfID	Department for International Development (United Kingdom)	IHP	Integrated Health Project
DHIS2	District Health Information System 2	IHPplus	Integrated Health Project Plus
DMPA	Depo-Medroxy Progesterone Acetate	IMCI	Integrated management of childhood illness
DOTS	Directly Observed Treatment Short Course	IMNCI	Integrated management of neonatal and childhood illnesses
DPS	<i>Division Provinciale de la Santé</i> (Provincial Health Division)	INH	Isoniazid
DQS	Data Quality Self-Assessment	INRB	National Institute of Biomedical Research
DRC	Democratic Republic of Congo	IPS	<i>Inspections Provinciales de la Santé</i>
DTP-HepB-Hib1 and Hib3	Diphtheria, tetanus, polio, hepatitis B Haemophilus influenzae type B1 and B3	IPT	Intermittent Preventive Treatment (of malaria)
		IPT3	Intermittent Preventive Treatment (of malaria) with 3 doses of Sulfadoxine-Pyrimethamine (SP)
		IQA	Integrated Quality Approach

ITN	Insecticide-treated net	PNLP	<i>Programme National de lutte contre le Paludisme</i> (National Malaria Control Program)
IUD	Intra-uterine device	PNLS	<i>Programme National de lutte contre le Sida</i> (National AIDS Program)
IYCF	Infant and young child feeding	PNLT	<i>Programme National de lutte contre la Tuberculose</i> (National Tuberculosis Control Program)
LAM	Lactational Amenorrhea Method	PNSR	<i>Programme National de la santé de la Reproduction</i> (National Program for Reproductive Health)
LDP	Leadership Development Program	PROSANI-SUS	PROSANIplus <i>Secours d'urgence sanitaire au Kasai</i>
LiST	Lives Saved Tool	PRONANUT	<i>Programme National de Nutrition</i> (National Nutrition Program)
LQAS	Lot Quality Assurance Sampling	ProVIC	Integrated HIV Program
MDR/RR-TB	Multidrug-resistant/rifampicin-resistant tuberculosis	PSC	Preschool consultation
MDR-TB	Multidrug-resistant tuberculosis	PY	Project Year
MISP	Minimum Initial Service Package	OI	Opportunistic infection
M&E	Monitoring and evaluation	OPV	Oral poliovirus vaccine
MOH	Ministry of Health	RBF	Results-based financing
MNCH	Maternal, newborn, and child health	RDQA	Routine Data Quality Assessment
MPA	Minimum package of activities	RDT	Rapid diagnostic test
MSH	Management Sciences for Health	SBA	Skilled birth attendant
NGO	Nongovernmental organization	SBCC	Social and behavior change communications
NHIS	National health information system	SCMS	Supply Chain Management System
OFDA	Office of U.S. Foreign Disaster Assistance	SIAPS	Systems for Improved Access to Pharmaceuticals and Services
OI	Opportunistic infection	SGBV	Sexual and gender-based violence
ORS	Oral rehydration solution	SNIS	<i>Système National d'Information Sanitaire</i> (National Health Information System)
OSC	Overseas Strategic Consulting, Ltd.	SP	Sulfadoxine-pyrimethamine
PCV	Pneumococcal conjugate vaccine	TB	Tuberculosis
PCIME-C	<i>Prise en charge intégrée des maladies de l'enfant au niveau communautaire</i>	TETU	Triage, Evaluation, and Emergency Treatment
PDSS	Health Systems Strengthening for Better Maternal and Child Health Results project	UNICEF	United Nations Children's Fund
PEP Kits	Post-Exposure Prophylaxis Kits	USAID	United States Agency for International Development
PEPFAR	President's Emergency Plan for AIDS Relief	USG	United States Government
PIRST	Performance Indicator Reference and Tracking Sheet	WASH	Water, sanitation, and hygiene
PLHIV	People living with HIV	WHO	World Health Organization
PMI	President's Malaria Initiative	XDR-TB	Ultra-resistant strains of tuberculosis
PMI-EP	PMI Expansion Project		
PMP	Performance Monitoring Plan		
PMTCT	Prevention of mother-to-child transmission		
PNDS	<i>Plan National de Développement Sanitaire</i> (National Health Development Plan)		



PNSR



PNSR

PNSR



EXECUTIVE SUMMARY

Country context

The U.S. Agency for International Development (USAID)-funded Integrated Health Project Plus (IHPplus) has been implemented in a context rife with development challenges, where women, infants, and children face dire health conditions and the health system faces a massive disease burden. Low-quality pregnancy and child-birth care contribute to high maternal and neonatal mortality, and diarrhea, malaria, respiratory infection, and chronic malnutrition to child deaths. The Democratic Republic of Congo (DRC) is a high-burden country for tuberculosis (TB), and for TB/human immunodeficiency virus (HIV) co-infection. Socioeconomic equity gaps are over 25 percentage points for critical coverage indicators.¹ The power dynamics and economics of gender drive harmful practices, such as early marriage, and are critical determinants of health service utilization and outcomes for women and girls. DRC ranks 149th out of 155 countries on

the Gender Inequality Index,² and only 46% of women participate in decisions about their own health care.³ Contraceptive use is very low, and fertility is high. Sexual and gender-based violence (SGBV) is prevalent—especially, and among men as well, in Eastern Congo—with devastating consequences for survivors.⁴ Years of conflict have left significant health system weaknesses. Health zone management is poor; health workers labor with insufficient skills, salary, resources, and security. Disjointed services are inconvenient for users and providers, and a lack of citizen ownership limits service utilization and accountability.

During the life of IHPplus, conflict in the Kasai region of central DRC, sparked by a violent local militia uprising that began in August 2016, caused significant population displacement and substantial disruption to the health system's ability to deliver essential health services. In Kasai Central province, host to 77% of the region's 1.3 million

internally displaced persons (IDPs), health service readiness was well below the national average even before the present crisis erupted. As a result, ongoing efforts to strengthen the health system to reliably and equitably deliver essential services through current IHPplus and President's Malaria Initiative (PMI) Expansion projects were disrupted. With funding from the Office of United States Foreign Disaster Assistance (OFDA), Management Sciences for Health (MSH) provided additional support to the health system in Kasai Central to coordinate with humanitarian actors to meet the urgent health needs of IDPs and others directly affected by conflict, while leveraging the ongoing capacity development and service delivery support it continued to provide through regularly programmed activities.

1 World Health Organization (WHO): Countdown to 2015; Maternal, Newborn, and Child Survival, *Democratic Republic of the Congo Health Data – 2015 Equity Profile* (Geneva: WHO, 2015), countdown2030.org/documents/2015Equity/CongoDRC_equity_2015.pdf

2 United Nations Development Programme (UNDP), *Human Development Report 2015: Work for Human Development* (New York: UNDP, 2015), hdr.undp.org/sites/files/2015_human_development_report.pdf

3 ICF International, *Demographic and Health Survey: Democratic Republic of the Congo* (Rockville, MD: ICF International, 2014), dhsprogram.com/pubs/pdf/FR300/FR300.pdf

4 Kristin Johnson et al., “Association of Sexual Violence and Human Rights Violations With Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo,” *JAMA* 304, no. 5 (2010): 553-562, doi: 10.1001/jama.2010.1086; and IMA World Health (IMA), with contributions by Lynn Lawry of OSC, *A Population-Based Household Study to Assess Practical Strategies of Prevention and Response to Sexual and Gender Based Violence In Katana, Walikale, and Karisimbi Health Zones, DRC* (Washington DC: IMA, 2016), <https://imaworldhealth.org/wp-content/uploads/2016/11/OSC-IMA-Ushindi-Baseline-2016-pdf>

Project performance

During three years of implementation, IHPplus made significant improvements in increasing facility-based health care services and products, improving quality health care services, and increasing knowledge, attitudes, and practices to support health-seeking behaviors in targeted health zones. The project achieved or surpassed targets (achievement rates of 100% or greater) for 47% of the indicators. Twenty-six (30%) of the indicators were almost achieved (75–99% achievement rate), and the project did not achieve 23% of its indicators (achievement rates less than 75%).

IHPplus made notable achievements in increasing facility-based health care services and products in target health zones. The project exceeded the targets for the percentage of general referral hospitals (GRHs) implementing the complementary package of activities (CPA), as well as the percentage of centers implementing the minimum package of activities (MPA). However, reducing stock-outs of tracer medicines remained challenging throughout the project due to a number of factors including insufficient quantity of pharmaceuticals ordered and delayed or extended delivery periods, coupled with poor accessibility of health facilities, insecurity, and poor infrastructure. As a result, the project did not achieve its target in reducing the number of health facilities experiencing stock-outs of Depo-Provera (11%), oral rehydration solution (ORS) (24%), folic acid (34%), and Artemisinin-based combination therapy (ACTs) (22%).

Malaria, diarrhea, and pneumonia are the three main killers of children under five in DRC. IHPplus' integrated community

case management (i-CCM) strategy was largely effective for increasing these community-based health care services. Project-supported providers treated 157,226 children with diarrhea, 105,281 children with pneumonia, and 235,255 children with malaria at i-CCM sites, with the most significant increases occurring between Project Year (PY)1 and PY2.

IHPplus almost achieved its target for increasing the number of people with first-time access to improved drinking water supply as a result of USG support, reaching a total of 513,492 for an achievement rate of 83%. The project's performance in increasing the number of people gaining access to an improved sanitation facility remained a challenge, however, reaching only a total of 366,970, for an achievement rate of 70%.

IHPplus improved the quality of health care services in all health areas. Performance was particularly strong in improving health results in the areas of maternal, neonatal, and child health (MNCH), family planning (FP), and nutrition. In the area of maternal, neonatal, and child health, IHPplus almost achieved, achieved, or exceeded performance for all indicators except for the number of USG-assisted facilities experiencing stock-outs of ORS during the quarter (achievement rate of 24%). IHPplus almost achieved, achieved, or exceeded performance for four out of the six FP indicators. Performance was particularly strong in improving couple years of protection (CYP) after exclusion of the Lactational Amenorrhea Method (LAM) and self-observation methods for FP; in the percent of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider; and in the number of community health workers (CHWs) providing FP

information, referrals, and/or services during the year. IHPplus exceeded targets for the proportion of pregnant women who received iron folate to prevent anemia, and almost achieved performance the number of mothers of children two years of age or less who received nutritional counseling for their children. Project results for the number of people trained in child health and nutrition through the project fell below the target.

IHPplus achieved or almost achieved four of the seven TB indicators and achieved or almost achieved 85% of its HIV indicators, or 17 of the total 20 indicators. The project did not achieve targets for three indicators: the number of adults and pediatric anti-retroviral therapy (ART) patients with a viral load result documented in the patient medical record within the past 12 months; the number of HIV-exposed infants with a documented outcome by 18 months disaggregated by outcome type; and the number of viral load tests from adult and pediatric ART patients conducted in the past 12 months with a viral load inferior to 1000 copies/ml.

Overall, TB results were strongest for the case notification rate in new sputum smear positive pulmonary TB cases and the therapeutic success rate for multidrug-resistant TB (MDR-TB). The project almost achieved targets for the therapeutic success rate of new smear positive TB cases and the percentage of HIV-positive patients screened for TB through USG-supported programs. Results related to the number of MDR-TB cases detected and the percentage of HIV-positive patients without TB receiving isoniazid (INH) prophylaxis fell below the project target.

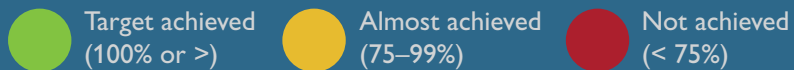
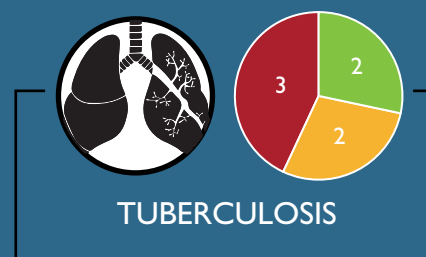
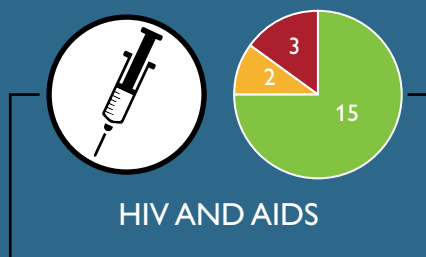
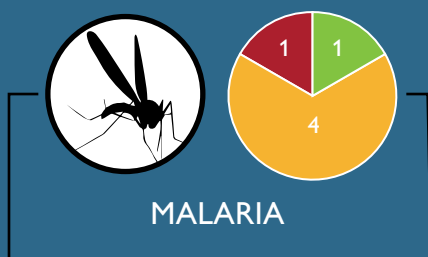
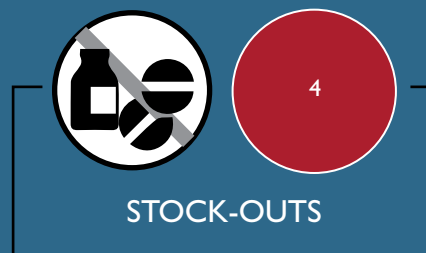
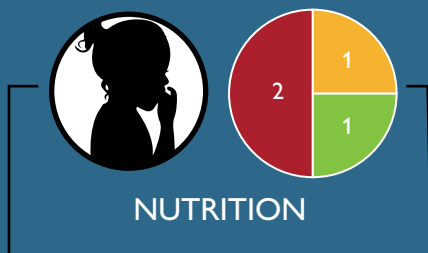
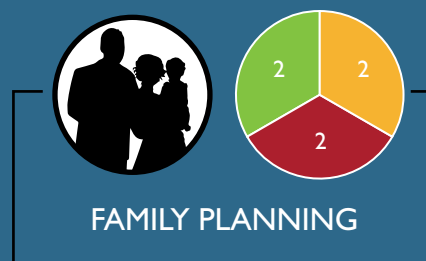
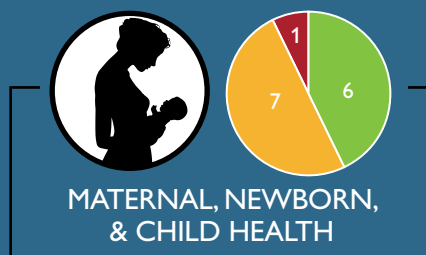


Fig 1. Project performance summary by number of indicators achieved
 Figures represent results from the period of October 1, 2015, to March 31, 2018, only.
 (see Appendix 1 for detail)



IHPplus almost achieved, achieved, or exceeded performance for five of the six malaria indicators. The strongest performing indicator was the percent of pregnant women who received at least two doses of sulfadoxine-pyrimethamine (SP) for Intermittent Preventive Treatment (IPT) during ANC visits. Increasing the number of patient referrals to health facilities is an important aspect of improving the quality of health services provided to the community. IHPplus exceeded results for the percent of patients referred to health centers and almost achieved the target for number of patients referred to a GRH after being seen by a CHW or health care provider.

With regard to improving gender-based services, IHPplus exceeded targets for the number of social and behavior change communication (SBCC) campaigns that delivered key health messages targeting

Key achievements

NOTE: Numbers presented in this report include only the period between October 1, 2015, and March 31, 2018. The first quarter of IHPplus PY1, June through September 2015, was included in the reporting for IHP during transition. For April through June 30, 2018 (Q4 PY3), numbers were not available at the time of this writing.

IHPplus was designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices for more than 31 million people in nine provinces of the DRC with 168 target health zones (an increase of 115 percent from the 78 health zones supported by IHP).

women and girls and for the number of people reached by a USG-supported intervention providing SGBV services (e.g., health, legal, psychosocial counseling, shelters, hotlines, and other).

IHPplus continued to implement the *Formation Sanitaire Complètement Fonctionnelle* (FOSACOF, or fully functional service delivery point, in English) and results-based financing (RBF) approaches to promote the adoption of minimum quality standards at health facilities and improve the quality of care. The project did not achieve its target for the percentage of health facilities and GRHs that completed an evaluation of the nine FOSACOF minimum standards. RBF evaluations demonstrated that the RBF approach contributed to an increase in the utilization rate of curative services and the quality of health center and GRH services.

Through comprehensive community- and facility-based support, IHPplus created healthier communities and saved lives. Some of the project's key achievements included:

- Saving the lives of more than 88,000 children and newborns
- Counseling approximately 2.3 million mothers of children under two years of age about proper nutrition
- Providing access to assistance from a skilled birth attendant (SBA) for more than 1 million women
- Providing approximately 1.2 million children less than 12 months of age three doses of diphtheria, tetanus, pertussis (DTP), Hepatitis B (HepB), and Haemophilus Influenza type B (Hib) (or DTP-HepB-Hib3)

IHPplus' performance in increasing knowledge, attitudes, and practices to support health-seeking behaviors was strong. The project almost achieved, achieved, or exceeded targets for the majority of community mobilization and SBCC strategies, including the percentage of communities with active *Comité de Développement Sanitaire* (CODESAs, or health development committee, in English) the number of CODESAs with a communication action plan, the number of Champion Communities achieving the deliverables set in their significant fixed amount awards, and the number of youth organizations conducting awareness raising campaigns. These strategies also proved effective in increasing and improving the quality of health services.

- Providing antiretroviral therapy (ART) to approximately 4,600 HIV-positive adults and children
- Providing access to an improved drinking water source for more than 500,000 people
- Providing CYP for approximately 1.1 million clients who have accepted a modern contraceptive method
- Providing almost 1.2 million newborns with essential neonatal care





PROJECT BACKGROUND

This report covers the life of project results of the US Agency for International Development (USAID)-funded Integrated Health Project Plus (IHPplus) in the Democratic Republic of Congo (DRC). Implemented by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd. (OSC), under a subcontract via Pathfinder/Evidence to Action (E2A), IHPplus was implemented from June 2015–June 2018 to avoid a gap in services in USAID-supported health zones upon completion of the USAID Health Office’s five-year flagship Integrated Health Project (IHP) in September 2015. Field activity implementation started in October 2015 to complement the end of IHP.

IHPplus aimed to improve the basic health conditions of the Congolese people in selected health zones. The objective contributed to the United States Government (USG) Country Development and Cooperation Strategy and emerging USG priorities in the Global Health Initiative. The project fully supported: (1) the Government of the DRC policies and strategies for the health sector, as articulated in its Health Systems Strengthening Strategy (*Stratégie de Renforcement du Système de Santé*/SRSS) (2010); and (2) the 2016-2020 National Health Development Plan (*Plan National de Développement Sanitaire*/PNDS). Project workplans aligned with the Ministry of Health (MOH) planning framework based on its annual operational plans (AOPs).

The original, five-year DRC-IHP worked

closely with the Government of DRC to strengthen the country’s health system at every level and to achieve the MOH target of saving the lives of 437,000 mothers and children over five years. Data modeling using the Lives Saved Tool (LiST) showed that IHPplus contributed towards saving more than an estimated 88,000 lives of children and newborns.

The final report of the original DRC-IHP was entitled *Working Together, Saving Lives*, in recognition of the many strengthened partnerships which resulted from the project. This IHPplus report is entitled *Empowerment Builds Capacity for Stronger, Healthier Communities* to emphasize the important role that community empowerment played, building on those initial partnerships, in the success of IHPplus—and its sustainability going forward.

Continuing the work of DRC-IHP, IHPplus addressed “Services” and “Other Health Systems” to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices initially in 83 health zones in Project Year (PY)1 and in a total of 168 health zones by the end of PY3 (including the original 78 of IHP, 48 former President’s Malaria Initiative [PMI]-focused zones,⁵ and 42 former PMI-Expansion Project health zones⁶), within nine *Divisions Provinciales de Santé* (DPS, or Provincial Health Divisions). These are: 1) Kasai; 2) Kasai Central; 3) Lomami; 4) Kasai Oriental; 5) Sankuru; 6) Haut Lomami; 7) Lualaba; 8)

Sud Kivu; and 9) Haut Katanga (formerly the four provinces of Kasai Occidental, Kasai Oriental, Katanga, and Sud Kivu).

IHPplus provided varying levels of support to the project-supported health facilities and general referral hospitals (GRHs) throughout the life of project. At project start, IHPplus was providing support to 1,562 facilities (1,479 health centers and 83 GRHs), and by the end of PY3, the project was supporting a total of 3,994 health facilities (3,826 health centers and 168 GRHs). In addition to maintaining a project office in Kinshasa to facilitate communication with the MOH, other host government authorities, and USAID, IHPplus had eight coordination offices to facilitate activity implementation at the field level. To ensure consistency and continuity of data analysis, IHPplus reported its achievements based on the coordination “clusters” of Bukavu, Kamina, Kolwezi, Lodja, Luiza, Mwene Ditu, Tshumbe, and Uvira—the same clusters used under the previous IHP.

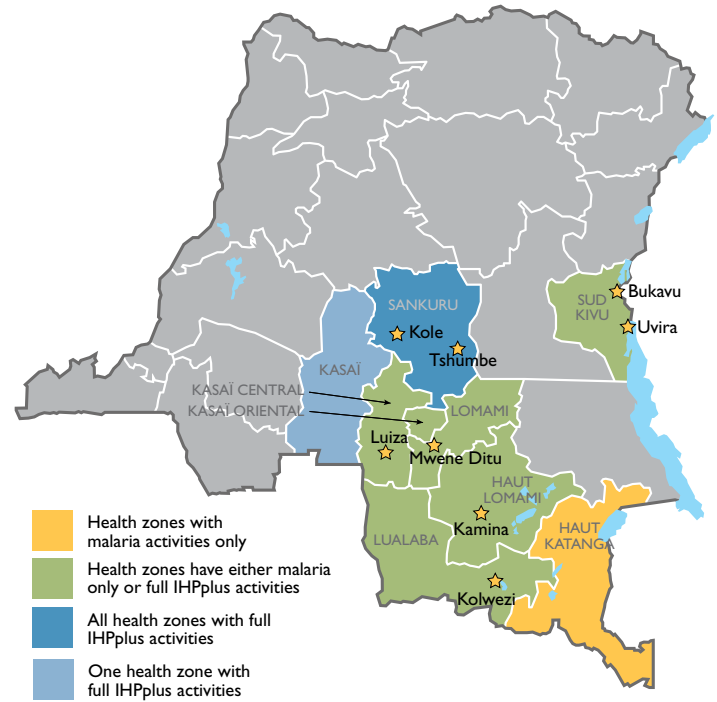
The overarching objective of the project was to improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for family planning (FP); maternal, neonatal, and child health (MNCH); nutrition; malaria; tuberculosis (TB); HIV and AIDS; and water/sanitation/hygiene (WASH) in target health zones (see Figure 2, page 8). Several cross-cutting priorities were included for each IHPplus technical area, including sustainability, gender, and SGBV.

5 The 48 health zones were comprised of former Global Fund, Systems for Improved Access to Pharmaceuticals and Services (SIAPS) program, Malaria Care, USAID|DELIVER and Measure Evaluation (covering only malaria activities) health zones.

6 IHPplus began supporting the 42 former PMI-Expansion project health zones in PY3Q3.



Fig 2. Map of IHPplus activity areas



Dr. Blandine Kalafula, above, head doctor at Bukavu Prison, led an anti-tuberculosis campaign funded by IHPplus in 2017. The results were astonishing. There were 1,523 prisoners at the prison when the campaign was held. Prisoners who had a cough – 740 – were tested. Of these, 22 tested positive, an astonishingly high number. Those who tested positive all received treatment through DRC’s National Campaign Against Tuberculosis. Photo by Rebecca Weaver.

The IHPplus strategy integrated activities across health system sectors, levels, and geography through people-centered health systems strengthening.

At the heart of the strategy was outreach to providers, health authorities, community organizations, and families with evidence-based techniques they could use to impact the health system in ways they experienced as meaningful and sustainable.

USAID/DRC designed a new portfolio of programs to ensure the programmatic continuity of its two completed flagship service

delivery programs: the Integrated HIV Program (ProVIC) and IHP. Since these two programs ended before the new programs could be launched, to avoid major disruptions in services the mission continued key activities from both of these programs through the USAID/Washington-managed mechanism, E2A, as a “bridge mechanism.”

In PY2, at USAID’s request, IHPplus incorporated activities from the Supply Chain Management System (SCMS) and Systems for Improved Access to Pharmaceuticals and Services (SIAPS) projects into its workplan to continue to provide the essential health activities and services of those projects

and sustain USAID investments. As such, IHPplus ensured the availability of medications in IHPplus-supported health facilities and strengthened the management of essential medicines and medical consumables. Staff from these two projects joined the IHPplus team in November 23, 2016, following the SIAPS and SCMS project closeout.

IHPplus’ people- and team-centered approach aimed to strengthen the health system in DRC by focusing on the four intermediate results detailed in Table 1.

Table 1. IHPplus results framework

IHPplus Objective: Improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for family planning; maternal, newborn, and child health (MNCH); nutrition; malaria, and tuberculosis (TB); HIV and AIDS; and water/sanitation/hygiene (WASH) in target health zones.			
Intermediate Result (IR) 1	Intermediate Result 2	Intermediate Result 3	Intermediate Result 4
Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	Quality of key family health care services (MPA/CPA-plus) in target health zones increased	Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones	Health sector leadership and governance in target provinces improved
Strategies/Activities by Sub-Intermediate Result			
<p>1.1: Increased facility-based health care services/products</p> <ul style="list-style-type: none"> ■ Provide materials and equipment ■ Provide essential medicines, commodities, and materials <p>1.2: Increased community-based health care services/products</p> <ul style="list-style-type: none"> ■ Integrated Community Case Management (i-CCM) at community treatment sites ■ <i>Comité de Développement Sanitaire</i> or health development committee (CODESA) collaborative strategy at community level <p>1.3: Effectively engaged provincial management</p> <ul style="list-style-type: none"> ■ Leadership Development Program (LDP) 	<p>2.1: Clinical and managerial capacity of health care providers</p> <ul style="list-style-type: none"> ■ Training, supportive supervision <p>2.2: Minimum quality standards</p> <ul style="list-style-type: none"> ■ Fully functional service delivery point (FOSACOF) ■ Results-based financing (RBF) <p>2.3: Primary health care referral system for prevention, care, and treatment</p> <ul style="list-style-type: none"> ■ Community health worker to health center referrals ■ Health center to GRH referrals 	<p>3.1: Health sector community outreach linkages</p> <ul style="list-style-type: none"> ■ CODESA ■ Youth outreach groups <p>3.2: Health advocacy/community mobilization organizations</p> <ul style="list-style-type: none"> ■ Education Through Listening ■ CODESA <p>3.3: Behavior change campaigns</p> <ul style="list-style-type: none"> ■ Social and behavior change communication (SBCC) messaging ■ Mini-campaigns ■ Champion Communities 	<p>4.1: Health sector policy alignment</p> <ul style="list-style-type: none"> ■ Gender equity activities <p>4.2: Evidence-based strategic planning and decision-making</p> <ul style="list-style-type: none"> ■ Strengthening M&E systems ■ Support to DHIS2 <p>4.3: Community involvement in health policy and service delivery</p> <ul style="list-style-type: none"> ■ Leveraging relationships with civil society for SBCC messaging

IR1

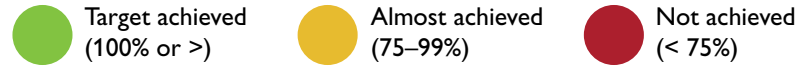
INTERMEDIATE RESULT 1

Access to and availability of minimum package of activities (MPA) and complementary package of activities (CPA) services and products in target health zones increased

- IR 1.1 Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased
- IR 1.2 Community-based health care services and products in target health zones increased
- IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery







All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

IR 1.1 FACILITY-BASED HEALTH CARE SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED

Utilization of health care services

At the end of PY3, IHPplus reported a 45% average utilization rate of health care services among health centers in the project-supported coordinations, only a slight decrease from the 46% achieved at the end of IHP, remaining below the national target of 50% (Figure 3). While Kolwezi was the only coordination where the three-year average surpassed the national target, its service utilization rate decreased during the life of the project, falling from 63% in PY1 to 48.4% in PY3 as a result of poor quality and completeness of data in the District Health Information System 2 (DHIS2) from some health zones.

Overall, the failure to achieve the national target across the majority of coordinations is due to the following factors:

- Ongoing and extensive stock-outs of essential generic medicines (EGM) in some health zones from procurement delays encountered by the project, including ACTs and rapid diagnostic tests (RDTs), as well as EGM retention by some health zone central offices;
- Difficulty reaching and accessing populations, especially in the flood-impacted areas around health facilities during the rainy season (Kamina);
- Lack of actual implementation of pay-per-use fees in health facilities (as a result of varying fee structures across different facilities);
- Incomplete internal data in the majority of health zones in the Tshumbe coordination due to ongoing instability in internet access and the movement of data managers.

The poor performance recorded in the Mwene Ditu and Luiza coordinations during PY3 is a result of the ongoing insecurity in the Kalenda, Kamiji, and Wikong health zones (Mwene Ditu), and across all of the health zones in Luiza, where facilities have either been destroyed or are no longer operational.

To help increase the timeliness and completeness of health zone data in the DHIS2, IHPplus provided funding to all the health zones and DPSs within the project-supported coordinations to purchase laptops and modems. These modems are recharged with bandwidth on a monthly basis to upload data in DHIS2.

Fig 3. Curative services utilization by coordination office

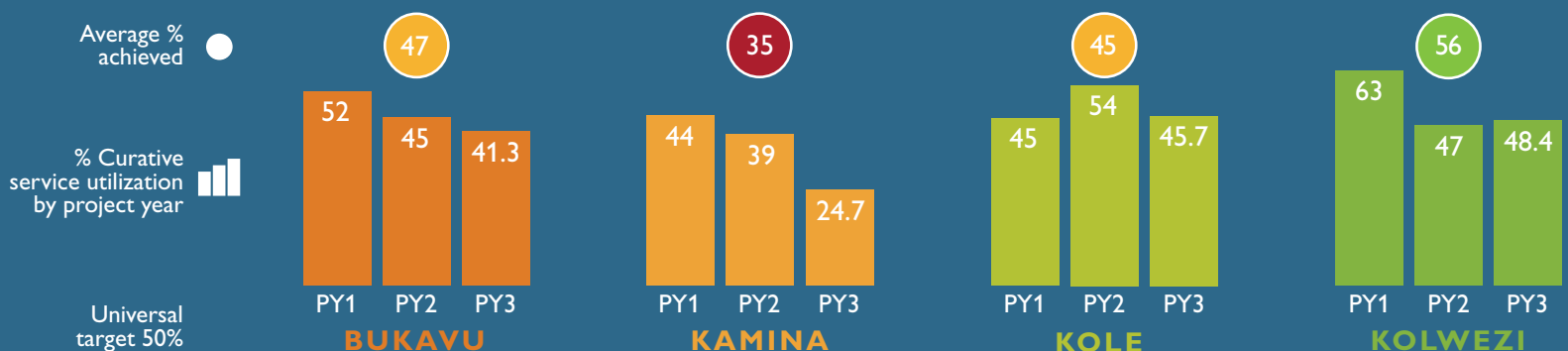
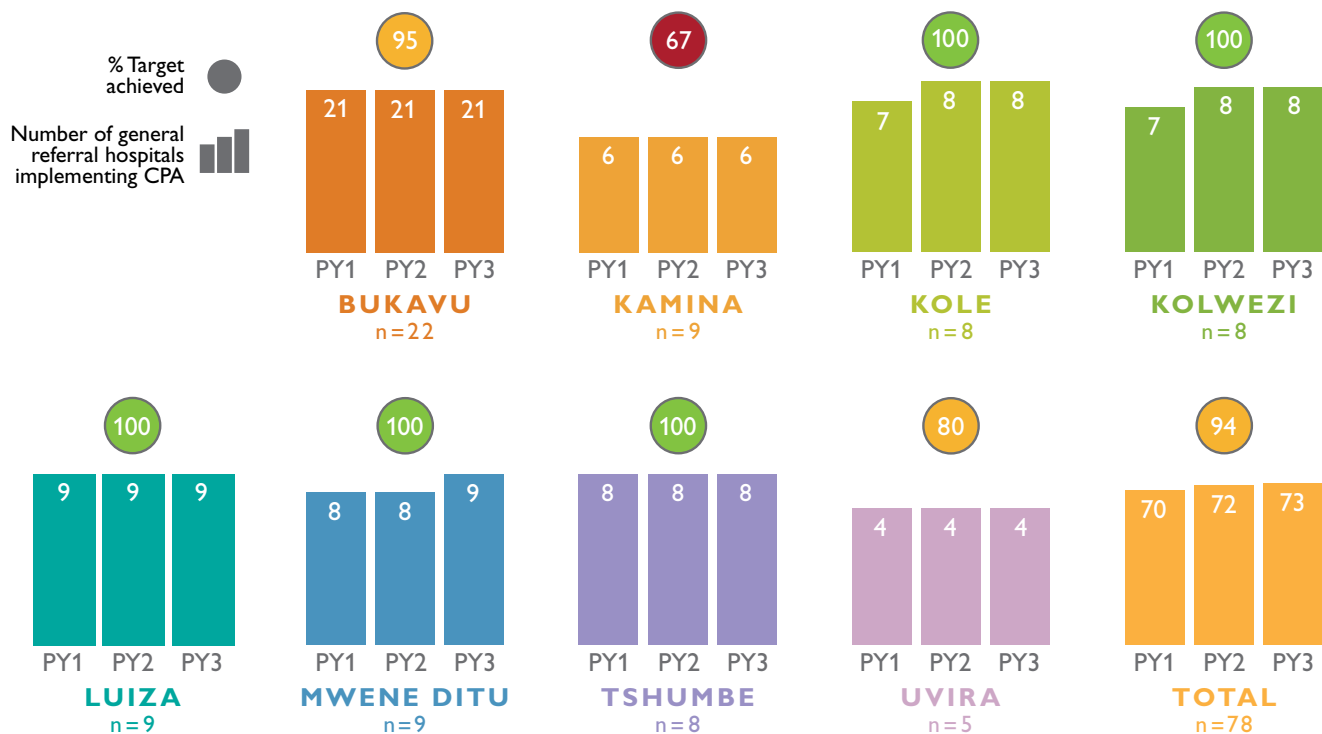


Fig 4. Number of GRHs implementing CPA by coordination office



Availability of health services - facility-based minimum package of activities/complementary package of activities

During the course of IHPplus, the complementary package of activities (CPA) was implemented in 94% (73/78) of the project-supported GRHs, as presented in Figure 4. In PY2, the Dipeta health center in the Fungurume health zone (Kolwezi coordination) earned the status of GRH due to investments and funds collected through

the RBF approach implemented through IHPplus, as well as donation of equipment and materials by the health zone management team. Dipeta is now comprised of four units—surgical, internal medicine, obstetrics, and pediatrics. In the Kole coordination, the Omendjadi referral health center was also inaugurated as a GRH in

PY2 thanks to the support of IHPplus and the health zone management teams.

With support of the health zone management teams (HZMTs), IHPplus supplied the equipment and material—including delivery tables for birth and desks for consultations—to all GRHs located in health zones supported by the project.

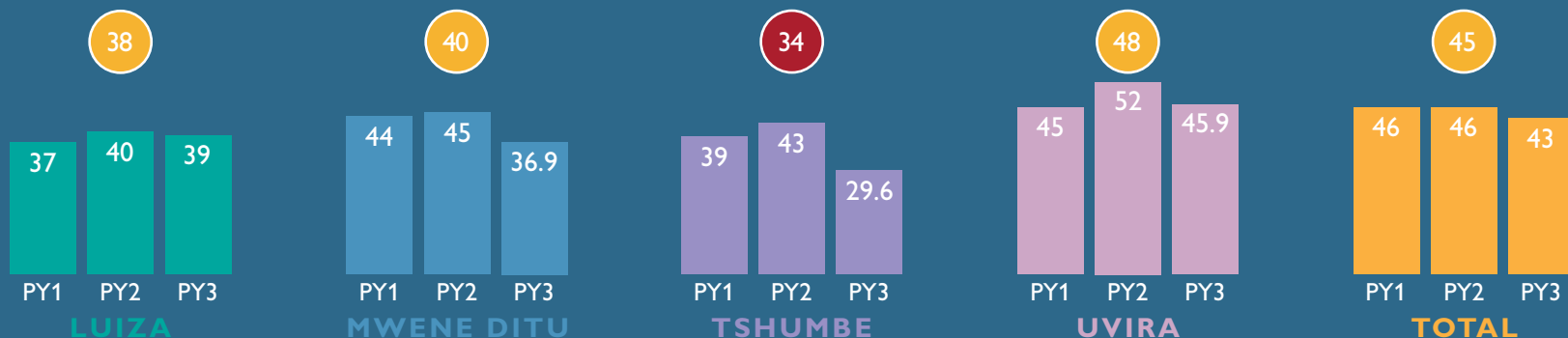


Fig 5. Number of health centers implementing MPA by coordination office

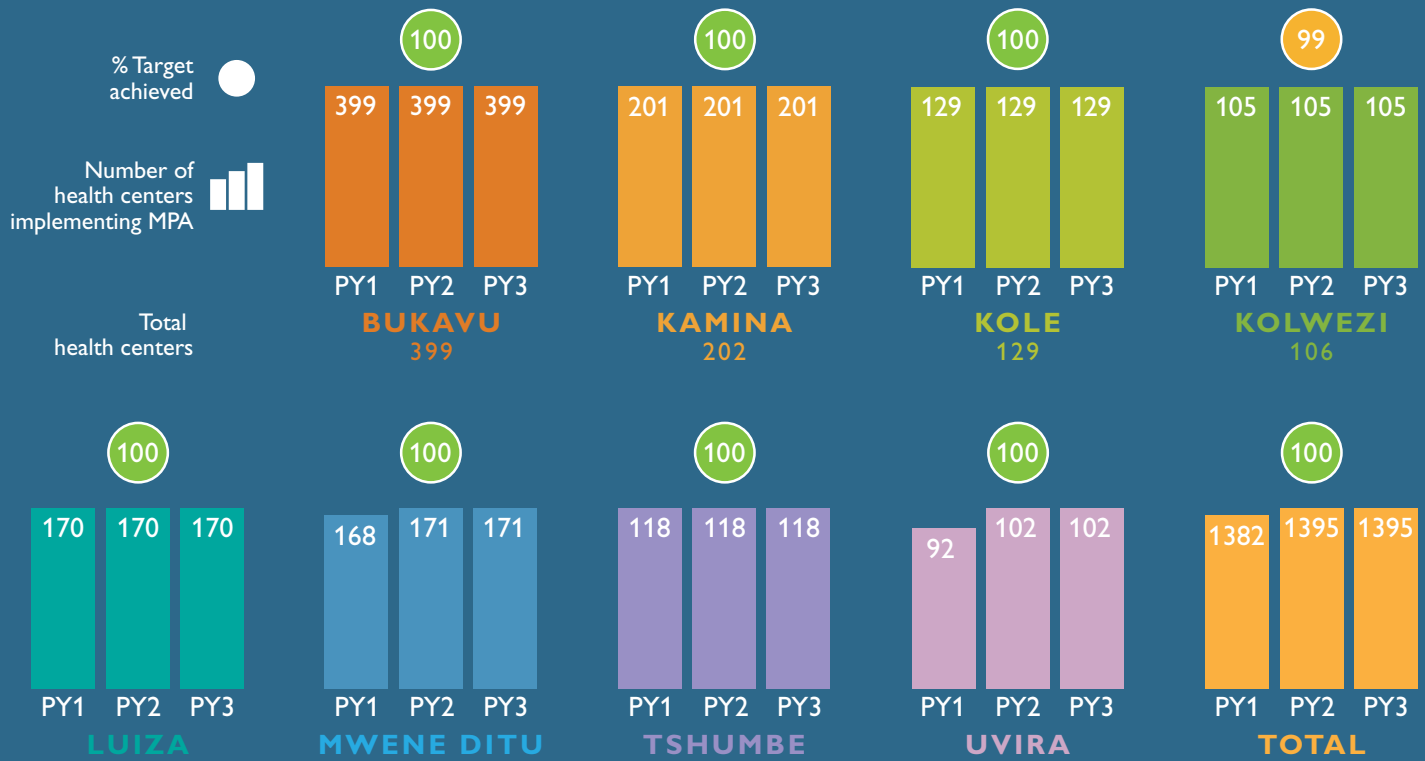
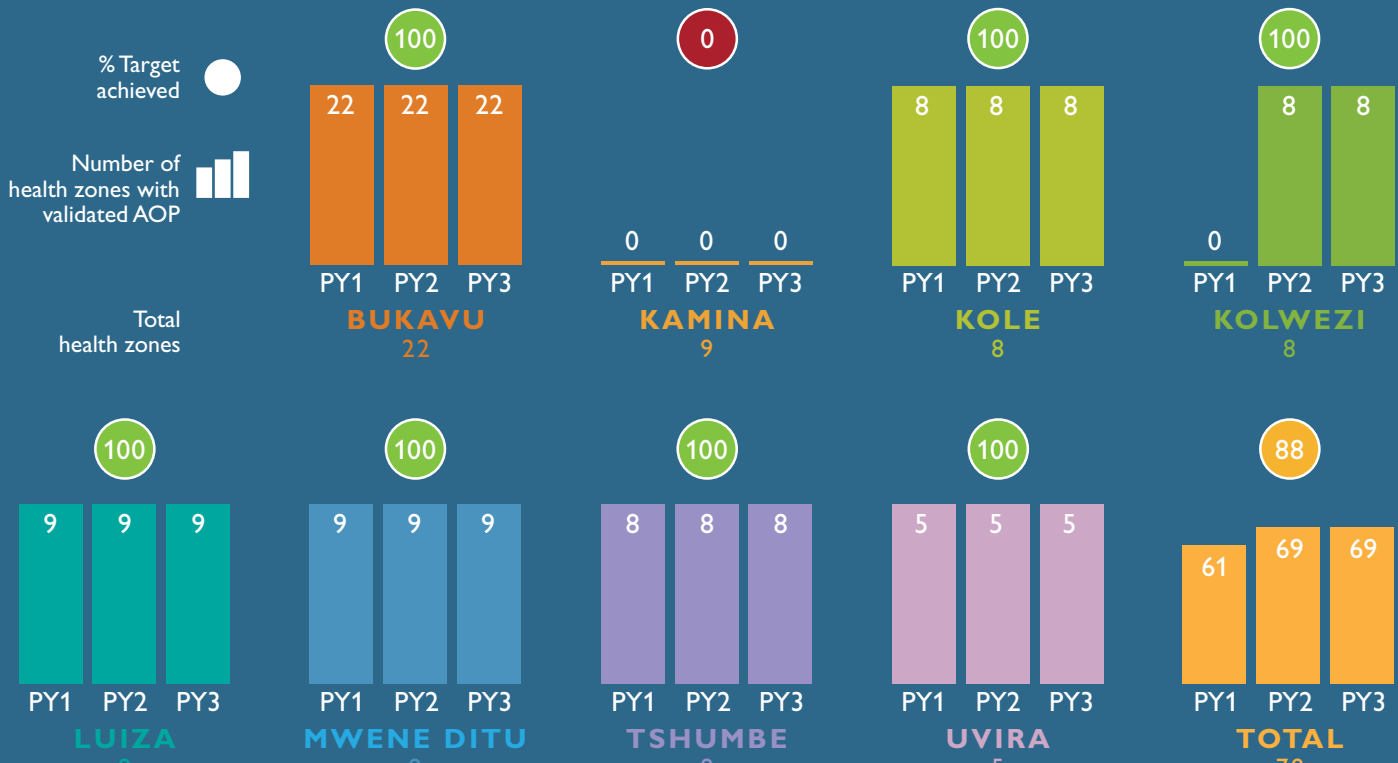


Fig 6. Number of health zones with an AOP



Number of health centers implementing minimum package of activities

As of PY3, the minimum package of activities (MPA) was implemented in approximately 100% (1,395/1,397) of all project-supported health centers, in line with the project target of 100% (Figure 5). This strong performance throughout the life of project has allowed for the implementation and provision of preventive and curative

services in these health centers in an effort to increase the quality of services offered to the population.

Over the life of project, IHPplus supported the development and validation of AOPs across health zones, achieving a 100% achievement rate in all coordinations except for Kamina (Figure 6). In the case of Kamina

(0%), the coordination was unable to organize even one board meeting to validate its AOP as a result of the cholera outbreak, as well as other coordination-specific challenges including scheduling conflicts of board members, changes in provincial authorities, and the cVDPV campaign. The overall achievement rate for the indicator is 88%.

Availability of medicines, commodities, and equipment

IHPplus' role in ensuring the availability of medicines, commodities, and equipment changed throughout the life of the project. IHPplus procured essential generic medicines (EGM) in two subsequent orders in collaboration with SIAPS who provided technical support for the quantification and the monitoring of the deliveries of these orders to IHPplus-supported *Centrales de Distribution Régionales* (CDRs or regional distribution centers, in English). As agreed with USAID, the third order of EGMs was transferred to the Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) in December 2016 following the foreseen IHPplus closeout and funding uncertainty.

During PY1, IHPplus provided funding for the storage and management fees in CDRs, and distribution from CDRs to health zones to health facilities of all pharmaceuticals including EGM, malaria, family planning, and HIV commodities. SIAPS was responsible for providing technical support improve the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. During PY2, following the close out of SCMS and SIAPS, USAID requested that IHPplus incorporate activities from both projects in its work plan in order to maintain the provision of essential

health activities and services. In PY3 (as of October 1, 2017), IHPplus transferred to the new USAID mechanism led by the Global Health Supply Chain-Technical Assistance (GHSC-TA) the role of providing technical and financial support for the storage and management in CDRs, and distribution from CDRs to health zones of all pharmaceuticals including EGM, malaria, family planning, and HIV commodities. IHPplus' role was limited to funding the distribution of and monitoring the availability of essential generic medicines and other pharmaceutical commodities at the health facility level.

ENSURE THE AVAILABILITY OF MEDICATIONS IN IHPplus-SUPPORTED HEALTH FACILITIES

IHPplus collaborated with SIAPS to complete the quantification of health zones needs, monitor the delivery of several IHPplus' EGM orders with suppliers by developing distribution plans and monitoring the process of obtaining all documents to facilitate the customs clearance process and the transportation of goods to IHPplus-supported CDRs. SCMS was responsible for ensuring that the HIV commodities are quantified, ordered, and delivered in the IHPplus contracted CDRs. IHPplus collaborated closely with the USAID|DELIVER project responsible for quantifying, ordering, and delivering malarial commod-

ities in CDRs and contraceptives in the IHPplus-managed warehouse in Kinshasa.

IHP PY5 emergency orders 1 and 2:

IHPplus monitored IHP PY5 emergency orders 1 (valued at \$322,333.37) and 2 (valued at \$702,641.60) with IDA and IMRES, respectively. In total, 100% of both orders was delivered.

IHPplus orders (1–2):

IHPplus monitored order #1 with suppliers IDA, IMRES, MEG, and ASRAMES and order #2 with Mission Pharma. Order #2 was quantified to include the anticipated needs for 6–9 months of EGM for IHP-DRC (the follow-on project to IHPplus) with a priority focus on the 13 life-saving commodities for mothers and children.

Table 2 on page 16 illustrates the total project funds for storage and delivery of medicines to health facilities (by province).

IHPplus order 3:

IHPplus established quantities for a third order in September 2016; however, USAID later decided that the GHSC-PSM project would be responsible for placing and delivering this order. The delivery is currently scheduled to arrive around March 2019.

Emergency order for eight EGMs:

As agreed with USAID in March 2018, IHPplus placed an emergency order with

Table 2. IHPplus funding for storage and delivery of medicines to health facilities

Province	Warehouse (CDR)	PY	Storage Costs (USD)			Delivery Costs to Health Facility			TOTAL
			Malaria	HIV	FP	Malaria	HIV	FP	
Sud Kivu	APAMESK, 8th CEPAC, and BDOM	PY1	275,921		17,515	63,874			357,310
		PY2	97,519			61,998			159,517
Kasaï Central	CADIMEK	PY1	43,192		7,683	16,210			67,085
		PY2	44,789		4,052	15,326			64,167
Kasaï Oriental	CADMEKO	PY1	42,418			19,334			61,752
		PY2	37,219			37,914			75,133
Sankuru	CAMESANK	PY1	26,942			14,249			41,191
		PY2	32,722		2,740	36,795			72,257
Lualaba	CAMELU	PY1	38,834		9,665	33,825			82,324
		PY2	89,472	146,186	4,107	116,490			356,255
Kinshasa	CAMESKIN	PY1							0
		PY2		268,181			9,567		277,748
Order/Delivery Total			729,028	414,367	45,762	416,015	9,567	0	1,614,739

Table 3. Status of emergency order for eight EGMs

CDR	Total order value (USD)	Order delivered as of July 2018 (USD)	Order remaining to deliver as of July 2018 (USD)
APAMESK	106,275.35	67,493.28	38,782.07
BDOM Bukavu	97,469.01	72,239.97	25,299.04
CAMELU Kolwezi	55,026.97	55,026.97	0
CAMESANK – Lodja	195,226.29	162,112.39	33,113.90
CEPAC Bukavu / Depot Pharm	91,516.33	60,260.79	31,255.54
Depot Chemonics Kamina	15,257.03	15,257.03	0
MSH / CADIMEK – Kananga	74,681.84	29,315.70	45,366.14
MSH / CADMEKO – Mbuji Mayi	71,302.00	46,732.03	24,569.97
Order/Delivery Total	706,754.82	504,438.16	\$193,316.66
Level of execution	100%	72%	28%

All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

ASRAMES for eight essential medicines to help fill the gap in stock at health facilities. These eight EGMs were selected out of the 28 priority items, in agreement with USAID, based on short delivery time. The status of the orders as of July 2018 is presented in Table 3.

STRENGTHEN THE MANAGEMENT OF ESSENTIAL MEDICINES AND MEDICAL CONSUMABLES

Management of expired and medicines and commodities at risk of expiration:

In 2017 (quarter three), the project observed that large quantities of commodities, especially the 13 life-saving medicines for women and children, were underutilized and reaching expiration by December 2017. To avoid product losses, the project implemented emergency measures, including briefings and awareness sessions with DPS, members of the health zone leadership teams, and providers about the use of these products; mini-campaigns about the treatment of pneumonia, simple malaria, and diarrhea in most health zones of all IHPplus coordinations except Luiza; distribu-

tion of norms and user guides for eight of the 13 life-saving medicines; and redeployment of commodities at risk of expiration from CDRs to health zones and to health facilities and i-CCM sites in collaboration with PMI-Expansion and Measure Evaluation. As a result, commodities valued at \$716,588.27 were saved in five CDRs based on inventory conducted at the end of June 2017.

As part of its technical assistance to the DPS, IHPplus also supported the DPS to hold quarterly technical medicine group meetings. These meetings focused mainly on coordinating commodity supplies to ensure their availability in health facilities and avoid overstocks in CDRs. IHPplus also organized meetings to develop strategies for increasing the use of IHPplus products nearing their expiration date and overstocked in the CDRs and to discuss the issue of managing and safeguarding revenues generated by the medicines.

The project provided technical and financial support to *Inspecciones Provinciales de la Santé*

(IPS) and DPS for the disposal of expired products in all partner CDRs and supported the completion of half-yearly inventories in the MSH/Kinshasa warehouse.

Management of ongoing stock-outs:

PY3 was marked by stock-outs in health zones due to delays in the delivery of the third order placed by GHSC-PSM (delivery scheduled for February 2019). IHPplus collaborated with USAID and Global Health Supply Chain Project-Technical Assistance (GHSC-TA) to discuss the most realistic options to address stock-outs in health facilities for the interim period. The prioritized options included the following: (1) expediting a local procurement from ASRAMES; (2) asking the MOH to instruct the health zones to use their funding set aside in CDRs or their bank accounts to buy medicines and commodities (see Table 4 for the health zone savings per province); and (3) Working with USAID, GHSC-TA, and the World Bank, which had enough EGM stock in Lubumbashi and Kinshasa

Table 4. Health zone savings per province (from use of their EGM credit lines during IHP and IHPplus)

Province	CDR	Number of health zones	Funds available (USD)	Observations
Kasaï Central	CADIMEK	9	134,875	Funds managed by CADIMEK
Kasaï Oriental	CADMEKO	9	115,007	Funds managed by CADMEKO
Lualaba	CAMELU Kolwezi	8	11,802	Funds managed by health zones
Sankuru	CAMESANK	16	153,297	Funds managed by DPS
Sud Kivu	BDOM Bukavu	27	665,176	Funds managed by health zones in their respective bank accounts
	APAMESK			
	DCMP 8th CEPAC			
Haut Lomami	Chemonics warehouse (BRASSIMBA)	9	37,485	Funds managed by health zones in their respective bank accounts
Order/Delivery Total		78	1,117,641	

for its PDSS, to deliver the medicines from the World Bank PDSS to the common USAID-World Bank health zones to address the stock-out situation, especially in Haut Katanga, Haut Lomami, and Lualaba. As for provinces supported by USAID but not the PDSS (including Kasai Central, Kasai Oriental, Lomami, Sankuru, and Sud Kivu), GHSC-TA conducted an assessment of stock needs, and USAID/DRC submitted a request to the World Bank to borrow stock to meet these needs.

Warehouse management:

In collaboration with SIAPS, IHPplus worked to improve commodity management and monitoring by making improvements to the Kinshasa warehouse (including installing air conditioning units to decrease the room temperature to 23 degrees Celsius, in alignment with national standards). Once the renovation work was completed, SIAPS and IHPplus moved the commodities previously stored in the PROCOKI warehouse to the Kinshasa warehouse, which improved the efficiency of commodity management and monitoring.

Technical assistance to CDRs:

CDRs requested SIAPS and IHPplus assistance in managing multiple orders. The projects supported CDRs to reconcile purchase orders with packing lists, aligning proof of delivery with bills of lading; produce an accurate and complete inventory of all the commodities received; and monitor CDR compliance with IHPplus norms and contractual terms.

Supervision of medicines management:

IHPplus and SIAPS led quarterly supportive supervision missions to CDRs. Supervision teams provided assistance in reconciling orders and provided coaching on good pharmaceutical practices, including availability and use of management tools, monitoring and evaluation of storage conditions, and verification of discrepancies between

reported and physical stocks.

MINIMIZE STOCK-OUTS OF TRACER MEDICINES

Long-standing supply chain issues—which include insufficient quantity of pharmaceuticals ordered and delayed or extended delivery periods, coupled with poor accessibility of health facilities, insecurity, and poor infrastructure of roads weakened during the rainy season, among other challenges—contributed to stock-outs of tracer medicines (Depo-Provera, folic acid, artemisinin-based combination therapy [ACT], and oral rehydration solution [ORS]) throughout the project.

IHPplus implemented several strategies to reduce stock-outs, including subsidizing the transport of commodities from health zone central offices to health centers and i-CCM sites, using push and pull approaches for supplying health facilities, and organizing supportive supervision in supply chain management, among others.

Overall, the number of health facilities reporting stock-outs remained higher than project targets, with the number of folic acid stock-outs recording the best performance (587 health facilities reporting stock-outs compared to the target 100; 34% achievement), followed by stock-outs of ORS (422 compared to the target 100; 24% achievement), ACT stock-outs (465 compared to the target 100; 22% achievement), and Depo-Provera stock-outs (640 compared to the target 70; 11% achievement). The number of stock-outs for each tracer medicine per coordination are outlined below. For most medicines, except ACT, the project reduced the number of stock-outs from PY1 to PY3.

Stock-outs of Depo-Provera:

The highest number of Depo-Provera stock-outs was 640 in PY1, followed by 318 in PY2, and 177 in PY3. Compared to the target of 70, this represents an achievement rate of 11% (Figure 7A).

Performance improved significantly from PY1 to PY3. Kamina coordination reported the largest number of health facilities with stock-outs, with an annual average of 247 in PY1 and 107 in PY2.

Some of the stock-outs reported are “false” stock-outs; at times, these products are available at CDRs or health zone central office warehouses. Other factors contributing to poor performance include insufficient estimation of needed quantities in health areas, logistical challenges particularly in the Kamina and Bukavu coordinations, insecurity, and poor accessibility of health facilities, among others.

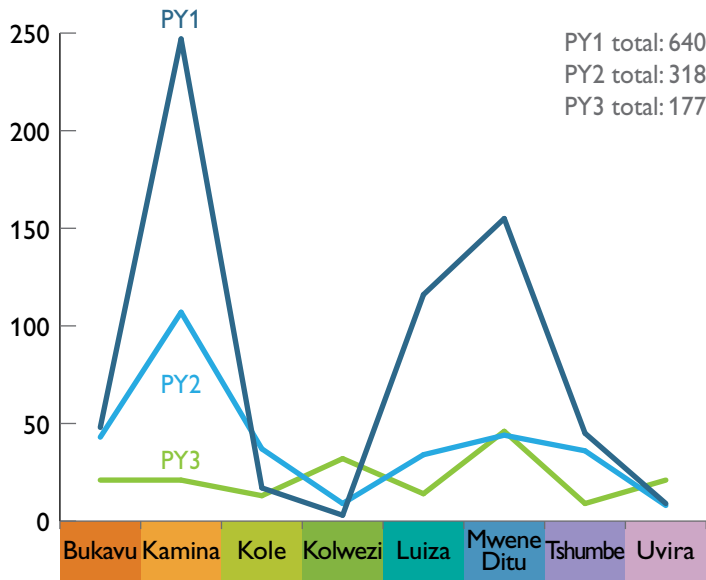
Stock-outs of folic acid:

As indicated in Figure 7B, the highest number of folic acid stock-outs was 587 in PY1, followed by 339 in PY2, and 161 in PY3. Compared to the project target of 200, this represents an achievement rate of 34%.

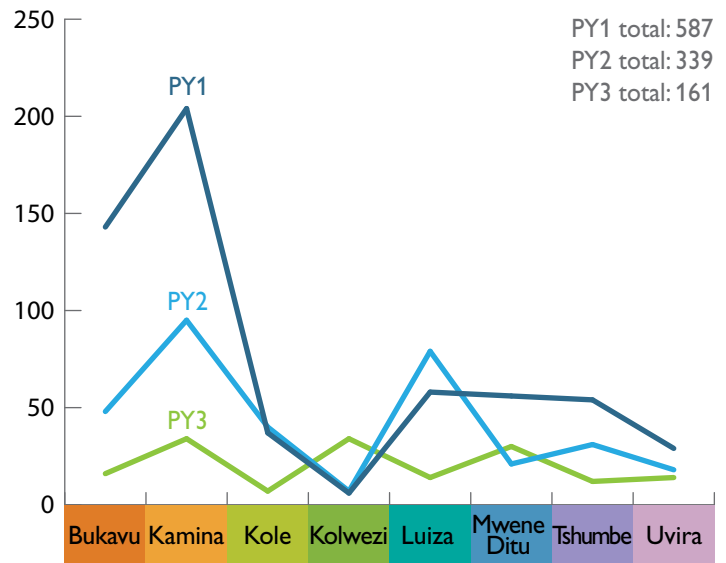
Performance improved from one year to the next as a result of several strategies, including transporting stock from CDRs to health zone central offices, health facilities coming to health zone central offices to receive stock each month, and regular monitoring of the management of folic acid at health facilities. Ongoing challenges include health providers’ lack of understanding of the average monthly consumption of medicines and irregular supply of sufficient quantities of stock based on consumption needs.

Fig 7. Stock-outs by essential medicine and project year

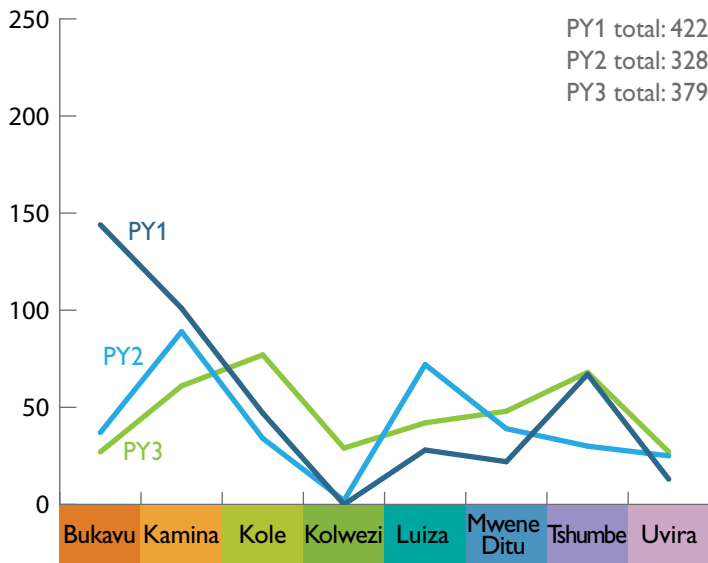
A. Stock-outs by PY, Depo-Provera



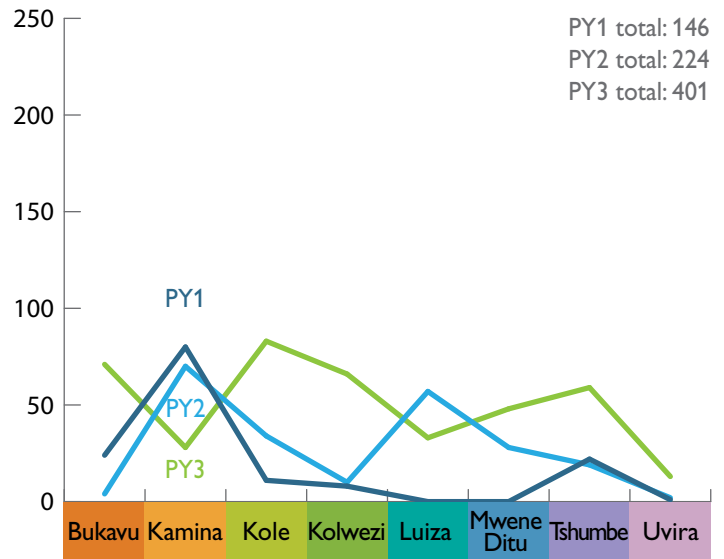
B. Stock-outs by PY, folic acid



C. Stock-outs by PY, ORS



D. Stock-outs by PY, ACT 1-5



All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

Stock-outs of ORS:

As shown in Figure 7C on page 19, the highest number of ORS stock-outs was 422 in PY1, followed by 328 in PY2 and 379 in PY3. Compared to the target of 100, this represents an achievement rate of 24%.

The Kamina coordination consistently reported the highest number of health facilities with stock-outs, due to ongoing challenges with distribution to the area because of difficult access. Insecurity also contributed to stock-outs in Luiza in PY2. The increase in the number of stock-outs in PY3 relates to “false” stock-outs: while stock-outs were reported at health facilities, commodities were available at CDRs. Delays in delivering commodities from CDRs to health facilities and health zone central offices, insecurity, and difficult geographic access contributed to the high number of stock-outs.

Stock-outs of ACT:

Figure 7D on page 19 shows that the number of health facilities reporting stock-outs of ACT increased from one year to the next over the course of the project, with the

highest number of stock-outs recorded in PY3 (465 health facilities). Compared to the project target of 100, this represents an achievement rate of 22%.

This poor performance is linked primarily to the stock-out of ACT observed in health facilities due to irregular distribution from CDRs during the second and third project years (PYs). The process of transferring the management of antimalarials from USAID|DELIVER to GHSC-TA caused delays in delivering orders. Currently, two shipments of ACT orders are expected to be delivered to CDRs.

During PY2 and PY3, IHPplus took over the management of an additional 90 health zones that required a supply of commodities. IHPplus provided funding to transport commodities from health zone central offices to health facilities (\$25/month/health facility) through subgrants to health zones (for the 78 health zones receiving the project’s full package) and via mobile money for the 90 new health zones, as a strategy for ensuring that funds are provided directly to beneficiaries. IHPplus also

collaborated with the *Programme National de lutte contre le Paludisme* (National Malaria Control Program) (PNLP), GHSC-TA, and SANRU/Global Fund to redistribute ACT from CDRs with a surplus and at risk of expiring to those lacking in supply.

RECOMMENDATIONS

To strengthen the management of commodities and reduce the risk of expiration and overstocks at health facilities, additional support is needed to improve communication at various levels of the supply chain, address inefficiencies in the monitoring system, improve the use of health care flow charts and treatment protocols, reinforce knowledge among health providers about national guidelines and use of new medications, ensure that quantification calculations reflect actual needs at the health facility and health zone levels (calculations are often done at the central level), strengthen supervision of pharmaceutical management, and address challenges posed by the high turnover of staff trained in supply chain management techniques.



Muger health center pharmacy. Photo by Rebecca Weaver.



“ People come from around Sud Kivu province to benefit from our high-quality services, including those we offer in our maternity and neonatal ward, our modern radiology department, and our well-regarded intensive care unit. In January 2018, we received a container from IHPplus that contained **MODERN OPERATING BEDS, EQUIPMENT FOR OUR RADIOLOGY DEPARTMENT, HOSPITAL BEDS, ROLLING MEDICAL SERVICES CARTS, AND POST-OPERATIVE CHAIRS.**

“IHPplus staff engaged with our staff, particularly on improving maternal and newborn care. For example, IHPplus trained our staff in Helping Babies Breathe (HBB), a technique used when babies are not breathing after they’re born. The project returned for follow-up training, which is crucial to our success because it ensures that training is well-learned and effectively practiced. As my staff become better at their jobs, they can provide better services.

“Over the last few years, thanks in part to IHPplus support, we have been able to invest in our hospital. **WE ARE PROUD OF OUR COLLABORATION, AND WE WANT TO SAY TO THOSE WHO HAVE PROVIDED THE MONEY—YOUR INVESTMENT IS REALLY PAYING OFF!**”

EXCERPTS FROM AN INTERVIEW WITH

DR. GISELLE FATUMA on IHPplus SUPPORT
Director, Ciriri Hospital, outside Bukavu

“ We’re impressed by what the Champion Communities have achieved and are inspired to implement the approach in health zones throughout the country.”

— Lydie Wema,
Head of Information, Education, and Communication Office,
National Health Communication Program



IR 1.2 COMMUNITY-BASED HEALTH CARE SERVICES AND PRODUCTS IN TARGET HEALTH ZONES INCREASED

Integrated management of newborn and childhood illness

The UN Inter-agency Group for Child Mortality Estimation Report 2017 states that the DRC's under-five mortality rate of 94 deaths per 1000 live births is the fourth highest in the world, representing 304,000 deaths per year of children under five. This elevated mortality is attributable mainly to preventable conditions, with 50% of deaths being attributed to malaria, pneumonia, diarrhea, and malnutrition.

To address these challenges, IHPplus supported the MOH in the implementation of the integrated management of newborn and childhood illness (IMNCI) strategy by improving the skills of health workers, improving family and community practices, and improving the health system. This was achieved by:

- Supporting 1,221 integrated community case management (i-CCM) sites, including the establishment of 132 new ones and 378 previously supported by the PMI Expansion and the Global Fund. The project supplied all of these sites with medicines and basic equipment (timers, medicine boxes, flashlights, etc.).
- Revitalizing 139 of the sites inherited from PMI and the Global Fund that only supported malaria to integrate management of simple cases of diarrhea, malaria, and pneumonia, and detection and referral of cases of malnutrition;
- Building the capacity of 197 providers at the health center level in IMNCI, to ensure quality care compatible with the MPA;
- Building the capacity of 60 providers and health care personnel at the hospital level for Triage, Evaluation, and Emergency Treatment (TETU in French) in five hospitals in the Mwene Ditu coordination in order to complete the IMNCI package at all levels of the health system (community, health center, and GRH);
- Providing medicines, tools, supplies, and equipment to ensure quality care compatible with the delivery of MPA at the health center level and CPA at the hospital level;
- Organizing mini-campaigns for IMNCI detection and treatment clinics and open house days at the i-CCM sites, during which community members received explanations of services offered and sick children received care;
- Supplying i-CCM sites and health facilities with medicines, management tools, and basic health care supplies;
- Subsidizing i-CCM site supervision visits, including for community health workers (CHWs) upon submitting their monthly reports and for the head nurses conducting the supervisions.

At the national level, IHPplus provided technical, logistical, and financial support to the IMNCI National Coordination in the organization of its quarterly meetings, the development of the IMNCI 2017–2021 strategic plan, the mapping of i-CCM sites, and the updating of IMNCI documents and normative tools (i-CCM sites, clinical IMNCI, TETU).

The project encountered difficulties in the implementation of activities due to insecurity that prevailed in the Kasai Central and Lomami provinces, the demotivation of CHWs when their subsidies were suspended between October 2017 and January 2018 due to lack of funds, stock-outs of essential medicines, supplies, and management tools, and budget constraints that limited the planned activities the project could complete.

i-CCM sites

To improve family and community practices, IHPplus supported i-CCM sites in the management of simple cases of malaria, pneumonia and diarrhea. As shown in Table 6 below, the number of i-CCM sites went from 777 in PY1 to 843 in PY3. In addition, the project inherited 378 sites previously supported by the Global Fund (105) and PMI-Expansion Project (273), of which 185 sites are in Haut Katanga,

48 sites in the DPS of Haut Lomami, and 142 sites in the Lomami DPS (Mwene Ditu coordination), for which the data are not included in the table below.

Table 5 shows an increase in the utilization rate of services from PY1 to PY2, with a decrease in PY3. However, it is important to note that the data for PY3 cover only the period PY3Q1 to PY3Q3 (three

quarters). Service utilization for diarrhea and pneumonia was higher than for malaria, and may have been a result of ongoing stock-outs of malaria supplies (RDTs, ACT), poor pharmaceutical management (average monthly consumption, ordering in time), and incomplete data from i-CCM sites in the DHIS2 (in which the only data available are related to cases of malaria, pneumonia, and diarrhea).

Table 5. Utilization rates for i-CCM interventions

Indicator	Total IHPplus		
	PY1	PY2	PY3
i-CCM			
# of i-CCM sites	777	843	843
Population covered by CHWs	779,936	960,826	960,826
Covered population <5	147,408	181,596	136,197
Malaria			
# expected malaria cases	235,853	290,554	217,915
# malaria cases diagnosed and treated	61,667	115,298	58,290
Malaria treatment rate	26%	40%	27%
ARI			
# expected ARI cases	45,696	56,295	42,221
# pneumonia cases diagnosed and treated	34,243	49,850	21,188
Pneumonia treatment rate	75%	89%	50%
Diarrhea			
# expected diarrhea cases	51,151	63,014	47,260
# diarrhea cases diagnosed and treated	53,247	76,626	27,354
Diarrhea treatment rate	104%	122%	58%
Total of all			
# expected cases for the three diseases	332,700	409,862	307,397
Total cases	149,157	241,774	106,832
Average for all three diseases	45%	59%	35%

RESULTS

Pneumonia:

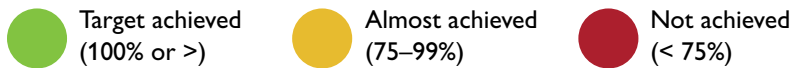
IHPplus treated a total of 1,243,469 pneumonia cases with antibiotics, for an achievement rate of 107%. As shown in Figure 8, the number of cases treated increased from 332,922 in PY1 to 455,342 in PY3. I-CCM sites treated 105,281 children, equivalent to 8.5% of the total number of cases treated, thereby assuring more rapid treatment for those children. However, during PY3, fewer children were treated in i-CCM sites than in the GRHs, due to the insecurity that prevailed in the

Luiza and Mwene Ditu coordinations, leading to the displacement of the population and medicine stock-outs.

All coordinations surpassed their targets with the exception of Kamina, which had incomplete data in the DHIS2. Some of the factors contributing to such a strong performance for this indicator were: free health care services provided by IHPplus in Luiza; the availability of antibiotics, especially amoxicillin, at the i-CCM sites in Bukavu, Kolwezi, and Uvira; the organization of open house days; and the substantial increase in population due to the mining boom in Kolwezi.

Diarrhea:

For the past three years, IHPplus assisted health facilities and i-CCM sites in treating diarrhea with ORS-zinc kits. In total, 1,560,853 cases of diarrhea were treated with ORS-zinc kits, equivalent to a 99% achievement rate (Figure 9, page 26). Although the figure shows a drop in number in PY3, this is primarily because the data for PY3 cover only the first three quarters of the year. There is a substantial increase in the number of cases treated between PY1 and PY2 due to the availability of ORS-zinc kits, the provision of free health care services in Luiza by IHPplus, and the establishment



All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

Fig 8. Number of cases of childhood pneumonia treated with antibiotics in USG-supported health facilities (percentage at i-CCM sites) For the total project, 8.5% of cases were treated at i-CCM sites for a total achievement of 107%.

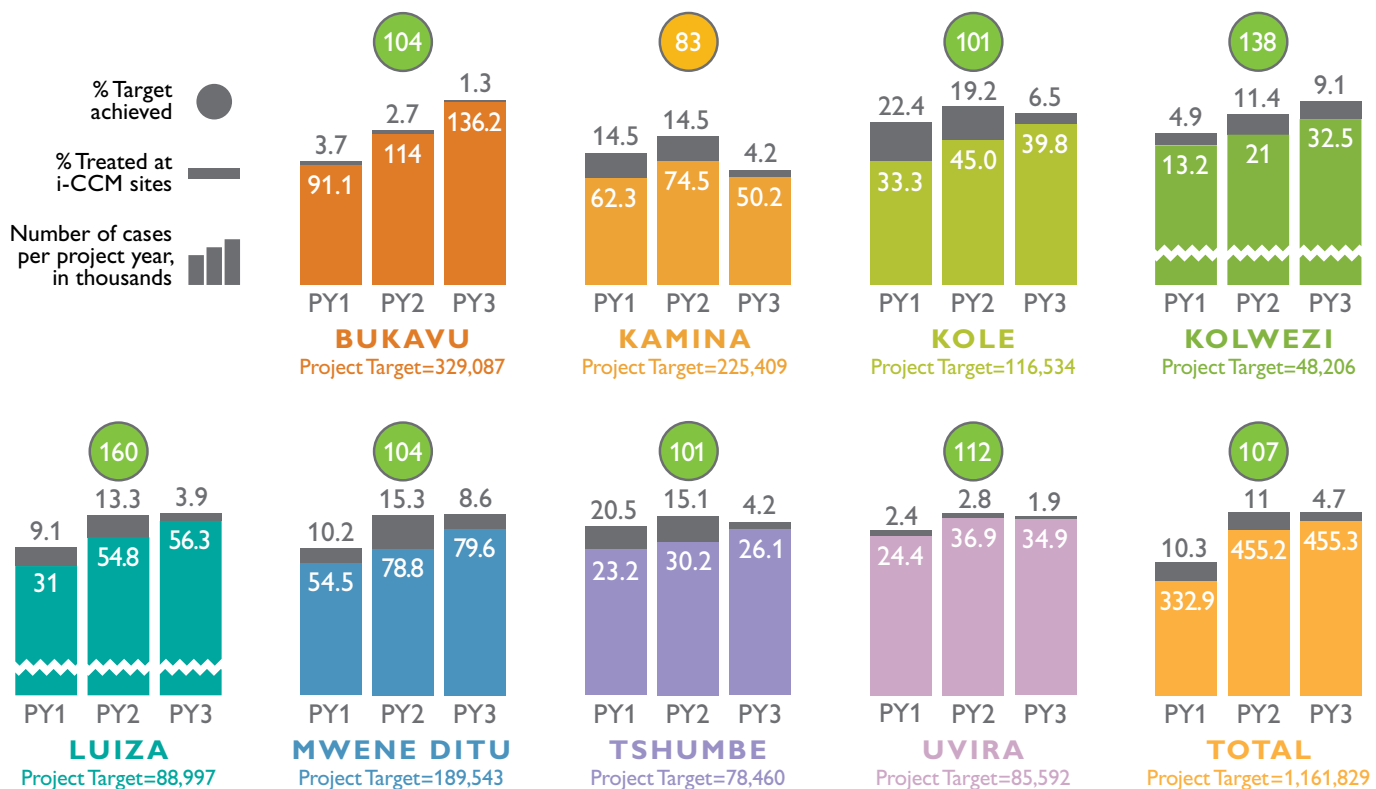


Fig 9. Number of cases of childhood diarrhea treated in USG-supported health facilities (percentage at i-CCM sites)
 For the total project, 10.1% of cases were treated at i-CCM sites for a total achievement of 99%.

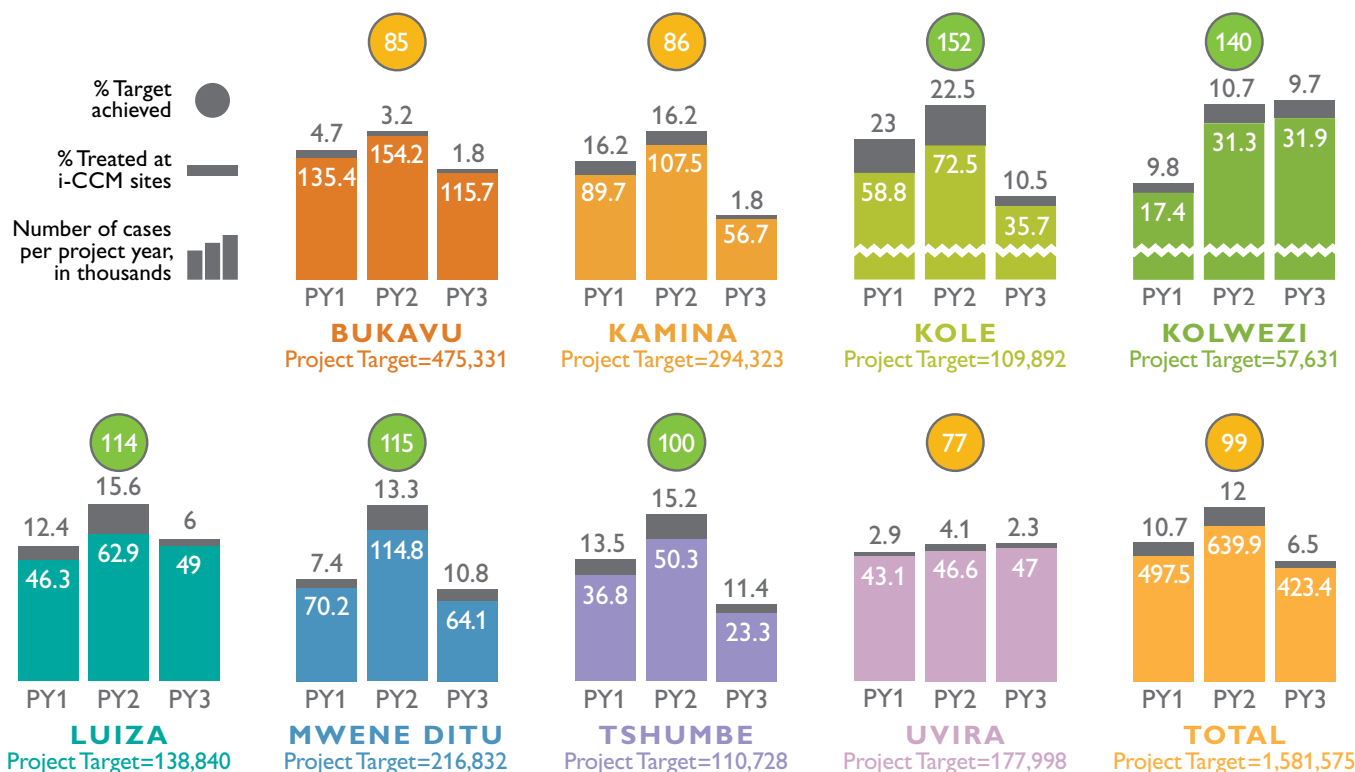
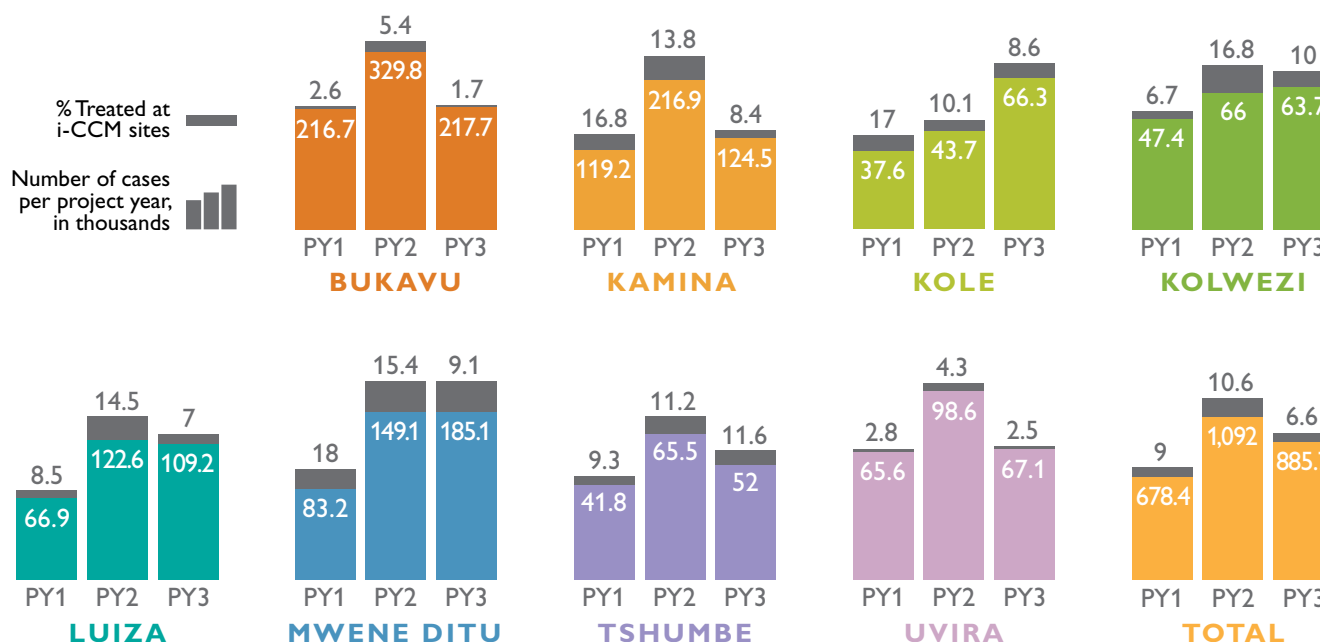


Fig 10. Number of cases of children under five years with malaria treated in USG-supported health facilities (percentage at i-CCM sites)
 For the total project, 8.9% of cases were treated at i-CCM sites.



of i-CCM sites in Kolwezi (45), Luiza (45), and Mwene Ditu (42) coordinations. The decreased performance in Bukavu, Kamina, and Uvira i-CCM sites is primarily due to stock-outs in the CDRs and incomplete data entry in DHIS2.

Malaria:

As with pneumonia and diarrhea, IHPplus supported the management of malaria through i-CCM at both the health facility and community care site levels. A total of 2,656,331 children under the age of five were treated for malaria, of which 8.9% (235,255) were treated at i-CCM sites, thus reducing the burden of mothers who would have had to travel long and difficult distances to access health centers. As shown in Figure 10, there was an increase in the number of cases treated between PY1 and PY2 and a decrease in PY3. This decline could be due to the previously mentioned stock-outs at the CDRs of both the RDTs for confirming malaria cases and of ACT for

treatment of confirmed malaria cases. This resulted in a reduction in the use of services, as parents were not finding satisfactory care for their sick children at i-CCM sites.

LESSONS

- Treatment of simple malaria cases, diarrhea, and pneumonia in i-CCM sites, and the use of rectal artesunate prior to referral, have decreased pediatric emergencies in hospitals. An increased number of i-CCM sites in remote villages, regular supply of medicines, and monthly monitoring visits by trained nurses are important to improve utilization of services and reduce child mortality.
- Group monitoring of i-CCM sites, exchange of experiences among CHWs, and the supply of equipment increased the visibility of the sites and utilization of services. Intervention packages should be standardized at the sites, and community case management should be extended to hard-to-reach villages. Regular supervision and mon-

itoring of CHWs and providers improves their capacity and reinforces the demand for services by the population; in emergency and crisis situations, the population first seeks care at i-CCM sites. Incomplete data in the DHIS2 result in the non-inclusion of certain indicators and limit the analysis of the performance of i-CCM sites.

RECOMMENDATIONS

- Monitor and supervise CHWs and providers regularly.
- Improve the supply chains for medicines and management tools to avoid stock-outs.
- Revitalize and extend the collaborative approach to coaching CHWs and improving services at the i-CCM level.
- Expand and integrate the same approach at the health center and GRH levels with clinical IMNCI and TETU.
- Promptly disburse funds to implement planned activities.
- Provided technical and financial support to build WASH infrastructure to beneficiary communities and health facilities (including aspects of hospital and health center hygiene), and to health teams and local authorities so that they take ownership of the results. This support was provided with the knowledge that changes in behavior, attitudes, and practices generally require a long time to take root, go beyond setting up infrastructure and WASH committees, and need to continue without external input;
- Safeguarded water quality by taking appropriate measures to protect water source catchment areas and conduct regular quality control tests, strengthening the local governance of clean water sources through user contributions and

Evidence-based WASH activities

IHPplus WASH interventions focused on improving the availability, accessibility, quality, ownership, sustainability, and use of clean drinking water sources and improved latrines and hand-washing stations, thus contributing to the development of a healthy environment for the beneficiary communities. To achieve this, the project adopted a zonal strategy consisting of a concentration of interventions in four health zones: Kanda Kanda and Luputa in Lomami province, and Luambo and Ndekesa in Kasai Central.

An additional eight health zones that reported outbreaks of cholera or were at risk were added for preventive purposes. These include: five health zones in Sud Kivu (Bagira, Kadutu, Katana, Miti Murhesa, and Walungu), one health zone in Haut

Lomami (Songa), one health zone in Kolwezi (Fungurume), and one health zone in Kasai Oriental (Bibanga).

IHPplus focused on developing clean drinking water sources, co-financed by the project and the beneficiary communities, based on the principles of community-led total sanitation (CLTS). IHPplus educated and supported communities in the establishment of improved latrines and hand-washing stations and in the adoption of basic hygiene and sanitation measures to improve their overall health conditions.

TECHNICAL APPROACH AND ACTIVITIES

- Improved clean drinking water sources and mobilized communities to build improved latrines and hand-washing stations;

participation in decision making, and by implementing measures to promote access and adequate utilization by all (e.g., building stairs for access to water sources near steep slopes and encouraging water source management committees to charge fees that are affordable for even the poorest families);

- Organized and restructured clean drinking water management committees to enhance ownership and sustainability;
- Raised awareness among households with access to clean drinking water, encouraging them to build improved latrines and hand-washing stations;
- Shared the CLTS standards to eliminate open-air defecation through social and behavior change communications (SBCC) campaigns and construction of family latrines;
- Monitored and evaluated WASH activities with the health zone central office teams;
- Considered the needs of health facilities in WASH interventions (hospital hygiene and hazardous waste management);
- Supplied construction materials for clean water sources (e.g., iron, cement, pipes, fittings) that could not be obtained locally, with the beneficiaries supplying locally available materials;
- Strengthened the capacity of masons to build and repair sustainable improved latrines and involved specialists in the water collection and management of clean drinking water sources.

RESULTS

From PY1 to PY3, 513,492 people gained access to improved drinking water sources, out of a target population of 617,126, representing an 83% achievement rate;

366,970 people gained access to improved latrines, out of a target population of 524,768, representing a 70% achievement rate (Figure 11, page 30). The numbers of people gaining first-time access to WASH infrastructures were derived from population counts collected by Champion Communities and WASH committees at the community level, which were then shared at the health zone level and collected by each IHPplus coordination office.

After initially setting a low coverage rate based on a minimum target population, which resulted in achievement rates above 100%, the target population was revised upward from one PY to the next, taking into account the actual capacity of the infrastructure and beneficiary participation. In PY3, (as of March 31, 2018) the project provided technical and financial support to renovate one water source in Fungurume health zone that serves an estimated population of 25,000, as part of its contribution to the emergency response to the cholera outbreak in the Lualaba DPS. The plan to build clean drinking water sources was delayed until the fourth quarter due to logistical problems that included lack of construction materials in certain areas due to transportation difficulties and lack of professional suppliers. The number of people gaining first-time access to improved latrines also decreased in PY3 due to financial uncertainties and delayed disbursements.

Although not represented in the figures and tables of this report, during the last quarter of PY3, IHPplus supported the establishment of 173 new water sources, thus providing access to safe drinking water to and additional 423,493 people; and 194,415 more people gained access to 29,554 improved latrines built by the sensitized communities.

CHALLENGES

- Insecurity resulting from the presence of armed groups in certain areas, especially in Kasai and Sud Kivu;
- Emergence of a cholera epidemic;
- Absence of water quality control tests and individuals who are properly trained to use them;
- Poor monitoring and evaluation of WASH activities by health zone teams and local water management committees;
- Geographic accessibility still remains a challenge, as many of the clean drinking water sources are far from the villages and place a burden on women and children to access them;
- The idea of financial or in-kind contributions from users is generally accepted, but can create financial management and conservation challenges since most rural areas do not have financial institutions;
- Unavailability in some health areas of local materials such as small stones and clay bricks used to develop or renovate clean water sources, which increased planned building costs;
- Logistical constraints due to the lack of professional local building material retailers or shippers, especially in the Kasai provinces.



VOICES OF IMPACT

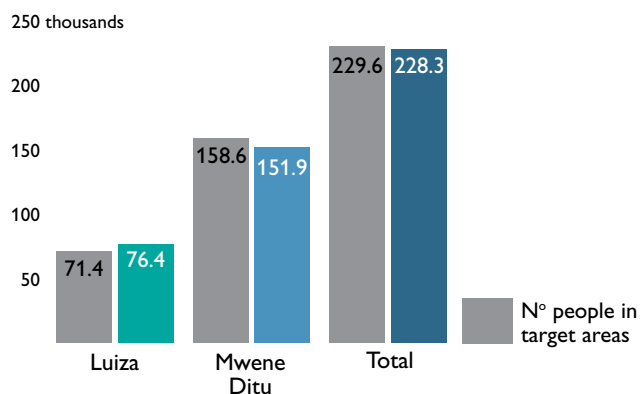
“ I have been the CHW in charge of the Beya community care site for seven years. **I BECAME A CHW BECAUSE I SAW HOW MANY YOUNG CHILDREN IN OUR VILLAGE WERE DYING** without access to medical care, since we are located far from the nearest health center. I am not a nurse, but thanks to the training that I received, I know how to manage simple cases of fever, cough, and diarrhea in children from two months to five years old. I also **KNOW HOW TO RECOGNIZE DANGER SIGNS**, and to provide initial treatment before referring cases to the health center.

“I typically provide care to 16 children per month, always at no charge. I also regularly perform door-to-door home visits, educating parents on providing initial basic care when their children fall sick and encouraging them to take advantage of the community care site. I have taught them that if their children have a fever during the night, they should wrap them in a damp cloth and give them ACTs. Now, the mothers in our village all know to give their children ORS and zinc when they have diarrhea, and to continue to breastfeed them. **THE KNOWLEDGE AND SKILLS THAT I HAVE GAINED FROM IHPplus WILL STAY WITH ME FOREVER.**”

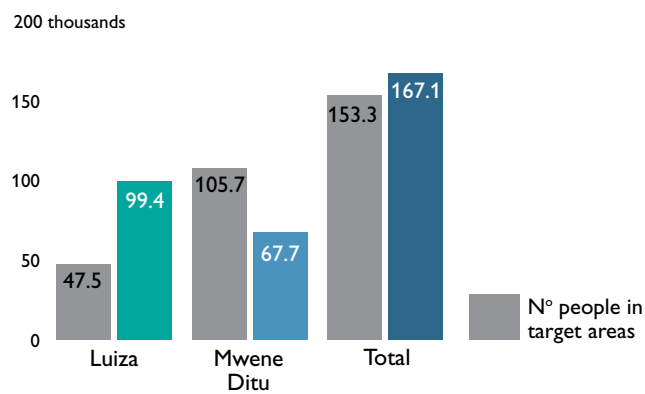
EXCERPTS FROM AN INTERVIEW WITH
TIMOTHÉE MUKENDI on MNCH
CHW, Beya community care site, Bilomba health zone

Fig 11. WASH indicator results varied widely by coordination and PY. For the total project, the achievement rate was 70%.

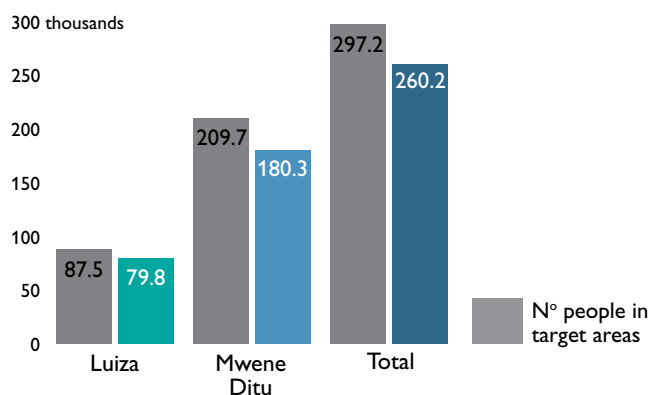
WASH PY1, access to improved water supply **99**



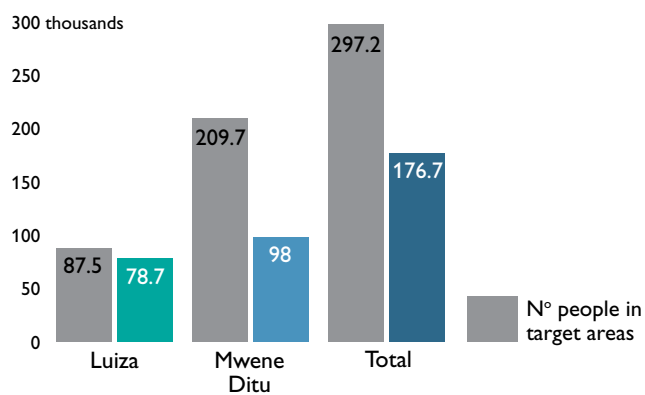
WASH PY1, access to improved latrines **109**



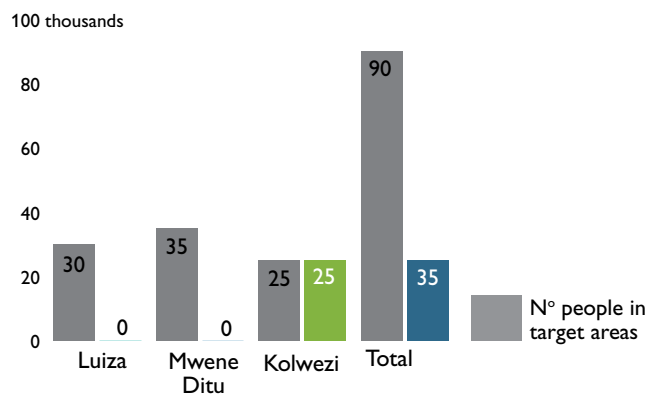
WASH PY2, access to improved water supply **88**



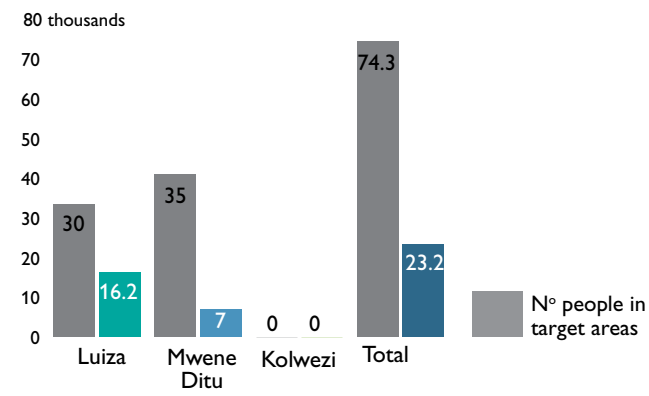
WASH PY2, access to improved latrines **59**



WASH PY3, access to improved water supply **28**



WASH PY3, access to improved latrines **31**



RECOMMENDATIONS

- Water source improvement is the first step to implement a WASH program, and then to improve hygiene and sanitation, including appropriate household waste disposal and the use of improved latrines. However, this process should be accompanied by the CLTS approach in order to foster sustainable behavioral changes. Setting up water point committees including health staff and local territorial entities, and motivating civil society organizations (CSOs) helps ensure water quality and sustainability. The

introduction of a cost-benefit approach to strengthen collaboration with building material suppliers and users of new technologies, such as for well drilling, could improve hygiene and sanitation practices at the community level.

- Adopt a context-driven approach to determining the types of improved water source technology to implement, and do not focus solely on small sources, which typically have a low water flow rate and are generally located far from villages or at the bottom of valleys, where the terrain is hilly and access is difficult. Alternative

technologies could improve geographical accessibility by providing improved water sources closer to larger populations, such as boreholes, manual wells, and collected rainwater, while prioritizing efficiency.

- Quality latrine building materials are lacking in rural areas and the introduction of a sanitation marketing strategy could be very useful in bringing together suppliers, the health sector, and community members through a formative research process.



PHOTO: Sarah Ranney, MSH

IR 1.3 PROVINCIAL MANAGEMENT MORE EFFECTIVELY ENGAGED WITH HEALTH ZONES AND FACILITIES TO IMPROVE SERVICE DELIVERY

Leadership Development Program

TECHNICAL APPROACH AND ACTIVITIES

The Leadership Development Program (LDP) was designed specifically for health sector professionals, nongovernmental organizations (NGOs), community groups, and other stakeholders. LDP participants work in teams, learning to lead and manage collaboratively and effectively. Teams develop a shared vision, identify long-term strategies, and commit to short-term results. They analyze what stands in the way of progress and create opportunities to practice their new skills at every step. Their superiors are fully aligned with the program and hold the teams accountable for intended results. Teams receive support from facilitators and coaches. Whether they are health officials, nurses, or volunteers, participants tend to emerge from the program with increased skills, commitment, confidence, and a sense of power. This method of leadership development goes beyond theory and helps teams apply their new knowledge through practice, so they can obtain measurable results for their organizations.

With the aim of addressing challenges encountered at work, creating an empowering environment, and promoting transparency and accountability, LDP teams develop a shared vision and identify long-term strategies to achieve their desired goals within six months of implementation. Team members analyze obstacles hindering progress and create opportunities to practice their newly acquired skills at each stage of the process.

During the implementation of IHPplus, teams set the target of increasing the availability and access to MPA and CPA services and products in targeted health zones. Achieving this target required rigorous leadership and management at all levels. To engage DPS management teams and uphold their commitment to making positive change, IHPplus provided financial and technical support to provincial management teams to allow them to supervise a total of 78 HZMTs participating in the LDP (through routine monitoring and supervision visits) for improved provision of health services.

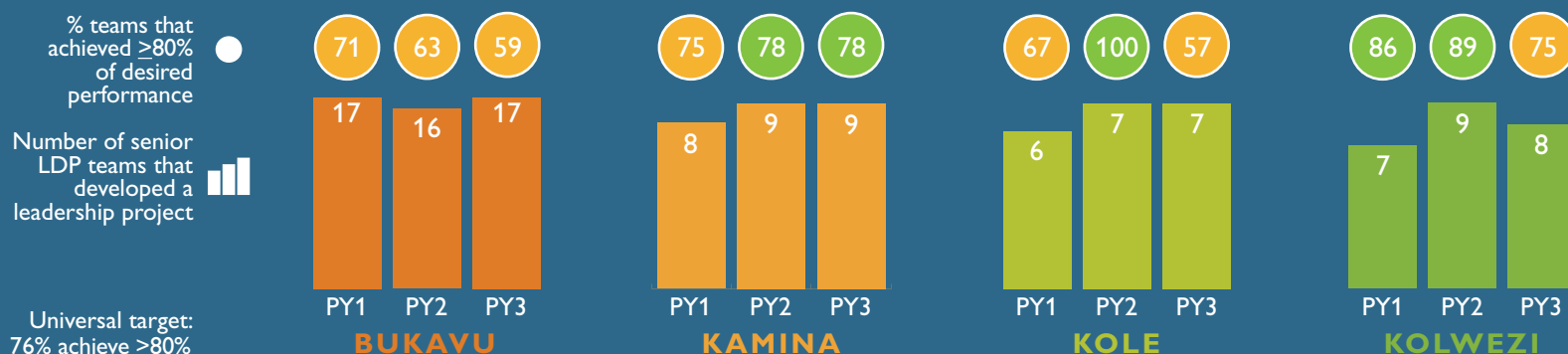
IHPplus provided quarterly support to LDP teams to:

- Identify a challenge in their work environment;
- Develop leadership projects to address the challenge selected;
- Implement activities detailed in the leadership project implementation plan;
- Organize quarterly meetings to advocate with and sensitize stakeholders, mobilize resources, adjust and revise desired performance and activities as needed, and monitor and assess leadership project performance;
- Brief and train new DPS management teams to supervise LDP teams.

RESULTS

- IHPplus supported a total of 78 HZMTs that participated in the LDP.
- HZMTs developed a total of 197 leadership projects.

Fig 12. Proportion of senior LDP teams that achieved at least 80% of their desired performance



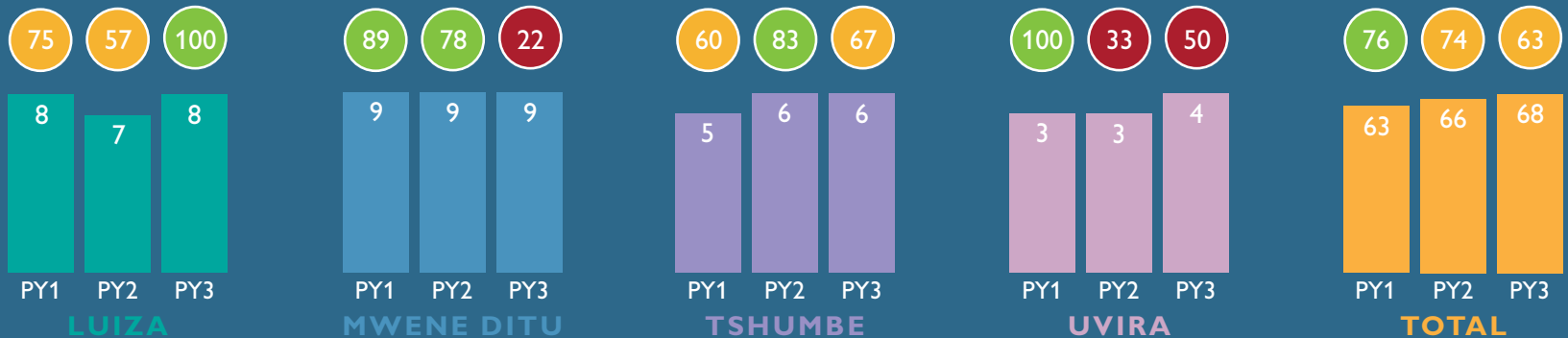
- Of the 190 leadership projects implemented by the HZMTs on which they worked for six to eight months, 140 (71%) achieved 80% or more of their desired performance.

Figure 12 below provides details for each coordination on the proportion of senior LDP teams that have achieved at least 80% of their desired performance.

During IHPplus, 71% of LDP-trained teams achieved 80% of their desired performance, attaining 94% of the project's target (76%). The total number of leadership projects developed by LDP-trained teams during the life of the project increased from 63 in PY1 to a total of 68 in PY3. From PY1 to PY3, the proportion of LDP teams that achieved 80% of their desired performance dropped from 76% to 63%. This decreased performance can largely be attributed to a selection of unrealistic targets at project start-up, as well as the resurgence of violence in most of the project-supported health zones—which hindered the close monitoring of activities and the organi-



PHOTO: Eleonora Kinnicutt, MSH





“ At the provincial level, **IHPplus BROUGHT US SOMETHING NEW TO IMPROVE GOVERNANCE AND LEADERSHIP,** and in particular, to strengthen our capacity to conduct supportive supervision visits, through joint supervision visits and coaching from IHPplus staff.

“ONE OF THE MOST INNOVATIVE AND EFFECTIVE TRAINING TOOLS, IN MY OPINION, HAS BEEN THE LDP, which has helped us to discover new ways to work as a team and to achieve a common goal. Our team in Kanzenze, for example, decided to construct a new health center in the village of Disombo. They developed a plan that they presented to their community, and with their support, were able to achieve this goal.

“The support we have received from IHPplus has helped us improve the quality of our work and ultimately better address the health needs of our community. **TODAY, WE HAVE A NEW WAY OF WORKING, A MORE EFFECTIVE WAY OF WORKING.** We can plan better; we coordinate with others more effectively, and as a result, the quality of our services and care is moving towards the level it needs to be.”

EXCERPTS FROM AN INTERVIEW WITH
DR. FRANCIS KAMOBÉ on LDP
Head of Health Information, DPS, Lualaba

zation of key meetings, including target review, stakeholder, and resource mobilization meetings, as well as the local teams' ability to focus on improvements.

As shown in Table 6, right, of the 190 leadership projects implemented by HZMTs, 134 (68%) focused on maternal and child health.

CHALLENGES

One of the primary challenges encountered during the course of this activity was ensuring that coordination offices, given the unstable security situation in several of the project-supported health zones, respected and implemented their action plans—particularly in Bukavu, Kamina, Luiza, and Uvira. It also was challenging to maintain the motivation of DPS teams to continue to supervise the LDP teams and to help them redefine targets as needed following mid-term evaluations of their projects.

RECOMMENDATIONS

The technical and coaching support provided by IHPplus to the coordination offices, DPS, and HZMT LDP teams helped them achieve their desired performance and improve as team members and individuals. In the future, IHPplus recommends expanding this approach by supporting the senior alignment meeting (an important first step in advocating for and raising awareness about the LDP with stakeholders), providing four additional trainings on the LDP, monitoring visits to field teams, conducting refresher trainings for LDP teams, and scaling up the LDP from HZMTs to health centers, DPS, and the national level.

Table 6. LDP projects per technical area

Focus and indicator areas	# projects achvg ≥80% of desired performance	# of projects dev. by LDP teams	% project achvg ≥80% of desired performance
MNCH			
ANC 1	9	13	69
ANC 4	13	14	93
Assisted deliveries	9	10	90
AMTSL*	6	8	75
More than two PSCs	8	10	80
Immunization/DTP-HepB-Hib3	7	9	78
Immunization/OPV3	4	6	67
Dropout rate DTP-HepB-Hib3	6	6	100
Immunization/VAT 2+	6	7	86
Immunization/PCV-13	4	10	40
Malaria/IPT 2+	5	7	71
PSC (12-59 months)	4	5	80
i-CCM diarrhea	3	5	60
i-CCM pneumonia	5	6	83
i-CCM malaria	4	6	67
FP			
Availability of contraceptives	8	12	67
Nutrition			
Pregnant women who receive iron folate	9	12	75
L+M+G			
Referral rate	9	12	75
Bed occupancy rate	4	8	50
Rate of post-op infection	4	6	67
TB			
Cure rate	9	15	60
Detection rate	4	10	40
TOTALS	140	197	71

IR2

INTERMEDIATE RESULT 2

Quality of key family health care services in target health zones increased

- IR 2.1 Clinical and managerial capacity of health care providers increased
- IR 2.2 Minimum quality standards for health facilities (general referral hospitals and health zone health centers) and services developed and adopted
- IR 2.3 Primary health care referral system for prevention, care, and treatment improved

IHPplus has provided training in modern methods of family planning to health workers, including nurse Damas Cirimwami at Katana Nuru health center. The poster was provided with the support of IHPplus to help clients at the health center understand the family planning options that were made available at Katana Nuru health center, free of charge, with IHPplus support.

Photo by Rebecca Weaver



Ministère de la Santé Publique
Projet AXxes Monitoring mensuel des activités SSP
 (IMA, ECC, CRS/WHO)
 USAID
 Année

USAGE MULTIPLE DE L'ARBRE



Vasectomie
 Une vasectomie est une opération simple, sans douleur et sans danger. Elle consiste à couper les canaux déférents. Elle est définitive. Elle ne modifie pas votre apparence et ne vous empêche pas d'avoir des relations sexuelles normales. Elle ne vous empêche pas de concevoir des enfants.

Diaphragme avec spermicide

La femme positionne le diaphragme profondément dans le vagin avant chaque rapport sexuel. La pose peut se faire à l'avance. Méthode efficace si le diaphragme est utilisé correctement et systématiquement. La femme doit subir un examen interne pour obtenir un diaphragme de la taille adéquate. Les infections urinaires sont plus fréquentes.

Comparaison de l'efficacité des méthodes

Plus efficaces
 Moins de 5 grossesses pour 100 femmes sur une année



Moins efficaces
 Environ 30 grossesses pour 100 femmes sur une année

Méthode non recommandée

Conditions

Contre-indiqué pour les grossesses écartées	Contre-indiqué pour les grossesses écartées
Contre-indiqué pour les grossesses écartées	Contre-indiqué pour les grossesses écartées
Contre-indiqué pour les grossesses écartées	Contre-indiqué pour les grossesses écartées

Plus d'infos et prescriptions : Pour obtenir une orientation spécifique, consulter également les normes nationales.

Liste de Con

NO	NOM	ADRESSE	NO CARTE
01	NTAKA AARAK		
02	SIVA ANKIA		
03	DARUZA PAIKON		
04	CAMILONGA NGA		

Tableau de données de santé

NOM	SEXE	ADRESSE	NO CARTE
NTAKA AARAK	M	COMBESAR I	
SIVA ANKIA	F	" II	
DARUZA PAIKON	M	BAKONGA II	4750
CAMILONGA NGA	F	" "	4750

The reduction of mortality depends on the availability of services that meet the standards and the demands of the client both with regards to quantity and quality. According to the World Health Organization (WHO), health care must be safe, effective, timely, efficient, equitable and people-centered. The provision of quality key family health services to the population is one of the intermediate results of IHPplus. During three years of implementation, quality service provision was provided across a variety of different areas including FP; MNCH; nutrition; TB; malaria; nutrition; and SGBV. The focus on high quality and accessible services during implementation of the project activities contributed to the improvement in health of the population, and the project has made considerable progress in ensuring that hospitals and health centers provide high quality services that meet standards and needs of the clients. Innovative strategies and approaches have been used to achieve these outcomes, including skills-focused training; integrated and holistic supervision of all primary health care interventions; and the implementation of functional referral systems between i-CCM sites and health facilities. All of these interventions have helped to improve the quality of services offered to the people of the DRC. Interventions by thematic area and results from these interventions are presented below.

IR 2.1 CLINICAL AND MANAGERIAL CAPACITY OF HEALTH CARE PROVIDERS INCREASED

Maternal, neonatal, and child health

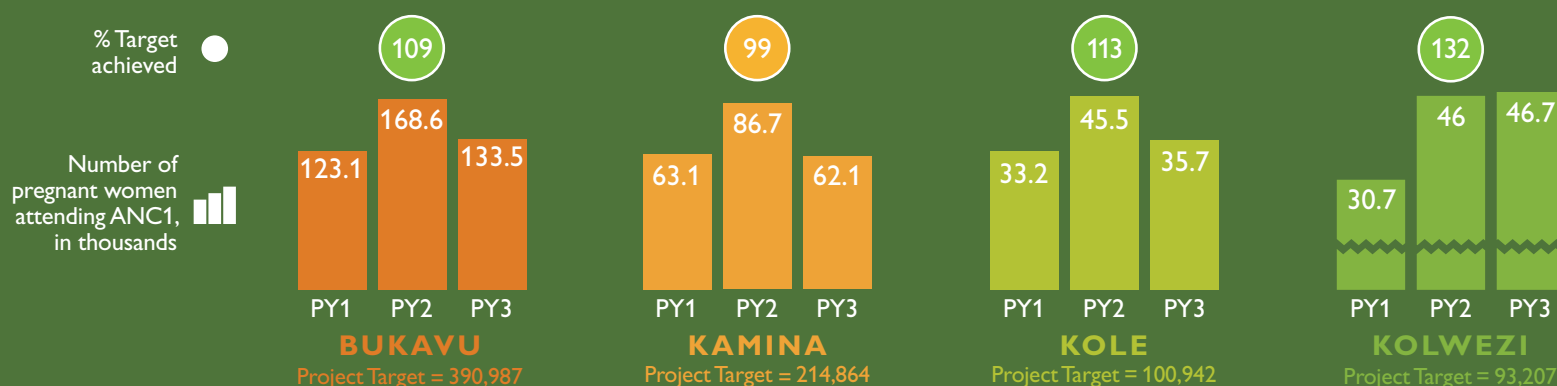
The government of the DRC and its technical and financial partners, including USAID, remain concerned about the state of MNCH in the country. Although decreasing slightly, maternal and neonatal mortality rates in the DRC remain among the highest in the world, at 693 maternal deaths per 100,000 live births (World Bank, 2015) and 29 neonatal deaths per 1,000 births, equivalent to 96,000 neonatal deaths, or 4% of the total number of neonatal deaths worldwide (IGME, 2017). The primary causes of maternal deaths are postpartum hemorrhaging, hypertension during pregnancy (preeclampsia and

eclampsia), and infections. The primary causes of neonatal deaths are asphyxia, preterm birth, and infection.

Faced with this alarming situation, the DRC identified priority concerns in its PNDS 2016–2020 for addressing maternal and neonatal mortality, many of which are related to poor health care access and coverage. Apart from problems of geographical and financial access, there is little integration of interventions offered during childbirth and postnatal care, particularly emergency obstetric and neonatal care, due to:

- Insufficient number of trained health personnel;
 - Limited emergency obstetric care (less than half, or 47% of all hospitals) and basic obstetric care (less than 15% of health centers and referral facilities);
 - Inadequate supplies and medicines for maternal and neonatal care; less than 20% of health facilities have the essential medicines necessary (SARA, 2014).
- To achieve its objectives, IHPplus assisted the MOH in the implementation of selected priority activities, including:
- Capacity building of providers in Emergency Obstetric and Newborn Care (EmONC) by focusing on good delivery

Fig 13. Number and percentage of pregnant women attending ANC1 with skilled providers in USG-supported health facilities



practices with active management of the third stage of labor (AMTSL), management of postpartum hemorrhage, and neonatal resuscitation according to two approaches: Helping Mothers Survive (HMS) and Helping Babies Breathe (HBB). Capacity building consisted of:

- » Short-term theoretical trainings with practice on mannequins and a day of clinical training were held at the maternity ward (1,227 providers trained).
- » Maintenance clubs were formed for neonatal resuscitation training and management of postpartum hemorrhage in each health zone, consisting of groups of providers who meet once a month to train in resuscitation techniques.
- » Training was followed by the provision of neonatal resuscitation supplies (namely the ambu bag with mask) to each health facility for neonatal resuscitation, and the baby mannequin “Nathalie” to the various health zone central offices, GRHs, and resuscitation clubs for training purposes.
- » In PY3, IHPplus also conducted capacity building of providers in the management of low birth weight neonates (including implementa-

tion of the kangaroo mother care approach), and the integration in ten demonstration sites of the WHO simplified protocol for the management of serious bacterial infections when a referral is not possible.

- To improve quality of care, IHPplus equipped maternity wards with delivery beds, hospital beds, examination tables, and basic medical equipment (e.g., sphygmomanometers, stethoscopes, delivery boxes, pinard fetal stethoscopes, thermometers).
- Regular provision of 13 medicines that save the lives of women and children, supplies for quality prenatal visits (Sulfadoxine-pyrimethamine [SP], iron folate, insecticide-treated nets [ITNs], etc.), and management tools and forms for quality care provision.
- Antenatal care (ANC) mini-campaigns in health zones with poor coverage for ANC visits, targeting all ANC interventions—including HIV and the intermittent treatment of malaria during pregnancy. The primary objective of these campaigns was to increase coverage and improve the quality of ANC.
- The project’s reproductive, maternal, child, neonatal and adolescent health unit, together with the National Program for Reproductive Health (PNSR in

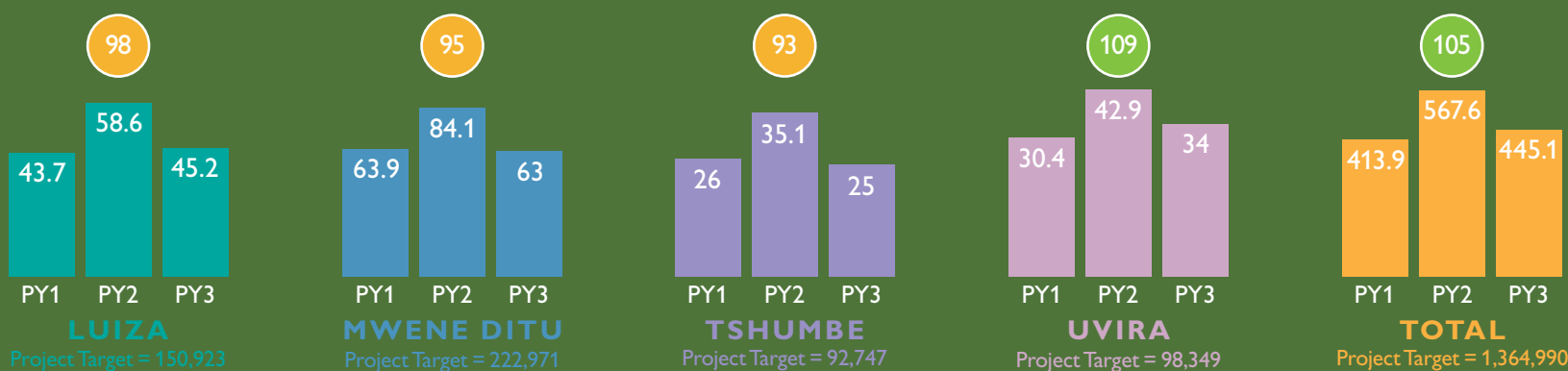
French) carried out on-site provider follow-up and supervision in MNCH through briefings based on real cases and practical training on mannequins.

- Supervision of CHW home visits promoting early prenatal consultation starting at 16 weeks, which include identification of warning signs, proper hygiene, and nutrition of pregnant women and the identification and follow-up of signs of neonatal infection.

RESULTS

Percentage of pregnant women attending ANC1 visit:

During the three years of IHPplus, there was a strong sustained performance in the number of pregnant women receiving ANC, with 1,426,586 women having attended at least one ANC visit (ANC1), which represent a 105% achievement rate compared to the target of 100% (Figure 13). Overall, four coordinations (Bukavu, Kole, Kolwezi, and Uvira) surpassed the target, and the remaining four coordinations had achievement rates over 90%. In general, several factors may have contributed to this performance, including the sensitization of pregnant women during home visits by the CHWs, the implication of community leaders and Champion Communities in identifying



pregnant women and encouraging them to attend their ANC visits, the participation of CODESAs in raising community awareness, ANC mini-campaigns, and the distribution of free ANC medicine and supplies (e.g., SP, iron folate, ITNs).

Percentage of pregnant women attending at least four ANC visits:

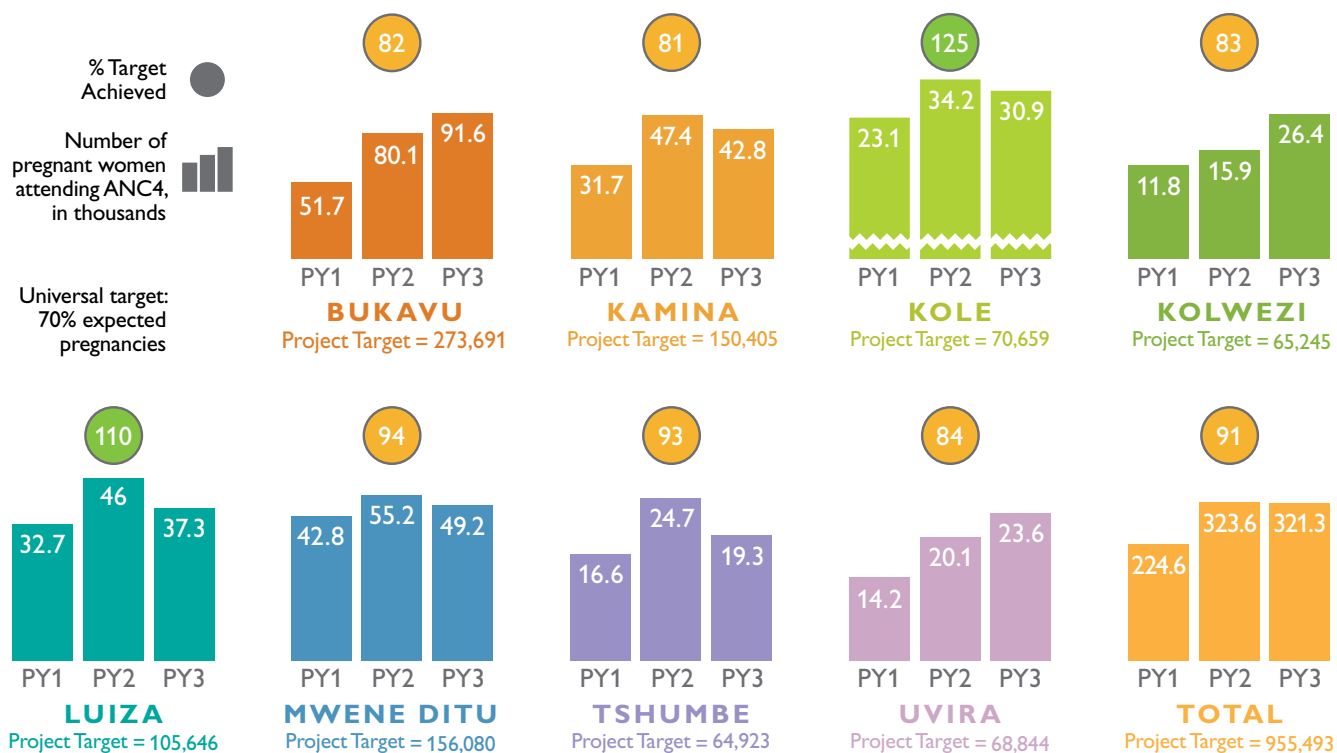
During IHPplus a total of 869,486 women attended at least four ANC visits (ANC4), representing an achievement rate of 91% (Figure 14). Two coordinations (Kole and Luiza) surpassed the target, and the remaining coordinations achieved at least 80% of the target. The number of ANC4 visits increased progressively over the three years (taking into consideration that PY3 data consists of only the first three quarters).

Many pregnant women start their ANC late and therefore cannot achieve the recommended four visits, sometimes due to cost, personal habits or customs, or the long distance to get to a health facility. Some women start their ANC visits on schedule, but do not meet the deadlines to complete all four. While the project did not achieve the highly over-estimated PNDS target of 90% for ANC4 visits, it did surpass it for ANC1. In addition to the strategies mentioned for increasing ANC1 visits, the increase in ANC4 visits may also be linked to the use of mobile phone messaging for awareness raising (Luiza and Tshumbe) and the adoption of this indicator as an LDP goal in certain health zones in Luiza.

Deliveries by a skilled birth attendant:

There were 1,211,726 deliveries with a skilled birth attendant (SBA), which represents 98% of the project target and 89% of the target population—almost reaching the national target of 90% (Figure 15). There was a large increase in the number of women giving birth with a skilled birth attendant between PY1 and PY2. The coordinations of Kole, Kolwezi, and Luiza surpassed the project target, while the remaining coordinations achieved at least 84% of the target. Factors likely to have contributed to the noted increase and high achievement rates are awareness raising by CHWs, Champion Communities, and CODESAs among pregnant women and the community on the importance of delivering at a health facility, the implica-

Fig 14. Number and percentage of pregnant women attending ANC4 with skilled providers in USG-supported health facilities



tion of political and administrative leaders in encouraging women to deliver at health facilities (Dikungu), the introduction of flat fee pricing for deliveries (Dekese, Dibaya, and Kalomba), the improvement of conditions in delivery rooms and hospital rooms (acquisition of exam tables, delivery beds, and hospital beds), the improvement in quality of care after the scale-up of the HMS approach, and the supervision and follow-up of MNCH trainings.

Women giving birth who received a uterotonic in the third stage of labor (or immediately after birth):

Figure 16 on page 42 shows that 1,128,076 mothers received a uterotonic within one minute of delivery, which represents 93% of all deliveries attended by a skilled birth

attendant, and 95% of the project target. This number has steadily increased every year (taking into account that PY3 only includes data from the first three quarters). Half of the coordinations (Kole, Kolwezi, Luiza, and Mwene Ditu) achieved or surpassed the target, and the remaining coordinations had achievement rates of at least 85%. The following activities contributed to this strong performance: provider capacity building in the HMS approach emphasizing the prevention of postpartum hemorrhage and AMTSL; various MNCH trainings; supervision and monitoring by IHPplus and PNSR staff at the national and provincial level; and the provision of oxytocin to health facilities.

Newborns receiving essential neonatal care:

A total of 1,173,431 newborns received essential care at birth, which represents 99% of the project target (Figure 17, page 42). Two coordinations (Kolwezi and Mwene Ditu) surpassed the target, and the remaining coordinations had achievement rates over 80%. Factors that likely contributed to this strong performance are: provider capacity building through various MNCH trainings; training in neonatal resuscitation, which included neonatal essential care; briefings during MNCH supervision and monitoring; and the provision of essential neonatal medicines (chlorhexidine 7.1%, vitamin K1, ophthalmic cream, etc.) to health facilities. The substantial increase from PY1 to PY2 is

Fig 15. Number and percentage of deliveries with an SBA in USG-supported facilities

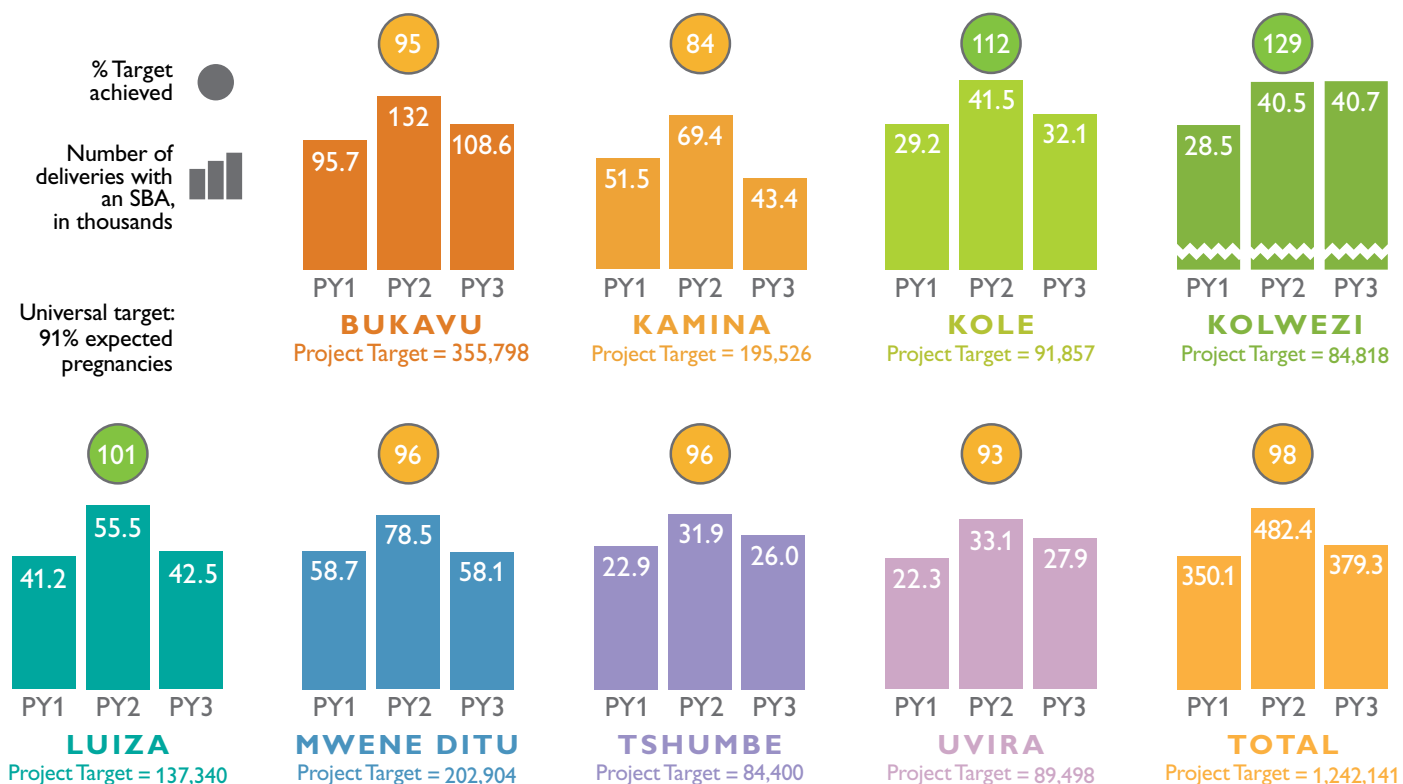
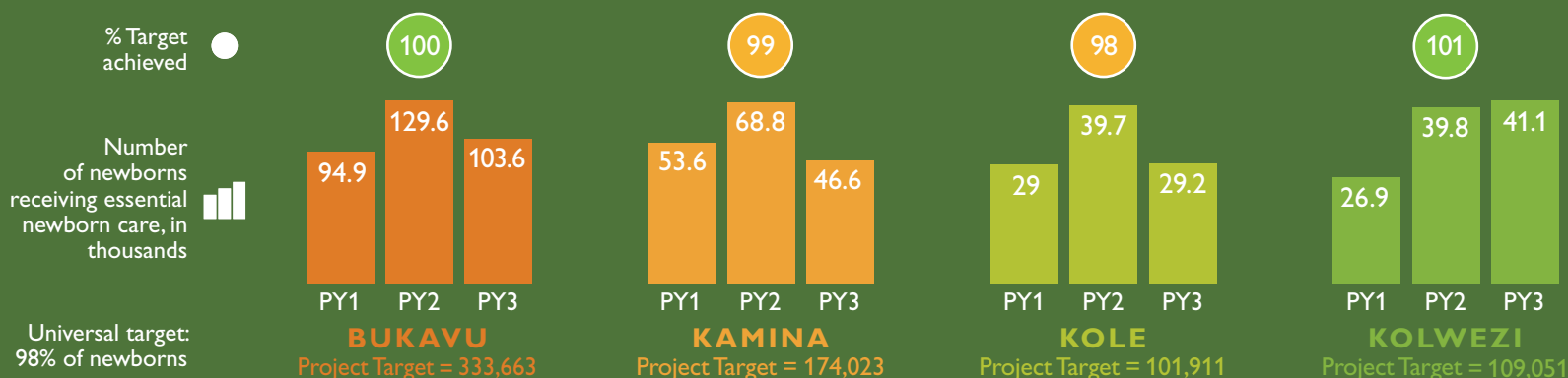


Fig 16. Number of women giving birth who received a uterotonic in the third stage of labor (or immediately after birth) through USG-supported programs



All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

Fig 17. Number and percentage of newborns receiving essential neonatal care through USG-supported programs



also a result of the integration of data from private health facilities into the DHIS2.

Newborns receiving antibiotic treatment for infection from appropriate health workers:

During IHPplus, 77,304 newborns received antibiotic treatment at birth due to suspected neonatal infections, representing an achievement rate of 95% (Figure 18, page 44). Two coordinations surpassed the target, with the Kolwezi coordination reporting an achievement rate of 283%, indicating a potentially irrational use of antibiotics for newborns in this area, as well as an underestimation of the population of Kolwezi due to a high migration to the area as a result of mining activities. Despite the actions taken at the provincial, health zone, and even health facility level in Kolwezi, there is still an excessive use of antibiotics in newborns at birth, especially in the health zones of Dilala and Manika. In the remaining coordinations, the provision of antibiotics to health facilities, training on neonatal sepsis (Katana and Walungu), and briefings on the appropriate use of antibiotics likely contributed to the overall performance of this indicator.

When comparing the IHPplus results to the baseline data from IHP (Appendix 1), there appears to be a decrease in the number of newborns receiving antibiotic treatment for

infection compared to a baseline of 30,357. This is due to a revised definition and data collection method and overall improved understanding of this indicator during the course of the project.

Helping Babies Breathe:

During the three years of IHPplus, 19,296 newborns with asphyxia were resuscitated using the HBB approach, of which 16,462 were saved, for a successful resuscitation rate of 85% (Figure 19, page 44). The number of newborns resuscitated has dramatically increased every year, going from 2,227 in PY1 to 11,209 in PY3, representing a five-fold increase. Aside from the Tshumbe coordination, which had incomplete data in PY2, all the coordinations had resuscitation rates over 80%. The scale-up of the HBB approach in all coordinations accompanied by the provision of resuscitation supplies to all health facilities and resuscitation training mannequins to the health zone central offices and provider training sites likely contributed to the success of this indicator.

CHALLENGES

- Likely irrational use of antibiotics for newborns at birth with suspected neonatal infections in the health zones of Dilala and Manika in Kolwezi;
- Lower rate of achievement of ANC4 compared to ANC1 due to late onset

of ANC visits and costs associated with prenatal care;

- High number of home births in Kamina coordination as a result of poor accessibility to health facilities, especially during the rainy season;
- Limited and delayed training on neonatal infections and resuscitation in certain health zones in Tshumbe coordination.

RECOMMENDATIONS

- Sustain the training, monitoring, and supervision of MNCH providers by supporting the provider groups for neonatal resuscitation and the management of postpartum hemorrhage.
- Expand the provision of health care supplies (e.g., delivery kits, blood pressure monitors, thermometers, stethoscopes, ambu bags) in all maternity wards.
- Expand the trainings for basic EmONC, complete EmONC, and the kangaroo mother care approach.
- Integrate the review of maternal death surveillance data and the response in all health zones.
- Promote the use of best practices in the management of neonatal infection, especially in Kolwezi (Manika and Dilala), Kamina, and Tshumbe.

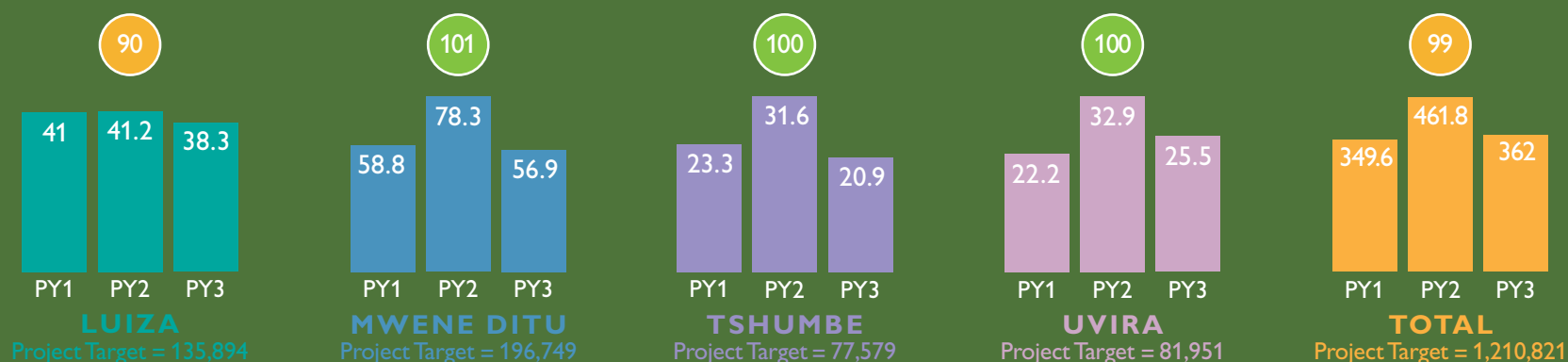


Fig 18. Number of newborns receiving antibiotic treatment for infection from health workers through USG-supported programs

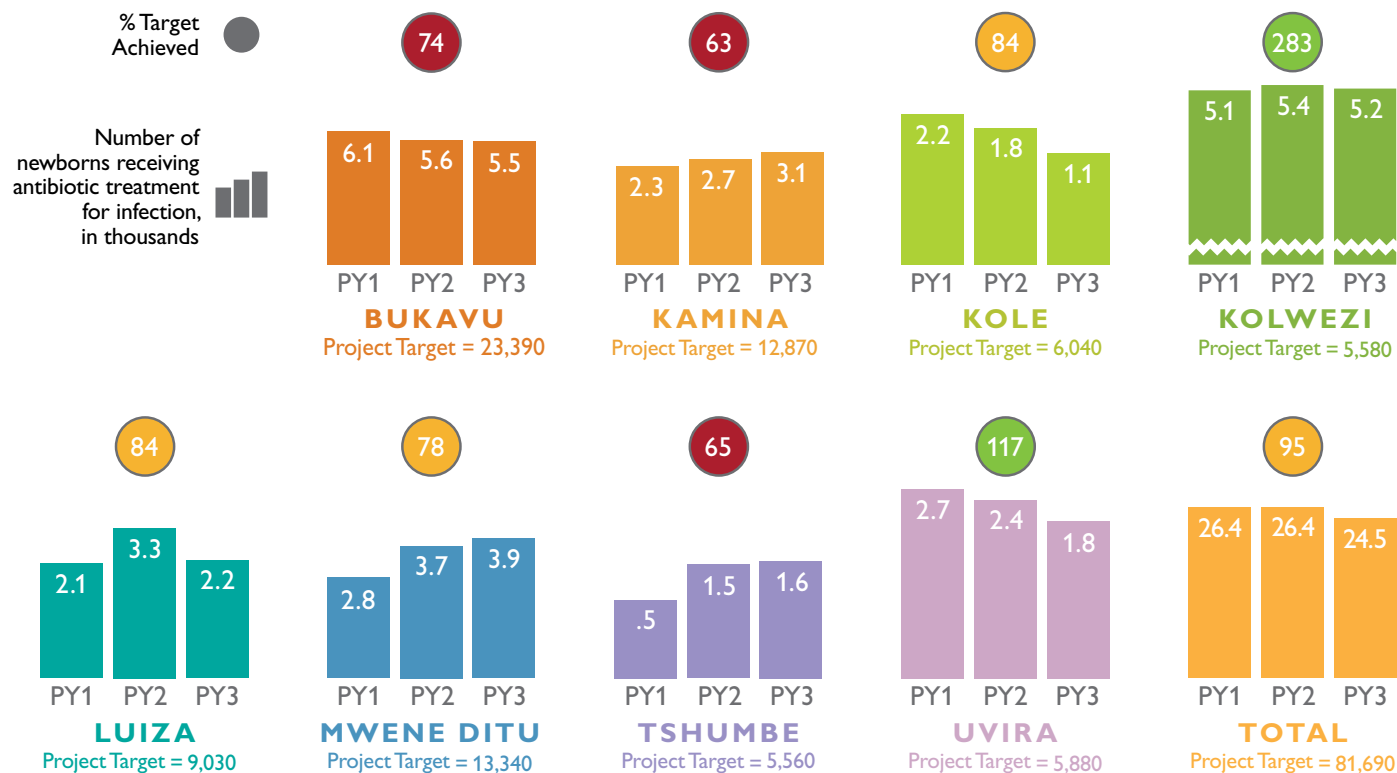
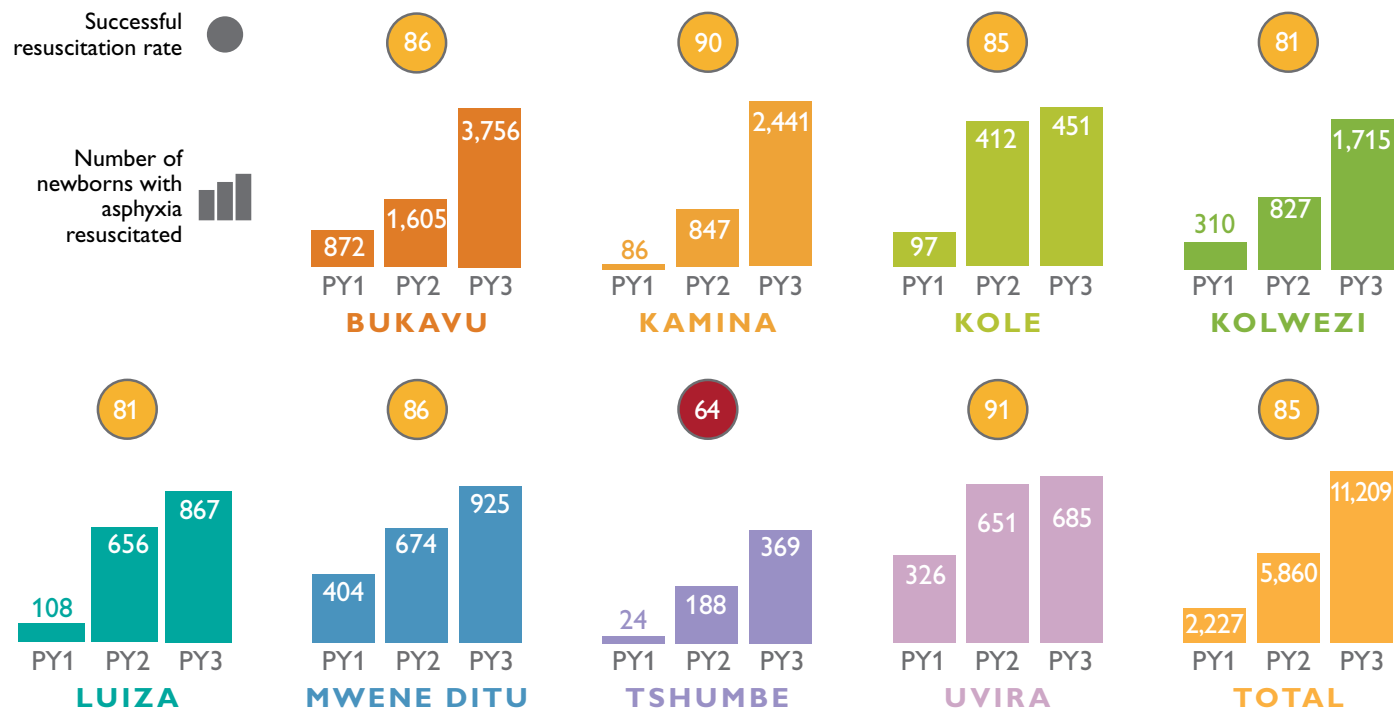


Fig 19. Number of newborns with asphyxia resuscitated in USG-supported programs





“ My baby was born not breathing... I was so scared that I began to cry. Then, when he began to breathe, I was so happy and thankful that Mama Nsimire knew what to do!”

—Julienne Kandanda, Mulamba Health Center

- Expand the integration of the WHO simplified protocol for the management of serious bacterial infections in newborns and infants.
- Integrate the grouped ANC strategy to increase the rate of ANC4 visits.
- Advocate with provincial decision-makers to build roads to facilitate access to health facilities in Kamina.

- Revitalize the family kit strategy for deliveries, especially in Kamina, where there are many home deliveries.

LESSON LEARNED

Peer training does not lead to the development of required skills for adequate child-birth management and neonatal resuscitation. Since it is difficult to train all providers

in all health facilities, other innovative capacity building strategies (e.g., on-the-job trainings, “centers of excellence”) should be implemented to address the skill gaps of providers working in health facilities, while also teaching them to impart these skills to others; and appropriate strategies are needed for supportive monitoring by technically stronger facilities.

Expanded Program on Immunization

The DRC’s Expanded Program on Immunization (EPI) was launched in 1978 and is coordinated by the disease control division (*Direction de la lutte contre la maladie, 4e Direction*). Its purpose is to help reduce vaccine-preventable morbidity, mortality, and disabilities.

The DRC faces major logistical challenges to providing sustainable immunization

services through the “Reach Every Zone” (*Atteindre chaque zone [ACZ]*) approach, DRC’s national vaccination approach as outlined in the complete multiannual plan (*Plan Pluriannuel Complet*) 2015–2019, and EPI Strategic Plan. IHPplus succeeded in reaching and maintaining its objective of a minimum 9% vaccination coverage for most antigens, including *Bacillus Calmette-*

Guérin (BCG), diphtheria, tetanus, whooping cough, haemophilus influenza type B, and hepatitis B (DTP-HepB-Hib3), polio (OPV3), measles (VAR), tetanus diphtheria (Td2+), which are administered according to the country’s current vaccination schedule.

IHPplus strengthened vaccination services by focusing on local capacity building



“ I became a nurse because my grandmother was a nurse, my sisters are nurses, and one of my aunts is a nurse. **IN APRIL 2017, I WAS ONE OF FIVE PEOPLE FROM BAGIRA GRH TRAINED IN HBB TECHNIQUES BY IHPPLUS.** I then trained the other midwives in the technique, which is used when babies are not breathing after they're born. I also provide refresher training in HBB for them every three months and train new hires.

We used to hit the baby on the side, turn him or her upside down, and use mouth-to-mouth resuscitation. **NOW, WE HAVE A CLEAR PLAN TO RESUSCITATE BABIES WHO ARE NOT BREATHING AT BIRTH, AND IT WORKS.**

On average, I use HBB techniques on two babies each month out of about 70 women who deliver. One mother I was able to help was Deborah Ndema, whose first-born baby was not breathing when he was born. We used the three steps of HBB on him—**aspiration, stimulation, and ventilation—before he began to breathe. IT WAS SCARY FOR DEBORAH WHEN SHE SAW HER BABY NOT BREATHING, BUT BECAUSE OF OUR TRAINING, I KNEW WHAT TO DO!**”

EXCERPTS FROM AN INTERVIEW WITH
NEEMA KITIMA on **HELPING BABIES BREATHE**
Head midwife, Bahira GRH, Bukavu health zone

through monthly and quarterly supportive supervision visits to HZMTs and providers, by providing technical and financial support for joint visits by DPS and EPI teams to health zones, and for visits by HZMTs to health centers and other health facilities to monitor vaccination activities and data reported. In lieu of organizing formal trainings, the project specifically focused its supervision visits on building provider capacity to implement the EPI in health zones and health areas.

The project participated actively in all major MOH interventions targeting accelerated control of vaccine-preventable disease, including: the polio eradication initiative

(*Initiative pour l'éradication de la polio*), measles eradication, maternal and neonatal tetanus (*Tétanos Maternel et Néonatal*), and yellow fever control. For each vaccine-preventable disease component, the project supported the development and implementation of activity plans at the national level and in 78 project-supported health zones.

IHPplus provided technical and financial support for monthly monitoring meetings; support to validate vaccination data from health zones and health centers before data entry into DHIS2; and support to develop immunization management tools for health zones and health areas. This contributed to improvements in the quality of immuni-

zation data (data completeness and timeliness), although much remains to be done to improve data quality.

The project supported the MOH to reproduce the community-based disease surveillance guide, disseminate it to the 78 project-supported HZMTs, and brief head nurses and CHWs about community-based vaccine-preventable disease surveillance (acute flaccid paralysis (AFP)/poliomyelitis, measles, maternal and neonatal tetanus, yellow fever, etc.) especially in vaccine-preventable high-risk health zones (such as Bilomba, Kalomba, Luambo, Luiza, Malemba, Ruzizi, and Uvira).

Table 7. Vaccination coverage per antigen and per coordination office, PY1–PY3

Antigens	Years	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	IHPplus	Target	Achievement %
VAT2+	PY1	83	107	95	103	88	98	94	91	95	95	100
	PY2	73	118	99	99	84	95	82	91	93	95	98
	PY3	85	108	89	93	107	83	66	87	90	95	94
BCG	PY1	67	98	88	126	84	89	74	70	87	95	92
	PY2	83	114	139	71	87	96	64	84	92	95	97
	PY3	102	105	93	94	91	84	72	70	89	95	94
DTC-HepB-Hib1	PY1	108	107	107	125	100	100	93	104	106	95	111
	PY2	89	109	126	102	88	95	88	102	100	95	105
	PY3	102	109	93	83	87	83	67	82	88	95	93
DTC-HepB-Hib3	PY1	103	104	117	103	98	95	89	98	101	95	106
	PY2	86	103	98	116	86	92	84	97	95	95	100
	PY3	97	105	83	87	84	79	64	71	84	95	88
PCV-13 (3)	PY1	94	33	115	31	45	91	50	87	68	95	72
	PY2	79	64	58	87	60	68	24	94	67	95	70
	PY3	97	102	81	86	85	79	61	84	84	95	89
OPV 3	PY1	99	100	110	92	92	63	82	89	91	95	96
	PY2	86	108	110	111	87	97	88	96	98	95	103
	PY3	96	109	76	87	91	79	64	82	86	95	90
VAR	PY1	100	103	107	104	98	96	93	89	99	95	104
	PY2	79	109	107	110	88	93	75	91	94	95	99
	PY3	94	102	107	89	89	76	64	86	88	95	93

To improve geographic coverage of the cold chain in health zones and health areas, IHPplus contributed to preparations for introducing new vaccines, including the rotavirus vaccine planned for 2018.

IHPplus provided fuel (125,600 liters of fuel oil) for cold storage in EPI outposts (Bukavu, Kananga, Kando Dianda, Kolwezi, Luiza, and Uvira), supported the use and maintenance of the 655 absorption refrigerators in health zones and health areas with kerosene (658,800 liters), and provided spare parts (8,740 wicks), burners (4,410 burners), and glass containers (4,410 containers).

This assistance contributed to supplying and managing sufficient quantities of active vaccines for each immunization round.

The data presented in Table 7, page 47, show that immunization coverage was maintained at around 90% over the three years (within a range of 84% to 106%) for most antigens except for PCV13 (between 67% and 84%), which was due to low availability of this antigen in the country and in most project health zones.

These strong results confirm that the project implemented strategies and activities conducive to improving and maintaining immunization indicators. Strategies included logistical support to the cold chain (provision of wicks, glass containers, burners, and 1.5 liter of kerosene per day and per absorption refrigerator for all project-supported health zones); transport of vaccines and auto-disable syringes from EPI outposts to remote health zones (e.g., Luamba, Malemba, Mulungu, Shabunda, Walungu), supportive supervision, validation of data, monthly monitoring of activities in the health zones, institutional capacity building and organizational development,

and community development (CODESA involvement in analysis meetings and the monitoring of immunization data).

Health zones in the Tshumbe coordination registered inconsistent and often weak results over the three years (between 24% for PCV13-3 during PY2 and 94% for VAT2+ during PY1) compared to other health zones. Immunization coverage decreased for the majority of antigens in PY3 in Tshumbe. This situation is due to the poor availability of vaccination commodities at the EPI outpost in Tshumbe; the cold room was not operating correctly as a result of lack of fuel. The Lusambo, Minga, and Pania Mutombo health zones were the most affected by these stock-outs since they are more difficult to reach by road and by river and have lower immunization coverage. The drop in Tshumbe's performance between IHP and IHPplus is explained by the creation of new provinces in 2015. During IHP, some health zones (including Lusambo and Pania Mutombo) in the Tshumbe coordination received EPI commodities from the Mbuji Mayi EPI outpost. Since the restructuring, these health zones now rely on the more distant and less functional EPI warehouse for the Sankuru province located in Tshumbe, which has resulted in reduced availability of vaccines and other immunization commodities.

During PY3Q4, with GAVI funding, WHO provided a team of technicians to install solar power for cold storage in Lodja and Tshumbe to help improve the availability of immunization commodities. The challenge will remain to transport these inputs to the three remote health zones and to recover children insufficiently vaccinated in these health areas.

CHALLENGES

The major challenge to improving vaccination coverage remains poor availability of

vaccines and other immunization commodities at the national and provincial level and in the EPI outposts or DPSs. Other logistical challenges include less than optimal operation of EPI cold rooms in the EPI outposts and in the DPSs, the irregular supply of vaccines and other immunization commodities from the central EPI level according to the distribution plan, and maintaining and servicing cold rooms at this level.

The lack of micro-planning of routine vaccination at the grassroots level and some geographical challenges explain the large number of children that have not been vaccinated or have not been fully vaccinated, which could result in new outbreaks of vaccine-preventable diseases. Micro-planning at the grassroots level involves community members, leaders of groups unwilling to vaccinate and of special groups (e.g., pygmies, refugees), and specific and innovative strategies, and could help achieve the goal of eliminating vaccine-preventable deaths.

Additional challenges include poor quality of immunization data, the turnover of trained personnel, non-cyclical training of health personnel (no agreement on frequency), and inaccurate annual counting of target populations in health areas leading to immunization coverages exceeding 100% in some health zones and health areas having difficulties with data analysis.

RECOMMENDATIONS

- Support the operations and maintenance of the cold chain (kerosene, wicks, glass containers), supply solar refrigerators to health areas and health zone central offices as required by the national policy, which aims at gradually replacing kerosene refrigerators to significantly reduce the costs of making the cold chain functional.



- Scale up the ACZ approach to make vaccines available at the last mile. Additional support is needed to improve ACZ microplanning (reaching every health zone), population census at the health area level, and for EPI-specific training. While coverage at the health

zone level is good, there are still unvaccinated children at the community level. Future efforts should focus at this level.

- To help improve immunization data quality, assistance is needed to produce additional copies of management tools and conduct data audits, including Data

Quality Self-Assessment and Lot Quality Assurance Sampling, in households for health zones with an immunization coverage exceeding 95% for three months to compare reported immunization coverage with actual coverage in households.

Family planning

IHPplus aligned its activities with the DRC government's priority policy on FP outlined in the 2014–2020 multi-sectoral strategic FP plan, which aims to increase modern contraceptive prevalence from 6.5% to at least 19% by 2020. This increase will ensure access and use of modern contraceptive

methods to at least 2.1 million additional women.

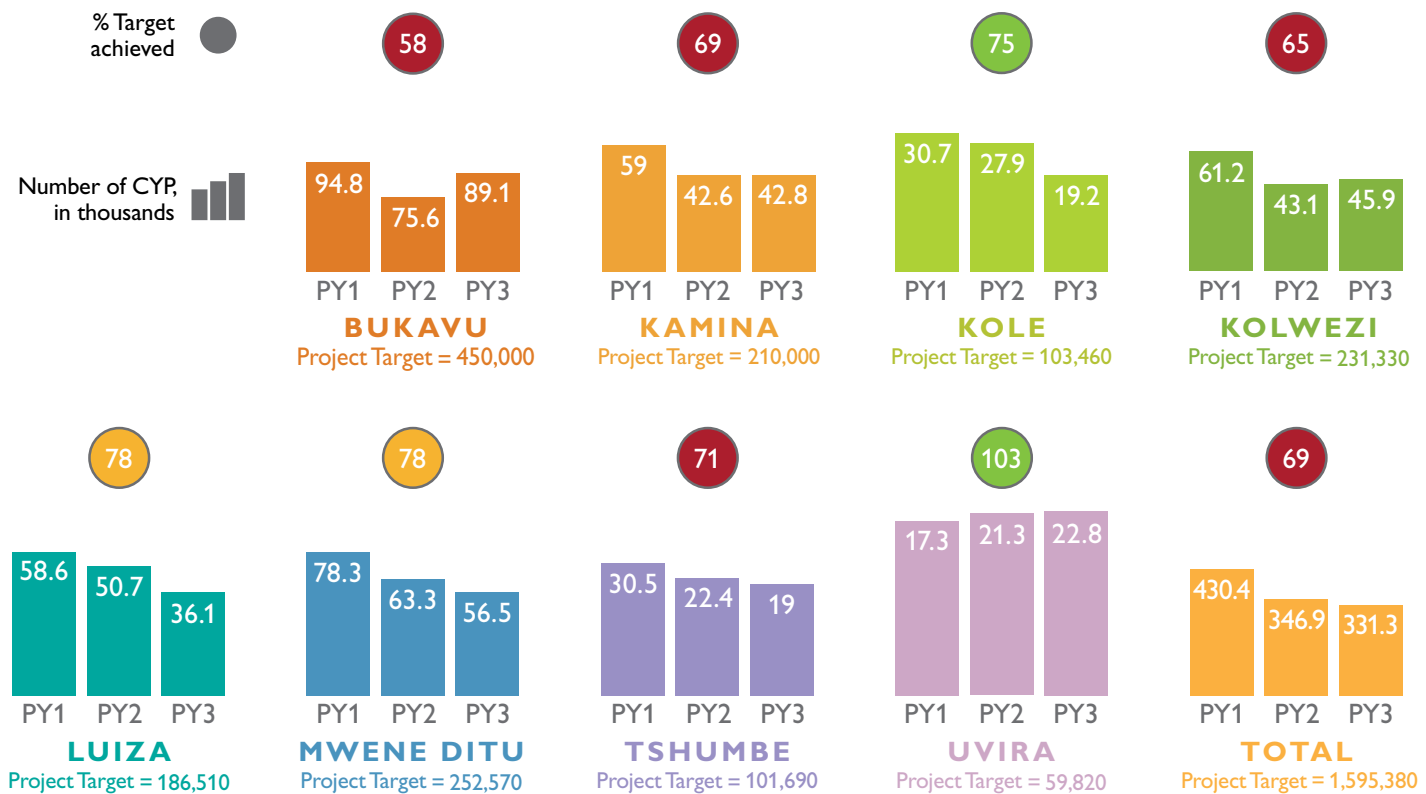
Continuing the work of IHP, IHPplus supported the extension of FP service coverage to 160 new health areas; support to community-based distributors (CBDs) in 82 new health areas; the integration of new contraceptive

technologies (Sayana Press, Implanon NxT, voluntary surgical contraception, postpartum FP) at health facilities; the organization of mini-FP campaigns and regular supply of a variety of contraceptive methods; and supervision of and follow-up on the regulations about voluntary and free choice.



Community health worker Heri Nyamwijima swabs the arm of Esperance Mwalukula before giving Esperance her injection of Sayana Press. The injection of Sayana Press provides effective birth control for three months. Heri Nyamwijima is very proud of the new skill – to give injections – that she has acquired thanks to IHPplus training. Photo by Rebecca Weaver.

Fig 20. Couple years protection (CYP) in USG-supported programs



To achieve these results, IHPplus:

- Participated actively as a permanent member of the national *Comité Technique Multisectoriel Permanent*;
- Provided technical support to the MOH to develop standards for the provision of FP services at the health facility level and develop the scale-up plan for subcutaneous Depo-Medroxy Progesterone Acetate;
- Participated in the annual workshop on FP data consensus;
- Trained 1,612 providers and community members on quality FP service provision in 30 health zones across the eight project-supported coordinations. Of the total trained providers, 944 are CBDs, including 295 women (31% gender parity). Of the remaining 668 clinical providers trained, 207 are also women (31% gender parity). IHPplus was successful in aligning its efforts with the government recommendations to achieve a 30% gender parity rate and promoted the participation of women and the integration FP implementation activities;
- Integrated permanent methods (tubal ligation and vasectomy) and postpartum FP methods, along with the implementation of a voluntary surgical contraception campaign in four health zones of the Sankuru DPS. Provided financial support to purchase the needed equipment for the voluntary surgical contraception campaign;
- Organized 160 mini-FP campaigns to promote access to community-based FP services by employing the following strategies: SBCC campaigning, door-to-door service delivery, and fixed-site clinical service delivery at the health center;
- Managed and supported provision of FP commodities and management and delivery tools. These include a range of

FP methods including male and female condom, contraceptive pills, Depo-Provera, Sayana Press, Implanon NxT, Jadelle, Levonorgestrel, cycle beads, the intra-uterine device (IUD) and other commodities such as Lidocaine, pregnancy tests, wadding, compresses, scalpels, syringes, gloves, and FP posters and informational pamphlets describing the various FP methods;

- Established a permanent multi-sectoral FP technical committee in the Lualaba and Sankuru provinces;
- Developed abstracts to document project results. The following abstract was selected for presentation during the International Family Planning conference that will be held in Kigali, Rwanda, in November 2018: “The impact of the organization of mini-campaigns for community-based family planning service provision.”

At the national level, IHPplus staff participated in the validation and dissemination of the PNSR’s operational action plan. In addition, IHPplus jointly organized collaboration meetings to manage the supply of FP and other commodities with GHSC-TA.

RESULTS

CYP in USG-supported programs:

During IHPplus, FP methods were provided to a total of 1,108,633 couples, protecting them against unwanted pregnancies using at least one of the contraceptive methods (Figure 20). This estimate is based on the number of contraceptives distributed to clients by IHPplus. This represents an achievement rate of 69% against a PMP target of 1,595,380. A decrease in the CYP was recorded between the PY1 and PY2, dropping from 430,425 in PY1 to 346,890 in PY2. Results from PY3 were overall very strong (96% achievement rate) despite there only being data available for the first three

quarters of the project year.

During the revision of the Performance Indicator Reference and Tracking Sheet (PIRTS), which includes the definition and calculation of indicators, IHPplus discovered that the conversion factor used for calculation of CYP for two methods was incorrect. Once these calculation errors were corrected, the number of CYP decreased compared to previous quarters (during which the data were incorrectly calculated). The increase in CYP performance in PY3Q3 may be due to the following intensive FP activities: integration of private facilities into the DHIS2 database; availability of FP commodities; community monitoring of CBD; the increasing adoption by clients of long-acting methods; effective training of providers and CBDs, coupled with the organization of mini-FP campaigns; and the integration of new contraceptive technologies, including voluntary surgical contraception, postpartum FP, and Sayana Press.

FP counseling visits:

Counseling in FP is one of the most important factors for monitoring and ensuring client adherence to contraceptive methods. During IHPplus implementation, a total of 1,841,691 counseling visits were completed. This represents an 87% achievement rate compared to a target of 2,125,040 (Figure 21, page 52). The overall positive trend of this indicator may be primarily due to training of providers and CBDs, integration of postpartum counseling visits, counseling for the renewal of FP methods, implementation of mini-campaigns, and follow-up of the clients who requested FP methods. Mwene Ditu surpassed its target (104%), while Bukavu and Uvira also performed well, achieving a 98% and 91% achievement rate respectively. Kamina, Kole, Kolwezi, Luiza, and Tshumbe were also close to achieving their targets as a result of the effective implemen-

tation of FP mini-campaigns organized in their respective health zones.

LESSON LEARNED

The introduction of new FP methods (Sayana press®, Implanon NxT) that can be administered by CBDs and their inclusion in mini-campaigns at the village level had an impact on the uptake of new FP methods. However, women newly using FP methods should be monitored by motivated CBDs to ensure adherence and program retention.

Nutrition

Malnutrition is a widespread public health concern in the DRC that most severely affects young children. According to the 2013–2014 Demographic and Health Survey, 43% of children in the DRC are stunted, 23% are extremely underweight, and 8% of all children in the country die as a result of malnutrition. Causes of malnutrition are many and multifaceted and include poor feeding practices in infants and children, as well as poverty, and lack of information and access to facilities. According to the same study, only 48% of mothers practice exclusive breastfeeding up to six months, and only 23% of children 6–24 months are adequately fed a balanced complementary diet of semi-solid and solid foods.

RECOMMENDATIONS

- Continue to implement the CBD approach in conjunction with FP mini-campaigns in the health zones.
- Extend training and introduction of new contraceptive methods to more health zones.
- Establish pools of trainers at the health zone and DPS levels to guarantee sustainability.

- Regularly monitor the supply of FP commodities.
- Train providers on management of FP commodities.
- Organize supervision visits of trained providers and CBDs to monitor quality of services offered.
- Organize quarterly FP mini-campaigns in the health areas to increase awareness about FP methods.

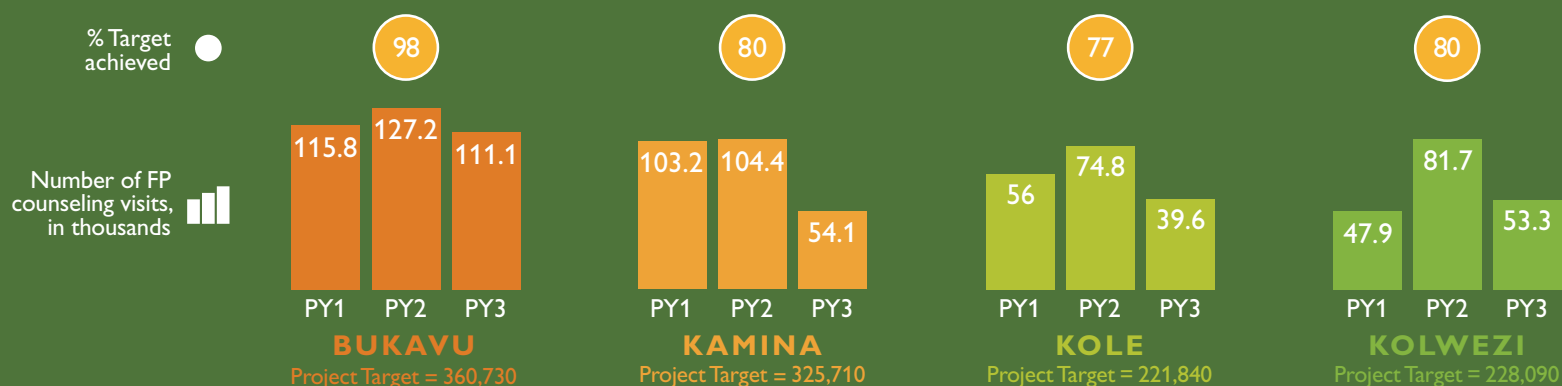
TECHNICAL APPROACH AND ACTIVITIES

In an effort to address chronic child malnutrition in the DRC, IHPplus carried out a number of interventions, including:

- The promotion of infant and young child feeding (IYCF) on a monthly basis in all project-supported health zones, including nutritional counseling, the promotion of IYCF support groups, and the management and distribution of iron folate at both the health facility and community level in 31 health zones;
- Joint IHPplus-PRONANUT (DRC National Nutrition Program) supervision visits to monitor IHPplus-supported nutrition activities in the health zones;

- Capacity building of IYCF facilitators and health care providers through training in IYCF and revitalized preschool consultations (PSC);
- Procurement of commodities including 250,000 tablets of Albendazole (400mg), 90,000 vitamin A capsules (dosed at 100,000 international units), and 250,000 vitamin A capsules (dosed at 200,000 international units) through the company Vitamin Angels in August 2016;
- Integration of PSC in 337 health structures across 18 project-supported health zones to monitor growth of infants. In addition, a PSC pilot intervention was implemented in the health zones of Bagira and Dilala that aimed to provide

Fig 21. Number of FP counseling visits during IHPplus



care and support to mothers along with their infants during these visits;

- Distribution of 1,329 informational pamphlets on nutrition and data collection tools to providers and CHWs at their respective health facilities;
- Organization of events to celebrate World Breastfeeding Week in August 2017 in the health zone of Dilala which included awareness-raising campaigns and testimonials led by CHWs on the importance of exclusive breastfeeding for the first six months;
- Implementation of a nutrition study in three health zones that aimed to collect data on knowledge, attitudes, and practices around IYCF to assess and measure the impact of IYCF promotion in the IHPplus-supported health zones (see Appendix 4).

RESULTS

Stock-outs of folic acid:

In PY1, the project recorded the highest number of health facilities experiencing stock-outs of iron folate (587), as indicated prior in Figure 7B, page 19. This number decreased during the course of the project, with 339 health facilities experiencing stock-outs in PY2 and only 161 facilities experiencing stock-outs in PY3, compared

to a project target of 221. The steady improvement of this indicator throughout the project is a result of the support provided by IHPplus to strengthen supply chain management and monitoring of the distribution of iron folate from the regional distribution center to the health zone central offices and finally to the health facilities. In addition to providing logistical and financial support in the transportation and distribution of these commodities to the health facilities, IHPplus also organized regular meetings with the health zone central office to review stock levels across health facilities.

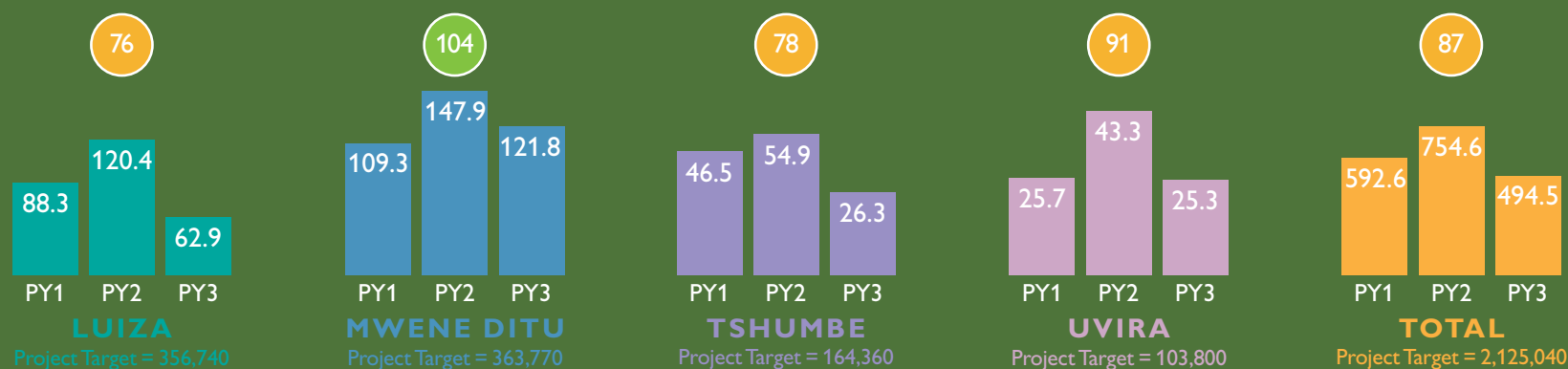
Proportion of pregnant women who received iron folate tablets to prevent anemia during the last five months of pregnancy:

During the life of the project, 1,113,507 pregnant women received iron folate tablets to prevent anemia during the last five months of pregnancy, an achievement rate of 128% against the total number of women attending at least four ANC visits (869,486) (Figure 22, page 55). With the exception of Kole (at 95%), all other coordinations surpassed a 100% achievement rate. This strong performance may have been due to steady improvement in the availability of commodities at the health facilities, regular administration of iron folate by providers to

pregnant women during routine ANC visits in the majority of health facilities, as well as strong and effective awareness raising efforts by CHWs and providers on the importance of iron folate for pregnant women and families. Engaging CHWs in nutrition-related activities is an effective strategy for increasing the number of women receiving iron folate supplements during their ANC visits because it is primarily the role of the CHW to inform and encourage women to go in for their ANC visits.

Number of people trained in child health and nutrition through USG-support:

Between PY1 and PY3, a total of 916 against the target of 1,869 people were trained in child health and nutrition by the project, or 49% (Table 8, page 56). IHPplus has trained providers and CHWs on IYCF, PSC, HBB, and IMCI), with particular emphasis on detecting malnutrition. IHPplus staff have also led briefings and trainings for members of DPS on PSC, IYCF promotion, management of acute malnutrition, the community-based nutrition approach, as well as monitoring and supervision of nutrition-related activities, and nutritional surveillance. With the exception of Kolwezi and Mwene Ditu, the majority of coordinations performed under 80% of the achievement rate. The lowest





“ I first heard about the YCF support group at an ANC visit during my most recent pregnancy. The head nurse, Elisée, had noticed that I would start giving water and solid foods to my four older children when they were three months old, at the urging of my husband. **AS BABIES, OUR CHILDREN WERE ALWAYS SICK.** We spent a lot of money on hospital visits and medicine for them.

“On Elisée’s recommendation, I began to attend the support group meetings, led by Angel Mbuyi. **I LEARNED THAT I SHOULD EXCLUSIVELY BREASTFEED MY YOUNGEST DAUGHTER UNTIL THE AGE OF SIX MONTHS.** Since then, I have seen a huge difference in the health of this child compared to her siblings at the same age. She is now six months old, and has never been sick.

“The support group also encouraged me to bring my older children to the health center for regular check-ups, and **TAUGHT ME HOW TO PREPARE A PROTEIN-RICH PORRIDGE** for them. Their health has greatly improved as well. My husband is now enthusiastically supportive, and often participates in the support group meetings with me. **I CALL ELISÉE AND ANGEL MY GODS, BECAUSE OF THE WAY THAT THEY HELPED MY FAMILY.**”

EXCERPTS FROM AN INTERVIEW WITH
SCHOLASTIQUE MUKENYI on ICYF
33 years old, married with five children, Dibindi health zone

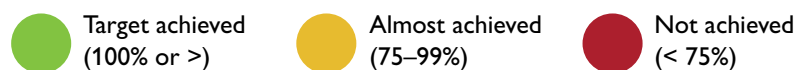
performing coordinations include Bukavu (7%), Kole (0%), Tshumbe (0%), and Uvira (36.6%). The poor performance is due to a lack of funding available to carry out nutrition-related trainings as planned.

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

A total of 2,393,793 out of 3,115,432 mothers of children under two years of age or less received nutritional counseling during the life of project, a 77% achievement rate (Figure 23, page 56). Two coordinations, namely Bukavu (123%) and Mwene Ditu (106%) surpassed the target. Strong performance can be attributed to the high level of motivation and capacity among providers in these coordinations to provide nutritional counseling to mothers during

consultation sessions at the health center, as well as the support and motivation of CHWs (members of IYCF) to organize effective awareness-raising campaigns and nutrition and essential family practice counseling sessions for breastfeeding mothers in the community—including the 2017 World Breastfeeding Celebration, where a total of 1,508 households were reached. The strong performance noted in these coordinations may have been facilitated by the supportive supervision visits conducted by HZMTs to health facilities, with the technical support of IHPplus, to monitor the quality of nutrition-related activities, including IYCF promotion and counseling at the health facility level, as well as IYCF support groups.

Despite these strengths, the overall indicator had a lower achievement rate than expected, which can be attributed to the underperformance in the coordinations of Kole, Kolwezi, and Tshumbe, which achieved 55%, 51%, and 27% of their respective project targets. This underperformance may be due to an ongoing low level of engagement of HZMTs in monitoring nutrition-related activities at the facility level, weak or ineffective monitoring and support provided to IYCF facilitators by health providers, and a general lack of awareness or motivation among health care providers on the need to integrate and collect data on nutrition counseling during consultation visits with mothers of children two years or less.



All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

Fig 22. Pregnant women who received iron folate tablets to prevent anemia during the last five months of pregnancy

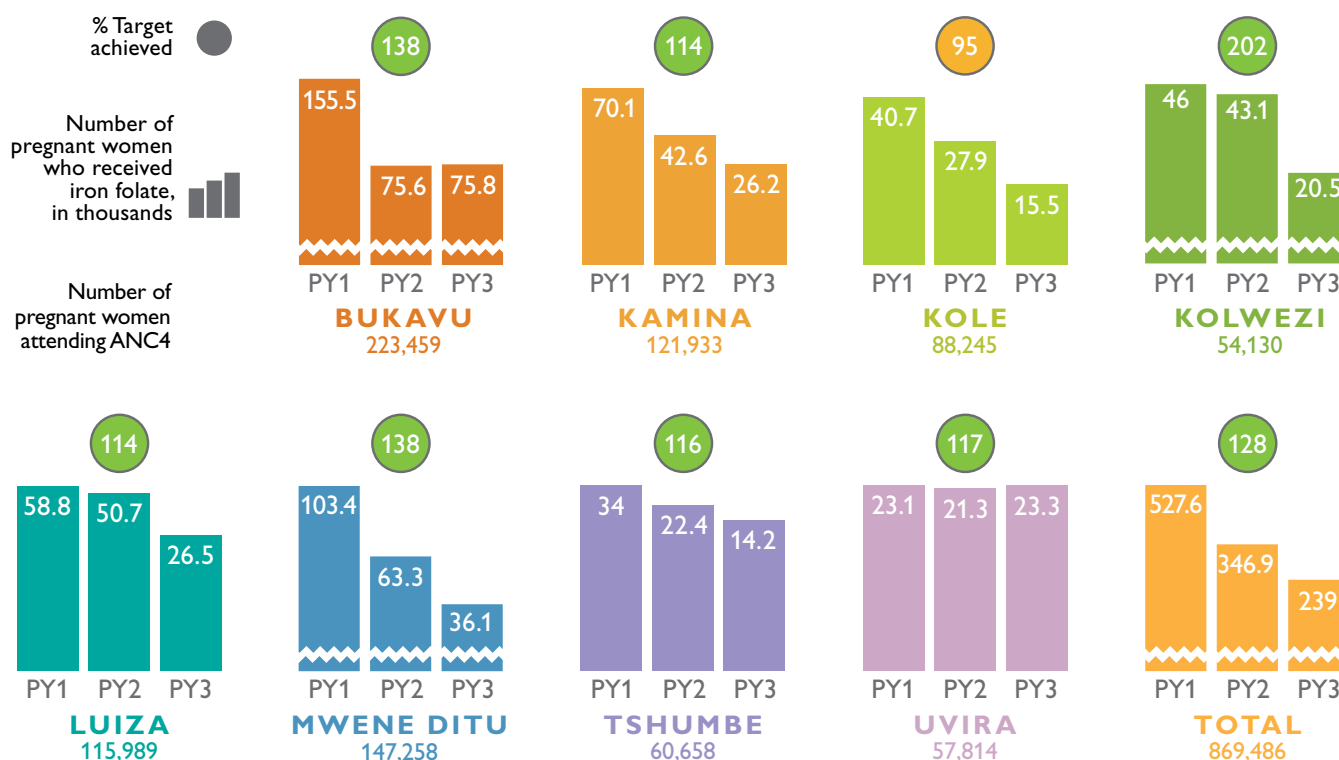


Table 8. Number of people trained in child health and nutrition

Coordination	PY1	PY2	PY3	Total	Target	Ach %
Bukavu	0	21	0	21	300	7
Kamina	0	170	0	170	249	68
Kole	0	0	0	0	180	0
Kolwezi	57	50	50	157	180	87
Luiza	0	182	0	182	360	51
Mwene Ditu	74	184	62	320	180	178
Tshumbe	0	0	0	0	240	0
Uvira	0	66	0	66	180	37
Total	131	673	112	916	1,869	49

CHALLENGES

- Extreme poverty and lack of access to food products and information continue to pose barriers for families to applying nutritional guidelines and recommendations and effectively promoting proper IYCF practices.
- There is a gap in knowledge among providers on the average monthly consumption of commodities, thus hindering regular procurement and supply of commodities based on need.

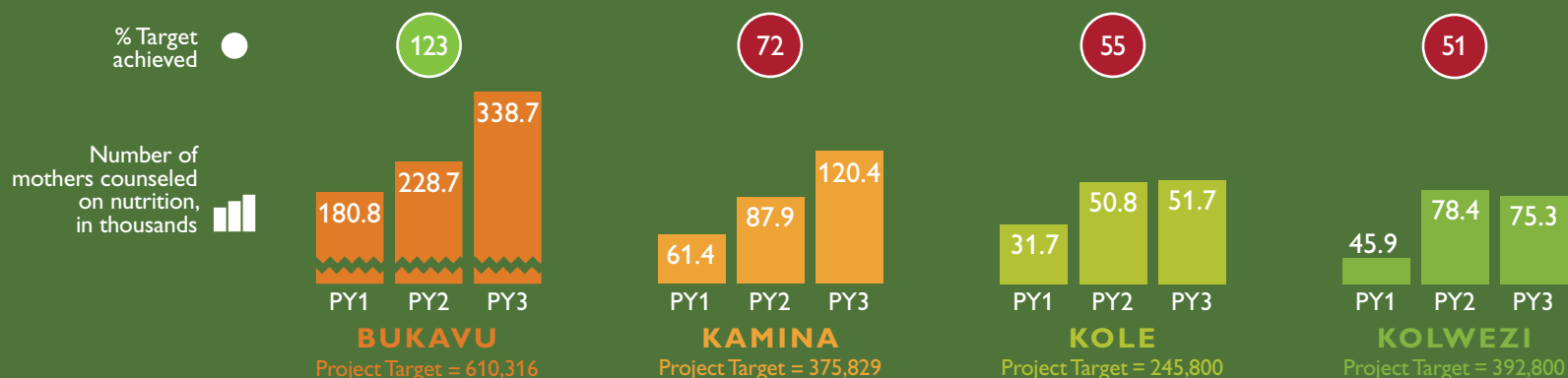
LESSONS LEARNED

- The promotion and integration of IYCF into maternal and child care, and in particular, the implementation of IYCF support groups for mothers and families, is an effective way for mothers to learn correct feeding practices and to build a network and support system and is an approach that should continue to be implemented.
- The revitalized CPS is a new approach recommended by PRONANUT that has only been in place since 2017, and needs more time to take effect. Providers have noted that it takes some time for women to adjust to the new schedule, and many

still stopped attending after their child's immunization schedule was complete. The revitalized CPS approach also requires a certain level of staffing in the health facility—at least four providers and two CHWs—which often is not possible in many of the health facilities. Moving forward, it will be important to explore how to best adapt this approach given the limited resources available.

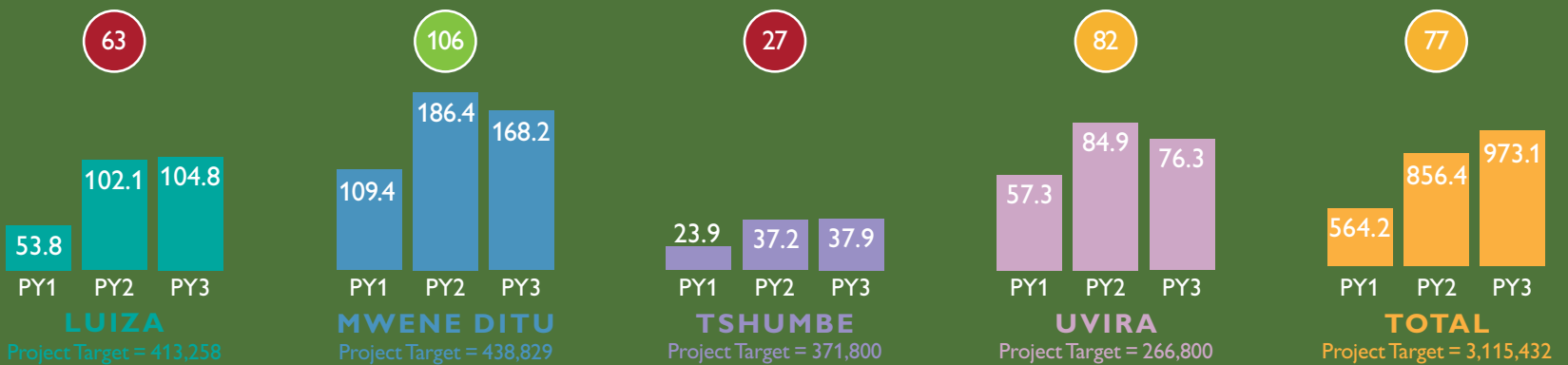
- It is also important to continue to train providers on supply chain management and proper monitoring of commodities to avoid stock-outs and guarantee a regular and sufficient supply of iron folate and other commodities across health facilities.

Fig 23. Number of mothers with children two years or less who received counseling on nutrition





Cooking demonstration at Pwimbe Health Center. Photo by Eleonora Kinnicutt, MSH.



“ In July 2017, I led a USAID-funded IHPplus campaign to help fight malaria in pregnant women. During the month we ran the campaign, we saw an increase of more than 40% in the number of women who came to the Miti Murhesa health center to receive free bed nets.”

— Focas Bihigi, member of CODESA in Miti Murhesa



Malaria

TECHNICAL APPROACH AND ACTIVITIES

Malaria-related activities under IHPplus were implemented in a total of 168 health zones, including the 42 PMI-Expansion Project (PMI-EP) health zones acquired in December 2017. The total population covered by IHPplus malaria interventions is 31,517,457, or approximately 39% of the population of the DRC. Pregnant women and children under five are the most vulnerable and at-risk groups for malaria. In response, IHPplus focused activities and interventions on prevention, diagnosis, and treatment of malaria for the population, with particular focus on vulnerable groups.

With regard to prevention, IHPplus provided technical and coaching support to health providers to distribute ITNs to pregnant women and new mothers during ANC and post-natal visits; trained providers on national malaria case management guidelines, including the administration of intermittent preventive treatment (IPT) for pregnant women during ANC visits; administration of RDTs, and correct prescription of ACT to patients; and led SBCC efforts, primarily through malaria mini-campaigns, to raise awareness of the importance of early ANC for pregnant women and IPT administration, with support of trained CHWs and the Champion Communities.

Regarding diagnosis and treatment of malaria, IHPplus managed the procurement and distribution of antimalarial commodities, including ACTs, SP, ITNs, and treatment kits for severe malaria; trained providers and laboratory technicians on diagnosis and management of malaria; organized and led post-training and joint supportive supervision visits with the MOH to assess quality of malaria services offered

at the health facility level as well as provider's overall understanding and adherence to malaria case management guidelines; and led joint data evaluation visits in the field.

All malaria-related activities implemented by the project were developed in line with the PNLP 2016–2020 National Strategic Plan, with the objective of reducing the morbidity and mortality rates of malaria by 40%. The key activities carried out by IHPplus in collaboration with the PNLP are the following:

- Procurement of antimalarial commodities, tools, and equipment: IHPplus provided financial support throughout the life of the project to transport and distribute commodities, including ITNs, SPs, RDTs, and malaria treatment kits, to all project-supported health zones; stock health facilities and i-CCM sites with data collection and management tools; and equip i-CCM sites with essential tools needed to function, including medicine cases, scales, decanters, water cans, plastic chairs, timers, and plastic baskets with lids.
- Capacity strengthening efforts in malaria case management, supervision, and data quality: IHPplus provided technical and financial support throughout the project to train doctors, nurses, and CHWs on prevention, diagnosis, and treatment of malaria in adherence to national guidelines; conducted joint supervision visits with the PNLP and DPS to health zone central offices and health facilities in the 168 project-supported health zones; and led monitoring and supportive supervision visits to i-CCM sites with the support of PMI, as well as data validation visits at the DPS and health zone central offices in the project-supported health zones.
- SBCC: IHPplus provided technical, logistical, and financial support to carry out malaria mini-campaigns in two health zones within each project-supported coordination, as well as a four-month malaria campaign in the health zones of Idjwi and Miti Murhesa in Sud Kivu to raise awareness of the importance of early ANC for pregnant women and IPT administration; and provided financial and technical support to carry out activities for World Malaria Day annually at both at the national and DPS level.
- Research and innovation: IHPplus provided financial support to carry out research on malaria interventions, including a study on the utilization of rectal artesunate at i-CCM sites for severe malaria cases, as well as an evaluation of the impact of malaria campaigns on IPT of malaria for pregnant women in Sud Kivu (Miti Murhesa and Idjwi health zones); participated in two international conferences, including the Roll Back Malaria SBCC Conference in 2016 during which IHPplus project staff presented the abstract “The Contribution of the Champion Communities Approach to Healthy Behaviors and Utilization of Health Services in Democratic Republic of Congo,” and the 2016 American Public Health Association (APHA) conference where IHPplus staff presented an abstract entitled: “High-impact malaria interventions save children’s lives in the Democratic Republic of Congo.”
- Coordination and partnerships: At the central level, IHPplus has worked closely with the PNLP to organize and lead meetings with its different units, and has provided technical assistance to develop, update, and review national-level normative documents and guidelines related to malaria case management.

RESULTS

It is important to note that as of October 1, 2017, responsibility for the management and distribution of medicines was transferred to the USAID-funded GHSC-TA, implemented by Chemonics, including the procurement and distribution of malaria commodities. As such, malaria-related indicators under IHPplus were reduced from nine to five, as the four indicators related to distribution of commodities were transferred to GHSC-TA.

Number and percentage of pregnant women who received at least two doses of SP during ANC visits:

In PY1, 292,105 pregnant women out of a total of 398,416 (73%) received at least two doses of SP during their ANC visits (Figure 24A); in PY2, this increased to 558,789 pregnant women out of a total of 616,644 (91%), for an achievement rate of 98% and 121%, respectively, against the national target of 75% (Figure 24B). This represents an overall improvement of this indicator between PY1 and PY2, despite a low performance recorded in Haut Katanga (64%). When the health zones of Haut Katanga were integrated into IHPplus in PY2, the rate of SP2 was very low in health facilities.

In PY3 (Figure 24C), in accordance with the PNLN's 2016–2020 national strategic plan, the indicator was changed to report on the number of pregnant women who received at least three doses of SP during their ANC visits, the newly-recommended minimum by the government for preventing malaria among pregnant women. As such, in PY3, 381,111 pregnant women out of a total of 841,712 (45%) received three doses of SP during their ANC visits, for an achievement rate of 91% against the new national target of 50%, which was a decrease from the original 75% target used in PY1 and PY2. The stock-outs of SP reported primarily

between September 2017 and March 2018 across health facilities were due mostly to delays experienced by GHSC-PSM in delivering SP and other antimalarial commodities to the CDRs and subsequently to the health zones; these delays may have contributed to the lower performance of the indicator during the last year of the project.

Despite the decrease noted in PY3, the overall strong performance of this indicator, particularly in PY1 and PY2, was likely affected by the trainings and capacity strengthening efforts carried out by IHPplus for providers and CHWs on malaria prevention, diagnosis, and management.

The project trained 2,274 out of a total of 2,798 providers on malaria prevention (81%), including administration of RDTs and IPT; and 2,608 providers and CHWs out of a total of 3,330 (78%) were trained in accordance with national malaria case management guidelines.

In DRC, many women delay their first ANC visit, often missing the benefit of the antimalarial care and services offered by the health center. In response, IHPplus organized malaria mini-campaigns across its coordinations to sensitize pregnant women on the importance of early ANC visits in order to benefit from at least three doses of SP as an effective way of protecting themselves and their babies against malaria.

Malaria mini-campaigns played an important role in sensitizing and improving knowledge among pregnant women and providers on malaria prevention. Results from the longer four-month malaria campaign conducted in Miti Murhesa and Idjwi show that in Miti Murhesa alone, as a result of the campaign, the number of women who do not know about SP has

decreased from 79% to 38.7% following the campaign; the percentage of providers who do not discuss SP/IPT with their clients has decreased significantly from 85% to 18.1%.

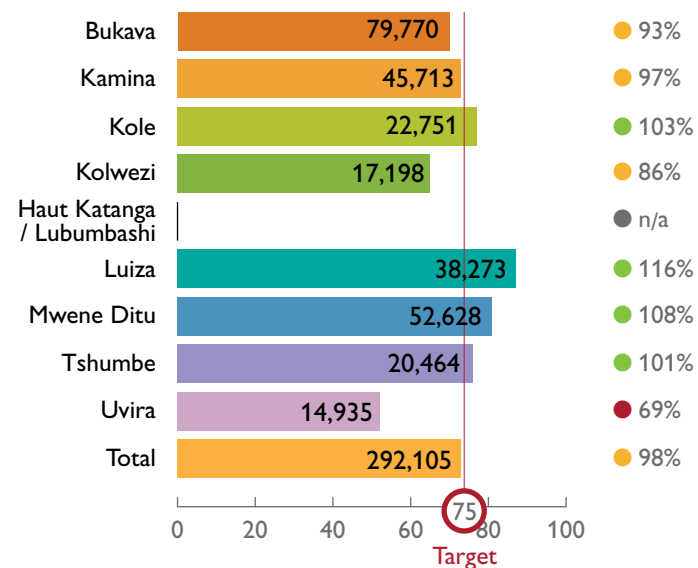
IHPplus also provided support to the PNLN to conduct quarterly supportive supervision visits to health zones as well as monthly joint supervision visits with health zone central offices to health facilities. During the course of these visits some of the key improvements noted include the number of pregnant women benefitting from SP2 and SP3 as well as the increase in the number of cases tested for malaria that were also administered ACTs following diagnosis.

CHALLENGES AND RECOMMENDATIONS

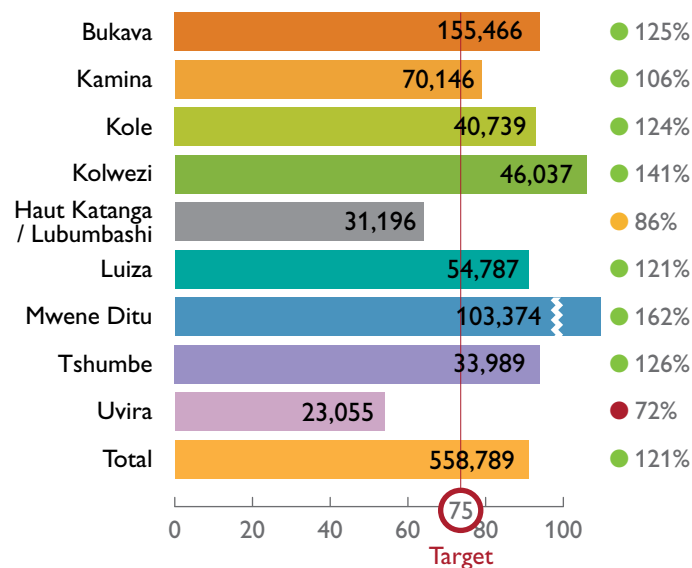
- The project observed improper use and administration of injectable artesunate, leading to frequent stock-outs. Currently, health facilities are stocked with a limited amount of injectable artesunate intended for children less than five years old who are the most vulnerable and at-risk group for malaria. During visits, however, it was noted that the medication was being administered to all patients and for longer periods than recommended, leading to frequent stock-outs and thus inability to treat the target population as needed. The recommendation is to sensitize and train providers on the need to prioritize administration of antimalarials, such as injectable artesunate, for children under five and for the correct period of time to ensure the most effective use of commodities available. It is also recommended that the DPS and health zones prioritize the implementation of a procurement mechanism that will allow them to sustainably purchase antimalarial commodities as needed for the rest of the population, as not all costs of commodities can be covered by the donor.

Fig 24. Number of expectant mothers who received SP during ANC, by the percentage of target achieved and the project year. Targets, locations, and/or dosage guidelines changed each project year.

A. PY 1, receiving at least two doses, target 75%



B. PY 2, receiving at least two doses, new location, target 75%



C. PY 3, receiving at least three doses, new location, target 50%

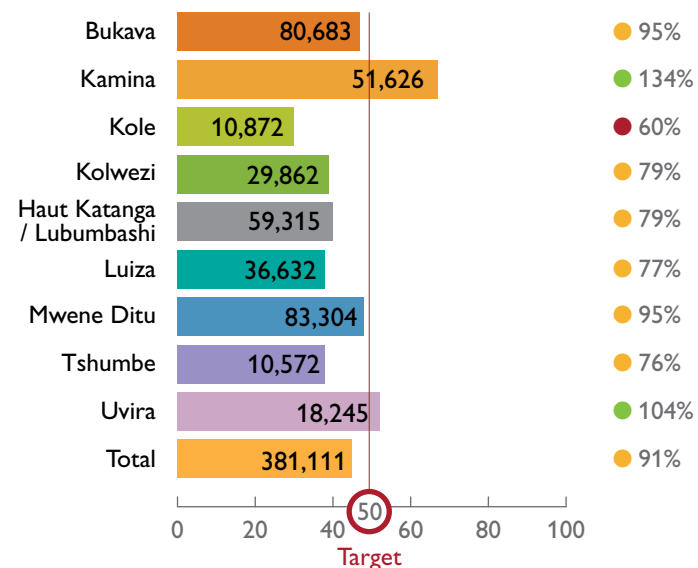


Photo by Warren Zelman



“ Before the arrival of IHPplus, we didn't have the capacity as a team to offer the quality of HIV services to our patients that we would have liked. We didn't have the capacity or means to monitor patients adequately to ensure adherence to treatment. **WE LOST A LOT OF PEOPLE THAT WOULD HAVE REALLY BENEFITED FROM THAT ONGOING SUPPORT.**

“We have been able to rehabilitate this health structure to adequately accommodate our patients. We have completely restructured our patient records and filing systems, and trained staff to properly fill out the forms, which has really helped to improve quality and timeliness of services and tracking of patients. **THESE IMPROVEMENTS MEAN THAT WE NOW NEED TO SPEND LESS TIME ON ADMINISTRATIVE TASKS AND MORE ON OUR PATIENTS.** I can ask questions and receive one-on-one feedback on my work. This has helped me grow and improve as a provider. Sustaining the gains we have achieved will not be easy; but thanks to our strengthened capacity, skills, and motivation, I am confident we can do it. **I'LL DO MY VERY BEST TO CONTINUE MY LIFE'S WORK: PROVIDING HIGH QUALITY CARE TO TREAT MY BROTHERS AND SISTERS.**”

EXCERPTS FROM AN INTERVIEW WITH
DR. FREDDY MBIYA on **SUPPORT FOR HIV CARE**
HIV focal point, Mwangeji Hospital, Kolwezi

- Non-adherence to management of negative RDT results was also observed. In 50% of the health facilities visited that are currently supervised by a doctor, it was noted that cases with negative RDT results were still being treated with ACTs. The recommendation moving forward is to maintain and increase the number of joint supportive supervision visits with the PNLP to assess quality of services, and, where needed, conduct hands-on refresher trainings for providers on malaria case management. USAID and its partners may also consider further study into the reason for this persistent behavior.
- Inconsistencies were seen in how data on malaria morbidity and management of malaria-related commodities are being collected and recorded by staff. In 90% of health facilities visited, it was noted that inconsistencies in data collection and reporting occurred frequently. In order to improve the quality of data, the project provided financial support to purchase

data collection tools and hold data monitoring meetings. In collaboration with the national division of health information, the project developed a data quality validation tool that includes a guide on how to effectively analyze data. Support and training to ensure data quality must continue to be a priority moving forward.

- One of the greatest challenges encountered during the course of the project has been that of ensuring the availability of antimalarial commodities in health facilities. In order to address this challenge, IHPplus made it a priority to provide financial support to transport commodities from the health zone central offices to the health facilities and i-CCM sites. It is recommended moving forward that supervision visits be conducted on a monthly basis to verify commodity levels and identify stock-outs for all medications and commodities, and that a pull and push system be implemented to ensure facilities are stocked as needed.

- The delay in when pregnant women go in for their first ANC visit—which generally only happens after the fifth month of pregnancy as a result of cultural tendencies and beliefs that women do not need to access services until their pregnancy is visible—has been another challenge faced during the life of project. It greatly affects the impact of malaria prevention interventions, as it means that these women are not receiving the recommended doses of SP during their pregnancy, making them more vulnerable to malaria. In Sud Kivu, the project implemented mini- as well as larger-scale malaria campaigns to sensitize pregnant women and health care providers on the importance of early ANC visits (study results were shared with USAID). It is recommended that such community sensitization efforts be expanded and implemented in even more health zones across the country in order to reach more women.

HIV

IHPplus provided support to the DRC MOH's *Programme national de lutte contre le Sida* (PNLS, or National AIDS Program) during PY1 and PY2. During PY1, the project supported 73 HIV treatment sites, of which 28 were located in seven health zones of Haut Lomami province and 45 were located in eight health zones of Lualaba province. During PY2, IHPplus discontinued its HIV activities in Haut Lomami, but continued to support the 45 HIV treatment sites in Lualaba.

The project's HIV approach had four major components: rationalization of HIV interventions, promotion of the "Test and Treat" strategy in treatment centers, introduction of viral load monitoring in patients, and early infant diagnosis (EID). The minimum

package of services offered in all supported health facilities included HIV testing and counseling (HTC), prevention of mother-to-child transmission (PMTCT), ART; treatment of opportunistic infections (OIs), TB-HIV co-infection services (TB-HIV screening, TB diagnosis using microscopy and GeneXpert System), provision of ART to TB patients with HIV-positive test results, integration of FP and HIV services, RBF for HIV, facility-community linkage, and laboratory services.

At USAID's request, at the beginning of PY2Q4 (April 1, 2017), the project's HIV activities were transitioned to the Integrated HIV and AIDS Program Lualaba, implemented by PATH.

TECHNICAL APPROACHES USED AND ACTIVITIES

The project used the following technical approaches:

- Trained health care providers in HIV sites (see details in the following paragraph);
- Provided supportive supervision by joint MOH-IHPplus teams and on-site monitoring of activities and support for providers;
- Compiled and validated quarterly HIV data by a joint MOH-IHPplus team;
- Implemented a results-based financing (RBF) program focused on improving HIV indicators in five health zones (see section page 66);

- Involved people living with HIV (PLHIV) in monitoring patients within their communities through conducting home visits for psychosocial support and treatment observation, organizing self-help groups for PLHIV, and providing education on good personal hygiene habits.

With technical support from the PNLS at both the national and provincial levels (Lubumbashi and Haut Katanga), and from the *Programme national de la nutrition* (PRONANUT, or National Nutrition Program)-Lubumbashi, IHPplus conducted trainings on the following topics:

- HIV complete package of services and Option B+ (lifetime ART for HIV-positive pregnant women regardless of their CD4 count) for 109 health care providers;
- Quality control for HIV and sample collection for EID and viral load testing, for 97 lab technicians and HIV health care providers at health facilities that provide provider-initiated HIV testing and counseling, but are not HIV treatment sites;
- TB-HIV co-infection for 89 HIV and TB health care providers;
- Psychosocial counseling of PLHIV and facility-community linkage for 86 psychosocial assistants and mentor mothers;
- Nutritional assessment, counseling, and support for 110 health zone management team members and HIV health care providers;
- Briefing on the WHO “Test and Treat” directives and on the President’s Emergency Plan for AIDS Relief (PEPFAR) innovation for 106 health care providers;
- TIER.net, an Electronic Patient Management System, by the EQUIP team for ten HIV health care providers in the two urban health zones (Dilala and Manika) of the Kolwezi coordination and for Kinshasa- and Lualaba-based IHPplus staff.

In addition to trainings above, IHPplus implemented post-training follow-up; quarterly supervision visits by joint MOH-IHPplus teams; TB screening of HIV-positive patients; laboratory testing (including EID, viral load monitoring, and monitoring of the patient’s overall health status, such as through liver and kidney function tests); and compilation and validation of quarterly HIV data from each HIV treatment site by a joint MOH-IHPplus team in the eight IHPplus-supported health zone central offices.

RESULTS

As shown in Figure 25, during PY1 and PY2 of IHPplus, 93% of HIV treatment sites financed by PEPFAR via IHPplus provided ART for at least 90% of identified HIV-positive pregnant women. The total number of project-supported HIV treatment sites was reduced from 40 during PY1 (in Kamina and Kolwezi) to 32 during PY2 (in Kolwezi alone), while the proportion of these sites achieving 90% ART coverage slightly improved from 93% in PY1 (37/40) to 94% in PY2 (30/32), for an achievement rate of 96% against target. This strong performance can be attributed to the presence of trained personnel administering Option B+ and to the availability of antiretrovirals (ARVs).

During PY1 and PY2 of IHPplus, 94% of pregnant women knew their HIV status after counseling and testing and received their results during ANC visits or in the labor and delivery ward (see Figure 26). The project’s achievement rate was 94% against a target of 97%. IHPplus achieved this result through high-quality counseling by HIV health care providers who had been trained on the screening process, through the availability of commodities for HIV testing, as well as through the involvement of psychosocial assistants in the community.

The rate of HIV-positive pregnant women who visited IHPplus-supported PMTCT facilities in the Kamina and Kolwezi coordinations was 1.4% (324/22,722) during PY1 of IHPplus, compared to 2.1% in Kolwezi alone during PY2. Rates of HIV are higher in Kolwezi than in Kamina due to Kolwezi’s mining boom, which has resulted in high-risk behavior for HIV around mining sites. Overall, the HIV-positive rate among pregnant women was 1.7% (667/39,279), which is comparable to the rate reported by the PNLS in 2013, when it stood at 1.8% of pregnant women accessing ANC services (PNLS Annual Report, 2015).

During IHPplus PY1 and PY2, 97% (648/667) of HIV-positive pregnant women received ARVs to reduce the risk of transmitting the virus to their child during pregnancy, childbirth, or breastfeeding.

The 2015 PNLS Annual Report indicated that, at the national level, of all reported 14,466 women receiving ARVs for PMTCT, 77% received Option B+ and 23% received Option A. IHPplus achieved a rate of 97% of HIV-positive pregnant women receiving Option B+ against a target of 94%, resulting in an achievement rate of 103% (Figure 27). This performance was achieved because ARVs were available in treatment centers, and providers were well-trained in the use of Option B+ and supervised by joint teams from the health zone central offices/MOH and IHPplus staff.

During the life of the project, a total of 88,822 people were voluntarily tested and counseled for HIV and received their test results, as shown in Figure 28.

Fig 25. Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV-positive pregnant women

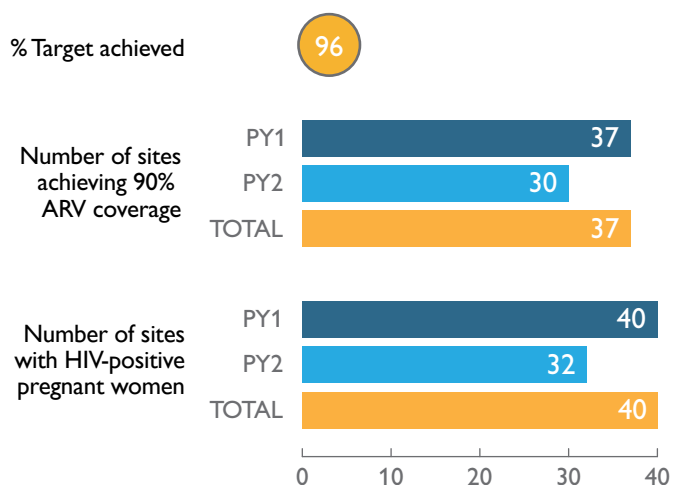
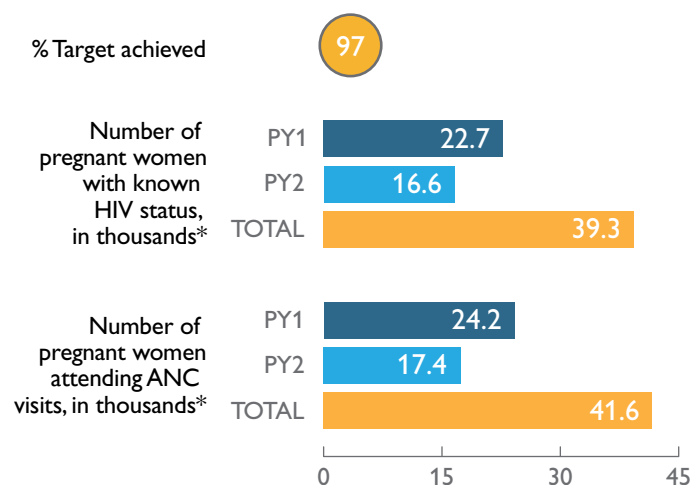


Fig 26. Number of pregnant women with known HIV status (includes women who were tested for HIV and received results)



*HIV positivity rate among pregnant women was PY1 = 1.4%, PY2 = 2.1%, project average = 1.7%.

Fig 27. Number of HIV-positive pregnant women who received ARVs to reduce risk of MTCT during pregnancy and delivery

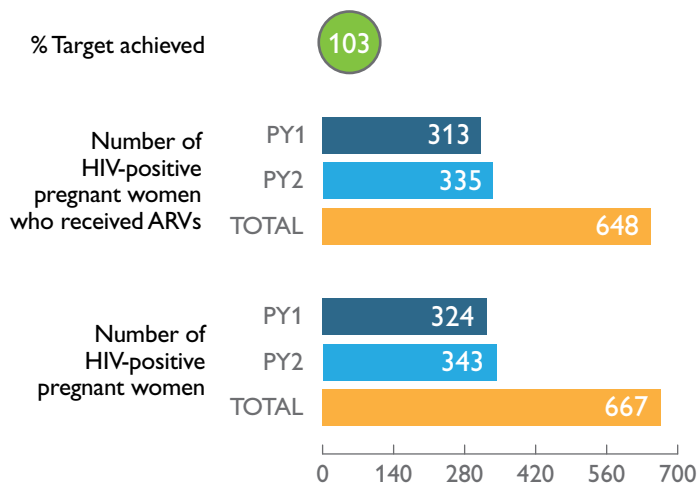
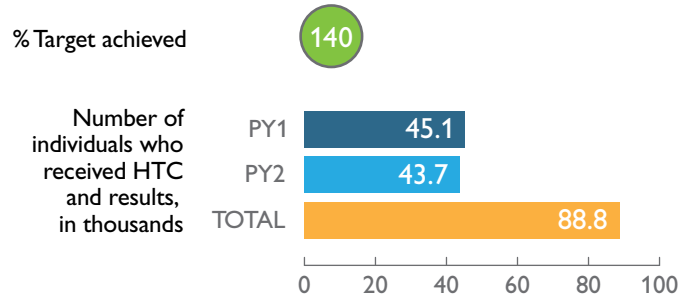


Fig 28. Number of individuals who received HTC and received test results



● Target achieved (100% or >)
 ● Almost achieved (75–99%)
 ● Not achieved (< 75%)

All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

Distribution by sex, age and HIV status is shown in Table 9. Of the total number of people tested, 76% were female, and 24% were male; 6% were under the age of 15, and 94% were 15 and over; and 95% (84,241/88,822) were HIV-negative vs. 5% who were HIV-positive.

The rate of 5% HIV-positive clients tested and counseled in IHPplus-supported HIV treatment centers was higher than the national average of HIV seroprevalence in the DRC (3.2%, according to the 2015 PNLs Annual Report). This warrants the PEPFAR directive focusing on HIV control in the former Katanga province, and especially in the new Lualaba/Kolwezi province.

Compared with the project target, the achievement rate was 140% (88,822/63,327) (Figure 28, page 65). This high performance was primarily the result of the HIV testing and counseling target specified in the COP 16 (PEPFAR Country Operational Plan for the DRC), along with the recommendation to target as many points of HIV service delivery as possible at various health facility levels, in order to help eradicate HIV and AIDS by 2030. Other reasons were the availability of HIV test kits, in addition to provider-initiated testing and counseling, and providers who were well trained and supervised by joint health zone central office/MOH and IHPplus teams.

During IHPplus in PY1 and PY2, a total of 4,722 PLHIV received at least one clinical evaluation of their HIV progression (Table 10). Compared with the project's target, the achievement rate was 153% (4,722/3,086). This overperformance results from an underestimated target in the COP16, the availability of cotrimoxazole and other commodities to treat OIs, and availability of Pima CD4 analyzers and CD4 kits provided to HIV sites by IHPplus. Additionally, PLHIV being monitored in two project-supported

urban health zones (Dilala and Manika) and two semi-urban health zones (Fungurume and Lualaba) received viral load testing.

As shown in Table 11, a total of 4,607 HIV-positive adults and children received ART by the end of PY2, for an achievement rate of 149% (4,607/3,086). This performance results from an underestimated target in the COP16, the availability of commodities in all treatment facilities, the scaling-up of Option B+, the PEPFAR "Test and Treat" innovation, and support from health zone central offices and the IHPplus team to providers in treatment centers, within the context of the mining boom in the Lualaba province.

To improve implementation of the HIV program, IHPplus involved five community-based organizations (CBOs) to help improve treatment adherence, identify HIV-exposed infants using EID and final infant diagnosis (at 18 months and/or when breastfeeding ends), recuperate PLHIV lost to follow-up, and organize support groups in health facilities and the community.

During PY1 and PY2, 94% of registered HIV-positive TB patients received ART, reflecting an achievement rate of 103% against a target of 92% (see Table 12). Factors contributing to this strong performance included training on the complete HIV and TB-HIV co-infection package, the availability of commodities for TB treatment and HIV testing and treatment, the innovative "test and treat" approach, and management tools for TB-HIV co-infection supplied to HIV sites by the project, within the context of overcrowded living conditions near the mining sites (conducive to TB contamination), and high-risk HIV behaviors in those areas.

As shown in Table 13, 100% of laboratories and POC testing sites at HIV sites in the eight IHPplus-supported health zones participated continuously in the full HIV

quality control process. This strong performance can be attributed to on-site training and monitoring provided by the PNLs Lubumbashi team to lab technicians and HIV health care providers at other HIV testing points on quality control of HIV tests, correct sampling, viral load monitoring, and EID.

As seen in Table 14, during IHPplus PY1 and PY2, a total of 72 project-supported HIV treatment sites systematically offered FP and maternity services in Kamina and Kolwezi, reflecting an achievement rate of 100%. IHPplus supplied FP commodities to all facilities, except to the Mariapolis health center in the Kolwezi coordination, which does not offer ANC or maternity services. Health care providers were trained in counseling services and modern FP methods, counseled on-site about the Tiaht regulations, and supervised by the health zone central offices. All HIV treatment sites had reporting tools and communicated FP data.

HIV-FOCUSED RBF PROGRAM

In 2013, the IHP project introduced the RBF approach in seven USAID-supported health zones in the country. The decision to implement an RBF program focused on improving HIV indicators in 2016 was based on the following observations:

- Poor motivation of providers who faced a heavy workload;
- Uncoordinated activities at the HIV treatment sites;
- Decreased retention of PLVIH receiving ARV treatment over two years;
- Focus on establishing effective strategies in order to achieve the WHO 90-90-90 objectives and by extension the UNAIDS 0-0-0 objectives;
- Need to subsidize HIV and AIDS activities to improve performance.

Table 9. Individuals receiving HTC services disaggregated by sex, age, and HIV status

Classification	PY1	PY2	Total
Female	35,445	32,046	67,491
Male	9,653	11,678	21,331
Under 15 years	1,348	3,607	4,955
15 years and over	43,750	40,117	83,867
HIV-negative	42,945	41,296	84,241
HIV-positive	2,153	2,428	4,581

Table 10. 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

PY1	PY2	Total
4,610	4,722	4,722
Target		3,086
Achievement %		153

Table 11. Number of adults and children receiving ART

PY1	PY2	Total
3,534	4,607	4,607
Target		3,086
Achievement %		149

Table 12. Percentage of registered TB cases that are HIV-positive who are on ART

Classification	PY1	PY2	Total
# registered TB cases with documented HIV+ status who start or continue ART	1,240	162	1,402
# registered TB cases with documented HIV+ status	1,322	167	1,489
Target			92
Achievement %			103

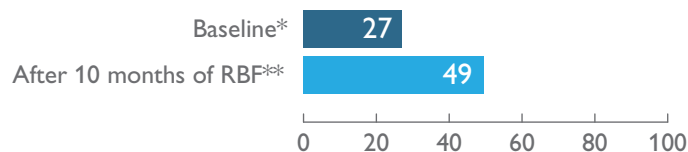
Table 13. Percentage of laboratories and HTC testing sites that participate in and successfully pass an analyte-specific proficiency testing program

PY1	PY2	Total
55	55	55
Target		55
Achievement %		100

Table 14. Number of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary FP services

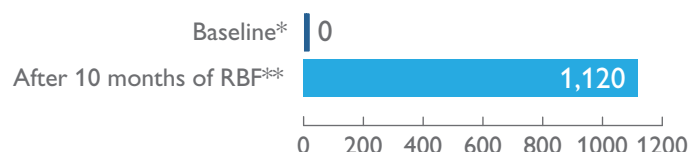
PY1	PY2	Total
72	44	72
Target		72
Achievement %		100

Fig 29. Percentage of people testing positive for HIV who knew their HIV status, before and after RBF



*Jan-Dec 2015 **Aug 2016-May 2017

Fig 30. Number of PLHIV receiving a viral load test, before and after RBF



*Jan-Dec 2015 **Aug 2016-May 2017

Under the leadership of the MOH, through its RBF technical unit, and with technical support from PNLs, IHPplus implemented the HIV-focused RBF program in five health zones in the Lualaba province from July 2016 to May 2017, with the objective of helping to strengthen the health system through improved health services and care delivery in HIV treatment sites. The five health zones (Dilala, Fungurume, Lualaba, Lubudi, and Manika) have a total of 30 HIV treatment sites and serve an estimated population of 1,296,636.

Implementation process of HIV-focused RBF:

Country level

- Selection of health zones for intervention: Selection was based on two criteria—being a PEPFAR-supported health zone and reporting at least two new HIV-positive cases per quarter. Selected control health zones were in the same geographical area and had a similar context; accordingly, the Lualaba health zone was compared with Mutshatsha, and the Lubudi health zone with Bunkeya. The Dilala, Fungurume, and Manika health zones did not have control zones; data analysis was planned to use the “difference in differences” method.

- Program costing: The project budgeted \$193,800 for performance payments, including \$12,000 per GRH, \$2,100 per health center, and \$2,400 per *bureau central de zone de santé*, or health zone central office, as well as \$10,000 per health zone for biological follow-up.
- Quantitative and qualitative indicators selected to determine subsidies: Selected indicators were related to HIV services, coordination between HZMTs and GRHs, as well as pharmaceutical management. Indicators were chosen based on PEPFAR objectives, PNLs priorities, and the framework for accelerating the reduction of maternal and child mortality in the DRC.

Provincial level

Preparatory phase

1. Baseline data collection in the five intervention health zones and in the two control health zones
2. Training of 74 providers and DPS managers and five CBOs involved in the RBF program
3. Cascade training of clinical providers, lab technicians, psychosocial assistants, and mentor mothers

4. Stakeholder education (political and administrative authorities, providers, managers of integrated private health facilities, and CBOs)
5. Contracting with health facilities, HZMTs, and the five CBOs selected to perform community verification of results
6. Development of management plans for health facilities
7. Reporting of baseline data to the national and provincial MOH
8. Negotiations with hospitals for pricing of biological follow-up for PLHIV

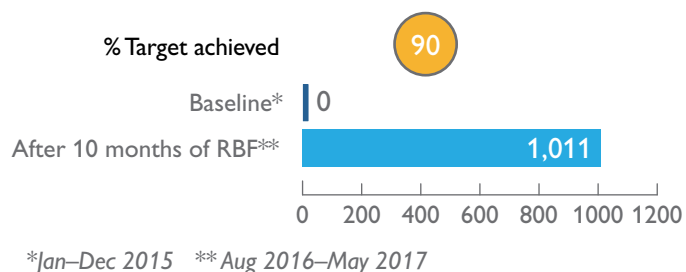
Implementation Phase

1. Implementation of contracts by providers
2. Coaching of providers in the health zones and of the Kolwezi coordination office between two technical verification visits
3. Technical and community verification of data
4. Reporting of community survey results
5. Payment of premiums based on performance

SELECTED RESULTS

As shown in Figure 29, the percentage of new HIV cases screened that knew their

Fig 31. Number of PLHIV receiving a viral load test who received their test results



HIV status increased from 27% to 49% after 10 months of implementing RBF. This improvement can be attributed to the fact that health centers educated more clients about knowing their HIV status, psychosocial assistants conducted monitoring visits to patients in their homes, and an active Champion Community in Fungurume raised awareness of voluntary HIV testing through conducting household visits and targeting high-risk groups.

As shown in Figures 30 and 31, viral load testing was performed on 1,120 samples from eligible PLHIV, achieving 56% of the target, and 90% of these results (1011/1120) were communicated to patients. The baseline for this viral load testing was at 0% due to the lack of an AIDS referral laboratory in Lualaba. IHPplus established a system for testing to be performed at the Lubumbashi referral laboratory (see the Challenges section below for more details). The correct use of management tools and improved archiving of documents ensured that 90% of patients received their test results.

As shown in Figure 32 on page 71, overall quality of health services in health centers, as measured by the *Formation Sanitaire Complètement Fonctionnelle* (FOSACOF)

tool, improved from 36% to 54% in health centers that implemented the HIV-focused RBF program. These gains in service quality were achieved through improvements in the availability of management tools, briefings for providers on their use, and improved organization of document archives.

Generally, health care quality also improved in hospitals as a result of the HIV-focused RBF approach, with average service quality increasing from 44% to 68% (see Figure 33, page 71).

CHALLENGES

- Offering laboratory testing (especially viral load monitoring and EID) to patients in all eight IHPplus-supported health zones was challenging in the absence of an AIDS referral laboratory in Lualaba, and in view of national and international requirements for sampling and analysis of viral load and EID samples. Therefore, the project team worked with the PNLS at the national and provincial levels to institute an effective system of collecting samples for viral load monitoring and EID at HIV treatment sites in Lualaba, transporting the samples to the nearest referral laboratory in Lubumbashi for analysis, and reporting results back to the treatment sites within a two-week
- period to ensure correct treatment of HIV-positive patients. However, the system only served the two urban health zones (Dilala and Manika) and the two semi-urban health zones (Fungurume and Lualaba) due to the remoteness of the four rural health zones supported by the project. In collaboration with the Lubumbashi referral laboratory team, IHPplus began to explore other mechanisms to better serve the remaining health zones (including building the capacity of the Lubumbashi laboratory to analyze dried blood spot samples and providing a rechargeable portable mini freezer to store and securely transport blood samples). While IHPplus was not able to implement these strategies, they have been implemented by IHAP and other partners.
- The configuration of the HIV-RBF complementary module in the RBF web portal was not implemented prior to data verification due to the excessive workload of the RBF technical unit's IT staff. The project worked around this issue by transmitting the data in Excel tables.
- It was necessary for fellow PLHIV to conduct community verification and provide psychosocial support due to the sensitive nature of HIV status, but there were few functional local CBOs (with legal

CENTRE DE SANTE KANINA



“ When people see me, they say they can’t believe that I have HIV because I look so healthy—like any other person. I tell my clients that the same is possible for them: they too can live a long, healthy life.”

— Raphael Kabangwe, HIV psychosocial assistant and PLHIV

Fig 32. Quality of health services in health centers implementing the HIV-focused RBF program, as measured by the FOSACOF tool (%)

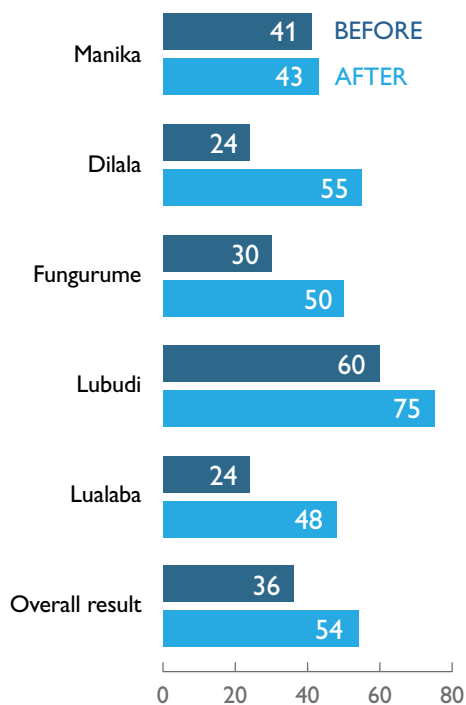
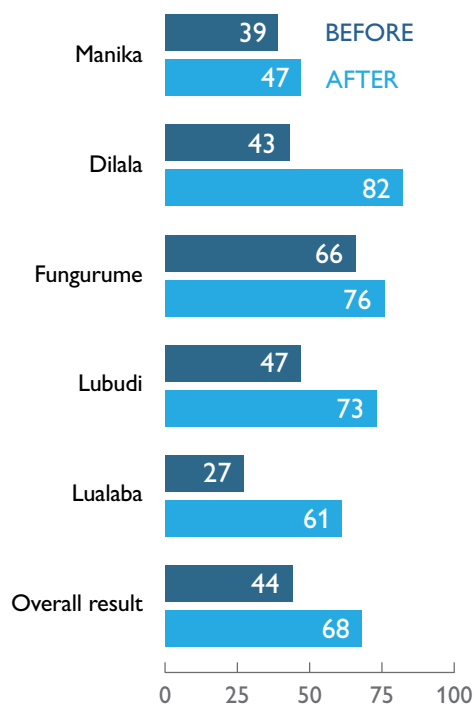


Fig 33. Quality of health services in GRHs implementing the HIV-focused RBF program, as measured by the FOSACOF tool (%)



documents) employing PLHIV who could perform this work. The project provided capacity building and close supervision of the available CBOs, and their performance had improved by the end of the program.

LESSONS LEARNED

- To be able to provide quality services to PLHIV, the support to HIV programs in resource-constrained countries should prioritize training HIV health care providers, providing adequate stocks of HIV commodities and appropriate equipment, involve the community, and motivate providers (e.g., through RBF programs).
- To retain patients receiving ART in the treatment program, programs should foster a strong connection between treatment facilities and communities to increase community involvement.
- Greater community acceptance of PLHIV leads people to be more open about their HIV status, which fosters increased utilization of services.
- The RBF approach focused on HIV in five health zones in the Lualaba DPS helped achieve the WHO 90-90-90 goal, through case management of PLHIV at points of care, leading to an increase of the number of new patients from 557 to 1,574, i.e., a 200% increase, and through follow-up and counseling of PLHIV. Extending this approach to several high-risk zones would further contribute to achieving the program objectives.
- An HIV-focused RBF program can rapidly increase the quantity and quality of indicators of population coverage and patient retention and well-being, as well as other system indicators not related to HIV.

CHW at Kanina Health Center. Photo by Eleonora Kinnicutt, MSH.

Tuberculosis

Tuberculosis is one of the leading causes of morbidity and mortality in the DRC; each year, half the cases are not diagnosed and therefore not treated (National TB Control Program, *Programme National de lutte contre la Tuberculose* [PNLT] 2017). To this challenge must be added the burden of co-morbidity with HIV as well as emerging drug-resistant strains. Communities already faced with socioeconomic challenges—such as migrants, refugees, prison populations, ethnic minorities, minors and other people working or living in high-risk environments, as well as marginalized women—are most affected (PNLT).

During PY1, PY2, and PY3, IHPplus worked closely with the MOH to implement the new PNLT directives to roll out TB care by ensuring free access to the population to diagnostic, treatment, and prevention services. IHPplus supported the PNLT in 78 project health zones to implement activities to improve the quality of TB services and care, including multi-drug resistant TB (MDR-TB), TB-HIV co-infection and pediatric TB.

TECHNICAL APPROACH

IHPplus used the following main strategies for TB:

- Supported community involvement in the active detection of TB cases and community Directly Observed Treatment Short Course (DOTS);
- Strengthened the capacity of health care providers in TB care and prevention;
- Improved laboratory diagnostic capacity by training lab professionals on sputum smear microscopy and GeneXpert;
- Arranged secure collection and transport of sputum samples from presumptive TB patients for drug-sensitive and drug-resistant TB;

- Conducted joint supervision visits and mentoring with the PNLT and PNLs to health zones and health centers;
- Supplied medicines, laboratory equipment, and commodities to health facilities;
- Monitored and evaluated TB control activities.

ACTIVITIES

Project activities aimed at:

- Building health care provider capacity in case notification, diagnosis, treatment and prevention;
- Intensifying TB screening at community and health facilities;
- Ensuring proper treatment and follow-up of TB patients, as well as education of communities about the importance of adherence to TB treatment and stigma against those infected;
- Helping the Provincial Coordination Unit for Leprosy and TB (*Coordinations Provinciales lèpre et tuberculose* [CPLT]) to integrate new PNLT approaches of active case detection of TB cases in the community; and supplying health zones and health centers with commodities and lab supplies, including RDTs, GeneXpert machines, and cartridges;
- Strengthening awareness-raising efforts through financial and technical support to *Clubs des Amis Damien* (a community-based organization composed of former TB patients who raise awareness of TB prevention and participate in community monitoring of patients being treated for TB);

- Organizing joint technical support supervisions in health zones;
- Pursuing effective collaboration with the central unit of the PNLp through the participation in strategic meetings and workshops as well as in World Tuberculosis Day activities.

RESULTS

Results achieved by the project in TB are presented according to innovations introduced in cooperation with USAID. During PY2, the TB indicators were revised to create a cascade structure and according to priorities determined by the PNLT for TB control within the framework of the WHO End TB Strategy.

During PY1 and PY2, as well as PY3Q1, the DOTS coverage was implemented by a network of 293 health centers for TB diagnosis and treatment (CSDT) in 78 health zones. In PY3Q2 and PY3Q3, this was reduced to only 73 CSDTs in 17 health zones, specifically nine in Kamina and eight in Kolwezi, following the proposed resource rationalization process of the PNLT and its partners. As part of this process, the Global Fund, responsible for conducting active case detection activities in the country, asked USAID in October 2017 to take over the Haut Katanga DPS because it did not have a management mechanism set up in this province. As a result, IHPplus began to provide support to Haut Katanga DPS in October 2017, to implement catalytic activities.

Community participation in active case detection of TB cases:

During PY3, 26% (2,308/8,951) of the DOTS was provided by community health agents, a 1% increase when compared to PY2 (4,875/19,674 or 25%) (Figure 34, page 74). In addition to providing



VOICES OF IMPACT

“ Like many of the patients I counsel today, I knew nothing about TB when I was first diagnosed; I had no idea of how it would affect my life. **AFTER FULLY RECOVERING, I KNEW I WANTED AND NEEDED TO HELP OTHERS LIKE ME,** and I decided to join the CAD. Our goal is also to sensitize the community and individuals on the realities of TB and to wash away the deeply ingrained stigma.

“If I see someone showing symptoms of TB, I refer them to the nearest health facility to be screened. I also have them fill out a billet de suivi (follow-up ticket) that includes their contact information. **IN TWO DAYS I CAN FOLLOW UP TO CONFIRM THEY HAVE GONE IN FOR SCREENING.** If the patient is positive for TB, **I PROVIDE THEM THE SUPPORT THEY NEED**—whether bringing them their medication or helping them get transportation to the health center, supervising the community-led DOTS program, or simply counseling and serving as a point of support for them.

“I have a stronger appreciation and understanding of how important it is to be visible and present in the community in order to have an impact. **I AM SO GRATEFUL EVERY DAY TO HAVE BEEN GIVEN THE OPPORTUNITY TO DO THE WORK THAT I DO.**”

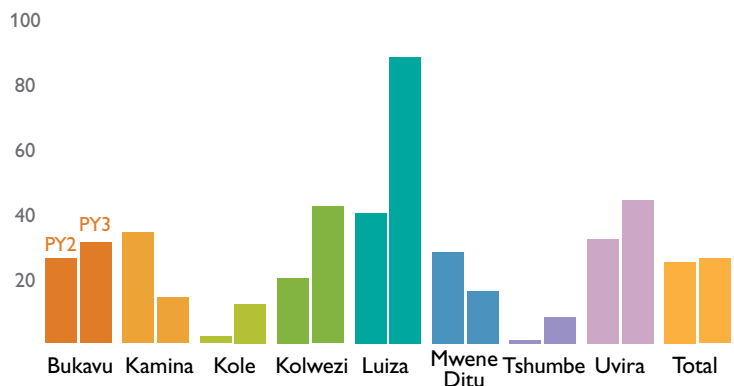
EXCERPTS FROM AN INTERVIEW WITH

YOUSOUF IBRAHIM on TB CARE

Former TB patient,

current member of *Club des Amis Damien*, Lualaba

Fig 34. Percentage of registered TB cases supported by community health agents in the project-supported health zones, PY2 and PY3



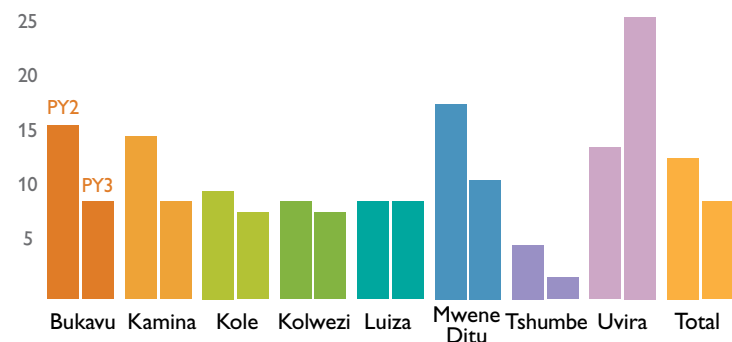
the DOTS, community health agents also provided TB education and awareness-raising to communities and conducted active door-to-door screening of index TB case contacts. During PY3, the strongest performing coordinations with regards to adherence to treatment for the community DOTS were Luiza (88%), Uvira (44%) during PY3Q1, and Kolwezi (42%) in PY3Q3. The strong performance in Luiza is likely due to active door-to-door community DOTS service by community health agents. The Kamina, Kole, Mwene Ditu, and Tshumbe community health agents, however, had the lowest performance with regards to adherence to treatment for the community DOTS, reaching less than 20% of TB patients.

The community TB prevention and care intervention has combined several community approaches, using former TB patients now members of the CAD, a community-based organization composed of former TB patients who raise awareness of TB prevention and participate in community monitoring of patients being treated for TB, CHWs, the TB control group *Ambassadeurs de lutte contre la TB* and Champion Communities.

Screening for pediatric TB:

During PY3, out of the 8,951 cases of all forms of TB reported in the project-supported health zones, 828 (9%) were recorded in children aged 0–14 years old (Figure 35). The achievement is lower than

Fig 35. Percentage of registered TB cases among children aged 0–14 years in the project-supported health zones, PY2 and PY3



the national estimate of 13.1% in 2016, and lower than the 13% rate (1,920/14,313) reported during PY2. Uvira recorded the highest percentage of children diagnosed, at 26% (69/269), because although health care providers here used the Keith Edwards score grid for the diagnosis of pediatric TB, as in other coordinations, in Uvira emergency response partners made it mandatory for all children regardless of their condition. Especially in Nundu and other places affected by cross-border displacement populations from Burundi, this increased the number of cases detected. To improve TB case detection in children, it is therefore necessary to intensify health care provider support in the use of pediatric TB screening algorithms, especially for providers treating

Fig 37. Number of MDR-TB cases detected

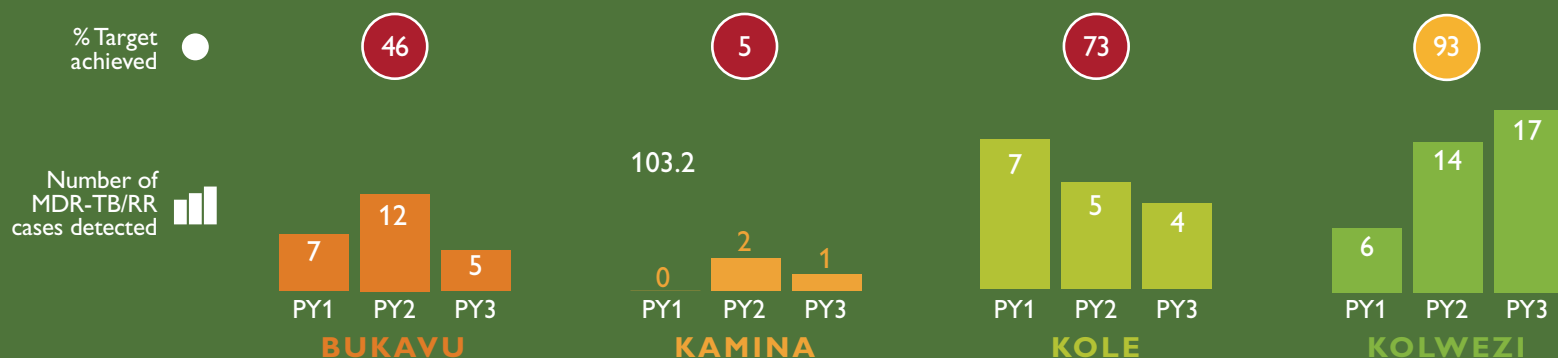


Fig 36. Notification rate for new cases of smear-positive pulmonary TB in USG-supported health zones, by project year

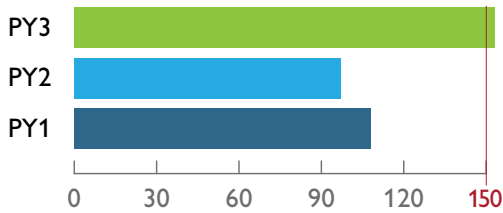


Photo by Warren Zelman

children, and to ensure the timely and effective transport of samples from health centers to GeneXpert diagnostic sites.

Notification rate for new cases of smear-positive pulmonary TB in USG-supported health zones:

During PY3, a total of 3,441 new sputum smear-positive pulmonary TB patients were notified in the 17 health zones of the Kamina and Kolwezi coordination, which is 153 new cases per 100,000 population (Figure 36). This rate is significantly higher than the rates of 97 and 108 per 100,000 population recorded respectively during PY2 and PY1. The notification rate of 153 per 100,000 population exceeds the PMP target (150 per 100,000), for an achievement rate of 102% (153/150). This

performance is mostly due to the active case detection of TB cases, including mini door-to-door screening campaigns in the Kamina and Kolwezi coordinations.

In order for the sputum smear-positive pulmonary TB patient notification trend to remain positive in the IHPplus-supported coordinations, it is necessary to intensify the active case detection campaigns in the community, with particular focus and attention to at-risk groups including migrants, refugees, prison populations, ethnic minorities, marginalized women, contacts of TB patients, and other people working or living in more vulnerable environments and thus at higher risk of infection.

Number of MDR-TB cases detected:

A total of 152 MDR-TB cases were reported during the life of project, with 27 cases recorded during three quarters of PY1, 84 cases during PY2, and 41 during three quarters of PY3 (see Figure 37, below). This corresponds to an achievement rate of 54% compared to the project target of 280 patients. The low performance of this indicator is likely primarily due to the fact that the majority of health facilities do not have access to GeneXpert diagnostic machines, and the sputum sample system for presumptive MDR-TB cases was not in place in most sites. Beginning in PY3Q2, following the decision by the PNLT, USAID, and the Global Fund to reallocate resources, only two of the eight project-

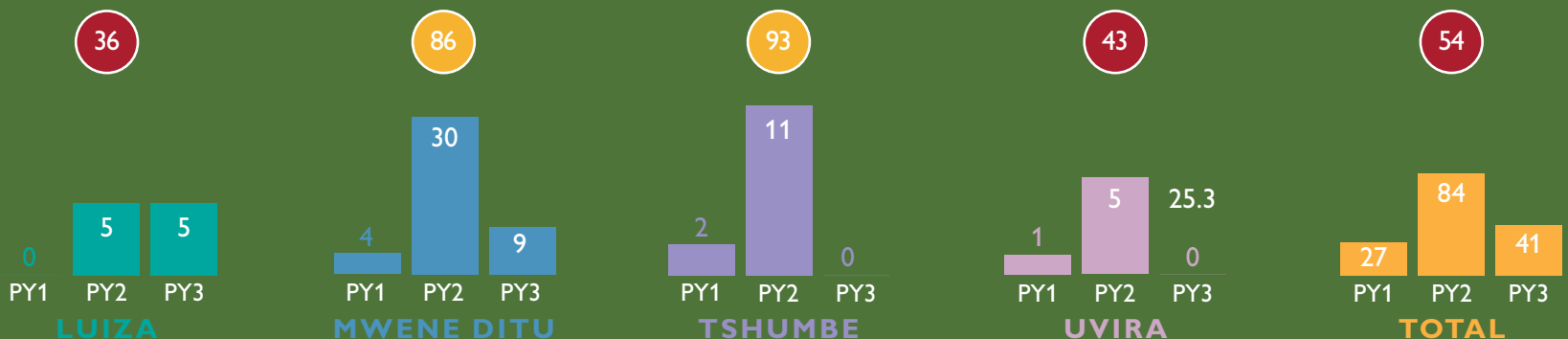


Table 15. MDR/RR-TB therapeutic success rate

Coordination	PY2	PY3	Target %	Ach %
Bukavu	29	-	75	-
Kamina	-	-	75	-
Kole	-	-	75	-
Kolwezi	-	100	75	133
Luiza	50	-	75	-
Mwene Ditu	71	-	75	-
Tshumbe	67	-	75	-
Uvira	-	-	75	-
Total	53	100	75	133

supported coordinations (Kolwezi and Kamina) continued to be supported by IHPplus on MDR-TB; as a result, the number of cases reported by the project decreased. In addition, due to project closeout, IHPplus was only able to collect data for MDR-TB for the first three quarters of PY3, which also contributed to lower performance in the final project year.

To improve the detection of MDR-TB cases, partners supporting the MOH will need to work together with the PNLT to extend the availability of RDTs and implement measures to ensure good coordination for the transport of sputum samples in the health zones to the GeneXpert sites. It should be noted that from PY1 to PY3, no cases of pre-ultra-resistant X-DR-TB or XDR-TB were reported in the project-supported health zones.

Therapeutic success rate (bacteriologically confirmed TB among pulmonary) through USG-supported programs:

During PY3, in the Kamina and Kolwezi coordinations, the therapeutic success rate (TSR) for the cohort of 2,803 sputum smear-positive pulmonary TB patients who

started treatment the previous year (PY2) reached 95% (2,649/2,803). The achievement was more than 99% compared to the project's PMP target of 95% (Figure 38, page 77). The Kolwezi coordination had the best result with a TSR rate of 100% and Kamina recorded a 94% therapeutic success rate just under the target of 95%. This result exceeds the 93% therapeutic success rate recorded for all 78 health zones in PY2. In order to maintain this positive trend, ongoing support should focus on strict DOTS implementation in health facilities treating TB patients and on community DOTS, as well as on recovery of patients who dropped out.

Therapeutic success rate for MDR-TB through USG-supported programs:

In the Kamina and Kolwezi coordinations, four patients with MDR/rifampicin-resistant TB (MDR/RR-TB) were enrolled and all four of them completed the treatment (100%), for an achievement rate of 133% compared to the PMP target of 75% (Table 15). The Kolwezi coordination had the best results with a therapeutic success rate of 100%. The Kamina coordination recorded no MDR/RR-TB patients who started

treatment during the previous year or two years previously. This result is significantly better than the result reported for all 78 health zones in PY2 (53%), due in part to the transport of sputum samples of suspected MDR-TB cases to GeneXpert sites.

Percentage of newly enrolled HIV-positive patients screened for TB through USG-supported programs:

Of the 3,279 newly enrolled HIV-positive patients in the project-supported health zones, 91% (2,976/3,279) were screened for TB (Figure 39, page 77). This amounts to a 91% achievement rate compared to the PMP target of 100% (91/100), which is a significant increase when compared to the 71% achievement rate in PY2. Kole, Kolwezi, and Luiza recorded the highest rates of newly enrolled HIV-patients screened for TB both in PY2 and PY3, whereas Mwene Ditu and Uvira recorded the lowest rates during both years due primarily to poor integration of TB-HIV activities at the operational level. As a recommendation for moving forward, interventions that can continue to significantly improve active TB screening among HIV-positive patients include increased collaboration between the PNLT and PNLS

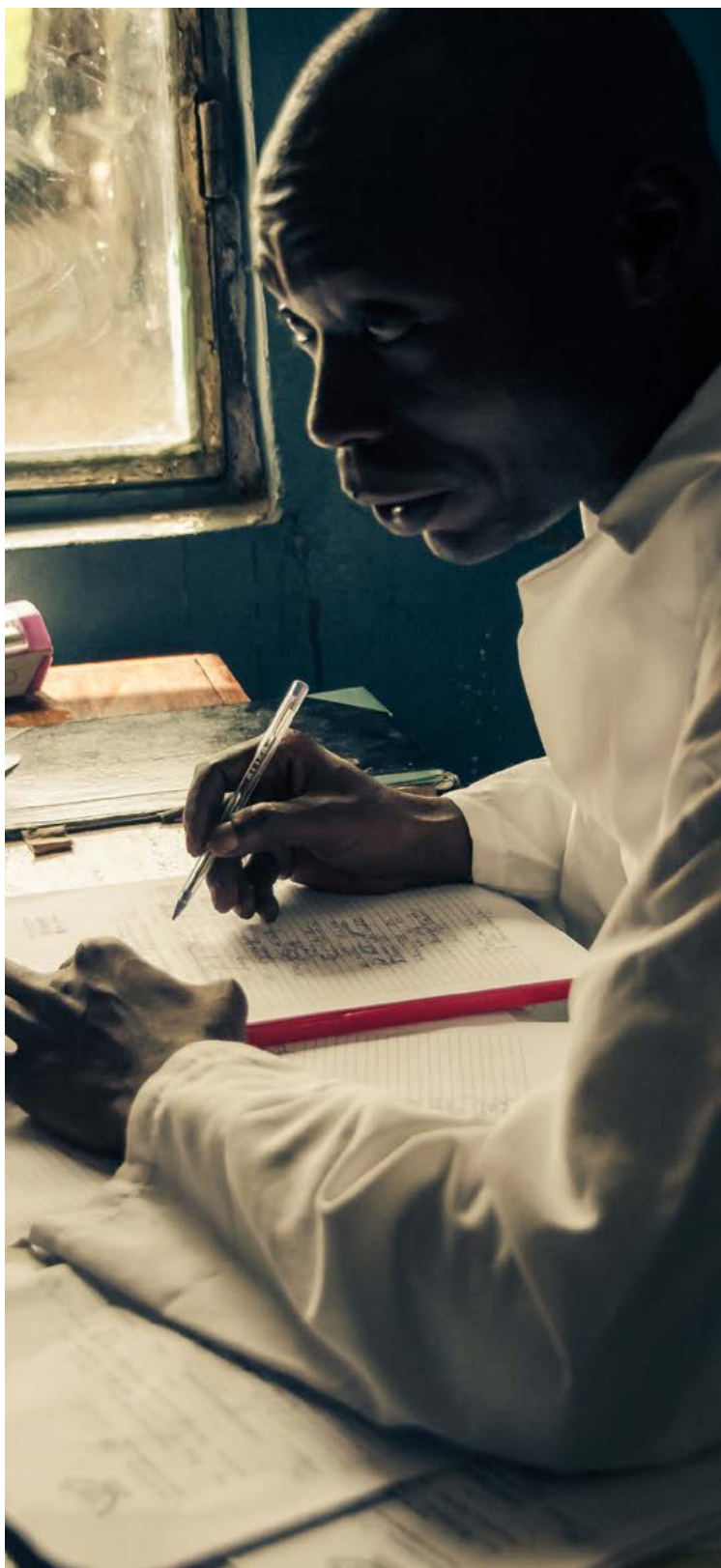
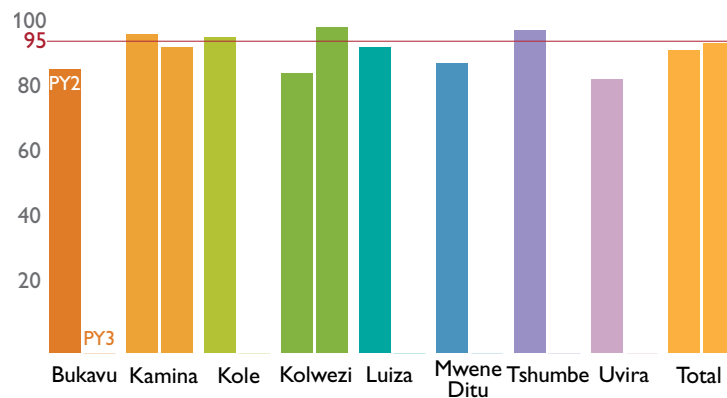


Photo by Warren Zelman

Fig 38. Therapeutic success rate (for new smear positive TB patients) through USG-supported programs*



*Supported activities in PY3 were limited to Kole and Kolwezi.

Fig 39. Percentage of newly enrolled HIV-positive patients screened for TB through USG-supported programs

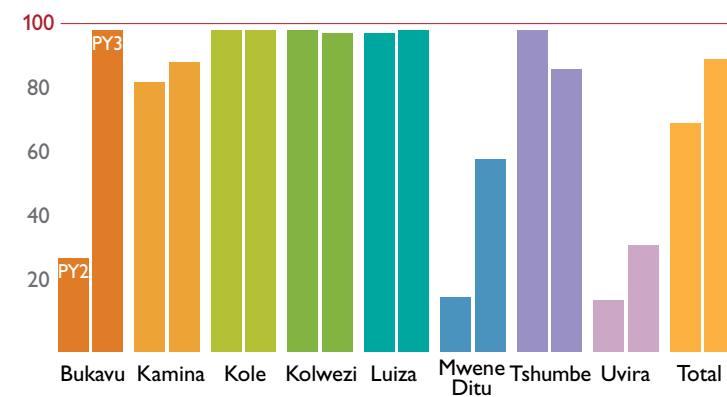
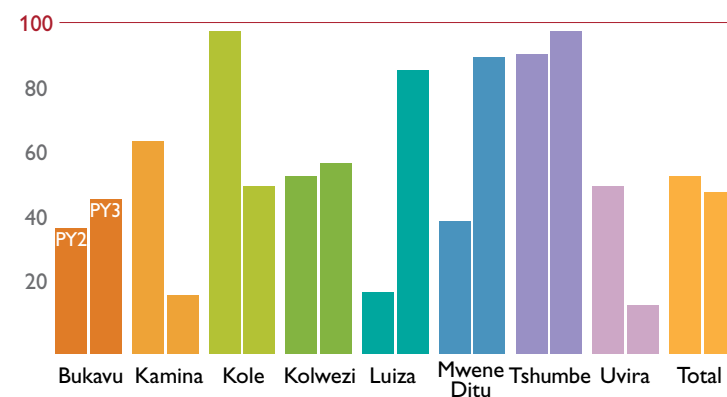


Fig 40. Percentage of HIV-positive patients without TB receiving INH prophylaxis



programs, capacity building of health workers in HIV treatment centers, and reproducing and distributing the tools developed by both programs in all health centers.

Percentage of HIV-positive patients without TB receiving INH prophylaxis:

During PY3, out of a total of 2,857 PLHIV who were not TB positive, 1,434 (50%) were placed on isoniazid (INH) prophylaxis. This reflects an achievement rate of 50% against the PMP target of 100% (Figure 40, page 77). This result is less than the 55% rate recorded during PY2. Kamina, Kole, and Uvira all recorded a significant drop in the indicator when compared to PY2, which appears to be due to INH stock-outs in health zones.

Key recommendations for improving efforts in HIV/TB co-infection include improving the synergy among partners involved in TB-HIV activities, through provincial coordination meetings for joint TB-HIV activities, support to the CPLTs to promote the use of updated guidelines on INH prophylaxis administration, and increased joint CPLT/IHPplus supervision and assistance to community organization activities in the area of TB-HIV co-infection.

According to WHO, approximately half of all TB cases expected each year are not

detected in the DRC. To identify these missing patients, funds have been dedicated to so the called “catalytic” activities that aim to identify undetected cases, focusing in particular on marginalized groups that are not identified through routine activities but through innovative activities and screening of specific groups, like prison populations, children, minors, refugees, and other vulnerable groups. IHPplus conducted the following catalytic activities:

- Developed educational and awareness-raising materials on TB
- Conducted TB awareness raising through community radio stations
- Developed and disseminated TB data collection and reporting tools
- Briefed and coached health care providers on catalytic activities
- Actively detected TB cases, including contact investigation, in 13 health zones

As part of these catalytic activities in Haut Katanga, USAID, in collaboration with the Global Fund and the PNLT, requested that IHPplus implement these activities from January to June 2018. During that period, with IHPplus support, the MOH and its partners, including USAID and the Global Fund, officially launched catalytic activities

as well as detection activities for missing active TB cases in nine priority health zones in the Haut Katanga CPLT. At the time this report was completed, the PNLT was not able to share the report of these activities.

LESSONS LEARNED

Overall, rates of notified TB cases in IHPplus-supported health zones have improved since the start of the project, primarily as a result of active screening of TB cases. However, additional efforts are required to improve the detection of TB cases, with increased community support, in order to achieve the WHO and PNLT’s objective to eradicate TB. Community involvement, training of providers, the procurement of GeneXpert, as well as joint monitoring and supervision have helped improve TB detection and increased screening of all forms of TB. However, efforts must be maintained to search for TB cases in communities and in specific groups (prisoners, miners, children, and refugees) and to integrate both programs (TB and HIV) in the same sites.

Line at the laboratory, Dibindi health zone.
Photo by Sarah Ranney, MSH.



LABORATOIRE



“ When I was raped in early 2017, I was traumatized and had no idea what would happen to me. Luckily, CHWs in my community told me about the services and treatment I could get at the health center. On my first visit, which was already a few weeks after the rape took place, I was immediately tested for diseases and counseled. **BECAUSE WE WAITED WEEKS BEFORE COMING IN, I FOUND OUT DURING MY VISIT THAT THAT I WAS HIV POSITIVE AND PREGNANT.** This has been incredibly hard on me and my family.

“Because of the nurses at Saint Paul, who have supported and counseled me throughout, **I CONTINUED TO COME TO THE HEALTH CENTER FOR MY ANC VISITS AND EVEN DELIVERED HERE NINE MONTHS LATER.** Now I continue to come to the center regularly for post-natal care consultations and nutritional counseling, as well as for my own counseling and psychosocial support. I also just found out that **MY BABY IS HIV NEGATIVE,** which is such a relief. While I have to live with the horrible thoughts of what I went through, the counseling I get has helped me to get a little better day by day. **I TRULY DON'T KNOW WHERE I'D BE WITHOUT THIS SUPPORT.**”

EXCERPTS FROM AN INTERVIEW WITH
EMILIE [NAME WITHHELD] on SGBV SERVICES
19 years old, Saint Paul Health Center, Dilala health zone

Sexual and gender-based violence

SGBV remains a public health and human rights issue, and it is one of international and national concern for which governments are encouraged to develop strategies and action plans to address. IHPplus supported the DRC government's PNSR to implement the National Strategy for Combating SGBV through prevention and response activities in 78 project-supported health zones.

The project's approach was based on the following prevention activities: mass awareness campaigns against SGBV; capacity building and supervision of CHWs to raise awareness and respond to cases of SGBV; capacity building of service providers in the provision of medical and psychosocial care for survivors of sexual violence, including the supply of post-exposure care kits; and the provision of guidance on educational and economic reintegration and legal assistance for SGBV survivors.

ACTIVITIES

At the national level:

- Participated in and documented the 16 Days of Activism in 2017, which were held from November 25, the International Day for the Elimination of Violence against Women, to December 10, Human Rights Day. The theme for 2017 was "Leave no person behind: Ending violence against women and girls." This event was devoted to raising awareness on various documents, laws and strategies to protecting the rights of women and girls;
- Participated in monthly meetings of the sexual violence sub-group, coordinated by UN Women;
- Participated in the gender thematic groups, under the coordination of the Ministry of Women, Family, and

Children and with support from UN Women;

- Participated in the monthly meetings of the technical group on sexual and reproductive health;
- Collaborated with GHSC-TA to compile and distribute post-rape kits with the medication available at the CDRs.

At the provincial level:

- Trained 30 care providers at the health center and hospital levels of the Dilala and Manika health zones on provision of medical and psychosocial care for SGBV survivors;
- Trained 30 CHWs in the Dilala and Manika health zones on SGBV;
- Trained 59 providers on the minimum initial service package for sexual and reproductive health in humanitarian emergencies, with a specific focus on medical care for survivors of sexual violence in IHPplus-supported health zones;
- Supplied health facilities with post-rape kits;
- Collaborated with the health divisions of Bukavu, Kolwezi, and Mwene Ditu to support activities for International Women's Day. The international theme for 2018 was "The Time is Now: Rural and Urban Activists Transforming Women's Lives." This was adapted for the DRC context to be: "Investing in the productive force of rural women: A priority for the DRC." The event included awareness-raising and educational activities at four schools on the different laws that protect the rights of women and girls;
- Conducted mini-awareness-raising campaigns on the fight against SGBV in Bukavu (Bunyakiri, Kaniola, and Kamitunga), Kolwezi (Fungurume and

Manika), and Uvira (Lemera and Ruzizi) coordinations;

- Created a WhatsApp group called Kijana with more than 100 youth in the Kolwezi coordination, which uses social networks to inform and educate peers on different themes around sexual health including HIV, sexually transmitted infection, and SGBV. One topic that generated a lot of interest and discussion was emergency contraception, which was explored in episode 48 of the TV5 show "C'est la Vie."

RESULTS

Over the course of IHPplus, a total of 10,324 cases of SGBV were reported in the project provinces, with women comprising 97% of victims. Over the three years of the project, the number of cases reported increased on a yearly basis, going from 2,526 in PY1 to 3,591 in PY2, and ending with 4,207 cases in the final project year, as presented in Table 16, page 82.

The Kasai Central, Lomami, and Sud Kivu provinces reported a large increase in the number of SGBV cases, primarily due to the insecurity in certain health zones within these provinces that contributed to SGBV prevalence. With this increase in cases, however, there has also been an increased demand for services among these populations, and subsequently higher levels of reporting. Awareness-raising efforts among CHWs and providers, including initiatives such as the mini-campaigns on SGBV awareness and the implementation of the Office of U.S. Foreign Disaster Assistance (OFDA) project in the Luiza coordination, helped to shed light on this problem and begin to address it as needed.

Of the 10,324 cases reported in the IHPplus-supported zones, 5,306 cases were consulted within 72 hours of the

violation (51%), and 4,346 cases were consulted between 72 and 120 hours of the rape (42%) as presented in Figure 41, page 83. Preventive care against HIV must be given within 72 hours, and 4,169 of the survivors of sexual violence consulted within 72 hours, were given ARV treatment (40%). Additionally, in 3,843 cases (37%), survivors of SGBV received the emergency contraception pill to prevent pregnancy, and in 3,994 (39%) of cases, they received psychosocial support. It should be noted that care for survivors remains a large challenge in the health zones.

RECOMMENDATIONS

- Intensify awareness-raising campaigns on the fight against SGBV in the health areas, taking advantage of campaigns already planned on these themes;
- Expand the training of CHWs and providers to include care for survivors of sexual violence beyond the project-supported health zones;
- Consistently and effectively monitor quality of post-exposure prophylaxis (PEP) kit storage and supply and management tools at the health facilities.

Full quotation: “My name is Furaha [name withheld]. I have five children, three girls and two boys. My husband abandoned me after I was raped to take a second wife, leaving me to look after my children alone. I’m a farmer, and I also go into the forest to make charcoal from wood that I find there. I sell the charcoal at the market in Walungu. Nine months ago, I was in the forest with an older friend, collecting wood to make charcoal. We encountered three civilian men who were armed with knives. They told my older friend to guard our things and took me further into the forest. One after the other, they raped me. They let me go afterward and disappeared. Somehow my friend and I made it to the closest village. A man from the village called an ambulance that brought me to the Kaniola Health Center. It was here that I was treated with the kits provided by IHPplus. I took anti-retrovirals (ARVs) for a month and took the antibiotics and the morning after pill. I’m extremely grateful that the medical attention was available; however, I still have flashbacks and experience psychological difficulties. I’m currently being treated for post-traumatic stress disorder at Kaniola Hospital!” Photo by Rebecca Weaver.



“ I’m extremely grateful that medication attention was available...however, I still have flashbacks and am being treated for post-traumatic stress disorder at Kaniola Hospital.”

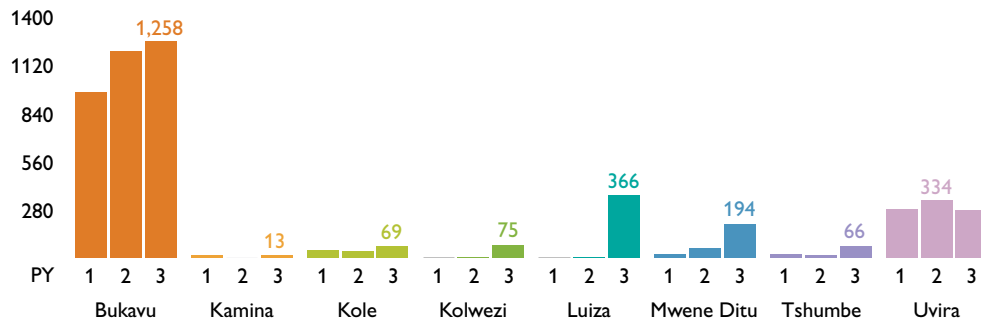
—Furaha

Table 16. Number of people reached by USG-funded SGBV services, disaggregated by sex

Coordination	PY1	PY2	PY3	Female	Male	Total
Bukavu	2,086	3,079	2,474	7,550	89	7,639
Kamina	15	3	17	34	1	35
Kole	49	56	115	195	25	220
Kolwezi	0	3	108	105	6	111
Luiza	0	1	575	454	122	576
Mwene Ditu	25	57	352	368	66	434
Tshumbe	30	18	108	137	19	156
Uvira	321	374	458	1,136	17	1,153
Total	2,526	3,591	4,207	9,979	345	10,324

Fig 41. Care of SGBV survivors

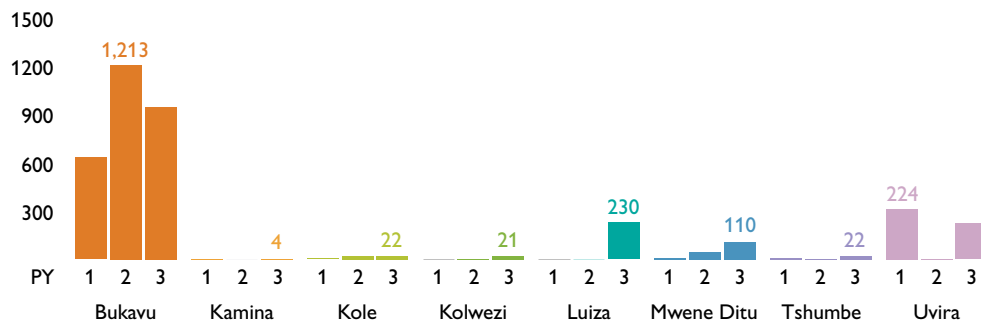
A. Number of people reporting sexual violence within 72 hours



B. Number of people reporting SGBV between 72 and 120 hours



C. Number of people reporting SGBV given emergency contraceptive



D. Number of people reporting SGBV who received psycho-social support

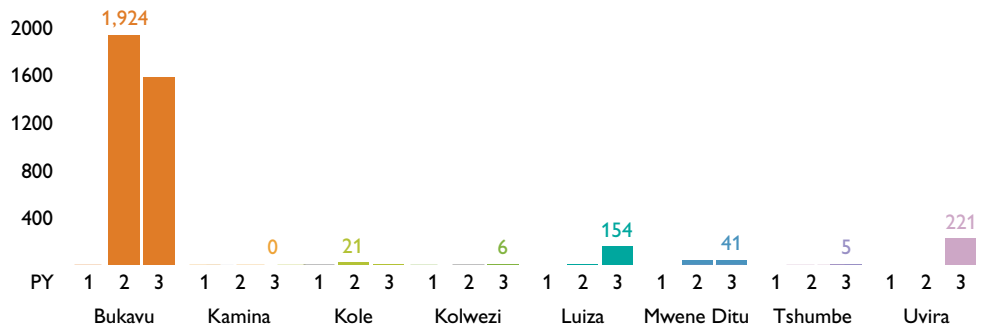


Table 17. Fistula repair at Kaziba GRH, Bukavu

Indicator		PY1	PY2	PY3	Total	%*
Number of operations		180	240	110	530	—
Causes	Home birth	62	79	31	172	33
	Obstructed labor	83	115	62	260	49
	Other (stage 3 cystocele and stage 3 uterine prolapse)	35	46	17	98	19
Type of operation	Urogenital fistula	129	188	53	370	70
	Recto-vaginal fistula	14	25	34	73	14
	Recto and urogenital fistula	2	0	11	13	3
	Other (prolapse, incontinence)	35	27	12	74	14
Operation outcome	Successful	161	232	110	503	95
	Failed	19	8	0	27	5
	Death	0	0	0	0	0

*Numbers may not add exactly due to rounding.

Fistula

IHPplus provided technical and financial support to the Kaziba GRH in the Sud Kivu province to provide fistula repairs and economic reintegration of fistula patients. During the three years of the project, 530 women received surgery. Data for this intervention are co-managed with EngenderHealth, which implements Fistula Care Plus.

As seen in Table 17, out of a total of 530 women who underwent surgery for obstetrics sequelae repair, 456 (86%) were fistula cases, including 370 vesico-vaginal fistula cases, 73 recto-vaginal fistula cases, and 13 recto and urogenital fistula cases. The other 14% of patients suffered from third degree uterine prolapse and were cured of incontinence and received a hysterectomy.

The primary causes of the fistula among the cases assisted were prolonged labor at health facilities (260 cases; 57%) and inadequate

monitoring and care during home deliveries (172 cases; 38%). Over the course of the project, the recovery rate from fistula repair was 87%. The majority of the failed recoveries were from cases of recurrent fistula. Patients ages 20-34 received the most repairs, for a total of 401 cases, or 75%.

The health zones of Fizi, Itombwe, Kalonge, Kaziba, Lemera, Nyangezi, and Uvira were most impacted by IHPplus support. Two of these health zones (Fizi and Itombwe) were outside the IHPplus intervention area, demonstrating that IHPplus work has an impact beyond the zones of intervention.

LESSONS LEARNED

Technical and financial support for obstetric fistula repair in the GRH of Kaziba helped hone provider skills and improve the hospital's technical capacities. Performance achieved in this area fostered confidence in

the communities that were sending women with fistulas from remote locations like Fizi and Shabunda. The socio-economic integration of treated women and preventive measures should be included in the priorities promoted by the politico-administrative authorities. It is also important to note that raising community awareness about fistula helps women living with fistula to come out of hiding and receive care.



“ Three years ago, following a long and difficult labor, my baby was stillborn. It was a very hard time for me. As I was recovering from my baby’s death, I developed a fistula, which meant I passed urine involuntarily. **SINCE I HAVE NINE CHILDREN AND NEED TO WORK IN THE FIELDS TO SUPPORT MY FAMILY, I COULD NOT STAY IN MY HOUSE AS MANY WOMEN WHO HAVE A FISTULA DO.** Every day, I would use rags to absorb the urine, and I would wash the rags every evening. Even so, I smelled, and my husband told me that he was going to leave me; my friends didn’t want to be with me anymore.

“Even though I live eight hours walking distance from Kaziba, I went there seeking treatment. When I returned home, the fistula had been successfully repaired. **ALL MY FRIENDS CAME TO OFFER THEIR CONGRATULATIONS AND WELCOME ME BACK.** Four women in my community also have fistulas and asked me for information. I told them I would help them if they want to go to Kaziba to have the operation.

“All is well now with my husband and my friends. I go to work in the fields and live among my community without worrying. **MY LIFE IN MY COMMUNITY HAS BEEN GIVEN BACK TO ME!**”

EXCERPTS FROM AN INTERVIEW WITH
FAIDA NABINTU on FISTULA SURGERY
47 years old, nine children, Lubarika health zone



From one quarter to the next, the health service utilization rate rose with the health service quality score, showing a relationship between service quality and utilization.

IR 2.2 MINIMUM QUALITY STANDARDS FOR HEALTH FACILITIES (GENERAL REFERRAL HOSPITALS AND HEALTH ZONE HEALTH CENTERS) AND SERVICES DEVELOPED AND ADOPTED

Results-based financing (integrating the FOSACOF approach)

The IHPplus RBF program is a transversal program that aims to improve the quality and availability of health care services, leadership performance, and resource management by incentivizing providers to improve their performance. Originally implemented by IHP in November 2013, the program continued under IHPplus in partnership with the MOH's RBF technical unit from June 2015 to August 2017.

TECHNICAL APPROACH

Under RBF, facilities receive payments based on achievement of agreed-upon targets, rather than for commodities or processes, as in traditional financing. Relative to other interventions, RBF has been shown to increase the availability and quality of health services; motivate health personnel; contribute to more efficient allocation of resources; improve data quality (through technical and community verification) and data-based decision-making; and strengthen the links between health facilities and their communities.

To implement the RBF program, the project supported the following:

- Established contracts with 35 contracting structures (30 HIV treatment sites and 5 health zone central offices) and collected baseline data to set targets for HIV indicators under the HIV-focused RBF program (please refer to the HIV section on page 66 for more information);
- Renewed annual contracts with the 132 contracting structures in 7 health zones: 7 health zone central offices, 7 GRHs, and 118 health centers;
- Established contracts with three new CBOs, to replace three CBOs (of a total of 14) contracted under IHP whose performance was not satisfactory, and trained them on community verification;
- Verified, through joint MOH-IHPplus teams, quarterly technical data to validate the provision of services reported by the contracting structures before issuing payments;
- Confirmed quarterly community verification of services provided, based on a random sampling of clients who reportedly received health care services at contracting facilities. After technical verification was completed, CBOs visited these clients in the community to verify whether they actually visited the health facility and received the reported services, and to determine their level of satisfaction with the services. Patient authenticity and satisfaction also affected the amount of the bonus payments received by health facilities;
- Made quarterly performance-based payments to contracting structures for validated data.

ACTIVITIES

RBF implementation guides:

IHPplus provided technical and financial support to the MOH's RBF technical unit to organize a January 2017 workshop to develop RBF implementation guides. In September 2017, the project participated in a workshop to finalize and validate these guides, which covered the following activities: technical verification, community-led verification, creating invoices, validating data in the RBF web portal, using the indexing tool, developing a management plan, and supporting the *Agence de contractualisation et de vérification* (contractualization and verification agency).

FOSACOF evaluations:

Through the RBF program, performance-based payments were made to contracting structures based not just on the quantity of services provided, but also on their quality, which was evaluated on a quarterly basis through the nine criteria presented in the FOSACOF—specifically adapted to the standards and norms in the PNDS of the DRC—to evaluate the overall quality of health facilities. At the end of IHPplus, 839

health facilities (including 799 health centers and 40 GRHs) were using FOSACOF in 78 of the 168 health zones currently supported by IHPplus. The project trained 734 managers (including DPS, IHPplus coordination offices, and health zone managers), 1,549 health care providers, and 3,735 community leaders to implement FOSACOF. Under the RBF program, 125 contracting health facilities each benefited from 10 FOSACOF evaluations.

Integrated quality approach:

Over the past several years, many different approaches (including FOSACOF) have been used in the DRC to evaluate and improve the quality of health care services, resulting in an inability to compare service quality among facilities using different approaches, or to implement country-wide interventions to improve service quality. To overcome these challenges, in October 2016, the DRC MOH decided to develop one standard approach to be implemented throughout the country. An inclusive and participatory process was launched around a core of experts and then extended to other departments in the MOH and its partners, leading to the implementation of the integrated quality approach (IQA) in March 2018. The IQA evaluates quality according to the six main pillars of the health care system defined in the PNDS and weighted according to their importance. The FOSACOF evaluation thresholds have been maintained for availability, demand, and quality.

IHPplus provided support for various coordination meetings as well as workshops for tool development, revision, and approval; and helped to train pools of national trainers on the IQA and integrated supervision. The project also conducted trainings on IQA for seven DPS and IPS teams (Bukavu, Haut Lomami, Kasai Oriental, Kasai Central, Lomami, Lualaba, and Sankuru), and 35 HZMTs (including the seven HZMTs participating in the RBF program). From March to June 2018, the project also supported the promotion and gradual implementation of this approach in project-supported health facilities and institutions.

RESULTS

Among the seven indicators presented in Figure 42, the proportion of discrepancies between reported and validated data is significantly higher in non-RBF health zones than in RBF health zones. This is due to the fact that HZMTs in RBF health zones provided more regular support for health facility staff to implement their management plans than did HZMTs in non-RBF health zones.

Figure 43 shows that the utilization rate of curative services in health facilities increased along with the average FOSACOF quality score of health centers and GRHs from July 2015 to March 2018, relative to the results of the baseline evaluation. From one quarter to the next, the health service utilization rate followed the same pattern as the health service quality score, indicating an association between service quality and service utilization.

CHALLENGES

- Inclusion of RBF activities in the MOH's national budget to ensure continuation of RBF activities, given that the budget development and approval process does not involve the RBF technical unit
- Sustainability and continued improvement in the performance of contracting structures after the end of implementation of the RBF program

LESSONS LEARNED

- Payment based on performance can increase the motivation of health service providers and lead to improvements in their performance, increasing the quality of services as well as service utilization rates.
- The effectiveness of the FOSACOF tool observed during joint supervision visits and its use in the RBF fostered MOH ownership and led to the development of the IQA tool, which is expected to be implemented at a larger scale under MOH leadership with the participation of all partners.
- The RBF approach has helped strengthen the health system in targeted zones. However, the high cost of monitoring has delayed the scale-up, and other strategies are required to reduce its cost without altering its quality and main objective.

Fig 42. Percentage of discrepancies between reported and validated data in four RBF health zones and four non-RBF health zones from October to December 2016

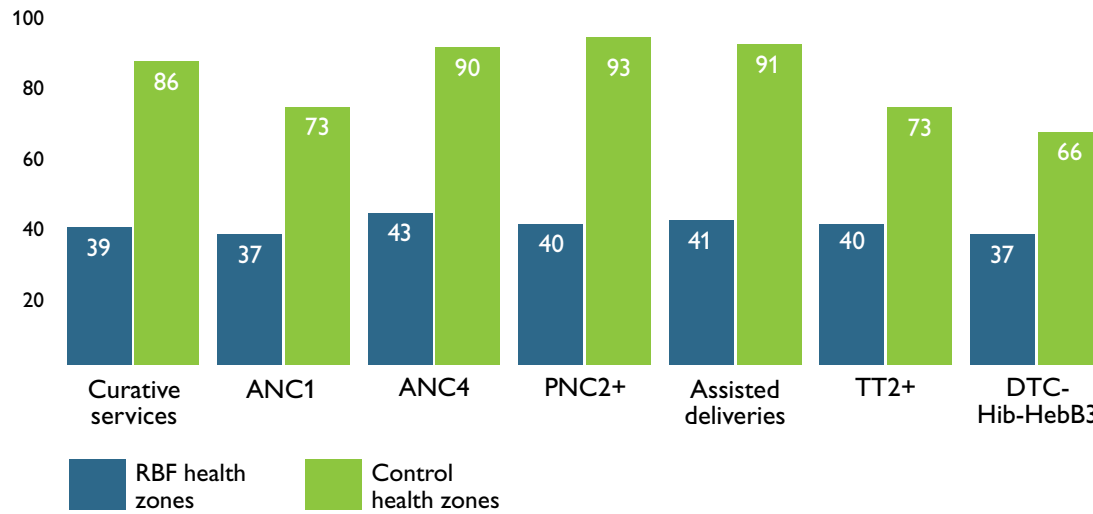
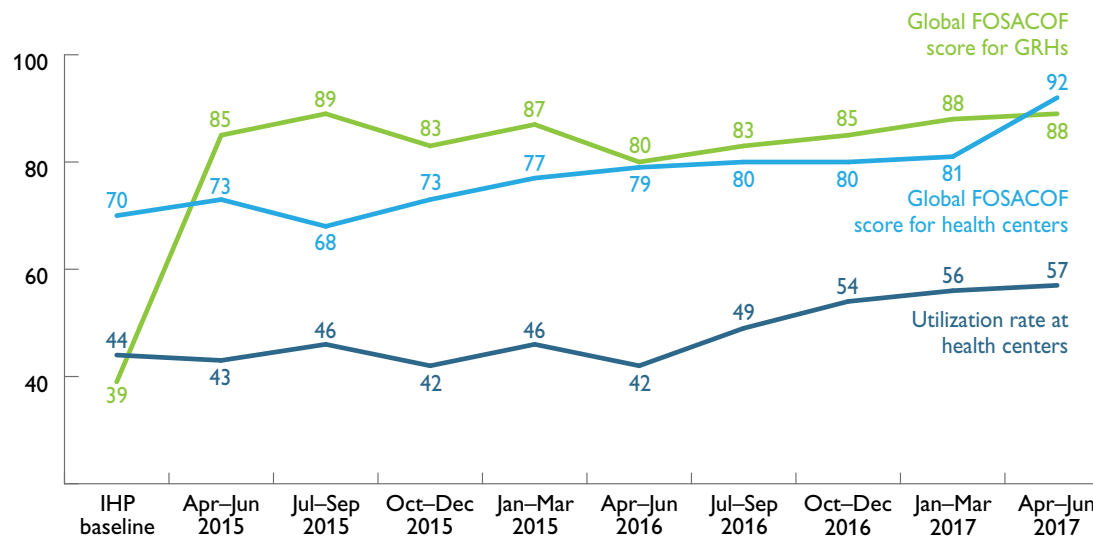


Fig 43. Evolution of utilization rate of curative services and average FOSACOF scores at health centers and GRHs (%)





“ Our health center serves more than 15,000 people and is located in a pretty hard to reach area. IHPplus training on detecting and treating sepsis has been particularly helpful. Thanks to the updated protocol we follow, we also know which cases can be treated safely at the health center and which cases should be sent to the hospital.

“I THINK THERE IS A GOOD RELATIONSHIP BETWEEN OUR HEALTH CENTER AND THE CHWs. Following the IHPplus training, I ran a campaign with CHWs from the local villages to provide information to community members about the importance of coming to the health center for treatment. I’ve also trained CHWs in the signs of sepsis that they need to recognize. **THEY KNOW THAT WHEN THEY SEE THESE SIGNS, THEY SHOULD URGE THEIR CLIENTS TO GO TO THE COMMUNITY HEALTH CENTER FOR TREATMENT.**

“When I first arrived three years ago, people would go to the traditional healers rather than rely on modern medicine from the health center. **NOW, THEIR FIRST IMPULSE IS TO COME TO OUR HEALTH CENTER FOR TREATMENT.** I’m so happy how this training has made me better at the work I do to support the community I serve!”

EXCERPTS FROM AN INTERVIEW WITH
IGNACE KOKO WANDUMA on SEPSIS REFERRALS
Nurse, Mulamba Health Center, near Walungu

Fig 44. Number of patients referred to health centers by a CHW

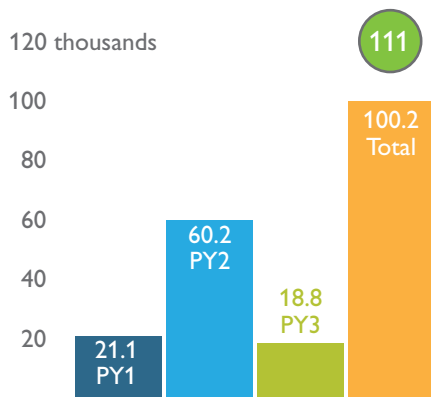
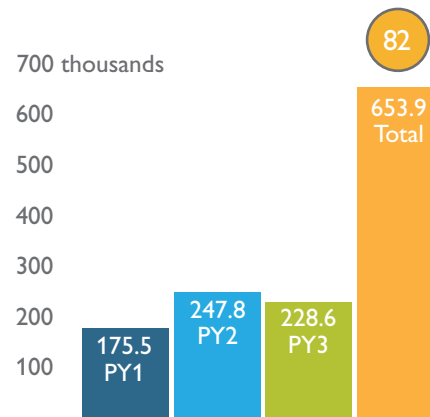


Fig 45. Number of patients referred to GRHs by a CHW or other health provider



● Target achieved (100% or >)
 ● Almost achieved (75–99%)
 ● Not achieved (< 75%)

All figures represent results from the period of October 1, 2015, to March 31, 2018, only.

IR 2.3 PRIMARY HEALTH CARE REFERRAL SYSTEM FOR PREVENTION, CARE, AND TREATMENT

IHPplus continued to perform well in two indicators of referral system functioning. By the end of PY3Q3, 17% of patients (adults and children) who needed care were referred to a health center by a CHW, exceeding the target by two percentage points for 111% achievement (Figure 44), and four percent of patients were referred to hospitals, nearly reaching the target of 5%, for 82% of target achieved (Figure 45).

Both the number of patients visited by a CHW and the number of patients referred have increased significantly since 2010, when IHP began. This is largely attributable to the i-CCM approach, the organization of supervision and joint monitoring visits at i-CCM sites, the provision of release forms and referral notes, and the continuous training of CHWs. In addition, the revitalization/rehabilitation of i-CCM sites and

health centers in supported health zones, coupled with the measures listed above, have improved the reputation of health centers in their communities. The percentage of cases of diarrhea, pneumonia, and malaria treated and referred at the i-CCM level climbed from an average of 7.5% at the close of IHP in 2015 to nearly 10% percent of cases by the third quarter of PY3 during IHPplus.

IR3

INTERMEDIATE RESULT 3

Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones

- IR 3.1 Health sector community outreach linkages
- IR 3.2 Health advocacy/community mobilization organizations
- IR 3.3 Social and behavior change campaigns



A community in the Luputa health zone celebrates the opening of a clean water source for the village. Photo by Sarah Ranney, MSH.



IR 3.1 HEALTH SECTOR COMMUNITY OUTREACH LINKAGES

IHPplus social and behavior change communication initiatives contributed to strengthening community solidarity and resilience, as health development requires community engagement. Approaches included establishing Champion Communities and sub-groups such as Champion Men to address negative norms, Champion Mamas to focus on MNCH behaviors, and Champion Youth to address youth-related concerns. The SBCC approaches utilized Education through Listening (ETL) and mHealth. These methods were intended to encourage health-related knowledge exchanges, dissuade negative attitudes and practices, help communities to promote healthy behaviors, and increase demand for health services. IHPplus helped to optimize relationships between the health sector and the community, promote awareness of health issues, mobilize communities, and facilitate SBCC.

Community mobilization campaigns

IHPplus implemented targeted mini-campaigns to respond to specific priorities and health topics such as malaria, FP, WASH, MNCH, TB, prenatal consultations, immunizations, and exclusive breastfeeding. The mini-campaigns targeted indicators that were not improving and reinforced local health messaging efforts and activities. IHPplus reached more than one million people during 139 mini-campaigns (Figure 46), with nearly 40% of beneficiaries being women. Compared to the PMP target of 32, this represents an achievement rate of 434%. The collaboration of existing community structures, including CODESAs, Champion Communities, CHWs, health authorities, and other stakeholders made mini-campaigns effective tools for increasing demand and improving access to high-impact services. Mini-campaigns

included the composition of songs in local languages, community meetings, and the participation of religious and opinion leaders in the dissemination of messages on healthy behaviors.

The number of community mobilization campaigns declined over the lifespan of the project due in part to project planning that called for a decrease in campaigns. In PY2, community mobilization campaigns in Luiza were cancelled due to insecurity issues. SBCC activities were stopped during PY3Q2 and the majority of PY3Q3.

Fig 46. Number of mini-campaigns conducted

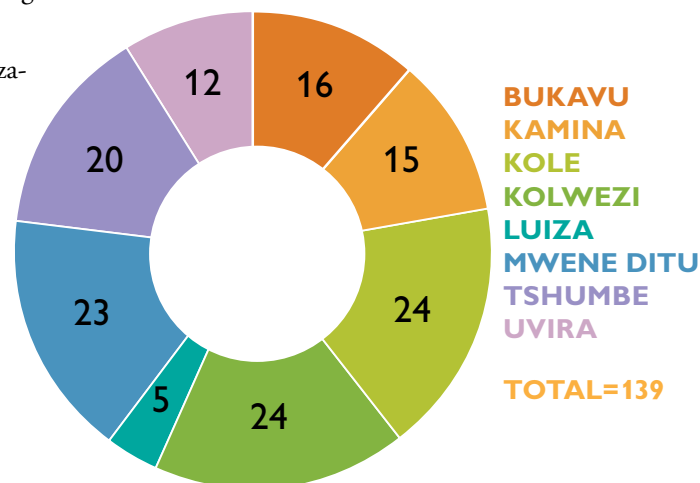


Fig 47. Number and percent of CODESAs that were revitalized and functional

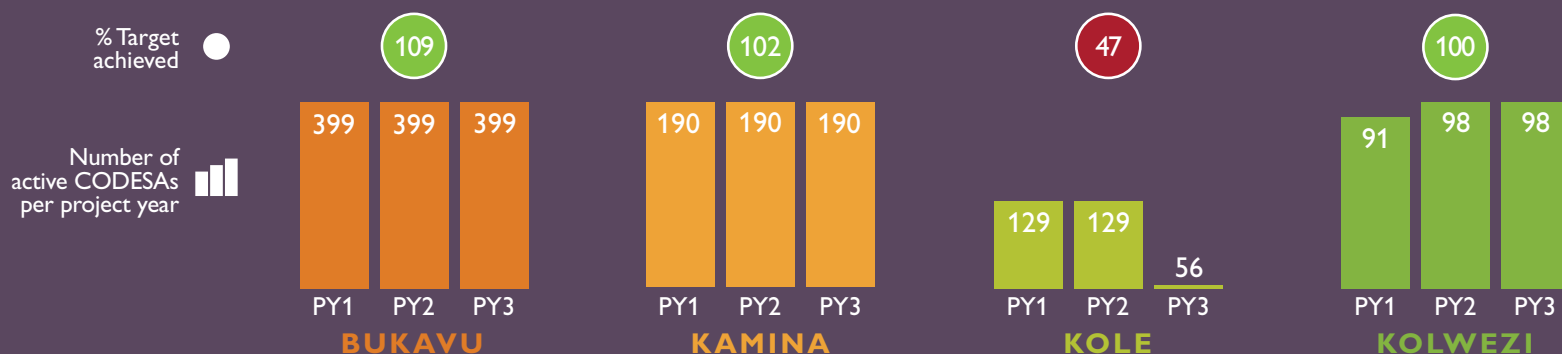


Table 18. Number of CODESAs with communication action plans

Coordination	PY1	PY2	PY3	Target	Ach %
Bukavu	380	380	380	399	95
Kamina	190	179	179	190	94
Kole	129	129	56	56	100
Kolwezi	89	91	98	98	100
Luiza	142	169	144	151	95
Mwene Ditu	149	149	149	171	87
Tshumbe	74	74	74	86	86
Uvira	72	80	80	82	98
Total	1,225	1,251	1,160	1,233	94

CODESAs

IHPplus revitalized 1,233 CODESAs, which represents an achievement rate of 96% (see Figure 47, below). CODESAs are one of the community mobilization approaches supported and utilized by IHPplus to strengthen community participation and encourage civic engagement.

IHPplus actively engaged CODESAs in numerous project activities. IHPplus provided financial support to CODESAs in targeted health zones in the form of fixed subsidies of \$15.00 USD per month per CODESA to hold monthly meetings, purchase supplies, and finance operations. The main role of CODESAs was to bridge

the gap between health centers and the community by transmitting information, carrying out awareness-raising activities, providing referrals, and participating in health messaging campaigns to disseminate information, mobilize community resources, and participate in the distribution of FP products, ITNs, and spittoons, and supporting health personnel in the field.

As part of their civic commitment initiatives, CODESAs contributed to the construction, development and maintenance of health centers and other public health works, including placenta disposal pits, biomedical incinerators, water sources, and latrines. The number of IHPplus-supported active CODESAs with communications

workplans is 1,160 (an achievement rate of 283% compared to the target).

The number of active CODESAs from PY1 to PY2 increased as IHPplus continued to provide support and partnerships increased with UNICEF, Save the Children, and CORDAID. The decrease in active CODESAs from PY2 to PY3 was due to increased instability in areas such as the Kole and Luiza coordinations. Due to financial limitations of uncertain project continuation, SBCC activities were stopped during PY3Q2 and the majority of PY3Q3. The same reasons affected the number of IHPplus-supported active CODESAs with communications workplans (Table 18).

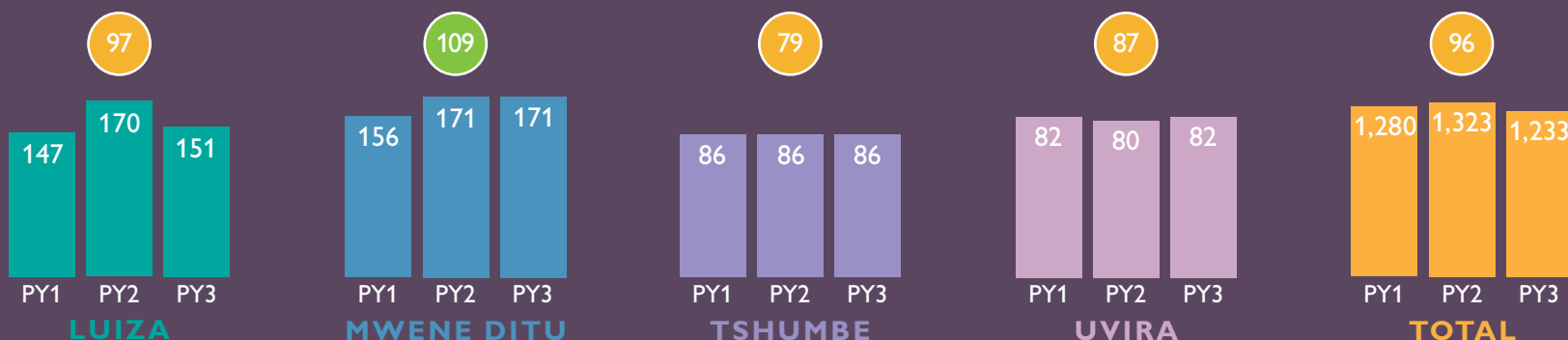


Fig 48. Overall summary of the percent of Champion Communities with statistically improved indicator rates

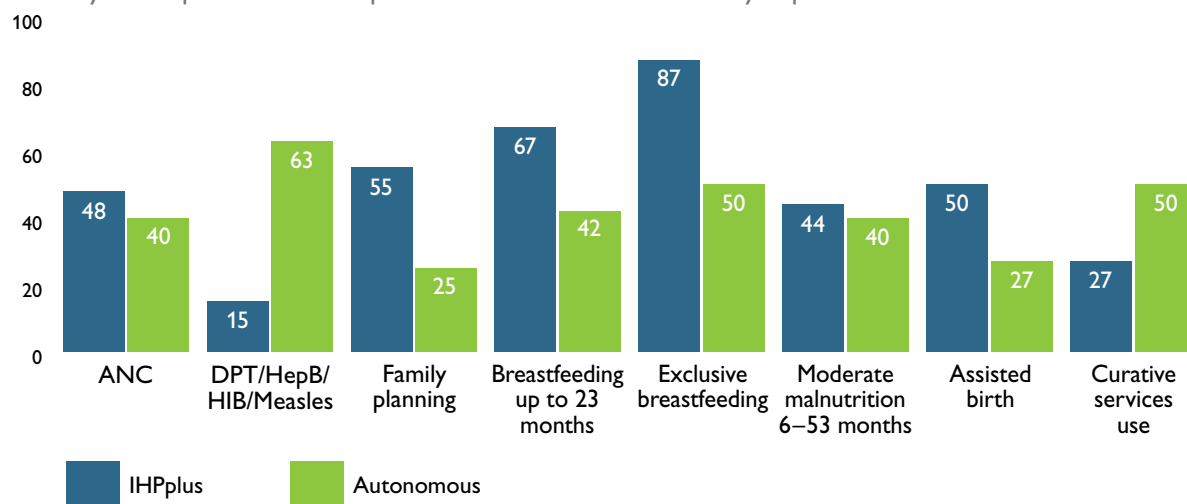


Table 19. Champion Communities, both initiated by IHPplus and autonomously, which gained NGO status

Coordination	IHPplus	IHPplus with NGO status	NGO status in process	Auto-nomous	Auto-nomous with NGO status	NGO status in process	Non-functional	Total functional	Health zones
Bukavu	4	4	0	1	0	1	1	5	3
Kamina	3	3	0	9	0	0	0	12	3
Kole	3	3	0	2	0	4	0	5	5
Kolwezi	4	4	0	5	0	2	0	9	5
Luiza	8	6	1	6	0	1	0	14	6
Mwene Ditu	4	2	1	4	1	1	0	8	5
Tshumbe	2	1	0	2	0	0	1	4	4
Uvira	5	5	0	2	0	0	0	7	3
Total	33	28 (85%)	2	31	1	9	2	64	34



CODESA reviews site of possible water source. Photo by MSH staff.

Table 20. Number of Champion Men trained, IHPplus vs. Other

Coordination	PY1, by training		PY2, by training		Total, by training	
	IHPplus	Other	IHPplus	Other	IHPplus	Other
Bukavu	25	533	0	91	25	649
Kamina	0	0	0	0	0	0
Kole	18	102	0	207	18	309
Kolwezi	10	32	0	83	10	115
Luiza	56	168	0	280	56	448
Mwene Ditu	0	45	0	630	0	675
Tshumbe	0	0	0	0	0	0
Uvira	0	0	0	0	0	0
Total	109	880	0	1,291	109	2,196

IR 3.2 HEALTH ADVOCACY/COMMUNITY MOBILIZATION ORGANIZATIONS

Champion Communities

During IHPplus, the number of project-implemented Champion Communities increased to 33 (from 29 at the beginning of IHPplus) with the development of an additional 31 autonomous Champion Communities (see Table 19, page 96). There are a further nine autonomous Champion Communities that are in development as of 2018. The project exceeded the goal of 36 functional Champion Communities, reaching a success rate of 177% including functional autonomous Champion Communities. OSC conducted a study on the Champion Community approach in the DRC, which will be submitted separately.

The number of Champion Communities with NGO status is 28, or 85% of the IHPplus-implemented Champion Communities. One of the autonomous Champion Communities, *Réseau d'associations congolaises des jeunes* (Network of Congolese Youth Associations) Champion

Youth, also gained NGO status in 2018 and was the first autonomous Champion Community to do so. Obtaining NGO status allows Champion Communities to sign partnership agreements and receive funding with various state partners, as well as national and international organizations. Of the 28 Champion Communities with NGO status, 23 have partnered with organizations on various projects and received outside funding.

Champion Communities had different action plans based on participatory assessments of local health needs. Using DHIS2 data and chi-square analysis for comparing Champion Community health areas with non-Champion Community health areas, Figure 48 shows the percent of Champion Community health areas (IHPplus and autonomous) with statistically significant improvements in various MNCH indicators. For example, 87% of IHPplus Champion

Communities and 50% of autonomous Champion Communities had statistically significant increases in exclusive breastfeeding rates when compared with non-Champion Community health areas.

CHAMPION MEN

IHPplus implemented the Champion Men approach, a subgroup of the Champion Community initiative, to change men's perceptions on the roles of women in their families and communities. A total of 2,196 Champion Men participated in the initiative, of which 109 were trained by IHPplus (see Table 20). The initiative strived to achieve gender equality, reduce SGBV, and increase balanced decision making within the family in regards to children's education, health care, and finances. Champion Men were taught to resolve issues with the family through discussion and were expected to have a positive influence on the behaviors

Table 21. Number of youth organizations conducting awareness-raising activities

Coordination	PY1, active	PY2, active	PY3, active	Total youth organizations		% active to identified
				Identified	Active	
Bukavu	10	10	14	28	14	50
Kamina	13	13	8	13	8	62
Kole	35	35	35	38	35	92
Kolwezi	10	7	10	12	10	83
Luiza	15	49	30	35	30	86
Mwene Ditu	58	49	54	56	54	96
Tshumbe	11	8	8	8	8	100
Uvira	28	28	0	0	0	N/A
Total	180	199	159	190	159	84

of the men in their community. Champion Men strived to increase women's participation in the management of family finances, increase school attendance for both boys and girls, and increase joint decisions for FP, gender equality, equitable partition of household tasks (e.g., food preparation, baby rearing, cleaning), and were particularly effective in Dibaya, Dilala, Kanda, Katana, Kole, Lomela, Lodja, Luambo, Luiza, and Ndeksha health zones.

CHAMPION MAMAS

Women within the Champion Community took on a more interpersonal approach (case management approach) by identifying pregnant women and/or women with children under 2 years old in their community to ensure women were prioritized for MNCH topics relevant to them. Champion Mamas' efforts had statistically documented improvements in MNCH indicators when compared with health areas that did not have champion mamas.

Health areas with IHPplus Champion Communities which include a Champion Mamas sub-group who work specifically

on maternal health issues reported higher rates of ANC-4, FP, and breastfeeding rates (exclusive and breastfeeding up to 23 months) than health areas with no Champion Communities. And although the malnutrition rates are lower in the Champion Community health areas, they did not reach statistical significance in 2017.

YOUTH

Youth demonstrated their interest in participating in the health and socioeconomic development of the DRC through their work with IHPplus. By the end of PY3, 159 out of the 190 youth associations were active (84%), exceeding the project target of 129 for an achievement rate of 126% (Table 21). The project provided support to young leaders of youth groups and NGOs working within communities. IHPplus worked to integrate Champion Youth in schools to implement sensitization activities through peer youth education, increase literacy rates of young mothers, and support vocational training.

Champion Youth:

Champion Youth make up a specialized sub-group of Champion Communities. Champion Men took on youth specific messaging in the community, including FP, staying in school, drugs, alcohol, early marriage and HIV and AIDS. Although Champion Youth typically used mass media, in some cases they employed interpersonal approaches for at-risk groups. Schools and sporting events were usual settings for their SBCC messaging targeting youth specific health needs. Some Champion Youth used gaming (foosball tables) as a means for gathering youth for message dissemination; others used soccer events to reach larger groups of youth. Youth were the most creative in message development modalities including puppet shows, plays, song and creation of soccer teams that not only competed, but spread messages during games. Where youth clubs already existed, Champion Youth were integrated into existing groups to ensure sustainability. A handful of Champion Youth applied for NGO status and received outside funding, making their efforts sustainable.



VOICES OF IMPACT

“ I became a community health worker because I saw so many people in my community who were sick but not going to the health center for care. I **KNEW THAT, AS A CHW AND AS A MOM, I COULD HELP CONVINCe MOTHERS TO TAKE THEIR CHILDREN TO THE HEALTH CENTER** for health checks and for care when their children were ill.

“I was so pleased when I was chosen by the central health center to take part in the IHPplus training to help detect people sick with TB in my community. I now send six to 10 people each month to Kaniola Hospital for this testing. As a result of my referrals, five people in my community are now being treated for TB. One of my happiest moments was when **A MAN I'D REFERRED TO THE HOSPITAL FOR TREATMENT CAME UP TO ME IN MY VILLAGE AND TOLD ME THAT BECAUSE OF ME, HE HAD FOUND HIS HEALTH AGAIN!**

“Now, when I tell mothers that their children are looking ill or malnourished and should go the health center for treatment, they listen to me. Because of me, not just people suffering from TB, but **MANY OTHER PEOPLE IN THE COMMUNITY ARE FINDING THEIR HEALTH AGAIN, TOO.**”

EXCERPTS FROM AN INTERVIEW WITH
PATIENCE MAHESHE on i-CCM SITES
President of the CODESA, Kaniola health zone

Table 22. Number of SMS messages by coordination office

Coordination	PY1	PY2	PY3	Total	Target	Ach %
Bukavu	56,207	137,056	19,355	212,618		
Kamina	45,009	94,066	0	139,075		
Kole	66,691	56,746	0	123,437		
Kolwezi	31,539	87,244	3,857	122,640		
Luiza	166,700	270,250	1,400	438,350		
Mwene Ditu	36,156	66,752	8,750	111,658		
Tshumbe	58,833	45,111	150	104,094		
Uvira	49,033	77,856	5,000	131,889		
Total	510,168	835,081	38,512	1,383,761	1,134,000	122

IR 3.3 SOCIAL AND BEHAVIOR CHANGE CAMPAIGNS

IHPplus sent 1,383,761 MOH-approved SMS health messages on various topics (Table 22 and Figure 49). This amounts to an achievement rate of 122% of the target of 1,134,000 messages. Numerous health zones and Champion Communities capitalized on SMS messages to supplement sensitization activities. The project reached an estimated 1,273,060 people with SMS messages.

IHPplus utilized SMS messaging to reinforce mini-campaigns. Throughout the project life, 8,500 SMS messages were sent in support of TB mini-campaigns in Dibaya, Fungurume, Katako Kombe, Lubondaie, Tshumbe, and Wembo Nyama health zones. One of the main objectives of the mini-campaigns was to identify and refer suspected TB cases for testing and treatment at CSDTs. Following the mini-campaigns, a poll of 8,442 health center patients was completed. The poll found that 50% of the polled patients confirmed having received an SMS on TB testing and 25% of the polled patients stated that they had shared the information received with others, whether individually or during community meetings. To further assist SMS messaging, Champion Communities have

created and maintained mobile phone directories of their communities. The directories include groupings of telephone numbers that distinguish recipients by age and sex to facilitate targeted messaging.

CHALLENGES

Remote communities:

Remoteness and the status of roads during the rainy season for many of the Champion Communities limited frequent oversight and capacity building on a regular basis.

Using skills to “fish”:

Changing the mindset of community members related to receiving handouts versus using skills to “fish” remains one of the biggest challenges. Women were more likely than men to understand that independence was more important than waiting for “handouts” and were able to be the change agents for some of the most successful Champion Communities.

Women’s participation:

In many areas where the Champion Community approach was implemented, paternalism persists. Some Champion

Communities formed without asking for the participation of women. These Champion Communities were not as successful (e.g., Kabongo) as Champion Communities with a more representative group of women. IHPplus urged Champion Communities to better represent the community and include women and youth.

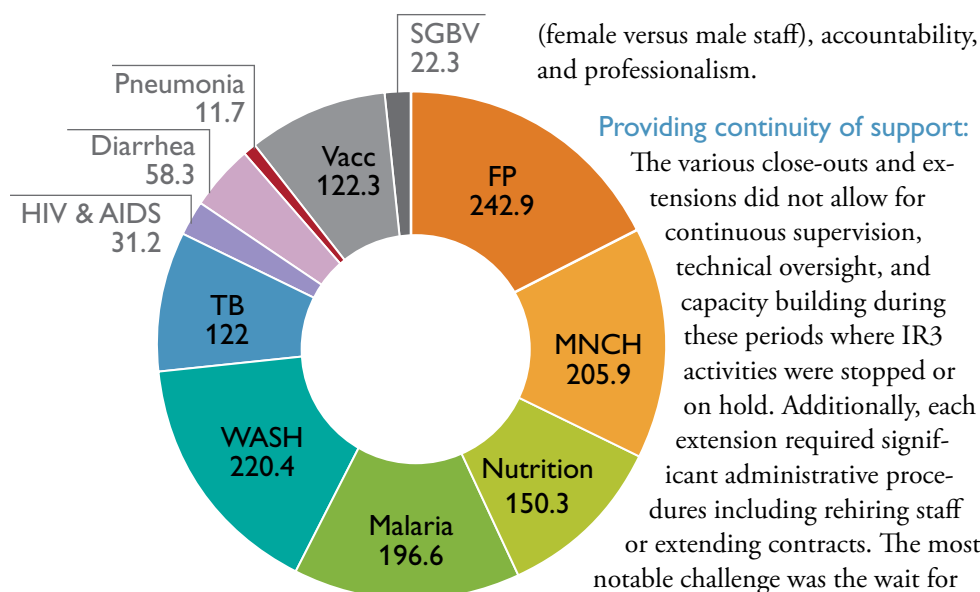
Use of local language:

To ensure women’s participation, the use of local language in meetings was very important. It was not uncommon for men in the group or even district and zonal authorities to insist on the use of French. It was apparent during visits to the Champion Communities that the use of French disenfranchised women who would not raise their hands to say they did not understand what was being said.

Accounting and transparency:

Champion Communities need more capacity building for accounting and more importantly transparency when funds are given as small grants. There was poor understanding of contracts, and many utilized funds on activities that were not within the

Fig 49. Number of SMS messages, in thousands, by health topic



scope of the contract they signed. Better transparency will improve their credibility and eligibility to receive outside funding.

Data collection:

Data collection skills are lacking at the community level. Data for some of the indicators chosen by Champion Communities in their action plans were not collected at the health facility level or integrated into DHIS/DHIS2 such as WASH, latrines, potable water points, mosquito net use, tuberculosis referral and treatment, and SGBV. These could have been easily collected by Champion Communities.

Staff capacity and accountability:

There are few, if any SBCC educational opportunities in DRC. Although staff have degrees from universities, and some in SBCC, these programs are not comprehensive and lack the necessary rigor to allow expertise in community mobilization in a range of contexts of DRC. In many cases, staff suffered from paternalism at higher levels, as well as from a lack of diversity

(female versus male staff), accountability, and professionalism.

Providing continuity of support:

The various close-outs and extensions did not allow for continuous supervision, technical oversight, and capacity building during these periods where IR3 activities were stopped or on hold. Additionally, each extension required significant administrative procedures including rehiring staff or extending contracts. The most notable challenge was the wait for extension funding during 2017-2018 just after funding a small grants program to new Champion Community NGOs. Without supervision, it was impossible to supervise the granting process to ensure transparency and fund utilization as per the contract.

Youth:

Large numbers of youth organizations are unorganized and require extensive assistance and oversight for the planning and implementation of activities. Compounding this issue, health zone officials and staff are frequently disinterested and provide limited mentorship and assistance. Furthermore, insufficient numbers of trainers are available to teach the communications techniques created by the Programme National des Jeunes et Adolescents (PNJA).

CODESAs:

CODESA members and CHWs do not always prioritize their community health duties and activities. IHPplus project staff on numerous occasions experienced challenges accessing health areas and zones due

to difficult terrain, weather, and security problems caused by conflicts in Bukavu, Kole, and Uvira. Lack of offices, facilities, materials, and equipment complicate planning, tasks, and the implementation of activities, as well as monitoring and record keeping. Lack of coordination between CODESAs and other organizations, such as religious groups, teachers, local government leaders, community-based organizations, and community leaders is not uncommon and wastes potential opportunities for collaboration and synergy of efforts. Overrepresentation of males in CODESAs and sexism make it difficult for female members to participate in discussions and the development of activities. Male members do not accord their female colleagues an equivalent amount of floor time and often dismiss their views.

mHealth:

mHealth initiatives are dependent on cell phone coverage and networks that are not reliable in all health zones and areas. Costs for SMS messages have risen over the life of project. Rates of cell phone ownership are lower for women, which affects the equal distribution of messaging. Some health zones have a low degree of commitment to SMS messaging, as they perceive the method to be expensive and time consuming. Many health zones also lack staff members with Frontline software fluency, complicating the distribution of messages.

LESSONS LEARNED

The Champion Community approach shows “economy of effort” and “value for money” as Champion Communities are being contracted for their expertise by other USAID, international and local partners

such as the MOH and health zones to aid in health campaigns and household sensitization. In addition, the creation of autonomous communities gives the project “three for one” (three autonomous for every project-implemented Champion Community). The IHPplus Champion Community approach in DRC is now a “gold standard” [2] in community mobilization and behavior change. Champion Communities change behavior and increase access and utilization of high impact health services. Given the sustainability of the approach and acceptability among other communities through the development of autonomous Champion Communities, this approach should be integrated into the developing National Community Health Plan.

Location:

Based on the IHPplus experience and analysis, Champion Communities performed best when located in remote and/or insecure areas. Although the Champion Community approach can work in any context, in more urbanized areas the same indicators may not be priority (MNCH) whereas problems such as HIV/STDs, SGBV, and drug and alcohol use may be higher priority health issues for communities that are not remote.

Monitoring, evaluation, learning, and impact:

Impact analysis should be periodically done to assess whether the mobilization activities are working. Quarterly impact assessment allows incremental adjustment to the program and allows feedback to each Champion Community through analysis of DHIS2 data which now has health area level data.

Membership and decision making:

It is vital to incorporate community leaders (religious, traditional, health) into the approach including local (district) authorities so they can learn the approach and

support the Champion Community on priorities. Additionally, decisions must be democratic. Women must be represented and included in all levels of the process, as it is important to overcome the paternalism that exists in many areas.

Making the approach sustainable:

More than 85% (28/33) of the IHPplus-established Champion Communities are registered NGOs; the rest have submitted their paperwork for approval. Unlike previous Champion Community approaches in DRC which did not continue after the cessation of funding, the IHPplus Champion Community approach has proven to be not only successful but sustainable and “naturally transitioning.” Income generation and NGO status were important transformative steps in autonomy, sustainability, and independence. Technical capacity building should be prioritized over funding or material support, and small grants from the project should be avoided and instead focus on building the capacity for grant writing, presentation, accounting, and transparency. A standard package of training, in addition to the community mobilization techniques, would help to ensure capacity is uniform across the approach.

Autonomous development of Champion Communities and mentoring:

Other communities realized the benefits and are starting their own autonomous Champion Communities and using IHPplus communities to mentor them in the process of development. For each established Champion Community, on average, three other Champion Communities develop autonomously.

Youth:

Due to their proximity to key target populations, youth organizations play an important role in implementing health zone

action plans. Youth organizations contribute to positive health behavior changes within youth populations. Engaging youth groups and organizations is an effective way of raising awareness on STDs, sexual violence, and early marriage. Increased awareness on these subjects leads to greater youth participation in health-related discussions, testing for STDs, and reporting on suspected cases of illness. Utilizing youth organizations for peer education is a cost-effective channel for the spread of information where funds are limited. Where community leaders engage with youth organizations, trust and communications between youth and adults increases.

CODESAs:

Conducting CODESA activities in rapid succession with IHPplus and health zone support helps facilitate group cohesion and keeps members engaged. Monitoring and supervising CODESAs in the development of their workplans reinforces CODESA leadership, improves the implementation of activities, and leads to greater results.

mHealth:

Communities appreciate receiving health messaging via SMS and expressed a desire for more information dissemination via this means to IHPplus staff, CHWs, and health zone officials. Champion Communities started spreading health information via SMS messaging using funds raised through income-generation activities and outside funding.



“ Before our spring was rehabilitated, some of us gathered water from the unprotected spring, which was open to the sky, while others used a nearby stream. **THE WATER THAT WE CONSUMED WAS FILTHY. WE SUFFERED FROM FREQUENT CASES OF DIARRHEA, TYPHOID, AND WORM INFECTIONS.** Then, three years ago, IHPplus came to rehabilitate our spring and establish a WASH committee to maintain it. The community held elections and chose me to be the president of the committee. I accepted because I wanted to help my community.

“IHPplus taught us how to maintain our spring, how to educate our community on hygienic behaviors, and how to set up a collection box where each household contributes a small monthly fee. **PEOPLE’S HABITS HAVE CHANGED; NOW, EVEN OUR SIX-YEAR-OLD CHILDREN AUTOMATICALLY WASH THEIR HANDS WHEN THEY RETURN FROM THE TOILET.** Cases of diarrhea and typhoid have plummeted. Although we are not paid, we gladly perform this work, and will continue to do so with the support of our community.”

EXCERPTS FROM AN INTERVIEW WITH
AUGUSTIN KABONGO on WASH
President, WASH committee, Kanda Kanda health zone

IR4

INTERMEDIATE RESULT 4

Health sector leadership and governance in target provinces improved

- IR 4.1 Health sector policy alignment
- IR 4.2 Evidence-based strategic planning and decision-making
- IR 4.3 Community involvement in health policy and service delivery



A dirt road stretches from the bottom center towards the horizon, flanked by green grass and trees. The sky is filled with large, dramatic clouds, with a bright light source breaking through near the horizon, creating a golden glow. The overall mood is one of hope and forward movement.

“ During the last USAID field visit, communities insisted that several innovations brought by IHPplus will be supported by them in the future—transformative programs such as the Leadership Development Program, Champion Communities, and Champion Men. They said that they had committed themselves to these innovations because they made a difference in the lives of the people.”

— Richard Matendo, USAID Agreement Officer’s Representative for DRC-IHPplus

IR 4.1 HEALTH SECTOR POLICY ALIGNMENT

Provincial-level oversight of health services is required under the decentralization strategy of the government of the DRC. IHPplus activities focused on strengthening provincial health governance—including management, coordination, and communication—moving upward from decision-makers at the national level as well as downward through coordination and collaboration with local/zonal health authorities. IHPplus helped provincial decision-makers reinforce their role in developing and aligning relevant policies, legislation, and norms to reduce system

bottlenecks, improved transparency and accountability, and increased citizen involvement in health systems strengthening. The project also helped provincial leaders to partner with citizens to define health system priorities and rate the system's efficacy. As noted in the national health systems strengthening strategy, citizens provide an estimated 70% of the funding for the recurrent expenditures of some health zones and therefore must be involved in joint consideration of health policies, priorities, and activities.

Under this IR, IHPplus focused on activities that institutionalized community involvement in health policy and service delivery, especially the involvement of women. Women must be fully involved in the decision making in their communities not only because they are the direct beneficiaries of the project's interventions, are more available, committed, and creative, but also because they are the focal points for organization and development of their own households; to this end, they must occupy positions of responsibility—not just serve as figureheads or in the background.

IR 4.2 EVIDENCE-BASED STRATEGIC PLANNING AND DECISION-MAKING

Improved data for decision making

IHPplus provided financial support to the MOH to conduct regular monitoring meetings at the health facility level as well as monthly reviews of health zone data. In addition, IHPplus conducted the following activities:

- Conducted a global review of the project's M&E system (including the *Système National d'Information Sanitaire* [SNIS], or National Health Information System [NHIS]) and adopted strategies to address gaps;
- Assisted the MOH to integrate the DHIS2 system into the SNIS;
- Adopted DHIS2 as the data management system;
- Provided support to conduct evaluations to demonstrate the impact of IHPplus' work (i.e., WASH, SBCC, impact evaluation).

STRENGTHENING THE PROJECT'S M&E SYSTEM

Based on findings from the project monitoring and evaluation (M&E) capacity assessment, IHPplus prioritized the review and improvement of data flow; helped to clarify the various roles and responsibilities related to reporting; provided technical support to integrate DHIS2 and create interoperability with the project's DHIS2 instance; and evaluated data quality and revision of the PIRTS. IHPplus also provided technical support to the NHIS to create and adapt supervision tools at the health zone level, including data quality dimension to simplify and increase the efficiency of Routine Data Quality Assessments (RDQA). IHPplus' M&E team also provided support to conduct impact evaluations on social and behavioral change communication in the context of malaria case management in the health zones of Idjwi and Miti Murhesa (Bukavu coordination).

The IHPplus M&E team reviewed all 83 project PMP indicators, including definitions, data collection sources, calculation methods, and frequency of data collection. This activity was conducted during RDQA missions with the aim of identifying gaps in data collection and reporting related to PMP indicators. The project used these revised and updated PIRTS to identify and review the “challenging” indicators with USAID and other stakeholders to achieve a common understanding and to standardize the project's reporting system.

SUPPORT TO THE MOH DHIS2 SYSTEM TO IMPROVE THE QUALITY OF DATA AND REINFORCE THE SNIS

The SNIS remains the principal source of information on performance management of IHPplus. The quality of project implementation is directly linked to the quality of data generated by and through this infor-



VOICES OF IMPACT

“ At the national level, the project has provided support in the procurement and management of commodities; the development of national level TB-related documents, guidelines, and strategic plans; and **HELPING US TO GAIN VISIBILITY AND LEAD SENSITIZATION EFFORTS AROUND TB AT THE COMMUNITY LEVEL** through initiatives such as World TB Day, which aims to raise awareness and eliminate stigma.

“The project’s **SUPPORT TO TRAIN CHWs AND STRENGTHEN AWARENESS-RAISING EFFORTS HAS CONTRIBUTED TO IMPRESSIVE INCREASES:** numbers of people getting tested, sputum tests completed, and patients utilizing services and receiving and adhering to treatment.

“**WHAT HAS TRULY STOOD OUT TO ME IS JUST HOW ADAPTABLE AND RESPONSIVE THE PROJECT HAS BEEN TO OUR NEEDS AND CHALLENGES,** as well as its ability to work in line with our national priorities. IHPplus has never implemented their activities in a silo, but rather, they prioritize and value our engagement and feedback, and in the last few years, the project’s staff have come to my office requesting input and feedback on TB-related activities during the yearly planning cycles.”

EXCERPTS FROM AN INTERVIEW WITH

DR. MICHEL KASWA KAYOME on TB CARE
Director, National Tuberculosis Program, DRC



mation system. For this reason, IHPplus’ M&E unit conducted an evaluation of the project’s M&E capacity in February 2017 to use DHIS2. The activity was conducted in collaboration with the *Division du Système National d’Information Sanitaire* (Office of the National Health Information System, or DSNIS). During this evaluation visit, the team also verified the availability of existing data to help ensure better management of project performance and decision-making capacity. Based on the findings from this mission, IHPplus M&E staff and the DSNIS agreed upon and implemented the following action items:

- Equipped project-supported health zones with 99 laptops and consistent internet connection to enable access to DHIS2;
- Developed a complementary module within the MOH’s DHIS2 system that allows for the collection of data related to project indicators that are not currently captured in the SNIS;
- Created interoperability between the project and the MOH’s DHIS2 systems;
- Added “80% on-time reporting rate” to the list of indicators used for IHPplus monthly grant payments to health zones;
- Trained and built capacity of data managers on the complementary module at the health zone level;
- Transitioned to using DHIS2 for reporting purposes.

The project, in collaboration with the NHIS division, developed and implemented the following data quality activities:

- Developed additional standards for validating data in DHIS2;
- Integrated a data quality dimension into the health zone supervision tool;

- Customized the health zone supervision tool and integrated it into the DHIS2 through a DHIS2 data capture extension on tablets;
- Procured 169 tablets for health zones and DPS to be used for monthly supervision of health facilities;
- Trained and re-oriented 21 staff in the IHPplus coordination offices and 42 staff in the seven DPS on the integrated supervision tool and the RDQA process at the health zone and health facility levels;
- Integrated supervision tools implemented in 21 health zone and 126 health facilities;
- Identified the root causes of the poor data quality and developed an action plan to address weaknesses.

IHPplus also collaborated with the NHIS division to implement the following activities related to data analysis and use:

- Created dashboards with key indicators into DHIS2 at the DPS and health zone levels;
- Trained DPS and health zone staff on the data collection tools and dashboards;
- Standardized the methodology for periodic review meetings;
- Identified additional barriers to data analysis and use.

CHALLENGES

- Configuring the project’s DHIS2 instance, including mapping of data elements and organizational units and pulling data from the MOH DHIS 2 instance to the IHPplus instance at the health area level rather than at the health facility level, as the presence of health facilities often changes frequently within

the context of insecurity

- Lack of mobile data coverage in some health zones to access DHIS2 (available satellite-based data solutions are not cost-effective);
- High turnover of trained health zone data managers, leading to a loss in knowledge;
- Insufficient motivation of the health zones in adopting the new complementary module as an integral part of the MOH DHIS2.

LESSONS LEARNED

The new interoperability between the two DHIS2 systems—the project’s and the MOH’s—has helped:

- Reduce the burden of parallel reporting and promoted more efficient use of resources;
- Improve the availability and timeliness of data, data quality, data analysis, and data demand and use at every level of the health pyramid;
- Improve data quality both for data-driven decision making within the national health system, as well as for the project’s performance measurement;
- Improve data analysis and use at every level of the health system;
- Increase data quality supervision in more health facilities;
- Increase consistency of data among health sector stakeholders;
- Create a key data sharing and collaborative framework for health sector stakeholders;
- Increase monitoring of data quality trends across all levels of the health care system thanks to the new dashboard.

The community gathers at the new water source in Kanda Kanda health zone.
Photo by Sarah Ranney, MSH.



IR 4.3 COMMUNITY INVOLVEMENT IN HEALTH POLICY AND SERVICE DELIVERY

As has been discussed in prior sections and reports, IHPplus worked extensively at all levels of the health system to integrate communities into leadership roles. IHPplus worked with CSOs to strengthen their participation, representation, and accountability in provincial policy and planning processes (provincial steering committee [CPP], advisory boards, task forces, interagency coordination units); and worked with civil society groups to reinforce their voices.

IHPplus leveraged CSOs for men, women, and youth to promote health-seeking behaviors. The project engaged youth organizations to continue to play a vital role in the promotion of healthy practices and behaviors. They reached additional youth and adolescents working in mines in Kolwezi through education session on sexual violence and sexually transmitted infections, distributed condoms, referred suspected cases of infection to a clinic, and reported cases of suspected sexual violence to local authorities.

In Kolwezi, Kamina, Luiza, Tshumbe, and Mwene Ditu coordinations, a total of 4,251 adolescents and youth were sensitized on early marriage, unsafe abortions, rape, and early pregnancy. In Bukavu, the REMOPAK community-based organization sensitized 1,257 couples on family planning in the health areas of Nuru, Kabushwa, Kabamaba, and Mugeru of Katana. In Kalomba health zone, two youth associations even created a fish and rabbit farm. (They currently have 67 rabbits and the fish farm covers two acres.) These are only a few of the many outreach programs to which IHPplus lent support.

Through awareness-raising techniques and activities that encourage community participation, CODESA members contributed to social and behavior change by increasing community prevention actions and utilizing health services, in order to improve community health. The CODESAs were also able to mobilize the community to complete renovations of health facilities. CODESAs were actively involved in managing priority health activities. Through communications techniques and activities that encourage community participation, CODESA members have contributed to the adoption of positive healthy behaviors by increasing prevention and community-based promotion activities and using health services to improve community health. Moreover, CODESAs contributed to a polio vaccination campaign in six health zones (Dibaya, Luiza, Yangala, Kalomba, Lubombaie, and Luambo) in Luiza coordination in May 2017. CODESAs in Ndekesha and Kalomba health zones, in partnership with health centers, also sensitized 380 youth on the importance of seeking treatment at health clinics instead of traditional healers. In Kamina coordination, CODESAs built two maternity units in Lukanvwe and Mwambayi health areas; and in Mwene Ditu coordination, 17 CODESAs in Bibanga health zone received positive evaluations from their RBF reviews, and IHPplus provided further technical assistance to CODESAs to reach RBF targets.

LESSONS LEARNED

- Greater individual contact with adolescents and youth increases trust and uptake of healthy behavior changes.
- Developing a team spirit among community groups, NGOs, and other structures benefits community development.
- Development tasks, including sanitation work, can be achieved by teaming motivated CBOs and NGO members together.

RECOMMENDATIONS

- Organize youth group meetings at churches
- Assist health zones to further identify active youth and women groups
- Jointly increase the number of technical support visits to youth groups with the health zones
- Provide increasing support for the implementation of awareness-raising activities at schools, churches, and summer camps
- Contact the PNSA to request the use of training and informational materials

Champion Youth in Malemba perform a play on polio vaccination as their fascinated peers look on. Photo by Lynn Lawry, OSC.

IHPplus

PROJECT MANAGEMENT

Project implementation

Success stories

Cost share

Status of pharmaceutical procurement

Environmental Mitigation and
Monitoring Plan

Lessons learned

Conclusion





PROJECT IMPLEMENTATION

The project, as a bridge mechanism, was implemented to avoid a gap between IHP and the follow-on project, which USAID rescheduled several times. As a consequence, during the three-year implementation period, the project faced several periods of closeout and extension. The project spent at least five months preparing the closeout of the project each year, which necessitated slowing down the implementation of the approved workplan activities. During the periods of “contraction,” a number of critical project activities were negatively affected—grants to provincial and health zone entities, distribution of commodities to health facilities, support to the social and behavior change activities, training, monitoring, and supervision activities. The project had reached the stage of closing five out of eight field offices as of September 2017 but was able to secure continuity of its support by keeping some of project staff working on the premises of DPS or other partners. To ensure that these staff members continued to work effectively on project activities, IHPplus provided the required financial, managerial, technical support, and oversight to staff through daily “touch-bases” with the field office supervisors based in Kinshasa, as well as through weekly closeout touch-base sessions with the IHPplus management team. The project management team prioritizes sending staff from Kinshasa to provide support to the remaining field teams to address their specific needs.

Effective, ongoing collaboration between USAID/DRC, USAID/DC, Pathfinder, and IHPplus home office and DRC-based

team helped to address critical challenges pertaining to funding obligation delays, E2A extension and ceiling limit etc., and despite the challenges, project management—during the waves of contraction and expansion of project activities—was ultimately successful in delivering on the project goals. Furthermore, the project was able to adjust during the annual workplanning and in the course of implementation of an approved annual workplan to accommodate and help address urgent USAID needs in line with the IHPplus mandate of avoiding any gap. The adaptability of the project management resulted in the following achievements:

- **Expanding the geographical scope from an initial 83 health zones in PY1; to 126 health zones during PY2** due the malaria rationalization between PMI Global Fund and the Department for International Development (DfID) under the PNLN leadership, during which the project inherited health zones from the PMI implementing partner consortium (SIAPS, Malaria Care, USAID|DELIVER and Measure Evaluation); to 168 health zones during PY3 as the project inherited 42 health zones previously supported by the PMI-EP.
- **Supporting the research on the fractional doses of yellow fever vaccine** implemented by the DRC National Institute of Biomedical Research (INRB) in close collaboration with CDC. This support to the INRB contributed to worldwide understanding on the dosing for the yellow fever vaccine and informed

both routine and campaign vaccine strategies.

- **Assuming the most critical activities of the SCMS project for seven months**, including management of HIV and AIDS commodities delivered to CDRs in Kinshasa (CAMESKIN) and Lubumbashi (CAMELU), and the last mile distribution of these commodities to the target HIV sites. The project helped avoid a gap between the end of SCMS and startup of the GHSC-TA program.
- **Providing complementary support from November 2017 to March 2018**, to the PROSANIplus *Secours d'urgence sanitaire au Kasai* (PROSANI-SUS), funded by OFDA, to address emergency response needs in 69 health areas of 13 health zones in the Kasai Central DPS. IHPplus provided technical and financial support to train health care providers and community health workers; provided essential generic medicines, antimalarial commodities, and PEP kits; and replaced medical equipment looted during the Kasai conflict, including hospital beds, consultation and delivery tables for maternities. The joint and synergistic intervention between IHPplus (a health system strengthening project) and PROSANI-SUS (a short-term emergency response project) was well coordinated to ensure a restoration of the health system in target health zones and health areas, and a smooth transition was completed under the leadership of provincial health authorities and health zone management teams when PROSANI-SUS closed.

SUCCESS STORIES

The project produced a total of 86 success stories, exceeding the target of 80 stories. The topics covered were RBF (11),

nutrition (11), MNCH (10), FP (9), TB (8), Champion Community (6), WASH (6), HIV (6), access to care (4), SBCC (4),

malaria (4), i-CCM (3), FOSACOF (2), fistula (1), and youth (1). For more details, please refer to Appendix 5.

COST SHARE

The total IHPplus cost share requirement was \$2,552,486.99 (or three percent of the total obligation of \$85,082,899.53). The project booked a total of \$3,548,156.32 in cost share. This amount includes \$23,860 booked through Brother's

Brother Foundation on May 1, 2016; \$1,038,181.92 booked through the UNICEF-funded Health for Poorest Populations project on November 30, 2016; \$10,164 booked through Vitamin Angels on April 30, 2017; and \$2,475,950.00

booked through Project C.U.R.E. from May–July 2018, for six 40-foot containers of donated medical equipment and supplies. As such, the project has exceeded its cost share requirement by \$995,669.33.

ENVIRONMENTAL MITIGATION AND MONITORING PLAN

The project monitored environmental compliance and provided technical and financial support to health zones, health facilities, and communities to improve medical waste management and WASH, according to the IHP Environmental Monitoring and Mitigation Plan (EMMP) that was approved by USAID on July 21, 2015. The IHP staff members were not able to make joint visits with the MOH to all of the supported health facilities (3,826 health centers and 168 GRHs), but did visit all the health facilities in the seven RBF health zones during the verification of reported RBF results. In addition, IHPplus provided technical support for the continuation of FOSACOF implementation in 839 health facilities (including 799 health centers and 40 GRHs), as well as financial and technical support (through subgrants to 78 health zone management teams and through direct funding for the additional 90 health zones supported for malaria) to the DPS and the IPS management teams for monthly field visits for integrated supervision to health facilities.

In order to combat open air defecation and its negative impact in the environment—including spread of water borne diseases—IHPplus used the CLTS approach and WASH mini-campaigns to educate and support communities in adopting recommended basic hygiene and sanitation measures to improve their overall health conditions. As a result, the target communities built 82,707 improved latrines and hand-washing stations using the locally available materials during the course of project implementation.

IHPplus implemented its Water Quality Assurance Plan (WQAP) that was designed and aligned to the project's updated Environmental Mitigation and Monitoring Plan (approved December 11, 2017) and USAID/DRC's current Initial Environmental Examination (IEE) (approved July 21, 2015). The project acquired tests for arsenic and coliform and provided technical support to provincial and health zones management teams to perform tests for initial water quality on newly-established water sources. The project also tested the water sources established with IHP

support that were rehabilitated by IHPplus. A total of 648 water sources were included in the implementation of the WQAP during the course of the project. In order to ensure regular monitoring of the water quality from the newly-established and renovated water sources, the project provided technical and financial support to train chief nurses, CODESAs, and water source management committees on the use of the tests to assess the water quality quarterly using the tests supplied by the project to the health areas at the end of the training.

The water source management committees were responsible for regular maintenance of sources and ensuring that the water points were secured and appropriately used by beneficiaries; in addition, they were sensitized about their critical role in timely reporting of any change in the quality of their water sources and the recommended actions they must take—drawing upon input from the project and provincial, health zone and local authorities—which includes refraining from using the affected water for drinking and other domestic utilization needs.

Reinforcing the capacity of stakeholders is a critical intervention to ensure that the EMMP-recommended practices can be adopted by the beneficiaries of the project (including health care providers, health zone management teams, health development committee members, community leaders, Champion Communities, WASH committees, and families). IHPplus provided technical and financial support

to refresher trainings on hospital hygiene (including infection prevention, good hygiene practices, and use and maintenance of waste management devices in health facilities) and on renovation, use, and monitoring of WASH facilities in the community (including testing the quality of the drinking water from the improved sources and their maintenance by WASH committees). IHPplus continued deliver-

ing a standard and integrated PowerPoint presentation, comprising the Congolese legislation in regard to the environment and specific waste management, during all training sessions on clinical aspects of the project (maternal health, malaria, tuberculosis, HIV, family planning, IMCI, etc.), to reinforce the importance of the EMMP.

LESSONS LEARNED

While lessons learned in the technical areas and approaches have been integrated into their respective sections of the report, the following are some overarching lessons learned that are particularly relevant to project management.

1. As discussed under project implementation, IHPplus benefitted from collaboration with a number of partners to navigate more effectively the periods of “expansion and contraction” of the project. Yet, even as this process was ultimately effective, it was not without its pain points. If not for the unwavering commitment, engagement, and support of USAID/DRC—specifically, the health team leader and project activity manager—the issues that came up would have been much more difficult to address. USAID/DRC facilitated numerous meetings and communicated openly and transparently with all parties involved, and would need to do so in any similar situation. Such partnerships should not be considered lightly, as they can create organizational conflicts of interest and necessitate a level of transparency that not all partners would be willing to accept.

2. Involving the DPS, health zones, central departments, and national programs in the planning, implementation, and monitoring of project activities helped them understand the content of the project’s support activities, confirm their alignment to MOH priorities, and promote their ownership and commitment. However, it is essential to organize reviews at the provincial and central levels to adjust action plans and share and document experiences and results. The support system to health zones, DPSs, and IPSs—through fixed cost participation and in-kind subsidies—did not help improve their governance and management functions. Additional interventions need to be implemented to focus on these aspects of their responsibilities, such as performance-based contracts to ensure management transparency and accountability.

3. IHPplus attempted to engage with the MOH in a coordinated manner, and this approach achieved mixed results: duplicative donor funding at times focused MOH attention on individual partners and projects rather than on transparent joint planning,

Future efforts will need to systematically prioritize coordination, supporting joint action coordination forums at which provincial and health zone stakeholder teams will guide planning and coordination of health interventions in their respective jurisdictions.

These will need to align with the MOH’s DPS-level *contrat unique* framework, which is a joined commitment between the DPS, and provincial governments, and technical and financial partners. The collegial, and consolidated funding structure of the *contrat unique* needs to be understood by all stakeholders as a virtual basket fund for implementation of specific DPS activities related to the provincial health system governing functions, roles and responsibilities. The *contrat unique* should enhance efficiency, transparency and accountability of DPS and the stakeholders contributing to it.

This will increase coordination of provincial and health zone health activities, improving resource allocation and responsiveness to population health needs and priorities. Provincial, health zone, community, and

Victor Mwango (left), the president of the WASH committee in Kabamba, with Guillaume Mikabo (center), secretary of the organization, and Salome Mirhimbo (right), a WASH committee member, in front of the “Inyokator deux” water source. They have just finished digging out the water source that was inundated in the May rains. Photo by Rebecca Weaver,



“ I have seen a real change in people’s health in Kabamba. I see less sickness now in our community. People don’t go to the lake, the river, for their water now, they are now coming to get their water from the well, and as a result, they have many fewer intestinal problems.”

—Mikabo Guillaume (center), secretary of the WASH committee, Kabamba



“ I lived in a state of ignorance, which is why I did not properly treat my wife and children. The Champion Man initiative helped me establish a dialogue in my family and become more attentive to my wife and children.”

—Albert Mutombo,
Champion Man from Tshimayi health zone, Dibaya Province

women's leaders will need to institutionalize mechanisms for involving all partners in joint planning and coordination of development interventions.

4. Security has long been a very real factor in the successful implementation of the project, and project staff are sensitive to the view that—after so many years of implementation—the project should have solutions to these challenges. In view of insecurity

conditions in some health zones, several criteria should be taken into account in order to provide quality services to the population, including the existence of a security focal point capable of identifying alternate routes and means of reaching these health zones and of delivering commodities. Training of staff and providers about safety and security, their observance of neutrality rules, cooperation with other sectors, national and international NGOs, and involvement of community

members can help provide continued care in these areas.

5. Related to the above point, maternal deaths registered in insecure health zones increased because of turnover of trained staff, delays in referral, insufficient health care facilities and supplies, and extreme poverty. Organizing an emergency system in these health zones would help reverse this trend.

CONCLUSION

Under IHP, we acknowledged the roles of the many people who contributed to the project, borrowing from the African wisdom, “if you want to go quickly, go alone. If you want to go far, go together.” Never has this wisdom been more relevant than in the implementation of

IHPplus. The project served as a true bridge from numerous implementation mechanisms to the next, and this report marks the final transition to the new USAID-funded flagship project, IHP-DRC. IHPplus has had the opportunity to work not only with its main

partners—the DRC MOH and USAID—on this three-year extension, but also with the many partners mentioned in the report—DfID, GHSC, PMI-EP, SIAPS, Malaria Care, Project C.U.R.E., USAID|DELIVER, and Measure Evaluation—to name a few.

Men sensitized by Kabushwa Champion Men respond to the question: “How many helped with chores in the household this morning?” Photo by MSH staff.



APPENDICES

DRC-IHPplus Final Report 2015–2018

Integrated Health Project Plus
in the Democratic Republic of Congo



Published: July 31, 2018

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Appendices

Final Report:
The Integrated Health Project Plus
in the Democratic Republic of Congo
2015–2018

Integrated Health Project Plus
in the Democratic Republic of Congo



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PY1 – PY3

Appendix 1. IHP Performance Monitoring Plan: Indicator detail



USAID/DRC/IHPplus Objective: Improve the enabling environment for, and increase the availability and use of, high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, TB, HIV and AIDS, and WASH in target health zones

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)
			PY1	PY2	PY3	
1 FP: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients at health facilities and at the community level in the IHPplus target areas during that period	426,098	430,425	346,890	331,318	69
1.1 FP: Couple years of protection (CYP) after exclusion of LAM and self-observation methods (NFP) for FP in USG-supported programs	The estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives provided to clients (exclusion of LAM and NFP) in the IHPplus target areas during that period	169,760	213,253	236,885	281,569	104
2 FP: Number of counseling visits for FP/reproductive health (RH) as result of USG support	Number of FP/RH counseling visits at USG-supported service delivery points	605,616	592,592	754,641	494,458	87
3 FP: Percent of USG-assisted service delivery sites providing FP counseling and/or services	Numerator: Number of USG-assisted service delivery sites providing FP information and/or services Denominator: Number of service delivery sites planned to receive USG assistance over life of project Numerator/Denominator (in percentage)	n/a	2,152	2,154	2,069	
4 FP: Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year	<ul style="list-style-type: none"> ■ USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance ■ CHW: Any type of CHW as defined by country program ■ FP Information: FP information and/or FP counseling provided by a CHW ■ FP referrals: FP referrals to public or private sector services provided by a CHW ■ FP Services: FP contraceptive services provided by a CHW ■ Year: US Fiscal Year 	n/a	1,116	2,152	2,032	115
5 FP: Number of USG-assisted health facilities experiencing stock-outs of Depo-Provera during the quarter	Maximum number of USG-supported health facilities experiencing stock-outs of Depo-Provera during the quarter	146	640	318	177	11

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY1	PY2	PY3	TOTAL IHPplus		
						IHPplus	Target	Achievement Rate (%)
6	MNCH: Percent of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider from USG-supported health facilities	408,357	413,902	567,562	445,122	1,426,586	1,361,186	
	Numerator: Number of pregnant women attending at least one ANC visit with a skilled provider from USG-supported health facilities Denominator: Number of expected pregnancies in USG-supported health facilities (4% of total population)	386,812	401,981	544,474	418,535	1,364,990	1,361,186	
7	MNCH: Percent of pregnant women attending at least four ANC visits with a skilled provider from USG-supported health facilities	106%	103%	104%	106%	105%	100%	105
	Numerator: Number of pregnant women attending at least four ANC visits with a skilled provider from USG-supported health facilities Denominator: Number of expected pregnancies in USG-supported health facilities (4% of total population)	204,787	224,619	323,621	321,246	869,486	952,830	
8	MNCH: Percent of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	386,812	401,981	544,474	418,535	1,364,990	1,361,186	
	Numerator/Denominator (in percentage)	53%	56%	59%	77%	64%	70%	91
	Numerator: Number of deliveries with a SBA in USG-supported facilities Denominator: Number of expected deliveries in USG-supported health facilities (4% of total population)	352,626	350,075	482,390	379,261	1,211,726	1,238,679	
9	MNCH: Number of women giving birth who received uterotonic in the third stage of labor (OR immediately after birth) through USG-supported programs	386,812	401,981	544,474	418,535	1,364,990	1,361,186	
	Numerator/Denominator (in percentage)	91%	87%	89%	91%	89%	91%	98
	Number of women who gave birth who received a uterotonic in the third stage of labor (OR immediately after birth) supplied by a USG-assisted program or with assistance of a health worker trained by a USG-assisted program. Uterotonics could include oxytocin or misoprostol. Uterotonics represent one element of active management of third stage of labor (AMTSL).	331,511	327,239	459,535	341,302	1,128,076	1,189,960	95
10	MNCH: Number of postpartum/newborn visits within three days of birth in USG-supported programs	339,446	337,399	451,132	326,887	1,115,418	1,056,052	106
	Number of postpartum/newborn visits within three days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery) (4% of total population)							
11	MNCH: Number of newborns not breathing at birth who were resuscitated in USG-supported programs	n/a	1,964	5,531	8,967	16,462	10,750	153
	Number of newborns not breathing at birth who were resuscitated with stimulation and/or bag and mask provided by a USG-assisted program, or by a health worker trained in resuscitation by USG-assisted program.							

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY1	PY2	PY3	TOTAL IHPplus		
						IHPplus	Target	Achievement Rate (%)
12 MNCH: Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHPplus target area Denominator: Number of newborns delivered in the IHPplus target areas (3.49% of total population) Numerator/Denominator (in percentage)	339,780	349,626	461,768	362,037	1,173,431	1,337,690	
			386,812	349,626	480,774	380,421	1,210,821	1,209,922
13 MNCH: Number of newborns receiving antibiotic treatment for infection from trained health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/IHPplus target area (4% of total population *6% Infection rate-MICS 2010)	88%	100%	96%	95%	97%	98%	99
			30,357	26,373	26,440	24,491	77,304	81,690
14 MNCH: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	ART is viewed by the scientific community and PEPFAR not only as essential for decreasing morbidity and mortality, but also as a highly effective approach to prevent HIV transmission. This indicator monitors the proportion of viral load tests from adult and pediatric ART patients with an undetectable results (<1,000 copies/ml), allowing ART programs to evaluate to what degree they are improving the clinical outcomes of patients in care.	354,596	332,922	455,205	455,342	1,243,469	1,161,829	107
			447,108	497,516	639,907	423,430	1,560,853	1,581,575
15 MNCH: Number of cases of child diarrhea treated in USG-supported programs	Number of oral rehydration solution (ORS) packets distributed through USG-assisted programs (this is a proxy indicator for the number of cases of child diarrhea treated in USG-assisted programs)	346,925	368,475	480,774	357,168	1,206,417	1,172,552	
			337,493	347,618	480,774	405,873	1,234,265	1,234,265
16 MNCH: Percent of children less than 12 months of age who received three doses of Diphtheria, Tetanus, Pertussis (DTP), Hepatitis B (HepB) and Haemophilus Influenza type B (Hib) (or DPT-HepB-Hib3) from USG-supported programs	Numerator: Number of children less than 12 months who received DPT-HepB-Hib1-3 vaccine from USG-supported programs/IHPplus target areas Denominator: Number of children less than 12 months of age in the IHPplus target areas (3.49% of total population — Ref : Expanded Program of Immunization)	103%	106%	100%	88%	98%	95%	103
			19,045	15,592	20,354	18,157	54,103	60,610
17 MNCH: Drop-out rate in DPT-HepB-Hib3 among children less than 12 months of age	Numerator: Number of children less than 12 months who did not complete the full regimen of DPT-HepB-Hib1-3 vaccination Denominator: All children less than 12 months who received DPT-HepB-Hib1	365,970	366,645	462,758	382,804	1,212,207	1,212,207	
			5%	4%	4%	5%	4%	5%

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY			IHPplus	Target	Achievement Rate (%)
			PY1	PY2	PY3			
18	MNCH: Percent of children less than 12 months of age who received measles vaccine from USG-supported programs	334,963	344,862	435,678	375,069	1,155,609	1,167,120	
			337,493	347,618	405,873	1,228,547	1,228,547	
19	MNCH: Number of USG-assisted health facilities experiencing stock-outs of ORS during the quarter	99%	99%	92%	92%	94%	95%	99
			80	422	328	422	100	24
20	NUTRITION: Proportion of pregnant women who received iron-folate to prevent anemia	424,488	527,593	346,890	239,024	1,113,507	869,486	
			386,812	224,619	323,621	869,486	869,486	
21	NUTRITION: Number of mothers of children 2 years of age or less who have received nutritional counseling for their children	110%	235%	107%	74%	128%	100%	128
			487,081	564,212	856,437	2,393,793	3,115,432	77
22	NUTRITION: Number of people trained in child health and nutrition through USG-supported programs	n/a	131	673	112	916	1,869	49
			304	587	161	587	200	34
23	NUTRITION: Number of USG-supported health facilities experiencing stock-outs of iron-folate tablets during the quarter	9,692	8,655	13,140	3,441	3,441	5,104	
			9,670,297	10,728,594	13,611,907	3,003,143	13,295,611	
24	TB: Case notification rate in new sputum smear positive pulmonary tuberculosis (TB) cases per 100,000 population in USG-supported areas	100	108	97	153	153	150	102
			113	27	84	152	280	54
25	TB: Number of multi-drug resistant (MDR) TB cases detected	113	27	84	41	152	280	54
			113	27	84	152	280	54

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)	
			PY1	PY2	PY3		
26 TB: Therapeutic success rate (new smear positive TB cases)	Numerator: Number of patients recovered plus number of patients with treatment completed	n/a	n/a	11,679	2,649	14,328	16,545
	Denominator: Number of new smear positive TB cases treated (1 year ago)	n/a	n/a	12,617	2,803	15,420	17,416
	Numerator/Denominator (in percentage)	n/a	n/a	93%	95%	93%	95%
27 TB: Therapeutic success rate for MDR-TB	Numerator: Number of MDR-TB patients recovered plus the number of MDR-TB patients with treatment completed	n/a	n/a	18	4	4	36
	Denominator: Number of MDR-TB patients for which a treatment has been initiated (1–2 years ago)	n/a	n/a	34	4	4	48
	Numerator/Denominator (in percentage)	n/a	n/a	53%	100%	100%	75%
28 TB: Percentage of HIV-positive patients screened for TB through USG-supported programs	Numerator: Number of HIV-positive patients screened for TB	n/a	n/a	8,321	2,976	11,297	TBD
	Denominator: Number of registered patients living with HIV	n/a	n/a	11,791	3,279	15,070	TBD
	Numerator/Denominator (in percentage)	n/a	n/a	71%	91%	75%	100%
29 TB: Percentage of TB cases detected among HIV-positive patients through USG-supported programs	Numerator: Number of TB cases detected among HIV-positive patients	n/a	n/a	776	220	996	TBD
	Denominator: Number of registered patients living with HIV	n/a	n/a	8,321	2,703	11,024	TBD
	Numerator/Denominator (in percentage)	n/a	n/a	9%	8%	9%	30%
30 TB: Percentage of HIV-positive patients without TB receiving INH prophylaxis	Numerator: Number of HIV-positive patients without TB receiving INH prophylaxis	n/a	n/a	3,938	1,434	5,372	TBD
	Denominator: Number of HIV-positive patients without TB	n/a	n/a	7,213	2,857	10,070	TBD
	Numerator/Denominator (in percentage)	n/a	n/a	55%	50%	53%	100%
31 HIV: Percentage of PEPFAR supported sites achieving 90% antiretroviral (ARV) or antiretroviral therapy (ART) coverage for HIV-positive pregnant women	Numerator: Number of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV-positive pregnant women	51	37	30	-	37	41
	Denominator: Total number of PEPFAR supported sites providing Prevention Mother to Child Transmission (PMTCT) services (HIV testing and counseling (HTC) and ARV or ART services)	69	40	32	-	40	45
	Numerator/Denominator (in percentage)	74%	93%	94%	-	93%	97%

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			PY3	PY2	PY1	IHPplus	Target	Achievement Rate (%)
			PY3	PY2	PY1						
32 HIV: Number and percentage of pregnant women with known status (women who were tested for HIV and received their results) (DSD)	Numerator: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	10,278	22,727	16,552	-	39,279	33,396				
	Denominator: Number of new ANC and labor and delivery (L&D) clients	13,587	24,195	17,403	-	41,598	35,194				
33 HIV: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	Numerator/Denominator (in percentage)	76%	94%	95%	-	94%	97%			97	
	Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery	232	313	335	-	648	492				
34 HIV: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (DSD)	Denominator: Number of HIV-positive pregnant women identified in the reporting period (including know HIV-positive at entry)	270	324	343	-	667	514				
	Numerator/Denominator (in percentage)	86%	97%	98%	-	97%	94%			103	
35 HIV: Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results during the reporting period	21,357	45,098	43,724	-	88,822	63,327			140	
	Number of HIV-positive adults and children (aggregated by age/sex: female, male, <15 and >15 years) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	1,088	4,610	4,722	-	4,722	3,086			153	
36 HIV: Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	Number of HIV-positive adults and children (aggregated by age/sex: female, male, <15 and >15 years) in the reporting receiving a minimum of one clinical service (DSD)	3,502	13,708	n/a	-	13,708	10,800			127	
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	584	1,968	4,123	-	6,091	3,745				
37 TB/HIV: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment setting	Denominator: Number of HIV-positive patients in USG-supported HIV care or treatment setting	1,157	2,264	4,722	-	6,986	5,350				
	Numerator/Denominator (in percentage)	50%	87%	87%	-	87%	70%			125	
38 HIV: Number of HIV-infected adults and children receiving antiretroviral therapy during the reporting period (current) DSD	Number of HIV-infected adults and children receiving antiretroviral therapy during the reporting period (current) DSD	2,850	3,534	4,607	-	4,607	3,086			149	

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)
			PY1	PY2	PY3	
39 HIV: Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR CD4 count OR viral load	Number of HIV-infected adults and children newly enrolled in clinical care (aggregated by age/sex: female, male, <15 and >15) during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	350	1,882	831	2,713	140
40 HIV/TB: Proportion of registered TB cases who are HIV-positive who are on ART	Numerator: The number of registered TB cases with documented HIV-positive status who start or continue ART during the reporting period Denominator: The number of registered TB cases with documented HIV-positive status during the reporting period Numerator/Denominator (in percentage)	180	1,240	162	1,402	803
41 HIV: Percentage of laboratories and POC testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program	Numerator: Number of PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing on HIV serologic/diagnostic testing, CD4, EID and TB diagnostic Denominator: Total number of laboratories and testing sites Numerator/Denominator (in percentage)	190	1,322	167	1,489	877
42 HIV: Family Planning and HIV Integration: Number of supported HIV service delivery point that are directly provide integrated voluntary family planning service	Number of supported HIV service delivery points that are directly provide integrated voluntary family planning service Numerator/Denominator (in percentage)	68	45	55	55	55
43 PMTCT_CTX: Number of infants born to HIV-positive women who were started on Cotrimoxazole (CTX) prophylaxis within two months of birth at USG-supported sites within the reporting period	CTX prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis pneumonia (PCP) among HIV-exposed and -infected infants. PCP is the leading cause of serious respiratory disease among young HIV-infected infants in resource-limited countries and often occurs before HIV infection can be diagnosed. The indicator is the sum of infants having received CTX within 2 months of birth during the reporting period at PEPFAR-supported facilities.	29%	122%	100%	100%	100
44 PMTCT_EID: Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	This indicator measures the extent to which infants born to HIV-positive women receive virologic testing to determine their HIV status within the first 12 months of life	68	72	44	72	72
		n/a	239	188	427	442
		n/a	129	188	317	268
						118

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			IHPplus	Target	Achievement Rate (%)
			PY1	PY2	PY3			
45 PMTCT_FO: Number of HIV exposed infants with a documented outcome by 18 months of age disaggregated by outcome type	In settings where national guidelines support breastfeeding of HIV-exposed infants, antibody testing of all HIV-exposed children at 18 months of age and/or 6 weeks after cessation of breastfeeding is recommended to determine final HIV status ('final outcome'/FO) of HIV-exposed children. In settings where national guidelines recommend HIV-antibody testing at 18 months of life, this indicator measures progress toward ensuring that all infants born to HIV-positive women have an outcome documented.	n/a	5	58		63	234	27
46 Tx_NEW: Number of adults and children newly enrolled on ART	The indicator measures the ongoing scale up and uptake of ART programs. The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/JUNAIDS standards).	n/a	1,312	2,201		3,513	1,767	199
47 Tx_VIRAL: Number of adults and pediatric ART patients with a viral load result documented in the patient medical record within the past 12 months	This indicator monitors the proportion of adult and pediatric patients on ART who have received a viral load test within the recommended testing interval (i.e., 12 months)	n/a	n/a	995		995	4,169	24
48 Tx_UNDETECT: Number of viral load tests from adult and pediatric ART patients conducted in the past 12 months with a viral load inferior to 1,000 copies/ml.	ART is viewed by the scientific community and PEPFAR not only as essential for decreasing morbidity and mortality, but also as a highly effective approach to prevent HIV transmission. This indicator monitors the proportion of viral load tests from adult and pediatric ART patients with an undetectable results (<1,000 copies/ml), allowing ART programs to evaluate to what degree they are improving the clinical outcomes of patients in care.	n/a	n/a	283		283	2,755	10
49 Tx_RET: Number of adults and children who are still alive and on treatment at 12 months after initiating ART	The indicator measures the proportion of individuals who have retained on antiretroviral therapy (ART). Death and loss to follow-up are the two highest causes of patient attrition from ART, especially in the first few months after initiating on ART. High retention is one important measure of program success, specifically in reducing morbidity and mortality, and is a proxy for overall quality of the ART program.	n/a	n/a	n/a		n/a	3,236	n/a

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)	
			PY1	PY2	PY3		IHPplus
50 CARE_COM: Number of HIV infected adults and children receiving care and support services outside of the health facility	The purpose of this indicator is to determine how many PLHIV receive care and support services outside of the health facilities where they are registered for HIV care and treatment. Data collected through this indicator will inform PEPFAR country programs about the scale-up and coverage of community care services.	n/a	n/a	1,897	1,897	752	252
51 TB/HIV_TB outcome: Aggregated outcome of TB treatment among registered new and relapsed TB cases who are HIV-positive in the treatment cohort	This indicator measures the aggregated outcomes of TB treatment among registered new and relapsed TB cases who are HIV-positive in the treatment cohort	n/a	77	182	259	180	144
IR 1: Access to and availability of Minimum Package of Activities (MPA) and Complementary Package of Activities (CPA) services and products in target health zones increased							
IR 1.1: Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased							
52 ***L+M+G: Percent general reference hospitals (GRHs) implementing complementary package of activities (CPA)	Numerator: Number of GRHs implementing CPA Denominator: Total number of GRHs	69	70	72	73	73	71
53 ***L+M+G: Percent of health centers implementing minimum package of activities (MPA)	Numerator: Number of health centers implementing MPA Denominator: Total percent of health centers	78	78	78	78	78	78
54 MALARIA: Percent of pregnant women who received at least two doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Number of health centers implementing MPA Denominator: Total percent of health centers	88%	90%	92%	94%	94%	91%
	Numerator: Number of pregnant women who received at least three doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	1,382	1,382	1,395	1,395	1,395	1,398
	Numerator: Total percent of health centers Denominator: Denominator (in percentage)	1,398	1,398	1,398	1,398	1,398	1,398
	Numerator: Number of pregnant women who received at least three doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	99%	99%	100%	100%	100%	100%
	Numerator: Number of pregnant women who received at least three doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	255,509	292,105	558,789	n/a	850,894	759,795
	Numerator: Denominator (in percentage) Numerator: Number of pregnant women who received at least three doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	386,812	398,416	614,644	n/a	1,013,060	1,013,060
55 MALARIA: Percent of pregnant women who received at least three doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Denominator (in percentage) Numerator: Number of pregnant women who received at least three doses of SP for IPT during ANC visits Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	66%	73%	91%	n/a	84%	112
	Numerator: Total number of pregnant women attending ANC visits in the reporting period (12 months) Denominator: Denominator (in percentage)	n/a	n/a	n/a	381,111	420,856	
	Numerator: Total number of pregnant women attending ANC visits in the reporting period (12 months) Denominator: Denominator (in percentage)	n/a	n/a	n/a	841,712	841,712	
	Numerator: Denominator (in percentage)	n/a	n/a	n/a	45%	50%	91

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)			
			PY1	PY2	PY3		IHPplus	Target	
56	MALARIA: Number of USG-supported service delivery points experiencing stock-outs of Artemisinin based combination therapy (ACT) for 1 – 5 year olds	80	351	314	465	465	100	22	
57	MALARIA: Number of health workers trained in IPTp with USG funds (disaggregated by gender)	0	1,231	1,043	0	2,274	2,798	81	
		0	1,000	858	0	1,858	1,851		
		0	231	185	0	231	947		
58	MALARIA: Number of health workers trained in case management with ACTs with USG funds (disaggregated in 2 sub-categories and by gender)	0	1,231	1,043	0	2,274	2,798	81	
	(a) Number of health facility workers trained (male/female)	0	1,000	858	0	1,858	1,851		
	(b) Number of community-level workers trained (male/female)	0	231	185	0	231	947		
		0	0	0	0	0	5		
		0	0	0	0	0	6		
59	MALARIA: Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnosis Tests (RDT) or microscopy) with USG funds (disaggregated in 3 sub-categories and by gender)	0	1,231	1,043	0	2,274	2,798	81	
	(a) Number of health facility workers trained (male/female)	0	1,000	858	0	1,858	1,851		
	(b) Number of community-level workers trained (male/female)	0	231	185	0	231	947		
	(c) Number of laboratory workers trained (male/female)	0	0	0	0	0	14		
		0	0	0	0	0	15		
		0	0	0	0	0	16		
		0	0	0	0	0	17		
IR 1.2: Community-based health care services and products in target health zones increased									
60	**L+M+G: Percent of communities with CODESAs actively involved in management of priority health services	1,282	1,280	1,323	1,233	1,233	1,284		
		1,282	1,280	1,323	1,233	1,233	1,284		
		1,398	1,398	1,398	1,398	1,398	1,398		
		92%	92%	95%	88%	88%	92%	96	

* Achievement rate is not applicable when target is 0.
*** ????/???

Indicator	Definition	Baseline	TOTAL IHPplus			Achievement Rate (%)		
			PY1	PY2	PY3		IHPplus	Target
61	WASH: Number of people gaining access to an improved drinking water source as a result of USG support	35,441	228,314	260,178	25,000	513,492	617,126	93
62	WASH: Percent of the population using an improved drinking water source as a result of USG support	n/a					TBD	n/a**
63	WASH: Number of people gaining access to an improved sanitation facility as a result of USG support	21,318	167,108	176,703	23,159	366,970	524,768	70
64	WASH: Percent of the population using an improved sanitation facility as a result of USG support	n/a					TBD	n/a**
IR 1.3: Provincial management more effectively engaged with health zones and facilities to improve service delivery								
65	*** L+M+G: Percent of senior Leadership Development Program (LDP) teams that have achieved at least 80% of their desired performance according to indicators in their action plans within six months of completing the LDP. LDP team are made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas	46	48	49	43	47	n/a	
IR 2: Quality of key family health care services (MPA/CPA) in target health zones increased (Component 1)								
IR 2.1: Clinical and managerial capacity of health care providers increased								

* Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY			IHPplus	Target	Achievement Rate (%)
			PY1	PY2	PY3			
66 ***L+M+G: Percent of health zones with validated action plans	Numerator: Number health zones with validated actions plans	53	61	69	69	69	78	
	Denominator: Total number health zones in IHPplus target areas	78	78	78	78	78	78	
	Numerator/ Denominator (in percentage)	68%	78%	88%	88%	88%	100%	88
67 ***L+M+G: Percent of health centers with accurate and up-to-date inventory records	Numerator: Number of health centers with up-to-date and accurate record of inventory of essential drugs and supplies ("accurate" means that the records correctly reflect the inventory of essential drugs and supplies that are currently in stock)	1,058	1,238	1,343	1,024	1,024	n/a	
	Denominator: Total number of health centers in IHPplus areas	1,398	1,398	1,398	1,398	1,398	n/a	
	Numerator/Denominator (in percentage)	76%	89%	96%	73%	73%	97%	76
68 ***L+M+G: Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies ("accurate" means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	64	71	75	75	75	n/a	
	Denominator: Total number of hospitals in IHPplus areas	78	78	78	78	78	n/a	
	Numerator/Denominator (in percentage)	82%	91%	96%	96%	96%	100%	96
69 GENDER: Number of people reached by a USG-supported intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Number of people reached by a USG-supported intervention providing GBV health services	1,937	2,526	3,591	4,207	10,324	7,250	142
	Number of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHPplus target areas	5	85	44	10	139	32	434
	IR 2.2: Minimum quality standards for health facilities (general referral hospitals and health zone health centers) and services developed and adopted							
71 *L+M+G: Percent of health facilities that completed an evaluation of the nine FOSACOF minimum standards	Numerator: Number of health centers and GRH that completed an evaluation of the nine FOSACOF minimum standards	n/a	419	432	374	374	583	
	Denominator: Total number of health facilities implementing the FOSACOF approach	n/a	737	807	839	839	737	
	Numerator/Denominator (in percentage)	n/a	57%	54%	45%	45%	79%	56

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY			PY3	TOTAL IHPplus		
			PY1	PY2	PY3		IHPplus	Target	Achievement Rate (%)
71.1	*L+M+G: Percent of health centers meeting that completed an evaluation of the nine FOSACOF minimum standards	332	400	415	352	352	545		
	Denominator: Total number of health centers implementing the FOSACOF approach	312	699	767	799	799	699		
	Numerator/Denominator (in percentage)	106%	57%	54%	44%	44%	78%	52	
71.2	*L+M+G: Percent of general reference hospital that completed an evaluation of the nine FOSACOF minimum standards	37	19	17	22	22	40		
	Denominator: Total number of GRH integrating the FOSACOF approach	455	38	40	40	40	40		
	Numerator/Denominator (in percentage)	8%	50%	43%	55%	55%	100%	55	
IR 2.3: Referral system for primary health care prevention, care, and treatment between community structures and health zone health facilities institutionalized									
72	Percent of patients referred to health centers by a CHW, disaggregated by gender, and age groups (< 5 years; 5–14 years; > 15 years)	17,204	21,080	60,240	18,840	100,160	9,830		
	Denominator: Total number of patients seen by a CHW	111,776	162,547	262,621	174,308	599,476	65,532		
	Numerator/Denominator (in percentage)	15%	13%	23%	11%	17%	15%	111	
73	Percent of patients referred to GRHs by a CHW or health care provider, disaggregated by gender, and age groups (< 5 years; 5–14 years; > 15 years)	174,245	177,538	247,803	228,603	653,944	77,877		
	Denominator: Total number of patients seen by a CHW or health care provider	4,474,662	4,654,045	5,888,502	5,415,520	15,958,067	1,557,537		
	Numerator/Denominator (in percentage)	4%	4%	4%	4%	4%	5%	82	
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones (Component 1)									
IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations—established									
74	***L+M+G: Percent of NGOs representing women, youth and vulnerable groups participating in coordination meetings	146	332	199	159	159	124		
	Denominator: Number of NGOs representing women, youth and vulnerable groups registered in DRC	212	445	357	190	190	207		
	Numerator/Denominator (in percentage)	69%	75%	56%	84%	84%	60%	139	

*Achievement rate is not applicable when target is 0.

Indicator	Definition	Baseline	PY			IHPplus	Target	Achievement Rate (%)
			PY1	PY2	PY3			
75 *** L+M+G : Number Community Champions achieving the deliverables set in their signed fixed amount awards (FAAs)	Number community Champions achieving the deliverables set in their signed fixed amount awards (FAAs)	33	n/a	n/a	64	64	36	177
76 *** L+M+G : Number youth organizations participating in youth education outreach strategy	Number youth organizations conducting member outreach and health education as part of IHPplus youth health education strategy	146	180	199	159	159	126	126
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influencers (people and technologies) launched								
77 BCC : Number of CODESAs supported by IHPplus which have a "communications action plan"	Number of CODESAs supported by IHPplus within the IHPplus target areas which have a "communications action plan" developed	1,192	1,225	1,251	1,160	3,636	1,284	283
78 BCC : Number of educational SMS messages during BCC campaigns or mini-campaigns on malaria, nutrition, FP, WASH, etc.	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHPplus target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	500,000	510,168	835,081	38,512	1,383,761	1,134,000	122
IR 4: Health sector leadership and governance in target provinces improved (Component 2)								
IR 4.1: Provincial health sector policies and national level policies aligned								
79 *** L+M+G : Percent of health zones with an annual operational plan based on National Development Plan ("PNDS")	Numerator: Number of health zones with an annual operational plan based on National Development Plan ("PNDS")	78	61	69	69	69	n/a	
	Denominator: Total number of health zones	78	78	78	78	78	n/a	
80 *** L+M+G : Percent of health zone management teams with a performance management system that includes essential components	Numerator/Denominator (in percentage)	100%	78%	88%	88%	88%	100%	88
	Numerator: Number of health zone management teams with a performance management system that includes any of the three essential components: 1) <i>Up-to-date job descriptions and organigrams</i> , 2) <i>Work plans (including supervision plan and guide)</i> 3) <i>Performance review reports</i>	48	60	78	65	65	n/a	
Project Management	Denominator: Total number of health zones	78	78	78	78	78	n/a	
	Numerator/Denominator (in percentage)	62%	77%	100%	83%	83%	100%	83
81 PM : Number of success stories developed	Number of success stories developed disaggregated by technical components and sub-components where applicable (HIV/AIDS, TB, malaria, MNCH, FP/RH, nutrition, WASH, GBV, gender, HSS, BCC, commodities, coordination, M&E, etc.)	23	26	36	24	86	80	108

*Achievement rate is not applicable when target is 0.

Appendix 2. List of all Health Zones

PROVINCE	HEALTH ZONES					
	Received IHPplus Support for MNCH, FP, Malaria, TB, WASH, and Nutrition	Population 2018	Received IHPplus Support for Malaria (GFATM et al.)*	Population 2018	Received IHPplus Support for Malaria (PMI Expansion)**	Population 2018
Haut Lomami	Kinkondja	274,462	Bukama	350,749		
	Kabongo	400,469	Kamina	324,087		
	Kayamba	108,349	Kabondo Dianda	533,570		
	Kitenge	281,111	Butumba	283,715		
	Songa	188,265	Baka	74,219		
	Lwamba	131,798	Kaniama	386,447		
	Malemba Nkulu	296,748	Kinda	89,460		
	Mukanga	229,613				
	Mulongo	331,765				
		9	2,242,580	7	2,042,247	0
Lualaba	Dilala	129,460	Dilolo	171,867		
	Bunkeya	56,644	Kafakumba	134,727		
	Fungurume	120,598	Kalamba	102,684		
	Lubudi	132,305	Kapanga	182,349		
	Manika	245,342	Kasaji	279,785		
	Kanzenze	101,513	Sandoa	236,973		
	Mutshatsha	77,001				
	Lualaba	108,367				
	8	971,229	6	1,108,385	0	
Kasai Oriental	Bibanga	166,438	Kasansa	251,115	Bipemba	407,828
	Dibindi	293,640	Chilundu	212,836	Bonzola	195,629
	Mpokolo	339,297	Miabi	188,556	Citenge	261,793
			Kabeya Kamuanga	159,449	Diulu	403,984
			Tshilenge	328,284	Kansele	282,365
					Lubilanji	270,925
					Lukalenge	221,858
					Mukumbi	160,340
					Muya	362,181
					Nzaba	325,646
					Tshishimbi	216,802
	3	632,937	5	889,125	11	2,701,523
Kasai	Dekese	157,024				
		1	157,024	0	0	

* Health zones inherited from the GFATM and SIAPS/MalariaCare/Deliver in 2016

** Health zones inherited from the PMI Expansion in January 2018

PROVINCE	HEALTH ZONES					
	Received IHPplus Support for MNCH, FP, Malaria, TB, WASH, and Nutrition	Population 2018	Received IHPplus Support for Malaria (GFATM et al.)*	Population 2018	Received IHPplus Support for Malaria (PMI Expansion)**	Population 2018
Haut Katanga			Kambove	150,485	Mitwaba	126,524
			Kikula	260,227	Mufunga Sampwe	190,440
			Kilela Balanda	74,765		
			Likasi	155,219		
			Panda	92,720		
			Kafubu	110,966		
			Kamalondo	33,936		
			Kampemba	520,708		
			Kasenga	162,420		
			Kashobwe	167,468		
			Mumbunda	415,459		
			Pweto	387,356		
			Rwashi	438,115		
			Sakania	328,781		
			Tshamilemba	298,966		
			Vangu	202,939		
			Katuba	208,766		
			Kenya	276,932		
			Kilwa	353,697		
			Kipushi	232,378		
			Kisanga	366,309		
			Kowe	58,448		
			Kapolowe	164,243		
			Lubumbashi	255,671		
			Lukafu	108,028		
	0		25	5,825,000	2	316,964
Lomami	Kamiji	110,070	Kabinda	303,362	Gandajika	335,091
	Kalenda	233,392			Kalambayi Kabanga	175,084
	Luputa	320,087			Kalonda-Est	251,100
	Wikong	133,885			Kamana	205,126
	Kanda Kanda	258,259			Lubao	228,716
	Mwene Ditu	468,361			Ludimbi Lukula	168,292
					Mulumba	343,754
					Tshofa	151,974
				Makota	255,706	
	6	1,524,056	1	303,362	9	1,779,752

* Health zones inherited from the GFATM and SIAPS/MalariaCare/Deliver in 2016

** Health zones inherited from the PMI Expansion in January 2018

PROVINCE	HEALTH ZONES					
	Received IHPplus Support for MNCH, FP, Malaria, TB, WASH, and Nutrition	Population 2018	Received IHPplus Support for Malaria (GFATM et al.)*	Population 2018	Received IHPplus Support for Malaria (PMI Expansion)**	Population 2018
Sankuru	Lusambo	107,316				
	Pania Mutombo	87,308				
	Djalo Djeka	87,450				
	Katako Kombe	146,960				
	Wembo Nyama	92,054				
	Dikungu	158,167				
	Tshumbe	108,802				
	Minga	178,418				
	Ototo	144,674				
	Omendjadi	145,746				
	Vangakete	138,651				
	Lodja	206,568				
	Bena Dibele	105,037				
	Kole	105,840				
	Tshudi Loto	124,145				
	Lomela	81,255				
		16	2,018,389	0		0
Kasai Central	Dibaya	153,376	Bunkonde	121,965	Bena-leka	318,825
	Lubombaie	172,534	Mikalayi	246,474	Bena Tshiadi	126,382
	Bilomba	97,092	Bobozo	44,784	Demba	384,772
	Kalomba	162,036			Kananga	307,214
	Ndekesha	171,919			Katende	105,577
	Yangala	172,267			Katoka	238,311
	Luambo	301,736			Lubunga	214,187
	Luiza	184,707			Lukonga	400,987
					Muetshi	226,345
					Mutoto	242,322
					Ndesha	215,894
					Tshikula	216,596
					Masuika	320,633
					Tshibala	369,882
		8	658,710	3	14	2,445,157

* Health zones inherited from the GFATM and SIAPS/MalariaCare/Deliver in 2016

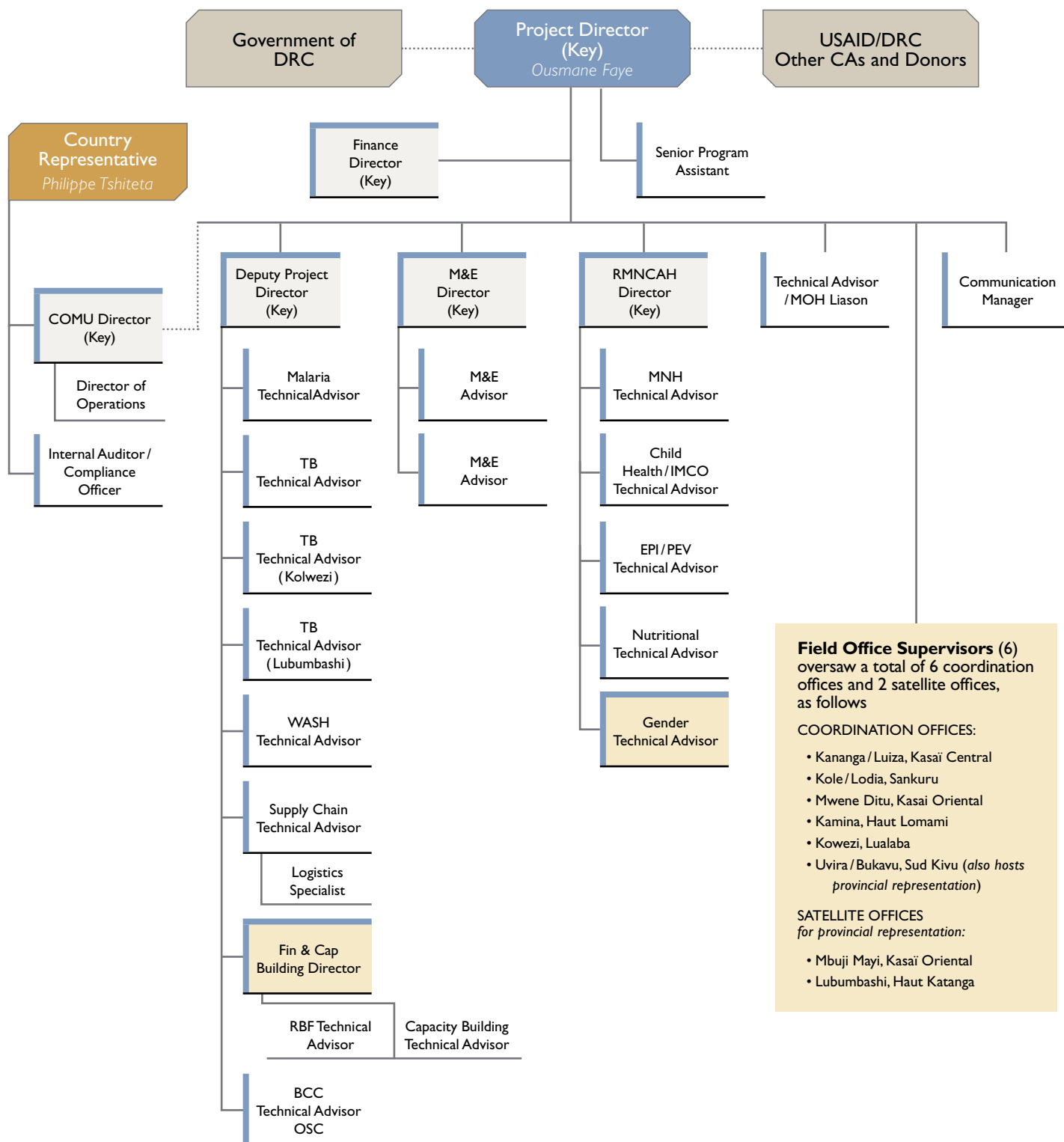
** Health zones inherited from the PMI Expansion in January 2018

PROVINCE	HEALTH ZONES					
	Received IHPplus Support for MNCH, FP, Malaria, TB, WASH, and Nutrition	Population 2018	Received IHPplus Support for Malaria (GFATM et al.)*	Population 2018	Received IHPplus Support for Malaria (PMI Expansion)**	Population 2018
Sud Kivu	Ibanda	345,494	Kalehe	181,415	Kabare	113,877
	Bagira	106,539			Nyantende	136,096
	Kadutu	217,489			Fizi	315,376
	Idjwi	265,262			Itombwe	98,946
	Katana	218,550			Kimbi Lulenge	184,397
	Miti-Murhesa	223,570			Minembwe	88,733
	Bunyakiri	165,226				
	Kalonge	199,254				
	Minova	213,886				
	Kamituga	171,658				
	Kitutu	143,146				
	Mwana	144,269				
	Mwenga	149,907				
	Kalole	113,079				
	Lulingu	172,772				
	Mulungu	151,308				
	Shabunda	156,103				
	Kaniola	190,697				
	Kaziba	129,214				
	Mubumbano	185,863				
	Nyangezi	137,113				
	Walungu	273,877				
	Nundu	266,818				
	Haut-Plateau	125,912				
	Lemera	170,826				
	Ruzizi	157,689				
	Uvira	303,623				
	27	5,099,142	1	181,415	6	937,425
TOTAL	78	13,304,066	48	10,349,534	42	8,180,821

* Health zones inherited from the GFATM and SIAPS/MalariaCare/Deliver in 2016

** Health zones inherited from the PMI Expansion in January 2018

Appendix 3. Organizational Structure of Kinshasa Office Headquarters



Appendix 4. Publications and Presentations PY1–PY3

Date	Title	Event *	Type	Location*	Link
2015					
14–15 Dec	Motivating village health development committees with incentives based on performance to improve service utilization rates in DRC	8th Annual Conference on the Science of Dissemination and Implementation	Abstract (created under IHP) Poster	Washington, DC, USA	https://drive.google.com/open?id=1vYgYSX7ZDKiLR-GLtViEoIYpffrH3TiK
2016					
8–10 Feb	The Contribution of the Champion Communities Approach to Healthy Behaviors and the Utilization of Health Services in the DRC	International SBCC Summit 2016	Abstract (created under IHP) Poster	Addis Ababa, Ethiopia	https://drive.google.com/open?id=1JGs9-EjeiWennrn-mWy2_utlPjXFepkQQ
16–17 Apr	Saving Lives and Improving Health in the Democratic Republic of Congo: A Health Systems Approach to Saving Mothers and Neonates	Global Health and Innovation Conference (GHIC)	Abstract (created under IHP) Poster	New Haven, CT USA	https://drive.google.com/open?id=1FzeBtXdzYiZO-O3wNdfqh0a-K6Qmi5bDZ
16–17 Apr	Breathing Easier in DRC: Simple Technology Saves Newborn Lives	GHIC	Abstract (created under IHP) Poster	New Haven, CT USA	https://drive.google.com/open?id=0Bzb5aEGf5H-bcTHZVZ1JTa283NW8 https://drive.google.com/open?id=12Ef-NZW9FGc77ZUsRD-4Qv0n6UPnP-6oUa
26–29 Sep	<i>Les facteurs déterminants de la satisfaction des usagers des services de santé dans la zone de santé de Luiza au Kasai Occidental en RDC</i>	African Health and Economics Policy Association Fourth Biennial Scientific Conference	Abstract Presentation	Rabat, Morocco	https://drive.google.com/file/d/1FzeBtXdzYiZO-O3wNdfqh0a-K6Qmi5bDZ/view?usp=sharing
26–29 Sep	The Contribution of the Champion Communities Approach to Healthy Behaviors and the Utilization of Health Services in the DRC	Roll Back Malaria Communication Community of Practice Annual (RBM CCoP) Meeting	Abstract (created under IHP) Presentation	Dakar, Senegal	https://drive.google.com/open?id=1JGs9-EjeiWennrn-mWy2_utlPjXFepkQQ
29 Oct–2 Nov	Balanced and nutritious complementary feeding of children from 6–24 months old: Promoting children's consumption of animal products in the DRC	American Public Health Association (APHA) Annual Meeting 2016	Abstract Presentation	Denver, CO USA	https://drive.google.com/open?id=127cnuQbkAK-0grn0cmmMdXRRK13iKX-HkL
29 Oct–2 Nov	High-impact malaria interventions save children's lives in the DRC	APHA Annual Meeting 2016	Abstract Presentation	Denver, CO USA	https://drive.google.com/open?id=11wXUeYrA-MYrpE6jvQsekVV2DR1d3h_ng
29 Oct–2 Nov	Can RBF significantly improve the quality of health services? The case of health facilities in the DRC	APHA Annual Meeting 2016	Abstract Presentation	Denver, CO USA	https://drive.google.com/open?id=128Htm7zAyM-blrnOMOCfMO9zQVG7n4_m8
29 Oct–2 Nov	Community-Led Total Sanitation: A pilot approach in nine health zones in the DRC	APHA Annual Meeting 2016	Abstract Poster	Denver, CO USA	https://drive.google.com/open?id=0Bzb5aEGf5HbcM-3d1R0dKUF9aUmM
14–18 Nov	<i>L'amélioration de l'utilisation des services de la santé de la mère et de l'enfant par le Financement Basé sur les Résultats en RDC</i>	Fourth Global Symposium on Health Systems Research	Abstract	Vancouver, Canada	https://drive.google.com/open?id=1nEftmdHgAvqniX-akXwKRuFHc_J0skZ8f

* where applicable

Date	Title	Event *	Type	Location*	Link
14–18 Nov	Testing of Quality of Care Indicators for Maternal and Neonatal Health Services in Eight Health Zones in the Democratic Republic of Congo	Fourth Global Symposium on Health Systems Research	Roundtable discussion	Vancouver, Canada	https://drive.google.com/open?id=1EbKCRpq8A3k-KDGu5Ny4vhOoAeP6Rc_Vs
14–18 Nov	Saving Lives and Improving Health in the Democratic Republic of Congo: A Health Systems Approach to Saving Mothers and Neonates	Fourth Global Symposium on Health Systems Research	Abstract (created under IHP) Poster	Vancouver, Canada	https://drive.google.com/open?id=1FzeBtXdzYiZO-O3wNdfqh0a-K6Qmi5bDZ
2017					
8–11 Jul	The effect of RBF on the quantity of maternal and child health services and health governance in the DRC	International Health Economics Association (iHEA) Biennial Congress	Abstract Presentation	Boston, MA USA	https://drive.google.com/open?id=1FKXkeXUpwZHP-CyNuUTMXblrsGnsBRfkS
8–11 Jul	The effects of RBF on the quality of services and the accuracy of reported health information in the DRC	iHEA Biennial Congress	Abstract Presentation	Boston, MA USA	https://drive.google.com/open?id=1O2NkUecoE7hk-KydQ4H_cygnDwBW_Tf_1
23–26 Jul	Therapeutic Outcomes of TB-HIV Co-Infected Patients in the Lualaba Mining Province in the DRC	9th Annual International AIDS Society Conference on HIV Science	Abstract Poster	Paris, France	https://drive.google.com/open?id=19i9GJjzXJC-jQwyuXGp5665Go-QQekuZx9
26–28 Oct	<i>Evaluation de l'effet de la trithérapie anti-retrovirale sur la survie des patients VIH sous traitement et les facteurs associés : la cohorte de l'hôpital de la GECAMINE, ville de Kolwezi-République Démocratique du Congo</i>	<i>Vème Congrès de Pharmacoéconomie et Pharmacoépidémiologie de la Société Marocaine de l'Economie des Produits de Santé</i>	Abstract Poster	Casablanca, Morocco	https://drive.google.com/open?id=1CNctbtetqDQH-gEo0LWxU7uEbdCB8MRo6
4–8 Nov	Early Infant Diagnosis Saves Lives in Kolwezi, DRC	APHA Annual Meeting 2017	Abstract Presentation	Atlanta, GA USA	https://drive.google.com/open?id=11k2UMVU-oUgSVOix8kUdddojwjq-8GUteb
4–8 Nov	Impact of nutrition interventions on child survival in the DRC	APHA Annual Meeting 2017	Abstract Presentation	Atlanta, GA USA	https://drive.google.com/open?id=11TnlZdi82lkle-1ie8wuk2spUmiLKQYLU
4–8 Nov	Improving the proportion of HIV-positive patients treated with IPT in the Lualaba Province of the Democratic Republic of Congo	APHA Annual Meeting 2017	Abstract Poster	Atlanta, GA USA	https://drive.google.com/open?id=11ZRtia0bR7B-wuDxHFB4IZnxrrAkl2B4c
4–8 Nov	Therapeutic Outcomes of TB-HIV Co-Infected Patients in the Lualaba Mining Province in the DRC	APHA Annual Meeting 2017	Abstract Presentation	Atlanta, GA USA	https://drive.google.com/open?id=11blsB5FLE-zFr-Ni5cMkF49ERVR1hcXfj
6–Dec	Uniting to end violence against women and girls: 16 days of activism launched in DRC		Story	MSH Stories	http://www.msh.org/news-events/stories/uniting-to-end-violence-against-women-and-girls-16-days-of-activism-launched-in

* where applicable

Date	Title	Event *	Type	Location*	Link
2018					
22–23 Mar	Strengthening health data reporting by integrating national and project DHIS 2 instances: experience from the DRC	DHIS 2 Symposium	Abstract Presentation	Washington, DC USA	https://drive.google.com/open?id=11bYSmjPjh4c-clQFwNX-FULgJjrx6ESJ
Jul	Nutrition		Fact sheet		
Jul	MNCH		Fact sheet		
Jul	Tuberculosis		Fact sheet		
Jul	Malaria		Fact sheet		
Jul	Family planning		Fact sheet		
Jul	LDP		Fact sheet		
Jul	HIV/AIDS		Fact sheet		
Jul	<i>Le succes de la mise en oeuvre des approches Aider les meres a survivre et Aider les babes a respirer dans les zones de sante PROSANIplus</i>		Technical brief		
Jul	Strengthening health data reporting and improving data quality and use by integrating national and project DHIS 2 instances: experience from the DRC		Technical brief		
Jul	<i>La prise en charge simplifiée des nourrissons malades avec possibilité d'infection bactérienne grave</i>		Technical brief		
Jul	Reach Every Household with Family Planning: Door to door mini-campaigns promote contraceptive methods		Technical brief		
Jul	The Champion Community Approach in DRC: A Gold Standard for Community Mobilization		Technical brief		
Jul	Quality of Care Indicators for Maternal and Newborn Health: A Study in 8 Health Zones in the Democratic Republic of Congo		Technical brief		
Jul	The Champion Community Approach in Democratic Republic of Congo: The New Gold Standard for Community Mobilization		Video		
Jul	Champion Community Approach Implementation Manual, Democratic Republic of Congo		Manual		
12–15 Nov	Reach every household with family planning: Door-to-door mini-campaigns promote contraceptive methods in IHPplus-supported health zones in the Democratic Republic of Congo	ICFP: International Conference on Family Planning	Abstract Presentation (future, accepted)	Kigali, Rwanda	https://www.xcdsystem.com/icfp/abstract/invite.cfm?uid=361777&hid=7D69D876-92BF-1CA5-B1355B610F-1BCE96&aid=168801&-caid=2061&cid=1484

* where applicable

Appendix 5. List of Success Stories

Qtr	N°	Story Location	Health Topic	Title
PY1Q2	1	Kanzenze health zone, Lualaba province	RBF	If you can measure it, you can change it: Collecting reliable health data in DRC
	2	Mwene Ditu health zone, Lomami province	Access to Care	Renovate it and they will come: Raising utilization rates in Lukola
	3	Uvira health zone, Sud Kivu province	MNCH	Lowering maternal mortality one life at a time: Active management of the third stage of labor in DRC
	4	Mulongo health zone, Haut Lomami province	HIV	The medicines work: An HIV-positive woman regains her health and her life in DRC
	5	Kayamba health zone, Haut Lomami province	FOSACOF	In a nurse's words: How measurement inspired one health center to turn itself around
	6	Kanda Kanda health zone, Lomami province	Access to Care	Providing better services to more people: Upgrading a health center in DRC
	7	Lodja health zone, Sankuru province	Champion Community	Champion Communities: Changing the world, village by village
	8	Ndeksha health zone, Kasai Central province	Nutrition	Learn from the children: A young student helps her mother better nourish the family
	9	Dibaya health zone, Kasai Central province	Malaria	Neighborhood care for malaria and a new pre-referral treatment save lives in Dibaya
PY1Q3	10	Kamiji health zone, Lomami province	TB	Now I know my condition and I believe in a cure: Mama Bec's TB story
	11	Kanda Kanda health zone, Lomami province	WASH	Clean water is a community affair in Kabuela, DRC
	12	Ruzizi health zone, Sud Kivu province	Nutrition	It takes a support group and good information: Healthier children in DRC thanks to IYCF support groups
	13	Luiza health zone, Kasai Central province	RBF	Life will be radiant in this village: Health education at the hospital turns mother into hygiene activist
	14	Bibanga health zone, Kasai Oriental province	RBF	Results-based financing brings back the water—and patients
	15	Katana health zone, Sud Kivu province	FP	Spacing births for healthier lives: Health support groups bring family planning to rural areas of DRC
	16	Bilomba health zone, Kasai Central province	MNCH	Hands-on training empowers health providers to save the lives of mothers and newborns in the DRC
	17	Katana health zone, Sud Kivu province	BCC	A father takes his girls to school: The story of Jean Paul

Qtr	N°	Story Location	Health Topic	Title
PY1Q4	18	Fungurume health zone, Lualaba province	MNCH	“I didn’t even know how I got to the hospital”: Saved from eclampsia by skilled medical attention
	19	Luiza health zone, Kasai Central province	RBF	A clinic of our own:A health-facility team and CODESA make their dream a reality
	20	Bunkeya health zone, Lualaba province	HIV	Beating two major diseases thanks to upgraded, free health services:“I once again believe in my future and that of my children”
	21	Fungurume health zone, Lualaba province	MNCH	Simple techniques make (radio) waves in the DRC:A grateful mother broadcasts the message to others
	22	Luiza health zone, Kasai Central province	FP	Theory and practice:A family-planning “mini-campaign” inspires 1,000 couples to try modern contraception
	23	Malembea health zone, wHaut Lomami province	TB	For tuberculosis patients in rural DRC, fighting stigma is half the battle:A community-based organization seeks patients out so they can be treated
	24	Lomela health zone, Sankuru province	RBF	Community-based organizations check on the performance of health facilities, and also lend a hand, thanks to results-based financing
	25	Dibaya health zone, Kasai Central province	BCC	From shunning to solidarity: Helping young mothers in Dibaya
PY2Q1	26	Kole and Lodja health zones, Sankuru province Dibaya and Luiza health zones, Kasai Central province	BCC	Making health education accessible and fun: Health SMS texts and quiz games become popular in the DRC
	27	Dilala health zone, Lualaba province	HIV	Knowing your status:An HIV-positive couple gives life to an HIV-free child
	28	Lodja health zone, Sankuru province	Nutrition	Paying it forward:A mother counseled on breastfeeding becomes the counselor
	29	Mulongo health zone, Haut Lomami province	Access to Care	Saving people’s lives with education and affordable care
	30	Bibanga health zone, Kasai Oriental province	RBF	A healthy investment: Health center leaders take ownership of improving service quality
	31	Katana health zone, Sud Kivu province	FP	It’s all in the timing:Access and education help families plan for healthy babies
	32	Luiza health zone, Kasai Central province	RBF	Improving the quality of health services in Luiza through results-based financing
	33	Ndeksha health zone, Kasai Central province	WASH	WASH interventions reduce diarrhea cases in Ndeksha
	34	Lomela health zone, Sankuru province	Champion Community	Children in the Lomela Pilote health area benefit from strategic partnership
	35	Tshumbe health zone, Sankuru province	BCC	Behavior change communication mini-campaigns improve tuberculosis indicators

Qtr	N°	Story Location	Health Topic	Title
PY2Q2	36	Ndeksha health zone, Kasai Central province	WASH	Changing attitudes, improving lives: Latrines protect a family from typhoid
	37	Baka health zone, Haut Lomami province	TB	I would have died of ignorance: A TB survivor's story
	38	Mwene Ditu health zone, Kasai Oriental province	TB	Mass media and door-to-door campaigns increase the detection of tuberculosis in Mwene Ditu
	39	Kanda Kanda health zone, Kasai Oriental province	Nutrition	Support groups improve infant nutrition in Kanda Kanda, DRC
	40	Lubudi health zone, Lualaba province	HIV	Speaking against the silence: HIV-positive women in Lubudi find their voices
	41	Kitutu health zone, Sud Kivu province	i-CCM	It takes a village... to raise a new community care site
	42	Kitenge health zone, Haut Lomami province	i-CCM	In Kitenge, DRC, a chief's grandson is saved
	43	Nundu health zone, Sud Kivu province	FP	A family in Sud Kivu thrives, thanks to family planning
	44	Songa health zone, Haut Lomami province	Champion Community	The innovative integration of youth into Champion Communities improves community health
PY2Q3	45	Kaniola health zone, Sud Kivu province	TB	Tuberculosis steals a man's wealth — but community referral and treatment restore his health
	46	Walungu health zone, Sud Kivu province	WASH	The 'water glass test' challenges traditional attitudes to improve hygiene practices
	47	Mwene Ditu and Kanda Kanda health zones, Lomami province	i-CCM	"On World Pneumonia Day, mini-campaigns encourage parents to seek screening and treatment for their children"
	48	Luambo health zone, Kasai Central province	MNCH	On the border, a life is saved from eclampsia
	49	Lualaba health zone, Lualaba province	Nutrition	Nutrition education sessions reach hundreds of mothers in Lualaba
	50	Dilala health zone, Lualaba province	HIV	A young woman finds a way forward with HIV
	51	Manika health zone, Lualaba province	MNCH	A campaign to promote antenatal care becomes a lifeline for a teenager in need
	52	Dibaya health zone, Kasai Central province	Champion Community	"Youth, take responsibility for your actions": Reversing youth delinquency in Dibaya, DRC

Qtr	N°	Story Location	Health Topic	Title
PY2Q4	53	Katana health zone, Sud Kivu province	FP	Training community health workers to provide injectable contraceptives
	54	Kalenda health zone, Lomami province	Malaria	Open-door days improve malaria management in the Kalenda health zone
	55	Manika, Bunkeya, and Lualaba health zones, Lualaba province	TB	Mini-campaigns improve TB detection in Lualaba Province
	56	Luiza health zone, Kasai Central province	FP	A farmer becomes a community-based distributor of family planning services
	57	Nundu health zone, Sud Kivu province	RBF	Performance-based payments motivate a health center to improve health service delivery
	58	Mubumbano health zone, Sud Kivu province	Access to care	Getting children to health facilities for treatment of childhood illnesses
	59	Mpokolo health zone, Kasai Oriental province	Nutrition	Survival thanks to nutritional counseling: Emmany's story
	60	Manika health zone, Lualaba province	HIV	Improving HIV care and management in hard-to-reach places
	61	Luputa health zone, Lomami province	WASH	Building ownership for maintaining water sources in the rural DRC
	62	Lodja health zone, Sankuru province	Champion Community	Champion Communities: Autonomous capacity building boosts community activities
PY3Q1	63	Bibanga health zone, Lomami province	MNCH	Results-based financing engages community health workers in the fight against maternal mortality in Bibanga
	64	Mwene Ditu health zone, Lomami province	MNCH	A life saved at the Emmaüs maternity ward
	65	Dilala health zone, Lualaba province	Nutrition	Growing up healthy: Exclusive breastfeeding makes a champion out of Mamie Itshika
	66	Dilala health zone, Lualaba province	Nutrition	Stopping postpartum hemorrhage by initiating breastfeeding within one hour of delivery
	67	Nundu health zone, Sud Kivu province	RBF	Providing better-quality services through results-based financing brings health care home to Nundu Hospital
	68	Kabondo Dianda health zone, Haut Lomami province	Malaria	Intermittent preventive treatment benefits the women of Kabondo Dianda
	69	Nundu health zone, Sud Kivu province	FP	Increased number of new family planning acceptors following a mini-campaign in Nundu
	70	Fizi health zone, Sud Kivu province	Fistula	"Now I can live like everyone else, thank you!"

Qtr	N°	Story Location	Health Topic	Title
PY3Q2	71	Mwene Ditu health zone, Lomami province	TB	Identifying drug-resistant cases of tuberculosis in the DRC
	72	Mpokolo health zone, Kasai Oriental province	MNCH	Better leadership, better health: A health zone management team improves the rate of antenatal care visits
	73	Mwene Ditu health zone, Lomami province	FOSACOF	Evaluating and improving clinical quality at Tshiamala Hospital through the FOSACOF approach
	74	Katana health zone, Sud Kivu province	MNCH	Community health workers improve service utilization rates in Katana
	75	Idjwi health zone, Sud Kivu province	Nutrition	“Synergy between community health workers and health care providers improves nutrition for infants and young children”
	76	Kayamba health zone, Haut Lomami province	RBF	Results-based financing leads to infrastructure improvements
	77	Bibanga health zone, Kasai Oriental province	RBF	The Network of Congolese Youth Associations builds its capacity through results-based financing
	78	Dilala health zone, Lualaba province	Nutrition	Practicing exclusive breastfeeding yields many benefits for babies and families
PY3Q3	79	Dibaya health zone, Kasai Central province	FP	Family planning education turns husband and wife into community advocates
	80	Dilala health zone, Lualaba province	Nutrition	“Baby Genesis grows up healthy, with support from her parents and community health workers”
	81	Kamiji and Luputa health zones, Lomami province	FP	Increasing the number of contraceptive method users in Kamiji and Luputa
	82	Bilomba health zone, Kasai Central province	WASH	Sustainability of WASH activities in the Bilomba health zone
	83	Kalenda health zone, Lomami province	Malaria	“Providing more pregnant women with intermittent preventive treatment for malaria through a mini-campaign in Kalenda”
	84	Bibanga health zone, Kasai Oriental province	TB	Community involvement helps increase TB case detection in Bibanga
	85	Dilala health zone, Lualaba province	Youth	Social media: The key to conducting youth outreach
	86	Ruzizi health zone, Sud Kivu province	Champion Community	Champion Mamas: The autonomous Champion Community of mothers

Appendix 6. List of Trainings

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
1	AEN training for health care providers of Bibanga health zone	30-Aug-16	3-Sep-16	Mwene Ditu	28	14	42
2	AEN training of health care providers and CHWs of two health zones (Malemba and Kinkondja)	28-Mar-17	1-Apr-17	Kamina	71	9	80
3	Briefing/training of health care providers of two health zones of Kolwezi coordination (Dilala and Manika) on the PNLS single framework and new WHO instructions on HIV/AIDS	27-Sep-16	25-Oct-16	Kolwezi	127	66	193
4	Clinical Integrated Care Management (CICM) training of health care providers and Community Health Workers (CHW) of three health zones (Fungurume, Lubudi, Bunkeya)	25-Feb-17	5-Mar-17	Kolwezi	39	11	50
5	Family Planning training for health care providers of four health zones (Ndeksha, Lubondaie, Bilomba, Dibaya)	22-Jun-15	26-Jun-15	Luiza	22	6	28
6	Family Planning follow-up visit of health care providers of Dikungu and Tshumbe health zones	3-Jul-17	5-Jul-17	Tshumbe	21	1	22
7	Family Planning follow-up visit of health care providers of Katako Kombe and Djalo health zones	29-Jun-17	7-Jul-17	Tshumbe	17	5	22
8	Family Planning training for Community-based Distributors (CBDs) of Bibanga health zone	10-Jul-16	15-Jul-16	Mwene Ditu	64	11	75
9	Family Planning training for health care providers and CHWs of Fungurume health zone	24-Jun-16	2-Jul-16	Kolwezi	51	24	75
10	Family Planning training of DBC of Dibaya health zone	27-Dec-15	4-Jan-16	Luiza	48	20	68
11	Family Planning training of health care providers and CHWs in two health zones (Dilala and Manika) of Kolwezi	14-Nov-16	24-Nov-16	Kolwezi	32	54	86
12	HIV training for Psycho-social Assistants (APS) of HIV care sites for two health zones (Fungurume and Lubudi)	1-Jul-16	3-Jul-16	Kolwezi	34	21	55
13	HIV training for APS of HIV care sites for three health zones (Manika, Dilala, Lualaba)	21-Jun-16	24-Jun-16	Kolwezi	36	37	73
14	HIV training of laboratory technicians (LT) of HIV care sites for two health zones (Fungurume and Lubudi)	20-Jun-16	23-Jun-16	Kolwezi	30	17	47
15	HIV training of LTs of HIV care sites for three health zones (Manika, Dilala, Lualaba)	25-Jun-16	27-Jun-16	Kolwezi	25	14	39
16	HIV training on HIV/B+ option for Haut-Lomami Management Team, health care providers, and LTs of three health zones (Kitenge, Kayamba, Songa)	27-Jun-15	2-Jul-15	Kamina	26	11	37
17	HIV training on HIV/B+ option for Haut-Lomami Management Team, health care providers, and LTs of Kabongo health zone	27-Jun-15	2-Jul-15	Kamina	8	7	15
18	HIV training on HIV/B+ option for Haut Lomami Management Team, health care providers, and LTs of three health zones (Malemba, Muolmba, Kinkondja)	6-Jul-15	8-Jul-15	Kamina	19	2	21
19	Integrated Community Care Management (iCCM) follow-up visit of CHWs of Tshumbe health zone	29-Jun-17	7-Jul-17	Tshumbe	55	52	107
20	iCCM training of health care providers and CHWs of two health zones (Kabongo and Songa)	4-Mar-17	20-Mar-17	Kamina	38	5	43
21	iCCM training of health care providers and CHWs of Kabinda health zone	11-Sep-16	17-Sep-16	Mwene Ditu	50	8	58

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
22	iCCM training of health care providers and CHWs of Kafakumba health zone	14-Jan-17	22-Jan-17	Kolwezi	44	3	47
23	iCCM training of health care providers and CHWs of Kalamba health zone	20-Jan-17	26-Jan-17	Kolwezi	42	6	48
24	Leadership Development Program (LDP) approach workshop of Muresha health zone teams	11-Jul-17	13-Jul-17	Bukavu	14	1	15
25	Malaria training of health care providers of Bibanga health zone	24-Apr-16	25-Apr-16	Mwene Ditu	18	1	19
26	Malaria training of health care providers of Bunyakiri health zone	21-Jul-16	23-Jul-16	Bukavu	64	3	67
27	Malaria training of health care providers of Dikungu health zone	25-Jun-16	30-Jun-16	Tshumbe	36	3	39
28	Malaria training of health care providers of Dilala health zone	16-Dec-15	18-Dec-15	Kolwezi	18	9	27
29	Malaria training of health care providers of Djalo health zone	6-Jan-16	8-Jan-16	Tshumbe	27	7	34
30	Malaria training of health care providers of Ibanda health zone	24-Nov-15	26-Nov-15	Bukavu	37	20	57
31	Malaria training of health care providers of Kabongo health zone	12-Dec-15	14-Dec-15	Kamina	60	8	68
32	Malaria training of health care providers of Kadutu health zone	1-Dec-15	3-Dec-15	Bukavu	35	16	51
33	Malaria training of health care providers of Kalenda health zone	26-Apr-16	27-Apr-16	Mwene Ditu	30	0	30
34	Malaria training of health care providers of Kamiji health zone	27-Apr-16	28-Apr-16	Mwene Ditu	14	1	15
35	Malaria training of health care providers of Kanzenze health zone	12-Dec-15	14-Dec-15	Kolwezi	27	9	36
36	Malaria training of health care providers of Katana health zone	14-Jan-16	16-Jan-16	Bukavu	44	11	55
37	Malaria training of health care providers of Kayamba health zone	11-Dec-15	13-Dec-15	Kamina	26	4	30
38	Malaria training of health care providers of Kitenge health zone	17-Dec-15	19-Dec-15	Kamina	54	6	60
39	Malaria training of health care providers of Lemera health zone	16-Aug-16	18-Aug-16	Uvira	54	8	62
40	Malaria training of health care providers of Lomela health zone	30-Dec-15	1-Jan-16	Kole	42	7	49
41	Malaria training of health care providers of Luputa health zone	24-Apr-16	25-Apr-16	Mwene Ditu	29	4	33
42	Malaria training of health care providers of Manika health zone	11-Dec-15	13-Dec-15	Kolwezi	29	6	35
43	Malaria training of health care providers of Minova health zone	1-Aug-16	3-Aug-16	Bukavu	54	4	58
44	Malaria training of health care providers of Miti-Murhesa health zone	18-Jan-16	20-Jan-16	Bukavu	51	12	63
45	Malaria training of health care providers of Mpokolo health zone	27-Apr-16	28-Apr-16	Mweneditu	11	4	15
46	Malaria training of health care providers of Mubumbano health zone	17-Dec-15	19-Dec-15	Bukavu	43	8	51
47	Malaria training of health care providers of Mutshatsha health zone	17-Dec-15	19-Dec-15	Kolwezi	22	10	32
48	Malaria training of health care providers of Mweneditu health zone	7-Dec-15	9-Dec-15	Mwene Ditu	29	2	31
49	Malaria training of health care providers of Nundu health zone	14-Aug-16	16-Aug-16	Uvira	56	6	62
50	Malaria training of health care providers of Ruzizi health zone	23-May-16	25-May-16	Uvira	48	9	57
51	Malaria training of health care providers of Songa health zone	16-Dec-15	18-Dec-15	Kamina	52	10	62
52	Malaria training of health care providers of Tshumbe health zone	9-Jan-16	11-Jan-16	Tshumbe	31	3	34
53	Malaria training of health care providers of Uvira health zone	19-May-16	21-May-16	Uvira	51	9	60
54	Malaria training of health care providers of Vangakete health zone	3-Jan-16	5-Jan-16	Kole	31	9	40
55	Malaria training of health care providers of Walungu health zone	21-Dec-15	24-Dec-15	Bukavu	49	11	60
56	Malaria training of health care providers of Wembonyama health zone	1-Jul-16	5-Jul-16	Tshumbe	32	3	35
57	Malaria training of health care providers of Winkong health zone	24-Apr-16	25-Apr-16	Mwene Ditu	17	2	19

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
58	Malaria training of health care providers of Kamina DPS health zone	14-Jun-16	16-Jun-16	Kamina	13	0	13
59	Malaria training of health care providers of Sankuru health district	29-Dec-15	12-Jan-16	Kole	132	25	157
60	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Kalole health zone	24-Oct-16	26-Oct-16	Bukavu	14	5	19
61	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Kamituga health zone	12-Nov-16	14-Nov-16	Bukavu	50	15	65
62	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Kaziba health zone	26-Oct-16	26-Oct-16	Bukavu	32	18	50
63	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Kitutu health zone	21-Oct-16	23-Oct-16	Bukavu	42	18	60
64	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Mwana health zone	20-Oct-16	20-Oct-16	Bukavu	45	20	65
65	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Mwenga health zone	8-Nov-16	10-Nov-16	Bukavu	43	14	57
66	Management of malaria with artesunate suppository and injectable training/Briefing of health care providers of Nyangezi health zone	17-Oct-16	17-Oct-16	Bukavu	42	15	57
67	RBF Workshop for health care providers of Kolwezi district to implanting HIV approach	19-Jul-16	27-Jul-16	Kolwezi	53	21	74
68	RBF contractualization workshop (Year 3) for RBF contracting structures of Nundu health zone	25-Nov-15	29-Nov-15	Uvira	26	1	27
69	RBF contractualization workshop (Year 3) for RBF contracting structures of Bibanga health zone	12-Nov-15	21-Nov-15	Mwene Ditu	12	0	12
70	RBF contractualization workshop (Year 3) for RBF contracting structures of Kanzenze health zone	18-Nov-15	22-Nov-15	Kolwezi	24	3	27
71	RBF contractualization workshop (Year 3) for RBF contracting structures of Kayamba health zone	10-Nov-15	14-Nov-15	Kamina	16	3	19
72	RBF contractualization workshop (Year 3) for RBF contracting structures of Lomela health zone	28-Oct-15	30-Oct-15	Kole	34	0	34
73	RBF contractualization workshop (Year 3) for RBF contracting structures of Wembonyama health zone	28-Oct-15	30-Oct-15	Tshumbe	28	1	29
74	RBF contractualization workshop (Year 4) for RBF contracting structures of Bibanga health zone	10-Nov-16	14-Nov-16	Mwene Ditu	17	3	20
75	RBF contractualization workshop (Year 4) for RBF contracting structures of Kanzenze health zone	14-Nov-16	18-Nov-16	Kolwezi	37	2	39
76	RBF contractualization workshop (Year 4) for RBF contracting structures of Kayamba health zone	13-Nov-16	17-Nov-16	Kayamba	21	4	25
77	RBF contractualization workshop (Year 4) for RBF contracting structures of Lomela health zone	17-Dec-16	22-Dec-16	Kole	25	0	25
78	RBF contractualization workshop (Year 4) for RBF contracting structures of Luiza health zone	7-Nov-16	10-Nov-16	Luiza	27	1	28

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
79	Malaria refresher training for health care providers of Kalonge health zone	6-Apr-17	8-Apr-17	Bukavu	41	3	44
80	Malaria trainings for health care providers of Bilomba health zone	11-Dec-15	13-Dec-15	Luiza	23	2	25
81	Several Malaria trainings of health care providers of Dibaya health zone	10-Dec-15	15-Dec-15	Luiza	23	2	25
82	Several Malaria trainings of health care providers of Idjwi health zone	24-Mar-17	28-Mar-17	Bukavu	50	9	59
83	Several Malaria trainings of health care providers of Kaniola health zone	28-Feb-17	2-Mar-17	Bukavu	34	6	40
84	Several malaria trainings of health care providers of Lubondaie health zone	11-Dec-15	13-Dec-15	Luiza	23	2	25
85	Several Malaria trainings of health care providers of Lulingi health zone	18-Mar-17	19-Mar-17	Bukavu	21	1	22
86	Several Malaria trainings of health care providers of Ndeksha health zone	11-Dec-15	13-Dec-15	Luiza	23	2	25
87	Sexual and Reproductive Health training for Youth and Adolescents of Dilala and Manika health zones	26-Jan-17	28-Jan-17	Kolwezi	13	7	20
88	TB/HIV,TB/MDR and PATI-5 training for health care providers, LTs, HTZMTs, and CHWs of three health zones (Songa, Kabongo, Kitenge)	18-Sep-16	22-Sep-16	Kamina	26	2	28
89	TB training on PATI-5 for DPS management team of Kasai Oriental and IHPplus staff of Mweneditu	20-Mar-17	24-Mar-17	Mwene Ditu	7	3	10
90	TB training on PATI-5 for DPS management team of Lualaba and IHPplus staff of Kolwezi	26-Feb-17	4-Mar-17	Kolwezi	1	13	14
91	TB training on PATI-5 for DPS management team of Sankuru and IHPplus staff of Kole and Tshumbe	30-Mar-17	3-Apr-17	Kole	14	5	19
92	TB training on PATI-5 for DPS management team of Sud Kivu and IHPplus staff of Bukavu	27-Mar-17	31-Mar-17	Bukavu	16	1	17
93	Technical verification of RBF data of contracting structures for PY2Q2 of Lomela health zone	21-May-15	6-Jun-15	Kole	14	0	14
94	TOT AEN training for health zone management teams (HZMT) and health care providers of two health zones (Malemba and Kinkondja)	8-Sep-16	12-Sep-16	Kamina	66	18	84
95	TOT AEN training for HZMTs and health care providers of Kinkondja health zone	8-Sep-16	12-Sep-16	Kamina	35	7	42
96	Training for health care providers and CHWs of Kanzenze and Mutshatsha health zones in Ante natal consultation revitalized	24-May-16	28-May-16	Kolwezi	49	8	57
97	Training for HZMT,WASH providers, and WASH committee of Kanda Kanda health zone on WASH participative approach	14-Sep-16	24-Sep-16	Mwene Ditu	375	78	453
98	Training of 3 Champion Communities (Kabongo) and 2 Champion Communities (Songa) on management of subsidies	30-Aug-16	10-Sep-16	Kamina	37	26	63
99	Training of 3 Champion Communities (Fungurume) and 1 Champion Community (Dilala) on management of subsidies	29-Dec-15	8-Jan-16	Kolwezi	39	20	59
100	Training of BATWABEMBA Community Organization (CBO) members of Kayamba health zone in RBF/community verification C103	23-Jun-15	25-Jun-15	Kamina	6	4	10
101	Training of Champion Communities of Bukavu on management of subsidies	6-Dec-15	19-Dec-15	Bukavu	11	4	15

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
102	Training of Champion Communities of Uvira on management of subsidies	16-Dec-15	19-Dec-15	Uvira	24	6	30
103	Training of CWHs of Kanda Kanda on competence approach	23-Jun-16	28-Jun-16	Mwene Ditu	48	19	67
104	Training of CBO members of Kolwezi in RBF/community verification	3-Oct-16	5-Oct-16	Kolwezi	21	27	48
105	Training of District Health Management Team (DHMT) and IHPplus of Sankuru on DHIS2	5-Dec-15	9-Dec-15	Kole	4	0	4
106	Training of DHMT and IHPplus staff of Kasai Central on DHIS2	2-Dec-15	4-Dec-15	Kananga	10	2	12
107	Training of DHMT and IHPplus staff of Kasai Central on Routine Data Quality Assessment (RDQA)	25-Oct-15	27-Oct-15	Kananga	16	2	18
108	Training of DHMT and IHPplus staff of Lualaba on DHIS2	26-Nov-15	30-Dec-15	Kolwezi	6	0	6
109	Training of DHMT and IHPplus staff of Lualaba on RDQA	28-Dec-15	30-Dec-15	Kolwezi	15	0	15
110	Training of DHMT and IHPplus staff of Sankuru on RDQA	7-Sep-15	16-Sep-15	Tshumbe	17	0	17
111	Training of health care providers of Luiza health zone on the MNCH competency-based approach	27-Dec-15	10-Jan-16	Luiza	14	2	16
112	Training of health care providers and HZMT of Bibanga health zone in revitalized preschool consultation	8-Mar-17	12-Mar-17	Mwene Ditu	4	16	20
113	Training of health care providers and HZMT of Dibindi health zone in revitalized preschool consultation	27-Feb-17	3-Mar-17	Mwene Ditu	4	12	16
114	Training of health care providers and HZMT of Lemera health zone on revitalized preschool consultation	6-Feb-17	12-Feb-17	Uvira	24	2	26
115	Training of health care providers and HZMT of Mweneditu health zone in revitalized preschool consultation	7-Mar-17	11-Mar-17	Mwene Ditu	20	6	26
116	Training of health care providers of Bibanga on competency-based approach	30-Aug-16	3-Sep-16	Mwene Ditu	28	14	42
117	Training of health care providers of Kanda Kanda on competency-based approach	19-Jun-16	29-Jun-16	Mwene Ditu	16	2	18
118	Training of health care providers of Luambo health zone on the competency-based approach of MNCH	8-Jul-16	22-Jul-16	Luiza	23	25	48
119	Training of health care providers two health zones of Luiza on MNCH competency-based approach	26-Dec-15	16-Jan-16	Luiza	99	0	99
120	Training of health care providers of Ndekeshya on competency-based approach	27-Dec-15	7-Jan-16	Luiza	54	12	66
121	Training of health care providers of the two health zones (Dikungu and Wembonyama) in revitalized preschool consultation	29-Dec-15	12-Jan-16	Tshumbe	132	25	157
122	Training of health care providers of the two health zones (Kayamba and Songa) in revitalized preschool consultation	17-Sep-16	21-Sep-16	Kamina	73	15	88
123	Training of health care providers of the Dibaya health zone in revitalized preschool consultation	8-Sep-16	12-Sep-16	Luiza	20	3	23
124	Training of health care providers of five health zones of Malemba in HBB and MNCH competency-based approach	26-Feb-17	17-Mar-17	Kamina	243	116	359
125	Training of health care providers of Dibaya health zone on competency-based approach	27-Dec-15	11-Jan-16	Luiza	14	2	16
126	Training of health care providers of Dilala and Manika health zones in MNCH competency-based approach	20-Feb-17	17-Mar-17	Kolwezi	25	41	66
127	Training of health care providers of Luiza health zone on competency-based approach	27-Dec-15	11-Jan-16	Luiza	34	11	45

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
128	Training of health care providers on community-based nutrition of Kolwezi DPS	9-Dec-16	11-Dec-16	Kolwezi	64	24	88
129	Training of health care providers of Bibanga Hospital on the TETU approach	10-Dec-16	21-Dec-16	Mwene Ditu	25	5	30
130	Training of maternity providers of three health zones (Kadutu, Bagira, Miti Murhesa) in HBB and AMS	20-Apr-17	25-Apr-17	Bukavu	40	62	102
131	Training of maternity providers of four health zones of Sankuru DPS (Dikungu, Djalo Ndjeka, Katako Kombe, Tshumbe) in HBB and AMS	25-Jun-17	6-Jul-17	Tshumbe	105	41	146
132	Training of Trainers (TOT) of Kolwezi DPS on community-based nutrition	4-Oct-16	7-Oct-16	Kolwezi	19	9	28
133	TOT for HZMTs of Luiza and Mwene Ditu DPS on WASH participatory approach	24-Aug-16	27-Aug-16	Luiza and Mwene Ditu	35	2	37
134	Training on water quality control for health care providers and WASH supervisors of Ndeksha health zone	16-Aug-16	17-Aug-16	Luiza	58	6	64
135	Briefing of trainers and HZMTs on the IQA and practical training in the health zones of the regional division of Mweneditu	19-Feb-18	26-Feb-18	Mwene Ditu	42	7	49
136	Briefing of providers and CHWs on the management of sexual violence cases in the health zones of Dilala and Manika	20-Feb-17	1-Mar-17	Kolwezi	25	41	66
137	Briefing of providers of the health zones of Lodja, Ototo, Bena-Dibele, and Kole on HBB,AMS, and SMK	16-Feb-18	6-Mar-18	Kole	50	39	89
138	Briefing of trainers and HZMTs on the IQA and practical training in the health zones of the Lualaba DPS	5-Feb-18	11-Feb-18	Kolwezi	36	5	41
139	Data quality enhancement efforts: RDQA and support for monthly reviews in Luiza coordination	27-Feb-18	3-Mar-18	Kasai Central	12	0	12
140	Data quality enhancement efforts: RDQA and support for monthly reviews in the Sankuru DPS	27-Feb-18	3-Mar-18	Kole	12	0	12
141	Briefing of providers of the health zone of Bibanga on HBB,AMS, and SMK	6-Feb-18	9-Feb-18	Mwene Ditu	12	1	13
142	Briefing of providers of the health zone of Mpokolo on HBB, AMS, and SMK	6-Feb-18	9-Feb-18	Mwene Ditu	11	10	21
143	Briefing of providers of the health zone of Kanda Kanda on HBB, AMS, and KMC	8-Feb-18	10-Feb-18	Mwene Ditu	20	4	24
144	Briefing of providers of the health zones of Luputa on HBB,AMS, and KMC	11-Feb-18	14-Feb-18	Mwene Ditu	30	6	36
145	Briefing of trainers on the implementation strategy of the IQA in the DPS of Sankuru	27-Feb-18	3-Mar-18	Kole	12	0	12
146	Training of regional trainers on the implementation of the integrated supervision approach in the DPS of Sud Kivu	7-Mar-18	10-Mar-18	Bukavu	19	1	20
147	Briefing of trainers and HZMTs on the IQA and practical training in the health zones of the DPS of Bukavu	26-Feb-18	5-Mar-18	Bukavu	41	4	45
148	Briefing of providers of the health zones of Lodja, Dikungu, Omendjadi, and Tshumbe on HBB,AMS, and SMK	8-Mar-18	21-Mar-18	Kole	73	57	100
149	Briefing of trainers and HZMTs on the IQA in the health zones of the DPS of Luiza	15-Feb-18	24-Feb-18	Kolwezi	12	0	12
150	Briefing of CBDs in the health zone of Lualaba, coupled with the FP mini-campaign supervised by Kolwezi	22-Mar-18	1-Apr-18	Kolwezi	12	4	16

N°	Training Topic	Dates		Location	Participants		
		Start	End		M	F	T
151	Briefing of CBDs in four Sud Kivu health zones (Walungu, Katana, Nundu, Minova), coupled with FP mini-campaign supervised by Bukavu	26-Feb-18	5-Mar-18	Bukavu	63	37	100
152	Data quality enhancement visit: RDQA and support for monthly reviews in the health zones of Yangala and Kalomba	5-Feb-18	13-Feb-18	Luiza	78	9	87
153	Briefing of providers of the health zones of Mwene Ditu on HBB, AMS, and KMC	2-Feb-18	5-Feb-18	Mwene Ditu	27	3	30
154	Briefing of CBDs in the two Lomami health zones (Kamiji and Luputa), coupled with mini-campaign on FP supervised by Mwene Ditu	12-Feb-18	17-Feb-18	Mwene Ditu	23	11	34
155	Briefing of CBDs in the six Sankuru health zones (Dikungu, Lodja, Lomela, Omendjadi, Tshumbe, Wembonyama), coupled with mini-campaign on FP supervised by Kole	9-Mar-18	20-Mar-18	Kole and Tshumbe	73	57	130
156	Data quality enhancement efforts: RDQA and support for monthly reviews	9-Apr-18	13-Apr-18	Luiza	12	0	12
157	Training of regional trainers on the implementation of the integrated supervision approach in the DPS of Lualaba	8-May-18	12-May-18	Kolwezi	24	3	27
158	Training of regional trainers on the implementation of the integrated supervision approach in the DPS of Sankuru	8-May-18	11-May-18	Kole	22	3	25
159	Briefing of providers in health zones of Uvira coordination on HBB, AMS, and KMC	26-Apr-18	8-May-18	Bukavu	82	76	158
160	Training of regional trainers on the implementation of the integrated supervision approach in the DPS of Kasai Oriental	7-May-18	12-May-18	Luiza	15	2	17
161	Training of regional trainers on the implementation of the integrated supervision approach in the DPS of Lomami	7-May-18	12-May-18	Mwene Ditu	11	3	14
TOTAL					6,025	1,914	7,909

Appendix 7. Documents and/or Tools Developed by the MOH with support from DRC-IHPplus

N°	Document Description	Purpose	Use		Participation Type			Status
			Internal	External	Technical	In-kind	Financial	
TB								
1	HIV-TB data collection tool		✓	✓	✓		✓	Distributed to health centers
2	Registration record of TB contact cases	Lists persons who help identify suspected cases of TB in the community	✓	✓	✓		✓	Distributed to health centers
3	Tool to centralize records of contact cases during mini-campaigns	Centralizes suspected cases and sorts them by category; this data collection tool is used during mini-campaigns.	✓	✓	✓			Distributed to local NGOs
EPI								
4	Data collection and management tool (revised version)	Updating tools with new vaccines to be used starting in Sept. 2018			✓			
5	Growth monitoring chart for girls and boys			✓			✓	Reprinting in progress
RBF								
6	Guide for the technical monitoring procedures of RBF services		✓	✓	✓		✓	
7	Invoice approval guide		✓	✓	✓		✓	
8	Indicator tool guide		✓	✓	✓		✓	
9	Handbook for the contracting and monitoring agency		✓	✓	✓		✓	
10	Community monitoring guide		✓	✓	✓		✓	
11	Portal user guide		✓	✓	✓		✓	
12	Guide for developing management plans		✓	✓	✓		✓	
13	Integrated supervision tools		✓	✓	✓		✓	Shared with DPS, BCZ, GRH, and health centers (during training sessions)
14	Guide for implementing the IQA		✓	✓	✓		✓	Shared with DPS, BCZ, GRH, and health centers (during training sessions)

N°	Document Description	Purpose	Use		Participation Type			Status
			Internal	External	Technical	In-kind	Financial	
MNCH								
15	iCCM case recording form (graphical)	Updated tools, 2016 version; reprinting for distribution to community care sites and health centers						
16	Register of sick-child visits to the community care site			✓	✓	✓		
17	Community care site trainer's guide			✓	✓			
18	Community care site implementation guide			✓	✓			
19	Job aids for CHWs working at community care sites			✓	✓	✓		
20	Supervisor's manual			✓	✓			
21	Community care site "RUMER" (Register for the record of essential drugs use and revenues)			✓	✓	✓		
22	Community care site monthly report			✓	✓	✓		
23	Community care site practical training manual			✓	✓			
24	Clinical IMNCI Form 0–2 months			✓	✓	✓		
25	Clinical IMNCI Form 2 months–5 years			✓	✓	✓		
26	Logbook of child consulting at the Health Center for illness			✓	✓			
27	Triage form for GRHs			✓	✓			
28	IMNCI Strategic Plan 2017–2021			✓	✓			
29	ENAP plan development: 2017–2020 Action Plan for each newborn				✓	✓		

N°	Document Description	Purpose	Use		Participation Type			Status
			Internal	External	Technical	In-kind	Financial	
Communication								
30	Social media survey to identify more effective ways of reaching youth and adolescents with sexual health messages, conducted in the health zones of Dilala and Manika, Lualaba province		✓	✓	✓		✓	
31	Evaluation of WASH services in rural areas of the WASH health zones of Luputa and Kanda Kanda		✓		✓		✓	
Malaria								
32	Evaluation of use of pre-referral treatment for severe malaria in community care sites in the DRC		✓	✓	✓		✓	
RH								
33	FP communication plan development		✓	✓	✓			Pending approval
34	RH strategic plan development		✓	✓	✓		✓	Pending approval
35	National Strategy for obstetric fistula eradication		✓	✓	✓			Pending approval

Appendix 8. Select Pharmaceutical Data

Table 1. IHPplus funding for storage and delivery of medicines to health facilities

			Storage Costs (USD)			Delivery Costs to Health Facility			TOTAL
Province	Warehouse (CDR)	PY	Malaria	HIV	FP	Malaria	HIV	FP	
Sud Kivu	APAMESK, 8th CEPAC, and BDOM	PY1	275,921		17,515	63,874			357,310
		PY2	97,519			61,998			159,517
Kasaï Central	CADIMEK	PY1	43,192		7,683	16,210			67,085
		PY2	44,789		4,052	15,326			64,167
Kasaï Oriental	CADMEKO	PY1	42,418			19,334			61,752
		PY2	37,219			37,914			75,133
Sankuru	CAMESANK	PY1	26,942			14,249			41,191
		PY2	32,722		2,740	36,795			72,257
Lualaba	CAMELU	PY1	38,834		9,665	33,825			82,324
		PY2	89,472	146,186	4,107	116,490			356,255
Kinshasa	CAMESKIN	PY1							0
		PY2		268,181			9,567		277,748
Order/Delivery Total			729,028	414,367	45,762	416,015	9,567	0	1,614,739

Table 2. Status of emergency order for eight EGMs

CDR	Total order value (USD)	Order delivered as of July 2018 (USD)	Order remaining to deliver as of July 2018 (USD)
APAMESK	106,275.35	67,493.28	38,782.07
BDOM Bukavu	97,469.01	72,239.97	25,299.04
CAMELU Kolwezi	55,026.97	55,026.97	0
CAMESANK – Lodja	195,226.29	162,112.39	33,113.90
CEPAC Bukavu / Depot Pharm	91,516.33	60,260.79	31,255.54
Depot Chemonics Kamina	15,257.03	15,257.03	0
MSH/CADIMEK – Kananga	74,681.84	29,315.70	45,366.14
MSH/CADMEKO – Mbuji Mayi	71,302.00	46,732.03	24,569.97
Order/Delivery Total	706,754.82	504,438.16	\$193,316.66
Level of execution	100%	72%	28%

Table 3. Health zone savings per province (from use of their EGM credit lines during IHP and IHPplus)

Province	CDR	Number of health zones	Funds available (USD)	Observations
Kasaï Central	CADIMEK	9	134,875	Funds managed by CADIMEK
Kasaï Oriental	CADMEKO	9	115,007	Funds managed by CADMEKO
Lualaba	CAMELU Kolwezi	8	11,802	Funds managed by health zones
Sankuru	CAMESANK	16	153,297	Funds managed by DPS
Sud Kivu	BDOM Bukavu	27	665,176	Funds managed by health zones in their respective bank accounts
	APAMESK			
	DCMP 8th CEPAC			
Haut Lomami	Chemonics warehouse (BRASSIMBA)	9	37,485	Funds managed by health zones in their respective bank accounts
Order/Delivery Total		78	1,117,641	

Appendix 9. Integrated Health Project Plus STTA and Conference Attendance PY1 – PY3

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
STTA/Project Management and Monitoring: International Travel PY1						
1	Program Management	Daniel Nelson	MSH	20 Jul–23 Aug 15	Serve as acting DCOP/Technical Director after the former DCOP's departure, while IHPplus recruited for a permanent DCOP	Washington, D.C. / Kinshasa
2	RBF	Alfred Antoine Uzabakiliho	MSH	26 Aug–3 Oct 15	Improve management and usability of the DRC-RBF web portal	Nairobi / Kinshasa
3	Program Management	Dixon Quenensse	OSC	6–19 Feb 16	Assist in the preparation and presentation of the IHPplus International SBCC Summit poster presentation, and assist with the orientation of three new BCC staff members	Newark / Kinshasa / Addis Ababa
4	RBF	Jean Kagubare	MSH	28 Feb–5 Mar 16	Conduct and support the second annual review workshop of the IHPplus RBF program	Boston / Kinshasa
5	MNCH	Stephanie York	MSH	11–19 Mar 16	Conduct needs assessments at seven hospitals in Bukavu, DRC, and surrounding villages in order to determine the composition of a prospective in-kind donation of medical supplies and equipment from Project C.U.R.E. to IHPplus	Newark / Bukavu
6	BCC	Lynn Lawry	OSC	14 Mar–4 Apr 16	Assess and monitor the newly-formed IHPplus independent (autonomous) Champion Communities that are mentored by established Champion Communities, as well as the new Champion Men initiative, and work with the BCC Technical Advisor and BCC field experts to create new reporting and auditing tools	Washington, D.C. / Kinshasa
7	Program Management	Kristin Cooney	MSH	19 Mar–1 Apr 16	Monitor project progress, work with project team on reporting requirements, meet with key partners and USAID, and provide technical inputs as needed to the IHPplus program activities	Boston / Kinshasa
8	BCC	Paul Neely	OSC	19 Apr–10 May 16	Assess the possibilities for an integrated Closed User Group (CUG) covering three telecom operators (Orange, Vodacom, and Airtel) with an emphasis on recommending immediate next steps	Montreal / Kinshasa

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
9	Operations	John McKenney	MSH	18–26 May 16	Assess country security, review the security policy, plans, and guidelines; meet with the County Operations Management Unit, MSH's DRC security committee, and country team; and review the transportation and communication plan	Boston / Kinshasa
10	Program Management	Jeanne Hamon	MSH	7 May–18 Jun 16	Finalize and submit the IHPplus PY1Q3 progress report, prepare for and participate in the PY2 workplanning workshop, and provide project management support to advance other key deliverables	Boston / Kinshasa
International Travel: IHPplus Local Staff and Partners PY1						
1	HIV/AIDS	Dorah Kashosi	MSH	15–20 Nov 15	Participate in the 2015 “Accelerating Children’s HIV/ AIDS Treatment (ACT) Initiative” Regional Workshop	Kinshasa / Lusaka
2	RBF	Delmond Kyanza	MSH	11–18 Dec 15	Attend the 8th Annual Conference on the Science of Dissemination and Implementation and deliver a poster presentation on “Motivating village health development committees with incentives based on performance to improve service utilization rates in DRC”	Kinshasa / Washington, D.C.
3	Nutrition	Matthieu Koy	MSH	17–23 Jan 16	Attend the West Africa “Multi-Sectoral Nutrition Strategy and Global Learning and Evidence Exchange” (MSN-GLEE) conference	Kinshasa / Accra
4	MNCH/ Malaria	Jeanine Musau	MSH	14–20 Feb 16	Attend a meeting on “Scaling up i-CCM in the context of the UNICEF-GFATM Memorandum of Understanding,” organized by UNICEF, and a conference on implementing pre-referral rectal artesunate as a treatment for severe malaria cases, organized by the Medicines for Malaria Venture	Kinshasa / Nairobi
5	MNCH/ Malaria	Jean-Fidèle Ilunga	MOH	14–20 Feb 16	Attend a meeting on “Scaling up i-CCM in the context of the UNICEF-GFATM Memorandum of Understanding,” organized by UNICEF, and a conference on implementing pre-referral rectal artesunate as a treatment for severe malaria cases, organized by the Medicines for Malaria Venture	Kinshasa / Nairobi

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
6	BCC	Jean Baptiste Mputu	OSC	7–11 Feb 16	Attend the First International Summit on SBCC and deliver a poster presentation on “The Contribution of the Champion Communities Approach to Healthy Behaviors and Utilization of Health Services in the DRC”	Kinshasa / Addis Ababa
7	MNCH	Dorah Kashosi	MSH	14–22 Apr 16	Attend the 13th Annual Global Health & Innovation Conference and deliver two poster presentations on “Saving Lives and Improving Health in the DRC: A Health Systems Approach to Saving Mothers and Neonates” and “Breathing Easier in DRC: Simple Technology Saves Newborn Lives,” and visit MSH’s headquarter offices in Medford to share project experiences and lessons learned from the conference	Kinshasa / New Haven / Boston
8	MNCH	Narcisse Naia Embeke	MSH	14–22 Apr 16	Attend the 13th Annual Global Health & Innovation Conference and deliver two poster presentations on “Saving Lives and Improving Health in the DRC: A Health Systems Approach to Saving Mothers and Neonates” and “Breathing Easier in DRC: Simple Technology Saves Newborn Lives,” and visit MSH’s headquarter offices in Medford to share project experiences and lessons learned from the conference	Kinshasa / Hartford / Boston

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
STTA/Project Management and Monitoring: International Travel PY2						
1	DHIS 2	Ismail Yusuf Koleleni	MSH	17 Jul-1 Aug 16	Finalize pending DHIS2 tasks as per workplan activities and train IHPplus users on new features which have been integrated into the system	Washington, D.C./ Kinshasa
2	BCC	Lynn Lawry	OSC	19 Aug-10 Sep 16	To assess the status of IHPplus’ Champion Community sustainability efforts, with an emphasis on assessing their efficiency in obtaining and using grant funds and in exercising their status as NGOs to achieve new community driven BCC campaigns	Washington, D.C./ Kinshasa

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
3	BCC	Paul Neely	OSC	3-24 Sep 16	Update the CommCare application to include maternal, newborn, and child health (MNCH), nutrition, and family planning indicators and implement the application and support its implementation within the IHPplus Champion Communities	Montreal/Kinshasa
4	BCC	Paul Neely	OSC	26 Nov-14 Dec 16	Implement the CommCare data collection application in the Kolwezi coordination	Montreal/Kinshasa
5	HIV/AIDS	Kanjinga Kakanda	MSH	6-22 Feb 17	Provide technical assistance in the implementation of the Electronic Dispensing Tool in the Haut Katanga and Lualaba provinces	Washington, D.C./ Kinshasa
6	Program Management	Kristin Cooney	MSH	18 Feb-10 Mar 17	Monitor project progress, work with project team on reporting requirements, meet with key partners and USAID, and provide technical inputs as needed to the DRC-IHPplus program activities	Boston/Kinshasa
7	BCC	Lynn Lawry	OSC	18 Feb-14 Mar 17	Assess the sustainability of the IHPplus Champion Communities in Mwene Ditu	Washington, D.C./ Kinshasa
8	Communications	David Aronson	MSH	2 Mar-2 Jun 17	Support IHPplus to communicate project successes and results to decision-makers and stakeholders	Washington, D.C./ Kinshasa
9	M&E	Monita Baba Djara	MSH	4-11 Mar 17	Provide support for developing protocols for the planned WASH survey, orient the M&E team on documenting lessons learned and share new orientations and strategies of MSH's M&E at the global level, and review the project M&E plan and staffing	Washington, D.C./ Kinshasa
10	MNCH/FP/RH	Kate Ramsey	MSH	18 Mar-8 Apr 17	Provide technical support to IHPplus FP/RH and MNCH activities and to document end-of-project results	New York/Kinshasa
11	BCC	Lynn Lawry	OSC	16 Apr-10 May 17	Assess IHPplus Champion Communities with small grants funding in Bukavu, Kolwezi, Uvira, and Lodja	Washington, D.C./ Kinshasa

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
International Travel: IHPplus Local Staff and Partners PY2						
1	Finance	Desiré Zongo	MSH	10-29 Aug 16	Complete the Inside NGO trainings "Financial Management for US Government Funding" in Addis Ababa and "USAID Rules and Regulations: Grants and Cooperative Agreements" in Boston, and receive an introduction to the MSH organizational structure and an orientation to MSH and IHPplus at MSH's headquarter offices in Medford	Kinshasa-Addis Ababa-Boston
2	Program Management	Hortense Angoran-Benié	MSH	10-29 Aug 16	Complete the Inside NGO trainings "Financial Management for US Government Funding" in Addis Ababa and "USAID Rules and Regulations: Grants and Cooperative Agreements" in Boston	Abidjan-Addis Ababa-Boston
3	M&E	Moussa Traore	MSH	14-29 Aug 16	Complete the Inside NGO training: "USAID Rules and Regulations: Grants and Cooperative Agreements" in Boston, and receive an introduction to the MSH organizational structure and an orientation to MSH and IHPplus at MSH's headquarter offices in Medford	Kinshasa-Boston
4	EPI	Joseph Kongolo	MSH	10-16 Sep 16	Attend the EPI Managers' meeting organized by the World Health Organization (WHO) Inter-country Support Team for Central Africa, to strengthen and improve access to immunization services in 10 countries in Central Africa	Kinshasa/Douala
5	RBF	Florence William Mpata	MSH	19 Sep-6 Oct 16	Attend the African Health and Economics Policy Association Fourth Biennial Scientific Conference and deliver an oral presentation on "Les facteurs déterminants de la satisfaction des usagers des services de santé dans la ZS de Luiza en RDC"	Kinshasa/Rabat
6	Malaria	Jeanine Musau	MSH	25 Sep-1 Oct 16	Attend the Roll Back Malaria Communication Community of Practice Third Annual Meeting and deliver an oral presentation on "The Contribution of the Champion Communities Approach to Healthy Behaviors and Utilization of Health Services in the DRC"	Kinshasa/Dakar

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
7	BCC	Jean Baptiste Mputu	OSC	25 Sep-1 Oct 16	"Attend the Roll Back Malaria Communication Community of Practice Third Annual Meeting and deliver an oral presentation on ""The Contribution of the Champion Communities Approach to Healthy Behaviors and Utilization of Health Services in the DRC"""	Kinshasa/Dakar
8	Nutrition	Matthieu Koy Matili	MSH	23 Oct-10 Nov 16	Attend the American Public Health Association (APHA) 2016 Conference to present four abstracts on IHPplus interventions in the areas of malaria, nutrition, WASH, and RBF, and visit the MSH headquarters in Medford before and after the conference to prepare their presentations and share findings from the conference with colleagues	Kinshasa/Boston/ Denver
9	Malaria	Jeanine Musau	MSH	23 Oct-10 Nov 16	Attend the APHA 2016 Conference to present four abstracts on IHPplus interventions in the areas of malaria, nutrition, WASH, and RBF, and visit the MSH headquarters in Medford before and after the conference to prepare their presentations and share findings from the conference with colleagues	Kinshasa/Boston/ Denver
10	RBF	Freddy Tshamala	MSH	23 Oct-10 Nov 16	Attend the APHA 2016 Conference to present four abstracts on IHPplus interventions in the areas of malaria, nutrition, WASH, and RBF, and visit the MSH headquarters in Medford before and after the conference to prepare their presentations and share findings from the conference with colleagues	Kinshasa/Boston/ Denver
11		Narcisse Naia Embeke	MSH	12-26 Nov 16	Attend the Fourth Global Symposium on Health Systems Research and deliver an oral presentation on "Improving the usage and quality of maternal and child health services with RBF in the DRC" and a poster presentation on "Saving lives and improving health in the DRC: A health systems approach to saving mothers and neonates," and visit MSH's headquarters in Medford to share his presentation and experiences with MSH colleagues	Kinshasa-Vancouver-Boston

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
12	MNCH	Narcisse Naia Embeke	MSH	26-31 Mar 17	Attend the Institutionalizing Community Health Conference and deliver an oral presentation on "The involvement of community-based organizations: a major factor in the success of RBF projects"	Kinshasa-Johannesburg
13	RBF	Augustin Mwala	MSH	26-31 Mar 17	Attend the Institutionalizing Community Health Conference and deliver an oral presentation on "The involvement of community-based organizations: a major factor in the success of RBF projects"	Kinshasa-Johannesburg
14	RBF	Célestin Bukanga	MOH	26-31 Mar 17	Attend the Institutionalizing Community Health Conference and deliver an oral presentation on "The involvement of community-based organizations: a major factor in the success of RBF projects"	Kinshasa-Johannesburg
15	M&E	Derek Kahongo	MSH	22 Apr-8 May 17	Attended a regional training seminar on monitoring and evaluating HIV and AIDS programs	Kinshasa/Dakar
16	M&E	Alidor Kuamba	MSH	22 Apr-8 May 17	Attended a regional training seminar on monitoring and evaluating HIV and AIDS programs	Kinshasa/Dakar
17	Contracts	Nathalie Mansubi	MSH	6-12 May 17	Attend the Inside NGO training: "USAID Rules and Regulations: Grants and Cooperative Agreements"	Kinshasa/Dakar
18	Contracts	Patricia Kakassi	MSH	6-12 May 17	Attend the Inside NGO training: "USAID Rules and Regulations: Grants and Cooperative Agreements"	Kinshasa/Dakar

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
STTA/Project Management and Monitoring: International Travel PY3						
1	HR	Nadine Murebwayire	MSH	9-30 Oct 17	Provide closeout support to IHPplus with a focus on HR activities	Kigali/Kinshasa
2	Program Management	Kristin Cooney	MSH	2-17 Nov 17	Monitor project progress, work with project team on reporting requirements, meet with key partners and USAID, and provide technical inputs as needed to the DRC-IHPplus program activities	Boston/Kinshasa

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
3	TB	Muluken Melese	MSH	4-17 Mar 18	Review current PMP and targets with the IHPplus team, assess the current project implementation by visiting the TB DOTs programs in communities and health facilities, and hold discussions with the IHPplus TB team and the provincial TB managers on current performance, gaps, and strategies to improve TB DOTs	Washington, D.C./ Kinshasa
4	MNCH/FP/RH	Kate Ramsey	MSH	9-25 Mar 18	Provide technical support to IHPplus FP/RH and MNCH activities and document end-of-project results	New York/Kinshasa
5	Program Management	Dixon Quenensse	OSC	11-22 Mar 18	Provide management support for the resumption of IR 3 activities under the new subaward for OSC	Paris/Kinshasa/ Philadelphia
6	Program Management	Robert Arsenault	OSC	16-23 Mar 18	Provide technical and management support for the resumption of IR 3 activities under the new subaward for OSC	Philadelphia/ Kinshasa
7	BCC	Lynn Lawry	OSC	10 Mar-9 Apr 18	Plan regional conferences for Champion Communities, start the final Champion Community report and Champion Community manual, and review final reports of the small grants program for Champion Communities	Washington, D.C./ Kinshasa
8	BCC	Lynn Lawry	OSC	20 Apr-20 May 18	Attend the Champion Community Regional Exchanges in Bukavu and Lubumbashi, support the production of the Champion Community mini-documentary, and finalize the IR3 section of the IHPplus final report	Washington, D.C./ Kinshasa
9	Program Management	Dixon Quenensse	OSC	10-24 May 18	Attend the Champion Community Regional Exchanges in Bukavu and Lubumbashi and assist with the filming, coordination, and storyboarding of the Champion Community mini-documentary; consolidate reports from the four Champion Community Regional Exchanges; and provide support to the BCC team to draft the IR3 section of the IHPplus final report	Philadelphia/Goma/ Kinshasa

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
10	BCC	Donald Mitchell	OSC	10 May-9 Jun 18	Attend the Champion Community Regional Exchanges in Bukavu and Lubumbashi, and create a high quality mini-documentary featuring the conference proceedings as well as Champion Community activities in the Bukavu coordination	Philadelphia/Goma/Kinshasa
11	Communications	Eleonora Kinnicutt	MSH	25 Apr-18 May 18	Provide support to end-of-project documentation through taking photographs and collecting personal testimonials from beneficiaries and stakeholders in Kinshasa and at IHPplus field sites, to be included in the IHPplus final report	Boston/Kinshasa
12	Communications	Sarah Ranney	MSH	25 Apr-24 May 18	Provide support to end-of-project documentation through taking photographs and collecting personal testimonials from beneficiaries and stakeholders in Kinshasa and at IHPplus field sites, to be included in the IHPplus final report	Boston/Kinshasa
13	Communications	Rebecca Weaver	MSH	2-24 May 18	Provide support to end-of-project documentation through taking photographs and collecting personal testimonials from beneficiaries and stakeholders in Kinshasa and at IHPplus field sites, to be included in the IHPplus final report	Nairobi/Goma/Kinshasa
14	Program Management	Kristin Cooney	MSH	26 May-14 Jun 18	Provide monitoring, supervision, and technical and management support to IHPplus, with a focus on close-out priorities	Boston/Kinshasa
15	Program Management	Dixon Quenensse	OSC	6-22 Jun 18	Backstop the BCC Technical Advisor in all activities relating to the transition and close out of BCC programming and the transition of activities to project partners	Philadelphia/Kinshasa
International Travel: IHPplus Local Staff and Partners PY3						
1	RBF	Augustin Mwala	MSH	4-15 Jul 17	Attend the International Health Economics Association Conference and deliver two oral presentations on IHPplus' RBF experience in seven health zones in the DRC, and visit the MSH headquarters in Medford to share findings from the conference with colleagues	Kinshasa/Boston

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
2	RBF	Célestin Bukanga	MOH	4-15 Jul 17	Attend the International Health Economics Association Conference and deliver two oral presentations on IHPplus' RBF experience in seven health zones in the DRC, and visit the MSH headquarters in Medford to share findings from the conference with partners	Kinshasa/Boston
3	HIV/AIDS	Emmanuel Mulowayi	MSH	17 Jul-2 Aug 17	Attend the 9th Annual International AIDS Society Conference on HIV Science and deliver a poster presentation entitled "Therapeutic Outcomes of TB-HIV Co-Infected Patients in the Lualaba Mining Province in the DRC"	Kinshasa/Paris
4	HIV/AIDS	Robert Tuala Tuala	MSH	17 Jul-2 Aug 17	Attend the 9th Annual International AIDS Society Conference on HIV Science and deliver a poster presentation entitled "Therapeutic Outcomes of TB- HIV Co-Infected Patients in the Lualaba Mining Province in the DRC"	Kinshasa/Paris
5	Nutrition	Matthieu Koy Matili	MSH	1-9 Nov 17	Visit the MSH headquarters in Medford to prepare their presentations, and attend the APHA 2017 Conference to deliver a poster presentation entitled "Improving the proportion of HIV-positive patients treated with Isoniazid Preventive Therapy (IPT) in Lualaba" and three oral presentations entitled "Impact of nutrition interventions on child survival;" "Therapeutic outcome of TB/HIV co-infected patients;" and "EID Saves Lives in Lualaba."	Kinshasa/Boston/ Atlanta

N°	Technical Area	Traveler's Name	Organization	Travel Dates	Indicative Scope of Work	Origin / Destination
6	HIV/AIDS	Dorah Kashosi	MSH	1-9 Nov 17	Visit the MSH headquarters in Medford to prepare their presentations, and attend the APHA 2017 Conference to deliver a poster presentation entitled "Improving the proportion of HIV-positive patients treated with Isoniazid Preventive Therapy (IPT) in Lualaba" and three oral presentations entitled "Impact of nutrition interventions on child survival," "Therapeutic outcome of TB/HIV co-infected patients," and "EID Saves Lives in Lualaba."	Kinshasa/Boston/ Atlanta
7	M&E	Moussa Traore	MSH	17-24 Mar 18	Participate in the fourth annual DHIS2 Symposium and present key findings from the abstract entitled "Strengthening Health Data Reporting by Integrating National and Project DHIS2 Instances: Experience from DRC"	Kinshasa/ Washington, D.C.



Photo : Lynn Lawry, OSC

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