USAID INTEGRATED HEALTH PROGRAM

Fiscal Year 2019 Quarterly Report 3 (April 1 through June 30, 2019)

Submitted August 15, 2019

Approved on September 20, 2019

DISCLAIMER
This report is made possible by the support of the American People through the United States Agency for International Development (USAID). The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

Recommended Citation: USAID Integrated Health Program. “Fiscal Year 2019 Quarterly Report 3 (April 1 through June 30, 2019).” Prepared for USAID IHP by Abt Associates, Rockville, Maryland, August 15, 2019.

Submitted to: Richard Matendo, COR, Maternal & Child Health Program Specialist, Health Office, USAID/Democratic Republic of the Congo, (+243 81 555 4514), Kinshasa, DRC.

Cover Photo: In May 2019, USAID IHP helped train community health workers in Lualaba province, who conducted an awareness campaign in the Fungurume Market to connect families with contraceptive methods and information. Photo: Landry Malaba, Abt Associates for USAID IHP.

Abt Associates. I 6130 Executive Boulevard I Rockville, Maryland 20814 I

T. 301.347.5000 I www.abtassociates.com

With:

International Rescue Committee (IRC)
BlueSquare
Mobile Accord/Geopoll
Viamo
Pathfinder International
Training Resources Group (TRG)
i+Solutions
Matchboxology

USAID INTEGRATED HEALTH PROGRAM

Fiscal Year 2019 Quarterly Report 3 (April 1 through June 30, 2019)

Contract No.: 72066018C00001

DISCLAIMER: This report is made possible by the support of the American People through the United States Agency for International Development (USAID). The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

TABLE OF CONTENTS

Table of Contents i

LIst of Tables iii

Acronyms and Abbreviations iv

1. Introduction 1

1.1 Programmatic and Geographic Scope 1

1.2 Partnerships 1

2. Program Management 3

2.1 Program Implementation 3

2.2 Program Staffing 4

2.3 Program Operations 5

2.4 Security 6

3. Objective 1 7

IR 1.1: Enhanced Capacity to Plan, Implement, and Monitor Services at Provincial, Health Zone, and Facility Levels 8

IR 1.2: Improved Transparency and Oversight in Health Service Financing and Administration at Provincial, Health Zone, Facility, and Community Levels 9

IR 1.3: Strengthened Capacity of Community Service Organizations and Community Structures to Provide Health System Oversight 10

IR 1.4: Improved Effectiveness of Stakeholder Coordination at the Provincial and Health Zone Levels 11

IR 1.5: Improved Disease Surveillance and Strategic Information Gathering and Use 13

IR 1.6: Improved Management and Motivation of Human Resources for Health 16

IR 1.7: Increased Availability of Essential Commodities at Provincial, Health Zone, Facility, and Community Levels 16

IR 1.8: Strengthened Collaboration between Central and Decentralized Levels through Sharing of Best Practices and Contributions to Policy Dialogue 18

Objective 1 Summary 18

4. Objective 2 21

IR 2.1 Increased Availability of Quality, Integrated Facility-Based Health 22

IR 2.2 Increased Availability of Quality, Integrated Community-Based Health Services 31

IR 2.3 Improved Referral System from Community-Based platforms to health centers and referral hospitals 35

IR 2.4 Improved Health Provider Attitudes and Interpersonal Skills at Facility and Community Levels 35

IR 2.5 Increased Availability of Innovative Financing Approaches 36

IR 2.6 Improved Basic Facility Infrastructure and Equipment to Ensure Quality Services 36

IR 2.7 Strengthened Collaboration between Central and Decentralized Levels through Sharing of Best Practices and Contributions to Policy Dialogue 37

Objective 2 Summary 39

5. Objective 3 42

IR 3.1 Increased Practice of Priority health Behavior at Individual, Household and Community Levels 43

IR 3.2: Increased Use of Facility and Community Based Health Services 50

IR 3.3: Reduced Socio-Cultural Barriers to the Use of Health Services and the Practice of Key Healthy Behaviors 52

IR 3.4: Strengthened Collaboration between Central and Decentralized Levels through Sharing of Best Practices and Contributions to policy Dialogue 53

Objective 3 Summary 53

6. Cross-Cutting Areas 55

6.1 Institutionalization and Sustainability of Gender Equality 55

6.2 Conflict Sensitivity 56

6.3 Capacity Building 56

6.4 Environmental Mitigation and Monitoring 57

7. Activity Research, Monitoring, and Evaluation 58

8. Lessons Learned 61

Annex A: Performance Indicators, Targets, and Achievements 62

Annex B: Success Stories 84

Annex C: Staff Hired During FY2019 Quarter 3 94

Annex D: Environmental Mitigation and Monitoring Report 97

LIST OF TABLES

Table 1: Where USAID IHP works 1

Table 2: USG-assisted service delivery points that experienced a stock-out of selected tracer drugs* at any time during the reporting period 17

Table 3: Number of carriers trained on secure specimen transportation and infection control by province and region during the quarter April-June 2019 27

Table 4: Investigation results of contact-subjects of TB index cases in four provinces, April–June 2019 29

Table 5: Number of cases of malaria, pneumonia, and diarrhea treated at USAID IHP-supported iCCM sites, April–June 2019 31

Table 6: Number of children under 5 who received treatment for an acute respiratory infection from an appropriate provider, April–June 2019 32

Table 7: Number of cases of diarrhea in children under 5 treated in USG-supported provinces, April–June 2019 33

Table 8: Retraining for community-based family planning actors in Wikong ZS in Lomami, April–June 2019 34

Table 9: Number of people reached through SBC campaigns, April–June 2019 49

Table 10: Number of acceptors new to modern contraception in USG-supported family planning service delivery points 50

Table 11. Do No Harm Workshop participant attendance by region 56

Table 12. Participants in USAID IHP M&E Systems and Procedures Orientation 58

ACRONYMS AND ABBREVIATIONS

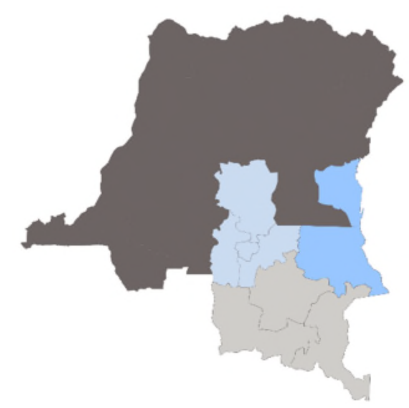
ACT	Artemisinin-based combination therapy
AMEP	Activity Management and Evaluation Plan
ANC	Antenatal care
BCZS	*Bureau Central de la Zone de Santé* (Office of the Health Zone Team)
BEmONC	Basic emergency obstetric and newborn care
CAD	*Club des Amis Damien* (Club for the Friends of Damien)
CADIMEK	*Centrale d'Achat, d'Administration et de Distribution des Médicaments Essentiels du Kananga* (Office for the Purchase, Supply and Distribution of Essential Medicines in Kananga)
CAMELU	*Centrale d'Achat des Médicaments Essentiels de Lubumbashi* (Office for the Purchase of Essential Medicines in Lubumbashi)
CBD	Community-based distributor (community health worker trained in family planning)
CCTM	*Cellule de Coordination de la Tuberculose Multirésistante* (Multidrug-Resistant Tuberculosis Coordination Unit)
CDCS	Country Development Cooperation Strategy
CEmONC	Comprehensive emergency obstetric and newborn care
CHW	Community health worker
CLA	Collaborating, learning, and adapting
CNP-SS	*Comité National de Pilotage du Secteur de la Santé* (National Health Sector Steering Committee)
CODESA	*Comité de Développement de l'Aire de Santé* (Health Area Development Committee)
CPA	Complementary package of activities
CPLT	*Coordination Provinciale de Lutte contre la Tuberculose* (Provincial Committee for Tuberculosis Control)
CPN	*Consultation prénatale* (prenatal consultation)
CPP-SS	*Comité Provincial de Pilotage du Système de la Santé* (Provincial Health System Steering Committee)
CPR	Cardiopulmonary resuscitation
CRS	Catholic Relief Services
CSO	Community service organization
CTMP-PF	*Comité Technique Multisectoriel Permanent pour la Planification Familiale* (Permanent Multisectoral Technical Committee for Family Planning)
CYP	Couple years of protection
D4I	Data for Impact
DBC	*Distributeurs de base communautaire* (community health workers trained in family planning)
DFSA	Development Food Security Activities
DHIS2	District Health Information System 2
DPS	*Division Provinciale de la Santé* (Provincial Health District)
DRC	Democratic Republic of the Congo
DSNIS	*Direction du Système National d'Information Sanitaire* (Directorate for the National Health Information System)
E2A	Evidence to Action
ECDPS	*Equipe cadres de la DPS* (Executive Team of the Provincial Health Districts)

ECZS	*Equipe Cadre de la Zone de Santé* (Health Zone Management Team)
EDL	*Enquête d'état des lieux* (service delivery mapping survey)
EDM	*Enquête de ménage* (household survey)
EDS	*Enquête Démographique et de Santé* (Demographic and Health Survey)
EEI	*Equipe d'Encadrement Intégré* (Integrated Support Team)
EMMP	Environmental Mitigation and Monitoring Plan
EMMR	Environmental Mitigation and Monitoring Report
ETD	*Entité Territoriale Décentralisée* (Decentralized Territorial Entity)
FARCD	*Forces Armées de la République Démocratique du Congo* (Armed Forces of the DRC)
FFP	Food for Peace
FOSA	*Formation sanitaire* (health facility)
FP	Family planning
FY	Fiscal year
GBV	Gender-based violence
GDRC	Government of the Democratic Republic of the Congo
GHSC-TA	Global Health Supply Chain-Technical Assistance Project
GIBS	*Groupe Interbailleurs Santé* (International Health Donors Group)
HCD	Human-centered design
HMIS	Health Management Information System
HSS	Health systems strengthening
iCCM	Integrated community case management
IEE	Initial Environmental Examination
IGA	Integrated Governance Activity
IHPplus	Integrated Health Project Plus
iHRIS	Integrated Human Resource Information System
IPM	Informed Push Distribution Model
IPS	*Inspection Provinciale de la Santé* (Provincial Health Inspectorate)
IPTp	Intermittent preventive treatment for pregnant women
IR	Intermediate result
IRB	Institutional review board
IRC	International Rescue Committee
IT	Information technology
ITN	Insecticide-treated net
IVR	Interactive voice response
LLIN	Long-lasting insecticidal nets
LMIS	Logistics Management Information System
LNAC	*Ligue Nationale Antituberculeuse et anti-lépreuse du Congo* (National Anti-tuberculosis and Anti-leprosy Association of Congo)
LNRM	*Laboratoire National de Référence de Mycobactériologie* (National Referral Laboratory for Mycobacteriology)
M&E	Monitoring and evaluation
MDR-TB	Multi-drug resistant TB
MDSR	Maternal death surveillance and response
MECC	Monitoring, Evaluation and Coordination Contract
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, neonatal, and child health
MMR	Maternal mortality rate

MOH	Ministry of Health (*Ministère de la Santé*)
MPA	Minimum package of activities
MR	Mortality rate
NGO	Nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ORS	Oral rehydration salts
PAO	*Plan d'Action Opérationnel* (Annual Operations Plan)
PCIMNE	*Prise en Charge Intégrée de la Maladie du Nouveau-né et de l'Enfant* (Integrated Management of Newborn and Infant Illness)
PDSS	*Projet de Développement de Système de la Santé* (Health Care System Development Project)
PEV	*Programme Elargi de Vaccination* (Expanded Program on Immunization)
PICAL	Participatory Institutional Capacity Assessment and Learning
PIRS	Performance Indicator Reference Sheet
PITT	Performance Indicator Tracking Table
PMR	Project monitoring report
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	*Programme National de Lutte contre le Paludisme* (National Program to Combat Malaria)
PNLT	*Programme National de la Lutte Contre la Tuberculose* (National Program to Combat Tuberculosis)
PNSR	*Programme National de la Santé de la Reproduction* (National Program for Reproductive Health)
PRODS	*Programme de Renforcement de l'Offre et Développement de l'Accès aux Soins de Santé* (Program for Strengthening of Supply and Development of Access to Health Care)
PRONANUT	*Programme National de Nutrition* (National Nutrition Program)
RBF	Results-based financing
RDT	Rapid diagnostic test
RECO	*Relais communautaire* (community health worker)
RH	Reproductive health
RME	Research, monitoring, and evaluation
RR-TB	Rifampicine-resistant TB
RR/MDR-TB	Rifampicine-resistant/multi drug-resistant TB
SBA	Skilled birth attendant
SBC	Social and behavior change
SDMR	*Surveillance de Décès Maternels et Riposte* (Surveillance and Response to Maternal Deaths)
SGBV	Sexual and gender-based violence
SMS	Short-messaging service
SNIS	*Système National d'Information Sanitaire* (National Health Information System)
SONU	*Soins obstétrico-néonatal d'urgence* (emergency obstetric and newborn care)
SONU B	*Soins obstétrico-néonatal d'urgence de base* (basic emergency obstetric and neonatal care)
S/P	Sulfadoxine/pyrimethamine
TB	Tuberculosis
TFP	Technical and financial partner
TIP	Trafficking in Persons

TIPTOP	Transforming Intermittent Preventive Treatment for Optimal Pregnancy
TRG	Training Resources Group
U5MR	Under 5 mortality rate
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID IHP	USAID Integrated Health Program
USG	United States Government
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
XDR-TB	Extensively drug-resistant TB
ZS	*Zone de santé* (health zone)

EXECUTIVE SUMMARY



USAID's Integrated Health Program (USAID IHP) in the Democratic Republic of the Congo (DRC) is designed to strengthen the capacity of Congolese institutions and communities to deliver quality integrated health services that sustainably improve the health status of men and women in target provinces. The Program works across nine provinces clustered in three regions in the country's southeast: Eastern Congo; Kasaï; and Katanga (see map). We are building on previous USAID health investments in the DRC, USAID's Country Development Cooperation Strategy (CDCS), and related Government of the DRC (GDRC) strategies and policies. We partner with the Ministry of Health (MOH) and with *zones de santé* (ZS, health zones) and *aires de santé* (health areas) within provinces, as well as communities and *Comités de Développement de l'Aire de Santé* (CODESA, Health Area Development Committees).

During the third quarter of fiscal year (FY) 2019, the Program laid essential groundwork for public organizational development that should improve health service management and delivery; strengthened health information systems for data-informed monitoring; and reached almost 30,000 women, men, and children through community campaigns on malaria, tuberculosis (TB), and family planning. USAID IHP also spent much of the quarter preparing for a significant reorientation toward private sector interventions, although circumstances downgraded this priority just after the quarter closed. With all 10 of our provincial offices open this quarter, we actively engaged with partners and counterparts and participated in several highly visible meetings and field visits.

USAID IHP Objectives

1. **Strengthen health systems, governance, and leadership** at provincial, health zone, and facility levels in target health zones
2. **Increase access to quality integrated health services** in target health zones
3. **Increase adoption of healthy behaviors**, including use of health services, in target health zones

Programmatic activities. Working within USAID IHP's three objectives (see box), as well as cross-cutting areas, we ramped up implementation this quarter, carrying out pivotal first-year initiatives.

Under Objective 1, the Program met our first-year target for organizational capacity building by facilitating institutional assessments of six *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) and two ZS. Staff performed guided self-assessments of their organizations with USAID's Participatory Institutional Capacity Building Assessment and Learning Index (PICAL), which will shape training and coaching plans for the upcoming year. We designed and developed a data completeness dashboard to help DPS understand whether their health data is actually being reported as expected. Our focus on supply chain management included defining supply chain distribution approaches specific to each ZS that will reduce stock-outs and lower transportation costs. This quarter, in eight of nine provinces, with fewer facilities reported a stock-out of an essential medicine. Overall, 50.7 percent of facilities reported a stock-out, against a target of 69.7 percent.

Under Objective 2, USAID IHP partnered with local health providers to fill essential gaps in health services to improve early detection and treatment of dangerous diseases and conditions. These included successful tracing of more than 5,000 people who had contact with TB index patients and treatment of nearly 70,000 children under 5 for malaria, pneumonia, and diarrhea at supported integrated community case management (iCCM) sites. We had some marked successes with treatment indicators, including in

the Katanga region, where we met 100.7 percent of the Program's target for children under 5 treated appropriately for diarrhea in United States Government-supported provinces. Some interventions were material—such as diesel for refrigerators to keep vaccines from spoiling and cups to observe pregnant women taking malaria prevention medication—while others focused on training providers on treatment and diagnosis. USAID IHP also began developing a field-based mobile data collection tool that will create a map of iCCM sites and track stocks of medications held at each site.

Under Objective 3, the Program trained hundreds of community health workers and providers to promote adoption of healthy behaviors that counteract negative social and cultural norms. Mini-campaigns for social and behavior change reached nearly 30,000 Congolese this quarter, while more than a quarter million people became new users of modern contraceptive methods in United States Government-supported service delivery points. We partnered with Breakthrough Action to develop and use a human-centered design (HCD) approach with local governments, health providers, and community members to shape social and behavior change messaging for the upcoming Healthy Family Campaign. The Program also supported 12 community forums in Haut-Katanga and Sud-Kivu that attracted 345 people to tackle their own health challenges—including construction of hygienic latrines—and in Haut-Lomami, we supported the DPS to investigate why members of a religious group refuse to vaccinate children.

In USAID IHP's cross-cutting areas, the Program organized trainings of our own staff and DPS teams and on Do No Harm Principles, conflict sensitivity, and zero tolerance of sexual abuse and exploitation. We funded a water, sanitation, and hygiene (WASH) workshop for the *Direction de l'Hygiène et Salubrité Publique* to validate "WASH Standards and Guidelines in Care Settings" and escorted and actively participated in the USAID/DRC Environmental Office visit to health centers in Sud-Kivu to review environmental standards.

Cooperation and collaboration. Through all interventions, USAID IHP partnered with MOH bodies and health system organizations, including DPS and ZS, and participated in key meetings of the *Comités Provinciaux de Pilotage du Système de la Santé* (Provincial Health System Steering Committees) and the *Comité National de Pilotage du Système de la Santé* (National Health System Steering Committee). Where our work overlaps with other donor projects, we are syncing our efforts. These include collaboration with the Global Health Supply Chain-Technical Assistance project on supply chain initiatives and with the Budikadidi project in Kasaï-Oriental and with the Development Food Security Activities in Sud-Kivu and Tanganyika on nutrition activities. We organized province-level meetings with the Integrated Governance Activity to discuss use of the PICAL tool, and prepared for handover of Challenge TB activities in five provinces. USAID IHP also presented our programming to the *Groupe Interbailleurs Santé* (GIBS, International Health Donors Group) and participated in a GIBS field visit to Haut-Katanga and Lualaba.

Looking forward. As USAID IHP moves into the last quarter of FY19, we are preparing to support the MOH's Healthy Family Campaign, drawing on information gleaned through our HCD approach and the lessons learned through social and behavior change interventions. We will ramp up our supply chain program to ensure essential medicines make it through the "last mile" to reach health facilities, no matter how remote or inaccessible. The Program will also complete our household surveys and service delivery mapping survey, giving us valuable data to measure results in coming years. With the MOH, we will kick off our learning agenda and research program, to ensure the Program contributes meaningful knowledge that strengthens the Congolese health system's ability to better serve its people.

1. INTRODUCTION

This report describes implementation of USAID's Integrated Health Program (USAID IHP) during the third quarter of USAID's fiscal year (FY) 2019 (April–June 2019). The goal of the Program is to work with the Government of the Democratic Republic of Congo's (GDRC's) Ministry of Health (MOH) and other stakeholders to strengthen the capacity of Congolese institutions and communities to deliver sustainable, quality, integrated health services that improve the health status of Congolese men and women. To meet this goal, USAID IHP has three objectives:

1) Strengthen health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones
2) Increase access to quality integrated health services in target health zones
3) Increase adoption of healthy behaviors, including use of health services, in target health zones

USAID IHP seeks to leverage the potential of decentralization and accelerate reductions in maternal, newborn, and child deaths. The program supports the MOH to tackle challenges identified in the *Plan National de Développement Sanitaire* (PNDS, National Health Development Plan) 2019–2022. We work within the country's existing health systems framework, especially by including communities and their respective health committees, known as *Comités de Développement de l'Aire de Santé* (CODESA, Health Area Development Committees), as prime stakeholders of a stronger health system.

1.1 PROGRAMMATIC AND GEOGRAPHIC SCOPE

Table 1: Where USAID IHP works

Region	Province	*Zones de Santé*
Eastern Congo	Sud-Kivu	34
	Tanganyika	11
Kasaï	Kasaï-Central	26
	Kasaï-Oriental	19
	Lomami	16
	Sankuru	16
Katanga	Haut-Katanga	26
	Haut-Lomami	16
	Lualaba	14
TOTAL		**178**

USAID IHP's programmatic scope covers six health technical areas: malaria; maternal, neonatal, and child health (MNCH); nutrition; reproductive health and family planning; tuberculosis (TB); and water, sanitation, and hygiene (WASH).

The Program works across three regional clusters—and Eastern Congo, Kasaï, and Katanga—and in nine provinces with 178 *zones de santé* (ZS, health zones), 6,030 health center catchment areas, and 2,878 integrated community case management (iCCM) sites. Certain activities also take into account the importance of economic corridors. These entities—*Divisions Provinciales de Santé* (DPS, Provincial Health Districts), ZS, communities, health centers, iCCM sites, etc.—are not equal targets or beneficiaries of USAID IHP's different technical programs. The Program tailors assistance to meet the needs and capacities of each ZS.

1.2 PARTNERSHIPS

Prime contractor Abt Associates leads a team of two core contract partners, the International Rescue Committee (IRC) and Pathfinder International, and six niche contract partners: Bluesquare, iPlusSolutions, Matchboxology, Mobile Accord/Geopoll, Training Resources Group (TRG), and Viamo.

USAID IHP collaborates with various stakeholders, including Breakthrough Action, Challenge TB, and the Integrated HIV/AIDS Project, and with other agencies and donors supporting health systems

strengthening. To ensure complementarity and leverage resources toward common goals, the Program coordinates closely with numerous programs funded by USAID and other donors, including Global Health Supply Chain-Technical Assistance (GHSC-TA) Project; the MEASURE Evaluation Phase IV project; the Integrated Governance Activity (IGA); the Food for Peace (FFP)-funded Budikadidi project and Development Food Security Activities (DFSA); the Data for Impact (D4I) project; the Evidence to Action (E2A) project; the *Projet de Développement de Système de la Santé* (PDSS, Health Care System Development Project); the *Programme de Renforcement de l'Offre et Développement de l'Accès aux Soins de Santé* (PRODS, Program for Strengthening of Supply and Development of Access to Health Care).

2. PROGRAM MANAGEMENT

2.1 PROGRAM IMPLEMENTATION

USAID IHP achieved pivotal first-year interventions this quarter, which will cascade to faster uptake of interventions and inform priorities. Examples include the following:

- *Institutional self-assessments* conducted in partnership with the DPS will set the pace and trajectory for multiple capacity-building interventions selected by the provinces. We used the Participatory Institutional Capacity Building Assessment and Learning Index (PICAL) tool to complete assessments of six DPS and two ZS this quarter, enabling us to meet our annual target.
- *Strategic supply chain interventions* conducted with GHSC-TA will ensure that investments in service delivery capacity lead to effective care and improved treatment for priority diseases at health facilities.
- *Strengthening the health information system* will bolster data-driven approaches for provincial and ZS capacity building and ensure effective program monitoring.
- *Key steps in our human-centered design* of behavior change communication content and strategy, carried out in collaboration with Breakthrough Action, will grow demand for service delivery.

These achievements took place despite internal and external challenges that led to programmatic delays. Below, we detail these challenges, our responses, and our initiatives to raise operational flexibility.

We also significantly raised the Program's visibility with the MOH and on-the-ground implementers through meetings with *Groupe Interbailleurs Santé* (GIBS, International Health Donors Group). During an April 4, 2019, meeting, Thibaut Mukaba, USAID's Family Planning and Reproductive Health Specialist, introduced Chief of Party Peter Eerens, who presented USAID IHP's alignment with national priorities and funding stream integration challenges. The Program also participated in a GIBS field visit to Haut-Katanga and Lualaba from May 27 to 31, 2019.

Addressing administrative delays

As USAID IHP implemented activities this quarter, home office and field leadership staff took a close look at the sources of administrative delays. In early June 2019, the Program instituted a decentralization plan to speed up disbursement of funds for activities in provinces and ZS. This should also accelerate operational and technical decisions and elevate technical standards across all activities.

Home office and field leadership teams conducted a joint review of the Program's administration and determined that a new position focused on operations would strengthen administrative capacity and response time, particularly considering the scale of the Program. The proposed staff change would split the duties of the current Director of Finance and Administration, who would retain oversight of finance, administration, and sub-grants. Human resources, logistics and procurement, subcontracts, and information technology (IT) would fall within the scope of a new Director of Operations, to be hired pending USAID approval.

Preparing for Trafficking in Persons Report restrictions

USAID IHP staff spent much of the quarter—from April 18 to June 30, 2019—preparing for a radical shift in Program implementation, triggered by USAID's announcement that the DRC, a Tier 3 country in the Trafficking in Person (TIP) Report, would likely not receive a waiver to secure the Program's

funding. This meant the Program's focus on government institutions would switch to non-government actors in the health system. Home office and field leadership responded quickly, conducting research, mapping, and workshops to shape a new approach.

As a starting point, the USAID IHP team drew on a 2018 study that Abt Associates conducted for the World Bank, "The Role of the Private Sector in Improving the Performance of the Health System in the Democratic Republic of Congo," which found that the private sector accounted for 46 percent of the DRC's 469 hospital structures in 2017 and offered numerous opportunities for collaboration. Our provincial staff then conducted an informal internal mapping exercise, uncovering faith-based organizations already integrated within the health sector that could begin joint activities with USAID IHP as soon as October. Working with for-profit organizations, which are more numerous in urban settings, would require longer-term planning.

In May, USAID IHP organized an internal workshop to design an implementation strategy exclusively focused on the private sector and to identify key activities with the MOH that could continue in the short term. On May 14, 2019, USAID approved the extension of the current work plan through June 30, 2019, and the submission in June of a July–September 2019 work plan. Two additional planning workshops in early June involved home office staff, provincial directors, regional directors, technical leads, and program subcontractors to explore a shift towards the private sector and options for transitioning to a Year 2 work plan. Of the three Program objectives, Objective 3 would be the least affected by the new focus, as it would just need a strategy to work with communities and conduct campaigns in collaboration with the MOH but without providing technical or financial assistance.

In mid-June 2019, USAID IHP received news that upcoming funding would not be affected by TIP restrictions. Just after the quarter closed, on July 1, 2019, USAID announced that the Program had received a clearance after all and that no reorientation of technical assistance would be required in the foreseeable future. Besides diverting considerable Program resources toward addressing the TIP issue, the uncertainty generated during the preceding months took a toll on implementation of some activities involving the MOH, as USAID and Program staff did not want to start interventions we would not be able to finish. Although USAID IHP no longer has an immediate need for reorientation, the exercise may yet prove useful, as we now have a foundation for more significant private sector collaboration.

2.2 PROGRAM STAFFING

Continued to hire and onboard Program staff

The work plan in place through June 2019 called for USAID IHP to have 244 personnel in place when fully staffed. On June 30, 2019, we had 226 personnel (21 percent women) on board—including 23 *Equipes d'Encadrement Intégré* (EEI, Integrated Support Teams), each of which will have three staff, for a total of 69 EEI staff. Twelve positions were on hold due to TIP restrictions, and there are five additional unfilled positions for which we are recruiting. During this quarter, one staff member resigned, and we are in the process of recruiting for a replacement.

In Quarter 3, USAID IHP hired 45 people, including six EEI/Health Systems Strengthening (HSS) Specialists placed in provincial offices in Kananga, Kalemie, and Kamina, as well as the new branch office in Uvira. Nine Provincial Supply Chain Officers, one for each province, also came on board. We continued recruiting for the remaining five EEI positions, one of whom was set to start with IHP mid-July 2019, one on August 1, 2019, and two likely to start mid-August. Our candidate for the fifth EEI/HSS

Specialist position declined to stay in a more managerial role, and we are in the process of recruiting another candidate.

Provided orientation and training to staff

USAID IHP oriented all new hires on standard operating procedures, safety and security, compliance with regulations, USAID programming guidelines, human resources management, and recruitment and interviews. In addition, all Abt staff members completed the company's mandatory online e-learning programs on general security awareness, freedom from harassment, and Abt's code of conduct.

In May and June, the Program's Compliance Officer trained regional and provincial operations managers in Bukavu, Kalemie, Kolwezi, Kamina, Kananga, Mbuji-Mayi and Kabinda on Abt and USAID procedures. The Senior Project Operations Advisor also conducted a brief training of accountants in Lubumbashi.

2.3 PROGRAM OPERATIONS

All 10 of USAID IHP's provincial offices were open this quarter, including new offices in Uvira and Kamina. We finished equipping and furnishing our Kinshasa office and 10 regional and provincial offices and continued to work on procurement of supplies and equipment:

Generators and internet service. Five generators were delivered to five provincial offices (Bukavu, Kananga, Lodja, Kabinda, and Kamina), while three generators were scheduled for delivery in mid-July to offices in Mbuji-Mayi, Lubumbashi, and Kalemie. The supplier was late delivering the order from Europe, which also delayed delivery of our order.

The Program was awaiting USAID approval for internet cabling this quarter, during which offices were using temporary wifi set-ups through local companies.[1]

Vehicles. During start-up, we received vehicles from previous USAID implementing partners. However, some of them are in less-than-ideal operating condition, and the Program will need to purchase 10 to 15 additional vehicles. USAID IHP received a Toyota Land Cruiser from the recently closed USAID-funded Maternal Child Survival program project on May 31, 2019. We will issue a procurement for the new vehicles during the coming quarter.

This quarter also saw partial resolution of the legal matter that arose in late 2018 and early 2019 over six vehicles transferred to USAID IHP during the handover from the previous USAID Integrated Health Project Plus (IHPplus) implementing partner. In March 2019, the U.S. Government filed two lawsuits in Kananga's High Court over four vehicles seized by local authorities in Kananga and two sold by the local tribunal there. On April 1, 2019, the High Court ruled in the U.S. Government's favor on the first case, and lifted the attachment to the four cars that were seized, so Abt is now able to use the four cars. In May, vendors in Kananga filed a criminal complaint against the U.S. Department of Justice, Abt Associates, and the previous implementer, claiming these parties had filed false paperwork in trying to reclaim the sold vehicles.[2]

---

[1] USAID approval came through in mid-July and installation was expected later that month.

[2] The Program was made aware of this development in mid-July and believes it is an attempt to stall the U.S. Government's civil case; a hearing is scheduled for August 21, 2019.

2.4 SECURITY

This quarter, USAID IHP hired two new security officers for Kolwezi and Kamina and for Kalemie, making a total of six dedicated security officers in provincial and regional offices to give direct support to staff under the guidance of the Security Director The Security Director is planning an induction training package and security risk management course in Mbuji Mayi in July 2019.

General security trends. Demonstrations markedly decreased this quarter and often occurred on Sundays, so there was minimal disruption to Program operations. Staff were somewhat impacted by heavy police deployments and traffic disruptions in the areas of Limete, Pascal, Triomphal, and Ndjili in Kinshasa.

Eastern Congo continues to have the most security challenges. There is no direct impact of Ebola Virus Disease on the Program at this time; we are continuing normal travel, operations, and activities. We are monitoring the outbreak for security threats, and we have followed World Health Organization (WHO) guidelines in establishing our security action plan, which includes new protocols should Ebola spread closer to our offices or transport routes. As a precaution, we have set up additional sanitation stations in our closest offices (300 kilometers from the outbreak) and are following a limited sensitization program on Ebola detection and measures, delivered by security officers in our Bukavu office only.

The Islamic State has recently claimed attribution for attacks by the Allied Democratic Forces militia in North Kivu. We are monitoring for developments in tactics, targets, and weapon delivery systems.

Regional trends

- **Kinshasa**. No "villes mortes" (literally "dead towns", referring to general strike-type actions) were recorded in Kinshasa this quarter, and high-profile demonstrations tended to have been supportive in nature. Police reactions were subdued in each case, and casualty figures were relatively low compared to similar periods in 2017 and 2018. A series of industrial actions by staff of foreign-owned commercial premises downtown were localized and easy to avoid.
- **Kasaï region**. Since last quarter, the number of illegal checkpoints by military personnel have dropped significantly in the Kasaïs, although security forces or criminal elements continue to exploit the opportunity to profit by hindering movements around town. In Kananga, three main groups of antagonists are searching for opportunities to profit, so crime rates have increased, especially targeting international community facilities with burglaries and illegal checkpoints throughout town. The security team, in consultation with partner organizations and key stakeholders, has established a "neighborhood watch" scheme for early warning of suspicious activity around the offices of the Program, partner organizations, and key stakeholders.
- **Eastern region**. In Bukavu and Uvira, and especially in the *haut plateau* of Fizi territory, the United Nations (UN) estimates 180,000 displaced persons, including 142,000 recently displaced due to ongoing clashes between militia and Forces Armées de la République Démocratique du Congo (FARDC, Armed Forces of the DRC). Ninety percent of displaced females are reported to have been raped. Illegal checkpoints are frequent in remote areas, especially on high-transit routes between Bukavu and Uvira. FARDC tend to be overwhelmed and unable to detect, deter, or deny all militia activity. In Tanganyika, Mai Mai factions continued to destabilize the area, with frequent ambushes and attacks on civilians and local residents, particularly on the roads to the north of Kalemie that lead to Bendera.
- **Katanga region**. The region remains generally calm with fewer recorded burglaries and incidents in Lubumbashi city.

3. OBJECTIVE 1

Strengthen Health Systems, Governance, and Leadership at Provincial, Health Zone, and Facility Levels in Target Health Zones

In Haut-Katanga, members of the DPS filled out questionnaires about how their organization functions, as part of the USAID IHP-led PICAL process. (*Credit:* Jean Manasse for USAID IHP)

- Met first-year target for organizational capacity building by completing institutional assessments of six DPS and two ZS
- **Exceeded targets** for IPS audits and inspection visits in Sankuru **by 266 percent**
- **Exceeded targets for stockouts** in eight of nine provinces, with fewer facilities reporting lack of an essential medicine

IR 1.1: ENHANCED CAPACITY TO PLAN, IMPLEMENT, AND MONITOR SERVICES AT PROVINCIAL, HEALTH ZONE, AND FACILITY LEVELS

Conducted DPS and institutional self-assessment exercise with PICAL and developed capacity development plans

> "Change is not easy. People know what they can do, but they don't know how to make it possible. That needs time, and we have to accompany them."
>
> Toss Mukwa, PICAL consultant for USAID IHP

Contributes to indicators:[3]
Directly ✓ 1.1 ✓ 1.2.1 ✓ 1.2.2 ✓ 1.4.3 **Indirectly** ✓ 1.5.1

By the end of June 2019, USAID IHP had completed our PICAL evaluation plan for the first year of the Program. We use the PICAL tool as the principal methodology to reinforce institutional capacity. These assessments enable the DPS and the ZS to identify their institutional gaps and develop capacity-building plans to address them.

This quarter, USAID IHP completed institutional assessments in six DPS: Tanganyika, Lomami, Sankuru, Kasaï-Central, Kasaï-Oriental, and Haut-Lomami. This, combined with the completion of institutional self-assessments in two ZS (see next activity), enabled us to meet our first-year target for organizational capacity building. By the end of June 2019, seven DPS (the six completed this quarter and one in Sud-Kivu completed during the previous quarter) had capacity building plans based on their institutional assessment analyses.

Each capacity building plan contains key activities that will be priorities for the DPS in the second year of the program. They include leadership and management training, coaching, team building, IT training, financial management training, primary health care management, results-based management training, and integration of specialized programs into the structure of the DPS.

Carried out institutional self-assessments with the PICAL tool adapted for ZS

Contributes to indicators:
Directly ✓ 1.5.1

USAID IHP adapted the PICAL instrument for use by the ZS. The adapted tool takes into account the special status of ZS and their prominent role in implementation of primary health care. We adjusted the PICAL evaluation domains accordingly.

We chose to test the PICAL methodology at the ZS level in Haut-Katanga and Lualaba because these were the two provinces where the Health Finance and Governance (HFG) project had previously conducted PICAL assessments and where USAID IHP would therefore not be conducting DPS-level assessments. The fact that they had already used the PICAL tool meant that these DPS could lead the process in the ZS, which is in an experimental phase. The Haut-Katanga DPS Division Chief selected Katuba based on that ZS's weak performance in organizational development. The Lualaba DPS Division

[3] Each activity contributes directly and/or indirectly to specific indicators. See the table in Annex A for information about each of these indicator numbers.

Chief selected Manika because IGA had conducted an institutional assessment there. These factors make it possible to better track progress resulting from the PICAL process and replicate it in other ZS. By the end of June 2019, both the Katuba and Manika ZS had capacity building plans in place based on the PICAL assessments.

Conducted a team building exercise for regional staff, including provincial teams

This activity pulled in Capacity Building Advisors from all nine provinces. Participants at a May 21–23, 2019, workshop reviewed data from the institutional assessments that had been carried out so far in Sud-Kivu, Kasaï-Central, and Tanganyika. They evaluated the relevance of the activities selected for the institutional capacity building plans, which were based on analysis from the PICAL assessments and on weaknesses identified by DPS management teams. The workshop also looked at the lessons learned from these first institutional assessment exercises and discussed different techniques to improve future assessments.

There was significant interest in first institutional analyses conducted, and participants learned how to make the exercise even more productive. Those who had not yet been part of PICAL assessments practiced good coaching techniques that would allow ECDPS to express themselves freely, identify gaps, and propose concrete actions. Those who had already participated learned how to guide the ECDPS in consolidating their improvement plans by choosing activities that would take into account the strengths, weaknesses, threats, and opportunities identified in the institutional assessments. Participants discussed and clarified the concept of the gender dimension.

Launched an SMS- and IVR-based survey to provide quantitative baseline information on perceptions of the performance of health system components

Contributes to indicators:

Indirectly ✔ 18 ✔ 1.4.1 ✔ 2.9 ✔ 2.5 ✔ 3.1

As described in IR 1.5, USAID IHP launched a survey on June 25, 2019, that examines the quality of health care, knowledge and perceptions of civil society organizations and CODESA, and knowledge and perceptions of *relais communautaires* (RECO, community health workers).

IR 1.2: IMPROVED TRANSPARENCY AND OVERSIGHT IN HEALTH SERVICE FINANCING AND ADMINISTRATION AT PROVINCIAL, HEALTH ZONE, FACILITY, AND COMMUNITY LEVELS

Provided support for quarterly inspection visits and audits of ZS by the *Inspections Provinciaux de la Santé*

Contributes to indicators:

Directly ✔ 1.2.3 **Indirectly** ✔ 1.2.1

USAID IHP provided financial support for six provinces (Haut-Katanga, Lomami, Lualaba, Sankuru, Sud-Kivu, and Tanganyika) to carry out audit and control missions in the ZS. The *Inspections Provinciaux de la Santé* (IPS, Provincial Health Inspectorates) audited a total of 40 ZS

Snapshot: An IPS audit success story in Sankuru

The audit program was particularly successful in Sankuru, where the IPS was able to inventory resource management in all 16 ZS, against a target of six ZS (266 percent). This achievement is attributable to efficient management of the audit budget and to the zeal and determination of the IPS itself.

with an average of three institutions per ZS (see text box for results in Sankuru). These missions allowed the IPS to understand the difficulties experienced by providers in the management of health care facilities and coordination bodies. The IPS submitted reports from these missions to the provincial health authorities with clear recommendations, including to train providers in financial management.

Organized coordination meetings with USAID-funded Integrated Governance Activity on the institutional assessment of local government entities

USAID IHP organized four provincial-level meetings with IGA in April and May 2019—one at the IGA office in Bukavu and three at the USAID IHP office in Kolwezi. Like USAID IHP, IGA uses the PICAL tool to analyze local governance institutions. However, while USAID IHP focuses on DPS, IGA has used the PICAL for institutional assessments of the IPS in Lualaba, Haut-Katanga, Sud-Kivu, Kasaï-Central, and Kasaï-Oriental. These meetings between USAID IHP and IGA helped harmonize our interventions to avoid duplication, promote effectiveness and efficiency of USAID support, and share our experiences and lessons learned, especially with regard to IGA's work with CODESA and *Entités Territoriale Décentralisée* (ETD, Decentralized Territorial Entities) in the fields of health, education, and governance.

IR 1.3: STRENGTHENED CAPACITY OF COMMUNITY SERVICE ORGANIZATIONS AND COMMUNITY STRUCTURES TO PROVIDE HEALTH SYSTEM OVERSIGHT

Conducted assessments of the level of functionality of CODESA

Contributes to indicators:
Indirectly ✓ 1.4.2 ✓ 1.3.3 ✓ 1.3.2 ✓ 1.3.1

Four DPS used a questionnaire and focus group discussions to evaluate the functionality of 110 CODESA in 24 ZS: three in Tanganyika, three in Kasaï-Oriental, seven in Kasaï-Central, and 11 in Haut-Katanga. The evaluations showed that the concept of a CODESA is well-known at the level of the ZS and facility managers: about 45 percent of CODESA evaluated know their role and responsibility within the local health system. However, few are still functional—they require revitalization to increase community participation in health system surveillance at the local level.

About 55 percent of the CODESA evaluated did not understand their responsibilities. More than 10 percent used whether or not a person volunteered as the only criteria for selecting RECO, ignoring other criteria such as being a person of influence, being credible, knowing the environment, and being an opinion leader. The report notes that in some cases, communities do not even know who their CODESA members are. In Tanganyika, for example, evaluations found that none of the 22 CODESA evaluated was completely functional; only one was moderately functional, while 11 were not very functional, and 10 were barely functional. As an example, the text box on the following page summarizes the results of the CODESA evaluations in Kasaï-Oriental.

Supported MOH workshop to develop community scorecard tool

Contributes to indicators:
Indirectly ✓ 1.3.2

A community scorecard tool is being developed for CODESA to use to monitor the quality of health service delivery at facilities. This tool will serve as the Program's approach for promoting community engagement and social accountability in health management. This objectives of this approach are for

services to be accountable to the community, for community members to be stimulated to seek their own solutions to their own problems, and for there to be effective community participation in decision-making and management of health centers.

USAID IHP supported an MOH workshop to develop implementation protocols for the community scorecard. The workshop took place in two phases:

- At a preliminary meeting on May 30 and 31, 2019, participants were briefed on the community scorecard process and obtained feedback from the MOH and Cordaid on their experiences with the scorecard in DRC.
- A workshop from June 3 through 8, 2019, covered the analytical framework, tools for social accountability, and the scorecard process. Participants reached consensus on adopting the community scorecard within the MOH as a tool for community engagement. They agreed on specific steps for the scorecard, then divided into working groups to address individual steps.

MOH experts will pre-test the scorecard in one ZS in each of the Program's target regions. After the tool is validated by the *Comité National de Pilotage du Secteur de la Santé* (CNP-SS, National Health Sector Steering Committee) Service Delivery Committee, the tool can be used in all nine USAID IHP provinces.

Snapshot: CODESA evaluations in three ZS in Kasaï-Oriental

EEI teams led this activity, which took place from May 30 to June 2, 2019.

Targets: Ninety-two providers (72 men and 20 women) in three ZS (Bibanga, Dibindi and Citenge): 42 from the CODESA, including 33 registered nurses, 13 assistant nurses, and four members of the *Equipe Cadre de la Zone de Santé* (ECZS, Health Zone Management Team).

Preparatory phases: Six preparatory meetings, including three with ECZS members on organization of activities, a briefing on the evaluation tool, and other meetings on sharing results.

Results summary:

- **Bibanga ZS.** Out of 17 CODESA, 14 (82.3 percent) were not very functional, having scores between 51 percent and 75 percent. One CODESA (6 percent) was barely functional, with scores between 26 percent and 50 percent. Two CODESA (11.7 percent) are moderately functional, with scores from 76 percent to 80 percent. In short, no *aire de santé* had a fully functional CODESA.
- **Citenge ZS.** Out 16 CODESA, 100 percent were very inefficient, with scores from 26 percent to 50 percent. No CODESA was completely or even somewhat functional.
- **Dibindi ZS**. The 13 CODESA had scores varying between 51 percent and 75 percent. No CODESA was completely functional.

IR 1.4: IMPROVED EFFECTIVENESS OF STAKEHOLDER COORDINATION AT THE PROVINCIAL AND HEALTH ZONE LEVELS

Aligned with and supported implementation of the *contrat unique* at the DPS level

Lualaba is currently the only USAID IHP-supported province to have signed its *contrat unique* (single contract). The *contrat unique* rationalizes resources among all technical and financial partners (TFPs). The process is led in each province by one organization or project designated as the lead TFP. USAID IHP is the lead TFP in Lualaba as well as in Haut-Lomami, where signature of the *contrat unique* is pending until the *Comité Provincial de Pilotage du Secteur de la Santé* (CPP-SS, Provincial Health Sector Steering Committee) is convened. The Program is also participating in the process in Haut-Katanga, where the United Nations Children's Fund (UNICEF) is the lead TFP.

Several factors hinder implementation of the *contrat unique*, including an erroneous belief by some provincial executives that this mechanism limits contributions from other partners. To discourage such beliefs, USAID IHP is encouraging provincial officials to take ownership of the *contrat unique,* attending meetings to explain the benefits of this mechanism, and holding national-level discussions to strengthen monitoring of the *contrat unique* process in the provinces.

Contributed financial and technical support for the quarterly coordination meetings of DPS

During this quarter, the Program provided technical and/or financial support for partner coordination meetings of DPS, leading these meetings in six provinces (Haut-Lomami, Kasaï-Central, Lomami, Lualaba, Sankuru, and Tanganyika). For example, in the Kasaï region, the coordination meetings were organized with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Santé Rurale* (the Rural Health Program of the DRC), the *Programme de Renforcement de l'Offre et Développement de l'Accès aux Soins de Santé* (PRODS, Program for Strengthening of Supply and Development of Access to Health Care), and GHSC-TA. In the Katanga region, the coordination meetings were primarily held with the *Projet de Développement de Système de la Santé* (PDSS, Health Care System Development Project) and UNICEF. In other provinces, we actively participated in all partner meetings. All meetings aimed to harmonize the *contrat unique* roadmap and update stakeholder mapping within the province. Partners are seeking to pool efforts and share financial information to effectively support the MOH in implementation of the PNDS 2019–2022.

Organized regular coordination meetings with other USAID implementing partners

USAID IHP was particularly active in the Eastern Congo region during this quarter, including through participation in the WASH Learning and Sharing Meeting in Bukavu on April 18, 2019. Participants at this event included USAID and other stakeholders—Breakthrough Action; Food for the Hungry; Kivu Food Security; the Budikadidi project; Asili; IGA; and the USAID Monitoring, Evaluation and Coordination Contract (MECC).

In the Kasaï region, USAID IHP organized several provincial-level partner meetings. In Sankuru, we held collaboration and coordination meetings with Catholic Relief Services (CRS). In Kasaï-Central and Kasaï-Oriental, USAID IHP met with multiple stakeholders, including UNICEF, the OCHA, and a wide range of international and Congolese nongovernmental organizations (NGOs). The purpose of all these meetings was to discuss technical and financial support for surveillance of diseases with epidemic potential following a surge of measles, cholera, and vaccine-derived polio cases in the Kasaï region. Partners committed to coordinate their interventions in support of the MOH to address these challenges.

Other partner coordination activities included the following:

- **Held coordination meeting with the Evidence to Action (E2A) project**. Discussion topics included preparing for the transition of specific activities from E2A to USAID IHP in November 2019, determining a supply mechanism to transport commodities from the ZS level to service delivery sites (see IR 1.7), standardizing family planning data collection and management tools, and supporting the supervision of *Equipes cadres de la DPS* (ECDPS, Executive Teams of the Provincial Health Districts).
- **Met with the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project**. We learned about TIPTOP's experiences with an innovative approach—using community-based distribution of quality-assured sulfadoxine pyriméthamine

(S/P) to increase the frequency of prenatal care. We found the approach beneficial and believe USAID IHP could also use it to increase the number of women in prenatal care.

- **Challenge TB**. USAID IHP participated in weekly meetings of Challenge TB to prepare to transition implementation of TB activities in the five provinces supported by the two programs. Challenge TB stopped its support to the Programme National de la Lutte Contre la Tuberculose (PNLT, National Program to Combat Tuberculosis) at the end of June 2019. USAID IHP will now support the entire TB package in these provinces.

Contributed to financial and technical support of DPS biannual review meetings

We provided technical and financial support to eight of the Program's nine target DPS to organize and hold their biannual reviews in April and May 2019. The Tanganyika DPS did not request this support because the review was already funded by GAVI. The meetings assessed the determinants of primary health care for each pillar of the PNDS 2019–2022; presented ZS performance in the supply of the minimum package of activities (MPA) and the complementary package of activities (CPA);[4] presented the main bottlenecks in supply and demand of health care services; and evaluated the quality of the services offered to the population. Recommendations for adjustments followed each strategic axis of the PNDS 2019–2022. These reviews also identified the need for interoperability of the District Health Information System 2 (DHIS2) with the health information platforms of specialized programs and for improved coordination of support among TFPs. Information from these reviews contributed to the development of the USAID IHP July–September 2019 work plan and the Program's Year 2 work plan.

IR 1.5: IMPROVED DISEASE SURVEILLANCE AND STRATEGIC INFORMATION GATHERING AND USE

Initiated baseline surveys

Contributes to indicators:

Directly ✔ 2 ✔ 4 ✔ 6 ✔ 8 ✔ 11 ✔ 12 ✔ 14 ✔ 16 ✔ 18 ✔ 19 ✔ 1.3.3 ✔ 1.4.1 ✔ 2.5 ✔ 2.6 ✔ 2.7 ✔ 2.9 ✔ 2.2.2 ✔ 2.2.3 ✔ 2.2.4 ✔ 2.2.5 ✔ 2.4.2 ✔ 2.4.3 ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4 ✔ 3.1 ✔ 3.2

We launched a household survey as described in Chapter 7 (Activity Research, Monitoring, and Evaluation). In addition, in early April 2019, USAID IHP finalized survey instruments for three fact-finding surveys, one each on the following topics:

- Perceptions related to understanding health systems, governance, and leadership at the provincial, ZS, and facility levels in target ZS (see IR 1.1)
- Perceptions about access to integrated and quality health services in target ZS (see IR 2.2)
- Adoption of healthy behaviors, including use of health services, in target ZS (see IR 3.3)

The instruments' design reflects the planned modes for administering the survey: short-messaging service (SMS) and interactive voice recording (IVR). The majority of the survey will be implemented via SMS, but we included IVR because it allows illiterate customers to participate.

---

[4] MPA includes curative, preventive, promotional, and community outreach activities provided by health center staff, who are supervised by the ZS management team. MPA is to be provided at all health centers. CPA includes the full MPA and preventive, curative, and promotional activities organized within the framework of internal medical services, surgery, gynecology, obstetrics, and pediatrics. Management of hospital health information; human, material, and financial resources; action research and supervision of ZS personnel are also included. CPA is to be provided at all general reference hospitals.

We finalized the survey in English and then translated the instrument into French, Swahili, Lingala, and Tshiluba. We then tested the surveys internally and with local testers in Kinshasa. USAID IHP launched the SMS portion of the surveys on June 25, 2019.

For the survey on perceptions about access to integrated and quality health services, the overall sample comprised roughly 2,634 mobile subscribers. We applied a targeted sampling approach, given the finite numbers of the sample and target population of the survey. For the other two surveys, we used GeoPoll's database of mobile subscribers, since GeoPoll has direct access to all mobile subscribers of Orange, Airtel, and Vodacom. We used a simple random sampling approach, randomly selecting respondents from the database of mobile subscribers in the USAID IHP target ZS and asking them to consent and participate in the survey.

We will report on progress and survey results during the coming quarter, after the surveys conclude. During the coming quarter, we will continue SMS data collection and launch the IVR portion to account for illiterate subsets of the population. We will also evaluate IVR's suitability to reach illiterate populations.

Trained USAID IHP staff on use of M&E data platform

As described in Chapter 7 (Activity Research, Monitoring, and Evaluation) the Program trained all national and provincial monitoring and evaluation (M&E) staff on how to use the USAID IHP M&E platform and analyze the data. The training took place during a retreat in Lubumbashi in May 2019.

Designed and developed dashboards to assist DPS in monitoring the performance of provincial health services

Contributes to indicators:
Indirectly ✓ 1.5.3

USAID IHP developed a data completeness dashboard and posted it online to help DPS identify areas where the *Système National d'Information Sanitaire* (SNIS, National Health Information System) needs to be completed. This dashboard provides access to information on different data sets—basic services, the Logistics Information and Management System (LMIS), hospital services—for both the provinces and the ZS. We created the data completeness dashboard at the request of the Secretary General for Health. Originally designed for use by DPS, it has proven to also be very useful to the Program and we are including data gathered through the dashboard in the USAID IHP M&E platform.

Organized training on SNIS and DHIS2 framework for staff of the DPS, IPS, and *Equipe Cadre de la Zone de Santé*

All indicators that were downloaded from DHIS2 were **indirectly produced** from this activity.

USAID IHP provided technical and financial support to the Lualaba and Tanganyika DPS to organize training on the normative SNIS framework and on DHIS2 for executives from the DPS, IPS, and *Equipe Cadre de la Zone de Santé* (ECZS, Health Zone Management Team). These June 2019 trainings, facilitated by national-level experts from the *Direction du Système National d'Information Sanitaire* (DSNIS, Directorate for the National Health Information System), aimed to empower these executives and USAID IHP technical staff to conduct analysis and use quality data for evidence-based decision-making, while using different management tools updated and issued by the MOH.

Organized training on the integrated quality improvement approach for DPS and IPS staff

Contributes to indicators:
Directly ✓ 2.8

A total of 17 people—six DPS executives, three IPS executives, and eight USAID IHP staff—were trained on the integrated quality improvement approach in Mbuji Mayi in Kasaï-Oriental from June 7 to 11, 2019. The trainees assessed the quality of services in the Dibindi *Bureau Central de la Zone de Santé* (BCZS, Office of the Health Zone Team), the Mpokolo General Referral Hospital, and the Saint Pierre Health Center. During the next quarter, the trained managers will assist these two ZS in conducting self-assessment of the BCZS and health facilities to help improve the quality of services and delivery of care.

Conducted training needs and equipment needs assessment at ZS level with regard to DHIS2 and SNIS

All indicators that were downloaded from DHIS2 were **indirectly produced** from this activity.

USAID IHP supported the DPS in our nine target provinces to assess their needs for capacity building and equipment for the effective use of DHIS2 and SNIS by all target ZS and DPS offices. Results showed that the primary needs are Internet connectivity, data management tools, computer equipment, and capacity building for users. The Program's Kinshasa-based M&E team compiled the data from this assessment; by the end of the coming quarter, we will submit a detailed report on training and equipment needs for use of DHIS2 and SNIS. Meanwhile, to enable transmission of data by DHIS2, 23 ZS in the Katanga region and 38 ZS in the Kasaï region have received modems and air time for Internet connections.

Provided technical and/or financial support for quarterly data validation reviews by DPS and special programs

All indicators that were downloaded from DHIS2 were **indirectly produced** from this activity.

To improve the availability, quality, and analysis of data from specialized programs, USAID IHP technically and financially supported seven DPS from the Katanga region and the Kasaï region to organize TB data analysis and validation workshops in April and May 2019. The workshops enabled participants to validate all data from the health centers on diagnosis and treatment, improved availability, and DHIS2 reporting—and to analyze performances over the period. Challenges remain to stabilize the health care pyramid within the DHIS2 for the diagnostic and treatment health centers, increase the availability and use of TB data encoded in the DHIS2 by ZS executives, and ensure Internet connectivity in the ZS so that ECZS can encode and transmit data in a timely fashion.

Provided technical and financial support for monthly monitoring meetings of ZS and *aires de santé*

All indicators that were downloaded from DHIS2 were **indirectly produced** from this activity.

To improve analysis and use of data at the ZS level, USAID IHP provided direct technical and financial assistance in April and May 2019 to ECZS in a total of 20 ZS: three in Kasaï-Central and 17 in Haut-Katanga. The meetings helped the ZS analyze and validate data using the DHIS2 reporting tool and ensured strict application of MOH directives. With USAID IHP unable to provide grants to support ZS,

the majority of the ZS do not have access to funding to support semi-annual reviews. The other provinces can learn from the experiences of Haut-Katanga and Kasaï-Central, applying those lessons to carry out the process themselves.

IR 1.6: IMPROVED MANAGEMENT AND MOTIVATION OF HUMAN RESOURCES FOR HEALTH

No activities were planned under this intermediate result during this quarter.

IR 1.7: INCREASED AVAILABILITY OF ESSENTIAL COMMODITIES AT PROVINCIAL, HEALTH ZONE, FACILITY, AND COMMUNITY LEVELS

By the first week of the quarter, all nine USAID IHP Provincial Supply Chain Officers were on board and working. They attended a six-week online training course on the i+academy platform, which prepared them to undertake their responsibilities advising the ECZS (in collaboration with DPS) and health facilities.

Made supply chain inventory management tools available at the ZS and health facility levels

Contributes to indicators:
Indirectly ✔ 1.7.2 ✔ 1.7.3

USAID IHP supported ZS and their health facilities for all nine target DPS by funding local reprography of inventory management tools, such as ZS and health facility synthesis reports; stock cards; and registers that provide details on day-to-day product use. The transport of these tools to ZS was carried out gradually and will be completed in mid-July 2019, particularly for the DPS who do not have a risographe (Kasaï-Oriental, Lomami, Lualaba, Sankuru, and Tanganyika). The tools produced under this activity will also be available to cover the next quarter. This purpose of this activity is to improve the LMIS through the collection, reporting, and use of quality drug data in all ZS.

Provided financial support to ZS to enable health facilities and CODESA to transport medicines and manage the supply chain from the ZS to health facilities

Contributes to indicators:
Indirectly ✔ 1.7.1-1.7.4

Traditionally, health facilities pick up supplies at the ZS pharmacy. However, routing products to difficult-to-access health facilities requires more appropriate and context-specific distribution approaches.

To facilitate this, USAID IHP undertook activities during this quarter to help us define distribution approaches that are context-specific for each ZS. First, we created a distribution planning tool that each ZS will use to create a plan for distribution from the ZS pharmacy to the health facilities. This is a logistics profiling tool takes into account criteria such as distances, road conditions, and geographic and security obstacles to better design last-mile transportation via the three to four most efficient and effective distribution axes to four or five health facilities. The results should be fewer stock outs, lower transportation costs, and improved collection of stock and consumption.

The tool will allow us to create three logistics-related categories of health facilities around a BCZS: 1) those who can support transport of their own products, 2) those who will receive financial support from USAID IHP for a specific period of time, and 3) those who will require financial assistance for the transport of products throughout the USAID IHP lifecycle. Those in the first category will continue to pick up medicines from the BCZS. Those in the second and third categories will benefit from a community Informed Push Distribution Model (IPM) approach that USAID IHP is helping establish.

USAID IHP tracks the percentage of facilities that report a stock-out of at least one tracer commodity. An analysis of the quarter's data, as shown in Table 2, shows that in eight of nine provinces (all except Haut-Lomami), fewer facilities than expected experienced a stock-out of an essential medicine.

Table 2: USG-assisted service delivery points that experienced a stock-out of selected tracer drugs* at any time during the reporting period

Region	Province	Number SDPs	Baseline 2017	Quarterly 2019 Target	Achieved Q1	Achieved Q2	Achieved Q3
Eastern Congo	Sud-Kivu	1,027	71%	69%	43%	47.0%	44.2%
	Tanganyika	308	93%	91%	68%	76.9%	81.8%
Kasai	Kasai-Central	806	92%	90%	83%	68.0%	69.4%
	Kasai-Oriental	602	65%	63%	51%	52.8%	41.7%
	Lomami	728	79%	77%	56%	65.7%	41.1%
	Sankuru	465	69%	67%	33%	32.8%	40.9%
Katanga	Haut-Katanga	1,092	48%	46%	26%	30.2%	38.4%
	Haut-Lomami	577	70%	68%	66%	71.1%	72.1%
	Lualaba	425	84%	82%	44%	47.8%	51.8%

SDP=Service delivery point

(*) Depo Provera (DMPA) 150mg Inj.; Oral rehydration salts kit (ORS+Zinc); Oxytocin 10 IU/ml Vial 1ml; Iron-folate 200/0.25 mg tablet; Artemisinin-based combination therapy (ACT 1-5 years) blister; Rifampicin-Izoniazid (RH) 150/75 mg tablet

Since the beginning of the Program, analysis of data trends confirms that a smaller and smaller number of health facilities experienced a stock-out of one of the six selected tracer drugs. A comparison of actuals to targets shows that the decline was 26 percent in the Kasai region, 21 percent in the Eastern Congo region, and 9 percent in the Katanga region. Between Quarter 2 and Quarter 3 the decline was 8 percent in the Kasai region and 1 percent in the Eastern Congo region. In the Katanga region, there was with a 5 percent increase in stock-outs between Quarter 2 and Quarter 3, even though we are continuing to stay within our target of an annual reduction of 2 percent (See Annex A, indicator 1.7.1). The province of Lomami in the Kasai region performed best with a 25 percent drop between Quarter 2 (65.7 percent) and Quarter 3 (41.1 percent, N=728). Although the provinces of Sankuru (32.8 percent to 40.9 percent, N=465) and Haut-Katanga (30.2 percent to 38.4 percent, N=1,092) performed worse in Quarter 3 than in Quarter 2, they still experienced significantly fewer stock-outs than expected in our targets. USAID IHP cannot yet identify all the factors that explain this performance, but it is clear that our interventions have contributed to it. These interventions include active participation in coordination through the provincial Essential Drugs Working Group, introduction of planning tools for distribution in the ZS, and contributions to the stock rationalization at the ZS level.

All provinces reported a stock-out of ORS kits (ORS+zinc) at all levels—regional distribution center, BCZS, and health facility. This meant that the ZS were unable to deliver the products to their health facilities during the quarter. Only the *Centrale d'achat, d'Administration et de Distribution des Médicaments*

Essentiels du Kananga (CADIMEK, Office for the Purchase, Supply and Distribution of Essential Medicines in Kananga), the regional distribution center of Kasaï-Central, has had a stock since May 2019 and continues to supply the ZS. It will continue to do so during the fourth quarter. Note that the *Centrale d'Achat des Médicaments Essentiels de Lubumbashi* (CAMELU, Office for the Purchase of Essential Medicines in Lubumbashi), the regional distribution center in Haut-Katanga and Lualaba, has its own stock for sale. The World Bank-funded PDSS finances the purchase of this item using a performance-based financing approach with ZS.

IR 1.8: STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

Participated in *Comité National de Pilotage du Système de Santé* meetings

USAID IHP participates in various committee meetings of CNP-SS. This quarter we supported four of these committee meetings, including the last meeting of the governance committee, which focused on preparations for the annual health sector review at the end of July.

The Program is still working to develop strong approaches for sharing lessons learned with national-level CNP-SS technical committees, which are where all new MOH strategies and approaches are discussed before they are approved by the CNP-SS Assembly and disseminated across the health sector. Now, however, after supporting institutional assessments of DPS and ZS with the PICAL tool, and after the success of the *Plan d'Action Opérationnel* (PAO, Annual Operations Plan) 2019 alignment process during the previous quarter, the Program is ready to explore and share the lessons we have learned to date.

OBJECTIVE 1 SUMMARY

The table on the following pages shows that in general, about 72 percent of planned Objective 1 activities were started, but only 63 percent of these planned activities were completed during Quarter 3 (with many activities foreseen to take more than one quarter to complete). Twenty-eight percent of planned activities were not started.

Operational problems were the major cause of low performance, stemming from difficulties ensuring the availability of USAID IHP funds. We have applied corrective measures, including finalizing recruitment of operational staff, training staff on systems and procedures, decentralizing operations to empower provincial offices, and opening provincial bank accounts to streamline funding.

In addition, USAID IHP encountered conflicts with DPS schedules and the availability of DPS staff, both of which impacted the timing of activities. In Objective 1, a limiting factor for implementation was the Program's inability to put a system in place to ensure direct funding of DPS or ZS activities. We will be studying this system during Quarter 4.

Objective 1: Status of Activity Implementation by Province

IR	Page	Activity	H-KAT	TAN	SAN	KAS-C	LUA	H-LOM	LOM	KAS-O	SUD
IR 1.1 ENHANCED CAPACITY TO PLAN, IMPLEMENT, AND MONITOR SERVICES AT PROVINCIAL, HZ, AND FACILITY LEVELS											
1.1	**8**	Conduct DPS and institutional self-assessment exercise with PICAL and developed capacity development plans									
1.1	**9**	Conducted a team building exercise for regional staff, including provincial teams									
1.1	**9**	Launched an SMS- and IVR-based survey to provide quantitative baseline information on perceptions of the performance of health system components									
1.1		Provide financial support to activities of DPS									
IR 1.2 IMPROVED TRANSPARENCY AND OVERSIGHT IN HEALTH SERVICE FINANCING AND ADMINISTRATION AT PROVINCIAL, HZ, FACILITY, AND COMMUNITY LEVELS											
1.2	**10**	Organize coordination meetings with USAID funded IGA on the institutional assessment of local government entities									
1.2	**9**	Provide support for quarterly inspection visits and audits of ZS by the *Inspections Provinciaux de la Santé*									
IR1.3 STRENGTHENED CAPACITY OF COMMUNITY-SERVICE ORGANIZATIONS (CSOS) AND COMMUNITY STRUCTURES TO PROVIDE HEALTH SYSTEM OVERSIGHT											
1.3		Train CODESAs in the use of score cards									
1.3		Provide financial and technical support to the integrated communication plans of CODESAS									
1.3	**10**	Conduct assessments of the level of functionality of CODESAS									
1.3		Train ECSZs in the use of score cards									
IR 1.4 IMPROVED EFFECTIVENESS OF STAKEHOLDER COORDINATION AT THE PROVINCIAL AND HEALTH ZONE LEVELS											
1.4	**12**	Contribute financial and technical support for the quarterly coordination meetings of DPS									
1.4	**11**	Align with and support the implementation of the *contrat unique* at DPS level									
1.4		Provide technical and financial support to meetings of the Technical Secretariat of DPS									
1.4		Provide financial support to meetings of CODESAs									
1.4	**13**	Contribute to financial and technical support of DPS biannual review meetings									
1.4	**12**	Organize regular coordination meetings with other USAID implementing partners									
IR 1.5 IMPROVED DISEASE SURVEILLANCE AND STRATEGIC INFORMATION GATHERING AND USE											
1.5		Train CAC members on community based health surveillance									

1.5	**15**	Provide technical and/or financial support for quarterly data validation reviews by DPS and special programs
1.5		Develop data based identification of low performance zones in the different program areas
1.5		Organize training on use of data and dashboards
1.5	**15**	Provide technical and financial support for monthly monitoring meetings of ZS and *aires de santé*
1.5	**15**	Address equipment needs for DHIS use, VSAT subscriptions of ZS
1.5	**13**	Conduct baseline surveys (household survey, facility based survey, health systems survey)
1.5	**14**	Organize training on SNIS and DHIS2 framework for staff of the DPS, IPS, and *Equipe Cadre de la Zone de Santé*
1.5	**15**	Organize training on the integrated quality improvement approach for DPS and IPS staff
IR1.7 INCREASED AVAILABILITY OF ESSENTIAL COMMODITIES AT PROVINCIAL, HEALTH ZONE, FACILITY, AND COMMUNITY LEVELS		
1.7	**16**	Make supply chain inventory management tools available at the ZS and health facility levels
1.7	**16**	Provided financial support to ZS to enable health facilities and CODESA to transport medicines and manage the supply chain from the ZS to health facilities

Key

- Planned for the quarter and completed
- Planned for the quarter and in process of implementation
- Planned for the quarter, but not implemented
- Not planned for the quarter

4. OBJECTIVE 2

Increase Access to Quality, Integrated Health Services in Target Health Zones

USAID IHP hosted a nutrition awareness event in collaboration with the National Nutrition Program (PRONAUT) in Zewe, in the Kabinda ZS in Lomami Province. The event taught parents about best practices to prevent malnutrition. (*Credit:* Louis Mulembe for USAID IHP)

- Supported **tracing of 5,472 contacts** of 1,396 TB index cases to improve early detection and treatment
- **Helped treat over 68,700 children** under 5 for malaria, pneumonia, and diarrhea at supported **iCCM sites**
- Katanga region met **100.7 percent of its target** for children under 5 treated appropriately for diarrhea in Program-supported health facilities

IR 2.1 INCREASED AVAILABILITY OF QUALITY, INTEGRATED FACILITY-BASED HEALTH

Provided support for bi-annual supervision visits of two experts from national-level specialized programs to the DPS

Contributes to indicators:[5]
Indirectly ✓5 ✓7 ✓9 ✓10 ✓11

In April 2019, USAID IHP provided technical and financial support for two teams of experts from the MOH's *Prise en charge intégrée des maladies du nouveau-né et de l'enfant* (PCIMNE, Integrated management of newborn and childhood illness) Committee to carry out semi-annual supervisory visits to the Kasaï-Oriental and Kasaï-Central DPS. Their task was to improve the skills of the ECDPS in training supervision and on the correct use of PCIMNE booklets and flow diagrams by service providers.

USAID IHP staff accompanied the PCIME experts on their visits to regional distribution centers to verify quantities of medicines and essential child health inputs. The PCIME experts conducted supervision, including training, in four BCZS (Tshilenge and Bipemba in Kasaï-Oriental and Demba and Ndesha in Kasaï-Central) and seven health facilities. They also briefed the ECDPS and ECZS, interviewed service providers, and reviewed documents and delivery and management tools.

The key findings from these missions included poor availability of service delivery and management tools, non-compliance with pneumonia and diarrhea treatment protocols in health facilities, and shortages of supplies and equipment.

To address these challenges, the Program will deliver to ZS the MOH norms and directives on MNCH for them to provide to health facilities. Next quarter, we will support the DPS in Haut-Katanga, Haut-Lomami, Kasaï-Central, and Sankuru to retrain service providers to ensure they know how to use the PCIMNE packets and flowcharts. We will fund the cost of reproducing flowcharts for use by providers in health centers. During Year 2, we will provide supplies and equipment.

Provided support for dissemination of existing *Santé de la réproduction, de la mère, du nouveau-né, de l'enfant, et de l'adolescent* norms and guidelines

Contributes to indicators:
Indirectly ✓2 ✓3 ✓4 ✓5 ✓6 ✓7 ✓8 ✓9 ✓10 ✓11 ✓12 ✓13 ✓14 ✓15 ✓2.1 ✓2.2 ✓2.3 ✓2.4 ✓2.1.1 ✓2.1.2 ✓2.1.3 ✓2.1.4 ✓2.1.5 ✓2.1.6 ✓2.1.7 ✓2.1.8 ✓2.1.9 ✓2.1.10 ✓2.1.11 ✓2.1.12 ✓2.1.13

USAID IHP provided technical and financial support to the DPS in Lomami and Haut-Katanga to distribute MNCH data collection tools to health facilities. We also supported training for providers on use of these tools, which included partographs, and on health education for pregnant women attending antenatal care (ANC) visits. These tools—which included antenatal, family planning consultation, and growth monitoring cards, as well as standardized flowcharts—were left over from the IHPplus project.

In Haut-Katanga, 42 health care providers and 24 ECZS members from four ZS (Kasenga, Kafubu, Mufunga-Sampwe, and Mitwaba) attended the training sessions. In Lomami, there were 30 health care providers and 24 ECZS members from three ZS (Mwene-Ditu, Kanda-Kanda, and Kalenda). These

---

[5] Each activity contributes directly and/or indirectly to specific indicators. See the table in Annex A for information about each of these indicator numbers.

sessions will help improve the quality of care and services provided to pregnant women during ANC visits and during birth, as well as maternal and neonatal health outcomes.

Created a pool of trainers at DPS level covering critical maternal and neonatal mortality reduction program elements

Contributes to indicators:
Indirectly ✓ 19 ✓ 2.4 ✓ 2.1.2 ✓ 2.1.3 ✓ 2.1.4 ✓ 2.1.5 ✓ 2.1.6 ✓ 2.1.7 ✓ 2.1.8

USAID IHP provided technical and financial support to the DPS of Tanganyika, Kasaï-Oriental, Lomami, Haut-Katanga, Lualaba, and Haut-Lomami to train 71 trainers (50 men and 21 women) in essential obstetric and neonatal care, emergency obstetric and newborn care (SONU, *soins obstétrico-néonatal d'urgence*) and maternal death surveillance and response (MDSR). This resulted in the establishment of a core group of provincial trainers in each of the six provinces. In the coming quarters, they will provide further training of providers in 21 USAID IHP-supported ZS.

The next steps for the Program include support to DPS and ZS to:

- Train healthcare providers in essential obstetric and newborn care, SONU, and MDSR
- Organize awareness activities on the importance of using high-quality ANC services, especially from the first trimester of pregnancy
- Encode data in the DHIS2 framework to improve ZS data completeness on essential obstetric and neonatal care, SONU, and MDSR

We will also provide post-training support and will support supervision by ZS management teams and monitoring at the *aire de santé* level.

USAID IHP created a pool of trainers in Lualaba province who learned about reproductive, maternal, neonatal, and child health. Photo: Stanley Musumba, Abt Associates for USAID IHP.

Contributed to the running costs of the cold chain in collaboration with other partners

Contributes to indicators:
Indirectly ✓ 1.7.1

To maintain the cold chain and support vaccinations for children under 5, USAID IHP delivered a total of 1,000 liters of oil for refrigerators and 2,808 liters of diesel for cold rooms in two provinces:

- ***Lualaba.*** In April 2019, we purchased and distributed 1,000 liters of oil for eight refrigerators in ZS and delivered 1,400 liters of diesel to the DPS for the Kolwezi branch cold room.
- ***Kasaï-Oriental.*** We funded two deliveries, with a total of 1,408 liters of diesel, in April and June 2109 for operation of cold rooms and the provincial branch of the *Programme Elargi de Vaccination* (PEV, Expanded Program on Immunization), in synergy with UNICEF and GAVI.

In Sankuru, the process of purchasing oil is underway. We will also provide fuel in other provinces, based on their requirements, while the Mashako plan is covering this need in Haut-Lomami, Haut-Katanga, and Tanganyika.

During the next quarter, the Program will provide logistical support for preventive maintenance of cold chain equipment in Lualaba, Sud-Kivu, Kasaï-Oriental, Lomami, Kasaï-Central, and Sankuru. Given the frequent power outages in Mbuji-Mayi's PEV branch, USAID IHP, in collaboration with UNICEF, will equip the Mbuji-Mayi branch of the PEV with diesel fuel to automatically start the generator when power outages occur.

oto: Marie-Claire Okenge, Abt Associates for USAID IHP

USAID IHP delivered thousands of liters of oil and diesel to maintain cold chain equipment and keep vaccines safe.

Strengthened routine PEV activities by supporting the Reach Every Child strategy

Contributes to indicators:
Indirectly ✓ 2.1.9

From April 10–17, 2019, USAID IHP supported the PEV's Kasaï-Central provincial committee to reinforce the Reach Every Child approach in the Bilomba, Kalomba, and Ndekesha ZS. We helped with an analytical review of documents and collection tools and with observation of vaccination sessions and interviews with parents and guardians of children.

To ensure the Reach Every Child approach is followed, the Program conducted formative supervision visits to improve service providers' capacities to (1) organize immunization tours to facilitate reporting and use of the mid-upper arm circumference (MUAC) tool; (2) identify children who have skipped their immunization appointments; (3) estimate vaccination needs; and (4) prepare reports after the vaccination sessions. We provided assistance at immunization sessions to correct any problems that arose and helped develop strategies in these ZS for identifying children who did not come to vaccination sessions, based on the vaccination register and/or schedule. These strategies include home visits to look for identified children, establishment of appointments for the next immunization sessions, and finally efforts to go get children at their homes to make sure they receive their next vaccinations.

In collaboration with GAVI, UNICEF, and the Mashako Plan, USAID IHP will help strengthen routine vaccinations in low-performance ZS by implementing advance strategies[6] to ensure that health facilities achieve the required number of immunization sessions each month. The focus will be on provinces in the Kasaï region.

Established a framework for collaboration with Food for Peace on nutrition, WASH, and family planning activities

Contributes to indicators:
Indirectly ✔ 1.4.2 ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4

USAID IHP and the USAID-funded Budikadidi project held two meetings in Kasaï-Oriental this quarter to align our nutrition care and treatment framework and our WASH and family planning activities with the U.S. Government's FFP initiative. Together we reviewed indicators for malnutrition, prenatal consultations, and family planning; identified priority sites so we can pool efforts; scheduled joint supervision visits; and planned family planning trainings for community-based providers and RECO.

The Program will continue implementing preventive interventions and promoting nutrition in ZS where our work overlaps with Budikadidi initiatives in Kasaï-Oriental, as well as with DFSA in Sud-Kivu and Tanganyika, which is managed by Mercy Corps, Food for the Hungry, and other nutrition partners. Interventions will include training service providers on preschool consultations, folic acid supplementation for pregnant and lactating women, Vitamin A supplementation and deworming with Mebendazole for children under 5, promotion of key practices and nutritional advice, support for infant and young child feeding, and community-based nutrition.

Conducted training and retraining needs assessment for malaria

Contributes to indicators:
Directly ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6

In Haut-Katanga, USAID IHP conducted a baseline evaluation in 10 health facilities in the Kisanga and Kenya ZS. The *Programme National de Lutte contre le Paludisme* (PNLP, National Program to Combat Malaria) and USAID IHP technical staff interviewed 50 providers for the assessment, which used a table showing staff skills, availability of malaria inputs, and compliance with national policy for diagnosis and treatment of malaria. The assessment found that most care providers are not trained on the diagnosis and management of malaria. Malaria inputs are provided by USAID IHP in collaboration with GHSC-TA, but facilities reported some stock shortages in rapid diagnostic tests (RDTs) and long-lasting insecticidal nets (LLINs). Some facilities also reported that supplies do not always match needs and that needs are not always initially well-forecasted. Although the evaluation did not cover a large sample of ZS, it provided a useful snapshot of many of the real needs for strengthening the fight against malaria at the provincial level.

[6] Advance strategies refer to targeted campaigns to seek out clients in places where large numbers of people gather (markets, schools, churches, stadiums, traffic circles).

Conducted training on diagnosis and treatment of malaria according to most recent norms and standards

Contributes to indicators:
Directly ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6

During the quarter, USAID IHP provided technical and financial support to the PNLP at the DPS level in Haut-Katanga, Haut-Lomami, and Lomami to strengthen the capacity of 124 providers to diagnose suspected malaria cases using RDTs and to follow established protocols in treatment of confirmed cases of simple and severe malaria. The number trained was low during this quarter because most of the training is scheduled to take place during Year 2.

During FY2019 Quarter 3, our support facilitated the following activities:

- ***Standard training***. The DPS trained 96 providers in Haut-Lomami (Mukanga and Kitenge ZS) and Haut-Katanga (Lwamba, Mufunga Sampwe, and Mitwaba ZS). The training focused on early and correct management of simple and severe malaria cases. These target ZS were chosen for their underperformance in implementing malaria interventions and their poor use of case management, as well as for their inconsistent indicators of care and low levels of support from the DPS because of difficult access. There is a particularly high incidence of malaria in the riverside ZS in Haut-Lomami.
- ***Retraining.*** In Lomami, the PNLP retrained 28 providers from the Kamiji ZS (12 providers) and Wikong ZS (16 providers) on diagnosis and treatment of suspected and confirmed cases of malaria. These two ZS were selected because their reported malaria data is poor quality, they are difficult to access, and they have poor case management.

Equipped health facilities with water filters and cups to allow direct observation of adherence to intermittent preventive treatment for pregnant women

Contributes to indicators:
Directly ✔ 2.4

In collaboration with the *Programme National de la Santé de la Reproduction* (PNSR, National Program for Reproductive Health) and the PNLP, USAID IHP provided 2,520 cups and 64 water filters to facilitate supervised intake of S/P by pregnant women, with the goal of increasing the rate of uptake. Twenty-six ZS in Kasaï-Central received a total of 984 cups. Five ZS in Sud-Kivu received 1,536 cups and 64 filters.

Provided support for bi-annual supervision visits by two experts from national-level specialized programs to the DPS

Contributes to indicators:
Directly ✔ 2.4

The Program provided support for national-level PNLP executives to carry out two support missions from April 24–May 3, 2019, in Kasaï-Central and Kasaï-Oriental on the management of malaria in health facilities. The objective was to assess and improve the performance of mid-level actors in correctly managing malaria in health facilities. A total of five ZS were selected, including three in Kasaï-Central (Kananga, Katoka and Ndesha) and two in Kasaï-Oriental (Cilundu and Tshishimbi). In Kasaï-Central, six health facilities across the three ZS received supervision visits. They noted that formative supervisions

were rare; the updated PNLP guidelines on malaria management were not available; complete clinical examinations for signs of dangers were insufficient and sometimes not performed; traceability data recorded in the consultations, laboratory, and pharmacy registers were not clear; and there were shortages of basic anti-malarials. Corrective actions were implemented directly with the service providers.

During the next quarter, USAID IHP will help the PNLP extend the training by retraining and offering internship for providers on malaria treatment in the nine provinces; providing post-training follow-up of trained providers in the Katanga region; and continuing to support intermediate-level executives in Tanganyika and Sankuru provinces, which have alarming malaria indicators.

Organize briefing for carriers of sputum samples, including on infection prevention and control

Contributes to indicators:

Indirectly ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.25

USAID IHP supported five *Coordinations provinciales lèpre et tuberculose* (CPLT, Provincial Committees for Leprosy and Tuberculosis Control) to organize briefings for 142 carriers on secure transportation of sputum specimens and control of TB infection in 26 ZS (see Table 3). This briefing aimed to improve detection of TB cases in the ZS through facilitation of safe transportation of samples from treatment centers to diagnosis and treatment centers or GeneXpert sites. Training topics included sputum collection and safe transportation of specimens, investigation of contact subjects of TB patients, and follow-up of patients undergoing TB treatment. After these trainings, participants went back to their respective ZS, where their responsibilities include continuing to raise awareness about TB control and to ensure secure transportation of specimens from treatment centers and from diagnosis and treatment health centers to GeneXpert sites.

Table 3: Number of carriers trained on secure specimen transportation and infection control by province and region during the quarter April-June 2019

Region	Province (Number of ZS)	Number of Carriers Trained	Dates
Katanga	Haut-Katanga (9)	20	June 2019
	Lualaba (2)	45	June 2019
Eastern Congo	Sud-Kivu (9)	22	June 28–July 5, 2019
Kasaï	Lomami (3)	10	June 28–30, 2019
	Sankuru (3)	45	June 28–July 16. 2019
Total	**5 (26)**	**142**	

Subsidized the transport costs of sputum samples from health centers to GeneXpert sites and the *Laboratoire National de Référence de Mycobactériologie*

Contributes to indicators:

Indirectly ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 2.1.26

In June 2019, USAID IHP paid to transport suspected TB patients' samples from treatment centers and diagnosis and treatment health centers to GeneXpert sites and to the *Laboratoire National de Référence de Mycobactériologie* (LNRM, National Referral Laboratory for Mycobacteriology) to test for drug resistance. The activity took place in Lualaba in four ZS (Dilala, Bunkeya, Fungurume, and Manika) that

had reported cases of Rifampicine-resistant TB (RR-TB). The objective was to help improve the detection of RR-TB cases in these ZS. Index cases of RR-TB were established among the RR-TB patients who were under the care of diagnosis and treatment health centers. Seventy-three samples were gathered from the contact subjects of patients suffering from RR-TB; the samples were transported to GeneXpert sites. Out of these, a total of 12 patients (eight men and four women) were diagnosed with TB, but no cases of drug-resistant TB were detected. Transportation of specimens from RR-TB patients was also carried out in Sankuru in all 16 ZS during the last week of June 2019.

All DPS will ensure that this high-impact activity for TB detection is carried out during the next quarter.

Provided financial support for hospitalization costs of extensively drug-resistant TB patients

Contributes to indicators:
Indirectly ✓ 2.1.19

As part of efforts to improve the care of extensively drug-resistant TB (XDR-TB) patients, during the last week of June 2019 USAID IHP paid for the emergency transfer of two XDR-TB patients from Lubumbashi to Likasi and for their inpatient expenses at the Panda General Referral Hospital in the Panda ZS.

Provided nutritional support to multi drug-resistant-TB and XDR-TB patients

Contributes to indicators:
Indirectly ✓ 2.1.22

Photo: Stanley Musumba, Abt Associates for USAID IHP

USAID IHP supported the distribution of nutritional kits in Lualaba.

During June 2019, USAID IHP provided nutritional kits to 159 patients, including 157 Rifampicine-resistant/multi drug-resistant TB (RR/MDR-TB) cases and two XDR-TB cases in Haut-Katanga, Lualaba, and Tanganyika. We collaborated on this activity with the CPLT of each province and with community agents who are members of the *Club des Amis Damien* (CAD, Club for the Friends of Damien) and the *Ligue Nationale Antituberculeuse et anti-lépreuse du Congo* (LNAC, National Anti-tuberculosis and Anti-leprosy Association of Congo). These nutritional kits reinforce the RR/MDR-TB and XDR-TB patient management packages, helping improve patients' nutritional status and therapeutic success. The kits were distributed in Haut Katanga (116 patients, including 114 cases of RR/MDR-TB and two cases of XDR-TB); Lualaba (35 MDR-TB patients); and Tanganyika (eight RR/MDR-TB patients).

Getting these nutritional kits delivered to patients scattered across the provinces remains a logistical challenge. We are responding to this challenge by relying on support from members of CAD and the LNAC, as well from RECO. This support only partially addresses the challenge but does make a difference.

Provided financial support for monthly meetings to validate data at the diagnosis and treatment health center level

Contributes to indicators:

Indirectly ✓ 2.1.17 ✓ 2.1.18 ✓ 2.1.19 ✓ 2.1.20 ✓ 2.1.21 ✓ 2.1.22 ✓ 2.1.23 ✓ 2.1.24 ✓ 2.1.25 ✓ 2.1.26

To improve the availability, quality, and analysis of data from the *Programme National de la Lutte Contre la Tuberculose* (PNLT, National Program to Combat Tuberculosis), USAID IHP funded workshops to validate the PNLT's January–March 2019 TB epidemiological data from four provinces: Haut-Katanga, Lualaba, Haut-Lomami, and Sud-Kivu. Next quarter, we will validate data for FY2019 Quarter 3.

In the Katanga region, these workshops in April (Lualaba) and May (Haut-Lomami and Haut-Katanga) were attended by 27 nurses from the Haut-Katanga CPLT, 14 nurse-supervisors from the Haut-Lomami DPS, and six nurse-supervisors from the Lualaba DPS. The work enabled participants to validate all the data from the diagnosis and treatment health centers, in order to improve the reporting available through DHIS2 and to analyze performances achieved during the period.[7] USAID IHP fully funded the cost of organizing the workshops in Haut-Lomami and Haut-Katanga; *Action Damien* shared the cost of the workshop in Lualaba.

In Sud-Kivu, the validation workshop on May 20–23, 2019, included 34 nurse supervisors from 34 ZS; the Sud-Kivu DPS; and partners involved in the health sector, the CPLT, and the *Programme National de Lutte contra la SIDA* (National AIDS Control Program). Participants reviewed epidemiological data from the ZS, identifying and correcting inconsistencies and errors. Provincial health information teams encoded the validated data in the DHIS2 software and shared the validated database with stakeholders.

Provided support for contact tracing around TB index cases

Contributes to indicators:

Indirectly ✓ 2.1.18 ✓ 2.1.19

USAID IHP supported contact tracing for the DPS in Haut-Katanga, Haut-Lomami, Lualaba, and Sankuru. In collaboration with 16 ECZS and community workers, each DPS organized efforts in May and June 2019 to investigate contacts around TB index cases (see Table 4). This campaign is part of efforts to improve early detection of TB and place patients under immediate treatment ("detect and treat") to limit the spread of infection in the community.

Table 4: Investigation results of contact-subjects of TB index cases in four provinces, April–June 2019

Provinces	Date	Number of ZS	# of Index Cases	# of Contact-Subjects	Presumed TB Cases	Confirmed TB Patients *
Lualaba	June 2019	4	402	1,647	452	48
Haut-Lomami	May 31–June 9, 2019	5	199	N/A	473	53
Haut Katanga	June 28–July 9, 2019	2	561	1,235	192	10
Sankuru	June 2019	5	234	2,590	1,485	129
Totals		**16**	**1,396**	**5,472**	**2,602**	**240**

Source: PNLT field coordination (Lualaba, Haut-Katanga, Haut-Lomami, Sankuru)

* Bacteriologically confirmed

[7] The rates of completion of DHIS2 data were 96.1 percent for Haut-Katanga, 85 percent for Haut-Lomami, and 86.9 percent for Lualaba.

Photo: Stanley Musumba, Abt Associates for USAID IHP

USAID IHP supported an investigation of TB contact cases in Lualaba..

Provided support for active screening of TB among special groups

Contributes to indicators:
Directly ✔ 2.1.17 ✔ 2.1.20 **Indirectly** ✔ 2.1.18 ✔ 2.1.19

As part of active screening for TB among special populations, and with support from USAID IHP, the MOH organized a small campaign of active screening for patients with TB in the Kamituga and Katana ZS in Sud-Kivu from June 6–11, 2019. The campaign targeted mine workers, whose living and working conditions make them susceptible to TB. The purpose of this activity was to interrupt the chain of transmission through early identification and immediate treatment of TB among miners. First, RECO and local radio led an awareness campaign with involvement from political-administrative authorities. Then two CPLT experts, supported by the Kamituga and Katana ECZS and RECO, identified suspected TB patients. A total of 400 samples were collected during the screening

Photo: Stanley Musumba, Abt Associates for USAID IHP

Community health workers in Lualaba and Sud-Kivu screened and tested mine workers with materials provided by USAID IHP. Dozens of people have been diagnosed with pulmonary TB and referred for treatment.

campaign; analysis is in progress. The results will be shared with all stakeholders in July 2019 and confirmed TB patients will receive treatment immediately.

IR 2.2 INCREASED AVAILABILITY OF QUALITY, INTEGRATED COMMUNITY-BASED HEALTH SERVICES

Launched an SMS- and IVR-based survey on access to integrated and quality health services

Contributes to indicators:

Indirectly ✓ 18 ✓ 1.4.1 ✓ 2.9 ✓ 2.5 ✓ 3.1

As described in IR 1.5, we launched a baseline survey on perceptions about access to integrated and quality health services in the Program's target ZS.

Designed and developed a mobile phone or digital data collection tool for surveys on iCCM sites in targeted ZS

Contributes to indicators:

Indirectly ✓ 4 ✓ 5 ✓ 6 ✓ 7 ✓ 8 ✓ 9 ✓ 10 ✓ 11 ✓ 14 ✓ 15

As part of our efforts to develop community-based health services, USAID IHP has begun to develop a field-based mobile data collection tool. This tool will create a map of iCCM sites by encoding GPS coordinates during entry and track the stocks of medications held at each site. It is designed for use by health center staff in charge of inventory inspection and replenishment. It is easy to use and allows encoding without permanent Internet access. The tool should make it possible to identify low-attendance iCCM sites and those with recurrent inventory problems so that appropriate solutions can be sought.

There are 2,878 iCCM sites in USAID IHP-supported provinces. These sites are established in remote villages or communities where access to health care is limited. As shown in Table 5, nearly 70,000 children under 5 were treated for malaria, diarrhea, and pneumonia at USAID IHP-supported iCCM sites during the quarter. More than 70 percent of those cases treated were malaria. The sites are able to treat malaria because inputs from the PNLP are available; treatment of diarrhea and pneumonia is more difficult because inputs for those illnesses are out of stock at many of the iCCM sites in some provinces, especially Haut-Katanga and Tanganyika.

Table 5: Number of cases of malaria, pneumonia, and diarrhea treated at USAID IHP-supported iCCM sites, April–June 2019

Region	Province	Number of Diarrhea Cases Treated	Number of Pneumonia Cases Treated	Number of Malaria Cases Treated	Total Cases Treated
Eastern Congo	Sud-Kivu	2,352	2,363	10,666	15,381
	Tanganyika	366	287	5,900	6,553
Kasaï	Kasaï-Central	1,161	1,365	5,312	7,838
	Kasaï-Oriental	1,494	1,034	5,031	7,559
	Lomami	1,870	1,659	9,109	12,638
	Sankuru	590	864	1,593	3,047
Katanga	Haut-Katanga	369	322	2,283	2,974

	Haut-Lomami	1,714	812	6,507	9,033
	Lualaba	706	700	2,297	3,703
Totals		**10,622**	**9,406**	**48,698**	**68,726**

Source: DHIS2, accessed July 23, 2019

In addition to tracking cases of malaria, pneumonia, and diarrhea among children under 5 who are treated at USAID IHP-supported iCCM sites, we also track children treated for these conditions at health facilities, using data collected from all facilities in Program-supported provinces. These data show that the numbers of children served at the community level are only a very small fraction (3 percent for pneumonia and 5 percent for diarrhea) of the numbers treated at the facility level.

As shown in Table 6, during this quarter, 291,644 cases of pneumonia were treated by qualified personnel at health facilities in USAID IHP-supported provinces, including 274,854 cases of simple pneumonia and 16,790 cases of severe pneumonia. Although the proportion of simple pneumonia cases admitted to health facilities and treated according to the national protocol is high (91 percent) the management of severe pneumonia remains a challenge: only 71 percent of severe pneumonia cases were treated according to the national protocol at health centers and general referral hospitals in provinces supported by USAID IHP.

Table 6: Number of children under 5 who received treatment for an acute respiratory infection from an appropriate provider, April–June 2019

Region	Province	Simple Pneumonia Cases			Severe Pneumonia Cases		
		Number	# Treated*	% Treated*	Number	# Treated*	% Treated*
Eastern Congo	Sud-Kivu	63,582	62,909	98.94%	9,088	6,464	71.1%
	Tanganyika	20,774	18,427	88.7%	916	717	78.3%
Kasaï	Kasaï-Central	64,837	56,002	86.4%	3,525	2,452	69.6%
	Kasaï-Oriental	35,812	32,666	91.2%	1,698	1,003	59.1%
	Lomami	38,538	32,442	84.2%	2,192	1,450	66.1%
	Sankuru	16,405	14,404	87.8%	2,154	1,478	68.6%
Katanga	Haut-Katanga	22,006	21,382	97.2%	1,396	1,250	89.5%
	Haut-Lomami	18,949	15,966	84.3%	1,583	1,199	75.7%
	Lualaba	20,872	20,656	99.0%	976	777	79.6%
	Totals	**301,775**	**274,854**	**91.08%**	**23,528**	**16,790**	**71.4%**

Source: DHIS2, accessed July 23, 2019

*Treated according to national protocol

As shown in Table 7, over 265,000 children under 5 received appropriate treatment for diarrhea with oral rehydration salts (ORS) and zinc sulphate in health facilities supported by USAID IHP. This represents 81 percent of all children who were received for diarrhea in health facilities and 78.3 percent of the overall USAID IHP target. As shown in the table, results varied across regions—the Katanga region had the best performance, at 100.7 percent of the USAID IHP target, while the Kasaï region met only 63.5 percent of the target and the Eastern Congo region met 83.5 percent of the target. The figures in the Kasaï region were heavily impacted by the situation in Sankuru, where numbers were particularly low because of a lack of ORS and zinc sulfate products.

Table 7: Number of cases of diarrhea in children under 5 treated in USG-supported provinces, April–June 2019						
Region	Province	Diarrhea Cases Received in Health Facilities	# Diarrhea Cases Treated*	% Diarrhea Cases Treated*	# Cases Treated	USAID IHP Target
Eastern Congo	Sud-Kivu	62,122	57,785	93.0%	69,769	83,582
	Tanganyika	14,240	11,984	84.2%		
Kasaï	Kasaï-Central	46,482	28,999	62.4%	77,976	122,801
	Kasaï-Oriental	24,410	19,665	80.6%		
	Lomami	27,995	21,532	76.9%		
	Sankuru	16,262	7,780	47.8%		
Katanga	Haut-Katanga	23,681	23,015	97.2%	62,162	61,748
	Haut-Lomami	24,042	20,805	86.5%		
	Lualaba	18,849	18,342	97.3%		
Overall		**258,083**	**209,907**	**81.3%**	**209,907**	**268,131**

Source: DHIS2, accessed July 23, 2019

*Treated according to national protocol

Developed audio job aids for iCCM sites

Contributes to indicators:

Indirectly ✔ 2.5 ✔ 2.2.2

USAID IHP organized a content validation workshop in Kinshasa, May 29–30, 2019, on the development of a pack of 30 IVR audio job aids whose purpose is to reinforce the capacity of rural RECO to understand iCCM protocols. The IVR job aids will be hosted on the national information hotline 42502, which is available nationwide to approximately 12 million Vodacom subscribers. We are working closely with the MOH to select the final 30 audio job aid messages. They will be translated into local languages and recorded for final launch, which is expected in August 2019. The activity was originally scheduled to commence in June 2019, but it was delayed during discussions about TIP restrictions.

Supported retraining of 50 percent of RECO at iCCM sites that provide integrated care of malaria, diarrhea, and pneumonia

Contributes to indicators:

Indirectly ✔ 2.5 ✔ 2.2.2

During the month of April, USAID IHP supported missions from the national level MOH to the DPS in Lualaba, Tanganyika, and Kasaï-Central. These missions had multiple purposes: 1) assess the quality of care in health facilities and iCCM sites; 2) ensure the quality of coaching and supervision at iCCM sites by registered nurses and ECZS and ECDPS members; 3) build the skills of RECO at iCCM sites; and 4) build supervisors' skills, including on use of the updated tools. The national experts briefed the ECDPS and ECZS on filling out patient forms and records; they also reviewed documents, conducted interviews, and reviewed iCCM site operations.

The Program provided technical and financial support for the MOH to retrain 56 iCCM RECO to provide quality care in Tanganyika, Lualaba, and Kasaï-Central. Two approaches were used:

- ***Formative supervision***. In Tanganyika and Lualaba, the provincial executive supervised retraining at iCCM sites for a total of 13 RECO: six in the Kalemie ZS in Tanganyika and seven in the Fungurume ZS in Lualaba.
- ***Group monitoring.*** In Kasaï-Central, 43 RECO (38 registered nurses and 9 members of the ECZS) were retrained through group monitoring in three ZS: Dibaya, Lubondaie, and Yangala.

During the coming quarter, USAID IHP will support efforts to streamline existing iCCM sites in Kasaï-Oriental, Lomami, Sud-Kivu, and Tanganyika by retraining RECO and providing the sites with supplies and equipment.

Retrained existing *distributeurs de base communautaire*

Contributes to indicators:
Directly ✓ 2 ✓ 3 ✓ 2.2 ✓ 2.3 **Indirectly** ✓ 2.1

USAID IHP provided technical and financial support to retrain 78 community-based family planning actors in three *aires de santé* in the Wikong ZS in Lomami, as shown in Table 8. USAID IHP selected the Wikong ZS for this activity because it was the ZS where we conducted a family planning mini-campaign (see IR 3.1). We retrained the DBC to prepare them for this mini-campaign.

Table 8: Retraining for community-based family planning actors in Wikong ZS in Lomami, April–June 2019

	No. per health area	Female	Male	Total
Distributeurs de base communautaire	8	13	11	24
Community leaders	10	7	23	30
Youth peer educators	6	12	6	18
Nurses	2	N/A	N/A	6
Total				**78**

The Program also provided technical support for training of 152 *distributeurs de base communautaire* (DBC, community health workers trained in family planning) in Kasaï-Central and Kasaï-Oriental. The training took place in 15 *aires de santé* in three ZS (Ndekesha, Bilomba, and Dibaya) in Kasaï-Central and four *aires de santé* in two ZS (Bibanga and Dibindi) in Kasaï-Oriental.

This activity is part of an overall strategy to support community-based distribution of contraceptives, which will contribute to demand and service utilization. The results of the service delivery mapping survey (see Chapter 7) will inform our ultimate strategy. In the meantime, we have carried out some activities in large urban areas to increase demand and use of services, with the ultimate objective of increasing the number of new acceptors of family planning services. The Program's strategy builds on the community-level family planning approach that proved successful under E2A.

IR 2.3 IMPROVED REFERRAL SYSTEM FROM COMMUNITY-BASED PLATFORMS TO HEALTH CENTERS AND REFERRAL HOSPITALS

Developed mHealth-based system for managing follow-up of referrals

Contributes to indicators:
Directly ✓ 2.3.1 **Indirectly** ✓ 2.3.3

During April 2019, USAID IHP began design of an mReferral Tracker, an mHealth system for managing follow-up after referrals.[8] We used a human-centered design (HCD) approach to gather inputs, starting by conducting interviews in April 2019 with end-users and stakeholders in Kasaï-Central and Haut-Katanga.

In Kasaï-Central, we met with the DPS and the following stakeholders:

- Katoka ZS (urban): St. George General Referral Hospital and three health centers
- Mikalayi ZS (rural): Mikalayi General Referral Hospital and one health center

In Haut-Katanga, we met with the DPS and the following stakeholders:

- Kapolowe ZS: Kapolowe General Referral Hospital and three health centers
- Kenya ZS: Kenya General Referral Hospital and two health centers
- Kipushi ZS: Adra 41 Referral Health Center and two health centers

What is human-centered design?

HCD puts human beings at the center of all challenges and opportunities. By understanding real needs and desires and uncovering deeper insights that feed into the development of programs, systems, and communication, HCD generates solutions based in reality. HCD increases the effectiveness of program adoption and implementation by government departments, partnership teams, community workers, district leaders, local program managers, policymakers, and funders.

At these sites, the Program team conducted interviews with the health zone chief medical officer, head nurses, and assistant nurses at local health center; the head doctor or head of staff at hospitals; community volunteers; and CODESA leaders. During the coming quarter, we will develop a prototype and conduct an internal demonstration. Then, in Program Year 2, we will create a timeline for piloting and implementation of the mReferral tracker.

IR 2.4 IMPROVED HEALTH PROVIDER ATTITUDES AND INTERPERSONAL SKILLS AT FACILITY AND COMMUNITY LEVELS

No activities took place under this intermediate result during the quarter.

---

[8] Referrals between the community and health centers and between health centers and general referral hospitals currently do not work. The mReferral Tracker is a system that will digitize the referral process using basic mobile phones (IVR and SMS). The system will track the number of patients referred and the number of completed referrals. It will also send notifications to help volunteers and health providers follow up on referral cases. The tracker will have two levels: 1) community level (RECO to health centers); and 2) facility level (health centers to general referral hospitals).

IR 2.5 INCREASED AVAILABILITY OF INNOVATIVE FINANCING APPROACHES

No activities took place under this intermediate result during the quarter.

IR 2.6 IMPROVED BASIC FACILITY INFRASTRUCTURE AND EQUIPMENT TO ENSURE QUALITY SERVICES

Designed a WASH needs assessment tool for use at the community and village levels

Contributes to indicators:
Indirectly ✔ 1.4.2 ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4

To help DPS and ZS make in-depth needs assessments prior to organizing WASH infrastructure investments or interventions, USAID IHP developed a simple tool that captures key information about a village or a community. It identifies water resources, sanitation, and hygiene issues in targeted villages to better plan prioritized interventions, budgets, and follow-up actions. This tool is designed to be used on a tablet and to be able to store data in DHIS2. We carried out several reviews and iterations this quarter to make the tool simpler and ensure that it is pertinent; it is now ready for use next quarter.

Rehabilitated WASH infrastructure in communities

Contributes to indicators:
Indirectly ✔ 2.6.1 ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4

In Kasaï-Oriental, Program staff exchanged technical data with the Budikadidi project (see IR 2.1) and assessed on-the-ground conditions via several field trips.

During a joint visit to the Kasansa ZS, officials from the DPS, ZS, Budikadidi, and USAID IHP selected five sites for drilling boreholes, with one well in each village this first year. The Program developed the bidding document and will start work in early August 2019. Activities this first year will not cover the drinking water needs of the entire population of these five villages. In Year 2, USAID IHP will increase the number of structures in these localities.

Before launching the community support activity for construction of latrines and washbasins, we harmonized the Program's approach with that of Budikadidi and briefed the EEI on the approach. Budikadidi is mobilizing populations for the construction of latrines, while USAID IHP is providing technical support in latrine design and sustainability.

In Sud-Kivu, USAID IHP conducted a field mission in June 2019 to gather technical data on the water networks to be rehabilitated in the Katana, Kalengo, and Miti-Murhesa ZS. This data will inform the invitation to tender planned for publication in July 2019, with work starting in August 2019. These sites were selected in coordination with DFSA in Sud-Kivu. USAID IHP also oriented the EEI on the approach for supporting the building of latrines and washbasins, which will start at the end of June.

Supported empowerment of communities

In parallel with these activities, USAID IHP started preparations for the participatory action research that will accompany WASH interventions. The participatory action research process reflects the community's thinking about its development and the mechanisms to find local solutions, allowing for greater accountability of the actors and opening avenues for escaping donor dependency. The Program

is preparing a call for expressions of interest for the launch of this activity. This step will allow us to generate a small pool of applicants to submit proposals for participatory action research for sustainable drinking water services. We will select one proposal.

IR 2.7 STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

Participated in meetings, workshops, and reviews of special programs of the MOH

USAID IHP supported and participated in meetings of special MOH programs on topics deeply relevant to Program implementation, including immunization, nutrition, malaria, and tuberculosis.

Programme Elargi de Vaccination. As the DRC contends with measles and polio outbreaks, the PEV is preparing a national forum on immunization for July 22 and 23, 2019. This quarter, USAID participated in preparatory meetings for this event on June 3 and June 10, 2019, together with UNICEF, the WHO, PATH, and the Bill & Melinda Gates Foundation. The objective of the national forum will be to advocate with political authorities, including provincial governors, national and provincial budget and finance ministers, the Minister of Health, and the office of the Presidency. In Sankuru, USAID IHP also participated in meetings of the Provincial Coordinating Committee to discuss local polio vaccination days and the post-measles response.

Programme National de Nutrition. The *Programme National de Nutrition* (PRONANUT, National Nutrition Program) organizes monthly coordination meetings with all nutrition partners. USAID IHP actively participated in these meetings this quarter. The key emphasis at this quarter's meetings was the need to develop a consistent approach for routine Vitamin A supplementation for children aged 6-59 months.

USAID IHP technical staff also participated in a June 4–6, 2019, USAID workshop in Kinshasa on the continuum of care for acute malnutrition. The event brought together various stakeholders operating at the provincial and ZS levels, with the aim of better coordinating efforts to prevent and treat acute malnutrition. Participants included PRONANUT, the World Food Programme, UNICEF, the Food and Agriculture Organization of the United Nations, and various USAID implementing partners.

Photo: Louis Mulembe, Abt Associates for USAID IHP

USAID IHP supported a PRONANUT workshop in the Kabinda health zone on malnutrition prevention.

Programme National de Lutte contre le Paludisme. USAID IHP actively participates in weekly meetings of the PNLP. During this quarter, we provided technical and financial support for the World Malaria Day on April 25, 2019, in Kinshasa and in the provinces. We also provided technical assistance for the development of the High Burden-High Impact document—a roadmap developed by the WHO for 11 countries with a high burden of malaria (including the DRC). The High Burden-High Impact document will be finalized in a workshop on July 20, 2019.

Programme National de Lutte contre le Tuberculose. The PNLT organizes monthly meeting of the *Cellule de Coordination de la Tuberculose Multirésistante* (CCTM, Multi drug-Resistant Tuberculosis Coordination Unit). On June 19, 2019, we supported a CCTM meeting at the LNRM that focused primarily on screening and treatment of drug-resistant TB during the January–March 2019 quarter.

Participants at the June 19, 2019, meeting identified challenges in programmatic management of pre-XDR-TB and XDR-TB patients, including lack of support for inpatients; lack of motivation among nursing staff; weak support from the PNLT central unit and from experts for the follow-up of drug-resistant TB patients; and the cessation of nutritional assistance to patients in provinces supported by TB Challenge, which is in its close-out phase. To overcome these challenges, USAID IHP, the Global Fund, and *Action Damien* have discussed the need to support the PNLT. In collaboration with *Action Damien*, USAID IHP will support TB-PR management activities in the provinces of Lualaba, Haut-Lomami, Haut-Katanga, and Tanganyika. We will also provide a drug-resistant TB package of services in the five provinces formerly supported by Challenge TB (Lomami, Kasaï-Central, Kasaï-Oriental, Sankuru, and Sud-Kivu).

The Program also participated in an April 7–16, 2019, workshop in Matadi aimed at revising the PNLT's guide for managing drug-resistant TB. This workshop brought together 12 experts from the PNLT and its partners. Given the WHO's changes in treatment protocol for MDR-TB, the MOH recommended developing a new therapeutic protocol using the new drug Bedaquiline as a study to provide a factual basis for the use of this new drug.

Provided support to *Comités Techniques Multisectoriels Permanents pour la Planification Familiale* meetings

Contributes to indicators:

Indirectly ✔ 2 ✔ 3 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.1.1

The Program provided technical and financial support for meetings of the *Comités Techniques Multisectoriels Permanents pour la Planification Familiale* (CTMP-PF, Permanent Technical Multisectoral Committees for Family Planning). We provided technical contributions for the CTMP-PF's annual consensus workshop on family planning data, held under the leadership of the PNSR. Since the evaluation of the national family planning strategic plan is largely based on routine data, the workshop focuses on analyzing and validating data on a province-by-province basis before these data are published in the FP2020 annual report. This workshop also provides an opportunity for capacity building on family planning data analysis. The participants analyzed family planning data, identified inaccurate data, and assessed the performance of their respective ZS and provinces. The key recommendation of the workshop was to strengthen coordination among donors and improve the availability and quality of family planning data. USAID IHP also provided financial support for participants from seven provinces where the CTMP-PF has already been established: Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, Lualaba, Sankuru, and Sud-Kivu.

The national CTMP-PF held two meetings to prepare for the fourth national conference on the repositioning of family planning, which will take place in December 2019. USAID IHP's Family Planning/Reproductive Health Technical Advisor is the CTMP-PF coordinator and presides over these meetings.

USAID IHP also provided technical and financial support to help the provincial CTMP-PF in the seven provinces mentioned above to organize monthly meetings. Participants at these meetings discussed repositioning family planning by implementing effective strategies to increase coverage of quality family

planning services, create demand, and ensure the availability of contraceptives up to the last kilometer (at the service delivery site).

Provided technical and financial support for maternal mortality review meetings at DPS level

Contributes to indicators:
Indirectly ✔ 2 ✔ 3 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.1.1

USAID IHP provided technical and financial support to train DPS and establish committees for *Surveillance de Décès Maternels et Riposte* (SDMR, Surveillance and Response to Maternal Deaths) in six provinces: Haut-Katanga, Haut-Lomami, Kasaï-Oriental, Lomami, Lualaba, and Tanganyika. All but Kasaï-Oriental had benefited from SONU B training (Kasaï-Oriental did not have this activity in its work plan this quarter). The objective of this activity was to establish functional, dynamic committees that are able to analyze data on maternal deaths; analyze problems and causes; propose strong, implementable solutions; and address the issues and contributors appropriately.

Based on recommendations arising from the initial SDMR committee meetings, the next steps for the Program include supporting meetings of already-established committees; helping establish SDMR committees at the ZS level; training and improving the capacity of midwives to improve service quality; and advocating for efforts to address critical factors that contribute to high maternal mortality and morbidity, such as insecurity, road conditions, and long distances to travel for services).

OBJECTIVE 2 SUMMARY

The table on the following pages shows that the absolute number of planned Objective 2 activities was lower than the number under Objective 1. Less than 70 percent of the planned activities were started and only 61 percent of them were completed. The takeaway from this table is very similar to the takeaway from the Objective 1 table: the reasons for low performance are also similar, with the dominant causes being operational and funding problems. Tackling these challenges with the measures described under Objective 1 will ensure continuity in the availability of funds and strengthen the Program's operational capacity to implement more activities during the next quarter.

Participation in the United States Embassy Health Fair

USAID IHP participated actively in the health fair organized by the U.S. Embassy in Kinshasa on May 22, 2019. More than 500 people visited the different stands, including ours. The program showcased inputs, posters, and leaflets on different themes, including nutrition, TB, malaria, family planning, and WASH. Employees of the U.S. Embassy and visitors talked with USAID IHP technical advisors about key practices. We also conducted the following activities:

- *Malaria*. We demonstrated the correct way to set up LLINs. We used RDTs to screen for malaria among around 100 people. Three tested positive and received immediate care.
- *Family planning*. Counselors promoted family planning methods, raised awareness about the benefits of birth spacing, and demonstrated the use of male condoms.
- WASH. Our handwashing demonstration site welcomed the Ambassador, with staff explaining proper procedures for hygienic hand washing to those gathered around.

Objective 2: Status of Activity Implementation by Province

IR	Page	Activity	H-KAT	TAN	SAN	KAS-C	LUA	H-	LOM	KAS-	SUD
IR 2.1 INCREASED AVAILABILITY OF QUALITY, INTEGRATED FACILITY-BASED HEALTH SERVICES											
2.1	**23**	Create a pool of trainers at DPS level covering critical maternal and neonatal mortality reduction program elements									
2.1		Conduct DQI to identify service delivery bottlenecks and to address them									
2.1	**24**	Strengthen routine PEV activities by supporting the Reach Every Child strategy									
2.1		Provide re-training of health workers in FP									
2.1		Provide malaria case management re-training for health workers									
2.1	**26**	Equip health facilities with water filters and cups to allow direct observation of adherence to intermittent preventive treatment for pregnant women									
2.1	**22**	Provide support for bi-annual supervision visits of two experts from national-level specialized programs to the DPS									
2.1		Provide financial support to monthly monitoring of TB at CSDTs									
2.1	**24**	Contribute to the running costs of the cold chain in collaboration with other partners									
2.1		Subsidize the transport of samples / slides from the community or CST to the CSDT									
2.1	**27**	Subsidize the transport costs of sputum samples from health centers to GeneXpert sites and the Laboratoire National de Référence de Mycobactériologie									
2.1	**27**	Organize briefing for carriers of sputum samples, including on infection prevention and control									
2.1	**30**	Provide support for active screening of TB among special groups									
2.1		Provide financial support to transport of samples of CDVs to GeneXpert sites or CSDT									
2.1	**28**	Provide financial support for hospitalization costs of extensively drug-resistant TB patients									
2.1	**29**	Provide financial support for monthly meetings to validate data at the diagnosis and treatment health center level									
2.1	**28**	Provide nutritional support to multi drug-resistant-TB and XDR-TB patients									
2.1		Pay for the enrollment of MDR and XDR TB patients in their pre-treatment assessment									
2.1		Provide funding for the technical support of ECDPS to ZS									
2.1	**29**	Provide support for contact tracing around TB index cases									
2.1		Support the joint DPS-USAID IHP supervision visits to ZS; ZS to FOSA and Community									
2.1		Provide financial support to ZS for supervision, basic functions and monitoring activities									

2.1	**25**	Conduct training and retraining needs assessment for malaria
2.1	**26**	Conduct training on diagnosis and treatment of malaria according to most recent norms and standards
IR 2.2 INCREASED AVAILABILITY OF QUALITY, INTEGRATED COMMUNITY-BASED HEALTH SERVICES		
2.2	**33**	Support retraining of 50% of RECOs at iCCM sites that provide integrated care
2.2	**34**	Retrain existing *distributeurs de base communautaire*
2.2		Provide iCCMs with small equipment and utensils where needed
IR 2.3 IMPROVED REFERRAL SYSTEM FROM COMMUNITY-BASED PLATFORMS TO HEALTH CENTERS AND REFERENCE HOSPITALS		
2.3		Provide training for CAC or CODESA members on identification of danger signs and referral criteria
2.3	**35**	Develop mHealth based system for managing follow-up of referrals
IR 2.4 IMPROVED HEALTH PROVIDER ATTITUDES AND INTERPERSONAL SKILLS AT FACILITY AND COMMUNITY LEVELS		
2.4		Provide gender training and post-training follow-up for trainers and providers
IR 2.6 IMPROVED BASIC FACILITY INFRASTRUCTURE AND EQUIPMENT TO ENSURE QUALITY SERVICES		
2.6	**34**	Rehabilitate WASH infrastructure in communities
IR 2.7 INCREASED COLLABORATION		
2.7		Provide technical and financial support to province level meetings of 6 technical working groups and sub groups
2.7	**39**	Provide technical and financial support for maternal mortality review meetings at DPS level
2.7	**38**	Provide support to Comités Techniques Multisectoriels Permanents pour la Planification Familiale meetings
2.7	**37**	Participate in meetings, workshops, and reviews of special programs of the MOH

Key

- Planned for the quarter and completed
- Planned for the quarter and in process of implementation
- Planned for the quarter, but not implemented
- Not planned for the quarter

5. OBJECTIVE 3

Increase Adoption of Healthy Behaviors, Including Use of Health Services, in Target Health Zones

A DBC explains the benefits of family planning to customers and vendors at the Fungurume city market in Lualaba province. (*Credit:* Landry Malaba, Abt Associates for USAID IHP)

- Introduced **237,484 new users to modern contraceptives** at family planning service delivery sites
- **Reached almost 30,000 people** through eight mini-campaigns **to prevent and treat malaria and TB** and adopt **family planning methods.**
- Supported **12 community-based forums** in Haut-Katanga and Sud-Kivu that encouraged **345 people** to tackle their own **health challenges**

Under this objective, USAID IHP carries out activities that emphasize increased adoption of healthy behaviors, including the use of health services, in the program's target ZS and *aires de santé*. These activities are particularly important given the context, where negative social and cultural norms inhibit the use of health services and prolong unhealthy behaviors. Other behavioral factors also play a role, in particular low levels of demand for health services and low levels of community involvement or engagement with the health system, financial accessibility challenges, poor quality of services, and geographic distance to available services.

IR 3.1 INCREASED PRACTICE OF PRIORITY HEALTH BEHAVIOR AT INDIVIDUAL, HOUSEHOLD AND COMMUNITY LEVELS

Provided technical and financial support to advocacy and celebrations of world days or national days

The theme of World Malaria Day on April 25, 2019, was "ZERO PALUDISME! Je m'engage!" USAID IHP supported national events as well as activities in five provinces (Kasaï-Central, Lualaba, Sankuru, Sud-Kivu, and Tanganyika). In the provinces, we supported different mixes of activities, including (1) facilitation by provincial MOH bodies; (2) promotion of awareness messages encouraging families to seek appropriate care in cases of fever for children under 5; (3) prenatal care visits; and (4) use of long-lasting insecticidal nets (LLINs). For a week beforehand, local radio and television stations broadcasted messages three times a day. We also went door-to-door during World Malaria Day celebrations to actively search for malaria cases among pregnant women, which gave us an opportunity to increase use of prenatal consultation services and improve screening and protection of pregnant women against malaria through IPTp. Behaviors targeted included knowledge of the signs of danger; use of antenatal care services to benefit from IPTp; and health-seeking behavior in cases of fever for children under 5.

Specific World Malaria Day activities by province follow.

- **Kasaï-Central.** In the commune of Ndesha in the Kamilabi *aire de santé*, the event enjoyed remarkable commitment by the mayor. Activities included 1) sessions to demonstrate use of LLINs in households; 2) distribution of 77 nets to pregnant women; 3) awareness-raising among 845 people (270 men, 300 women, 150 girls, and 125 boys) on malaria prevention; and 4) administration of 350 RDTs to community members, of whom 250 (including 143 children and 107 women) tested positive and received treatment.
- **Lualaba**. USAID IHP worked with the DPS on messaging about seeking care for children under 5 and supported distribution of LLINs during prenatal visits. We helped organize a mini-campaign on malaria prevention among pregnant women and malaria case management in three *aires de santé* in the Kanzenze ZS.
- **Tanganyika.** USAID IHP supported development and pre-testing of targeted awareness messages about malaria prevention intervention in 11 ZS. The DPS produced messages for community radio stations in the city of Kalemie. Focus groups—including 13 police officers, 12 male market vendors, 14 female market vendors, 10 secondary school teachers, and 12 students—explored malaria prevention and non-use of LLINs. We also supported a conference at the University of Kalemie on mistrust of the proliferation of anti-malaria products circulating in the market. Within communities, USAID IHP funded a theatrical troupe to spread the message through a sketch on the rapid use of care, especially for fever in children under 5.
- **Sankuru.** USAID IHP joined the World Malaria Day celebration launched by the Lodja administrator. In parallel, the Program helped organize three malaria awareness days as part of a

mini-campaign to guide pregnant women to use prenatal care services and directly observe them in taking doses of S/P.

- **Sud-Kivu.** In collaboration with the DPS, USAID IHP supported organization of a mini awareness campaign in the Miti-Murhesa ZS (in the Murhesa, Cifuma and Kalwa *aires de santé*) on the prevention of malaria in pregnant women and children under 5. During two sensitization days in the three *aires de santé*, the DPS used RDTs to screen 81 women (of whom 27 tested positive), and 283 children under 5 (of whom 152 tested positive).

Conducted coordination and collaboration meetings with Breakthrough Action

Contributes to indicators:

Indirectly ✔ 3.1.1

USAID IHP continues to deepen its collaboration with Breakthrough Action. Both programs apply HCD to generate the profiles that we use to target communications strategies and interventions and to exchange information about approaches. USAID IHP has fully endorsed the role Breakthrough Action is to play in coordinating the different SBC partners that support MOH interventions. Our two programs are at different implementation stages; during this quarter a great deal of community-based mobilization and community-based communication was taking place in each of USAID IHP-supported provinces. Once Breakthrough Action has made progress in designing interventions, USAID IHP will be ready to implement them at scale.

USAID had advocated for high-level coordination committees between the two programs, but both USAID IHP and Breakthrough Action agree that one coordination structure that meets on a regular basis (i.e., more than once a month) and holds at least one meeting per quarter attended by program management will be sufficient, given the ease with which our two programs collaborate. Since during the next quarter both USAID IHP and Breakthrough Action will be in the planning stages for Year 2, we agreed to strive towards developing an SBC work plan that could be looked at as a single USAID SBC work plan.

Photo: Jason Coetzee, Matchboxology, for USAID IHP

During immersion exercises, USAID IHP interviewed community members about their local health care systems.

Advanced toward SBCC strategy finalization and Health Family Campaign co-creation content development

Contributes to indicators:

Indirectly ✔ 3.2.2 ✔ 3.1.1 ✔ 3.3.1

USAID IHP commenced provincial immersion exercises and workshops in Lualaba and Haut Lomami to shape the upcoming Healthy Family Campaign.[9] Immersion exercises are 30–60 minute guided face-to-face conversations with stakeholders in public clinics and hospitals, as well as with various community members, including community elders, youth, women, and traditional medicine men. These conversations probe issues facing the health care system in these locations. During the immersion sessions, community members and health care providers explored facilitators of and barriers to health-seeking behavior. Examples of **facilitating factors** included (1) concern expressed by family members or friends; (2) perceptions by young people that messages or activities are authentic and co-created by other young people; (3) understanding of the links between good health and future non-health-related consequences (e.g., older people remaining healthy to see children and grandchildren grow); and (4) characterization of viruses and bacteria as personified enemies. Examples of **barriers** included (1) fear of stigma; (2) not knowing health facility staff as individuals on a social basis, so not perceiving them as part of the community; and (3) illiteracy and "ignorance," especially lack of understanding that good health is a tangible immediate reward.

Mini-campaign. An activity that rapidly and immediately facilitates access to and use of health services by the population in a ZS.

Immersion exercise. A listening phase during which we focus on understanding the lives of beneficiaries by meeting people where they live and work.

Healthy Family Campaign. A multimedia campaign that uses multiple means of communication to reach a large population. It requires significant resources and is often implemented at a national scale or over large areas. An average Healthy Family Campaign lasts seven days.

We use insights from the immersion exercises to design two-day workshops that bring together an array of community members to dive deeper into issues raised during the immersions. Participants are challenged to think about what successful health communications would look like for them. They also have the opportunity to design their own communications campaigns, taking into account the issues discussed.

Lualaba (Kolwezi)

- ***Immersion exercises.*** We interviewed stakeholders from June 3–7, 2019. On the first day, we met with the Provincial Director of Health, the DPS Head of Communications, the Head of the Lualaba ZS, and the ZS community liaison. The next day we held conversations with registered nurses, the matron, and the Walemba village chief. On the third day, we spoke to the medical officer of Manika, nurses in Manika and Kanina, and young people. The fourth day was spent in conversations with two

[9] As an example, the objectives for the malaria Healthy Family Campaign in terms of target population and behavior included (1) at least 50 percent of pregnant women in targeted *aires de santé* benefitting from IPT 3 according to national guidelines; (2) at least 60 percent of children under 5 with fever being taken to a health center; and (3) 100 percent of cases of fever tested with RDTs being brought to health centers. USAID IHP complies guidelines for testing people with suspected fever. During awareness-raising sessions, suspected cases are referred to the health facilities, where tests are conducted with RDTs.

NGOs: *Centre d'Initiative pour le Developpement Communautaire* (Community Development Initiative Center) and Ushindi.

- ***Workshop.*** USAID IHP held a June 17–18, 2019, co-creation workshop that introduced 39 community representatives to ways to foster empathy and deeply understand challenges others face. Participants questioned existing truths, talked about barriers and challenges in the health system, brainstormed potential solutions to top barriers, and created communications plans to address these main barriers in Kolwezi.

Co-creation workshops (above) generated ideas for the upcoming Healthy Family Campaign, such as the draft poster at right.

Comment pouvons nous rendre la communication plus interactive, plus efficace pour Lualaba?

Photo: Jason Coetzee, Matchboxology, for USAID IHP

Haut Lomami (Kamima)

- ***Immersion exercises.*** USAID IHP held in-depth conversations with stakeholders June 21–25, 2019. On the first day, we held internal team meetings of the USAID IHP team in Kamima to discuss the HCD objectives. The next day, we met with the Provincial Director of Health, the DPS Head of Communications, the registered nurse and midwife at Kamina General Hospital, and 11 young people. On Day 3, we held conversations with the priest of Kamina Church, the Minister of Health in Haut Lomami, and heads of local radio stations. The fourth day, we went to Louvouah, where we spoke with the village chief, nurses, the primary school director, the community liaison, and the head of the church.
- ***Workshop.*** A two-day co-creation workshop on June 27–28, 2019 involved 42 community representatives, who evaluated truths, discussed barriers and challenges, brainstormed solutions, and created communication campaigns.

Next quarter, USAID IHP will carry out immersion exercises and co-creation workshops in Tanganyika and Sud-Kivu. These remaining Healthy Family Campaign workshops will further refine prototype ideas and feed into creative content for the campaign media roll out. We will test prototypes in the Kananga ZS in Kasaï-Central, followed by iteration tests in Tanganyika. We will then present the pre-final Healthy Family Campaign content at the national level and co-host a campaign workshop with Breakthrough Action to finalize strategy and content. We will also conduct training of trainers on interpersonal skills development for health facility staff.

Conducted training of RECO on TB contact tracing

In Sud-Kivu, USAID IHP supported the CPLT, which worked through the DPS, to train 20 RECO (11 men and nine women) from the Kadutu and Bagira ZS on investigation of TB index cases. After this June 25–26, 2019, training, we will support RECO to raise awareness on the need for investigation of contact cases and referring suspected cases to care centers. The training also covered how to prepare monthly reports.

Provided support for implementation of an action plan for the community champions approach

Contributes to indicators:

Indirectly ✔ 2.7.1 ✔ 3.4.1

In Lualaba, the Program provided technical and financial support to the DPS to organize a workshop on the development of action plans for four champion communities; this approach emphasizes commitment, ownership, and sustainability of community-based actions. We asked participants in advance about their expectations and anticipated outcomes for this even; they said they wanted a deeper understanding about health system functioning to better equip them to engage during the event. Organizers incorporated this into the agenda. Sixteen community members (11 women and five men) participated by systematically analyzing the health and social situations in their communities. They identified critical health issues and priorities, identified strategies based on consensus and community participation, and developed realistic community action plans.

Provided technical and financial support to mini-campaigns

Indirect contribution to all malaria, TB, family planning, and behavior change indicators.

USAID IHP supported eight mini-campaigns for social and behavior change (SBC) that reached almost 30,000 people. The campaigns—four on malaria, three on family planning, and one on TB—raised awareness about priority health behaviors and encouraged greater utilization of health services. We had originally foreseen carrying out 18 mini-campaigns: two in each of our nine target provinces. However, funding challenges meant we only completed eight mini-campaigns in four provinces; next quarter, we will complete the other campaigns.

The campaigns targeted behaviors such as voluntary testing for malaria and TB and promptly seeking appropriate health services. The family planning campaign aimed to create demand for modern contraceptive methods. Each mini-campaign involved multiple players who played vital grassroots roles: the DPS, the ECZS; CODESA; community based organizations; RECO; CBD; nurses; community members; community leaders, including community champion members and youth peer educators; students; and educators.

Before the mini-campaigns, organizers worked with community members to identify issues specific to each focus area and conduct root cause analyses, which they used to develop feasible communications plans. They also examined data on malaria and TB to determine which ZS had low rates of TB detection and malaria counseling (IPTp and fever).

Malaria

USAID IHP provided technical and financial support for mini-campaigns on malaria in Haut-Katanga, Lualaba, Sankuru, and Sud-Kivu, each with a locally developed focus. The campaigns reached a total of 20,964 people.

- **Haut Katanga.** Over four days in the Kasenge ZS, five RECO went door to door to raise awareness among parents with children under 5. Overall, 336 women with children under 5 were reached and referred to health centers. Of these, 179 tested positive; all were treated based on the national policy for malaria care.
- **Lualaba.** During two mini-campaigns in the Kanzenze ZS, a total of 12 RECO and 10 community agents raised awareness of 3,524 women and 2,196 men on the prevention and management of malaria. A total of 181 pregnant women and 506 children under 5 were referred to health centers for MOH and malaria screening. Of these, 364 cases were positive, including 104 pregnant women and 260 children. During the mini-campaign, the DPS distributed LLINs to 166 pregnant women who came to prenatal sessions.
- **Sankuru.** The DPS organized mini-campaigns on the prevention of malaria in pregnant women in three *aires de santé* in the Lodja ZS. Twenty-four RECO visited households and provided information to pregnant women on the availability of improved prenatal care. Three registered nurses and three ECZS members supervised and closely monitored activities to ensure quality of the household visits and RECO efforts to convince pregnant women to complete their prenatal care. The mini-campaign raised awareness among 350 pregnant women, who were referred to health facilities for observed intake of SP.

Photo: Dieudonné Cigajira, IRC, for USAID IHP

Esperance Cibalonza got fast treatment for her son Eric during the mini-campaign in Kalwa Health Area that focused on diagnosing childhood fevers.

- **Sud-Kivu.** The malaria mini-campaign took place in three *aires de santé* in the Miti-Murhesa ZS. Thirty RECO—10 in each *aire de santé*—made door-to-door households visits, and criers with megaphones made announcements throughout the villages. RECO referred potentially ill children under 5 to health centers for diagnosis and case management. For two days during the World Malaria Day celebration, health centers were opened to the population for guided tours to show services offered. This helped direct children under 5 and pregnant women with a fever to health centers for free support. During the mini-campaign, RECO raised awareness among 14,558 people, including 6,447 men and 8,111 women, and referred a total of 518 children under 5 to health centers. Ultimately, 283 children were taken to the centers, of whom 152 had a positive RDT. The RECO also referred 81 pregnant women to health centers; 27 women went, of whom 10 had a positive RDT. Per national policy, RDTs and care were provided free to all people that arrived at health centers with fevers.

Tuberculosis

From May 16 through 20, 2019, USAID IHP supported the Lomami DPS to organize a mini-campaign to fight TB and improve detection of TB in six *aires de santé* in the Kamana ZS. Members of the CPLT briefed 12 RECO, 17 registered nurses, and five nurse-supervisors on the signs of TB and on interpersonal communication to facilitate high-quality counseling and dialogue with clients. At the end of the briefing, RECO went door to door to raise awareness and screen for active TB cases. After five days, the campaign raised the awareness of 513 people and referred them to health centers for screening, treatment, and care. Of these, 45 tested positive.

Family Planning

USAID IHP supported family planning mini-campaigns in three provinces to create demand for modern contraceptive methods. The campaigns were held in four *aires de santé* in the Kipushi ZS and five *aires de santé* in the Kisanga ZS in Haut-Katanga; three *aires de santé* in the Wikong ZS in Lomami; and three *aires de santé* in the Fungurume ZS in Lualaba. All followed a similar method. We worked with the DPS and PNSR, as well as with the ECZS, to brief providers and RECO and organize household visits and theater group performances. We also supported providers who had been retrained on counseling and informed choice to ensure they administered modern contraceptive methods effectively. The campaigns reached a total of 8,513 people in the three provinces, as summarized in Table 9.

Table 9: Number of people reached through SBC campaigns, April–June 2019

	People Reached	Women	Men
Haut-Katanga	4,534	2,765	1,769
Lomami	3,690	2,656	1,034
Lualaba	289	273	16
TOTAL	**8,513**	**5,694**	**2,819**

Data source : USAID IHP 2019

- **Haut-Katanga**. Mini-campaigns reached 1,830 households and raised awareness among 4,534 people (1,769 men and 2,765 women). A total of 793 people, including 657 women, became new users of a modern contraceptive method. According to the ECZS teams, the key challenge in the two ZS targeted by the mini-campaign is the low level of knowledge of the population about family planning.
- **Lomami**. During the DPS-organized mini-campaign on May 29–31, 2019, ECZS members first briefed 24 DBC, 30 community leaders, 18 youth peer educators, and six registered nurses on communication techniques and the administration of modern contraceptive methods. For three days, they conducted 23 community awareness sessions in markets, churches, and youth spaces, as well as with traditional and customary authorities. The campaigns reached a total of 3,690 people (2,656 women and 1,034 men) of whom 1,723 (1,144 women and 579 men) were counseled about family planning (of these, 1,508 were under 20). The campaign registered 999 new users of modern family planning methods; another 68 users renewed their modern family planning methods.
- **Lualaba**. The mini-campaign involved 16 RECO and 10 community champion members, who spent two days conducting individual interviews and facilitating group activities in households, markets, and churches. The campaign raised awareness and made health center referrals among 289 people, including 273 women and 16 men.

Supported family planning mini-campaigns targeted at vulnerable groups

Contributes to indicators:
Directly ✓ 3.3.1

USAID IHP supported family planning mini-campaigns in three provinces, as described in the activity above.

In addition to SBC campaigns, USAID IHP uses a variety of other tools to tackle the need for increased use of modern contraceptives in the DRC. We encourage new users to adopt modern family planning methods by carrying out multi-media campaigns; supporting training for both community-based and facility-based family planning providers; and actively supporting DPS, ZS, and community organizations engaged in family planning activities. The Program saw particularly strong results in this area during this quarter, as shown in Table 10.

Table 10: Number of acceptors new to modern contraception in USG-supported family planning service delivery points

Region	Target	Achieved	Percent of Target
Kasaï region	94,845	83,322	87.9
Katanga region	70,279	97,243	138.4
Eastern Congo region	53,378	56,919	106.6
Overall	218,502	**237,484**	**108.7**

IR 3.2: INCREASED USE OF FACILITY AND COMMUNITY BASED HEALTH SERVICES

Provided technical and financial support to organize community-based forums by ZS on health promotion

Contributes to indicators:
Indirectly ✓ 2.6.2 ✓ 2.6.3 ✓ 2.6.4

In **Haut Katanga**, USAID IHP provided technical and financial support to the DPS for the organization of nine community-based forums in four *aires de santé* (Kilwa, Pweto, Kasenga, and Lukafu). The events were attended by a total of 225 people, including 152 men, 36 women, 17 girls, and 20 boys. The focus varied according to the sites. Some raised awareness about late care-seeking behavior for children under 5 with a fever; others focused on adoption of healthy behaviors related to environmental sanitation. Participants agreed on common measures, developed action plans, and committed themselves to act together in alignment with the schedule in their action plans.

In **Sud-Kivu**, we supported the DPS to organize three community-based forums in the Katana ZS, attracting 120 people from three *aires de santé* (12 women and 28 men from Ciranga, 17 women and 23 men from Kabamba, and 10 women and 30 men from Kabushwa). The debates focused on the community's use of health services and adoption of healthy WASH behaviors (e.g., use of hygienic latrines and hand-washing).

Participants made a commitment to build 120 latrines in July 2019 (40 per *aire de santé*) and to sensitize other members of the community about the construction of hygienic latrines. Each *aire de santé* has defined its priorities, developed a related action plan in a participatory manner, and set up

implementation monitoring teams. These action plans will guide the implementation of WASH work plan activities during the upcoming reporting period. Future community-based forums will take place in six months to assess the level of achievement and define new priorities.

Supported the Lomami DPS to raise providers' awareness of health center services

Contributes to indicators:
Indirectly ✔ 2.5 ✔ 2.9 ✔ 2.2.2

USAID IHP support for mini-campaigns on malaria, family planning, and TB, as described under IR 3.1, not only enabled the population to have access to free care during the campaigns, but also raised their awareness of the services available at health centers. These awareness-raising efforts should continue, but activities must also focus on the variety of services offered at health facilities and within communities.

This quarter, USAID IHP supported the Lomami DPS to raise the awareness of 26 providers on the importance of promoting the services offered in their health centers. Each registered nurse was asked to draw up a list of functional services and describe them, then to provide these descriptions to RECO and other community agents to disseminate within households and during conversations with community members. The registered nurses were instructed to follow their RECO's lead to make the health centers' various services better-known.

Supported ZS to conduct mapping exercise to identify key influencers and design engagement plans

Contributes to indicators:
Indirectly ✔ 8 ✔ 9 ✔ 10 ✔ 11

In Haut Lomami, USAID IHP supported the DPS to carry out an investigative inquiry into why members of a religious group in the Luvua *aire de santé* in Kamina ZS refuse to vaccinate children. This inquiry found religious leaders and members of the group believe immunizations cause harm; they also mistrust both routine vaccinations and mass immunization sessions. Three of its members committed to help get the group at accept vaccination. They aided in identifying local influencers—a school principal, a member of the Batwa Bemba NGO, and a mother close to the religious leader—who will maintain contact with the religious group.

The DPS invited members to attend a workshop and stimulated dialogue around the issue. The approach also included bringing immunization skeptics to attend preschool consultation sessions at the health center, inviting members of the religious group to hear testimonies from mothers during vaccination sessions, and creating a vaccination site. After a month of contact with the church members, the influencers said the members are receptive and their leader is open to discussions with health professionals to better understand differences between mass and routine immunization and their benefits. The DPS will be informed weekly about the evolution of the behavior of the group and the leader's willingness to support the process.

In Haut-Katanga, USAID IHP technical staff supported the communication unit of the DPS to help the Kasenga ZS and Lukafu ZS brief 28 participants (eight ECZS members and 10 community members in each of the two ZS) on how to develop and analyze an influencer map and community engagement plan.

Snapshot: Students learn about reproductive health through school competitions

A third of the DRC's 78.7 million people are between 10-24 years old, many of whom lack knowledge of sexual and reproductive health issues. In 2018, the Ndekesha health zone registered 929 cases of teenage pregnancy and 2,659 incidents of sexually transmitted infections among teens.

USAID IHP technically and financially supported question-and-answer competitions to improve youth understanding of sexual and reproductive health issues. In Kasaï Central, the competition gave a multiple choice questionnaire to 387 secondary school students (100 girls and 287 boys) in the Ndekesha Health Zone and also involved teachers, prefects, and principals.

The school campaign focused on decreasing risk-taking behaviors and promoting awareness about early and unwanted pregnancies. Questions aimed to improve young people's knowledge about how to prevent unwanted pregnancies, sexually transmitted infections, early marriage, and child sexual abuse—even how to refuse unwanted sexual advances.

The Ndekesha Health Zone Winners Group was invited to Arc-en-Ciel Community Radio to explain what they had learned during the competition.

"I will never get pregnant early, because [the competition] supported by USAID laid out the consequences and harmful effects of early pregnancy and what needs to be done to prevent it," said Ivette Ngalula, a sixth-form student.

Participants established a list of influencers in each ZS and developed a commitment plan. Finalization and approval by all participants will take place during the coming quarter.

In Sankuru, USAID IHP supported a workshop to identify key influencers and leaders in vulnerable communities who will help strengthen healthy cultural values, raise awareness about issues related to child protection, and incorporate children's and women's protection strategies into SBC action plans. This workshop was attended by 20 people—13 members of the local community-based organization, five political-administrative authorities, one DPS delegate, and one representative from the PNSR—hailing from nine ZS: Lodja, Ototo, Omendjadi, Vangakete, Djalo Ndjeka, Katako, Tshumbe, Dikungu, and Bena Dibele. The group determined community actions to overcome cultural barriers that oppress women and children; next quarter, they will report on those actions.

In Sud-Kivu, the Program provided technical support for a two-day meeting on SBC in Katana ZS, attended by 46 community leaders (11 women and 35 men) from various social strata, including community service organizations, CODESA, religious denominations, BCZS, and health centers, as well as political-administrative authorities (chieftains and territory and administrative management officers) and community leaders. Participants discussed leadership and management, change techniques, the cycle of community engagement, how to conduct an advocacy campaign, and WASH. We helped establish a community dynamic around leaders and sought to rekindle leaders' awareness of the need to get involved in finding solutions to community problems.

IR 3.3: REDUCED SOCIO-CULTURAL BARRIERS TO THE USE OF HEALTH SERVICES AND THE PRACTICE OF KEY HEALTHY BEHAVIORS

Launched an SMS- and IVR-based survey on access to integrated and quality health services

Contributes to indicators:

Indirectly ✔ 18 ✔ 1.4.1 ✔ 2.9 ✔ 2.5 ✔ 3.1

As described in IR 1.5, we initiated a baseline survey this quarter on citizen behavior and perceptions. The questions are designed to help USAID IHP understand barriers to adoption of healthy behaviors, including use of health services, in target ZS.

Provided technical and financial support for question-and-answer competitions in secondary schools on family planning, malaria, gender, and WASH

Contributes to indicators:
Directly ✓ 3.3.1

USAID IHP supported question-and-answer competitions in two schools in Kasaï-Central to improve secondary school students' knowledge of handwashing, malaria, family planning, and gender. Sixty-one students from the Veterinary Institute in the Bilomba ZS and 51 students from Katabua High School in the Ndekesha ZS participated. Teachers will next guide classroom debates around these themes to improve students' knowledge. USAID IHP has set up an SBC initiative of the Healthy Family Campaign targeting young people in Kasaï-Central.

IR 3.4: STRENGTHENED COLLABORATION BETWEEN CENTRAL AND DECENTRALIZED LEVELS THROUGH SHARING OF BEST PRACTICES AND CONTRIBUTIONS TO POLICY DIALOGUE

Provided support for meetings to share lessons about community-based activities

USAID IHP supported two civil society meetings—one each in the Kasenga and Lukafu ZS in Haut-Katanga—that gathered 18 community influencers from 12 local organizations (nine each in Kasenga ZS and Lukafu ZS). Participants shared information about opportunities to support malaria control efforts in their ZS, including home-based monitoring of LLIN use; environmental sanitation; and raising awareness about prenatal care standards. Civil society organizations are open to discussion and sharing their experiences in the fight against malaria. To this end, they made commitments to support ZS efforts to fight malaria, including carrying out activities for environmental sanitation, raising awareness among pregnant women for to monitor antenatal care, and doing home monitoring of LLIN use. The key lesson learned is that ZS authorities should involve civil society in raising community awareness and finding solutions to health problems.

OBJECTIVE 3 SUMMARY

Objective 3 had a lower number of planned activities (46) than the other two objectives. The proportion of activities that started was lower, at 52 percent, but nearly all of the started activities were completed. This means that 50 percent of activities were started and completed. The same operational problems and funding challenges as under Objective 1 and Objective 2 caused this low level of performance.

Objective 3: Status of Activity Implementation by Province

IR	Page	Activity	H-KAT	TAN	SAN	KAS-C	LUA	H-LOM	LOM	KAS-O	SUD
IR 3.1 INCREASED PRACTICE OF PRIORITY HEALTHY BEHAVIORS AT THE INDIVIDUAL, HOUSEHOLD, AND COMMUNITY LEVELS											
3.1	**43**	Provide technical and financial support to advocacy and celebrations of world day or national days									
3.1		Promote optimal infant and child feeding (OICF) approach through culinary demonstration with breastfeeding mothers									
3.1	**50**	Support family planning mini-campaigns targeted at vulnerable groups									
3.1		Provide technical and/or financial support to DPS for developing communications plans									
3.1	**47**	Conduct training of RECO on TB contact tracing									
3.1		Fund transport costs for CHWs to follow-up TB cases									
3.1	**47**	Provide support for implementation of an action plan for the community champions approach									
3.1	**45**	SBCC strategy finalization and Healthy Family Campaign co-creation content development									
IR 3.2 INCREASED USE OF FACILITY- AND COMMUNITY-BASED HEALTH SERVICES											
3.2		Support training in family practices for 2 Communautes Championnes and CODESAs									
3.2		Support ECZS in organizing open door days in health centers									
3.2	**50**	Provide technical and financial support to organize community based forums by ZS on community action and health promotion									
3.2		Conduct peer educators training for youth and adolescents on Adolescent and Youth Sexual and Reproductive Health									
3.2		Support initiatives of ZS to support vulnerable communities in designing interventions to reduce socio cultural barriers									
3.2	**51**	Support ZS to conduct mapping exercise to identify key influencers and design engagement plans									
3.2		Provide technical and financial support to province level workshop to identify socio-cultural barriers for health services access									
IR 3.3: REDUCED SOCIO-CULTURAL BARRIERS TO THE USE OF HEALTH SERVICES AND THE PRACTICE OF KEY HEALTHY BEHAVIORS											
3.2	**53**	Provide technical and/or financial support for Q&A Competitions in secondary schools									
IR 3.4 INCREASED COLLABORATION											
3.4		Provide support to staff of ECZS to write success stories									

Key

- Planned for the quarter and completed
- Planned for the quarter and in process of implementation
- Planned for the quarter, but not implemented
- Not planned for the quarter

6. CROSS-CUTTING AREAS

6.1 INSTITUTIONALIZATION AND SUSTAINABILITY OF GENDER EQUALITY

USAID IHP's initial Gender Analysis and Implementation Strategy (approved December 10, 2018) analyzed gender at the environmental, social, economic, and structural levels. However, it did not focus primarily on the perceptions, beliefs, and gender sensitivity of the USAID IHP staff involved in implementation of the gender mainstreaming strategy. We will continue to implement gender-related activities in accordance with the recommendations in the Gender Analysis and Implementation Strategy, but also recommend more in-depth analysis in specific areas, as described below. This complementary study will target a group made up of MOH agents, ZS staff, civil society members for community engagement, and a few key USAID IHP staff. The complementary study will analyze gaps and update the Gender Analysis and Implementation Strategy.

In addition, USAID IHP will continue to sensitize our staff on the importance of women's representation in leadership and management.

Trained nine capacity building team members on gender integration in institutional capacity building

USAID IHP included a gender module in its May 21–23, 2019, training of nine new Provincial Capacity Building Advisors to efficiently support health system strengthening for the DPS (see Capacity Building section below). The gender module, informed by the results of and recommendations from the USAID IHP gender analysis, should ensure that advisors are gender-sensitive as they support DPS management.

All advisors trained were men. A values clarification exercise found that their perceptions of gender equality varied: some expressed beliefs in gender equality for women, while others said gender equality is important in sexual and reproductive health and rights but not in management. Next quarter, USAID IHP will conduct a gender audit to analyze and define gender perceptions and produce a training plan.

At the end of the session, participants practiced conducting a gender-sensitive capacity-building needs assessment for the DPS and IPS. In groups, participants analyzed the DPS recruitment process and developed a capacity building strategy to enable more women to join the ministry team.

Organized trainings of DPS teams and Program staff on Do No Harm Principles, conflict sensitivity and zero tolerance on sexual abuse and exploitation

During three trainings on conflict sensitivity (see Conflict Sensitivity section below), the USAID IHP Gender Advisor facilitated sessions to discuss zero tolerance on sexual exploitation, abuse, and harassment in the workplace within the Program's three targeted provinces. The sessions reviewed key definitions of sexual harassment, violence, and abuse; international and national legal frameworks on sexual abuse and exploitation; how gendered power dynamics can influence or reinforce gender-based inequalities, violence, and vulnerability; and prevention measures.

Applied a gender lens to USAID IHP internal sectoral documents

USAID IHP's Gender Advisor reviewed the WASH interview guide, finding that it should reflect gender balance in recruiting personnel assigned to the work and should consider the gender-specific needs of

men, women, girls, and boys in the targeted communities. The Gender Advisor also made several suggestions for improving the Program's research and learning agenda, including:

- In-depth analysis to guide integration of recommendations from the USAID IHP gender analysis reports into program activities and test their influence on key outcomes;
- Small studies to analyze how gendered practices influence people's perceptions and interactions; and
- Consideration of other issues around power relations and how they operate with regards to ethnicity, socioeconomic status, education, and disability status.

6.2 CONFLICT SENSITIVITY

In April 2019, USAID IHP trained 63 Program staff and provincial government officials (13 women and 50 men) in IRC's Conflict Sensitivity toolkit (see Table 11). The training enabled participants to better understand risks within Program implementation and ensure their behaviors and practices do not harm communities supported by the Program. During the three-day workshop, participants also reviewed the findings of USAID IHP's Conflict Sensitivity Analysis (published in August 2018), received extensive training on the Do No Harm framework, and discussed ethical challenges faced by staff and government officials in conflict settings. In their evaluations, most participants said they would recommend this training to a friend or colleague, and more than 70 percent of participants scored higher in the post-test than in the pre-test. Next quarter, USAID IHP will develop and implement the Do No Harm and Conflict Sensitivity Continuous Learning Strategy to ensure knowledge gained during the workshop translates into behaviors and practices of staff and government partners.

Table 11. Do No Harm Workshop participant attendance by region

Region and Dates	Sex	DPS	USAID IHP	Total
Katanga April 2-5, 2019	Women	0	2	2
	Men	6	14	20
	TOTAL	**6**	**16**	**22**
Eastern Congo April 8-10, 2019	Women	0	5	5
	Men	6	7	13
	TOTAL	**6**	**12**	**18**
Kasaï April 15-18, 2019	Women	1	5	6
	Men	7	10	17
	TOTAL	**8**	**15**	**23**

6.3 CAPACITY BUILDING

USAID IHP designed and facilitated a May 21–23, 2019, workshop in Kinshasa to strengthen the knowledge and skills of nine newly hired USAID IHP Provincial Capacity Building Advisors, clarify their roles, and identify lessons learned from the PICAL assessments. Joined by eight Kinshasa-based advisors, participants reviewed the three completed institutional assessments and shared experiences and lessons learned. The workshop yielded a better understanding of links between capacity strengthening plans and yearly PAO; ultimately, capacity building interventions will be included in the formal DPS PAO.

The workshop included a component to strengthen two sets of skills to implement institutional capacity building interventions: 1) facilitating effective meetings and 2) coaching, which complements workshop-based interventions and reduces reliance on training. Participants also discussed how best to approach

gender issues and identified portions of the PICAL instrument that can draw out gender-related data (see gender section above). All Capacity Building Advisors planned to share the workshop content with fellow provincial USAID IHP staff and with DPS staff. The advisors agreed to remain in contact with each other, forming a community of practice along with USAID IHP consultants in capacity building.

In a separate activity, USAID IHP accelerated completion of the seven DPS assessments and two ZS pilot institutional assessments by July 2019 instead of September 2019 as originally planned. This will enable earlier implementation of actual institutional capacity building interventions to maintain momentum with the DPS. USAID IHP is reviewing potential interventions from assessments conducted in three DPS and from existing PAO of the DPS yet to be assessed.

6.4 ENVIRONMENTAL MITIGATION AND MONITORING

The Program engaged in several activities this quarter aimed at ensuring that we comply with required environmental measures and regulations.

- USAID IHP's WASH Advisor participated in a May 13–14, 2019, training workshop for USAID/DRC staff and partners on "USAID Environmental Compliance + Environmentally Sound Design and Management in Project Implementation."
- A team from USAID/DRC's Environmental Office traveled to health centers in the Katana ZS in Sud-Kivu from May 7–10, 2019, accompanied by USAID IHP staff. The mission evaluated implementation of USAID environmental procedures, including interviews of health center staff. The team included Diane El Mbanzidi, Mission Environmental Officer; David Kinyua of USAID/East Africa; and James Jolley, an outside evaluator.
- USAID IHP presented the Environmental Mitigation and Monitoring Plan (EMMP) and Climate Risk Management Plan (CRMP) at a June 4–7, 2019, workshop on the transitional work plan attended by the Program's Regional Directors, Provincial Directors, Kinshasa staff, and support staff from Abt headquarters. Staff learned how to take environmental mitigation measures into account in future work plans.
- We funded a workshop of the *Direction de l'Hygiène et Salubrité Publique* (DHSP) where participants validated a document on "WASH Standards and Guidelines in Care Settings." The draft of this document was shared with USAID IHP. This document was produced with the support of government stakeholders; the School of Public Health; and technical and financial partners, including UNICEF and USAID IHP. It was drafted previously, before the administrative validation phase that was supported financially by USAID IHP. The DHSP sent us the final version after this validation phase.

7. ACTIVITY RESEARCH, MONITORING, AND EVALUATION

Oriented program staff on the USAID IHP M&E system and procedures

USAID IHP completed provincial M&E orientation sessions in Lualaba, Haut-Katanga, and Kasaï-Central. As shown in Table 12, participants included 25 staff from Program's provincial technical teams and 10 representatives of the SNIS office at the DPS.

Table 12. Participants in USAID IHP M&E Systems and Procedures Orientation

Province	PROSANI		DPS SNIS Office		Total Participants
	Women	Men	Women	Men	
Lualaba	5	1	3	1	10
Haut-Katanga	7	0	2	1	10
Kasaï-Central	10	2	3	0	15

SNIS counterparts provided brief overviews and training on DHIS2 to our technical staff. The orientation sessions also covered the following topics:

- USAID IHP objectives
- The Activity Monitory and Evaluation Plan (AMEP)
- The Performance Indicator Tracking Table (PITT)
- The Performance Work Statement to link activities and expected outcomes
- Content and importance of the Performance Indicator Reference Sheets (PIRS)
- Program data flow and discussions of associated challenges
- Challenges linked to the SNIS M&E system
- Evidence-based decision-making
- Data quality assurance
- The reporting schedule
- Challenges linked to TB indicators

These sessions gave staff a clear understanding of the USAID IHP M&E system and their own roles in data collection and reporting. They also guided participants in ways to report, identify, and manage challenges related to data quality, especially those from DHIS2 and other MOH information systems.

Held an M&E retreat for national and provincial staff

We held an M&E team retreat in Lubumbashi from May 13–17, 2019, which brought together all national- and provincial-level USAID IHP M&E staff and some additional technical staff. This retreat provided in-depth training on using indicators to help develop activities, using Huddle to archive research, monitoring, and evaluation (RME) data, and tracking activities through the USAID IHP M&E platform. Participants also received in-depth training on DHIS2, with Program M&E staff developing dashboards with indicator data for work planning. Kinshasa-based RME staff coached other staff to use standard USAID M&E tools for work planning and reporting such as the PITT and PIRS, and the branding and marking plan. Participants covered the standard statistics required by the Program to use data and discussed opportunities and resources (human and software) for conducting more in-depth statistical analyses. The retreat also included sessions on data quality assurance for specific indicators, and the M&E group developed an internal schedule to ensure that timely M&E contributions to routine reports.

Began work on baseline household survey in USAID IHP target provinces

USAID IHP is carrying out a baseline household survey to establish a baseline for health-seeking behaviors. This will enable us to track desired changes over time, measured by follow-on surveys in years 4 and 7. To advance implementation of the baseline household survey, the Program worked to obtain USAID and partner feedback on survey questionnaires and protocol. We also sought approval for the study design from the Abt Associates Institutional Review Board (IRBs) and the *Comité National d'Éthique de la Santé* (National Health Ethics Committee). The Program selected EXPERTS SARL to conduct the survey. After USAID approved the choice, both parties signed the contract on June 12, 2019.

Immediately after signing the contract, USAID IHP shared first drafts of questionnaires, the study protocol, consent scripts (including parental consent and assent for minors), and the data security plan with EXPERTS for refinement. We then shared updated documents with USAID and our partners Breakthrough Action, and D4I for comments and observations. The Program submitted updated drafts to Abt's IRB, which was refining these documents as of the end of the quarter. Abt IRB-approved study materials will be submitted to the Kinshasa School of Public Health next quarter. We also will conduct a training of trainers during the coming quarter, to be immediately followed by the pilot.

The RME team has been coaching the subcontractor, working with them to develop "best practices" and high-quality deliverables to be submitted directly to USAID in the future under other contracts—moving this local firm along the pathway to sustainability.

Prepared and obtained approval for materials for baseline service delivery mapping survey in USAID IHP target provinces

This quarter, the Program finalized, submitted, and obtained USAID approval for the survey materials for a service delivery mapping survey (see IR1.5), which we then shared with the MOH for approval. The objective of the service delivery mapping survey is to identify all public and private health facilities in USAID IHP's target provinces. We will collect in-depth information on available services, equipment, and staff capacities to identify opportunities to improve equitable and efficient service provision through Program implementation. Next quarter, we will conduct a three-day workshop, convened by the DGOGSS, to bring together MOH experts to validate and approve the survey tools. Immediately following approval, USAID IHP and MOH experts will be deployed for training in provinces and to oversee data collection operations.

Held retreat with the MOH to create an additional DHIS2 module to capture data for USAID IHP indicators

The USAID IHP AMEP indicators come from various sources, including surveys, DHIS2, PICAL reports, and other Program monitoring reports. Some indicators in the USAID IHP PITT are collected at the facility in the register but are not routinely reported in the monthly reports that are entered into DHIS2. To capture this data, we have negotiated with the MOH—through the Health Management Information System (HMIS)—to create an additional form the MOH will collect on behalf of USAID IHP to ensure data for these 22 additional indicators are captured and entered into DHIS2 for Program use.

This additional module was created during a workshop in Kinshasa from June 7–12, 2019. Three USAID IHP staff joined two MOH representatives at this workshop. Once the tools are printed, USAID IHP will support MOH trainings and test the module in Haut-Katanga, Kasaï-Central, and Sud-Kivu starting August 15, 2019.

Developed a research and learning agenda

During this quarter, USAID IHP developed a research and learning agenda that outlines our objectives and presents our approaches to achieve these objectives. The agenda—developed with inputs from USAID, MOH counterparts, and different public health schools—is structured around four interrelated research domains: 1) evaluation research, 2) operations research, 3) implementation research, and 4) health systems research.

Data for the evaluation research will come from three main sources: household surveys, the service delivery mapping survey, and qualitative investigations.

Six topics critical for USAID IHP's success form the basis of our implementation research/operations research agenda:

1. Health information system data quality and use for decision-making
2. Availability of essential health commodities
3. Health governance, leadership, and accountability
4. Innovative SBC communication
5. Quality of care improvement
6. Innovative health financing models

Finally, our activities under health systems research will address a wide range of questions arising from the implementation research/operations research agenda.

Following approval by USAID in late May 2019, USAID IHP shared our research agenda with our partners, namely the Kinshasa, Lubumbashi and Bukavu Schools of Public Health; Data for Impact (D4I); Breakthrough Action; and the *Centre de Connaissance Santé en RDC* (DRC Health Knowledge Center).

The Program initiated the following activities in June:

- Drafted an expression of interest for participatory action research on the sustainability of WASH services in Sud-Kivu and Kasaï-Oriental
- Planned formative research to understand USAID IHP staff perceptions of gender and identify gaps to be filled in to better incorporate key gender considerations in the Program
- Liaised with D4I and Breakthrough Action to brainstorm on publications, based on data from the baseline household survey, service delivery mapping survey, and (possibly) client exit interviews and provider interviews conducted by D4I.

In the next quarter, we will hold discussions with the USAID/Washington M&E Focal Person and the D4I/Malaria Project about a proposed 2019 publications plan, which will focus on two papers examining 1) quality of HMIS/DHIS2 data; and 2) use of HMIS/DHIS2 data for decision-making. Based on the FY2020 USAID IHP work plan, we will then develop the FY2020 plan for implementation research and operations research, which will also substantiate USAID IHP's collaborating, learning, and adapting (CLA) framework. In addition, we will work with partners on publications; at this point, our aim is to commission a special series of articles for a yet-to-be-identified peer-reviewed journal.

8. LESSONS LEARNED

This quarter brought opportunities to reflect on programmatic, operational, and strategic questions.

Ownership of the research agenda is jointly held between Ministry of Health and Ministry of Education institutions.

The Program's new research and learning agenda generated great interest from staff, partners and other stakeholders. In the course of preparing this agenda, we learned its ownership by the MOH partner at every relevant level is going to be important in coming years. The PNDS 2019-2022 recognizes the imperfect link between the MOH that produces the services and the Ministry of Education that provides the workforce. The research agenda is an opportunity to enhance collaboration between these ministries by ensuring greater involvement of research institutions.

Institutional strengthening and refusing dependence

Our financial and operational support to ZS and provinces has created unintended, natural experiment conditions for studying donor withdrawal and its consequences. MOH is financially dependent on international donors, which has become their expectation versus asking their own institutions/government for funding, Program staff has observed that when our financial support unexpectedly falls through, or when a province has to cope with a sudden emergency or unforeseen event (e.g. withdrawal of long-term partner; loss of assets due to accidents or theft; increase of certain needs during epidemics), institutional heads do not favor our suggestion to explore solutions within domestic resources. We have learned that institutional strengthening must explicitly addressing this trend towards donor dependence as we together explore new avenues for health financing.

A Ministry of Health in need of its own success stories

As we engage with our counterparts at zone, province and national level, we are learning untold stories about the many women and men who work tirelessly, day in day out, to serve their fellow Congolese. The health system is much better at identifying what does not work than in celebrating what is working, and the MOH has adopted the language of donors for whom there can be no solution without a problem. Our counterparts confirm that this is the new normal: denial of intrinsic capabilities. USAID IHP can help reorient this thinking toward celebrating MOH and community achievement and progress and transfer to MOH counterpart institutions the ability to identify and generate more positive narratives for target audiences in public, private and civil institutions.

PNDS 2019-2022 guiding principles can navigate a complex health system

Most challenges of health systems-strengthening programs stem from traditional thinking about tackling problems in isolation, e.g. instructions that ignore how people actually behave; supply chain interventions that ignore the economics of health commodities as sources of income, not just lifesaving products. During discussions with our anchor at MOH, i.e. the *Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé*, we agreed the six guiding principles underlying PNDS 2019-2022 implementation show how to interact within complex networks. We have encountered surprising openness to developing novel intervention strategies that follow these guiding principles, as referred to in our capacity-building strategy document.

ANNEX A: PERFORMANCE INDICATORS, TARGETS, AND ACHIEVEMENTS

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
Goal:	**Sustainably improved ability of the DRC health system to deliver quality services by building the leadership, management, and technical capacity of Congolese institutions and communities**											
1	IHP DRC Impact: MMR, U5MR, Neonatal MR, Infant MR, TB case notification rate, malaria mortality rate, CPR, and acute and chronic malnutrition rates*	Impact†									By definition, this data will be provided by USAID.	N/A
		Kasaï										
		Katanga										
		E. Congo										
2	FP: Percentage of married women using any modern method of contraception	Outcome	5.2%	5.9%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	4.8%	5.5%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	4.4%	5.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	6.7%	7.7%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
3 Fee Proxy	FP: Number of acceptors new to modern contraception in USG-supported family planning service delivery points (PROXY)	Outcome	848,549	869,763	218,502	**237,484**	108.7%	N/A	N/A	DHIS2	Katanga and Eastern regions far exceeded targets. We will work with DPS in Kasaï to realize improvements.	It is necessary to readjust the targets for the Katanga region. Provincial teams are investigating the reasons why Katanga and E. Congo exceeded their targets.
		Kasaï	368,326	377,536	94,845	**83,322**	87.9%	N/A	N/A	DHIS2		
		Katanga	272,927	279,750	70,279	**97,243**	138.4%	N/A	N/A	DHIS2		
		E. Congo	207,296	212,477	53,378	**56,919**	106.6%	N/A	N/A	DHIS2		
4 Fee	MNCH: Percentage of children 0-59 months of age for whom treatment/advice was sought for acute respiratory infection	Outcome	50.3%	52.3%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	53.7%	55.7%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	53.0%	55.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	42.3%	44.3%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
5 Fee Proxy	MNCH: Number of children under five years of age that	Outcome	1,143,154	1,171,735	294,363	**294,351**	100.0%	N/A	N/A	DHIS2	The completion	Readjust the targets for the

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
	received treatment for an acute respiratory infection from an appropriate provider	Kasaï	569,695	583,938	146,697	**141,897**	96.7%	N/A	N/A	DHIS2	rate is 100% although the ZS have shortages of some essential drugs.	Katanga and E. Congo. Verify the data in ZS of key provinces. Provincial team is investigating why Katanga exceeded its target.
		Katanga	229,925	235,674	59,206	**61,230**	103.4%	N/A	N/A	DHIS2		
		E. Congo	343534	352123	88,460	**88,517**	100.1%	N/A	N/A	DHIS2		
6 Fee	MNCH: Percentage of children 0-59 months for whom treatment/advice was sought for diarrhea	Outcome	38.0%	40.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	34.8%	36.8%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	33.3%	35.3%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	46.5%	48.5%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
7 Fee Proxy (Standard /PPR)	MNCH: Number of cases of child diarrhea treated in USG-supported programs (PROXY)	Outcome	1,041,286	1,067,317	268,131	**209,907**	78.3%	N/A	N/A	DHIS2	The Kasaï region has poor performance.	Kasaï must improve the completeness (<90%) and timeliness (<60%) of data for Kasaï Oriental and Sankuru.
		Kasaï	476,895	488,818	122,801	**77,976**	63.5%	N/A	N/A	DHIS2		
		Katanga	239,799	245,793	61,748	**62,162**	100.7%	N/A	N/A	DHIS2		
		E. Congo	324,592	332,706	83,582	**69,769**	83.5%	N/A	N/A	DHIS2		
8 Contract	MNCH: Percentage of children age 12-23 months who received all basic vaccinations	Outcome	44.8%	46.8%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	40.0%	42.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	45.4%	47.4%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	52.2%	54.2%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
9 Fee Proxy	MNCH: Number of children less than 12 months of age who received three doses of pentavalent vaccine (PROXY)	Outcome	1,157,027	1,185,953	297,935	**280,541**	94.2%	N/A	N/A	DHIS2	The overall performance is 94.2%, the Kasaï region having the lowest performance (<90%).	Verify the vaccination data in low performing ZS in Kasaï and availability of vaccines and commodities.
		Kasaï	479,997	491,996	123,599	**108,738**	88.0%	N/A	N/A	DHIS2		
		Katanga	344,494	353,106	88,707	**92,143**	103.9%	N/A	N/A	DHIS2		
		E. Congo	332,536	340,851	85,629	**79,660**	93.0%	N/A	N/A	DHIS2		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
10	MNCH: Number of children less than 12 months of age who received measles vaccine from USG-supported programs	Outcome	1,115,918	1,143,816	287,349	**276,197**	96.1%	N/A	N/A	DHIS2	Same observation as preceding indicator.	Same action as preceding indicator.
		Kasaï	478,162	490,116	123127	**110,506**	89.7%	N/A	N/A	DHIS2		
		Katanga	330,445	338,707	85090	**92,107**	108.2%	N/A	N/A	DHIS2		
		E. Congo	307,311	314,993	79132	**73,584**	93.0%	N/A	N/A	DHIS2		
11	MNCH: Percentage of children less than 12-23 months of age who received measles vaccine from USG-supported programs	Outcome	64.3%	66.3%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	61.6%	63.6%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	58.0%	60.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	75.6%	77.6%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
12 Fee	MNCH: Percent of pregnant women attending at least four antenatal visits with a skilled provider from USG-supported health facilities	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
13 Fee Proxy	MNCH: Number of pregnant women attending at least 4 antenatal care visits with a skilled provider (PROXY)	Outcome	778425	797885	200444	**201,917**	100.7%	N/A	N/A	DHIS2	The evolution of the indicator is generally satisfactory, only Kasaï did not reach its quarterly goal.	Work with the DPS to encourage women to start ANC.
		Kasaï	418461	428921	107753	**101,363**	94.1%	N/A	N/A	DHIS2		
		Katanga	174119	178472	44836	**48,536**	108.3%	N/A	N/A	DHIS2		
		E. Congo	185845	190492	47855	**52,018**	108.7%	N/A	N/A	DHIS2		
14 Fee	MALARIA: Percent of children under 5 years of age for whom treatment/advice was sought for fever	Outcome	37.7%	39.7%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	37.1%	39.1%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	41.4%	43.4%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	36.0%	38.0%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
15 Fee Proxy	MALARIA: Number of children under 5 years of age with confirmed malaria who received treatment for malaria from an appropriate provider in USG-supported areas (PROXY)	Outcome	2868866	2940588	738733	**674,515**	91.3%	N/A	N/A	DHIS2	The completion rate for the indicator is around 90%, Kasaï seems to	Verify case definitions in both provinces, also verify the availability of
		Kasaï	1397311	1432245	359808	**288,662**	80.2%	N/A	N/A	DHIS2		
		Katanga	681602	698641	175512	**195,175**	111.2%	N/A	N/A	DHIS2		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		E. Congo	789953	809702	203413	**190,678**	93.7%	N/A	N/A	DHIS2	have the lowest rates and Katanga the highest rate.	ACTs in both provinces.
16 Fee	MALARIA: Proportion of children 0-59 months who slept under an Insecticide treated net (ITN) the previous night	Outcome	53.5%	55.5%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	45.7%	47.7%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	61.9%	63.9%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	57.3%	59.3%	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
17 Fee Proxy	MALARIA: Number of insecticide-treated nets (ITN) distributed during antenatal and/or child immunization visits (PROXY)	Process	1,163,227	1,186,492	296623	**279,567**	94.2%	N/A	N/A	DHIS2	We have far exceeded expectations in Katanga.	Take our lessons learned in Katanga to improve performance in Kasaï.
		Kasaï	552,961	564,020	141,005	**87,640**	62.2%	N/A	N/A	DHIS2		
		Katanga	217,673	222,027	55,507	**78,097**	140.7%	N/A	N/A	DHIS2		
		E. Congo	392,593	400,445	100,111	**113,830**	113.7%	N/A	N/A	DHIS2		
18 Fee	Improved satisfaction by clients/citizens with the services they receive: % of individuals reporting satisfaction with health center services	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme.*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
19 Fee	Number of Basic Emergency Obstetric and Neonatal Center (BEmONC) or Comprehensive Emergency Obstetric Center (CEmONC) sites available in each province	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme.*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
20 Fee	Documentation and publication of operational research in peer reviewed journal	Process	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We did not have this in the Year 1 work plan.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
21 Fee	Conflict Sensitivity Analysis and Implementation Strategy	Process	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This indicator has been completed.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
22 Fee	Percent of targeted facilities with quality improvement action plans documented and being implemented	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
23 Fee	Capacity Development Approach	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This indicator has been completed.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
24 Fee	Gender Analysis and Gender Implementation Strategy	**Process**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This indicator has been completed.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
RESULT 1: Strengthened health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones												
1.1 Fee	Annual score derived from PICAL for USG-supported provincial health divisions	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.2	Percent of annual Provincial action plans and budgets aligned with National action plans and budgets (expected contract result)	**Outcome**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.3	Percentage of health zones with annual action plans and budgets that are aligned with provincial action plans and budgets (expected contract result)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.1: Enhanced capacity to plan, implement, and monitor services at provincial, health zone, and facility levels												
1.1.1	Percentage of DPS and health zones that have used data to produce their annual plans data analysis (expected contract result)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.1.2	Percentage of targeted sub-national health level divisions that successfully implement 80% of resourced action plan activities (expected contract result)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
1.1.3	Number of Results Based Financing (RBF) grants signed (expected contract result)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.2: Improved transparency and oversight in health service financing and administration at provincial, health zone, facility, and community levels												
1.2.1	Score for financial management sub-domains of the PICAL assessment for provincial health divisions (contract deliverable)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.2.2	PICAL assessment accountability sub-domain score for provinces and health zones receiving USG assistance (contract deliverable)	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.2.3	Percentage of DPS and Health Zones supported by the program that are audited with USAID IHP DRC technical and/or financial support (contract deliverable)	**Output**	N/A	100%	30.2%	**22.9%**	75.9%	41	179	PMR	Completion rate is 75.9% for program-supported regions; Katanga and Eastern Congo have the lowest rates.	Train IPS staff in auditing and using standardized reporting templates and audit tools.
		Kasaï	N/A	100%	31.2%	**29.9%**	95.8%	23	77	PMR		
		Katanga	N/A	100%	31.6%	**19.3%**	61.1%	11	57	PMR		
		E. Congo	N/A	100%	26.7%	**15.6%**	58.3%	7	45	PMR		
1.2.4	Number of tickets on the fraud and complaints hotline issue tracker (expected contract result)	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This activity has not yet begun.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.3: Strengthened capacity of Community Service Organizations (CSOs) and community structures to provide health system oversight												
1.3.1	Percentage of active CCSOs/CODESAs in health zones fully supported by the program, which receive financial support (contract deliverable)	Output	N/A	N/A	20.0%	**2.2%**	11.1%	68	3076	PMR	Percentage of active CODESA receiving financial support is low, only the Kasaï region was able to make this fund available for 68 SAs of 253.	Information to be verified for the Kasaï region and for other regions to provide the fund.
		Kasaï	N/A	N/A	20.0%	**5.4%**	26.9%	68	1268	PMR		
		Katanga	N/A	N/A	20.0%	**0.0%**	0.0%	0	916	PMR		
		E. Congo	N/A	N/A	20.1%	**0.0%**	0.0%	0	892	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
1.3.2	Number and Percentage of supported CSOs/CODESAs using accountability tools (such as scorecards and audit reports) to monitor and / or demand improvement of financial management and/or service delivery (contract deliverable) (contract deliverable)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This activity has not yet begun.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.3.3 Fee (Standard: CDCS-#)	Number of CSOs/CODESAs supported by the program that are woman-led (contract deliverable)	Outcome¥	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
IR 1.4: Improved effectiveness of stakeholder coordination at the provincial and health zone levels												
1.4.1	Percent of stakeholders who agree that their views are reflected in planning/policy processes	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
1.4.2 (Standard: CDCS-#)	Percent of coalitions or networks strengthened to fulfill their mandate as a result of USG assistance (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.4.3	Annual score of provincial level health divisions in PICAL sub-dimension 2.6 to assess for use of inclusive stakeholder feedback to inform decision-making and implementation (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.5: Improved disease surveillance and strategic information gathering and use												
1.5.1	Annual PICAL score of sub-national level health divisions	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
	assessed for information management capacity to monitor and inform their strategies (contract deliverable)	Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.5.2	Percentage of USG supported provinces and health zones with MAPEPI DHIS2 reporting rates > 95% (expected contract result)	Output	16.2%	21.7%	21.7%	**11.2%**	51.5%	20	179	DHIS2	In general, the MAPEPI % reporting is still too low. In the DHIS2 the average of all provinces is 51.5%. None has reached 70% reporting.	We will investigate the challenges to reporting and correct them.
		Kasaï	18.2%	20.2%	20.2%	**10.4%**	51.4%	8	77	DHIS2		
		Katanga	15.8%	18.7%	18.7%	**12.3%**	65.7%	7	57	DHIS2		
		E. Congo	13.3%	27.4%	27.4%	**11.1%**	40.6%	5	45	DHIS2		
1.5.3	Percentage of targeted DPS, ECZS and FOSA teams that use real-time data dashboards in routine management tasks (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.6: Improved management and motivation of human resources for health												
1.6.1	Average score of provinces and health zones assessed for HR management monitoring systems (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	Activity not yet started	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.6.2	Number of DPS/ECZS health workers trained in Human Resources Management using iHRIS (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	Activity not yet started	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.6.3	Number of ECDPs who have been coached according to Ministry of Health guidelines for Human Resources Management (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	Activity not yet started	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.6.4	Number of providers who have benefited from using the Pathways to Change tool to improve their attitudes and behaviors (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	Activity not yet started	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
IR 1.7: Increased availability of essential commodities at provincial, health zone, facility, and community levels												
1.7.1 (Standard: CDCS)	Number and percentage of USG-assisted service delivery points that experience a stock out of selected tracer commodities at any time during the reporting period (contract deliverable)	**Output**	71.7%	69.7%	69.7%	**50.7%**	127.2%	3060	6030	DHIS2	Fewer facilities reported stock outs of tracer drugs than in previous quarters.	We will investigate the immediate sources of success to continue to reduce this number
		Kasaï	77.9%	75.9%	75.9%	**49.9%**	134.2%	1299	2601	DHIS2		
		Katanga	61.4%	59.4%	59.4%	**50.4%**	115.1%	1055	2094	DHIS2		
		E. Congo	76.0%	74.0%	74.0%	**52.9%**	128.5%	706	1335	DHIS2		
1.7.2	Percent of USG supported health zones with LMIS reporting rates > 95% (expected contract result)	**Output**	32.4%	34.4%	34.4%	**20.1%**	58.5%	36	179	DHIS2	The reporting of SNIS MED is very weak.	Accelerate training on DHIS2 and later infoMed in program-supported provinces and FOSA.
		Kasaï	42.9%	44.9%	44.9%	**23.4%**	52.1%	18	77	DHIS2		
		Katanga	31.6%	33.6%	33.6%	**22.8%**	67.9%	13	57	DHIS2		
		E. Congo	15.6%	17.6%	17.6%	**11.1%**	63.1%	5	45	DHIS2		
1.7.3	Percent of supported sub-national level health divisions with a documented and budgeted distribution plan (expected contract result)	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have just introduced this tool and we will be collecting data in the next quarter	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
1.7.4	Percentage of Health Zones with improved conditions of medicines storage according the planned renovation (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We will not begin this activity until Y2, using the data from the EDL mapping activity.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 1.8: Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue												
1.8.1 (Standard DR.3.1-3)	Number of consensus-building forums (multi-party, civil/security sector, and/or civil/political) held with USG assistance (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
RESULT 2: Increased access to quality, integrated health services in target health zones												
2.1 CDCS (Standard /PPR)	FP: Couple years of protection (CYP) in USG-supported programs	Outcome	1,000,409	1025419	257605	**284,692**	110.5%	N/A	N/A	DHIS2	Only the Kasaï region has a rate <90%	We will check the data of the Katanga and Eastern regions to determine if it is necessary to adjust the target.
		Kasaï	383,777	393370	98822	**80,302**	81.3%	N/A	N/A	DHIS2		
		Katanga	329,122	337350	84749	**109,959**	129.7%	N/A	N/A	DHIS2		
		E. Congo	287,511	294699	74034	**94,431**	127.6%	N/A	N/A	DHIS2		
2.2	FP: Couple years of protection (CYP) after exclusion of LAM and Standard days methods (SDM) for FP in USG-supported programs	Outcome	937,735	961179	241467	**262,018**	108.5%	N/A	N/A	DHIS2	Only the Kasaï region has a rate <90%	We will check the data of the Katanga and Eastern regions to determine if it is necessary to adjust the target.
		Kasaï	360,468	369481	92821	**74,417**	80.2%	N/A	N/A	DHIS2		
		Katanga	303,164	310743	78065	**98,322**	125.9%	N/A	N/A	DHIS2		
		E. Congo	274,103	280955	70581	**89,279**	126.5%	N/A	N/A	DHIS2		
2.3	FP: Number of counseling visits for FP/ RH as result of USG support	Output	192,080	1087202	273126	**3,939**	1.4%	N/A	N/A	DHIS2	This indicator only gets data from zones that are using the old module *complementaire*	Trainings for the module *complement-aire* will begin next quarter so we will be able to reliably collect this information.
		Kasaï	150,200	471916	118554	**3,939**	3.3%	N/A	N/A	DHIS2		
		Katanga	26,796	349687	87848	**0**	0.0%	N/A	N/A	DHIS2		
		E. Congo	15,084	265599	66724	**0**	0.0%	N/A	N/A	DHIS2		
2.4 (Standard: CDCS)	MALARIA: Percent of pregnant women who received doses of sulfadoxine/ pyrimethamine (S/P) for Intermittent Preventive Treatment (IPT) during ANC visits	Outcome	67%	80%	80.0%	**64.2%**	80.2%	227577	354,646	DHIS2	Average in supported areas is 80.2%, the Kasaï region has a rate of <80%.	We want to assess the availability of trained staff
		Kasaï	70%	80%	80.0%	**61.8%**	77.3%	86907	140,575	DHIS2		
		Katanga	64%	80%	80.0%	**67.0%**	83.8%	76072	113,480	DHIS2		
		E. Congo	62%	80%	80.0%	**64.2%**	80.3%	64598	100,591	DHIS2		
2.5 (Standard: CDCS)	Percentage of population who use selected facilities	Outcome¥	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the Enquête Ménage de référence du programme	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
2.6		Outcome¥	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		N/A

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
	Percentage of Health centers supported by the USG implementing interventions to support the minimum package of activities (contract deliverable)	Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey référence du programme	
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
2.7	Percentage of hospitals supported by the USG implementing interventions to support the complementary package of activities. (expected contract result)	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey référence du programme	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
2.8	Percentage of supported health facilities using MOH QoC tool (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We will not begin this activity until Y2, using the data from the EDL and EDM activities.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.9 (Standard: CDCS)	Percentage of population reporting improved availability of selected services	Outcome¥	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the Enquête Ménage de référence du programme	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
IR 2.1: Increased availability of quality, integrated facility-based health services												
2.1.1 (Standard)	FP: Percent of USG-assisted service delivery sites providing FP counseling and/or services	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2	This is an annual indicator	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
2.1.2	MNCH: Percentage of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider from USG-supported health facilities	Output	95.7	100%	100%	**88.0%**	88.0%	354646	403191	DHIS2	The average CPN1 in the regions is 88.0%, the lowest rate is observed in the Kasaï region.	We plan to increase CPN sessions in the ZS of the Kasaï region. Make sensitizations and mini campaigns.
		Kasaï	96.3	100%	100%	**83.7%**	83.7%	140575	167893	DHIS2		
		Katanga	91.3	100%	100%	**88.3%**	88.3%	113480	128541	DHIS2		
		E. Congo	100.1	100%	100%	**94.2%**	94.2%	100591	106757	DHIS2		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
2.1.3	MNCH: Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Outcome¥	75.4	90%	90%	**74.2%**	82.4%	299004	403191	DHIS2	The assisted delivery rate is still <90% in all supported areas of USAID IHP.	We plan to sensitize pregnant women and improve maternity services.
		Kasaï	82.6	90%	90%	**74.7%**	83.0%	125458	167893	DHIS2		
		Katanga	69.6	90%	90%	**74.9%**	83.2%	96233	128541	DHIS2		
		E. Congo	70.7	90%	90%	**72.4%**	80.5%	77313	106757	DHIS2		
2.1.4 (PPR)	MNCH: Number of women giving birth who received uterotonics in the third stage of labor (OR immediately after birth) through USG-supported programs	Output	140458	184236	46059	**38,880**	84.4%	N/A	N/A	DHIS2	This indicator is only reported from hospitals via DHIS2. We will have a complete dataset when the module *complementaire* is operational.	We will verify data
		Kasaï	19244	25313	6328	**5,380**	85.0%	N/A	N/A	DHIS2		
		Katanga	37395	49958	12490	**11,589**	92.8%	N/A	N/A	DHIS2		
		E. Congo	83819	108965	27241	**21,911**	80.4%	N/A	N/A	DHIS2		
2.1.5 (Standard/ PPR)	MNCH: Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Output	33509	34346	8628	**7,280**	84.4%	N/A	N/A	DHIS2	The lowest rate is observed in the Kasaï region.	We plan to train birth attendants.
		Kasaï	9818	10063	2528	**1,749**	69.2%	N/A	N/A	DHIS2		
		Katanga	14450	14810	3720	**3,273**	88.0%	N/A	N/A	DHIS2		
		E. Congo	9241	9473	2380	**2,258**	94.9%	N/A	N/A	DHIS2		
2.1.6	MNCH: Number of postpartum/newborn visits within three days of birth in USG-supported programs	Output	1121703	1149745	288838	**298,957**	103.5%	N/A	N/A	DHIS2	We do not yet have access to this data	Data will be collected via the module *complement-aire*
		Kasaï	525049	538175	135200	**125,847**	93.1%	N/A	N/A	DHIS2		
		Katanga	336949	345372	86764	**97,958**	112.9%	N/A	N/A	DHIS2		
		E. Congo	259705	266198	66874	**75,152**	112.4%	N/A	N/A	DHIS2		
2.1.7 (CDCS)	MNCH: Number and percentage of newborns receiving essential newborn care through USG-supported programs	Output	91.5%	100%	100%	**93.6%**	93.6%	285,523	304,889	DHIS2	The average is> 90% in all regions under support.	Identify low performing ZS and strengthen the strategy.
		Kasaï	91.8%	100%	100%	**93.1%**	93.1%	118,323	127,044	DHIS2		
		Katanga	89.7%	100%	100%	**92.5%**	92.5%	93,146	100,650	DHIS2		
		E. Congo	93.2%	100%	100%	**95.9%**	95.9%	74,054	77,195	DHIS2		
2.1.8 (PPR)	MNCH: Number of newborns receiving antibiotic treatment for infection from trained health workers through USG-supported programs	Output	212375	217683	54686	**38,952**	71.2%	N/A	N/A	DHIS2	The average in Kasaï is below 71% for all provinces.	We need to establish who has been trained and increase the number of
		Kasaï	98016	100468	25240	**14,395**	57.0%	N/A	N/A	DHIS2		
		Katanga	89734	91976	23106	**19,329**	83.7%	N/A	N/A	DHIS2		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		E. Congo	24625	25239	6340	**5,228**	82.5%	N/A	N/A	DHIS2		trained service providers
2.1.9	MNCH: Drop-out rate in DTP-HepB-Hib3 among children less than 12 months of age	Output	5%	5%	5%	**6.2%**	124.0%	18541	299082	DHIS2	Very high levels of performance.	Prendre la norme de 10%
		Kasaï	5%	4%	4%	**5.1%**	126.6%	5802	114540	DHIS2		
		Katanga	7%	6%	6%	**8.5%**	141.1%	8521	100664	DHIS2		
		E. Congo	5%	5%	5%	**5.0%**	100.6%	4218	83878	DHIS2		
2.1.10 (Standard /PPR)	NUTRITION: Number of individuals receiving nutrition-related professional training through USG supported nutrition programs	Outcome	N/A	98	98	**111**	113.3%	N/A	N/A	PMR	We did not have goals but instead responded to need	N/A
		Kasaï	N/A	98	98	**90**	91.8%	N/A	N/A	PMR		
		Katanga	N/A	0	0	**7**	0.0%	N/A	N/A	PMR		
		E. Congo	N/A	0	0	**14**	0.0%	N/A	N/A	PMR		
2.1.11 (Standard /PPR)	NUTRITION: Number of children under-five (0-59 months) reached by USG-supported nutrition programs	Output	6609710	10245050	2643884	**1,973,879**	74.7%	N/A	N/A	DHIS2	The indicator is less than 90% for all regions.	We plan to increase the number of Nutrition activities: CPS and in the community (i.e. ANJE)
		Kasaï	2956495	4582566	1182598	**955,433**	80.8%	N/A	N/A	DHIS2		
		Katanga	1798520	2787707	719408	**497,057**	69.1%	N/A	N/A	DHIS2		
		E. Congo	1854695	2874777	741878	**521,389**	70.3%	N/A	N/A	DHIS2		
2.1.12 (Standard)	NUTRITION: Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs	Outcome	2045125	3169944	818050	**779,635**	95.3%	N/A	N/A	DHIS2	Same as the above indicator.	Expand activities in the community.
		Kasaï	911389	1412651	364555	**343,487**	94.2%	N/A	N/A	DHIS2		
		Katanga	435344	674784	174138	**195,283**	112.1%	N/A	N/A	DHIS2		
		E. Congo	698392	1082509	279357	**240,865**	86.2%	N/A	N/A	DHIS2		
2.1.13 (Standard /PPR)	NUTRITION: Number of pregnant women reached with nutrition interventions through USG-supported programs	Output	1043172	1616916	417269	**271,278**	65.0%	N/A	N/A	DHIS2	Folic acid supplemen-tation is low in all supported areas.	We need to ensure the availability in all health zones.
		Kasaï	415491	644012	166197	**104,628**	63.0%	N/A	N/A	DHIS2		
		Katanga	318553	493756	127421	**89,172**	70.0%	N/A	N/A	DHIS2		
		E. Congo	309128	479148	123651	**77,478**	62.7%	N/A	N/A	DHIS2		
2.1.14	MALARIA: Number of health workers trained in IPTp with USG funds	Output	N/A	446	112	**34**	30.4%	N/A	N/A	PMR	Initial goals were not met as we responded to need and target staff availability	We will continue to train as needed
		Kasaï	N/A	176	44	**34**	77.3%	N/A	N/A	PMR		
		Katanga	N/A	270	68	**0**	0.0%	N/A	N/A	PMR		
		E. Congo	N/A	0	0	**0**	N/A	N/A	N/A	PMR		
2.1.15	MALARIA: Number of health workers trained in case	Output	N/A	812	203	**105**	51.7%	N/A	N/A	PMR	Initial goals were not met	
		Kasaï	N/A	224	56	**34**	60.7%	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
	management with ACTs with USG funds	Katanga	N/A	588	147	**71**	48.3%	N/A	N/A	PMR	as we responded to need and target staff availability	We will continue to train as needed
		E. Congo	N/A	N/A	N/A	**0**	N/A	N/A	N/A	PMR		
2.1.16	MALARIA: Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnosis Tests (RDT) or microscopy) with USG funds	Output	N/A	812	203	**105**	51.7%	N/A	N/A	PMR	Initial goals were not met as we responded to need and target staff availability	We will continue to train as needed
		Kasaï	N/A	224	56	**34**	60.7%	N/A	N/A	PMR		
		Katanga	N/A	588	147	**71**	48.3%	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**0**	N/A	N/A	N/A	PMR		
2.1.17	TB: TB notification rate through USG- supported programs	Output	126	150	150	**133.0**	88.7%	11,039	33,180,687	DHIS2	TB data has not yet been validated and released by the MOH	N/A
		Kasaï	126	150	150	**128.2**	85.5%	4,667	14,559,655	DHIS2		
		Katanga	156	150	150	**175.7**	117.1%	4,276	9,737,405	DHIS2		
		E. Congo	94	150	150	**94.4**	62.9%	2,096	8,883,627	DHIS2		
2.1.18 PPR	TB: Number of patients diagnosed with TB that have initiated first-line treatment. (PPR)	Output	61974	TBD	TBD	**18,062**	UA	N/A	N/A	DHIS2	TB data has not yet been validated and released by the MOH	N/A
		Kasaï	28508	TBD	TBD	**8,997**	UA	N/A	N/A	DHIS2		
		Katanga	21823	TBD	TBD	**6,014**	UA	N/A	N/A	DHIS2		
		E. Congo	11643	TBD	TBD	**3,051**	UA	N/A	N/A	DHIS2		
2.1.19	TB: Therapeutic success rate through USG- supported programs	Output	64.7	95	95	**89.3**	94.0%	9,543	10,682	DHIS2	TB data has not yet been validated and released by the MOH	N/A
		Kasaï	55.5	95	95	**93.7**	98.6%	3,390	3,619	DHIS2		
		Katanga	76.7	95	95	**82.4**	86.7%	3,092	3,753	DHIS2		
		E. Congo	63.7	95	95	**92.5**	97.4%	3,061	3,310	DHIS2		
2.1.20 (Standard)	TB: HL.2.4-1 Number of multi-drug resistant (MDR) TB cases detected	Outcome	405	N/A	180	**129**	71.7%	N/A	N/A	DHIS2	TB data has not yet been validated and released by the MOH	N/A
		Kasaï	190	N/A	72	**16**	22.2%	N/A	N/A	DHIS2		
		Katanga	158	N/A	77	**89**	115.6%	N/A	N/A	DHIS2		
		E. Congo	57	N/A	31	**24**	77.4%	N/A	N/A	DHIS2		
2.1.21	TB: Number of multi-drug resistant TB cases that have initiated second line treatment	Outcome¥	237	N/A	129	**84**	65.1%	N/A	N/A	DHIS2	TB data has not yet been validated and released by the MOH.	N/A
		Kasaï	130	N/A	16	**11**	68.8%	N/A	N/A	DHIS2		
		Katanga	77	N/A	89	**55**	61.8%	N/A	N/A	DHIS2		
		E. Congo	30	N/A	24	**18**	75.0%	N/A	N/A	DHIS2		
2.1.22	TB: Therapeutic success rate for RR-/MDR-TB through USG-supported programs	Output	N/A	75	75	**81.7**	108.9%	89	109	DHIS2	TB data has not yet been validated and	N/A
		Kasaï	N/A	75	75	**89.5**	119.3%	34	38	DHIS2		
		Katanga	N/A	75	75	**82.0**	109.3%	41	50	DHIS2		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		E. Congo	N/A	75	75	**66.7**	88.9%	14	21	DHIS2	released by the MOH.	
2.1.23	TB: Percentage of under five children who received (or are receiving) INH prophylaxis through USG- supported programs	Output	5717	N/A	N/A	**3,193**	UA	UA	UA	DHIS2	TB data has not yet been validated and released by the MOH.	N/A
		Kasaï	2713	N/A	N/A	**1,646**	UA	UA	UA	DHIS2		
		Katanga	1784	N/A	N/A	**825**	UA	UA	UA	DHIS2		
		E. Congo	1220	N/A	N/A	**722**	UA	UA	UA	DHIS2		
2.1.24	TB: Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG- supported programs	Output	54	100	100	**43.7**	43.7%	2,432	5,563	DHIS2	TB data has not yet been validated and released by the MOH.	N/A
		Kasaï	48	100	100	**60.3**	60.3%	561	931	DHIS2		
		Katanga	59	100	100	**36.8**	36.8%	1,458	3,962	DHIS2		
		E. Congo	44	100	100	**61.6**	61.6%	413	670	DHIS2		
2.1.25	TB: Percentage of new-enrolled HIV-positive patients screened for TB through USG- supported programs	Outcome	64.7	100	100	**58.2**	58.2%	10,780	18,507	DHIS2	TB data has not yet been validated and released by the MOH.	N/A
		Kasaï	55.5	100	100	**36.2**	36.2%	3,329	9,187	DHIS2		
		Katanga	76.7	100	100	**81.4**	81.4%	4,991	6,135	DHIS2		
		E. Congo	63.7	100	100	**77.2**	77.2%	2,460	3,185	DHIS2		
2.1.26	TB: Number of individuals trained in any component of the World Health Organization Stop TB strategy with USG funding.	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity.	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.1.27 (PPR)	GBV: Number of women treated for gender-based violence. PPR.	Outcome	8318	7625	1906	**1,836**	96.3%	N/A	N/A	DHIS2	More women were treated than anticipated in Kasaï and Katanga.	Investigate how to improve performance in Eastern Congo and reconsider Kasaï/Katanga targets.
		Kasaï	2056	1885	470	**617**	131.3%	N/A	N/A	DHIS2		
		Katanga	599	549	138	**156**	113.0%	N/A	N/A	DHIS2		
		E. Congo	5663	5191	1298	**1,063**	81.9%	N/A	N/A	DHIS2		
2.1.28	GBV: Number of surgical fistula repairs provided with USG-assistance	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet received this data from the MOH	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.1.29	GBV: Number of surgical fistula repairs provided with USG-assistance that remained closed after discharge	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet received this data from the MOH	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 2.2: Increased availability of quality, integrated community-based health services												
		Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		N/A

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
2.2.1 (Standard PPR)	FP: Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year	Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2	This is an annual indicator	
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
2.2.2	Percent of target population who report that they are able to access the basic health services available to their community (contract deliverable)	**Output**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
2.2.3	Percent of citizens reporting improvement and equity in service delivery of local level institutions with USG assistance (contract deliverable)	**Impact**	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
2.2.4	Number of Integrated Community Case Management (iCCM) sites in USG-supported communities (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
2.2.5	Proportion of supervisory visits performed during the quarter to relais	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
IR 2.3: Improved referral system from community-based platforms to health centers and reference hospitals												
2.3.1	Number of individuals referred to supported health facilities by relais and CBDs (contract deliverable)	Output	61034	62255	15564	**15,469**	99.4%	N/A	N/A	PMR	Targets come from the MOH	We will investigate how to improve performance in the East and reconsider
		Kasaï	33073	33734	8434	**10,593**	125.6%	N/A	N/A	PMR		
		Katanga	8286	8452	2113	**2,174**	102.9%	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		E. Congo	19675	20069	5017	**2,702**	53.9%	N/A	N/A	PMR		Kasaï/Katanga targets.
2.3.2	Number of individuals referred by relais/CBDs that were received by supported health facilities (completed referrals) (expected contract result)	Output	350457	362121	91694	**101,768**	111.0%	N/A	N/A	DHIS2	Completion rates are above 100% for the Kasaï and Katanga regions	We will investigate how to improve performance in the East and reconsider Kasaï/Katanga targets.
		Kasaï	241407	247442	62162	**67,402**	108.4%	N/A	N/A	DHIS2		
		Katanga	44385	48398	12881	**19,105**	148.3%	N/A	N/A	DHIS2		
		E. Congo	64665	66281	16651	**15,261**	91.7%	N/A	N/A	DHIS2		
2.3.3	Number of women transported for facility delivery (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	DHIS2		
IR 2.4: Improved health provider attitudes and interpersonal skills at facility and community levels												
2.4.1	Average attitudes and interpersonal skills score as measured by the Provider / User checklist at supported health facilities (expected contract result)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.4.2	Number of supported facilities offering a package of youth-friendly family planning services (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
2.4.3	Number of supported facilities offering a package of comprehensive SGBV services (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019	Data for this will come from the Mapping survey *référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDL 2019		
IR 2.5: Increased availability of innovative financing approaches												
2.5.1	Number of innovative financing tools piloted (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	This is an annual indicator	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
IR 2.6: Improved basic facility infrastructure and equipment to ensure quality services												
2.6.1 (Fee, CDCS)	Percentage of targeted health care facilities receiving infrastructure and/or equipment support	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.6.2 (Standard /PPR)	HL.8.1-1 Number of people gaining access to basic drinking water services as a result of USG assistance	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
2.6.3 (Standard /PPR)	WASH: HL.8.2-2 Number of people gaining access to a basic sanitation service as a result of USG assistance	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
2.6.4 (Standard /PPR)	WASH: HL.8.2-4 Number of basic sanitation facilities provided in institutional settings as a result of USG assistance	Outcome	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
IR 2.7: Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue												
2.7.1	Number of knowledge sharing workshops supported (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.7.2	Number of strategies / policies that have been updated from good practices and lessons learned	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
2.7.3	Number of success stories developed	Output	N/A	36	9	**9**	100.0%	N/A	N/A	PMR	We exceeded our target in	We will work with the RDs

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
		Kasaï	N/A	16	4	**6**	150.0%	N/A	N/A	PMR	Kasaï but fell short in Katanga and E. Congo	and PDs to ensure potential success stories are identified & documented early.
		Katanga	N/A	12	3	**2**	66.7%	N/A	N/A	PMR		
		E. Congo	N/A	8	2	**1**	50.0%	N/A	N/A	PMR		
RESULT 3: Increased adoption of healthy behaviors, including use of health services, in target health zones												
3.1	Percentage of USG-supported health zones that demonstrate improvement in key accelerator behavior indicators	Outcome	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
3.2	Percentage of children under age 2 living with the mother who are exclusively breastfed, age 0-5 months	Outcomeβ	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019	Data for this will come from the *Enquête Ménage de référence du programme*	N/A
		Kasaï	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		Katanga	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
		E. Congo	N/A	TBD	N/A	**N/A**	N/A	N/A	N/A	EDM 2019		
IR 3.1: Increased practice of priority healthy behaviors at the individual, household, and community levels												
3.1.1 Fee	Percentage of health areas reached by Healthy Family Campaign SBC campaigns	Output	N/A	100%	1.5%	**1.0%**	71.1%	32	3076	PMR	The average is 71% Katanga and the East are less than 70%	SBC advisors strengthen these activities in both regions.
		Kasaï	N/A	100%	1.2%	**0.9%**	80.0%	12	1268	PMR		
		Katanga	N/A	100%	2.7%	**1.9%**	68.0%	17	916	PMR		
		E. Congo	N/A	100%	0.6%	**0.3%**	60.0%	3	892	PMR		
3.1.2	Percentage of trained community mobilizers active at community level (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We do not yet have access to this data	This data will be collected via the module *complement-aire*
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
3.1.3	Number of facilities providers trained in interpersonal communication skills	Output	N/A	N/A	180	**36**	20.0%	N/A	N/A	PMR	Percent of people trained in inter-personal communica-tion is low (20%) (CHW TB training)	Started reinforcing training in 2 provinces and providing training in the Kasaï region that hasn't begun yet.
		Kasaï	N/A	N/A	80	**0**	0.0%	N/A	N/A	PMR		
		Katanga	N/A	N/A	60	**16**	26.7%	N/A	N/A	PMR		
		E. Congo	N/A	N/A	40	**20**	50.0%	N/A	N/A	PMR		

Technical Areas, Illustrative Indicators		Region*	2017	2019 Target	Quarterly Target	Achieved Q3	% Achieved Q3	Percentage		Sources	Observations	Corrective Actions
								Num	Denom			
IR 3.2: Increased use of facility- and community-based health services												
3.2.1	Number of targeted communities that have access to real-time information about availability of health services in their catchment areas (contract deliverable)	Output	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	**N/A**	N/A	N/A	N/A	PMR		
3.2.2	Number of awareness campaigns designed, implemented, and evaluated with community participation. (contract deliverable)	Output	TBD	N/A	18	**8**	44.4%	N/A	N/A	PMR	Only 50% of the activities were completed.	We will work with RDs and PDs to identify obstacles to implementing this activity.
		Kasaï	TBD	N/A	8	**3**	37.5%	N/A	N/A	PMR		
		Katanga	TBD	N/A	6	**4**	66.7%	N/A	N/A	PMR		
		E. Congo	TBD	N/A	4	**1**	25.0%	N/A	N/A	PMR		
IR 3.3: Reduced socio-cultural barriers to the use of health services and the practice of key healthy behaviors												
3.3.1 Fee	Percentage of health areas reached by Healthy Family Campaign SBC events with messages disseminated targeting youth and other vulnerable groups per year	Output	N/A	N/A	0.3%	**0.1%**	20.0%	2	3076	PMR	We are responding to needs and are establishing the role of the	N/A
		Kasaï	N/A	N/A	0.8%	**0.2%**	20.0%	2	1268	PMR		
		Katanga	N/A	N/A	0	**0.0%**	0.0%	0	916	PMR		
		E. Congo	N/A	N/A	0	**0.0%**	0.0%	0	892	PMR		
IR 3.4: Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue												
3.4.1	Percentage of CSO organizations participating in experience-sharing / lessons learned event held at the ZS community participation day or provincial task force communication meetings	Output	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR	We have not yet started this activity	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		

* Kasaï region includes the following provinces: Kasaï-Central, Kasaï-Oriental, Lomami, and Sankuru
* Katanga region includes the following provinces: Haut-Katanga, Haut-Lomami, and Lualaba
* Eastern Congo region includes the following provinces: Sud-Kivu and Tanganyika

Notes:
1.3.1: The denominator was determined by assuming one CODESA for each aire de santé.
1.7.1: We use the percentage change to report this indicator because the target is a reduction in the number of facilities reporting a stock-out of any key tracer commodity during the reporting period.
2.1.17 – 2.1.26: The PNLT has not yet validated the data, We will update this table when it is available.
2.3.1: We used data from the DHIS2 indicator Refere vers CS for this indicator and will propose to update the PIRS in future reports.

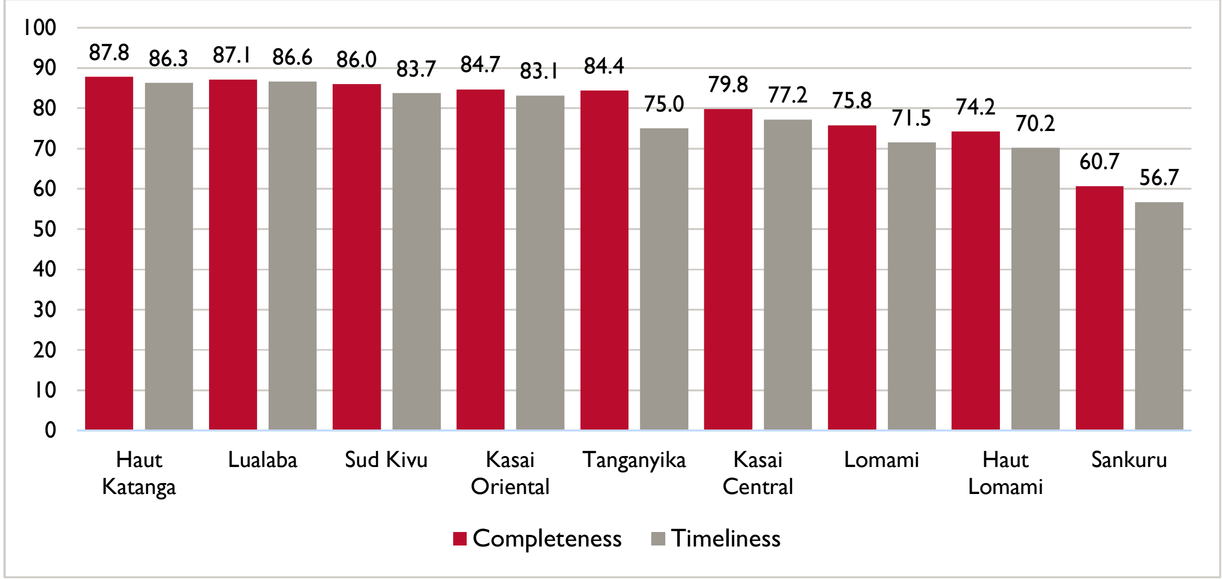
NOTES ON FY2019 QUARTER 3 DATA

USAID IHP's AMEP includes 118 indicators, of which 71 are reported quarterly. The data table is an edited version of the complete, disaggregated data set, described by the PIRS which should be used for a complete understanding of the indicators. The table is populated with data that is available through existing data information systems such as DHIS2 or as a direct result of program activities: the baseline/mid-line and end-line surveys and project monitoring reports (PMR). In addition, data on some of the indicators is not yet available because the corresponding activities have not yet started. These indicators have been noted in the Observations column.

We extracted data in this table from DHIS2 on July 23, 2019; they represent FY2019 Quarter 3 (April–June 2019). At the time the data was downloaded, the completeness rate was 80.1 percent and the on-time reporting rate was 76.7 percent. It was originally disaggregated by province. We reorganized the data into the regions for this table. The province data will be entered into MECC.

The graph below shows the reporting rates, defined by timeliness and completeness by July 23, 2019, when we downloaded the DHIS2 data.

Figure 1. Completeness and timeliness of DHIS2 data submitted for June 2019, accessed 23 July 2019



Source: DHIS2, accessed July 23, 2019, Basic Services data set (monthly SNIS framework)

In accordance with MOH standards, 80 percent is the acceptable reporting rate. This calls for actions to improve these rates and to determine the appropriate date at which data should be extracted from DHIS2. We use N/A (not applicable) to identify fields where there is no data because the relevant activities have not yet started and produced data or where the indicator is only reported annually. UA (unavailable) represents data that, at the time of reporting, had not yet been validated by the MOH and had not yet been released to us.

Furthermore, not all data have been integrated into the platform; some indicators are collected through the HMIS but not reported through DHIS2. We have worked with MOH partners to add modules to DHIS2 to capture these data. The MOH will begin data entry training for these data next quarter. Other

indicators, such as those measured by PNLT data, are not collected through DHIS2; we access that data directly from the PNLT.

Determination of baseline, targets, and Quarter 3 data represented in this table

Determination of Baseline Values

Baselines were or will be determined according to the sources of the indicator data. These include the *Enquête Démographique sur la Santé* (EDS, Demographic and Health Survey), the Multiple Indicator Cluster Survey (MICS), the USAID IHP survey of households and health structures, DHIS2, and the internal USAID IHP M&E system. For the baselines included in the table for this FY2019 Quarter 3 quarterly report, the EDS 2013-2014 report served as the basis for the baseline data for indicators with the data source listed as the household survey 2019 and service delivery mapping survey 2019. However, since the data in EDS 2013-2014 are presented according to the former configuration of provinces, they have been calculated to determine the USAID IHP regions. Other baseline indicators will be determined once data collection systems are established and we begin to collect data. The baseline household survey and the service delivery mapping survey will contribute targets and data next quarter. These indicators are identified in in the table as EDM 2019 or EDL 2019, respectively.

Determination of Targets

For the indicators for which we used EDS/MICS to determine baselines, we increased the targets from 2 percent to 3 percent, as per USAID's request for this report. These targets can be updated with 2017 survey data after we update the baselines with the EDM and EDL 2019 data.

For the indicators derived from HMIS, specifically DHIS2, we applied PNDS targets. We obtained these by calculating trends over the reported data from 2017 and 2018, using the IHPplus final report and knowledge of HMIS data. For custom indicators, we will continue to set targets according to planned activities, in collaboration with USAID and government partners.

ANNEX B: SUCCESS STORIES

1. Maintaining the cold chain for lifesaving vaccines
2. Heading off childhood malaria at the fever stage
3. Safeguarding pregnant women from malaria
4. Connecting new users to modern contraceptives
5. Raising TB detection rates to slow contagion
6. Designing health campaigns with communities in the driver's seat
7. At market, spreading the word about family planning
8. Organizations chart path for better service delivery
9. Mines are TB epicenters. Improving detection is vital.

SUCCESS STORY

Maintaining the cold chain for lifesaving vaccines

When electricity disruptions threatened to ruin refrigerated vaccines, USAID stepped in to supply generator fuel.

Photo: Marie-Claire Okenge, Abt Associates for USAID IHP

Handlers unloading fuel for the cold room generator in Mbuji-Mayi in Kasaï-Oriental

"It allowed us to better preserve vaccines and especially to stabilize the operation of the cold room and reach our targets, including children under one year, with quality vaccines."

Moise Kalala, Logistician for the Expanded Program on Immunization

In the southern Congolese province of Kasaï-Oriental, nearly 200,000 children are vaccinated each year before their first birthday against major infectious diseases: polio, measles, yellow fever, neonatal tetanus, diphtheria, pertussis, measles, epidemic meningitis, and pneumonia. Managing the vaccine supply chain is the responsibility of the national Ministry of Health's Expanded Program of Immunization, which guarantees the availability of quality vaccines in 317 health areas in 19 health zones in Kasaï-Oriental—and keeps young children current on their vaccines.

Maintaining the cold chain for vaccines is a frequent challenge in this province, due to its hot weather and erratic electricity supply. Starting in January 2019, electric currents to the refrigerated vaccine storage room were disrupted so frequently that the vaccines were in danger of losing their effectiveness, leaving young children vulnerable to major diseases.

Starting in February 2019, the USAID Integrated Health Program has assisted the Expanded Program on Immunization by sending nearly two cubic meters of diesel fuel to run the cold room generator so the vaccines would stay potent. Consequently, between February and April 2019, 72,800 children received the measles vaccine and nearly 31,000 children received a powerfully efficient vaccine that prevents diphtheria, tetanus, whooping cough, hepatitis B, pneumonia, and meningitis.

"The supply of diesel fuel by PROSANI USAID [the USAID Integrated Health Program] has been substantial," said Mr. Moise Kalala, Logistician for the Expanded Program on Immunization. "It allowed us to better preserve vaccines and especially to stabilize the operation of the cold room and reach our targets, including children under one year, with quality vaccines."

USAID | DEMOCRATIC REPUBLIC OF THE CONGO

SUCCESS STORY

Heading off childhood malaria at the fever stage

USAID trained campaigners to bring in sick children for diagnosis—and stocked centers with anti-malarial treatment.

Photo: Dieudonné Cigajira, IRC for USAID IHP

Esperance Cibalonza got fast treatment for her son during a USAID mini-campaign in the Kalwa health area that focused on diagnosing fevers.

"I told her that my son was sick and that I did not have the $2 required by the health center. She told me that I could go with the child and treat him for free because of USAID support."

Esperance Cibalonza, Kalwa health area

Esperance Cibalonza lives in the Kalwa health area in the Miti-Murhesa health zone in Sud-Kivu. In April 2019, her three-year-old, Eric, fell ill with a fever. Because she did not have the $2 consultation fee required at the health center, Esperance used ineffective traditional methods that did little to stop Eric's fever.

"I was already scared because my child's illness was getting worse, and the fever wasn't leaving," said Esperance. "But one day [the community health worker] came into my home…I told her that my son was sick and that I did not have the $2 required by the health center. She told me that I could go with the child and treat him for free because of USAID support. When I arrived at the center, we did a rapid diagnostic test and in 15 minutes we had results, positive, and then it was treated with ACT [Artemisinin-based combination] without me paying a single penny!"

In April 2019, USAID's Integrated Health Program (IHP) supported the Ministry of Health's one-day briefing of 30 community health workers (CHWs) and six providers on the benefits of early fever care. Afterwards, CHWs and providers led a mini-campaign in the health areas of Cifuma, Murhesa, and Kalwa. USAID IHP has supplied the Kalwa Health Center and other centers in Miti-Murhesa with anti-malarial treatments, including ACTs, rapid diagnostic tests, and rectal artesunate.

During the three-day campaign, 138 children under 5 were brought to the health center to treat fevers lasting more than one day. Of these, 99 children were diagnosed and treated for simple malaria; 40 others were treated for pneumonia and diarrhea. These numbers showed a huge increase from average attendance at the clinic, its staff said.

"From now on, I will put a particular emphasis on the awareness component to improve our indicators. In three days, we recorded 139 children under 5 while the monthly average from January to March 2019 was 142 children, including 75 with confirmed malaria," said Frank Byudania, Nurse-in-Charge of the Kalwa Health Center. "From April to June 2019, we [treated] 176 children including 100 with confirmed malaria. A success!"

USAID | DEMOCRATIC REPUBLIC OF THE CONGO

SUCCESS STORY

Safeguarding pregnant women from malaria

USAID supports national government campaign to refer pregnant women for preventative malaria treatment.

Photo: Donat Ngoie, Pathfinder for USAID IHP

A pregnant woman in Kasaï-Oriental takes sulfadoxine pyrimethamine (S/P) as Provincial Ministry of Health officials look on.

"With this mini-campaign, we received many pregnant women…184 in just three days at the clinic, even those who had never attended prenatal consultations and whose pregnancies were already in the second and third trimester!"

Paulin Nyengele, Nurse, Nyongolo health center

Pregnant women are especially vulnerable to malaria, which can disrupt fetal growth and cause maternal anemia, leading to premature delivery, low birth weight, and even death. In the southern province of Kasaï-Oriental, 12 percent of the 162,264 confirmed cases of malaria in 2018 were pregnant women.

Pregnant woman who take four serial doses of sulfadoxine pyrimethamine (S/P) as an intermittent preventive treatment for malaria can sharply reduce their chances of infection. But in Kasaï-Oriental's Bonzola health zone, fewer than half of pregnant women take S/P—well below the national average of 80 percent.

In the spring of 2019, the USAID Integrated Health Program (USAID IHP) supported the national Ministry of Health's campaign to target pregnant women living in the Bonzola health zone and refer them to the Nyongolo health center for intermittent preventive treatment.

USAID IHP prepared for the campaign by working with the National Malaria Control Program to brief members of the health zone management team: seven nurses and 52 community health workers (CHWs). The team then spread the word about the upcoming campaign through radio and door-to-door visits. USAID IHP stocked S/P at the Nyongolo health center and printed tokens for treatment and data collection cards.

"Many pregnant women have come to take their S/P dose. This has been a rich experience, and I thank PROSANI [USAID IHP] for briefing us; we will continue to do this regularly," said Didier Mpumbu, a CHW in the Nyongolo area.

During the campaign, CHWs referred 163 women to the health facility, providing tokens for S/P treatment. One hundred forty of the women were eligible for the treatment.

Prenatal consultations almost doubled at the health center during this quarter, from 256 to 429.

SUCCESS STORY

Connecting new users to modern contraceptives

USAID-supported campaign trained local workers and signed up 999 women to become new users of modern contraceptive methods.

Photo: Pepin Kayamba, Abt Associates for USAID IHP

A health worker supported by USAID IHP teaches a woman in the Wikong health zone about her options for modern contraceptives.

“I could have the time to cultivate my fields, save some money to feed my six children, and have the opportunity to build a new home.”

Ms. Naomie Tshow, New user of a long-term contraceptive in the Wikong health zone

Wikong is a health zone in Lomami province in central Congo, located 400 kilometers from the capital and home to an estimated 137,000 people. Of the 28,756 women of childbearing age, only an estimated 4.5 percent use contraceptives, well behind the still-low national rate of 28 percent. The region’s customs and religious beliefs bar uptake of contraceptives, and many believe erroneously that they cause cancer or sterility. Lack of family planning leads to clandestine abortions and deteriorating socio-economic situations within households.

To address the situation, the USAID Integrated Health Program and the Lomami Provincial Health District jointly organized a mini-campaign on family planning in the three health areas of Kayind, Carrière, and Notre Dame de Grace in May 2019. Ahead of the campaign, 24 community health workers who specialize in family planning, 30 community leaders, 18 youth peer educators, and six nurses were briefed on communication techniques and modern contraceptive methods. Over three days—in markets and churches, with youth and traditional leaders—they carried out 18 advance strategies (village-level counseling and distribution sessions) and 23 awareness-raising sessions on family planning.

The campaign reached a total of 3,690 people and counseled 1,723, including 1,144 women and 579 men. After the campaign, 999 women chose to start using modern contraceptives, including oral contraceptives, cycle necklaces, female condoms, injectables, and implants. New users of modern methods jumped from 966 between December 2018 to February 2019, to 1,809 between March and May 2019, and then to 2,151 between March and June 2019.

"I received the message about family planning through a community leader who was using the megaphone explaining the benefits of the methods, and [I] decided to put myself under a long-term contraceptive method to avoid a possible pregnancy, because I want this time to lengthen the space between two births,” said Ms. Naomie Tshow, 33, married and mother of six, including a 7-month-old.

SUCCESS STORY

Raising TB detection rates to slow contagion

Through door-to-door outreach and local training, a USAID-supported TB detection campaign brought treatment and diagnosis to the Kamana health zone.

Photo: Louis Malembe for USAID IHP

A nurse in the Kamana health zone assists a TB patient in taking his medicine.

"I am glad that it has been discovered that this is tuberculosis, [which was] long ignored… I now take the medicine without paying anything… thank you very much."

Sebastien Kapenga, Mini-campaign beneficiary

Among the 30 countries that pay the highest price for tuberculosis (TB), the Democratic Republic of Congo (DRC) ranks ninth—and fourth in Africa. Early detection is key to combatting this highly contagious disease. In the DRC, the World Health Organization estimates the TB incidence at 322 cases per 100,000 residents. However, in the Kamana health zone, home to more than 200,000 people in the Lomami province in southern DRC, officials recorded only 24 cases in April 2019—an incidence of 12 cases per 100,000 residents. Such a gap between the likely incidence and the number of actual diagnoses can result in hundreds of people living with this deadly disease but going untreated.

In May 2019, the USAID Integrated Health Program provided technical and financial support to the Ministry of Health for the Kamana health zone's mini-awareness campaign to help improve TB detection. The Ministry of Health briefed 12 community health workers, 17 nurses, five nurse-supervisors, and numerous laboratory technicians on identifying the signs of tuberculosis. Following this, the community health workers carried out door-to-door awareness campaigns and active TB screening. They referred all people with signs of tuberculosis, including coughs, to six diagnosis and treatment health centers.

After five days, the diagnosis and treatment health centers tested 513 suspected TB patients, 45 of whom had a positive diagnosis and were immediately put on treatment. The campaign nearly doubled the 24 cases reported in April 2019.

"I'm 70 years old and, considering my age, I thought the cough was normal, maybe due to aging," said Sebastien Kapenga. "I am glad that it has been discovered that this is tuberculosis, [which was] long ignored. Then I did all the exams and I now take the medicine without paying anything, in any case, thank you very much."

SUCCESS STORY

Designing health campaigns with communities in the driver's seat

USAID hosted conversations and workshops to shape upcoming Healthy Family Campaign.

Photo: Bamba Youssef, Matchboxology for USAID IHP

Participants play a collaborative design game during an HCD workshop in Kamina, Haut-Lomami.

"[My village] has the reputation of being opposed to vaccination. Through this workshop, I learned a new way to communicate and listen to the community to convince them more effectively. From this day I consider myself an ambassador of this new approach, which I am sure will help fight against myths and superstitions."

Mpoyo Wa Ilunga Antoine, Director of Mukangay Primary School, Louvouah, Kamina

To strengthen health systems in the Democratic Republic of Congo, the USAID Integrated Health Program (USAID IHP) is working with communities to develop health-seeking social and behavior change (SBC). But to make sure our interventions work, we needed informed insights from the people they're designed to help.

In 2019, USAID IHP launched the first steps in a human-centered design (HCD) approach to develop communications content for an upcoming Healthy Family Campaign. The process started with a national workshop in the capital, Kinshasa, to gain stakeholders' perspectives on health systems challenges and requirements for SBC campaigns. USAID IHP then held immersion exercises and provincial workshops to better understand health communications in communities and identify attitudes and beliefs about traditional medicine and other health interventions. Insights from these workshops will shape the the Healthy Family Campaign for addressing tuberculosis, family planning, and healthy family practices among youth.

Following workshops in Kasaï-Oriental province, USAID IHP rolled out the same process in June 2019 in Haut-Lomami and Lualaba. The Program conducted immersion exercises—30-60 minute, guided, face-to-face conversations about the healthcare apparatus in these locations—with stakeholders in public clinics and hospitals, as well as with community elders, youth, women, and traditional healers. USAID IHP then applied these insights to design two-day workshops that brought together dozens of community members to dive deeper into issues raised during the immersions. Participants were asked to visualize successful health communications and designed their own communication campaigns.

"This approach … allowed me to have a very good understanding of the human-centered design and empathy with the exercise of the exchange of shoes with others that allowed us to put on the skin of the other and act with more humanism," said Gaston Lumpungu, Communications Officer of Kamina's Provincial Department of Health.

In fall 2019, USAID IHP will carry out immersion exercises and co-creation workshops in Tanganyika and Sud-Kivu and test prototypes before rolling out the national Healthy Family Campaign.

SUCCESS STORY

At market, spreading the word about family planning

USAID supported community health workers to promote the use of modern contraceptives to marketgoers in Lualaba province.

Photo: Landry Malaba, Abt Associates for USAID IHP

A community health worker explains the benefits of family planning to customers and vendors at the Fungurume market.

"I saw a worker with a megaphone telling people at the market about contraceptive methods, and there was a team distributing them for free. We talked to a nurse here at the market and chose an implant that will help us with this pregnancy misery."

Siméon Kabila, Father of six, Fungurume

Fungurume, a city in Lualaba province, is home to more than 33,000 people, many of whom are miners and migrate to find work. Adoption of modern contraceptive methods there has been significantly lower than anticipated due to lack of awareness, untrained staff, and low or empty stock after several donor projects closed in 2018. In the Nehema health area, only 42 people became new users of modern contraceptives between January and March 2019.

"Since joining the health center, [I've noticed] that couples' adherence to contraceptive methods remains a problem," said Justin Kasenga Walifa, a nurse at the Nehema Health Center. "The culture … has mentally connected people with the idea of always having more children."

In May 2019, the USAID Integrated Health Program supported the Ministry of Health's Lualaba Provincial Health District to retrain Nehema's community health workers (CHWs) and outreach workers, who last received instruction in 2015. The coalition retrained three nurses and 20 CHWs on contraceptive distribution, case referrals, and complication management. USAID also provided them with registration kits, backpacks, jackets, and contraceptives, including oral contraceptives, implants, cycle beads, male and female condoms, and injectables.

The trained CHWs then held an awareness and distribution campaign at the Fungurume market, where they walked around with megaphones, telling people about the benefits of family planning. The CHWs offered short-term methods and helped people understand how to choose and access long-term methods.

In just one day, the campaign counseled 289 people, including 273 women, 169 of whom decided to adopt family planning methods. This raised the quarterly number of new users to 286 by the end of June 2019.

SUCCESS STORY

Organizations chart path for better service delivery

USAID IHP helps governmental bodies use the PICAL tool to assess their strengths and weaknesses—shaping their plans for organizational development.

Photo: Jean Manasse for USAID IHP

In Haut-Katanga, members of the Provincial Health District filled out questionnaires about how their organization functions.

"Change is not easy. People know what they can do, but they don't know how to make it possible. That needs time, and we have to support them."

Toss Mukwa, PICAL consultant for USAID IHP

"People working in groups, not teams. Weekly leadership meetings with no communication to anyone else in the organization. Less than fifth of paid personnel in some organizations actually working. Medication missing from location to location. Civilian institutions that operate more like the army: Obey orders, no questions asked."

These were some of the organizational issues raised by staff of seven Provincial Health Districts and two health zones during self-assessment exercises hosted by the USAID Integrated Health Program (USAID IHP) in the first half of 2019. USAID IHP used the Participatory Institutional Capacity Building Assessment and Learning (PICAL) tool—created by USAID/DRC a few years ago—so these governmental bodies could evaluate their own strengths and weaknesses and chart a course for improvement. The process starts with conversations with all personnel and narrows to in-depth discussions that cover four dimensions: performance, learning, administration, and systems strengthening.

"They can have a look at their organization, their personnel, how they share information, their leadership and management, how they treat people," said Toss Mukwa, a USAID IHP consultant who facilitated the PICAL exercises. "PICAL gives them the opportunity to talk about what they can't normally talk about."

Following the sessions, seven Provincial Health Districts—Tanganyika, Lomami, Sankuru, Kasaï-Central, Kasaï-Oriental, and Haut-Lomami—created their own capacity building plans. These featured key priorities for the coming year, including training and coaching in leadership and management, team building, information technology, financial management, primary health care management, and results-based management. USAID IHP will facilitate this training and coaching and support PICAL exercises again in a year to measure progress.

PICAL was originally designed for Provincial Health Districts, but USAID IHP adapted the tool for health zones, which play a leading role in primary health care in the DRC. After testing in two health zones, USAID IHP will host PICAL sessions with other health zones in the coming months.

SUCCESS STORY

Mines are TB epicenters. Improving detection is vital.

USAID helped diagnose miners and their families with TB, which spreads rapidly in the dusty, unsanitary quarries of the Kawama health area.

Photo: Stanley Musumba, Abt Associates for USAID IHP

Health workers and TB testing equipment arrive in a mining village to launch a door-to-door TB detection campaign.

"In the province of Lualaba, epidemiological data showed a 52% [TB] detection rate at the end of December 2018. At the end of June, we are at 70% thanks to our partners and USAID."

Dr. Dauphin Kalenga, Lualaba Provincial Health Coordinator

In the Kawama health area in Lualaba province, the leading employer for the 26,845 inhabitants is the artisanal mining industry. These cobalt and copper quarries place miners at a high risk for contracting tuberculosis (TB) due to poor sanitation and air quality Their families are at high risk of catching it from them. Yet TB detection rates have lagged 35 percent below national targets. For example, between January and March 2018, Kawama had only 18 bacterially confirmed TB cases, far below expectations.

To combat weak detection rates in an area increasingly vulnerable to TB, the USAID Integrated Health Program (USAID IHP) is supporting the Provincial Committee for Leprosy and Tuberculosis Control to organize research activities in TB epicenters such as quarries. USAID IHP partnered with the Ministry of Health, which briefed 15 community health workers on investigating suspected cases of TB and tracking its spread throughout the community.

USAID IHP provided the workers with equipment for collecting TB samples, including spittoons and materials to transport sputum samples. The workers conducted a multi-day door-to-door campaign, collecting samples from 725 people with TB symptoms and confirming 28 cases of pulmonary tuberculosis (18 women and 10 men). These cases brought the quarter's confirmed cases to 59.

"In addition to celebrating World TB Day—where we received USAID support to raise awareness—we also conducted outreach to a special population, miners. The results have been convincing," said Dr. Dauphin Kalenga, Lualaba Provincial Health Coordinator. "In the province of Lualaba, epidemiological data showed a 52% detection rate at the end of December 2018. At the end of June, we are at 70%, thanks to our partners and USAID."

ANNEX C: STAFF HIRED DURING FY2019 QUARTER 3

Position/Title	Employee Name	Gender	Start Date	Contractor
Kinshasa Office				
Bookkeeper	Manzuaku, Bopol K.	M	4/3/2019	Abt Associates
Bookkeeper	Luvunga, Aime K.	M	4/5/2019	Abt Associates
Human Resources Manager	Bonko, Solange O.	F	5/27/2019	Abt Associates
Finance Manager	Mfiti, Sady A.	F	6/5/2019	Abt Associates
IT Assistant	Mukendi, Alain L.	M	6/10/2019	Abt Associates
321 Product Manager	Muswema, Jean-Foré	M	4/8/2019	Viamo
Gender Advisor	Anny Modi Tengamendite	F	4/1/2019	Pathfinder
Grants/Subcontracts Assistant	*ON HOLD*			
Capacity Building Advisor	*TBD*		*TBD*	Abt Associates
Kasaï Regional Office				
Kasaï-Central Province Office located in Kananga				
Security Officer	Ruayi, Pascal K.	M	4/1/2019	Abt Associates
Senior Accountant	Lumbu Mbombo, Rita	F	4/3/2019	Abt Associates
Driver	Ntita, Willy M.	M	4/11/2019	Abt Associates
Driver	Tshibangu, Patrick M.	M	4/12/2019	Abt Associates
EEI/HSS Specialist	Ndaye, Nickson B.	M	5/23/2019	Abt Associates
EEI/HSS Specialist	Tshinzela, Raphael K.	M	5/23/2019	Abt Associates
Supply Chain Officer	Lutumba, Guelord	M	4/10/2019	i+Solutions
Regional HSS Director	*ON HOLD*			
Roving Grants/Subcontracts Manager	*ON HOLD*			
Kasaï-Oriental Province Office located in Mbuji Mayi				
Supply Chain Officer	Kadyanga, Johnny	M	4/2/2019	i+Solutions
Lomami Province Office located in Kabinda				
Admin. Assistant/Receptionist	Kamwiziku, Yvette N.	F	4/10/2019	Abt Associates
Bookkeeper	Lukusa, Grace B.	M	4/30/2019	Abt Associates
Driver	Mutuapi, Benoit M.	M	5/1/2019	Abt Associates
DPS Capacity Building Advisor	Mutombo, Jean-Michel M.	M	5/6/2019	Abt Associates
Supply Chain Officer	Konga, Marcus	M	4/2/2019	i+Solutions
Sankuru Province Office located in Lodja				
Admin. Assistant/Receptionist	Ngoy, Henriette K.	F	4/10/2019	Abt Associates
Accountant	Any Lushimba, David A.	M	4/22/2019	Abt Associates

Position/Title	Employee Name	Gender	Start Date	Contractor
Provincial Operations Manager	Kabwika, Bertrand M.	M	5/20/2019	Abt Associates
Supply Chain Officer	Tokembe, François	M	4/2/2019	i+Solutions
Eastern Congo Regional Office				
South Kivu Province Office located in Bukavu				
Admin. Assistant/Receptionist	Mwinja, Epiphanie K.	F	4/18/2019	Abt Associates
Human Resources Manager	Lunda Makaba, Edouard Patrick	M	4/23/2019	IRC
Supply Chain Officer	Kasigwa, Emmanuel	M	4/2/2019	i+Solutions
EEI/HSS Specialist	*Jean Claude Lolale resigned; in process of recruiting a replacement*		*TBD*	*Abt Associates*
Regional HSS Director	*ON HOLD*			
Roving Grants/Subcontracts Manager	*ON HOLD*			
Uvira Branch Office				
Office Lead and EEI/HSS Specialist	Kalambay, Arthur D.	M	6/17/2019	Abt Associates
Driver/Security Focal Point	*Ngakani, Clement*	*M*	*7/15/2019*	*Abt Associates*
Finance/Admin Officer	*Kazimbe Bengehya, Nathalie*	F	*08/12/2019*	*Abt Associates*
Tanganyika Province Office located in Kalemie				
EEI/HSS Specialist	Elefo, Louis B.	M	5/15/2019	Abt Associates
Human Resources Officer	Mika Osabyen, Junior	M	4/25/2019	IRC
Supply Chain Officer	Murhula, Emmanuel	M	4/2/2019	i+Solutions
Driver	*Luc Asumani – ON HOLD - identified; waiting to hire until there is a need*	*M*	*TBD*	*Abt Associates*
Finance Officer	*ON HOLD*			*IRC*
Service Delivery Specialist	*TBD*			*IRC*
Katanga Regional Office				
Haut-Katanga Province Office located in Lubumbashi				
Operations Manager	Tambwe, Nadine K.	F	4/3/2019	Abt Associates
Admin. Assistant/Receptionist	Tandu, Armandine M.	F	4/11/2019	Abt Associates
Security Officer	Kanyunyi, Emman	M	4/23/2019	IRC
Senior Human Resources Officer	Birhega, Esther	F	5/1/2019	IRC
Supply Chain Officer	Sanza, Pascal	M	4/10/2019	i+Solutions
Regional HSS Director	*ON HOLD*			

Position/Title	Employee Name	Gender	Start Date	Contractor
Driver	*ON HOLD until needed*			
Roving Grants/Subcontracts Manager	*ON HOLD*			
WASH and Renovations Engineer	*ON HOLD*			
EEI/HSS Specialist	*Yvette Mangunza*	*F*	*TBD*	*Abt Associates*
EEI/HSS Specialist	*TBD*			*Abt Associates*
EEI/HSS Specialist	*Patrick Kalombo*	*M*	*TBD*	*Abt Associates*
Finance Officer	*ON HOLD*			*IRC*
Haut Lomami Province Office located in Kamina				
EEI/HSS Specialist	Aberi, Rene S.	M	6/3/2019	Abt Associates
EEI/HSS Specialist	Bwazu, Bruno N.	M	6/3/2019	Abt Associates
Service Delivery Specialist	Mebwa Lepetikele, Paulin	M	4/22/2019	IRC
Community Engagement Specialist	Gubanja Mungu-A-Konkwa, Julie	F	5/27/2019	IRC
Supply Chain Officer	Jibikila Emmanuel	M	4/2/2019	i+Solutions
Driver	*ON HOLD- waiting until there is a need*			
Lualaba Province Office located in Kolwezi				
Bookkeeper	Ilunga Kinyinga, Cedrick O.	M	4/22/2019	Abt Associates
Driver	Lukusa, Francis	M	4/22/2019	Abt Associates
Service Delivery Specialist	Bashimbe, Jean Claude	M	4/22/2019	IRC
Supply Chain Officer	Kasangandjo, Nathan	M	4/2/2019	i+Solutions
EEI/HSS Specialist	*Adele Mujinga*	*F*	*7/15/2019*	*Abt Associates*
EEI/HSS Specialist	*Serge Tshienda*	*M*	*8/01/2019*	*Abt Associates*
Driver	*ON HOLD- waiting until there is a need*			*Abt Associates*
			TOTAL	**45**

Between the end of the quarter on June 30, 2019 and the date this report was submitted on August 15, 2019, an additional four staff had been hired.

As of 8/15/19 another six staff were in the process of being hired and 14 positions were on hold.

ANNEX D: ENVIRONMENTAL MITIGATION AND MONITORING REPORT

PROJECT/ACTIVITY DATA	
Project/Activity Name:	USAID's Integrated Health Program (USAID IHP)
Geographic Location(s) (Country/Region):	Democratic Republic of the Congo
Implementation Start/End Date:	May 26, 2018–May 29, 2025[10]
Contract/Award Number:	72066018C02001
Implementing Partner(s):	Rio Malemba, Abt Associates
Tracking ID:	
Tracking ID/link of Related EMMP:	
Tracking ID/link of Related IEE:	DRC_Health_Portofolio_IEE: https://ecd.usaid.gov/repository/pdf/45611.pdf
Tracking ID/link of Other, Related Analyses:	

ORGANIZATIONAL/ADMINISTRATIVE DATA	
Implementing Operating Unit(s): (e.g., Mission or Bureau or Office)	USAID/Democratic Republic of the Congo (USAID/DRC)
Lead BEO Bureau:	
Prepared by:	
Date Prepared:	
Submitted by:	USAID's Integrated Health Program
Date Submitted:	August 15, 2019

ENVIRONMENTAL COMPLIANCE REVIEW DATA	
Analysis Type:	EMMR
Additional Analyses/Reporting Required	Water Quality Assessment Plan

PURPOSE

Environmental Mitigation and Monitoring Reports (EMMRs) are required for USAID-funded projects when the 22CFR216 documentation governing the project imposes conditions on at least one project/activity component. EMMRs ensure that the ADS 204 requirements for reporting on environmental compliance are met. EMMRs are used to report on the status of mitigation and monitoring efforts in accordance with Initial Environmental Examination (IEE) requirements over the preceding project implementation period. They are typically provided annually, but the frequency will be

[10] Due to a stop work order, the Program did not start until May 26, 2018.

stipulated in the IEE. Responsibility for developing the EMMRs lies with USAID, but EMMRs are usually prepared by the Implementing Partner and submitted to USAID.

SCOPE

The following EMMR documents the mitigation measures implemented as detailed in the project Environmental Mitigation and Monitoring Plan (EMMP), challenges encountered, and corrective actions taken. It describes the status of each required mitigation measure as stipulated in the EMMP and provides a succinct update on progress regarding the implementation and monitoring of the EMMP.

These are the intervention activities that we anticipate. Each of these activities received categorical exclusion and negative determination based on what this activity involves.

INTERVENTION CATEGORY	CATEGORICAL EXCLUSION(S)	NEGATIVE DETERMINATION(S)	POSITIVE DETERMINATION(S)
1. Studies, surveys/public health surveillance, and other data-gathering assessments, models, and capacity-building in support of all areas above; dissemination of resulting information/ lessons learned/ best practices	X	X	
2. Healthcare provider training; health care workforce strengthening and development	X	X	
3. Direct and capacity-building support for health service delivery and access to health services, excluding commodity procurement/supply chain strengthening	X	X	
4. Procurement, storage, management, distribution, and disposal of medical and pharmaceutical commodities	X	X	
5. Social and behavior change communication	X		
6. Small-scale water supply and sanitation	X	X	
7. Construction other than water/sanitation infrastructure	X	X	
8. Technical support to indoor residual spraying		X	X
9. Policy and strategy development	X	X	

Those activities that have negative determination with conditions activate the need for the EMMP. The EMMP elucidates impacts that may be expected from USAID IHP and mitigation efforts to eliminate or minimize those potential impacts; it also describes the system for monitoring implementation of the mitigation measures. During the life of the project, if activities are developed that include potential environmental impacts not anticipated here, the EMMP will be amended to address and mitigate them.

A major environmental concern about health projects such as USAID IHP is the proper disposition of wastes generated from health facilities. These wastes include:

- General health care waste, which is similar or identical to domestic waste, including materials such as packaging or unwanted paper. This waste is generally harmless and needs no special handling; 75–90% of waste generated by health care facilities falls into this category.
- Hazardous health care waste, which includes infectious waste (except sharps and waste from patients with highly infectious diseases), small quantities of chemicals and pharmaceuticals, and non-recyclable pressurized containers.
- Highly hazardous health care waste, which includes sharps, highly infectious non-sharp waste, stools from cholera patients, bodily fluids of patients with highly infectious diseases, large quantities of expired or unwanted pharmaceuticals and hazardous chemicals and radioactive wastes, genotoxic wastes (affecting genetic composition and multiple generations), or teratogenic wastes (affecting development of the exposed individual). (http://www.usaidgems.org/Sectors/healthcareWaste.htm)

Particularly in developing countries, it can be difficult to identify facilities for proper disposal, and sensitivity of the need for proper disposal is often lacking.

Storing pharmaceutical and medical commodities poses challenges as well, particularly special storage temperature requirements and expiration dates. Over-ordering or an unexpected reduction in demand can each result in expired pharmaceuticals that must be properly disposed of. Care must be taken to ensure security during storage of pharmaceuticals and commodities, to guard against losses and improper usage. Pharmaceuticals must be protected from contamination from incompatible materials stored in close proximity to them.

Sub-grant activities can cover a wide range of interventions and the environmental compliance requirements will vary accordingly. Environmental Review Forms must be completed to gauge the potential environmental impacts of the contemplated activities under the grant and to develop mitigation strategies and plans. Due diligence must be performed on the grantee to confirm that they have the institutional knowledge, capacity, and will to perform within environmental compliance standards. Training must be provided and ongoing monitoring and inspection will likely be necessary.

Much like the sub-grant activities discussed above, funding the acquisition of medical equipment for use by others can carry a broad set of concerns, including misuse and improper disposal. Care must be taken to perform due diligence to confirm the acquiring institution has the ability to use the equipment correctly and safely, receives the required training, and has the orientation and commitment to dispose of it properly.

Another major concern that could arise from USAID IHP involves the small-scale construction and/or rehabilitation of existing facilities. Risks include construction methods that lead to contaminated runoff entering water resources; demolition of facilities containing hazardous substances, such as asbestos or lead piping; increased traffic from upgraded facilities leading to environmental degradation; and increased demand for water, sanitation, and hygiene (WASH) infrastructure, leading to environmental contamination if such facilities are not well-planned. There are distinct guidelines and requirements for rehabilitation of facilities delivering health care services, serving as diagnostic laboratories, or providing practical or lab-based health training, and for other types of buildings. Both types are represented and dealt with in the EMMP.

The construction of water and sanitation systems is also contemplated under this project; such work has an extensive set of requirements to ensure the supply of sufficient water quantity and quality without

compromising existing uses of source water. Proper location of facilities, use of appropriate materials, methods of purification, and maintenance of equipment must also be taken into consideration. Trainings on system operation and maintenance must also be provided.

Insecticide-treated nets generate waste streams upon initial distribution and disposal. This waste must be managed according to World Health Organization best practices to avoid negative impacts on the environment—and possibly on human health.

Office management and supply can also have negative impacts on the physical and social environment. Low-energy lighting and equipment must be preferentially purchased, and waste minimization and disposal must be planned and executed. Transportation of personnel and supplies must be carefully coordinated to minimize fuel usage and emissions.

USAID REVIEW OF EMMR

[***The routing process and associated signature blocks may be customized by Bureau or Mission. Please follow Bureau- or Mission-specific guidance***. *Include signature blocks in accordance with Bureau and/or Mission policy. At a minimum include the noted required signatures. Add other signatures as necessary.*]

Approval:

[NAME], Activity Manager/A/COR [required] Date

Clearance:

[NAME], Mission Environmental Officer [as appropriate] Date

Clearance:

[NAME], Regional Environmental Advisor [as appropriate] Date

Concurrence:

[NAME], ________ Bureau Environmental Officer [required] Date

DISTRIBUTION: [*Distribution lists may be customized by Bureau or Mission. Please follow Bureau- or Mission-specific guidance*.]

PROJECT/ACTIVITY SUMMARY

The goal of USAID's Integrated Health Program (USAID IHP) is to strengthen the capacity of Congolese institutions and communities to deliver high-quality, integrated health services that sustainably improve the health status of the Congolese population. The Program builds on previous health investments in the Democratic Republic of the Congo (DRC), USAID's Country Development Cooperation Strategy (CDCS), and related Government of the DRC (GDRC) strategies and policies.

The Program provides support to empower *zones de santé* (ZS) and sustainably improve the ability of the DRC's health system to deliver quality services in reproductive health and family planning; maternal, neonatal, and child health; nutrition; tuberculosis; malaria; WASH; and supply-chain services. Cross-sector areas of program focus include gender equity, conflict sensitivity, capacity building, and climate risk mitigation and environmental mitigation and monitoring. The Program aims to strengthen both facility-level and community-level primary health care platforms, including provincial administrative authorities and local organizations. USAID IHP operates in nine provinces, operationally grouped in three regions: Eastern Congo (Sud-Kivu and Tanganyika); Kasaï (Kasaï-Central, Kasaï-Oriental, Lomami, and Sankuru); and Katanga (Haut-Katanga, Haut-Lomami, and Lualaba).

The implementation of USAID IHP is subject to the requirements of the USAID/DRC Health Office Portfolio IEE (https://ecd.usaid.gov/repository/pdf/45611.pdf), which examined the proposed activities of the portfolio and assigned to each activity a threshold determination. These include Categorical Exclusion, indicating no expected environmental impact; Negative Determination with Conditions, signifying that possible environmental impacts can be mitigated by use of particular methods or actions; and Positive Determination (likely to have an impact on the environment). Please see table below for results.

INSTRUCTIONS

No Bureau-specific EMMR requirements have been communicated.

MANAGEMENT STRUCTURE FOR ENVIRONMENTAL COMPLIANCE

The organization of the mitigation measures is now the full responsibility of the technical teams. USAID IHP's WASH Advisor has taken the lead in organizing integration of mitigation measures into the overall program activities. He reports to his line manager (the Deputy Chief of Party), while overall reporting responsibility lies with the Chief of Party.

Many activities are still in early implementation stages. Few activities require specific attention to mitigation measures proposed in the EMMP.

The Program's WASH Advisor coordinates and supervises environmental compliance. WASH and Renovation Engineers (one in each region: Eastern Congo, Kasaï, and Katanga) have specific responsibilities in conjunction with their responsibilities regarding renovations and WASH installations.

Many technical staff are familiar with environmental compliance requirements, but more work remains to fully integrate ownership of design and implementation of mitigation measures.

MONITORING AND REPORTING FOR ENVIRONMENTAL COMPLIANCE

As per Africa and Global Health Bureau-approved Environmental Mitigation and Monitoring Plan.

EMMR TABLE FOR USAID IHP

PROJECT/ACTIVITY/SUB-ACTIVITY	STATUS OF MITIGATION MEASURES	OUTSTANDING ISSUES RELATING TO REQUIRED CONDITIONS	REMARK
Education, technical assistance, training to improve access to and delivery of health care.	Training activities in the facilities or community based services are implemented per the environmental compliance checklist to ensure compliance with key environmental requirements. The checklist contains information and instructions to help evaluate compliance in the facility, e.g. availability, use, and proper handling of incinerators, garbage pits, placenta pits, different bins, latrines, handwashing device, and the proper disposal of medical waste.	No outstanding issues identified yet	Activities related to attenuation measures are in the fourth quarter work plan
Procurement, storage, and management of public health commodities, including pharmaceuticals and supply chain strengthening activity.	Supply chain activities are in an initial stage. Activities that might generate waste are planned for year 2. In the meantime, USAID IHP teams apply the MOH guidelines on the treatment of chemical waste (drugs and laboratory inputs): records of non-used drugs, quarantine of products until recovery by BCZ or immediate transfer to BCZ for destruction.		
Funding private sector acquisition of diagnostic and treatment equipment.	No mitigation measures required since no such acquisition is in the pipeline yet		
Very small-scale construction or rehabilitation (less than1000m^2 total disturbed area) with no complicating factors.	No mitigation measures required since no such activity is underway		
Small-scale construction.	No mitigation measures required since no such small scale construction is underway		
Provision of long-lasting insecticidal nets for vector control.	LLINs are provided by UNICEF, Chemonics, and SANRU. Routine distribution is done at		

	the CPS and CPN level. On this occasion, USAID IHP recommends supporting the providers in handling waste, such as using incinerators for plastic packaging and sensitizing LLINs users on the potential negative effect of this tool if not used or disposed of properly. In the community, health care providers inform mothers on proper use and disposal of LLINs. To date, no supervision of this training of mothers has been conducted or supported.		
Sub-grant activities.	No mitigation measures are required since no such sub-grant activities are underway		
Construction and improvement of water and sanitation systems.	The WASH activities focused on the preparation of the procurement documents for the drilling in Kasaï Oriental and the rehabilitation / extension of water supply in South Kivu. These tender documents contain clauses on the environmental requirements for carrying out water and sanitation work.		The work will be implemented in the fourth quarter.
Office management and supply.	Some suppliers collect electronic waste, such as used printer cartridges. The offices installed water fountains to reduce the use of water bottles and thus reduce plastic waste. Electric hand dryers are used in the Kinshasa office's bathrooms to reduce paper waste. Staff is printing double-sided documents to reduce paper use and thus paper waste.		
Transportation of personnel and supplies.	The staff is encouraged to walk for short destinations. Some vehicles are fuel inefficient. Their use is kept to a minimum		

[Add / remove rows as needed]			

ADDITIONAL COMMENTS

Add comments as needed