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USAID'S INTEGRATED HEALTH PROGRAM

Fiscal Year 2020 Quarterly Report 3 (April 1 through June 30, 2020)

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Cover Photo: Nutritional support to patients of multi-drug resistant tuberculosis in Bena Dibela ZS, Sankuru. Photo credit: Blaise Ekofo, Abt Associates for USAID IHP.

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Contract No.: 72066018C00001

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based combination therapy
ALIMA	Alliance for International Medical Action
ANC	Antenatal care
ARI	Acute respiratory infection
ASSR	*Appui au système de santé en RDC* (Support to the health system in the DRC) (Project)
BA	Breakthrough Action
BCZS	*Bureau central de la zone de santé* (Central office of the health zone)
BEmONC	Basic emergency obstetric and newborn care
CAC	*Cellules d'animation communautaire* (community action groups)
CBD	Community-based distributor (of contraceptives)
CODESA	*Comités de Développement de l'Aire de Santé* (Health Area Development Committees)
COGE	*Comité de Gestion* (Management Committee)
COR	USAID Contracting Officer's Representative
CP	Clotrimazole and Placebo
CPLT	*Coordinations Provinciales Lèpre et Tuberculose* (Provincial Committees for Leprosy and Tuberculosis Control)
CPP-SS	*Commités Provinciaux de Pilotage du Secteur de la Santé* (Provincial Health Sector Steering Committees)
CPSr	*Consultations préscholaire* (Preschool consultations)
CSDT	*Centres de santé de diagnostic et traitement* (Diagnosis and treatment health centers)
CSO	Civil society organization
CTMP FP	*Comité Technique Multisectoriel Permanent de Planification Familiale* (Multisectoral Technical Committee for Family Planning)
CYP	Couple years of protection
D&F	Determination and Findings
DEP	*Direction d'Etudes et Planification* (Planning Directorate)
DFSA	Development Food Security Activities
DGOGSS	*Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé* (Directorate-General for the Organization and Management of Health Care Services)
DHIS2	District Health Information System 2
DMPA-SC	Dihydroxy Methyl Progestatif A – Subcutaneous (Subcutaneous Medroxyprogesterone acetate)
DPS	*Divisions Provinciales de Santé* (Provincial Health Districts)
DQC	Data quality control
DQST	Data Quality Supervision Tool
DQS	Data quality self-assessment
DRC	Democratic Republic of the Congo (*République démocratique du Congo*)
DR-TB	Drug-resistant TB
DTP3	Diphtheria-tetanus-pertussis immunization
E2A	Evidence to Action

ECDPS	*Equipe Cadre de DPS* (Executive Team of the Provincial Health District)
ECZS	*Equipe Cadre de la Zone de Sante* (Health Zone Mangement Team)
EMMP	Environmental Mitigation and Monitoring Plan
EMMR	Environmental Mitigation and Monitoring Report
EmONC	Emergency obstetric care
EOC	Essential obstetric care
EVD	Ebola Virus Disease
FFP	Food For Peace (*Bureau de l'alimentation pour la paix)*
FP	Family planning
FP2020	Global Family Planning 2020 Partnership
FY	Fiscal Year
GDRC	Government of the Democratic Republic of the Congo
GHSC-TA	Global Health Supply Chain-Technical Assistance
GIZ	*Deutsche Gesellschaft fur Internationale Zusammenarbeit* (German Corporation for International Cooperation)
GTM	*Groupe de Travail Médicament* (Essential Drugs Working Group)
HGR	*Hôpital Général de Référence* (General Reference Hospital)
HMIS	Health Management Information System
iCCM	Integrated community case management
IMNCI	Integrated management of newborn and childhood illness
INH	Isoniazid
IPC	Iinfection prevention and control
IPM	Informed Push Distribution Model
IPS	*Inspection Provinciale de la Santé* (Provincial Health Inspectorate)
IPTp	Intermittent preventive treatment in pregnancy
IRC	International Rescue Committee
ITN	Insecticide-treated net
IVR	Interactive voice response
IYCF	Infant and young child feeding
LMIS	Logistics Management Information System
LLIN	Long-lasting insecticidal nets
MAPEPI	*Maladies à potential epidémique* (*diseases with epidemic potential)*
MCZS	*Médecins chefs de zone de santé* (Health zone chief medical officers)
MDR-TB	Multi-drug resistant TB
MDR-TB/RR-TB	Multi drug-resistant/rifampicin-resistant TB
MDSR	Maternal death and surveillance response
M&E	Monitoring and Evaluation
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
NGO	Non-governmental organization
OCC	*Office* Congolais de *Contrôle* (Congolese Office of Control)
ORS+zinc	Oral rehydration salt + zinc sulfate
PAC	Post-abortion care
PAO	*Plan d'Action Opérationnel* (Annual Operation Plan)
PASS	*Programme d'Appui au Secteur de la Santé* (Program to Support the Health Sector)

PDSS	*Projet de Développement de Système de Santé* (Health Care System Development Project)
PEV	*Programme Elargi de Vaccination* (Expanded Program on Vaccination)
PIRS	Performance indicator reference sheets
PLHIV	People living with HIV
PMI	U.S. President's Malaria Initiative
PMR	Project Monitoring Report
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	*Programme National de Lutte contre le Paludisme* (National Malaria Control Program)
PNLS	*Programme National de Lutte contre la SIDA* (National AIDS Control Program)
PNLT	*Programme National de la Lutte Contre la Tuberculose* (National Program to Combat Tuberculosis)
PNSA	*Programme National de Santé des Adolescents (*National Adolescent Health Program)
PNSR	*Programme National de Santé de la Reproduction* (National Program for Reproductive Health)
PPE	Personal protective equipment
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)
RDQA	Routine data quality assessment
RDT	Rapid diagnostic test
RECO	*Relais communitaires* (Community health workers)
RH	Reproductive Health
RM&E	Research, Monitoring, and Evaluation
SANRU	*Santé Rurale* (Project)
SBC	Social and behavior change
SGBV	Sexual- and gender-based violence
S/P	Sulfadozine-pyrimethamine
STI	Sexually transmitted infection
TABGYN	Therapeutic abortion
TB	Tuberculosis
TP+	Bacteriologically confirmed pulmonary TB
TRG	Training Resources Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID IHP	USAID's Integrated Health Program
VAR	Varicella immunization
VSAT	Very-small-aperture terminal
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 of men, women, and children in target provinces.

USAID IHP Objectives

Strengthen health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones

Increase access to quality integrated health services in target health zones

Increase adoption of healthy behaviors, including use of health services in target health zones

The Program works in 178 *zones de santé* (ZS, health zones) across nine provinces within three regions: Eastern Congo, Kasaï, and Katanga. USAID IHP builds on previous USAID health investments in the DRC, USAID's Country Development Cooperation Strategy, and related Government of the DRC (GDRC) strategies and policies—particularly the *Plan National de Développement Sanitaire* (National Health Development Plan) 2019–2022. Major partners are the Ministry of Health (MOH) at the national level, the *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) and ZS within provinces, and communities and *Comités de Développement de l'Aire de Santé* (CODESA, Health Committees).

USAID IHP encompasses USAID programming in six health areas: malaria; maternal, newborn, and child health (MNCH); nutrition; reproductive health and family planning; tuberculosis (TB); and water, sanitation, and hygiene (WASH). During Quarter 3 of fiscal year (FY) 2020, Program activities generated impacts across all these domains, as well as in health systems strengthening, gender integration, conflict sensitivity, and environmental monitoring and mitigation. The emergence of the COVID-19 pandemic affected activities widely this quarter, with the GDRC declaring a national state of emergency starting March 24, 2020, to beyond the end of the quarter. USAID IHP program implementation in this context required redirection of funds and creative responses to address safety restrictions put in place by the GDRC. USAID IHP emphasized infection prevention and control; adjusted meeting protocols; redesigned trainings; executed many activities remotely; and procured personal protective equipment (PPE) to ensure that providers, *relais communautaire* (community health workers), and government counterparts at all levels could continue the provision of health care to the population of DRC.

Malaria. During this quarter, the Program supported the MOH with training for health care providers; supply of sulfadoxine/pyrimethamine (S/P) for intermittent preventive treatment for pregnant women; distribution of insecticide-treated nets (ITNs); and social and behavior change (SBC) awareness campaigns, especially around World Malaria Day. The MOH's key results included:

- 911,266 children under 5 received treatment for malaria from an appropriate provider (119.8 percent of the USAID IHP target).
- 314,429 pregnant women were provided with doses of S/P during antenatal care (ANC) visits.
- 407,910 ITNs were distributed during ANC and child immunization visits (133.5 percent of the USAID IHP target).

MNCH. USAID IHP continued to address the major killers of mothers and children through support for a range of activities, including ANC visits, delivery with skilled birth attendants, postnatal care visits, essential newborn care, emergency care, and integrated management of newborn and childhood illnesses and immunizations. Significant provincial results included:

- 417,238 pregnant women attended at least one ANC visit (99.9 percent of the USAID IHP target) and 251,283 attended at least four ANC visits (121.7 percent of the target).
- 354,622 women delivered with a skilled birth attendant (94.4 percent of the USAID IHP target).
- 354,117 postpartum/newborn visits were made within three days of birth (119 percent of the USAID IHP target).

Nutrition. The Program continued to advance the USAID and MOH goal of combatting malnutrition in children under 5, pregnant and breastfeeding women, and women of childbearing age. Major initiatives included training on preschool consultations and infant and young child feeding (IYCF), promotion of exclusive breastfeeding, supply of essential generic medicines, and support for SBC awareness campaigns. Key results included:

- 417,238 pregnant women attended ANC consultations (109.8 percent of the USAID IHP target).
- 645 health professionals received nutrition-related professional training.
- 90 ICYF support groups across four provinces were established or revitalized.

Reproductive health and family planning. USAID IHP supports GDRC and USAID commitments to the Family Planning 2020 global partnership through training for health care providers, community-based distributors, and youth peer educators; assistance to the *Comité Technique Multisectoriel Permanent de Planification Familiale* (Permanent Multisectoral Technical Committee for Family Planning); and promotion of SBC campaigns. Key results included:

- 332,974 couple years of protection reached (125.5 percent of the USAID IHP target).
- 337,458 new acceptors of modern contraceptive methods gained (149.9 percent of the target).

Tuberculosis. Program activities to improve the quality of TB management services and care in all 178 target ZS prioritized the detection and treatment of multi-drug resistant TB (MDR-TB); improvements in the quality of TB, TB-HIV, and MDR-TB data; active screening for TB cases; and directly observed therapy in the community. The provinces achieved the following results:

- 9,143 TB-positive patients out of a cohort of 10,454 were declared cured and 460 patients completed their treatment (97 percent of the USAID IHP target).
- 19,057 patients diagnosed with TB were put on first-line treatment, out of 19,832 cases registered (96 percent of the USAID IHP target).
- 4,019 children under 5 were put on Isoniazid prophylaxis treatment.

WASH. Toward the end of this quarter, USAID IHP began transitioning to a new WASH strategy in consultation with USAID, moving away from a community-based approach to a facility-based clean clinic approach in four target provinces. The Program trained health care providers on WASH and built the capacity of the *équipes cadre de la zone de santé* (ECZS, health zone management teams) to work with health centers to plan for WASH improvements. In parallel, the Program continued to complete in-progress community WASH activities and implement works to improve household access to clean drinking water in Sud-Kivu and Kasaï-Oriental. Key achievements included:

- 5,612 individuals in seven villages were sensitized about community WASH practices.
- 1,019 people had improved family latrines.
- 82 health facilities in four provinces were supported to launch the clean clinic approach.

Health system strengthening. USAID IHP continued initiatives to strengthen the DRC health system at all levels. Technical and financial support to DPS, *Inspections Provinciales de la Santé* (Provincial Health Inspectorates), ZS, CODESA, and community action groups helped sustainably improve stewardship over the health system in support of improved capacity to deliver quality health services. The Program worked with 12 ZS to conduct institutional analyses with the Participatory Institutional Capacity Assessment and Learning (PICAL) tool, while also assisting nine DPS to implement institutional capacity building plans based on FY2019 PICAL results. USAID IHP also supported the DPS in eight of those provinces to carry out supervision and coaching missions in 81 ZS, which were coupled with dissemination of preventive measures against COVID-19. A key achievement was that 44.7 percent of health facilities overall experienced a stock-out of selected commodities this quarter, lower than the expected 67.7 percent (for an achievement rate of 134 percent of the USAID IHP target) and particularly noteworthy given COVID-19 impacts on travel nationwide. In addition, the Program carried out a number of activities to improve health information and contribute to data quality and availability. All nine provinces exceeded the MOH's standard of 80 percent for data completeness in the District Health Information System 2 (DHIS2).

Looking forward. As USAID IHP moves into the last quarter of FY2020, priorities include ensuring that COVID-19 preventive measures—such as social distancing, infection prevention and control, and hand-washing—are in place to allow vital health system functions and support to continue. Supply chain activities will also be an important focus, particularly finalizing a system to ensure that essential generic medicines make it through the last mile to reach health facilities, especially in hard-to-access *aires de santé*. Further equipping DPS, ECZS, and health facilities to effectively manage health system data and use that data for informed decision-making is another area that USAID IHP will continue to emphasize through distribution of management tools and support for improvements in data quality and supervision. The Program will prioritize WASH by setting up a technically sound and operationally agile team of Program staff and local subcontractors to launch implementation of WASH rehabilitation and small-scale construction works at health centers in target ZS (to continue in FY2021). Finally, the results of the conflict sensitivity analysis, baseline service delivery mapping survey, and household survey will begin to better inform and impact USAID IHP's responsive, locally grounded implementation of activities.

1. INTRODUCTION

This report describes implementation of USAID's Integrated Health Program (USAID IHP) during Quarter 3 of USAID's fiscal year (FY) 2020 (April 1, 2020–June 30, 2020). The goal of the Program is to strengthen the capacity of Congolese institutions and communities to deliver quality integrated health services that sustainably improve the health status of Congolese men, women, and children. To meet this goal, USAID IHP has three objectives:

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

USAID IHP seeks to leverage the potential of decentralization and accelerate reductions in maternal, newborn, and child deaths. The Program supports the Ministry of Health (MOH) to tackle challenges identified in the *Plan National de Développement Sanitaire* (PNDS, National Health Development Plan) 2019–2022. The Program works 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.

PROGRAMMATIC AND GEOGRAPHIC SCOPE

USAID IHP's programmatic scope covers six health technical areas: malaria; maternal, newborn, and child health (MNCH); nutrition; reproductive health (RH) and family planning (FP); tuberculosis (TB); and water, sanitation, and hygiene (WASH). The Program works across three regional province clusters—Eastern Congo, Kasaï, and Katanga—and in nine provinces with 179 ZS,[1] 167 *hôpitaux générales de reference* (HGR, general referral hospitals), 5,861 health center catchment areas, and 2,273 integrated community case management (iCCM) sites (Table 1). Overall, the Program supports the MOH to steward the increased availability of integrated, accessible, and reliable health services. In addition to essential activities across all program-supported provinces and ZS, USAID IHP provides more comprehensive support to a limited subset of 60 ZS across the nine provinces; these 60 ZS have a high potential to improve the health status of the population due to their: location in economic cooridors as defined in the Country Development Cooperation Strategy (CDCS), high mortality rates, and/or baseline level of MNCH service offerings already available. The strategic selection of the 60 ZS also took into account presence of other technical and financial partner support, so USAID—through USAID IHP—can best leverage resources to improve health outcomes. The Program tailors assistance to meet the needs and capacities of each ZS.

[1] In the USAID solicitation for USAID IHP and all Program and contractual documents, 178 ZS are specified, although MOH DHIS2 data indicates 179 ZS. The additional zone is Kowe in Haut-Katanga, a *ZS militaire*. While not incorporated as part of the contract's Performance Work Statement, the Program has operated in and reported data for activities in all 179 ZS. This quarterly report simply refers to "all ZS," where USAID IHP currently implements activities.

Table 1. Where USAID IHP Works

Region	Province	# Zones de Santé	# Aires de Santé*	# General Referral Hospitals†	# Health Centers †	# iCCM Sites†	Population Covered
Eastern Congo	Sud-Kivu	34	641	38	622	157	7,703,971
	Tanganyika	11	267	7	243	867	3,246,186
Kasaï	Kasaï-Central	26	451	22	403	252	5,099,281
	Kasaï-Oriental	19	314	16	319	250	5,361,397
	Lomami	16	316	17	304	213	4,183,357
	Sankuru	16	248	16	229	163	2,531,768
Katanga	Haut-Katanga	26	388	24	708	147	6,250,148
	Haut-Lomami	16	329	15	301	89	4,125,593
	Lualaba	14	232	13	297	135	2,873,532
TOTAL		**178**	**3,186**	**168**	**3,426**	**2,273**	**41,375,233**

*Data based on the number used in June/July 2019 for sampling for the Baseline Household Survey.
†Data based on the Service Delivery Mapping Survey submitted August 7, 2020.

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, i+Solutions, Matchboxology, Mobile Accord/Geopoll, Training Resources Group (TRG), and Viamo.

During Quarter 3, USAID IHP continued to partner with MOH bodies and health system organizations. USAID IHP worked closely with the *Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé* (DGOGSS, Directorate-General for the Organization and Management of Health Care Services), *Comités Provinciaux de Pilotage du Secteur de la Santé* (CPP-SS, Provincial Health Sector Steering Committees), *Programme National de Lutte contre le Paludisme* (PNLP, National Malaria Control Program), *Programme National de Nutrition* (PRONANUT, National Nutrition Program) *Programme National de Santé de la Reproduction* (PNSR, National Program for Reproductive Health), *Programme National de la Lutte Contre la Tuberculose* (PNLT, National Program to Combat Tuberculosis), *Coordinations Provinciales Lèpre et Tuberculose* (CPLT, Provincial Committees for Leprosy and Tuberculosis Control), *Programme National de Lutte contre le SIDA* (PNLS, National AIDS Control Program). USAID IHP also collaborated with the *Ministre de Genre et Famille* to ensure programming alignment with national gender policies.

USAID IHP also carried out activities in collaboration with other partners to expand the scope and impact of activities. The Program worked with Breakthrough Action on social and behavior change (SBC). The Global Health Supply Chain-Technical Assistance (GHSC-TA) project and 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) offered support for improving the supply chain. The Program collaborated with the Food for Peace (FFP)-funded Budikadidi project, the Development Food Security Activities on nutrition and WASH activities, and with the non-governmental organization Alliance for International Medical Action and the United Nations Children's Fund (UNICEF) on nutrition. USAID IHP increased support in mutual technical assistance by collaborating with the World Bank's Performance-Based Financing Agency; Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ, the German Corporation for International Cooperation); the *Programme d'Appui au Secteur de la Santé* (PASS, Program to Support the Health Sector); the *Projet de Développement de Système de Santé* (PDSS, Health Care System Development Project); *Santé Rurale* (SANRU, Rural Health), *Appui au système de santé en RDC* (ASSR, Support to the health system in the DRC) and the United Nations Population Fund (UNFPA).

2. PROGRAM MANAGEMENT

IMPLEMENTATION

During Quarter 3, the COVID-19 pandemic, combined with related restrictions on travel and activities, emerged as a major variable in the Program, and adaptation to continuously changing conditions absorbed considerable management energy. The Program adopted the following principles in response:

- ***Rely on MOH guidance*** and ensure that Program staff refrain from sharing speculative information about the pandemic.
- ***Stay focused on the Program's unchanged mission,*** emphasizing the obligation of USAID IHP staff to continue strengthening the resilience of the health system by helping provinces address this new challenge.
- ***Mobilize creative responses*** to the perennial issue of limited health system resources. For example, to combat COVID-19, the USAID IHP team encouraged its field offices to help provinces adopt homemade facemasks.

Early in the quarter, USAID IHP submitted a request to redirect Program funding to urgent COVID-19-related interventions. Activities focused on three objectives: (1) strengthen capacities for surveillance and investigation of cases, (2) improve infection prevention and control (IPC) and WASH in all health facilities and the community, and (3) strengthen risk communication and community engagement.

Following the April 20, 2020 approval for redirection of Program funds, USAID IHP provincial offices engaged with their counterparts in the *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) to coordinate COVID-19 preparedness and response and to procure protective equipment. Such activities necessarily displaced a few routine activities. The Program also redesigned and standardized protocols for modified conduct of meetings, dissemination events, trainings, and even coaching and supervision. Working from home became the norm for staff in the USAID IHP Kinshasa office, and for a limited period in the Bukavu and the Lubumbashi offices.

The MOH introduced minimum service provision, but exhibited a prevailing sense of duty, typical for medical services. Most Ministry colleagues were eager to maintain a high level of performance. Almost all Ministry programs reviewed existing guidelines and incorporated changes relevant to the new COVID-19 context, demonstrating swift action to ensure cost-effective interventions could continue in the uncertain months to come.

Based on the reduction of occasions for interaction between USAID and USAID IHP staff, in April 2020, the USAID Contracting Officer's Representative (COR) suggested regular USAID-USAID IHP meetings for each technical program area to maintain effective levels of consultation. Work planning that started in June and July 2020 greatly benefitted from these established exchanges between USAID technical specialists and USAID IHP Program Advisors.

This quarter, a routine evaluation of MNCH and nutrition activities showed that among the 60 ZS that should be receiving targeted, comprehensive support (*paquet supplémentaire*), more than half had not benefitted from any USAID IHP support to-date. This triggered a detailed planning effort to ensure the Program follows the geographic prioritization for these activities, especially as the Program planned Year 3 interventions.

USAID IHP also observed that the WASH program was facing critical operational and procurement challenges. This was compounded by COVID-19 delays to community-based works slated for Sud-Kivu and Kasaï-Oriental. The Program therefore created a task force comprised of technical, management, and operations team focal points and organized internal awareness and advocacy sessions to ensure all field and home office staff shared the same sense of urgency. Thanks to this effort, which remains ongoing at the time of this report, the Program has harmonized an approach and established key milestones for implementing WASH rehabilitation and small-scale construction works.

This quarter marked the effective start of the Program's collaborative implementation of SBC interventions with Breakthrough Action, which is jointly responsible for the implementation of USAID/Democratic Republic of the Congo (DRC)'s vision of a single SBC strategy for the health sector. Such collaboration requires multiple meetings at different levels, but the collective is already seeing benefits in efficacy of USAID spending.

Finally, travel restrictions due to COVID-19 brought several field interventions to a standstill. USAID IHP's attempt to obtain USAID approval to fund interventions for ZS requires an involved process of Determination and Findings (D&F) in the nine provinces. The Program also gained greater appreciation of the importance of the MOH *Direction d'Etudes et Planification* (DEP, Planning Directorate) as an institutional partner, and so USAID IHP will engage both the DEP and DGOGSS. With this knowledge, USAID IHP can more effectively move forward amidst these challenges next quarter.

PROGRAM STAFFING

During the quarter, two *Equipe d'encadrement integrée* (EEI, Integrated Support Team)/Health Systems Strengthening (HSS) Specialists, an M&E Manager, and an Administrative Assistant/Receptionist resigned. In addition, and a Human Resources (HR) Assistant was hired in the Kinshasa office, yielding a staff count of 235 (152 Abt staff and 83 subcontractor staff).

During this quarter, the Program revised the organogram to reinforce operations and finance; Abt Associates included these changes in the budget realignment sent to USAID for approval in May. The May budget realignment submission proposed a total of 53 new positions (52 new employees, one existing employee to be transferred to a new position) across all offices: 21 in Kinshasa and 32 in the nine provinces. The proposed realignment added 15 new positions in Finance and Operations to the Kinshasa office, plus an additional three Subcontract/Grants Officer positions; three additional operationally-focused positions in Bukavu, Kalemie, Kamina, Kolwezi, and Lubumbashi and two in Kananga, Kabinda, Lodja, and Mbuji Mayi (as there was already an additional position in these offices that was proposed for repurpose). Adding these staff will significantly improve the efficiency and quality of support to the Program team as USAID IHP significantly ramps up the volume of activities.

SECURITY

This reporting period was dominated by the COVID-19 global pandemic. Measures to combat the spread of the virus have significantly impacted the security environment and Program operations.

On March 24, the President of the DRC announced a health-related State of Emergency, following a sharp increase in the number of cases detected in the capital, Kinshasa. On April 6, the Governor of Kinshasa implemented a series of measures to combat the spread of COVID-19, including restricting activities in the Commune of Gombe in Kinshasa, where the USAID IHP office is located. Effectively, all

movement in and out of Gombe was restricted to pass holders. All schools, universities, businesses, bars, restaurants, and terraces were closed.

At the end of this quarter, the State of Emergency was still in place. Additional measures implemented to prevent the spread of COVID-19 included:

1. The suspension of all travel, including flights, from countries considered to be high risk as well as travellers traveling from high-risk countries;
2. All travellers arriving from international borders required to complete a track and trace form, wash hands, and have temperature checked upon arrival to the DRC;
3. Imposition of 14-day quarantines for anyone suspected of illness following temperature checks;
4. All sea, river, airports, and entry points required to enforce surveillance controls on all arrivals from abroad; and
5. Strict controls on travellers leaving Kinshasa.

These restrictions effectively isolated Kinshasa from the rest of the country, although freight and cargo were permitted by land, air, and river. The government permitted very limited movement for individuals on special humanitarian flights—such as the United Nations Humanitarian Air Service, the Mission Aviation Fellowship and the European Union ECHO Flight service—and selected charter international flights arranged by the embassies of France, Belgium, the United States, and the United Kingdom. As a result, staff could not travel between Kinshasa and the provinces during this period.

As was previously reported, a result of travel restrictions, three staff members were unable to return to their offices in the Kasaï region and one was unable to return to Kolwezi.

1. Moniting & Evaluation (M&E) staff x2
2. Accounting staff x2

Outside of Kinshasa, local restrictions were also enforced with offices in the Eastern Congo region and Haut-Katanga, where the local Governor imposed lockdowns over short periods, which impacted the project opening in these areas:

1. Lubumbashi
    a. March 22-23, 2020
    b. April 28, 2020
2. Kolwezi
    a. March 24-25, 2020
3. Bukavu
    a. June 1-3, 2020

Overall, the USAID IHP security model, centered on responsiveness and adaptability, allowed the Program to continue operating in areas where there was little or no impact from COVID-19, while maintaining as high a level as possible of productivity in offices impacted by IPC measures.

Finally, COVID-19 pandemic-related travel restrictions meant that previously scheduled international travel had to be indefinitely postponed, including trips by the COP and DCOP to the USA for strategic planning and team building; a trip by the new Portfolio Manager to the DRC to meet key staff, resolve priority personnel issues, and gain first-hand understanding of program implementation in the field; and trips by several additional headquarters project team members related to M&E and work planning.

General security trends

The security picture in Kinshasa has stabilized somewhat, with many fewer demonstrations, public disorder, and disruption to normal operations. However, continued armed conflict in the Eastern Region continues to displace high numbers of the population, leading to reduced access to health care, safe drinking water, and sanitation.

In Kasaï-Central, Kasaï-Oriental, and Tanganyika, the scale and frequency of violence has decreased somewhat, although these provinces continue to be impacted by high numbers of internally displaced people. These people are highly vulnerable to criminality and lack of health and security structures.

The challenges in the east lead to operational security challenges in accessing the ZS where armed conflict proliferates. The Program had no major security incidents to report during this period.

3. PROGRAM AREAS

Helping Baby Breathe training in Lualaba. *Credit:* Patrick N'duwa, MOH for USAID IHP.

- **314,429 pregnant women** provided with doses of sulfadoxine/ pyrimethamine during antenatal care visits
- **354,622 women** delivered babies with a skilled birth attendant
- **337,458 new acceptors** of modern contraceptive methods gained
- **4,801 persons living with HIV** provided with doses of Isoniazid prophylaxis

- **407,910 ITNs distributed** during ANC and post-natal visits (133.5% of target)
- **9 percent reduction in malaria cases** observed between from January to June in Kasaï-Oriental
- **911,266 children under 5** treated for malaria by a provider (119.8% of target)

MALARIA

According to the World Health Organization (WHO) 2019 World Malaria Report, the DRC has the world's second-highest number of cases and deaths due to malaria. As one of the DRC's key partners in the implementation of its 2020–2023 National Strategic Plan, USAID—through USAID IHP—is implementing the U.S. President's Malaria Initiative (PMI) in nine provinces. The Program's malaria activities operate in 178 (34 percent) of the country's ZS. During FY2020 Quarter 3, USAID IHP activities planned in the provinces to support the *Programme National de Lutte contre le Paludisme* (PNLP, National Malaria Control Program) have included technical and financial support for (1) refresher training for providers on malaria prevention and case management for pregnant women; (2) training for providers on using rapid diagnostic tests (RDTs) to diagnose suspected malaria cases and on treating confirmed cases of uncomplicated and severe malaria; (3) equipping health facilities with materials to facilitate the observed uptake of sulfadoxine/pyrimethamine (S/P) during well child clinic visits; (4) celebration of World Malaria Day; (5) mobilization and awareness campaigns for communities on the use of health facilities; (6) routine distribution of long-lasting insecticidal nets (LLINs) to children under 5 during well child clinic visits, (6) training for *relais communautaire* (RECO, community health workers) on the management of malaria at integrated community case management (iCCM) sites and encouragement for communities to use iCCM sites.

Supported refresher training for providers on prevention and case management of malaria for pregnant women

Direct: ✔ 2.1.14 ✔ 2.1.16

During Quarter 3, USAID IHP supported a refresher training in Haut-Lomami, Lomami, Lualaba, and Sankuru and Tanganyika on the malaria prevention and case management for pregnant women (Indicator #2.1.14, Table 2). The refresher training focused on the correct use of RDTs, Artesunate+Amodiaquine, and Artemether + Lumefantrine with pregnant women with confirmed uncomplicated malaria. A total of 202 providers out of 353 planned (57.2 percent) were trained. Haut-Katanga was unable to carry it out the activity due to restrictions related to COVID-19 but will complete the activity in the next quarter. An additional problem was that Tanganyika trained only 17.9 percent of those planned because of challenges in accessing health facilities in the targeted ZS during the COVID-19 lockdown period when humanitarian flights were no longer travelling to this area. Sankuru reached its target (at 100.0 percent), while Haut-Lomami exceeded its target (at 110.0 percent). Kasaï-Central and Sud-Kivu reached its

target in Quarter 2, hence no refresher training was planned for Quarter 3. Kasaï-Oriental plans to conduct this activity next quarter to reach their targets.

Table 2. Number of health workers trained in IPTp with USG funds (Indicator 2.1.14)

Region	Province	Target	Q3 Achievement (#)	Achievement rate (%)
Kasaï	Kasaï-Central	0	N/A	N/A
	Kasaï-Oriental	0	N/A	N/A
	Lomami	86	68	79.1
	Sankuru	25	25	100.0
Total Kasaï		**111**	**93**	**83.8**
Katanga	Haut-Katanga	62	0	0.0
	Haut-Lomami	50	55	110.0
	Lualaba	52	40	76.9
Total Katanga		**164**	**95**	**57.9**
Eastern Congo	Tanganyika	78	14	17.9
	Sud-Kivu	0	N/A	N/A
Total Eastern Congo		**78**	**14**	**17.9**
Total General		**353**	**202**	**57.2**

Source: Project Monitoring Report

Provided S/P for intermittent preventive treatment for pregnant women during ANC visits

During this quarter, 314,429 pregnant women (out of 417,238 planned) were provided with doses of S/P for intermittent preventive treatment (IPT) during ANC visits (Indicator #2.4, Table 3). Against a target of 80 percent, 75.4 percent of pregnant women benefited from this treatment across the nine provinces, for an overall achievement rate of 94.2 percent. The Kasaï region met its target, with a 100 percent achievement rate. The Eastern Congo region had an achievement rate of 94.1 percent, while the Katanga region recorded 86.9 percent. Kasaï-Central, Kasaï-Oriental, Lomami, and Haut-Lomami all exceeded their targets. On the other hand, Sankuru (at 73.4 percent), Haut-Katanga (at 79.6 percent), and Lualaba (at 82.6 percent) had achievement rates under 90 percent.

Table 3. Percentage of pregnant women who received doses of sulfadoxine/pyrimethamine (S/P) for Intermittent Preventive Treatment (IPT) during ANC visits (Indicator 2.4)

Region	Province	Target (%)	Q3 Achievement (%)	Num.	Denom.	Achievement rate (%)
Kasaï	Kasaï-Central	80	81.5	44,390	54,484	101.8
	Kasaï-Oriental	80	80.7	42,582	52,774	100.9
	Lomami	80	89.6	37,765	42,151	112.0
	Sankuru	80	58.7	14,282	24,334	73.4
Total Kasaï		**80**	**80.0**	**139,019**	**173,743**	**100.0**
Katanga	Haut-Katanga	80	63.7	39,156	61,464	79.6
	Haut-Lomami	80	80.9	33,425	41,325	101.1
	Lualaba	80	66.1	22,335	33,786	82.6
Total Katanga		**80**	**69.5**	**94,916**	**136,575**	**86.9**
Eastern Congo	Tanganyika	80	74.0	21,430	28,970	92.5
	Sud-Kivu	80	75.8	59,064	77,950	94.7
Total Eastern Congo		**80**	**75.3**	**80,494**	**106,920**	**94.1**
Total General		80	**75.4**	**314,429**	**417,238**	**94.2**

Source: District Health Information System (DHIS2), accessed July 23, 2020

Provided water filters, cups, and related maintenance and cleaning advice, all for direct observation of adherence to intermittent preventive treatment in pregnancy

Indirect: ✔ 2.1.14 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9

During the third quarter, USAID IHP provided 125 health facilities in five ZS with directly observed therapy kits to facilitate observed uptake of S/P during ANC sessions. This activity reached 100 health facilities in Haut-Katanga (Lubumbashi, Kampemba, and Katuba ZS) and 25 health facilities in Lualaba (Dilala and Fungurume ZS).

Distributed insecticide-treated nets to prevent malaria transmission

During this quarter, 407,910 insecticide-treated nets (ITNs) were distributed in the ZS during ANC and post-natal consultation visits, out of a target of 305,522 (for a 133.5 percent achievement rate) (Indicator #17, Table 4). All three regions recorded scores above their expected targets: the Katanga region with the highest achievement rate (at 177.0 percent), the Kasaï region at 137.7 percent, and the Eastern Congo region at 103.5 percent. Six provinces exceeded their targets (Haut-Katanga, Tanganyika, Kasaï-Oriental, Lomami, Haut-Lomami, and Kasaï-Central). The other three (Sud-Kivu, Sankuru, and Lualaba) did not meet their targets. Sankuru's lower achievement rate was due to the lack of appropriate transportation for LLINs from the *Bureau central de la zone de santé* (BCZS, Central office of the ZS) to health facilities. There was also a stock shortage in Lualaba due to poor road conditions during the rainy season. It should also be noted that this was a catch-up quarter for the three regions who had been behind on ITN delivery the last quarter due to a batch of ITNs that had previously been quarantined by the Office of Congolais de Control and were able to be distributed this quarter. In the Katanga region, there were a number of community engagement activities that took place during this period. These activities, along with the availability of the ITNs supported the increased achievement rate in this region. Efforts included a mini campaign and community champion activities thatfocused on malaria prevention (specifically ITN use) and World Malaria Day activities where people were referred to health facilities where they received ITNs.

Table 4. Number of insecticide-treated nets (ITNs) distributed during antenatal and/or child immunization visits (Indicator 17)

Region	Province	Target	Q3 Achievement	Achievement rate (%)
Kasaï	Kasaï-Central	55,416	71,361	128.8
	Kasaï-Oriental	28,822	51,682	179.3
	Lomami	32,030	52,751	164.7
	Sankuru	28,967	24,237	83.7
Total Kasaï		**145,235**	**200,031**	**137.7**
Katanga	Haut-Katanga	13,668	52,857	386.7
	Haut-Lomami	26,045	35,935	138.0
	Lualaba	17,459	12,405	71.1
Total Katanga		**57,172**	**101,197**	**177.0**
Eastern Congo	Tanganyika	14,812	29,765	201.0
	Sud-Kivu	88,303	76,917	87.1
Total Eastern Congo		**103,115**	**106,682**	**103.5**
Total General		**305,522**	**407,910**	**133.5**

Source: DHIS, accessed July 23, 2020

Provided provider training on malaria diagnosis, based on RDTs, and on treatment of confirmed cases of simple and severe malaria

Direct: ✔ 2.1.16 **Indirect:** ✔ 2.1.14

USAID IHP provided technical and financial support for the training of 351 providers on diagnosis of malaria with RDTs (Indicator #2.1.16) and treatment with Artemisinin-based combination therapy (ACT) (Indicator #2.1.15) (Table 5). With a target of 655, the overall achievement rate was 53.6 percent. Those trained included 285 men and 66 women from 16 ZS in six provinces: Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Lualaba, and Tanganyika. Haut-Katanga was unable to hold this training due to COVID-19-related restrictions, which made it impossible to hold the training and precluded facilitators from travelling to lead the training.

The Kasaï Region organized the training throughout its four provinces, with a 124.0 percent achievement rate. This high achievement rate is the product of deciding to train additional providers in Lomami since it has been identified as a province with a high rate of malaria-related morbidity and mortality. The Katanga region and Eastern Congo region significantly underachieved their targets, at 21.1 percent and 13.3 percent respectively. The poor performance in Lualaba is related to the poor road conditions that prevented the target ZS of Diolo, Kapanga and Kalamba from implementing this activity. The USAID IHP team is working with these ZS to consider strategies to mitigate this in the future. Finally, Haut-Lomami and Sud-Kivu did not conduct these trainings during the reporting period since they already achieved their targets for the year.

Table 5. Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnosis Tests (RDTs) or microscopy) and case management with ACT with USG funds (Indicator #2.1.16 and Indicator #2.1.15)

Region	Province	Q3 Achievement (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	41	41	100
	Kasaï-Oriental	115	115	100
	Lomami	84	30	280
	Sankuru	39	39	100
Total Kasaï		**279**	**225**	**124.0**
Katanga	Haut-Katanga	0	62	0.0
	Haut-Lomami	NA	0	NA
	Lualaba	40	73	54.8
Total Katanga		**40**	**135**	**21.1**
Eastern Congo	Tanganyika	32	64	50.0
	Sud-Kivu	NA	0	NA
Total Eastern Congo		**32**	**64**	**50**
Total General		**351**	**655**	**53.6**

Source: Project Monitoring Report

Supported monitoring of achievements under the 2020–2023 National Strategic Plan for malaria control

The DRC's 2020–2023 National Strategic Plan for malaria control aims to reduce mortality by 50 percent and morbidity by 40 percent. During this quarter, USAID IHP provided technical and financial support to Kasaï-Oriental to begin monitoring the process of reducing malaria morbidity and mortality. The overall analysis showed a reduction of 9 percent in the number of malaria cases from January 2020 to June 2020; this reduction applies to all forms of malaria (uncomplicated and severe) and to all target

groups (general population, children under 5, and pregnant women). There was a reduction in the number of severe cases in the general population and especially among pregnant women, who saw a drop in the number of severe cases from 417 in January 2020 to 249 in June 2020. This corresponds to a decrease in the proportion of severe cases among uncomplicated cases for all target groups from 4.7 percent to 3 percent for the same period.

Supported treatment for malaria among children under 5

During Quarter 3, 911,266 children under 5 with confirmed malaria received treatment from an appropriate provider, compared to a target of 760,894, for an overall achievement rate of 119.8 percent (Indicator #15, Table 6). To support results under this indicator, USAID IHP organized training and refresher training on the correct diagnosis and case management of malaria in children under 5. The good performance achieved by the provinces can also be explained by the availability of RDTs and ACTs in health facilities. Other USAID IHP-supported activities that helped lead to strong results across in all provinces included awareness-raising campaigns, training, and mobilization and revitalization of community champions associated with the mini-campaigns.

Table 6. Number of children under 5 years of age with confirmed malaria who received treatment for malaria from an appropriate provider in USG-supported areas (Indicator 15)

Region	Province	Q3 Achievement	Target	Achievement rate (%)
Kasaï	Kasaï-Central	158,627	118,559	133.8
	Kasaï-Oriental	134,627	101,971	132.0
	Lomami	100,107	99,595	100.5
	Sankuru	59,272	50,477	117.4
Total Kasaï		**452,633**	**370,602**	**122.1**
Katanga	Haut-Katanga	81,178	65,816	123.3
	Haut-Lomami	108,724	74,430	146.1
	Lualaba	65,980	40,531	162.8
Total Katanga		**255,882**	**180,777**	**141.5**
Eastern Congo	Tanganyika	58,374	50,722	115.1
	Sud-Kivu	144,377	158,793	90.9
Total Eastern Congo		**202,751**	**209,515**	**96.8**
Total General		**911,266**	**760,894**	**119.8**

Source: DHIS2, Accessed July 23, 2020

Organized monthly malaria monitoring meetings at health centers

USAID IHP supported monitoring meetings that included the analysis of malaria data in 82 ZS: 35 ZS in the Katanga region, 31 ZS in the Kasaï region, and 16 ZS in the Eastern Congo region. Analysis in Kasaï-Central and Sud-Kivu showed consistency between the rates of treatment of uncomplicated malaria and confirmed cases among children under 5 in the ZS. This data indicates the number of children with positive RDTs are all being treated with ACT according to national policy. Briefings for providers, case definition, and reminders of the malaria case management protocol have improved the providers' level of knowledge.

Supported quarterly supervision visits by the PNLP to the ZS

PNLP provincial management teams provided integrated supervision to 52 ZS during Quarter 3. USAID IHP provided financial and technical support for PNLP supervision in Kasaï-Central (in seven ZS) and

Sud-Kivu (three ZS). Supervision by the provincial coordinators was supposed to contribute to the improvement of the quality of malaria care (diagnosis and treatment), the quality of malaria data (analysis and reporting), the prevention of malaria in pregnant women (through IPT) in health facilities, and the monitoring of the management of PMI inputs in the ZS.

Lessons Learned

- Refresher training for providers on malaria prevention and case management for pregnant women helped improve participants' knowledge of the revised guidelines for case management. The guidelines promote directly observed therapy with S/P in recognition that observation from a provider ensures that pregnant women have actually taken their dose of S/P.
- USAID IHP's support for "last-mile" delivery of inputs helped ensure the availability of ITNs in the ZS, particularly in health facilities and the community.
- Monitoring meetings made it possible to identify gaps among providers, namely the difficulty in estimating needs, the treatment of uncomplicated malaria cases with quinine, the case management of non-malarial fevers, and identification and disposal of poor quality RDTs.

Next steps

- Organize refresher training on malaria prevention and treatment in Tanganyika, since humanitarian flights resumed at the beginning of June 2020. In Quarter 4, the Program plans to reach the ZS where this activity was planned.
- Continue refresher training for providers on prevention and case management of malaria among pregnant women.
- Support monthly monitoring meetings at the BCZS level and the *équipe cadre de la zone de santé* (ECZS, health zone management team) supervision visits to health facilities to stay on track.
- Provide ITNs in all ZS where the nets are now available.

- **172,320 women** had at least one antenatal care (ANC) visit with a skilled provider (99.9 percent of achieved) and **251,283** had at least four ANC visits (121.7 percent achieved)
- **30,761 newborn visits** conducted of 22,909 target (119 percent achieved)
- **8,438 children** resuscitated after delivery (94.9 percent achieved)

MATERNAL, NEWBORN, AND CHILD HEALTH

The DRC is one of 24 USAID priority countries for MNCH. During FY2020 Quarter 3, USAID IHP continued to implement maternal and child health interventions in support of MOH standards and guidelines in the nine provinces. These interventions included support for antenatal care (ANC) visits, deliveries with a skilled birth attendant, postnatal care visits, essential newborn care, and emergency care. Activity implementation was challenging during this period as a result of two factors: (1) an increase in restrictive measures related to the COVID-19 pandemic; and (2) the postponement of activities in certain provinces (Haut-Lomami, Kasaï-Oriental, and Tanganyika) due to the unavailability of teams within the *Programme National de Santé de la Reproduction* (PNSR, National Program for Reproductive Health) to participate in USAID IHP activities.

MATERNAL AND NEWBORN HEALTH

ANC visits with a skilled provider

During this reporting period, as shown in Table 7, overall 99.9 percent of women attended their first ANC visit (ANC1) with a skilled provider (Indicator #2.1.2). The Kasaï region had a 101 percent achievement rate, with 173,743 women out of a target of 172,320 attending at least one ANC visit with a skilled provider. In the Katanga region, 136,575 women out of a target of 133,626 attended their first ANC visit, for a 102 percent achievement rate. The Eastern Congo region had a lower achievement rate (96 percent), with 106,920 women out of a target of 111,650 making ANC1 visits.

This strong performance in the Kasaï and Katanga regions is a result of the following activities: (1) provider supervision and coaching by the DPS; (2) capacity building of providers in basic emergency obstetric and newborn care (BEmONC); (3) the availability of ANC medicines and other inputs (specifically LLINs, S/P for IPT during ANC visits, and cups for taking S/P); (4) raising the awareness of pregnant women on the use of ANC services; (5) the organization of World Malaria Day activities coupled with an ANC mini-campaign; and (6) community champion activities, including raising awareness and referring pregnant women to ANC services. Performance in the Eastern Congo region was linked to the availability of ANC inputs (LLINs, S/P) and community champion activities in the ZS (awareness-raising and referral of pregnant women to ANC services).

All provinces exceeded their target for the number of pregnant women who attended at least four visits with a skilled provider (Indicator #13) in Quarter 3, with a total of 251,283 women out of a target of 206,457 making at least four ANC visits (a 121.7 percent overall achievement rate). This strong performance can be attributed to: (1) support for functional community champions and RECO to raise awareness and counsel women on the use of ANC and malaria services; (2) the organization of ANC/FP mini-campaigns; and (3) the celebration of World Malaria Day coupled with mini ANC awareness-raising campaigns and the referral of pregnant women to health centers. Increased awareness-raising activities focusing on the importance of ANC attendance has helped to increase the number of pregnant women who complete four ANC visits.

Table 7. Percentage of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider from USG-supported health facilities (Indicator #2.1.2) and Number of pregnant women attending at least 4 antenatal care (ANC) visits with a skilled provider from USG-supported health facilities (Indicator #13)

Region	Province	Percentage of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider from USG-supported health facilities				Number of pregnant women attending at least 4 antenatal care (ANC) visits with a skilled provider from USG-supported health facilities		
		Target (%)	Num.	Denom.	Achievement rate (%)	Target (#)	Q3 (#)	Achievement rate (%)
Kasaï	Kasaï-Central	100	54,484	50,986	107	37,992	44,541	117
	Kasaï-Oriental	100	52,774	53,712	98	29,700	35,776	120
	Lomami	100	42,151	42,192	100	27,200	29,096	107
	Sankuru	100	24,334	25,430	96	16,094	19,098	119
Total Kasaï		**100**	**173,743**	**172,320**	**101**	**110,986**	**128,511**	**116**
Katanga	Haut-Katanga	100	61,464	62,445	98	18,088	22,445	124
	Haut-Lomami	100	41,325	42,356	98	17,897	24,432	137
	Lualaba	100	33,786	28,825	117	10,195	15,273	150
Total Katanga		**100**	**136,575**	**133,626**	**102**	**46,180**	**62,150**	**135**
Eastern Congo	Tanganyika	100	28,970	32,669	89	10,303	14,497	141
	Sud-Kivu	100	77,950	78,981	99	38,988	46,125	118
Total Eastern Congo		**100**	**106,920**	**111,650**	**96**	**49,291**	**60,622**	**123**
Total General		**100**	**417,238**	**417,596**	**99.9**	**206,457**	**251,283**	**121.7**

Source: DHIS2, accessed July 23, 2020

Delivery with a skilled birth attendant and proper administration of uterotonics

During the reporting period, the Congolese health system in the nine target provinces achieved 94.4 percent of USAID IHP's overall target for the percentage of deliveries with a skilled birth attendant in USG-supported facilities (Indicator #2.1.3, Table 8). Overall, the Kasaï and Katanga regions achieved the best performance, at 98.9 percent and 97.6 percent of the target respectively. The Eastern Congo region's achievement rate was lower, at 83.6 percent of the target, due to the very weak performance of Tanganyika province (54.9 percent). This underperformance can be explained by (1) the absence of maternity wards in most health facilities; (2) the lack of qualified personnel in health facilities; (3) community customs and traditions that constitute barriers to the use of health services in the province;

and (4) ongoing insecurity throughout the province which limits women's ability to travel to CS (especially at night) and limits CS ability to operate.

Despite the relatively strong performance in the Katanga region, Haut-Katanga experienced a slight decline from 95.7 percent of the target in Quarter 2 to 91.8 percent in Quarter 3. Part of the reason for this change is a lack of providers trained in emergency obstetric care (EmONC), essential obstetric care (EOC), post-abortion care, and maternal death surveillance and response (MDSR). However, the figures were also impacted by under-reporting of data caused by challenges in the collection and use of management tools by providers at health facilities, which may be resolved over time with continued technical assistance. Haut-Lomami showed the opposite pattern: an increase from 88.4 percent of the target in Quarter 2 to 91.3 percent in Quarter 3. This increase can be explained by the routine awareness campaigns conducted by *cellules d'animation communautaire* (CAC, community action groups) in the *aires de santé*. In addition, quality care assessment missions supported by PDSS during the quarter helped contribute to this increase.

The Kasaï region's achievement rate of 98.8 percent of the target was impacted by Kasaï-Central's strong showing (110.1 percent of the target). The region's performance was due to (1) DPS support for and supervision of activities in Kasaï-Central; (2) provider capacity building in EmONC; (3) the involvement of CODESA to advocate for reduced cost of maternity services (for Kasaï-Central in particular); and (4) activities to raise the awareness of pregnant women about the use of maternity services.

During the reporting period, the number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs (Indicator #2.1.4, Table 8) was lower than the Program target, with an achievement rate of 69.6 percent. This underperformance can be explained as follows:

Although the Kasaï region did not meet the overall target (with an achievement rate of 84.4 percent), it was the only region where more uterotonics were administered in all provinces than during Quarter 2. This was due to (1) the availability of medicines; (2) provider capacity building in EmONC; (3) DPS support and supervision of ZS; and (4) financial support for ZS supervision of the *aires de santé*.

The Katanga region met 77.8 percent of its target. In Haut-Katanga, this was due in part to the low availability of uterotonics (oxytocin specifically) in health facilities. The Program also noted that indicator performance was also affected by a lack of understanding of this indicator definition in DHIS2 at the health center level, an opportunity to ensure more accurate reporting in the future. Haut-Lomami exceeded the target, achieving 127 percent in Quarter 3, due to the supply of oxytocin to ZS with the support from the GHSC-TA project. Other ZS in Haut-Lomami bought oxytocin with PDSS funds.

Eastern Congo had the worst performance of the three regions this quarter, with an achievement rate of 62.3 percent of the target. Notably, the percentage of women who received uterotonics after childbirth was low in Sud-Kivu, at 62 percent of the target, even though USAID IHP supported the provision of oxytocin to all ZS. Results for this indicator in this province were impacted by under-reporting of data at the maternity ward level and mistakes in filling out partographs during deliveries. In Tanganyika, challenges included (1) the absence of maternity wards in most health facilities; (2) the lack of availability of oxytocin; and (3) the low level of awareness of skilled birth attendants among women in the communities.

Table 8. Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities (Indicator #2.1.3) and Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs (Indicator #2.1.4)

Region	Province	Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities					Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs		
		Num.	Denom.	Q3 (%)	Target (%)	Achievement rate (%)	Q3 (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	50,543	50,986	99.1	90	110.1	3,263	3,238	100.8
	Kasaï-Oriental	45,975	53,712	85.6	90	95.1	1,850	2,588	71.5
	Lomami	34,803	42,192	82.5	90	91.7	1,093	1,449	75.4
	Sankuru	21,917	25,430	86.2	90	95.8	824	1,055	78.1
Total Kasaï		**153,238**	**172,320**	**88.9**	**90**	**98.8**	**7,030**	**8,330**	**84.4**
Katanga	Haut-Katanga	51,619	62,445	82.7	90	91.8	6,008	9290	64.7
	Haut-Lomami	34,803	42,356	82.2	90	91.3	2,766	2178	127.0
	Lualaba	30,978	28,825	107.5	90	119.4	4,336	5374	80.7
Total Katanga		**117,400**	**133,626**	**87.9**	**90**	**97.6**	**13,110**	**16,842**	**77.8**
Eastern Congo	Tanganyika	16,150	32,669	49.4	90	54.9	1,309	1,934	67.7
	Sud-Kivu	67,834	78,981	85.9	90	95.4	20,742	33,480	62.0
Total Eastern Congo		**83,984**	**111,650**	**75.2**	**90**	**83.6**	**22,051**	**35,414**	**62.3**
Total General		**354,622**	**417,596**	**84.9**	**90**	**94.4**	**42,191**	**60,586**	**69.6**

Source: DHIS2, accessed July 23, 2020

Essential newborn care and post-partum visits

In Quarter 3, the Congolese health system in the nine target provinces achieved 94.5 percent of USAID IHP's target for the percentage of newborns receiving essential newborn care (Indicator #2.1.7, Table 9). Activities that impact this performance included USAID IHP's support for post-partum visits, provider training in EmONC, and the supply of life-saving drugs for children and newborns. Despite these trainings, no provinces and the majority of ZS did not provide essential care for 100 percent of live births because of the lack of resuscitation materials and equipment (newborn baby dummies, ambu balloon, pediatric stethoscope). Additionally, the ZS outside the ZS corridors did not receive sufficient capacity building. Of all the provinces, Lomami had the lowest completion rate (88.5 percent) as a result of a lack of trained providers in the most heavily populated ZS (Luputa, Kanda Kanda, and Kamiji).

USAID IHP exceeded the target in all provinces for the number of postpartum/newborn visits within three days after birth (Indicator #2.1.6), with an overall achievement rate of 119 percent. This performance was a result of provider training in EmONC, EOC, post-abortion care, MDSR, and CEmONC for hospitals (specifically, midwives and doctors in charge of maternity wards), provider supervision and support, and the supply of nine of the 13 life-saving drugs for mothers, children and newborns. Lualaba province stands out with a completion rate of 139.3 percent (30,761 newborn visits were conducted compared to the 22,909 expected). This performance is due to the increase in joint DPS-USAID IHP follow-up visits in the Manika, Fungurume, Kasaji, Dilala, and Sandoa ZS, which recorded more than 2,500 cases each. The target for Tanganyika province was underestimated, leading

to an achievement rate of 163.4 percent (16,774 newborn visits were conducted compared to the 10,266 expected).

Table 9. Number and percentage of newborns receiving essential newborn care through USG-supported programs (Indicator #2.1.7) and Number of postpartum/newborn visits within three days of birth in USG-supported programs (Indicator #2.1.6)

Region	Province	Number of newborns receiving essential newborn care through USG-supported programs			Number of postpartum/newborn visits within three days of birth in USG-supported programs		
		Target	Q3 (%)	Achievement rate (%)	Target (#)	Q3 (#)	Achievement rate (%)
Kasaï	Kasaï-Central	100	97.3	97.3	48,596	50,936	104.8
	Kasaï-Oriental	100	92.1	92.1	40,787	46,081	113.0
	Lomami	100	88.5	88.5	32,029	35,281	110.2
	Sankuru	100	96.9	96.9	17,844	22,021	123.4
Total Kasaï		**100**	**93.6**	**93.6**	**139,256**	**154,319**	**110.8**
Katanga	Haut-Katanga	100	94.7	94.7	43,719	52,784	120.7
	Haut-Lomami	100	94.8	94.8	23,559	35,370	150.1
	Lualaba	100	94.2	94.2	22,090	30,761	139.3
Total Katanga		**100**	**94.6**	**94.6**	**89,368**	**118,915**	**133.1**
Eastern Congo	Tanganyika	100	90.0	90.0	10,266	16,774	163.4
	Sud-Kivu	100	97.6	97.6	58,614	64,109	109.4
Total Eastern Congo		**100**	**96.1**	**96.1**	**68,880**	**80,883**	**117.4**
Total General		**100**	**94.5**	**94.5**	**297,504**	**354,117**	**119.0**

Source: DHIS2, accessed July 23, 2020

Number of newborns resuscitated

The number of newborns not breathing at birth who were resuscitated in USG-supported programs (Table 10, Indicator #2.1.5) increased from 8,009 in Quarter 2 to 8,438 during Quarter 3. Overall, the Congolese health system in the the nine target provinces achieved 94.9 percent of the USAID IHP target (compared to 90.1 percent in Quarter 2). This improved performance can be explained by the services provided by 450 clinical actors of the 32 ZS in EmONC, EOC, and essential newborn care. An additional factor was the application of knowledge gained through previous provider trainings in areas such as resuscitation of newborns--the providers have now mastered the techniques from these trainings, which they use each time there is a complication or a problem related to a respiratory difficulty in a newborn. Other partners—including UNFPA, SANRU, and Pathfinder—helped support ZS that are not in the USAID IHP BEmONC corridor. For clinical mentoring, USAID IHP focused on the few *aires de santé* of the ZS corridor that lacked sufficient funds for the activity, due to poor planning.

The Kasaï region had the lowest achievement rate among the regions, at 86.9 percent of the USAID IHP target. Kasaï-Central, with a completion rate of 71.5 percent, was the weakest performing province in Kasaï region.

Helping Baby Breathe training in Lualaba. Credit: Patrick N'duwa, MOH.

The overall achievement rate for this indicator in the Katanga region was 95.0 percent. Haut-Katanga recorded a significant drop, meeting only 78.7 percent of the USAID IHP target this quarter. Only six ZS in Haut-Katanga recorded successful results: Lukafu (144 percent), Lubumbashi (233 percent), Kenya (133 percent), Mumbunda (126 percent), Katuba (108 percent), and Vangu (100 percent). This poor performance in Katanga overall was due to the lack of capacity building for service providers, (resulting in an inadequate number of trained providers), the lack of support from other partners (UNICEF, PDSS) in the purchase of health services, and the lack of a strong technical platform in health facilities (consisting of biomedical equipment and qualified staff for service provision).

In the Eastern Congo region, the achievement rate for this indicator exceeded the target (at 103.4 percent) and increased this quarter compared to the last quarter. This was due to the following factors: (1) increased number of providers (midwives and doctors in maternity wards) trained in EOC, essential newborn care, EmONC, and MDSR; (2) supply of essential generic medicines in the ZS in Tanganyika and Sud-Kivu; (3) supervision support in MNCH and maternal and perinatal death surveillance and response, which contributed to the retraining of providers in Sud-Kivu.

Table 10. Number of newborns not breathing at birth who were resuscitated in USG-supported programs (Indicator #2.1.5)

Region	Province	Q3 (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	633	885	71.5
	Kasaï-Oriental	785	735	106.8
	Lomami	583	703	82.9
	Sankuru	262	282	92.9
Total Kasaï		**2,263**	**2,605**	**86.9**
Katanga	Haut-Katanga	1,600	2,032	78.7
	Haut-Lomami	1,181	917	128.8
	Lualaba	859	884	97.2
Total Katanga		**3,640**	**3,833**	**95.0**

Region	Province	Q3 (#)	Target (#)	Achievement rate (%)
Eastern Congo	Tanganyika	466	436	106.9
	Sud-Kivu	2,069	2,015	102.7
Total Eastern Congo		**2,535**	**2,451**	**103.4**
Total General		**8,438**	**8,889**	**94.9**

Source: DHIS2, accessed July 23, 2020

Maternal death surveillance and response

During this quarter, USAID IHP provided financial support to 13 maternal death review meetings in 110 ZS in the nine provinces (Table 11). The ZS recorded a total of 349 maternal deaths, including 195 at the community level and 154 in health facilities. The reason that the review and response rate is still too low (154 cases out of the 349 recorded) is because the maternal and perinatal death surveillance and response teams have not yet been established in all the ZS, so that not all cases can be analyzed and reviewed. The lack of community cases in Sankuru reveals under-reporting and poor analysis of causes and contributing factors.

The direct causes of these maternal deaths are postpartum hemorrhage, septicemia, eclampsia/pre-eclampsia, uterine rupture, sepsis, dystocia, uterine ruptures, sepsis, and complications from caesarean sections. Meanwhile, contributing factors include the lack of a blood bank in the majority of the ZS; the four "toos" (too early pregnancies, too many, too close, too late); self-medication; sequestration by charlatans and churches; the three "delays" (delay in decision making, delay in care, delay due to road conditions), especially in Tanganyika; geographic inaccessibility and a poorly organized referral system; the presence of matrons in the health facility; and a lack of equipment and inputs for blood transfusion, as in Lomami.

Table 11 shows that Tanganyika has the highest maternal mortality rate. The challenges in Tanganyika are multifaceted and include the following factors: (1) the neglect or lack of ownership of the problem by the *Médecins chefs de zone de santé* (MCZS, ZS chief medical officers); (2) instability along with long distances to be travelled by parturient or pregnant women; (3) the low involvement of other partners despite multiple requests at various maternal death meetings; (4) lack of qualified personnel at the level of the local PNSR and poorly qualified RH focal points assigned to this task at the BCZS, who do not meet the requirements for this position. The number of maternal deaths in Tanganyika would be even higher if not for under-reporting of maternal death cases by the health facilities for fear of sanction from the government and the lack of maternal death surveillance and response committees at the provincial level and in some ZS, which means that not all maternal death cases were even reported.

Table 11. Maternal death surveillance and response (MDSR)

DPS	Maternal deaths					Period	Meetings held
	ZS level	Community level	Health facilities	Total deaths	Total reviewed		
Sud-Kivu	22	70	30	100	20	April-May 2020	2
Tanganyika	11	71	47	117	40	April 2020	1
Haut-Lomami	0	0	0	0	0	2020	0
Lualaba	7	2	8	10	9	April-May 2020	2
Haut-Katanga	27	32	46	78	26	April-June 2020	1
Lomami	10		23	47	25	April-June 2020	2
Sankuru	4	0	4	4	4	May 2020	1

DPS	Maternal deaths					Period	Meetings held
	ZS level	Community level	Health facilities	Total deaths	Total reviewed		
Kasaï -Oriental	6	13	14	29	3	April-June 2020	22
Kasaï -Central	23	15	28	41	28	April 2020	2
Total	**110**	**195**	**154**	**349**	**129**		**13**

Source: Provincial Maternal and perinatal death surveillance and response reports

Lessons learned

- Provider supervision conducted by the DPS, alongside community awareness-raising on care-seeking behavior and ANC attendance, helped to ensure that: (1) all pregnant women continue with ANC visits where they receive IPTp, tetanus vaccinations, and iron supplementation; and (2) access to skilled birth attendants.
- Delivery at health facilities remains counter-traditional among some segments of the population, linked to local customs and beliefs in Haut-Lomami, for example. This contributes to a reduction in the use of ANC services. Local community awareness-raising about the importance giving birth at a health facility is proving critical to help change these behaviors.
- Lack of data completeness and low capacity for data analysis can lead to under-reporting of performance indicator data at the DPS and ZS levels, meaning that results are not always fully and accurately reflected.
- RECO engagement and community awareness-raising activities seem to contribute to the use of ANC services (specifically in Kasaï-Central) and the number of women who give birth at health facilities.
- The BEmONC, EOC, and maternal and perinatal death surveillance and response provider training led not only to the increased knowledge and mastery of different skills for better emergency obstetric care and management of neonatal complications, but the ability to carry out maternal death reviews and to develop an adapted response plan.
- The lack of involvement of providers and ECZS members in the search for community-based maternal death cases hinders in-depth analysis to find appropriate solutions for maternal-infant mortality reduction.
- Recording and analyzing each case of maternal death immediately following the event is essential to understand real causes of death and to avoid a backlog of cases to review at the end of the month or quarter.

Next steps

- Provide technical and financial support for mini-campaigns on the use of ANC and FP services in the ZS, involving all community members.
- Support meetings (data analysis, maternal death analysis) at the DPS and ZS levels.
- Equip health facilities in Kasaï-Central, Kasaï-Oriental, and Haut-Katanga with RH/FP data collection and reporting tools.

- Provide data management tools to health facilities to improve data collection and management for community-based distributors (CBDs, RECO specially trained in FP);
- Organize coaching for service providers already trained in pediatric emergency care.
- Provide technical and financial support to the mini campaigns that emphasize the importance of delivery in a health facility.
- Ensure the regular supply of essential generic medicines at health facilities in the ZS.
- Organize post-training follow-up in BEmONC in the ZS which have already received training.
- Organize clinical mentoring for care providers in the ZS with high newborn mortality.
- Support the monitoring of early newborn care providers, which helps to improve these indicators.
- Provide financial support for ECZS for supervision of the health facilities.
- Extend EmONC training to all ZS covered by the Program and ensure post-training follow-up of trained providers.
- Equip health facilities with medical equipment and materials for BEmONC interventions and supply the ZS with partographs.
- Continue provider training in the ZS of Luputa, Kanda Kanda, and Kamiji (Lomami).
- Support the functioning of maternal and perinatal death review committees trained in EmONC in the various ZS.
- Supply facilities with 13 life-saving drugs.
- Establish MDSR committees in other ZS in all provinces and improve the review quality in the ZS through more in-depth analysis.
- Assess the implementation of the Provincial Recovery Plan for Maternal Death in Tanganyika.
- Secure blood transfusions for women who need blood during delivery or postpartum and/or for the children under 5 (see IR 2.1).

IMMUNIZATION

Quarter 3 data for USAID IHP's two immunization indicators (number of children less than 12 months of age who received three doses of pentavalent vaccine (Indicator #9) and measles vaccine (Indicator #10) from USG-supported programs) show that the Program achieved a good level of vaccination coverage for almost all targeted children in all nine provinces. The strong performance for these two indicators (see Table 12) this quarter was due to USAID IHP's technical and financial support for the improved supply of and demand for immunization services. This included in particular support of CAC and community leaders, in the search for unvaccinated children, in the six non-Mashako provinces (Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Lualaba, Sud-Kivu). In the three provinces that have already integrated the Mashako Plan (Haut-Katanga, Haut-Lomami and Tanganyika), USAID IHP provided technical support for activities and financed the maintenance of cold chain equipment in these three provinces, as they are primarily supported by partners UNICEF, PATH and Village Reach.

Implementation of service delivery and quality activities for immunization

In Quarter 3, USAID IHP supported trainings for 284 people 37 of whom were women), including 114 members of the ECZS, 156 providers, and 14 RECO in 15 ZS in Kasaï-Central, Kasaï-Oriental, Lualaba, and Sud-Kivu. The trainings included practical, hands-on immunization sessions. USAID IHP also supported the identification of unvaccinated children and children lost to follow-up. During Quarter 2, four ZS in Sankuru and Sud-Kivu were identified as having a high number of unvaccinated children. This quarter, USAID IHP supported the organization of recovery activities in these four ZS, which resulted in the vaccination of 438 children with pentavalent 3 and 572 children with the measles vaccines; in addition, 436 pregnant women received tetanus vaccines.

USAID IHP helped transport vaccines and other immunization inputs (auto-disposable syringes, dilution syringes, receptacles) from *Programme Elargi de Vaccination* (PEV, Expanded Program on Vaccination) sites to 27 hard-to-reach ZS and *aires de santé* in Sud-Kivu, Kasaï-Oriental, Kasaï-Central, and Lomami.

- Supplied 11,830 liters of oil for the functioning of refrigerators in Lomami, Sankuru, Kasaï-Oriental, Kasaï-Central, Lualaba, and Sud-Kivu ;
- Supplied 3,348 liters of diesel fuel for cold room generators in Tanganyika, Kasaï-Oriental, Kasaï-Central, and Lualaba;
- Supported the preventive maintenance for the three cold rooms and the repair of the power generator for the cold room of the Mbuji-Mayi branch office.

Despite the COVID-19 pandemic, USAID IHP supported the organization of supervision activities for vaccination in 27 ZS, including nine in Sud-Kivu, 15 ZS in Kasaï-Oriental, and three ZS in Sankuru. These formative supervision activities targeted the new *MCZS*, the registered nurses, and their assistants. Supervision sessions focused on the organization of practical, hands-on immunization sessions, the completion of several PEV technical data sheets, and the quality audit of immunization data using the data quality self-assessment (DQS) tool. In the Mashako Plan provinces (Tangayika, Haut-Katanga, and Haut-Lomami), these supervision activities were supported by UNICEF, PATH, and Village Reach. Supervision scores as of June 2020 were 100 percent, 94 percent, and 93 percent respectively for Tanganyika, Haut-Lomami (only the Kayamba ZS was not supervised), and Haut-Katanga (the Vangu and Kamalondo ZS was not supervised).

Table 12. Number of children less than 12 months of age who received three doses of pentavalent vaccine (Indicator #9) and Number of children less than 12 months who received measles vaccine from USG-supported programs (Indicator #10)

Region	Province	Children less than 12 months who received three doses of pentavalent vaccine			Children less than 12 months who received measles vaccine from USG-supported programs		
		Q3 Achievement	Target	Achievement rate (%)	Q3 Achievement	Target	Achievement rate (%)
Kasaï	Kasaï-Central	44872	39198	**114.5**	44143	40271	**109.6**
	Kasaï-Oriental	45899	39531	**116.1**	47067	39609	**118.8**
	Lomami	35119	32083	**109.5**	35801	30818	**116.2**
	Sankuru	19989	16496	**121.2**	20242	16122	**125.6**
Total Kasaï		**145879**	**127308**	**114.6**	**147253**	**126820**	**116.1**
Katanga	Haut-Katanga	53296	41038	**129.9**	54440	38666	**140.8**

	Haut-Lomami	34429	31353	**109.8**	33896	31408	**107.9**
	Lualaba	22819	18977	**120.2**	23280	17568	**132.5**
Total Katanga		**110544**	**91368**	**121.0**	**111616**	**87642**	**127.4**
Eastern Congo	Tanganyika	22527	23747	**94.9**	22983	21942	**104.7**
	Sud-Kivu	62555	64450	**97.1**	59567	59564	**100.0**
Total Eastern Congo		**85082**	**88197**	**96.5**	**82550**	**81506**	**101.3**
Total General		**341,505**	**306,873**	**111.3**	**341,419**	**295,968**	**115.4**

Data quality and other support activities for vaccination

USAID IHP helped finance immunization activities in Lomami and Sankuru. The Program supported a series of meetings in Lomami with the DPS, the Provincial Government, and the Provincial Assembly. During the meeting on June 19, 2020, the Governor of the Province declared a tax exemption for boat crossings on the Lomami River for vaccines and re-emphasized the importance of the immunization budget line. In Sankuru, the meeting with the legal representative of H.E. the Governor of Sankuru, under the chairmanship of the Administrator of Lodja Territory, served as an opportunity to disseminate the content of the Kinshasa Declaration,[2] and to share immunization results for the province. A follow-up meeting with the Governor is planned next quarter.

USAID IHP also conducted immunization data quality audits in Kasaï-Central and Sankuru. The audit reports reveal that most health facilities have a reporting system for the recovery of children lost to follow-up and that health facilities plot and display monitoring curves for doses of VAR and Diphtheria-tetanus-pertussis immunization (DTP3) administered. Regular monthly monitoring meetings including PEV activities are held with the RECO. However, USAID IHP identified the following challenges: 1) discrepancies in data between different data collection tools; 2) absence of sufficient planning at the *aires de santé* level; 3) limited understanding of routes to access hard-to-reach communities; 3) failure to meet standards for surveillance of adverse events following immunization; and 4) low availability of vaccines in *aires de santé*.

To address these problems, USAID IHP put in place corrective actions and recommendations, such as: 1) ensuring RECO carry out their role for the recovery of children; 2) ensuring correct, up-to-date completion of individual vaccine stock management forms; and 3) ensuring that visual presentations for follow-up of vaccination coverage are correctly drawn and posted on the facilities' walls.

Despite the overall good performance for the two immunization indicators, some ZS had low vaccine coverage during Quarter 3. For a subset of ZS in Kasaï-Central, Lualaba, and Sud-Kivu (Yangala, Sandoa, Kamituga, Kitutu, Mulungu, and Kalole), this was due to stockouts caused by breakdown in local transport (specifically the boat that links these access points). In Sankuru (Lusambo, Pania Mutombo, and Tshudi ZS), the poor performance was due to road impassability, making delivery impossible. In Sud-Kivu, low coverage was due to insecurity in ZS Minembwe, Haut-Plateau and Itombwe ZS. Poor performance in Tanganyika was due to vaccine stockouts in April-May 2020 at the Kabalo PEV office.

[2] The Kinshasa Declaration for vaccination and polio eradication (July 2019) is a commitment by the DRC's President, Central Government, and provincial governments to finance vaccination activities and improve immunization coverage and polio eradication by 2024.

Lessons learned

- For supervision activities carried out as part of PEV, the recovery plan put in place after the use of the DQS tool helped improve the quality of immunization services and the consistency of data reported across the different data sources.
- The RECO and community leader-led follow-up of children who have not yet received vital vaccinations is an important link that reinforces community-level demand for immunization services.

Next Steps

- Conduct recovery activities with unvaccinated children in the ZS with high drop-out rates.
- Continue supporting the vaccine supply chain from PEV sites to BCZS and remote *aires de santé*.
- Support the maintenance of cold chain equipment.
- Ensure post-training monitoring for trained providers.
- Monitor the establishment of the *Réseau des Parlementaires Congolais en Appui à la Vaccination* (Network of Congolese Parliamentarians in Support of Immunization) in Lomami.

CHILD HEALTH

Children under 5 years of age treated for acute respiratory infections (and diarrhea)

USAID IHP supports the MOH to implement the integrated management of newborn and childhood illness (IMNCI) strategy to treat children suffering from diseases such as acute respiratory infections (ARIs, or pneumonia), diarrhea, and malaria at the community and health facility levels. During Quarter 3, as shown in Table 13, the Program achieved a completion rate of 106.7 percent for Indicator #5 (323,543 ARI cases out of an expected 303,193) and a completion rate of 92.1 percent for Indicator #7 (254,553 cases of diarrhea). The following supported these results:

- Training of 238 health facility providers and 25 managers of the ZS and 10 DPS managers in clinical IMNCI in Sankuru, Sud-Kivu and Lualaba;
- Printing of clinical IMNCI flowcharts and booklets for providers in Sankuru, Sud-Kivu, and Lualaba;
- Training of 32 service providers from HGRs and Referral Health Centers and four managers from the Luiza and Dibaya ZS in *Triage évaluation et traitement d'urgence* (Emergency triage assessment and treatment) in the DPS of Kasaï-Central;
- *Equipe cadre de DPS* (ECDPS, Executive Team of the Provincial Health District) and ZS supervision and monitoring for ZS and health facilities in Haut-Katanga and Kasaï-Central;
- Briefing of RECO, community leaders, journalists, and political and administrative authorities, and dissemination of messages on how to identify danger signs and referral criteria for seeking child care, with households and the community members in Tanganyika, Kasaï-Oriental and Haut-Lomami;
- Financial support for 1,239 household visits by RECO, which reached 7,018 people and 74 children under 5 with danger signs were identified and referred to health facilities;
- The DPS of Lualaba, Haut-Katanga, Tanganyika, and Kasaï-Central also benefited from the Program's support for the transport of essential generic medicine by RECO to the hard-to-reach *aires de santé*.

For Indicator #5, all regions exceeded the target. At the provincial level, Tanganyika recorded the highest achievement rate of 157.5 percent (due to a steady supply of medicines), and Sankuru had the lowest achievement rate with 72.3 percent due to low availability of oral rehydration salt + zinc sulfate (ORS+zinc). With IRC's support, the Tanganyika DPS was able to facilitate care for malnourished children with ARIs. Other partners such as PRODS and UNICEF contributed the supply of EGM in Kasaï-Oriental, Lomami, and Kasaï-Central. Fever and cough cases were also referred to health facilities in the context of COVID-19, according to MOH guidelines.

For Indicator #7, the Katanga region exceeded the target with an achievement rate of 119.8 percent. Across the provinces, compared to antibiotics, ORS+zinc was less available during the quarter as a result of COVID-19-impacted supply chains. The Kasaï region in general had the lowest level of performance, at 79.6 percent of the target. At the provincial level, the lowest achievement rate was in Sankuru, at 38.3 percent. This was due to a significant shortage of medicines (specifically dispersible amoxicillin and ORS+zinc), without which children cannot receive treatment.

Table 13. Number of children under 5 that received treatment for an acute respiratory infection from an appropriate provider (Indicator #5) and Number of cases of child diarrhea treated in USG-supported programs (Indicator #7)

Region	Province	Number of children under 5 that received treatment for an acute respiratory infection from an appropriate provider			Number of cases of child diarrhea treated in USG-supported programs		
		Q3 (#)	Target (#)	Achievement rate (%)	Q3 (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	66,123	59,738	110.7	45,435	46,946	96.8
	Kasaï-Oriental	38,632	33,145	116.6	24,886	30,040	82.8
	Lomami	36,294	37,374	97.1	22,525	29,146	77.3
	Sankuru	15,069	20,840	72.3	7,800	20,352	38.3
Total Kasaï		**156,118**	**151,097**	**103.3**	**100,646**	**126,484**	**79.6**
Katanga	Haut-Katanga	24,719	21,018	117.6	24,216	22,552	107.4
	Haut-Lomami	23,037	21,581	106.7	30,917	25,486	121.3
	Lualaba	26,179	18,383	142.4	21,043	15,563	135.2
Total Katanga		**73,935**	**60,982**	**121.2**	**76,176**	**63,601**	**119.8**
Eastern Congo	Tanganyika	21,910	13,913	157.5	11,739	13,413	87.5
	Sud-Kivu	71,580	77,201	92.7	65,992	72,677	90.8
Total Eastern Congo		**93,490**	**91,114**	**102.6**	**77,731**	**86,090**	**90.3**
Total		**323,543**	**303,193**	**106.7**	**254,553**	**276,175**	**92.2**

Source: DHIS2, accessed July 23, 2020

Integrated community case management

- During Quarter 3, more than 1.5 million cases of major childhood killer diseases (ARI, diarrhea, malaria) were treated at health facilities and iCCM sites in the nine USAID IHP-supported provinces. This total includes 77,576 cases treated at iCCM sites, representing 5 percent of the total number of cases treated (see Table 14). This was a 20 percent decrease compared to the previous quarter when 96,346 cases for these illnesses were treated at iCCM sites. Earlier in the quarter, cases of fever and cough were referred to health facilities prior to the extension of the COVID-19 community management guidelines, shared with all provinces. As a result of the increased precautions due to COVID-19, fewer cases were treated at iCCM sites. The decrease in the number of children treated at iCCM sites this quarter is also due to the low availability of amoxicillin

DT 250 mg and ORS+zinc in the majority of the sites, due to availability issues at the *centrale de distribution régionale* (CDR, regional distribution center) level (IR 1.7).

Despite these challenges, USAID IHP helped the provinces improve care at iCCM sites through:

- Retraining of 389 on community and community-based care; supervision of 234 registered nurses and 56 managers in the ZS; and supervision of 285 iCCM in Sud-Kivu, Tanganyika, Kasaï-Central, Haut-Lomami and Lualaba;
- Providing 151 iCCM sites with equipment (garbage cans, soap, buckets, receptacles, water cans, decanters and cups, flashlights, plastic chairs), management tools, and patient assessment and iCCM management guidelines during the COVID-19 pandemic;
- Ensuring the supply of medicines (Amoxicillin and ORS+zinc) in Sud-Kivu and Tanganyika;
- Coordinating with partners such as PRODES in Lomami and UNICEF in in Kasaï-Central in the supply of medicines (Amoxicillin DT 250 mg and ORS+zinc).

The Program's data generally shows that the proportion of cases treated at the iCCM sites is directly related to the province's number of functional care sites. Tanganyika, with the most sites, recorded the highest proportion. However, Haut-Lomami has the least functional sites but a higher proportion of cases than Lualaba and Haut-Katanga. Nearly one million episodes of malaria were treated this quarter, representing more than 60 percent of all cases treated in health facilities and iCCM sites during the same period. Kasaï-Central, Kasaï-Oriental and Sud-Kivu recorded the highest number of malaria cases due to lack of preventive measures. This is consistent with their identification by the PNLP as HBHI (High Burden High Impact) provinces. Pneumonia in children under 5 is the second leading cause of demand for care in health facilities and iCCM sites. Due to the low availability of dispersible Amoxicillin

International Malaria Day event in Kasaï-Central. Credit: Aime Tshibanda, Pathfinder for USAID IHP.

DT 250 mg at iCCM sites, and COVID-19 travel disruptions, most cases were referred to health facilities where medicines were more generally available, even though health facilities are generally more difficult to reach. The same is true for diarrhea, due to the low availability of ORS+zinc at iCCM sites.

Lessons Learned

- Community care referrals during COVID-19 made it possible to maintain and continue activities at the iCCM sites.

Next Steps

- Organize supervision and monitoring activities of the ZS by the ECDPS.
- Organize support missions in the supply chain.
- Collaborate closely with GHSC-TA to ensure that Amoxicillin and ORS+zinc are available at CDRs so that the Program can ensure a continued supply of these medicines at the ZS level.
- Improve data coding in DHIS2.
- Ensure the supply of iCCM sites with medicines (ORS+zinc, Amoxicillin DT 250 mg).
- Continue to support the supervision of iCCM sites.

Table 14. Management of pneumonia, diarrhea, and malaria at iCCM sites

Region	Province	# of working SSCs	# pneumonia cases treated iCCM	# of pneumonia cases treated in health facility	# of diarrhea cases treated at iCCM site	# of diarrhea cases treated in health facility	# of malaria cases treated at iCCM site	# of malaria cases treated in health facility	Total cases treated at iCCM site	Total cases treated health in facility	Total cases treated at HF and iCCM	Proportion cases treated at iCCM
Kasaï	Kasaï-Central	252	1,884	66,123	2,167	45,435	10,965	158,627	15,016	270,185	285,201	5.3%
	Kasaï-Oriental	250	2,317	38,632	2,728	24,886	10,273	134,627	15,318	198,145	213,463	7.2%
	Lomami	213	1,659	36,294	976	22,525	7,251	100,107	9,886	158,926	168,812	5.9%
	Sankuru	163	441	15,069	191	7,800	4,314	59,272	4,946	82,141	87,087	5.7%
Total Kasaï		878	**6,301**	**156,118**	**6,062**	**100,646**	**32,803**	**452,633**	**45,166**	**709,397**	**754,563**	6.0%
Katanga	Haut-Katanga	147	264	24,719	299	24,216	1,960	81,178	2,523	130,113	132,636	1.9%
	Haut-Lomami	89	506	23,037	1,309	30,917	5,269	108,724	7,084	162,678	169,762	4.2%
	Lualaba	135	380	26,179	453	21,043	1,491	65,980	2,324	113,202	115,526	2.0%
Total Katanga		371	**1,150**	**73,935**	**2,061**	**76,176**	**8,720**	**255,882**	**11,931**	**405,993**	**417,924**	2.9%
Eastern Congo	Tanganyika	867	753	21,910	740	11,739	6,847	58,374	8,340	92,023	100,363	8.3%
	Sud-Kivu	157	2,383	71,580	2,161	65,992	7,595	144,377	12,139	281,949	294,088	4.1%
Total Eastern Congo		1024	**3,136**	**93,490**	**2,901**	**77,731**	**14,442**	**202,751**	**20,479**	**373,972**	**394,451**	5.2%
Total General		**2,273**	**10,587**	**323,543**	**11,024**	**254,553**	**55,965**	**911,266**	**77,576**	**1,489,362**	**1,566,938**	**5.0%**

Source: DHIS2, accessed July 23, 2020

- **417,238 pregnant women** attended prenatal consultations
- **645** healthcare providers and RECO received nutrition-related professional training
- **90** community-based infant and young child feeding support groups enabled

NUTRITION

The DRC is one of 21 USAID priority countries for nutrition. The MOH *Programme National de Nutrition* (PRONANUT, National Nutrition Program) has a 2016–2020 Multisectoral Strategic Plan that aims to reduce the prevalence of chronic malnutrition in children under 5 by 10 percent; anemia in women of childbearing age from 38.45 percent to 24 percent; anemia in children from 59.8 percent to 40 percent; and Vitamin A deficiency from 61 percent to less than 20 percent. The plan also seeks to increase exclusive breastfeeding coverage from 48 percent to 80 percent.

USAID IHP supports the MOH to meet these objectives by implementing prevention and promotion interventions centered on *consultations pré-scolaires rédynamisé* (CPSr, revitalized preschool consultations) and infant and young child feeding (IYCF) interventions. Specifically, USAID IHP (1) trains the DPS; ECZS; and frontline health workers, including providers and RECO; (2) establishes IYCF support groups for the promotion of exclusive breastfeeding; and (3) introduces appropriate complementary feeding starting at the age of six months. The Program also delivers technical assistance in the form of essential supplementation: nutrition for pregnant and lactating women, iron-folic acid supplementation, and bi-annual Vitamin A supplementation for children aged six months to five years and for postpartum women.

USAID IHP implements these interventions in all nine provinces and collaborates with USAID's Food for Peace program in support of the 11 ZS where both programs operate: three in Kasaï-Oriental, six in Sud-Kivu, and two in Tanganyika.

Reached providers and RECO with nutrition-related trainings

USAID IHP contributed to improving nutrition services at health facilities and in communities by training providers and RECO in essential family nutrition practices for children and for pregnant and breastfeeding women. The Program supported the training for providers and RECO (including iCCM site RECO) in CPSr and ANJE, exceeding the USAID IHP target for the quarter. The Program also supported the integration of IMNCI into these trainings.

In total, 1,597 health professionals (including 254 women) received training in nutrition during the quarter, covering four technical areas:

1. ***CPSr.*** Specific topics included supervising providers to conduct consultations with anthropometric measurements, growth monitoring, Vitamin A supplementation, and the promotion of essential

family nutrition practices. Providers and ECZS members from seven provinces received this training: Kasaï-Oriental, Sud-Kivu, Haut-Katanga, Tanganyika, Kasaï-Central, Sankuru, and Lualaba. In addition, USAID IHP collaborated with UNICEF to deliver a training in Sankuru on community-based nutrition.

2. ***IYCF.*** This training addressed promotion of optimal, early breastfeeding; complementary feeding; feeding of sick children and pregnant and lactating women; and communication for nutrition behavior change, particularly in the context of COVID-19. RECO in five provinces—Kasaï-Central, Sankuru, Lualaba, Lomami, and Haut-Lomami—received this training. Kasaï-Oriental and Sud-Kivu conducted IYCF training in previous quarters, and USAID IHP anticipates supporting Haut-Katanga and Tanganyika with IYCF training in the next quarter. The latter two provinces were unable to achieve training this quarter due to non-availability of provincial-level trainers, COVID-19 travel restrictions barring central-level trainer deployment, and prioritization of other activities.
3. ***IMNCI at the clinical level.*** Training topics covered building the capacities of providers on IMNCI, including malnutrition. Specific nutrition-related elements included assessment (anthropometric measurements, detection of edema, growth monitoring); classification; and management of malnutrition. USAID IHP supported the training of health center providers and provincial and ZS managers from Sankuru, Sud-Kivu, and Lualaba.
4. ***IMNCI at the community level.*** This covered building the capacities of RECO and their supervisors including iCCM site RECO, *aire de santé* charge nurses, and ZS managers. Training topics included community care, including detection and referral of malnutrition and anemia cases. USAID IHP strengthened the capacity of provincial facilitators in the use of updated community site tools from the national committee for IMNCI. The Program adapted to the COVID-19 travel restrictions, conducting this aspect of the training online and by phone. These skills-building activities took place with participants from Lualaba, Haut-Katanga, Tanganyika, and Sankuru.

Overall, the Program achieved 172.3 percent against the target number of nutrition-related training participants during the quarter, largely due to successfully re-engaging health professionals trained on other topics to participate in these trainings. Among USAID IHP-supported regions, four provinces exceeded their training targets for the quarter: Sankuru, Lualaba, Haut-Katanga, and Tanganyika (Table 15). The Eastern Congo region trained the fewest providers and RECO (178). This was because both Tanganyika and Sud-Kivu were unable to carry out many of their planned IMNCI trainings. In Sud-Kivu, only the training of trainers, which will equip new provincial trainers to facilitate future trainings, took place this quarter; provider training was rescheduled to Quarter 4. In Tanganyika, there are no provincial trainers for this technical topic and facilitators from the central level were unable to travel to the province due to COVID-19 restrictions. There is was similarly a challenge, though to a lesser extent, for Kasaï-Central, Kasaï-Oriental, Lomami, and Haut-Lomami.

Lualaba recorded the stronger performance (at 126 percent of its target). Scheduled trainings in the various topics occurred and provincial stakeholders were able to identify and engage providers and RECO who had not yet participated. The Lualaba DPS and ZS managers also benefited from the trainings.

Table 15. Number of individuals receiving nutrition-related professional training through USG-supported nutrition programs (Indicator 2.1.10)

Region	Province	CPSr	IYCF	IMNCI - Clinical	IMNCI - Community	Target (#)	Q3 Achievement (#)	Achievement rate (%)
Kasaï	Kasaï-Central	79	64	0	0	154	143	92.9
	Kasaï-Oriental	56	0	0	60	121	116	95.9
	Lomami	0	58	0	0	70	58	82.9
	Sankuru	16	50	80	349	93	495	532.3
Total Kasaï		**151**	**172**	**80**	**409**	**438**	**812**	**185.4**

Region	Province	CPSr	IYCF	IMNCI - Clinical	IMNCI - Community	Target (#)	Q3 Achievement (#)	Achievement rate (%)
Katanga	Haut-Katanga	55	0	0	106	105	161	153.3
	Haut-Lomami	0	67	0	0	79	67	84.8
	Lualaba	41	85	182	71	100	379	379.0
Total Katanga		**96**	**152**	**182**	**177**	**284**	**607**	**213.7**
Eastern Congo	Tanganyika	15	0	0	68	73	83	113.7
	Sud-Kivu	56	0	10	29	132	95	72.0
Total Eastern Congo		**71**	**0**	**10**	**97**	**205**	**178**	**86.8**
Total General		**318**	**324**	**272**	**683**	**927**	**1597**	**172.3**

Source: Project Monitoring Report

Established and monitored IYCF support group activities

USAID IHP supported provincial stakeholders to leverage RECO training in IYCF to revitalize and establish 90 IYCF support groups in 18 *aires de santé* in four provinces—Kasaï-Central, Sankuru, Lomami, and Kasaï-Oriental. The IYCF support groups include three to 15 people (mothers, fathers, and caregivers) who promote recommended exclusive breastfeeding and complementary feeding behaviors. Each group also includes experienced mothers who demonstrate best practices for breastfeeding, share information and experiences, and offer support to other women.

The Program supported IYCF support groups through observation, feedback, and correction of deficiencies noted during support group activities, carried out in compliance with barrier measures in the context of COVID-19. During trainings, the Program supported the MOH to increase participant awareness about the benefits of exclusive breastfeeding, complementary feeding, barrier measures against COVID-19, and the need for notification of suspected cases of malnutrition. Trainings included demonstrations of breastfeeding practices and cooking demonstrations.

Promotion of infant and young child feeding in Sankuru. Credit: Lambert Losambe, Abt Associates for USAID IHP.

Results for this activity during FY2020 Quarter 3 include:

- Kasaï-Central: 603 people (98 men and 505 women) educated on complementary foods (culinary recipes based on local foods) and various essential family nutrition practices.
- Sankuru: Awareness of 250 people raised, including through 10 cooking demonstration sessions and 20 demonstration sessions of breastfeeding practices.
- Lomami: Follow-up support to nine IYCF support groups.
- Kasaï-Oriental: Follow-up support to 47 IYCF support groups.

Reached pregnant women with nutrition interventions

The USAID IHP-supported nutrition package for pregnant and breastfeeding women includes the provision and supplementation of pregnant and lactating women with iron-folic acid administered during ANC and post-natal consultation, home visits by RECO to emphasize breastfeeding and monitor food and hygiene, sensitization of pregnant women on the importance of ANC, and recognition of danger signs by RECO. During Quarter 3, a total of 417,238 pregnant women (109.8 percent of the USAID IHP target) attended ANC consultations. They benefited from various interventions, including iron-folic acid supplementation, nutritional and hygiene advice, and deworming. Eight provinces exceeded their targets. The exception was Sud-Kivu, with an achievement rate of 98 percent.

Factors contributing to these strong results included (1) the availability of iron-folic acid; (2) the organization of VIVA (formerly Healthy Families Campaign) multimedia campaigns and the recruitment of pregnant women to start ANC during a mini-campaign on the prevention of malaria in Lualaba, Sud-Kivu, and Haut-Katanga; (3) support to champion communities in Lualaba that raised the awareness of 3,281 people through visits to 1,181 households, during which 112 women were referred to health centers; (4) outreach about key practices to encourage women clients at health centers to start ANC visits in Lualaba, Kasaï-Central, Tanganyika, Sud-Kivu, and Kasaï-Oriental; (5) sensitization and guidance of pregnant women by RECO in Kasaï-Central, Sankuru, Lualaba, Lomami, and Haut-Lomami (including activities originally programmed for Quarter 2); (6) support for the organization of mini multimedia campaigns on the prevention of malaria, which reached 1,496 households in Lualaba and raised the awareness of 4,259 people; (7) awareness-raising among 2,640 women, with referral of 381 pregnant women—including 212 for ANC, 169 for danger signs, and 142 for fever and iron-folic acid supplementation.

Table 16. Number of pregnant women reached with nutrition interventions through USG-supported programs (Indicator #2.1.13)

Region	Province	Q3 Achievement	Target	Achievement rate (%)
Kasaï	Kasaï-Central	54,484	50,499	107.9
	Kasaï-Oriental	52,774	48,747	108.3
	Lomami	42,151	39,286	107.3
	Sankuru	24,334	21,638	112.5
Total Kasaï		**173,743**	**160,170**	**108.5**
Katanga	Haut-Katanga	61,464	52,464	117.2
	Haut-Lomami	41,325	35,891	115.1
	Lualaba	33,786	26,275	128.6
Total Katanga		**136,575**	**114,630**	**119.1**
Eastern Congo	Tanganyika	28,970	25,759	112.5
	Sud-Kivu	77,950	79,318	98.3
Total Eastern Congo		**106,920**	**105,077**	**101.8**
Total General		**417,238**	**379,877**	**109.8**

Source: DHIS2, Accessed July 23, 2020

Lessons Learned

- COVID-19 preventative measures employed during trainings and adopted by providers during CPSr activities (e.g,, reception of children in groups of no more than five, hand-washing devices placed at the entrance of health facilities, wearing of washable fabric masks, etc.) and in IYCF support groups amplified direct USAID IHP assistance by improving hygiene in health centers and communities.
- Training of providers and RECO in nutrition strengthened their capacities to organize CPSr in health facilities, promote key family practices (especially exclusive breastfeeding), and promote essential family nutrition practices in IYCF support groups. This engagement in training also prompted the revitalization and establishment of IYCF support groups.
- Engaging mid-level managers to accompany ECZS monitoring of IYCF support groups increased registered nurses' and ECZS members' awareness of their roles in IYCF monitoring activities—a key to ensuring that IYCF support groups function effectively.
- Community-oriented nutrition activities (e.g., mini campaigns, home visits, sensitization by RECO and community champions) that enhance the availability of nutrition resources have seemingly improved the use of ANC services and the demand for CPSr services in the ZS by increasing awareness and better organizing supply.

Next Steps

- Train RECO and journalists on the use of multimedia tools for the promotion of exclusive breastfeeding in the Kitutu and Mubumbano ZS in Sud-Kivu.
- Train/retrain providers and ECZS in CPSr in Sankuru, Lualaba, Kasaï-Oriental, Haut-Lomami, and Sud-Kivu.
- Organize IYCF training for RECO.
- Organize training in IMNCI for service providers and RECO.
- Organize the supervision of the ZS on nutrition themes by PRONANUT and provincial leadership.
- Organize supervision of health facilities and communities by ECZS.
- Conduct advocacy and coordinate with partners such as GHSC-TA to supply nutrition resources to all 34 target ZS.
- Support RECO to follow up on IYCF support groups.
- Support ANC mini-campaigns in the nine provinces.
- Train RECO in Sud-Kivu on IYCF.
- Organize follow up of IYCF support groups in Haut-Katanga, Haut-Lomami, Lualaba, Sud-Kivu, and Tanganyika.

- **280 family planning service providers** supported to reduce maternal mortality
- **360 community-based distributors** trained to generate the demand, supply, and use of family planning services at the community level
- **59 providers and 47 peer educators** trained in reproductive health and family planning

REPRODUCTIVE HEALTH AND FAMILY PLANNING

USAID IHP supports the implementation of the DRC's National Multisectorial Strategic Plan for Family Planning 2014-2020, which aims to increase contraceptive prevalence from 8.1 to 19 percent by 2020. As one of the 69 focus countries of the Global Family Planning 2020 Partnership (FP2020), this translates to enrolling 2.1 million new contraceptive users by 2020 to reduce maternal deaths. In FY2020 Quarter 3, USAID implemented the following activities: 1) training of clinical providers in post-partum FP and *Dihydroxy Methyl Progestatif A - Subcutaneous* (DMPA-SC, subcutaneous Medroxyprogesterone acetate); 2) training of CBDs and young peer educators and providers in RH/FP; 3) post-training follow-up for CBDs and trained providers; and 4) financial and technical support for *Comité Technique Multisectoriel Permanent de Planification Familiale* (CTMP-PF, Permanent Multisectoral Technical Committee for Family Planning) meetings at the national and provincial levels (see IR 2.7 for more details).

Increased couple years of protection provided by family planning methods

In Quarter 3, couple years of protection (CYP) in USG-supported programs (Table 17, Indicator #2.1) exceeded the USAID IHP target, with an achievement rate of 125.5 percent. This means that in the three regions combines, 332,974 couples out of 265,335 used contraceptive protection. There were significant variations among provinces, however (as shown in Table 17), with three provinces falling short of their targets.

The Eastern Congo region saw the best performance, with a CYP achievement rate of 140.4 percent (107,071 couples out of 76,256 targeted were protected). This achievement was due to the availability of FP inputs (modern contraceptive methods, clinical and non-clinical, including injectables, oral contraceptives, implants and barrier methods) in all the ZS; the training of CBDs and providers; and the organization of FP mini-campaigns. Several distribution sites for FP methods were set up, accompanied by training for CBDs and health care providers in the ZS.

In the Katanga region, the CYP achievement rate was 130.2 percent (113,689 couples out of 87,291 targeted were protected). This performance is explained partly by the organization of a mini-FP campaign in ZS in Haut-Lomami and Lualaba. However, Haut-Katanga experienced a decrease in performance, from 139 percent in Quarter 2 to 98.5 percent in Quarter 3, compared to the target. This was due to the low availability of FP inputs and the lack of trained providers in the ZS.

The Kasaï region had the lowest CYP achievement rate of the three regions, although it was still above target at 110.2 percent (112,214 couples out of 101,788 targeted being protected). This achievement

was a result of the joint support by the E2A project and USAID IHP for the on-site training/retraining of CBDs and health workers in FP in target ZS in Kasaï-Central, Kasaï-Oriental, and Lomami, coupled with the organization of FP mini-campaigns.

Table 17. Couple years of protection (CYP) in USG-supported programs (Indicator #2.1)

Region	Province	Target (#)	Q3 (#)	Achievement rate (%)
Kasaï	Kasaï-Central	46,012	34,172	74.3
	Kasaï-Oriental	14,546	40,859	280.9
	Lomami	29,136	19,707	67.6
	Sankuru	12,094	17,476	144.5
Total Kasaï		**101,788**	**112,214**	**110.2**
Katanga	Haut-Katanga	46,266	45,560	98.5
	Haut-Lomami	18,111	36,054	199.1
	Lualaba	22,914	32,075	140.0
Total Katanga		**87,291**	**113,689**	**130.2**
Eastern Congo	Tanganyika	9,979	19,535	195.8
	Sud-Kivu	66,277	87,536	132.1
Total Eastern Congo		**76,256**	**107,071**	**140.4**
Total		**265,335**	**332,974**	**125.5**

Source: DHIS2, accessed July 23, 2020

Gained new acceptors of modern contraceptive methods

In Quarter 3, USAID IHP exceeded the target in all provinces and regions for new acceptors of modern contraceptive methods (Indicator #3, Table 18), with an overall achievement rate of 149.9 percent. The Program contributed to the recruitment of 337,458 new acceptors of modern contraceptive methods in all provinces (against a target of 225,056). This performance was achieved as a result of the following USAID IHP-supported activities: 1) Training for community-based distributors (CBD) on conducting FP chats, counseling on FP at the community level, providing FP consultations, and following up with clients on FP methods; 2) ZS provider training in FP and post-partum FP, including the integration of the new approach for DMPA-SC administration by community actors;[3] 3) mini-campaigns conducted by CBDs, which generated demand for the use of ANC and FP services; and 4) follow-up through home visits, which helped to new FP clients adhere to their contraceptive methods.

USAID IHP's technical and financial support for the CTMP-FP activities have helped to promote a rapid and sustained increase in the use of effective modern methods of contraception by Congolese men and women who want to use them; and have allowed for the discussion of strategies for accelerating the increase in modern contraceptive prevalence in the light of the national FP strategic plan. The plan takes into account the realities of implementing FP activities during the COVID-19 pandemic. Four thematic groups (youth; faith-based, medicines, and opinion leaders) have the goal of recruiting more FP users through different awareness-raising activities and channels.

[3] This new approach allows the client to self-inject, which contributed to the increase in the number of FP users.

Table 18. Number of new acceptors using modern contraceptive methods in USG-supported facilities (Indicator #3)

Region	Province	Target (#)	Q3 (#)	Achievement rate (%)
Kasaï	Kasaï-Central	43,906	49,325	112.3
	Kasaï-Oriental	13,656	30,060	220.1
	Lomami	17,411	31,957	183.5
	Sankuru	22,716	24,729	108.9
Total Kasaï		**97,689**	**136,071**	**139.3**
Katanga	Haut-Katanga	28,543	40,350	141.4
	Haut-Lomami	20,405	47,846	234.5
	Lualaba	23,439	39,610	169.0
Total Katanga		**72,387**	**127,806**	**176.6**
Eastern Congo	Tanganyika	4,410	10,227	231.9
	Sud-Kivu	50,570	63,354	125.3
Total Eastern Congo		**54,980**	**73,581**	**133.8**
Total General		**225,056**	**337,458**	**149.9**

Source: DHIS2, accessed July 23, 2020

Reproductive health and family planning activity. Credit: Paul Olongo, IRC for USAID IHP.

Lessons Learned

- FP mini-campaigns are helping to improve performance, in particular helping increase the number of new acceptors for long-lasting FP methods that offer protection for three to five years (e.g., Implanon NXT or the Jadelle Implant).
- Due to low uptake of contraceptive methods in the urban environment (Haut-Katanga) specifically, the Program needs to increase awareness-raising activities targeting the population in that particular context.

Next Steps

- Continue to retrain providers in the administration of clinical FP methods
- Support the integration of FP in collaboration with other technical and financial partners in all the ZS
- Supply health facilities with FP inputs as needed; supply CBDs with equipment
- Organize the FP data quality audit in the ZS
- Organize a targeted SBC campaign in urban areas in Haut-Katanga
- Supply the health facilities with FP inputs based on their needs;
- Provide the ZS with management tools and FP registers;
- Carry out post-training follow-up for providers and CBDs in FP;
- Provide CBDs with the necessary CBD kits (materials and equipment for service delivery).

- **19,057 partients** diagnosed with TB put on first-line treatment
- **9,143 TB-postitive patients** declared cured out of a cohort of 10,454
- **4,019 children under 5** put on INH prophylaxis treatment

TUBERCULOSIS

TB remains a major public health issue in the DRC, which is among the 30 countries most affected by this disease in the world: the DRC ranks ninth worldwide and second in Africa in reported TB patients. To help achieve the GDRC's goal of reducing morbidity and mortality from TB. To advance the goals of the GDRC's National Strategic TB Plan 2018–2020, USAID IHP is supporting the *Programme National de la Lutte Contre la Tuberculose* (PNLT, National Program to Combat Tuberculosis) in improving the quality of TB management services and care in 178 ZS in the nine target provinces.

Guided by the priorities of USAID and the PNLT, the Program encourages community civil society participation and carries out a range of strategies and activities, including (1) universal access to TB diagnosis and treatment; (2) improved management of TB/HIV co-infection; (3) programmatic management of drug resistant TB (DR-TB) and improved clinical and biological monitoring of patients with DR-TB, including providing nutritional support; (4) strengthened provincial ability to collect, analyze, and use TB data for decision-making; (5) improved capacity to diagnose and treat TB in children aged 0–14 years; and (6) improved TB infection control and prevention. In addition, USAID IHP supports the monthly meetings of the multi-drug resistant (MDR-TB) Coordination Unit at the national level and the quarterly TB / HIV Task Force meetings at the provincial level.
Note: This report excludes data from Sankuru province, because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

Improved TB notification rates

During FY2020 Quarter 3, a total of 11,977 new patients and relapses of bacteriologically confirmed pulmonary TB (TP+) were reported, out of a total population of 34,352,013 inhabitants (Indicator #2.1.17, Table 19). This notification rate for TP+ of 139 per 100,000 inhabitants represents an overall achievement rate of 93 percent of the USAID IHP target.

Haut-Lomami, Lualaba, Tanganyika, Kasaï-Oriental, and Haut-Katanga recorded notification rates above the target of 150 per 100,000 inhabitants. This performance could be explained in large part by an increase in the detection of TB cases due to active TB case tracing activities supported by USAID IHP among at-risk populations. This activity focused in particular on mine workers, people living with HIV (PLHIV), and vulnerable populations living in difficult socio-economic conditions.

At the other end of the spectrum, Sud-Kivu reported a notification rate of 81 per 100,000 inhabitants. As in previous quarters, poor performance in Sud-Kivu could be explained by various factors, including a mountainous landscape not conducive to the transmission of TB and armed conflicts that persist in this

province. The *centres de santé de diagnostic et traitement* (CSDT, diagnosis and treatment health centers) are in the zones of armed conflict, and are rarely supplied with diagnostic laboratory reagents. Without these reagents, these centers can no longer perform TB screenings. A disruption in the screening process impacts the ability to offer treatment. Additionally, transporters of drugs often avoid conflict zones, leading to drug stock-outs.

To address these challenges and improve notification rates, USAID IHP will increase its support to the *Coordinations Provinciales Lèpre et Tuberculose* (CPLT, Provincial Committees for Leprosy and Tuberculosis Control) for implementation of innovative strategies to improve TB notification rates. Such strategies include the screening of any cases of coughing received in a care facility and active screening in all low-detection ZS supported by the Program. The Program will continue to collaborate with other stakeholders (*Action Damien*, Cordaid, and PDSS) and involve community agents (RECO and members of the *Club des Amis Damien* [Club for the Friends of Damien]) in the sensitization and secure transportation of sputum samples to the CSDTs.

Table 19. TB notification rate through USG-supported programs (Indicator 2.1.17)

Province		Population covered by the DOT[1] program	Incident cases of TB					TP + notification rate per 100,000 inhabitants.	Target per 100,000	Comp-letion rate (%)
			Women (#)	Men (#)	Total	Ratio F:M	New patients and Relapses of TP +			
Eastern Congo	Sud-Kivu	6,974,979	777	1,309	2,086	0.6	1,414	81	150	54
	Tanganyika	1,981,961	724	759	1,483	1.0	901	182	150	121
Eastern Total		**8,956,940**	**1,501**	**2,068**	**3,569**	**0.7**	**2,315**	**103**	150	69
Katanga	Haut-Katanga	4,740,948	1,442	1,878	3,320	0.8	1,889	159	150	106
	Lualaba	2,023,841	637	823	1,460	0.8	1,116	221	150	147
	Haut-Lomami	2,886,515	1,466	1,281	2,747	1.1	2,115	293	150	195
Katanga Total		**9,651,304**	**3,545**	**3,982**	**7,527**	**0.9**	**5,120**	**212**	150	141
Kasaï	Sankuru	2,402,190	-	-	-	-	-	-	150	-
	Kasaï Oriental	5,144,920	2,317	2,490	4,807	0.9	2,242	174	150	116
	Kasaï Central	4,420,881	682	839	1,521	0.8	1,129	102	150	68
	Lomami	3,775,778	1,119	1,133	2,252	1.0	1,171	124	150	83
Kasaï Region		**15,743,769**	**4,118**	**4,462**	**8,580**	**0.9**	**4,542**	**115**	150	77
Total		**34,352,013**	**9,164**	**10,512**	**19,676**	**0.9**	**11,977**	**139**	**150**	**93**

Source: Official databases of the CPLT
[1]Directly observed therapy
Please note: This report excludes data from Sankuru province because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

Supported first-line treatment for patients diagnosed with TB and helped ensure children under 5 received Isoniazid prophylaxis

Out of a cohort of 19,832 patients registered during Quarter 3 as suffering from the drug-susceptible form of TB, 19,057 patients were put on first-line treatment (Indicator #2.1.18, Table 20). This represents an overall achievement rate of 96 percent of the USAID IHP target. Kasaï-Central, Kasaï-Oriental, and Lomami have started the treatment for 100 percent of the TB patients detected. Tanganyika and Lualaba, having started treatment of only 84 percent and 89 percent of registered cases respectively, underperformed. This was due to prolonged stock-outs of first-line anti-TB drugs, which were exacerbated by irregular air and road traffic due to the COVID-19 pandemic. Out of 716 CSDT (diagnosis and treatment health centers) that reported (in eight provinces), 160 recorded a stock-out of

one or more of the tracer drugs for seven days or more. The Program are working with Cordaid and GHSC-TA to improve the availability of anti-TB drugs in the ZS supported by the Program.

A total of 5,168 children under 5 were declared were declared eligible for Isoniazid (INH) prophylaxis treatment after exclusion of the active form of TB; of those, 4,019 (78 percent) were put on INH treatment (Indicator #2.1.23, Table 20). This low proportion of children under 5 on INH prophylaxis could be explained by stock-outs of the pediatric form of INH (100 milligrams [mg]) regularly observed in the regional distribution centers. The stock-outs are mainly caused by delays in supplying regional distribution centers by the PNLT central unit. Kasaï-Central and Haut-Lomami (both at 100 percent) and Lomami (at 99 percent) recorded strong performances. Their success can be largely attributed to the application of guidelines for the management of pediatric TB in the provinces supported by the TB Challenge project up until March 2018.

Table 20. Number of patients diagnosed with TB that have initiated first-line treatment (Indicator 2.1.18) and Percentage of under five children who received (or are receiving) INH prophylaxis (Indicator 2.1.23) through USG- supported programs (2.1.23)

Province		TB patients that have initiated first-line treatment				Children under 5 who received (or are receiving) INH prophylaxis			
		# Total TB cases registered	# Total registered TB cases under treatment	% of registered TB cases under treatment	Targets	# Child under 5 eligible for INH treatment	# Children under 5 on INH treatment	% Children under 5 on INH treatment	Targets
Eastern Congo	Sud-Kivu	2,111	2,100	99	100	437	388	89	100
	Tanganyika	1,492	1,247	84	100	703	305	43	100
Eastern Region		**3,603**	**3,347**	**93**	**100**	**1,140**	**693**	**61**	**100**
Katanga	Haut-Katanga	**3,428**	3,104	91	100	640	179	28	100
	Lualaba	1,463	1,298	89	100	490	448	91	100
	Haut-Lomami	2,747	2,723	99	100	1,195	1195	100	100
Katanga Region		**7,638**	**7,125**	**93**	**100**	**2,325**	**1,822**	**78**	**100**
Kasaï	Sankuru	-	-	-	100	0	0	-	100
	Kasaï Oriental	4,816	4,811	100	100	465	275	59	100
	Kasaï Central	1,521	1,520	100	100	383	383	100	100
	Lomami	2,254	2,254	100	100	855	846	99	100
Kasaï Region		**8,591**	**8,585**	**100**	**100**	**1,703**	**1,504**	**88**	**100**
	Total	**19,832**	**19,057**	**96**	**100**	**5,168**	**4,019**	**78**	**100**

Source: Official databases of the CPLT
Please note: This report excludes data from Sankuru province, because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

Sharpened detection of multi-drug resistant TB cases

During this quarter, 87 cases of multi drug-resistant/rifampicin-resistant TB (MDR-TB/RR-TB) (66 men and 21 women) were recorded across the Program's nine target provinces (Indicator #2.1.20, Table 21). Compared to a USAID IHP target of 180, this represents an achievement rate of 48 percent. No cases of extensively drug-resistant TB (XDR-TB) were detected. The overall poor performance of 48 percent can be explained in large part by the low coverage of the CPLT with GeneXpert diagnostic sites and frequent stock-outs of GeneXpert test cartridges. An additional factor was disruptions in the transport circuits for sputum samples from suspected DR-TB patients to diagnostic sites, in particular because of the difficulties in reimbursing transportation costs in remote ZS. In the USAID IHP nine target

provinces, the Program is working to develop a financial mechanism to support transportation costs to prevent stock-outs and more efficiently transport sputum samples.

Haut-Katanga and Kasaï-Oriental—recognized as MDR-TB "Hot Spots"—recorded higher numbers of cases (20 and 24 respectively), although they still fell significantly lower than the USAID IHP targets. In terms of meeting targets, the best performances were recorded in Haut-Lomami (150 percent, or six confirmed cases out of four expected cases); Lualaba (92 percent, or 11 cases out of an expected 12 cases); and Tanganyika (83 percent, or 10 cases out of an expected 12 cases). This performance can be explained in large part by the active case finding activities for DR-TB (with support from USAID IHP) among contacts of confirmed cases DR-TB and among people on first-line anti-TB retreatment.

Table 21. Number of multi-drug resistant TB (MDR-TB) cases detected (Indicator 2.1.20).

Province		Confirmed RR / MDR-TB cases		Confirmed XDR-TB cases		Total Confirmed RR /MDR / XDR-TB cases	Targets # MDR TB/RR	Completion rate (%)
		Male	Female	Male	Female			
Eastern Congo	Sud-Kivu	5	1	0	0	6	19	32
	Tanganyika	9	1	0	0	10	12	83
Eastern Congo Total		**14**	**2**	**0**	**0**	**16**	**31**	**52**
Katanga	Haut-Katanga	15	5	0	0	20	61	33
	Lualaba	10	1	0	0	11	12	92
	Haut-Lomami	6	0	0	0	6	4	150
Katanga Total		**31**	**6**	**0**	**0**	**37**	**77**	**48**
Kasaï	Sankuru	0	0	0	0	0	8	0
	Kasaï Oriental	15	9	0	0	24	40	60
	Kasaï Central	1	2	0	0	3	12	25
	Lomami	5	2	0	0	7	12	58
Kasaï Total		**21**	**13**	**0**	**0**	**34**	**72**	**47**
Total		**66**	**21**	**0**	**0**	**87**	**180**	**48**

Source: Official databases of the CPLT
Please note: This report excludes data from Sankuru province, because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

Boosted therapeutic success rates for TB

Out of 10,454 new patients and TP+ relapses evaluated during the quarter, representing the cohort enrolled in treatment during the corresponding quarter a year earlier, 9,143 patients were declared cured and 460 patients had completed their treatment (Indicator 2.1.19, Table 22). This represents therapeutic success rate of 92 percent, which is consistent with DRC's national average (also 92 percent). Given the USAID IHP target of 95 percent, this corresponds to an achievement rate of 97 percent. Of the three regions supported by the Program, only the Kasaï region exceeded the target, with a therapeutic success rate of 97 percent (for an achievement rate of 102 percent). The availability of anti-TB drugs in the provinces in the Kasaï region supported this performance. The provinces in the Katanga region recorded the lowest therapeutic success rates, with an overall regional rate of 86 percent (for an achievement rate of 93 percent).

To reverse this trend, it is important to improve coordination in the supply chain: the national level (the PNLT), the transporter, GHSC-TA and Cordaid and at the provincial level, the CPLT, the regional distribution centers, and USAID IHP. All parties need to collaborate more to ensure the transportation

of drugs and laboratory equipment to hard-to-access ZS and the CSDT. USAID IHP, which is in charge of supplying the CSDT, is working to find a better mechanism to ensure the transportation from the ZS to these CSDT.

Table 22. Therapeutic success rate for TB through USG-supported programs (Indicator 2.1.19)

Province		NP and TP+ relapses			Recovery rate (%)	Therapeutic success rate (%)	Targets (%)	Completion rate (%)
		Began treatment one year earlier (#)	Declared cured (#)	Completed treatment (#)				
Eastern Congo	Sud-Kivu	1,427	1,228	71	86	91	95	96
	Tanganyika	790	658	43	83	89	95	93
Eastern Congo Total		**2,217**	**1,886**	**114**	**85**	**90**	**95**	**95**
Katanga	Haut-Katanga	1,810	1,355	78	75	79	95	83
	Lualaba	953	833	15	87	89	95	94
	Haut-Lomami	1,630	1,593	16	98	99	95	104
Katanga Total		**4,393**	**3781**	**109**	**86**	**89**	**95**	**93**
Kasaï	Sankuru	-	-	-	-	-	95	-
	Kasaï Oriental	1,665	1,442	163	87	96	95	101
	Kasaï Central	1,095	1,034	14	94	96	95	101
	Lomami	1,084	1,000	60	92	98	95	103
Kasaï Total		**3,844**	**3,476**	**237**	**90**	**97**	**95**	**102**
Total		**10,454**	**9,143**	**460**	**87**	**92**	**95**	**97**

Source: Official databases of the CPLT
Please note: This report excludes data from Sankuru province, because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

New-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis

During Quarter 3, out of 6,479 newly enrolled PLHIV in whom TB was excluded (out of 7,031 PLHIV screened for TB), a total of 4,801 (74 percent) were placed on INH (Indicator #2.1.24, Table 23). This achievement rate of 74 percent represents an underperformance compared to the target of 100 percent. The most pronounced underperformances were recorded in Haut-Lomami (42 percent), Haut-Katanga (41 percent), and Tanganyika (38 percent). INH stock-outs at TB/HIV care sites partly explain this poor performance. These INH stock-outs were mainly caused by the disruption of supply from the national level to the provinces. Four provinces recorded high percentages of PLHIV having received INH prophylaxis: including Lomami (100 percent), Kasaï-Central (94 percent), Sud-Kivu (90 percent), and Lualaba (87 percent).

The implementation of collaborative activities between the PNLT and the *Programme National de Lutte contre le SIDA* (PNLS, National AIDS Control Program), as part of the WHO "One Stop Shop" strategy at the provincial and operational levels, largely explains this performance. This was particularly true in provinces receiving HIV support from partners such as FHI360 and HIV Epidemic Control (in Lualaba) and Cordaid (in provinces in the Kasaï region). The PNLT adopted and implemented the One Stop Shop strategy to reduce morbidity and mortality associated with TB-HIV co-infection. The aim is to improve the quality of care for co-infected patients by integrating the activities of HIV and TB programs in the same service within the same health facility. USAID IHP, which supports routine monthly meetings of

the provincial TB/HIV Task Force, supports the PNLT and PNLS to coordinate the implementation of these activities at the facility level.

Table 23. Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG- supported programs (2.1.24)

Province		Persons living with HIV (PLHIV)				Targets (%)	Completion rate (%)
		Screened for TB (#)	TB ruled out (#)	TB ruled out and receiving INH (#)	TB ruled out and receiving INH (%)		
Eastern Congo	Sud-Kivu	326	289	259	90	100	90
	Tanganyika	353	298	112	38	100	38
Eastern Congo Total		**679**	**587**	**371**	**63**	**100**	**63**
Katanga	Haut-Katanga	3,054	2,813	2,123	75	100	75
	Lualaba	1,346	1,272	1,105	87	100	87
	Haut-Lomami	720	706	297	42	100	42
Katanga Total		**5120**	**4,791**	**3,525**	**74**	**100**	**74**
Kasaï	Sankuru	-	-	-	-	100	-
	Kasaï Oriental	932	818	634	78	100	78
	Kasaï Central	202	187	175	94	100	94
	Lomami	98	96	96	100	100	100
Kasaï Total		**1,232**	**1,101**	**905**	**82**	**100**	**82**
Total		**7,031**	**6,479**	**4,801**	**74**	100	74

Source: Official databases of the CPLT

Please note: This report excludes data from Sankuru province, because the Sankuru DPS had difficulty obtaining authority to organize a data validation meeting. The validation meeting has now been planned and the full data set will be shared in the next quarterly report.

Lessons Learned

- The synergy attained by TB control partners working together at all levels of the health system improves program performance. USAID IHP supports the holding of monthly meetings of the MDR-TB Coordination Unit (CCTM) at the national level and the quarterly TB / HIV Task Force meetings at the provincial level.
- Community health workers who received training on the fight against TB sensitize and guide populations towards TB control services to improve access to diagnosis and treatment.
  Community participation in active TB case finding activities at the community level, and specifically among populations at risk such as mine workers and contacts of confirmed TB cases, improves detection of people with TB and reduces the risks of disease transmission.
- Involvement of health providers in the implementation of innovative active TB screening strategies (investigation of contact cases, active search for TB cases in populations at risk) helps reduce the number of missing cases and improves TB case detection.

Next Steps

- Support supervision visits by provincial-level officials to low-performing ZS and CSDT to improve the application of PNLT guidelines on the programmatic management of TB and MDR-TB.
- Improve the supply of anti-TB drugs to CSDT by intensifying collaboration with the CPLT and the ZS to facilitate the transport of drugs from the ZS to the CSDT. USAID IHP will use these visits to supervise and organize activities in different programmatic areas (malaria, MNCH, and family planning) for the transportation of drugs from the ZS to the CSDT.
- Support the transportation of samples of suspected DR-TB cases, with help from RECO, to improve

active case finding. Prioritize the screening of family and regular contacts of confirmed MDR-TB/RR-TB patients. Detect DR-TB cases in the coming quarters. USAID IHP, in collaboration with other stakeholders (e.g., GHSC-TA, Cordaid, Caritas, and *Action Damien*) and with the help of RECO, will ensure the transportation of samples from suspected DR-TB cases.

- Collaborate with the CPLT and other stakeholders at the provincial level to improve the treatment of latent TB in PLHIV and children under 5, by providing INH prophylaxis.

- **5,612 individuals** in target villages were sensitized in community WASH practices
- **1,018 individuals** in target villages have improved family latrines
- **82 health facilities** launched **clean clinic** approach

WATER, SANITATION, AND HYGIENE

The DRC is one of 20 USAID priority countries for WASH. USAID IHP's target indicators are (1) households' access to drinking water and sanitation, to combat the morbidity of children under 5 from poor WASH conditions; and (2) the improvement of the quality of care and infection prevention through improved WASH.

During this quarter the transition to the new WASH strategy took effect. While working to complete work in Sud-Kivu and Kasaï-Oriental, USAID IHP started to focus attention on the Clean Clinic approach. Based on USAID's recommendations, four provinces will be beneficiaries of funding for the Clean Clinic approach: Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central. Within those provinces, WASH beneficiaries will be selected from a pool of ZS that are targeted for receiving the *paquet supplementaire*.

Rehabilitated WASH facilities in communities

Indirect: ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4

USAID IHP continued to support community-based WASH facility rehabilitation efforts in Sud-Kivu and Kasaï-Oriental, all delayed due to COVID-19-related travel restrictions.

First, USAID IHP launched implementation of rehabilitation works, via local vendors, to provide access to drinking water for communities in Sud-Kivu. Specifically, the firm Action Design and Construction Engineering began rehabilitating the gravity flow water distribution systems in Lwiro, in the Miti-Murhesa ZS, and the firm Butshia Technical Construction Group launched the rehabilitation and extension of the drinking water supply system in Kabamba, in the Katana ZS. At the end of Quarter 3, the rehabilitation works were 70 percent and 80 percent complete, respectively, in Miti-Murhesea and Katana. Once completed, these activities will provide 5,000 people with access to potable water (2,500 per intervention).

Second, USAID IHP considered alternate options to realize the delayed construction of five boreholes in Kasaï-Oriental. Although USAID IHP awarded the contract for this construction to local vendor TRASCO in FY20 Quarter 2, because the firm is Kinshasa-based, it was unable to deploy due to COVID-19 restrictions. With an aim to start the works in Quarter 4, USAID IHP began preparing an alternate plan based on the use of cargo planes with the requirement that each traveler undergo a COVID-19 test and present an authorization from the Directorate General of Migrations in case

COVID-19 quarantine measures are extended. Accordingly, USAID IHP granted a no-cost extension to the contract to ensure the firm can implement once the COVID-19 context permits. Once completed, this USAID IHP support will provide an estimated population of 7,500 people with potable water.

Provided support to communities to build family latrines and handwashing stations in targeted ZS

Direct: ✔ 2.6.3

During Quarter 3, USAID IHP continued to financially support transportation of RECO to sensitize households to build one latrine per household in seven villages in the Miti Murhesa and Katana ZS in Sud-Kivu.

Originally, awareness campaign activities started in March 2020 with a target of reaching nine villages with 1,004 households and 5,912 inhabitants. However, following USAID IHP coordination and harmonization with Food for Peace (FFP), the Program determined that two villages receiving FFP support should be excluded. Accordingly, during Quarter 3, USAID IHP targeted 953 households and 5,612 inhabitants for community sensitization and local latrine construction activities (Table 24). As a result of these activities, 17 percent of target households (168) in the seven villages have improved latrines.

These improved latrines will serve 1,018 people, including 526 women (see Table 25). Compared to the quarterly target of 2,806 people, this number represents a coverage rate of 36 percent, mainly due to limitations related to COVID-19-restricted travel.

Children use a new handwashing station in Kasaï-Oriental. Credit: Rose Kiabu for USAID IHP.

Table 24. Number of beneficiaries of community awareness visits to build or rehabilitate latrines and handwashing stations

ZS	*Aire de sante*	Villages	Target for population of households visited				Improved latrines					
			Baseline	Men	Women	Total	April 2020	May 2020	June 2020	**Total Q3**	Gap	%
Miti-Murhesa	Lwiro	Buloli 2	263	748	686	1,434	6	7	8	**21**	242	8.0%
		Matete	166	520	541	1,061	7	9	13	**29**	137	17.5%
		Lwiro	169	464	465	929	4	14	10	**28**	141	16.6%
Total Lwiro			**598**	**1,732**	**1,692**	**3,424**	**17**	**30**	**31**	**78**	**520**	**13.0%**
Katana	Kabamba	Cheya 1					Villages covered by FFP					
		Cheya 2					Villages covered by FFP					
		Kahuzi	19	66	73	139	3	3	5	**11**	8	57.9%
		Murambi	91	247	292	539	6	7	8	**21**	70	23.1%
		Bushuranyambi	94	302	306	608	7	10	10	**27**	67	28.7%
		Bulindi - Ngoma	151	404	498	902	10	9	12	**31**	120	20.5%
Total Kabamba			**355**	**1,019**	**1,169**	**2,188**	**26**	**29**	**35**	**90**	**265**	**25.4%**
Total			**953**	**2,751**	**2,861**	**5,612**	**43**	**59**	**66**	**168**	**785**	**17.6%**

Source: Project Monitoring Report

Table 25. Number of beneficiaries with improved latrines

ZS	AS	Villages	Improved latrines in Q3	Number of beneficiaries in Q3		
				Men	Women	Total
Miti-Murhesa	Lwiro	Buloli 2	21	60	55	115
		Matete	29	91	95	186
		Lwiro	28	77	77	154
Total Lwiro			**78**	**228**	**227**	**455**
Katana	Kabamba	Cheya 1		Villages covered by FFP		
		Cheya 2		Villages covered by FFP		
		Kahuzi	11	38	42	80
		Murambi	21	57	67	124
		Bushuranyambi	27	87	88	175
		Bulindi - Ngoma	31	83	102	185
Total Kabamba			**90**	**265**	**299**	**564**
Total			**168**	**493**	**526**	**1,019**

In addition, on "Global Hand Hygiene Day" on May 5, 2020, USAID IHP implemented an awareness campaign around good hand hygiene practices, aligned with the 2020 theme "SAVE LIVES: Clean your hands."

Implemented the clean clinic approach

Direct: ✓ 2.6.4

The clean clinic approach—aimed at reducing health facility infection rates by improving WASH conditions and sensitizing beneficiaries on the adoption of good WASH practices (Table 26)—continued in Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central.

During Quarter 3, USAID IHP supported 82 health facilities in target ZS in the four target provinces (Table 27) through the various steps of the clean clinic approach, leading to the planning for WASH improvements (step 5). At that critical step, the Hygiene and Sanitation Committee analyzes data from

the "Knowledge, attitudes, and perceptions (KAP)" survey conducted by the ECZS (step 2) and the self-assessment conducted by the providers (step 4) to plan and prioritize health center improvements (Table 28) according to their level of risk and feasibility.

Table 26. Clean clinic approach

Step-by-Step Process	Clean Clinic Approach Standards
Step 0. Decision of the health facility management committee Step 1. Mutual commitment Step 2. Baseline external evaluation of the health facility (Knowledge, attitudes, and perceptions survey) Step 3. Local governance and training of providers Step 4. Self-assessment Step 5. Planning for improvements Step 6. Implementation of improvements Step 7. Post-action assessment and maintenance plan Step 8. Certification Post-Certification	1. The health facility has an established and functional Hygiene and Sanitation Committee. 2. The health facility has permanent water supply. 3. The health facility has access to hygienic and functional latrines with sufficient hand-washing stations and showers. 4. The health facility correctly manages medical waste. 5. The health facility staff wash their hands properly at critical times. 6. The staff of the health facility know the patterns of transmission of nosocomial infections and their prevention methods. 7. The health facility is cleaned at least once a day with water and detergent.

Table 27. Number of health facilities selected for the clean clinic approach in Quarter 3

DPS	Target ZS in FY2020	ZS supported in Q3	Clinics selected in Q3
Sud-Kivu	11	3	12
Lomami	5	3	30
Kasaï-Oriental	13	2	15
Kasaï-Central	9	3	25
Total	38	11	82

Table 28. Summary of identified improvements across health facilities

Nature of the work to be done (Construction / Rehabilitation)	Nature of the goods to be acquired
Latrines, bathrooms, ash pits, connection of a fountain system, installation of a water tank, incinerators, placenta pits.	Dustbins for waste management, handwashing stations (bucket with tap and wastewater collection basin), PEV kit, sanitation kit and communication posters with awareness messages.

In Sud-Kivu, USAID IHP trained 60 providers, including 15 women and 45 men, on WASH and the implementation of the clean clinic approach step-by-step process in the ZS of Katana, Kalehe, and Miti-Murhesa. By the end of the quarter, 12 health facilities completed the improvement planning step and were ready for implementation of identified WASH improvements.

In Lomami, USAID IHP collaborated with ECZS to support 30 health centers from ZS of Kanda, Luputa, and Mwene Ditu to plan improvements. Specifically, the Program and the ECZS helped each health center develop a plan that takes into account the local context and means available at the health center, community, and partner levels. Notably, the head of the local Hygiene and Public Sanitation Office held three provincial coordination meetings on WASH activities. The objective of each meeting was to harmonize the points of view with the different sectors working on hygiene and sanitation in the city of Kabinda and to have the same understanding on the actual and anticipated achievements of the clean clinic approach.

In Kasaï-Oriental, USAID IHP provided technical and financial support to 15 health centers in the ZS of Kasansa and Mpokolo, which reached step 5 (planning for improvements). USAID IHP received support from six members of the ECZS of the two ZS, including two women. These management representatives were actively involved in reviewing self-assessment and KAP survey data and planning for locally relevant improvements.

In Kasaï-Central, USAID IHP conducted a training of trainers for 19 people, including five members of the DPS/Hygiene and Public Health Office; nine members of the ECZS of Kananga, Luiza and Ndekesha ZS; three staff members from USAID IHP in Kasaï-Central; and two interested local community members. Following the training of trainers, 125 providers received training on the step-by-step process and the WASH module. These providers then conducted the self-assessment (step 4) with planning for improvements (step 5) as the next step.

Lessons Learned

- The promotion of the step-wise clean clinic approach, coupled with financial support, incentivized the active involvement of ZS and the DPS/BHSP management teams and motivated them to assume ownership of clean clinic approach initiatives.
- Step 5 of the clean clinic approach (deliberate planning for improvements) helped health facility stakeholders highlight and prioritize their WASH challenges and play an active role in their resolution.
- The clean clinic approach training helped strengthen the capacities of the CODESA, ECZS and DPS/BHSP managers to manage nosocomial and epidemic infections, especially relevant during the COVID-19 pandemic. The implementation of the clean clinic approach has also created an enabling environment for IPC associated with care in participating health centers. Of particular note, some CODESA members have consciously and independently implemented initiatives including fencing, yard cleaning and sanitation, and weekly self-assessments in their health centers.
- Providing technical assistance on the criteria and the use of suitable materials for constructing a hygienic latrine can motivate communities to invest in their own latrines and complementary health care improvements. In the absence of substantial resources, for instance, the community can assist with raising awareness and close monitoring. Further, community members may seek available alternatives: 168 households built hygienic family latrines with recycled materials

Next Steps

- Continue with the implementation of the step-by-step process in the ZS of Walungu, Kaziba and Mumbano in Sud-Kivu.
- Continue to support communities for the construction/improvement of family latrines and handwashing stations in the targeted ZS.
- Continue the extension and/or rehabilitation of the gravity flow water distribution systems of Kalengo and Kabamba in the Lwiro and Kabamba *aires de santé*.
- Launch the construction of five boreholes in five villages in Kasaï-Oriental.
- Coordinate the pooling of resources with FFP for the training of the Kasansa water management committees in the ZS of Kasaï-Oriental.

4. OBJECTIVE 1

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

Routine data quality audit in Kasaï-Central. *Credit:* Aime Tshibanda, Pathfinder for USAID IHP.

- In **all nine provinces**, exceeded the 80% MOH standard rate for DHIS2 data completeness
- Reduced stockouts to just **44.7 percent of supported health facilities**
- **40,798 managmeent and data collection tools** distributed in four provinces
- **1,966** community action groups revitalized
- ZS supervision and coaching missions supported in **81** ZS

During FY2020 Quarter 3, USAID IHP continued activities to strengthen the DRC's health system. Despite constraints imposed by COVID-19, the Program completed 220 Objective 1 activities out of a total of 312 activities planned for Quarter 3, for an achievement rate of 70.5 percent. These achievements include logistical, technical, and financial support to the DPS, *Inspections Provinciales de la Santé* (IPS, Provincial Health Inspectorates), and ZS in their missions of monitoring, control, and support of operational teams implementing planned activities (indicators #1.1.2, #1.2.3, #1.5.1, and #1.5.3). In FY2020 Quarter 3, USAID IHP achieved indicators related to support for coordination of interventions and stakeholders within the MOH, especially the completion of the *contrat unique* process in all provinces (Indicators #1.4.1, #1.4.2, and #1.4.3). Some indicators were indirectly affected via high-impact preparatory activities, such as surveys to collect primary data before the official launch of the fraud hotline in two provinces (see IR 1.2).

Due to COVID-19 restrictions, USAID IHP recorded no progress this quarter for indicators related to activities that require teams to travel to the provinces to launch activities or train provincial trainers. This impeded implementation of flagship activities such as training in primary health care (PHC) management in the provinces, technical support from the institutional capacity building (ICB) team in Kinshasa for institutional analyzes at the ZS level, and support from the MOH Human Resources Directorate to monitor management and deployment of human resources for health (HRH) in the provinces (e.g., support to Tanganyika to draft a human resources development plan).

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

In its first year, USAID IHP, through the technical expertise of partner TRG, conducted institutional analyses (using the Participatory Institutional Capacity Assessment and Learning (PICAL) tool) of seven DPS (Haut-Lomami, Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Sud-Kivu, and Tanganyika) and two ZS (Katuba in Haut-Katanga and Manika in Lualaba). During FY2020, the Program is continuing to implement ICB plans with each DPS based on FY2019 PICAL results, while also extending the process to carry out institutional analyses of 45 ZS in the nine provinces.

Conducted PICAL assessments in selected ZS

Direct: ✔ 1.1.1 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.4.3 **Indirect:** ✔ 1.1 ✔ 1.5.1

The Program conducted institutional analyzes in 12 ZS this quarter—one in Lomami, three in Kasaï-Oriental, two in Haut-Katanga, three in Haut-Lomami, and three in Tanganyika—with a minimum level of remote support from the Kinshasa-based ICB team. These analyses led to development of ICB plans for beneficiary ZS; these plans serve as credible advocacy tools and a solid basis for planning priority ICB interventions. USAID IHP considers DPS appropriation and mastery of the approach a major asset in the strategy for sustaining Program achievements. During the first three quarters of FY2020, the Program covered 20 ZS out of 45 planned (an achievement rate of 44 percent) and will conduct additional analyses during Quarter 4 in ZS where this process started before the COVID-19 outbreak.

Provided financial support to running costs of the DPS and some ZS

Indirect: ✔ I.1.1 ✔ I.1.2 ✔ I.1.3

USAID IHP supported the operating costs of all nine DPS and 64 ZS (see Table 29). This support was particularly appreciated during the COVID-19 period when most national and international organizations faced reduced operational capacities, to the detriment of the DPS and ZS they support. The Program's support helped ECDPS and ECZS keep offices running normally, strengthening ECDPS and ECZS capacity to steer the country's health system at intermediate and operational levels.

Table 29. DPS and ZS Where USAID IHP Supported Operational Costs, FY2020 Quarter 3

Region	DPS / Province	# ZS
Eastern Congo	Sud-Kivu	0
	Tanganyika	4
Kasaï	Kasaï-Central	4
	Kasaï-Oriental	15
	Lomami	12
	Sankuru	5
Katanga	Haut-Katanga	0
	Haut-Lomami	16
	Lualaba	8
TOTAL		**64**

Provided technical and financial support to the supervision and coaching missions of the ZS by the ECDPS

Indirect: ✔ 22 ✔ I.1.1 ✔ I.1.2 ✔ I.1.3

Box 1. Supervision and coaching of the ZS by the ECDPS Sud-Kivu

From May 19-31, 2020, USAID IHP and the Sud-Kivu DPS Technical Support Office provided technical and financial support to the ECDPS, enabling them to conduct a joint supervision mission on management of supply chain inputs in four ZS and ten (versus the target four) health facilities.

The mission also reinforced COVID-19 preventive measures to the ECZS of the four ZS. At the end of this mission, mid-level supervisors implemented corrective strategies, including:

- Briefing ECZS on the use and management of the InfoMED data reporting tool and production of quality data
- Supporting data managers with the encoding of available data in LMIS.
- Briefing pharmacy attendants on good stock management to mitigate false stock-out alerts based on those oberseverd during the quarter.

USAID IHP provided technical and financial support for ECDPS supervision and coaching missions in 81 ZS in eight provinces: Kasaï-Oriental (15 ZS), Kasaï-Central (10 ZS), Haut-Katanga (16 ZS), Sankuru (16 ZS), Haut-Lomami (five ZS), Lualaba (eight ZS), Sud-Kivu (four ZS) and Tanganyika (seven ZS). No missions took place in Lomami, due to scheduling conflicts.

These missions were particularly important for disseminating preventive measures against COVID-19 and for supporting ECZS to distribute necessary supplies to enable health facilities to protect staff and manage patients effectively. The number of ZS covered by this activity doubled (compared to FY2020 Quarter 2), when the ECDPS supervised and coached 38 ZS. The objective of the Program and the ECDPS is to provide supervision and coaching to all ZS every quarter.

Provided technical and financial support to ZS supervision of facilities and communities

Indirect: ✔ 2.2.5

USAID IHP's support for supervision activities sustainably improves providers' ability to deliver quality health services in targeted health facilities and the community. During Quarter 3, the Program provided financial and technical support for ECZS supervision of health facilities in 36 ZS: four in Tanganyika, five in Haut-Lomami, six in Haut-Katanga, four in Kasaï-Central, five in Kasaï-Oriental, and 12 in Lomami. Although USAID IHP's direct payment approach has not yet reached all ZS, the Program was able to reach most of the targeted ZS despite the constraints associated with direct payment. This led to a 44 percent improvement in the number of ZS supported during Quarter 3 compared to Quarter 2 (25 ZS). The health facilities greatly appreciated these missions, which also provided them with specific directives for managing epidemics in general and COVID-19 in particular.

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

Planned complaints and accountability hotline platform to increase transparency and reporting on abuse

Indirect: ✔ 22 ✔ 1.1.2 ✔ 1.2.4

USAID IHP finalized design of a hotline for reporting abuse and fraud in health facilities and developed a final script for the hotline phone survey. During the Quarter, the Program, led by partner Viamo, launched the survey, aiming to collect 50 complete responses from health workers in Kasaï-Central and Sankuru (see Box 2 for results). The Program then used the survey results in the final design of the accountability hotline. The Program used the survey to evaluate several aspects of the final script: (1) overall performance; (2) recurring abuse and fraud identified in health facilities and ZS; (3) targets' knowledge of procedures and actions to address abuse and fraud; and (4) respondents' perceptions of the fraud hotline.

The survey results showed that health providers perceive the hotline favorably, which will effectively help discourage bad practices in the management and delivery of health services. The survey also revealed some questions and doubts about how the data generated through the hotline would be managed and acted upon. The Program will further explore these and other potential implementation issues during the FY2021 pilot in Kasaï-Central and Lomami—originally planned for Sankuru but changed given political issues within the provincial administration. After the pilot, the Program will extend the hotline to all nine provinces.

Provided support to quarterly trips of IPS for audits and oversight of ZS

Direct: ✔ 1.2.3 **Indirect:** ✔ 1.1.2 ✔ 1.2.1 ✔ 1.2.2

USAID IHP supported five IPS to conduct audit and control missions in 21 ZS this quarter: Sankuru IPS in five ZS; Kasaï-Oriental IPS in five ZS; Lomami IPS in four ZS; Haut-Lomami IPS in one ZS; and Lualaba IPS in six ZS. In addition to their routine programs, IPS missions this quarter focused on compliance with health measures for COVID-19 and on strict application of measures and standards for steering bodies, which are greatly needed during the COVID-19 pandemic.

Box 2. Results of the pilot survey for implementation of the accountability hotline for reporting abuse and fraud in DRC health facilities.

USAID IHP conducted a phone survey in Kasaï-Central and Sankuru from April 22-May 20, 2020 about the accountability hotline for reporting abuse and fraud in health facilities. This phone survey collected 72 complete responses from 36 DPS or ZS agents and 36 community members. Respondents' perceptions included:

To the question of whether respondents encourage implementation of an anonymous accountability hotline to expose cases of abuse or fraud in health facilities:

- ***56.9 percent are favorable to implementation of the hotline*** (39 percent of these respondents expect it to expose and share cases of abuse and fraud, and 32 percent expect it to prompt actions such as unannounced visits of control teams in the field);
- ***27.8 percent were neutral and had no opinion***; and
- ***15.3 percent did not support implementation*** (45.5 percent of these respondents cited "concern for the fate of the colleague/health worker" being exposed as their main reason. They also thought the hotline would not lead to charges against the concerned agent).

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

Provided support to revitalizing CACs in selected ZS with integration of gender

Indirect: ✔ 1.3.1 ✔ 1.3.2 ✔ 1.3.3

During Quarter 3, USAID IHP supported targeted provinces in revitalization of CACs, a priority for USAID in its partnership with the MOH. These revitalized CAC allow each village to have a credible representative in CODESA. As shown in Table 30, from the Program's inception through this quarter, 2,874 out of 5,411 CAC have been revitalized (53 percent of the target).

Table 30. USAID IHP Support for Revitalization of CAC

Province	Revitalized CAC				Achievement Rate (%)
	Prior to FY2020 Quarter 3	During FY2020 Quarter 3	Total as of End of FY2020 Quarter 3	Target by End of FY2020 Quarter 3	
Haut-Katanga		158	158	200	79
Haut-Lomami		50	50	50	100
Lualaba		32	32	105	30
Kasaï-Central	540	340	880	550	160
Kasaï-Oriental		1,003	1,003	940	107
Lomami	90	195	285	1,282	22
Sankuru		100	100	800	13
Sud-Kivu	178	65	243	350	69
Tanganyika	100	23	123	1,134	11
Total	**908**	**1,966**	**2,874**	**5,411**	**53**

Source: Project Monitoring Report

USAID IHP is using the Community Scorecard as a community accountability approach within the revitalized CACs. The Program is prioritizing the gender dimension during the CAC revitalization

process, with a goal to have 30 percent of CAC led by women. At this stage, more than 20 percent of revitalized CACs are led by women; these are among the most efficient.

Provided technical and financial support to CODESA monthly meetings in selected ZS

Direct: ✔ 1.3.1 **Indirect:** ✔ 1.3.2

USAID IHP financially and logistically supported 188 CODESA in seven provinces to hold monthly meetings. The Program supported 57 CODESA in six ZS in Lomami; nine CODESA in two ZS in Sankuru; 34 CODESA in two ZS in Kasaï-Oriental; 30 CODESA in Haut-Katanga; 15 CODESA in two ZS in Haut-Lomami; 15 CODESA in three ZS in Lualaba; and 28 CODESA in three ZS in Sud-Kivu. Overall, USAID IHP supported 261 percent more CODESA meetings this quarter than the previous quarter's 72 CODESA meetings.

In addition, ECZS members and USAID IHP staff provided technical assistance for the development and validation of community action plans. A key goal was to share messages on COVID-19 prevention measures and integrate community actions for COVID-19 containment into community action plans.

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

Supported preparation and signing of *contrat unique* at the province level

Indirect: ✔ 1.4.2

Multidisciplinary national supervisors assisted with the *contrat unique* process this quarter, in the context of their support for the 2020 PAO process in the nine target provinces. Their support helped the provinces begin preparations for signing the *contrat unique*, which has the objective of pooling financial support so each DPS can engage all stakeholders to implement its 2020 PAO. Since the previous quarter, this process has led to the signing of the *contrat unique* in five provinces (Haut-Lomami, Lualaba, Tanganyika, Sud-Kivu, and Kasaï-Oriental). By the end of Quarter 3, two more provinces (Lomami and Haut-Katanga) continued the process leading to the *contrat unique*. To date, only Sankuru, confronted with DPS leadership ambiguity, and Kasaï-Central have not yet signed their *contrat unique*.

One major challenge raised during evaluations of the *contrat unique* is limited domestic funding from central-level and local government sources. Cumbersome procedures and low contributions from provincial health budgets are recognized reasons for such gaps.

Provided support to technical coordination meetings related to Ebola and COVID-19 preparedness planning

Indirect: ✔ 1.5.2 ✔ 2.7.1

USAID IHP provided technical and financial support for coordination meetings led by the DPS of six provinces: Sud-Kivu (one meeting); Haut-Lomami (six *Maladies à potential epidémique* (MAPEPI, diseases with epidemic potential) monitoring meetings); Kasaï-Central (six meetings); Kasaï-Oriental (12 meetings of the crisis committee); Sankuru (three meetings of the Provincial and Territorial Committee for the Fight Against COVID-19); and Lomami (two coordination meetings). These meetings follow national guidelines on organization and coordination of preparedness and response. They also aimed to pool stakeholder efforts in the fight against COVID-19. Each coordination committee will need to ensure that

measures to fight COVID-19 are well understood by the population and that all preparedness measures are in place.

Contributed technically and financially to the DPS primary health care semi-annual review meeting

Indirect: ✔ 1.4.1 ✔ 1.4.3

With technical and financial support from USAID IHP, the Kasaï-Central DPS and Tanganyika DPS held biannual reviews of PHC activities in Quarter 3. These meetings resulted in various recommendations for improving health indicators in the context of the fight against COVID-19. Each review meeting lasted eight days in total, with participants divided into two pools to comply with social distancing measures.

- **Kasaï-Central.** The first pool lasted four days, bringing together 10 MCZS with five provincial supervisors and three guests from technical and financial partners (UNICEF, WHO, USAID IHP). A second pool of 18 participants, (multidisciplinary provincial supervisors from the DPS and ZS supported by PRODS and ASSR) spent two days consolidating work across the province.
- **Tanganyika**. The meeting was attended by executives from all the province's ZS, ECDPS, IPS, representatives from specialized program committees, representatives of supporting structures of the DPS, technical and financial partners, and various organizations supporting the health system, delegates from other provincial ministries, and the provincial Minister of Health and some members of his cabinet.

Held technical and coordination meetings with other USAID partners

USAID's Country Development Cooperation Strategy in the DRC, through its Development Objective 2 (DO.2), states that lives are improved through a coordinated development approach in selected regions. In keeping with this priority, USAID IHP held coordination meetings with other USAID partners in the target provinces and in Kinshasa.

Evidence to Action (E2A). As part of its project close out, E2A and USAID IHP held monthly meetings in Lomami, Kasaï-Oriental, and Kasaï-Central to ensure continuity of services in health facilities. The two projects shared other relevant information on implementation, sourcing of inputs and management tools, and organization of monitoring and supervision visits.

Advancing Nutrition. USAID IHP met with the Advancing Nutrition project in Sud-Kivu Province and in Kinshasa. The two programs shared information on their mandated nutrition interventions.

Food for Peace (FFP). USAID IHP held coordination meetings with the Catholic Relief Services-managed Budikadidi project in Kinshasa and Mbuji-Mayi, especially on SBC interventions in the Cilundu ZS in partnership with Breakthrough Action and Save the Children, which work in the same ZS. In Tanganyika and Sud-Kivu, USAID IHP and Family Health monitored implementation of the joint work plan and shared updated mapping of nutrition stakeholders.

Pathfinder. USAID IHP participated technically in the scale-up workshop for self-injection of DMPA-SC. The goal of the workshop, organized by PNSR with funding from Pathfinder, was to increase the number of DMPA-SC users, especially those who self-inject. The PNSR's revised materials were shared with the nine DPS supported by USAID IHP.

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

In Quarter 3, USAID IHP continued to build the capacity of ECDPS, ECZS, and providers at health facilities to improve disease surveillance and strengthen gathering and use of strategic information. The Program also provided logistical support to ECDPS, ECZS, and service providers for data validation and control of data quality for better decision-making and rational planning.

Conducted routine activities to improve health information

The Program supported capacity building (training) to equip ECDPS and ECZS with the skills to carry out data processing and quality control using appropriate tools, including DHIS2 and the Data Quality Supervision Tool (DQST). Activities included:

Trained managers of DPS, IPS, and ECZS on the normative frameworks SNIS and DHIS2.

Indirect: ✔ 1.1.1 ✔ 1.5.2 ✔ 1.5.3

USAID IHP supported training of 75 DPS, IPS, and ECZS executives (including 31 women) in Haut-Katanga and Lualaba. DPS experts trained by the MOH at the central level, with technical support from the USAID IHP RM&E team, conducted the training. This capacity building aimed to improve data collection and use at the operational level. Coupled with monitoring by the ECZS, these measures assist provinces to maintain a health data availability level above 80 percent and of acceptable quality in DHIS2.

Trained DPS and ZS cadres on the DQST

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.3

USAID IHP supported the Haut-Katanga DPS to empower 10 DPS and 10 ECZS (including two women) agents to use the Routine Data Quality Assessment (RDQA) tool and the DQST. This support improved control of data quality; participants confirmed they acquired skills for drafting reports, organizing meetings for data analysis and validation, and using the DQST.

Contributed to improved data quality

FY2020 Quarter 3 activities to improve data quality included the following:

Provided support to data quality control field visits

Indirect: ✔ 12 ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.3

USAID IHP supported data quality control missions in five provinces, encompassing 38 ZS and 117 facilities, as shown in Table 31. To ensure quality retraining of ZS supervisors, the Program also organized an orientation workshop on RDQA before the missions.

Routine data quality analysis in Kasaï-Central. Credit: Aimé Tshibanda, Pathfinder for USAID IHP.

Table 31. ZS and Facilities Visited during Data Quality Control Missions

Provinces	ZS	BCZS/General Referral Hospitals/Health Centers
Sud-Kivu	7	25
Haut-Katanga	6	18
Haut-Lomami	10	32
Kasaï-Oriental	6	15
Kasaï-Central	9	27
Total	**38**	**117**

Source: Project Monitoring Report

In most facilities evaluated, the teams discovered:

- Poor availability of standard tools for data collection and transmission, the absence of a verification system for data entered by health center teams and general referral hospitals before transmission to the BCZS, and the low involvement of ECZS members in analysis of data submitted by health facilities.
- Scarce use of dashboards to monitor key indicators by some general referral hospitals and health centers; absence of effective monitoring meetings at the BCZS level.
- Few personnel capable of managing information in the SNIS, including executives from the BCZS, general referral hospitals, and health centers
- Poor monitoring of service providers on use of data collection, reporting and transmission tools.

The major challenge remains weak application of basic measures for data quality assurance by BCZS and health facilities. To address this problem, USAID IHP discussed a correction and improvement plan with each evaluated facility; the ECZS will monitor these plans.

Provided technical and financial support to DPS for the organization of quarterly data validation meetings.

Indirect: ✔ 2.7.1

Haut-Katanga and Lualaba organized meetings for integrated validation of data (which comes mostly from DHIS2). ECDPS facilitated the meetings, which drew 61 physicians, supervisor nurses, and full-time data managers (including nine women): 27 managers (including five women) from Haut-Katanga and 34 managers (including four women) from Lualaba. The validation shows inconsistencies persist among the data from DHIS2, the registers, and Excel files for PRONANUT, the PNLT, and the PNLP. In addition, there are miscalculations, outliers, and misinterpretation of indicators. The DPS developed an improvement plan to minimize errors and to update the health pyramid in accordance with reporting sites and rules for non-compliant validation. The challenge remains to use the analysis of data quality strengths and weaknesses, as produced in the field, to implement the plans.

Provided financial support to monthly monitoring meetings at the ZS and aire de santé levels.

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.2 ✔ 1.5.3 ✔ 1.7.2

USAID IHP supported the monthly monitoring meetings in 58 ZS in the nine target provinces.[4] Each ZS organized these monthly meetings at the BCZS level. Participants included members of the ECZS, registered nurses from the *aires de santé*, and representatives of technical and financial partners and the government. These meetings allow *aires de santé* and ZS to review and validate data collected the month before they are entered into the DHIS2 for analysis.

Supported activities to improve data availability

To ensure availability of data and allow health information generated by health facilities to be entered into DHIS2, USAID IHP supported the following activities:

Ensured availability of internet connection for the DPS and ZS (Purchase megabytes for 3G and 4G or V-Sat connection)

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.2 ✔ 1.5.3 ✔ 1.7.2

At the end of Quarter 3, more than half of USAID IHP-supported ZS had working very-small-aperture terminals (VSATs). The Program will continue during Quarter 4 to equip all DPS and ZS in target provinces with working VSATs.

[4] Given current contractual constraints, USAID IHP determines which ZS monthly monitoring activities our technical staff will support based on *aire de santé* accessibility and technical needs (as determined in concert with the DPS). This enables us to maximize opportunities to provide technical support in the *aires de santé* with the greatest need. For ZS where we are unable to physically attend monthly monitoring activities, we support DPS staff to provide this technical assistance. In tandem, we are developing USAID IHP's operational infrastructure to cover all 178 ZS, such as via the mobile money system pilot in Sud-Kivu.

Printed and disseminated health facility management tools (registers, index cards, report templates, and others)

Indirect: ✔ 1.5.1 ✔ 1.5.2 ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

USAID IHP initiated the process of printing SNIS management tools in all provinces except Haut-Katanga, which will launch in Quarter 4. These SNIS management tools help the provinces collect and submit the essential health services data that must be entered into DHIS2. The tools include: HGR outpatient registers, health center curative consultation registers, health center and HGR maternity, ANC, and postnatal registers, and health center, HGR, and BCZS report templates.

Supported the MAPEPI reporting system with information and communication technology (ICT)

Indirect: ✔ 1.1.1 ✔ 1.5.2

This support enabled the data completeness rate in the DHIS2 to be maintained at 93.2 percent, which is higher than the 80 standard decreed by the MOH. The overall average completeness rate in the nine provinces is over 90 percent, but two provinces recorded lower levels—Haut-Lomami at 84.8 percent and Tanganyika at 87.3 percent. These two provinces need special support to help them improve.

Table 32. Reporting Rate - Basic Services

	April 2020	May 2020	June 2020	Quarter 3 Average
Haut-Katanga	93.8	87.0	91.6	**90.8**
Haut-Lomami	91.3	84.8	78.3	**84.8**
Kasaï-Oriental	99.8	98.2	99.1	**99.0**
Kasaï-Central	98.4	98.2	99.5	**98.7**
Lualaba	97.9	93.1	94.2	**95.1**
Lomami	99.7	98.8	99.3	**99.3**
Sud-Kivu	92.7	91.2	92.8	**92.2**
Sankuru	98.5	90.3	87.2	**92.0**
Tanganyika	90.6	88.9	82.4	**87.3**
Total	**95.9**	**92.3**	**91.6**	**93.2**

Source: DHIS2, accessed July 23, 2020

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

Most USAID IHP interventions related to the HRH management focused on Tanganyika in FY2020, given this province's low level of competent, rationalized, and motivated human resources compared to other provinces.

Provide orientation to DPS staff on gender based HRH planning and deployment

Indirect: ✔ 1.6.1

On April 9–10, 2020, orientation workshop for the ECDPS in Tanganyika was an opportunity for the staff of different DPS programs and units to discuss integration of gender in HRH planning and deployment. Nineteen people, including 11 men and eight women, participated in this activity.

Workshop participants noted that although the Tanganyika DPS recruits women, they are not for leadership positions. This situation reflects the gender inequalities in all health institutions in the

province in general and in the DPS in particular. The Directorate and all six offices of the DPS are headed by men; it is rare to find a woman in leadership and management positions. Table 33 shows statistics on the levels of men's and women's education at health facilities in the province.

Table 33. Education Levels of Women and Men Working in the Health Sector in Tanganyika

Education Level	Women (%)	Men (%)
Uneducated	19	3
Completed secondary education	35	28
Higher education	4	11
Total	**58**	**42**

Source: MOH Gender, Family and Children Division

Holding this workshop triggered an approach to move toward women's equality and representation in governance and management bodies in the Tanganyika DPS. The Program will follow up on the various recommendations emanating from this workshop during an upcoming gender audit.

Provide technical assistance to DPS in the design of motivation systems for human resources

Indirect: ✔ 1.6.1

Ten Tanganyika ECDPS met on April 17, 2020, to design an incentives approach for HRH that relies on local resources, including:

- Conducting quarterly evaluations of agents
- Advocating for compliance with the internal recruitment process for ECDPS
- Advocating with authorities to fill vacant positions
- Conducting quarterly votes for the best employee
- Posting photo of the employee of the year at entrance to offices
- Advocating with authorities to promote successful agents through performance evaluations
- Applying sanctions to offending agents
- Favoring filling vacant positions in areas furthest from the provincial capital

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

Supply chain activities were impacted this quarter by restrictions due to the COVID-19 pandemic. USAID IHP postponed some activities planned for this period, like training in supply chain management and piloting the Informed Push Distribution Model, but was able to continue supply chain management initiatives.

Supported the GTM and management of supplies and stocks activities

Indirect: ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

USAID IHP held monthly meetings with GHSC-TA to plan joint activities, resolve emergencies involving the two projects, and harmonize views prior to meetings of the *Groupes de Travail Médicaments* (GTM, Essential Drugs Working Groups) which bring together all technical and financial partners in each province.

The Program supported the nine target DPS in organizing quarterly GTM meetings in Quarter 3 to address the following:

1. ***Stock inventory review in the centres de distribution régionale (CDR, regional distribution centers) and monitor distributions to the ZS.*** Distributions of CDRs to the ZS took place in April and May 2020. Travel restrictions, due to COVID-19, between territories within the same province or within provinces significantly lengthened the delivery times from 15-20 days on average to nearly 28-30 days in Sud-Kivu, Haut-Katanga and Lualaba. Travel challenges withstanding, USAID IHP supported the launch of MNCH product distribution to Haut-Katanga and Tanganyika ZS in mid-May ; the program helped distribute ten of the 14 expected items in the ZS. In general, there was good availability of TB and family planning products. Starting in May 2020, the CDRs serving the nine USAID IHP-supported DPS began reporting stocks of less than three months of malaria and MNCH products. The Program also noted that the CDR serving three provinces (Sankuru, Kasaï-Oriental and Tanganyika) reported a total break in S/P. The breaks will significantly increase at the health facilities level if no delivery is made between August and mid-September 2020. Ten of 14 expected items were distributed in the ZS. In general, there was good availability of TB and family planning products. Stocks of less than three months of malaria and MNCH inputs were reported starting in May 2020 in the CDR serving the nine DPS. A total break in S/P was reported in the CDRs serving three provinces (Sankuru, Kasaï-Oriental and Tanganyika)—if no delivery is made between August and mid-September 2020, the breaks will significantly increase in the health facilities the Program supports in the next quarter.
2. ***Tracking of credit lines of the ZS.*** USAID IHP supported seven DPS to prepare circular notes signed by the *Chef de Division* that explain how ZS allocate credit to health facilities and how ZS funds needed to source medicines are replenished. Contributions of medical products and consumables from other technical and financial partners (e.g., UNICEF, WHO, UNFPA, World Bank) made it possible to realign credit lines between the ZS and the provinces with the balance provided by USAID.
3. ***Monitor data completeness of ZS management reports in SIGL InfoMED.*** USAID IHP monitored data completeness mostly remotely by phone. USAID IHP teams and DPS conducted joint monitoring missions to 32 ZS across the nine provinces, addressing the revitalization of quantification committees; use of management tools; reporting in the Logistics Management Information System (LMIS; DHIS2/InfoMED); and use of the *Plans de distribution de ZS* tool (PDD-ZS) and ZS distribution plans.

Distributed normative LMIS management tools

Indirect: ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

During Quarter 3, four provinces distributed 40,798 supply chain management tools to fill gaps in supply before the next distribution during Quarter 4.

Table 34. Quantity of Management and Data Collection Tools Distributed				
Tools	Kasaï-Oriental	Lomami	Lualaba	Tanganyika
Fiche de Stock	-	7,045	10,000	11,650
RUMER	-	56	404	-
PV de Réception	-	-	-	307
Bon de Livraison (Carnet)	156	40	-	110
Bon de commande (Carnet)	-	-	460	307
Registres d'inventaire	-	-	614	274
Canevas de rapport mensuel FOSA	7,680	-	403	789
Canevas de Rapport mensuel BCZS	456	-	14	33

Supported the transport of products by RECO in difficult-to-access aires de santé

Indirect: ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 1.7.1 ✔ 1.7.2

USAID IHP has developed context-specific distribution approaches, which, once implemented, will enable us to reach health facilities in most ZS. In the meantime, during Quarter 3 the Program assisted with delivery of commodities in difficult-to-access *aires de santé*. Activities included using USAID IHP staff and vehicles to transport supplies directly in Tanganyika (94 *aires de santé* in four ZS); Lualaba (66 *aires de santé* in five ZS); Haut-Katanga (48 *aires de santé* in four ZS); Sud-Kivu (32 *aires de santé* in three ZS); Lomami (two ZS); and Sankuru (four *aires de santé* in one ZS). In Kasaï-Central, two ZS benefited for the first time from USAID IHP assistance with development and execution of their plans for distribution of MNCH essential generic medicines and inputs from the laboratory to health facilities.

Analysis of results

Number and percentage of USG-assisted service delivery points that experienced a stock-out of selected tracer commodities at any time during the reporting period (Indicator #1.7.1)

In Quarter 3, 44.7 percent of USAID IHP-supported health facilities experienced at least one incidence of a stock-out of one or more tracer commodities. This indicator did not change significantly from Quarter 2 (43.2 percent), but it has been underperforming compared to Quarter 1 (30 percent). A couple of factors impacted this trend: (1) low availability of MNCH products at upstream levels (CDR or BCZS);[5] and (2) longer-than-usual delivery times from CDR to the ZS due to COVID-19 restrictions , insecurity in Sud-Kivu, and deteriorating road conditions during the rainy season.

Nevertheless, USAID IHP technical support for last mile transport coupled with the logistical support of local USAID IHP offices and efforts to redeploy excess stocks in several provinces made it possible to limit the incidence of stock-outs. Overall, the number and percentage of USG-assisted service delivery points that experienced stock-outs was lower than expected (the FY2020 Quarter 3 overall target was 67.7 percent). This represents an achievement rate of 134 percent. All provinces exceeded their targets.

[5] For example, the May 2020 report showed that only five of 18 MNCH essential generic medicines monitored had enough stocks to last three or more months (Amoxycilline 250 mg dispersibles, Ferous Sulfate-Folic Acid 200mg/0.25 mg, Mebendazole 100 mg Clotrimazole and Placebo (CP), Clotrimazole 500mg Therapeutic abortion (Tab Gyn), and ORS+zinc kits).

Percent of USG-supported health zones with LMIS reporting rates > 95% (Indicator #1.7.2)

This quarter, the ZS in USAID IHP-supported provinces reported into LMIS at an average of 73.9 percent, down slightly from the 77.4 percent in the previous quarter. As of July 28, 2020, only 16.2 percent of BCZS exceeded the target of 95 percent of health facility reports submitted and published in INFOMED. This decline was largely due to the impact of COVID-19 which nearly stopped the reactivation of VSATs supported by USAID IHP, and it reduced the frequency of ZS support missions for better monitoring of INFOMED.

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

Organize a monthly review of good practices on gender mainstreaming

Indirect: ✔ 1.8.1 ✔ 2.7.1

In Quarter 3, five provinces organized exchange sessions on good practices for integrating gender into programs. Please find details of this activity in the gender section of this report.

Provided financial support to the organization of COGE meetings in selected ZS

Indirect: ✔ 1.8.1 ✔ 2.7.1

USAID IHP supported organization of *Comité de Gestion* (COGE, Management Committee) meetings in 43 ZS in six provinces, out of a quarterly target of 45 ZS, for a completion rate of 95.5 percent. These meetings took place in five ZS in Haut-Lomami, 10 ZS in Kasaï-Central, 14 ZS in Kasaï-Oriental, five ZS in Lomami, five ZS in Sankuru, and four ZS in Tanganyika. Three provinces—Haut-Katanga, Sud-Kivu, and Lualaba—were among the first to be affected by COVID-19 after Kinshasa and did not organize these forums because of constraints imposed by the pandemic. COGE meetings remain an ideal accountability framework for stakeholders to report on their commitments for improving health care services. These meetings have been particularly useful during COVID-19, as each community researches how to pool efforts to effectively fight the pandemic.

LESSONS LEARNED

- Assessments of data quality at the ZS level can draw health facility managers' attention to the importance of data quality available in DHIS2 and motivates them to improve data availability and quality.
- The proportion of women participating in monthly review meetings remains low; greater involvement of women in various community activities typically leads to more active participation in all decisions and at all stages of community development.
- Reactivating VSATs is a sustainable solution to maintain internet connectivity in the ZS and ensures improved timeliness of data reporting into the DHIS2.
- Provincial Essential Drugs Working Groups (GTM) are integral to local efforts to rationalize stocks. At that level, stakeholders can assess overarching availability of product stocks plus demand at the

ZS level, and determine allocation needs accordingly. For example, in Lomami, at the request of the DPS, technical and financial partners including PROSANI USAID facilitated the redeployment of surplus FP product stocks from 4 ZS where there were excess stocks to 3 ZS that were in need.

- While USAID IHP has used Program vehicles to ensure the transport of inputs to difficult-to-access health areas where alternatives do not yet exist, this practice has shown limits in terms of impact and efficiency, as it only covers a small part of the health areas in need. The Program will need to prioritize development of alternatives.

NEXT STEPS

- Conduct PICAL assessments in remaining target ZS
- Continue providing technical and financial support to select operating costs and procedures of the DPS and ZS
- Finalize planning and preparations for accountability hotline pilot phase
- Continue support to IPS audit control missions
- Support the signing of *contrats uniques* in the remaining provinces
- Support regularly monthly data monitoring meetings at the *aire de santé* level
- Conduct RDQA missions and develop DPS action plans to improve data management at health facilities
- Help the DPS initiate reactivation of VSATs in the ZS not yet covered and pay subscription fees for the next three months
- Provide reporting forms (for health centers, general referral hospitals, and BCZS) for two to three months.
- Follow up with the DPS on the application of commitments for motivating HRH.
- Continue supporting the GTM and other activities to ensure the sound management and distribution of essential generic medicines at the health facility level.

5. OBJECTIVE 2

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

Infant and young child feeding community outreach. (*Credit:* Lambert Losambe, Abt Associates for USAID IHP)

- **520 people** trained on infection prevention and control to prevent spread of COVID-19 and Ebola Virus Disease
- **679 people** trained to revitalize and better mange iCCM sites
- **60 health care providers** trained on blod transfusion safety
- **285 iCCM sites** in hard-to-access areas received supervision from DPS in **five provinces**

The main Objective 2 activities implemented in Quarter 3 included: (1) provider training in all six USAID IHP program areas; (2) transportation of vaccines and sputum samples to central offices and health facilities; (3) purchase of fuel for the cold chain, small equipment for iCCM sites, and utensils for directly observed therapy with S/P; (4) provider training in IPC and supply of health facilities with IPC materials; (5) technical and financial support for meetings, data monitoring, and supervision at different levels of the health system; (6) provider training in malaria, emergency obstetric and newborn care (EmONC), IMNCI, and nutrition. Most activities are described in Chapter 3 (Program Areas). With a few exceptions, this section of the report describes activities not linked to indicators described in Program Areas.

During Quarter 3, USAID IHP continued support to the MOH to ensure continuity of essential services during the COVID-19 pandemic and to prevent excess mortality, particularly among at-risk groups. The Program planned 349 activities for Objective 2 and implemented 223, a completion rate of 64 percent. This improves upon the previous quarter, when only 87 activities were implemented. The Program has prepared health facilities to address COVID-19 and continue caring for patients by disseminating revised guidelines for care, raising awareness about prevention and care-seeking, equipping health facilities with IPC materials, and complying with barrier measures required by the government.

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

Provide support to implementation of the Integrated Quality Improvement Approach (DQI) to identify bottlenecks and propose solutions

Indirect: ✔ I8 ✔ 1.1.1 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.4.3 ✔ 2.8

In Quarter 3, USAID IHP provided financial and technical support to Lomami and Sud-Kivu to train 24 people—17 ECDPS, 1 IPS staff, and six ECZS from six ZS—on application of the *Démarche de Qualité Intégré* (Integrated Quality Improvement Approach) to improve the quality of healthcare and services and entry of DQI data into DHIS2. This training enabled these two provinces to set up a pool of trainers and supervisors on DQI.

In Lualaba Province, the DQI was implemented in six ZS (Fungurume, Manika, Dilala, Bunkeya, Lualaba, and Kanzenze). The assessment covered the quality of care and services through the evaluation and quality improvement teams (EEAQ) at BCZS and general referral hospitals and evaluation and quality improvement units (CEAQ) at health facilities. USAID IHP field advisers served as members of these

teams. A total of 18 structures were assessed in the six ZS: six health centers, six hospitals, and six BCZS. At the BCZS and hospitals, factors inhibiting the quality of service lie in human resources (which are insufficient in number and quality, regularly unavailable, and frequently non-compliant with working hours) and governance and leadership (low numbers of meetings with minutes, poor follow-up of recommendations). The health centers also present major bottlenecks to quality service, especially low levels of community participation; poor management organization (e.g., absence of signs identifying services inside the health facilities); and non-compliance with care protocols. Overall, the evaluations showed good quality services in the six general referral hospitals, but health centers need to improve their quality of care. Following the assessments, the EEAPs and CEAQs developed improvement plans tailored for each health facility. Each EEAP and CEAQ team developed its own plan, with activity leads and deadlines; they will be evaluated after three months.

Next steps: Continue the DQI assessment and monitor implementation of improvement plans.

Trained providers on blood transfusion safety

Indirect: ✔ 14 ✔ 15 ✔ 2.1.3

To combat maternal mortality caused by post-partum hemorrhage (see MNCH section in Chapter 3) and anemia in young children suffering from malaria, USAID IHP carried out activities during Quarter 3 to ensure the quality and safety of blood transfusions. In April, USAID IHP supported training for 60 providers (45 men and 15 women) on blood safety in six ZS in Kasaï-Oriental. This training helped improve blood transfusion for key beneficiaries, including children under 5 and women needing blood during childbirth or post-partum.

Provider training in Sankuru on MNCH topics. Credit: Lambert Losambe, Abt Associates for USAID IHP.

Provided training for health workers on infection prevention and control (IPC) for COVID-19 and EVD

USAID IHP worked to prevent health facilities from spreading contamination. The Program supported IPC training for 520 people (including 144 women)—389 service delivery providers from health centers and general referral hospitals, six hygienists, 25 ECZS, and 100 RECO—in the nine target provinces (see Table 35). These nurses, doctors, midwives, hygienists, and RECO were selected primarily in frequently visited health facilities. Analysts from the DPS *Bureaux d'Hygiène et Salubrité Publique* (Hygiene and Public Health Offices) facilitated. Participants learned IPC techniques to reduce risk of infections associated with care. USAID IHP distributed IPC materials to 189 health facilities in eight provinces (with the exception of Sankuru, where distribution is currently underway). Materials included headgear, infrared thermometers, medical gowns, plastic aprons, plastic boots, household gloves, surgical gloves, masks, protective glasses, garbage bins, wheelbarrows, safety shoes, rakes, spades, and decontamination containers.

During the period, USAID IHP continued to support the nine DPS to disseminate guidelines for COVID-19 care parameters as they apply to MNCH, nutrition, RH/FP, TB, and malaria programs.

Table 35. Distribution of People Trained in IPC, by Province and by Gender

Province	Participants		
	Men	Women	Total
Kasaï-Central	59	27	86
Sankuru	22	2	24
Kasaï-Oriental	94	18	112
Lomami	49	12	61
Haut-Lomami	40	9	49
Lualaba	60	40	100
Haut-Katanga	11	14	25
Sud-Kivu	8	8	16
Tanganyika	33	14	47
Total	**376**	**144**	**520**

Source: Project Monitoring Report

Created a mobile training curriculum for providers distributed via mobile and push interactive voice response (IVR)

Indirect: ✔ 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 ✔ 2.1.14 ✔ 2.1.15 ✔ 2.1.16 ✔ 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

USAID IHP leverages its partner Viamo's 42502 service to support frontline workers by providing access to on-demand job aids. In Quarter 3, Viamo launched an additional pack of audio job aids on the topics of IPC and Integrated Community Case Management (iCCM), for health workers. When they access the platform, health workers (specifically RECO) can review training materials and take comprehension quizzes at no charge if using a Vodacom sim card. To encourage them to call back, the service also features a "best practice of the month."

Between April and June 2020, a total 8,204 listeners accessed the 42502 service for the audio job aids. During the quarter, use of the tools dropped significantly: by 54 percent for IPC content and by 79 percent for iCCM content. After further analysis of overall traffic on Viamo's platform over three

months, the Program found that the most popular health-based theme accessed by subscribers was for COVID-19. A detailed breakdown can be found in Table 36 below.

Table 36. Users of audio job aids on IPC and iCCM in FY20 Quarter 3

Sub-theme	Total number of unique listeners in Q2 2020	Total number of unique listeners in Q3 2020
IPC		
Hand washing	4,880	1,919
Personal protective equipment	3,501	1,661
Waste management	1,273	646
Management of sharp objects	1,750	998
Total	11,404	5,224
iCCM		
Prevention against childhood illness	6,316	1,009
Child care	3,464	745
Prevention and care of the mother	4,626	1,226
Total	14,406	2,980
Total IPC and iCCM	**25,810**	**8,204**

This quarter, Viamo conducted an in-depth analysis of the questions prompted at the end of each audio job aid message, to better understand reasons underlying the high failure rate of around 48 percent (at the end of Quarter 2). The results are as follows:

- Response rates differ by language (notably, Kikongo and Tshiluba had fairly high incorrect responses), so for future content, special attention should be paid to translation.
- Question type does not have any effect on listener responses. Therefore, whether the question is true/false or non-true/false does not matter.
- The answer option order has no significant outcome considering that the listeners could have guessed the answer.
- Repeat exposure provided much better correct response rates for over 70 percent of the total questions. This indicates that encouraging audiences to listen more than once will help with comprehension and improve short-term knowledge retention.

Based on these findings, USAID IHP will adjust future audio job aids and remote training curriculums.

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

Provide technical and financial support for supportive supervision of iCCM sites by the head nurses and the health team

Indirect: ✓4 ✓5 ✓6 ✓7 ✓8 ✓9 ✓10 ✓11 ✓12 ✓13 ✓2.1.2 ✓2.1.3 ✓2.1.4 ✓2.1.5 ✓2.1.6 ✓2.1.7 ✓2.1.8 ✓2.1.9 ✓2.2.2 ✓2.2.3 ✓2.2.4 ✓2.2.5 ✓3.1.2

USAID IHP continued retraining of iCCM site RECO to revitalize iCCM sites, in accordance with updated site-level tools (see MNCH Section in Chapter 3).

With support from USAID IHP, the provincial facilitators then retrained iCCM site RECO, their supervisors, registered nurses, and ECZS on how to care for sick children, fill out monthly report forms,

and manage iCCM sites. A total of 679 people were retrained, including 389 iCCM site RECO (336 men and 53 women). The COVID-19 care guidelines were communicated, including individualized use of MUAC, mask-wearing, individualized reception of each sick child and his/her caregiver, and hand-washing.

The 123 iCCM sites in Sankuru, Kasaï-Oriental, and Haut-Katanga received small equipment (garbage bins, handwashing basins, receptacles, water cans, jugs, cups, flashlights, plastic chairs) and service delivery tools (picture registers for case management at the site, checklists, counseling cards, guidance notes, monthly report forms, images of side effects).

USAID IHP also supported DPS in Sud-Kivu, Tanganyika, Kasaï-Central, Haut-Lomami, and Lualaba with supervision of 285 iCCM sites in areas that are hard for registered nurses to access. They were supported by the ECZS (RECO and nurse supervisors). The supervision aimed to enhance the skills of iCCM site RECO to comply with treatment protocols, given new directives for the COVID-19 context and the need to apply IPC measures.

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

Developed the referrals tracking mHealth app

Indirect: ✔ 2.3.1 ✔ 2.3.3

One of the activities to monitor the indicator over the life of the project is putting in place a digital mHealth referral tracker (mReferral), accessible via an app. The referral tracker will ensure that referral effectively takes place. In addition, the tracker will allow the DRC Ministry of Health (MoH) to collect data on patients referred from *Sites de Soins* to *Centres de Santés* and the number of patients who arrived at the referred facility, and it will reinforce timely reporting.

Previously, between February and March 2020, USAID IHP conducted trainings with health workers on mReferral in Haut-Katanga and in Tanganyika and implemented a pilot in three provinces with users of the mReferral. During Quarter 3, USAID IHP focused efforts on refining the design and functionality of the tracker and developing a user manual. Based on feedback from initial users, USAID IHP will make the following updates to improve the app's functionality next quarter:

1. Language selector for users in French, Swahili and Tshiluba.
2. A "contact" option for agents at RECO sites to request help from their supervisors.
3. Updates to questions and terminologies used in the app.

Next steps in the operationalization of mReferral are to: finalize the system's functionality and user interface and procure a toll-free shortcode from local authorities for SMS-based communications as a referral system. The previously planned pilot in June 2020, cancelled due to COVID-19 travel restrictions, has been rescheduled for November and December 2020, once restrictions are lifted. To mitigate impact on the implementation plan, USAID IHP is also considering a remote training model.

Provided community based organizations with guidance for disseminating messages on identification of danger signs and criteria for referral

Direct: ✔ 2.3.1 **Indirect:** ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 ✔ 19 ✔ 2.6 ✔ 2.7 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 2.2.2 ✔ 2.2.3 ✔ 3.1.1 ✔ 3.2.2

To improve the patient referral system, USAID IHP provided technical and financial support for community briefings to disseminate information about danger signs for children under 5 and pregnant women. The briefings targeted RECO, community leaders, journalists, and political and administrative authorities in Tanganyika, Kasaï-Oriental, and Haut-Lomami. The goal of these trainings was to build community members' capacity to identify danger signs and to react quickly to refer people to health facilities for care.

During Quarter 3, in Tanganyika and Haut-Lomami, those trained visited 1,239 households and reached out to 7,018 people, including 4,095 women. They identified 74 children under 5 and pregnant women with danger signs and referred them to health facilities.

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

Organize training for providers on provision of youth and adolescent-friendly services

Direct: ✔ 2.4.2

USAID IHP supported the *Programme National de Santé des Adolescents* (PNSA, National Adolescent Health Program) to train clinical providers on adolescent and youth sexual and reproductive health. This activity took place in Haut-Katanga (5 health facilities in one ZS), Kasaï-Oriental (21 health facilities in three ZS), and Lualaba (12 health facilities in one ZS), for a total of 38 health facilities supported. A total of 59 clinical providers, including 23 women, took part in the training, which used the competency-based approach to improve attitudes and interpersonal communication skills of providers caring for adolescents and young people at health facilities and in the community.

Train young peer educators for adolescent and youth sexual and reproductive health services

Direct: ✔ 2.4.2

In Kasaï-Oriental, USAID IHP supported communications training of 47 peer educators of adolescents and young people, including 27 girls, in four ZS. This activity impacted 20 health facilities, five per ZS. The PNSA provided this training to strengthen peer educators' understanding of the stages of an educational talk and the characteristics of adolescence and adolescent development, while increasing their sensitivity to the needs of their peers, and giving them more information on adolescent and youth sexual and reproductive health.

Conducted SGBV training for health workers

Indirect: ✔ 2.4.3

USAID IHP collaborated with the PNSR to provide technical and financial support to five DPS—Haut-Katanga, Sankuru, Lomami, Kasaï-Oriental, and Kasaï-Central—to establish a pool of locally based

trainers in sexual- and gender-based violence (SGBV), positive masculinity, and gender integration at the DPS. The Program then supported SGBV training for health providers in the same provinces.

By the end of the quarter, USAID IHP established 10 fully trained officials from the DPS in Haut-Katanga, including 3 women. The Program also supplanted the team with teaching materials—including PEP kits, mirrors, combs, and envelopes—to facilitate training in the ZS.

In addition, the Program enabled SGBV training of 111 providers (including 33 women) across ten ZS in the DPS of Lomami (Luputa, Mwene Ditu), Haut-Katanga (Kilwa), Kasaï-Central (Bobozo, Lubondaie, Kalomba, Yangala, Kananga), and Sankuru (Wembonyama, Katako Kombe), with a focus on psychosocial care and gender-informed care.

Of note, the Program noted that, though some women participated in the provider training, limited adherence to the gender aspect in the selection of providers could have a negative impact in the clinical and psychological care and the availability of data collection and clinical care tools for the direct care of SGBV at the health facility level. The Program is devising a strategy to overcome this potential challenge.

IR 2.5 INCREASED AVAILABILITY OF INNOVATIVE FINANCING APPROACHES

Disseminate the flat rate pricing strategy (For tarification forfaitaire)

Indirect: ✔ 2.5.1

During Quarter 3, USAID IHP supported missions to extend flat-rate pricing in Sud-Kivu and Haut-Lomami through COGE meetings in the Minova, Idjwi, Kalehe, Katana, Miti-Murhesa, Bagira, Kadutu, Ibanda, Nyantende, Nyangezi ZS in Sud-Kivu and at the monthly review meetings in the Kamina and Kayamba ZS in Haut-Lomami. At the end of these missions, the health facilities visited posted rates for care and services; COGE members were sensitized; and guidelines were made available to members of management committee of the ZS, who were mobilized to broadly disseminate the flat-rate pricing to CAC and CODESA.

Evidence in previous quarters showed that some health facilities have not applied flat-rate pricing to all services. Reasons for non-application included:

- Lack of community outreach about flat-rate pricing in some *aires de santé*
- Costs that seem exorbitant to the community
- Lack of subsidies for some laboratory and medicine inputs, and frequent stock-outs of medicine
- Pharmacy revenue that is not collected in the package, with most revenues being absorbed by staff bonuses
- Flat-rate pricing that was not negotiated with the population, leaving the community at the mercy of market forces and leading some facilities to return to pricing by illness episode

Given these challenges, USAID IHP is continuing to monitor facilities' application of flat-rate pricing.

Strengthened existing health insurance system (*Mutelles de santé*)

Indirect: ✔ 2.5.1

In Haut-Katanga, USAID IHP supported a mission to establish a baseline assessment of the teachers' mutual organization in the Ruashi ZS, headquartered at the Patient Kiwele High School in the city of Lubumbashi. The biggest challenge for proper functioning of this health insurance organization is irregular contributions from members. USAID IHP will support the training for members and awareness-raising among the population on risk-sharing to make the mutual organization viable.

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

Provided support to communities to build family latrines and handwashing stations in targeted ZS

Direct: ✔ 2.6.3

USAID IHP continued to support community-level awareness and activities that promote sound practices for the construction, rehabilitation, and improvement of latrines and handwashing stations in Sud-Kivu (see Chapter 3, WASH section). Overall, the project supported 1,018 people to gain access to basic sanitation services (see Table 37). These lower-than-expected results were due in part to lack of availability of input materials at the local level and partly due to the shift in Program strategy during this quarter from community-based WASH to the clean clinic approach, per consultation with USAID. As USAID IHP launches health facility improvements through the clean clinic approach, more community members will benefit from access to such services.

Table 37. Number of people gaining access to a basic sanitation service as a result of USG assistance (2.6.3)

Planned cumulative target	Annual cumulative actual	Annual performance achieved (%)	Number of people with improved access to a basic sanitation service in Quarter 3						Target (#)	Achieved (%)
			April 2020	May 2020	June 2020	Achieved (#)	Male	Female		
5,612	1,018	18%	262	354	402	1,018	492	526	2,806	36

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

Joint technical meetings USAID and USAID IHP

During Quarter 3, technical meetings were organized between USAID and USAID IHP teams in MNCH, gender, RH/FP, nutrition, WASH, and TB. The Program management team recommended these technical meetings to maintain and strengthen communication between the two teams, help USAID IHP anticipate details about questions arising from the quarterly report, and gather strategic and technical guidance from USAID on implementation of interventions and planning for FY2021. These meetings included regular updates on activities to combat COVID-19. Actions taken included bi-monthly

monitoring of 10 quality indicators for TB interventions, development of targets for MNCH and WASH indicators, and sharing of information on availability of FP inputs and supplies.

Support technically and financially the TB / HIV task force quarterly meetings

Indirect: ✔ 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 ✔ 2.7.1

In Kasaï-Central, Lomami, Lualaba, and Sankuru, USAID IHP provided technical and financial support for a TB/HIV collaboration meeting between PNLT and the PNLS, convened quarterly by the DPS and attended by other MOH partners. Points discussed related mainly to evaluation of recommendations from the previous meeting, evaluation of joint TB/HIV activities in the ZS, drug inventory levels, and the development of an improvement plan. This cooperation is intended to improve results for INH preventive therapy for PLHIV. USAID IHP will monitor progress during Quarter 4.

Provide financial support to activities of the CTMP PF

Indirect: ✔ 2 ✔ 3 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.1.1 ✔ 2.1.17 ✔ 2.1.26 ✔ 2.4.2 ✔ 2.7.1

USAID IHP provided technical and financial support for meetings of the CTMP-PF in Kasaï-Central, Kasaï-Oriental, Lomami, Haut-Katanga, Lualaba, and Tanganyika. Points covered during the CTMP-PF provincial meetings included: (1) evolution of FP indicators in the Lomami DPS, concentrating on the roles of existing thematic groups; (2) development of a work plan in Tanganyika that clearly describes the chronology of activities; (3) non-disbursement of resources promised by the provincial government in Sud-Kivu for purchase of contraceptives and drafting a terms of reference for training on FP and awareness messages; (4) updating FP stakeholder mapping with areas of intervention for each stakeholder group in Lualaba; (5) development of consensus on a promotional communication plan for FP and a major radio campaign to sensitize women of childbearing age on FP in Kasaï-Central; (6) monitoring of the Kasaï-Oriental provincial government's commitment to FP by creating a budget line for purchase of contraceptives; and (7) availability of contraceptives during the COVID-19 pandemic in Kinshasa to secure stocks, monitoring of FP indicators, evaluation of the Fourth National Repositioning Family Planning Conference in the DRC, preparations for evaluating the national strategic plan for family planning in the DRC 2014–2020, and development of the new strategic plan 2021–2024.

Coordination meeting of the Ministry of Health

During the COVID-19 pandemic, USAID IHP provided technical and financial support to the MOH at the national level to continue coordinating activities and developing guidelines for implementation of programs. The Program supported the PNSR, the CTMP-PF, the IMNCI committee, the sub-committee on community health of the Service Delivery, Implementation, and Monitoring and Evaluation Committee, and the monitoring and evaluation committee.

LESSONS LEARNED

- The DQI revealed most health centers do not correctly comply with treatment protocols, despite the training received, a situation that hinders the quality of care and services. The Program will determine how to support ECDPS and ECZS to motivate compliance.

- Training providers and distributing IPC kits helped providers ensure continuity of essential services during the COVID-19 pandemic, while enabling people to safely use health facilities.
- Disseminating danger signs to community participation bodies improves the referral and counter-referral system between iCCM sites and health centers in aires de santé.
- The institution of regular USAID - USAID IHP technical meetings helped align USAID IHP implementation strategies with USAID's strategic guidelines, priorities, and technical support for Program implementation.
- Holding regular CTMP-PF meeting with all FP stakeholders helps assess general planning and the availability of inputs, identify new strategies, update FP stakeholders mapping, and conduct advocacy in favor of FP to increase contraceptive prevalence.

NEXT STEPS

- USAID IHP and the DPS will monitor use of IPC equipment provided and improvements in the quality of service based on use rate of services and compliance with MOH protocols and directives
- Extend provision of IPC equipment to additional health structures
- Continue to support iCCM sites and supply them with drugs and other inputs.
- Provide community based organizations with guidance for disseminating messages on identification of danger signs and criteria for referral in all USAID IHP-supported provinces and report the data.
- Follow up with the provincial PNSA committees in the ZS already covered through meetings (focus groups) with peer educators
- Organize these meetings regularly, despite the challenges of conflicting schedules and the need to hold online meetings (while taking into account poor Internet connectivity).
- Document the actions of the CTMP-PF in mobilizing resources and strategies for increasing the prevalence of contraceptives during the COVID-19 pandemic
- Continue to advocate for all stakeholders to fulfill their commitments

6. OBJECTIVE 3

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

Water purification demonstration during World Water Day in Kasa-Central. (*Credit:* Aime Tshibanda, Pathfinder for USAID IHP)

- **106,826 people** reached during World Malaria Day campaigns in five provinces.
- **Three community champion initiatives** supported – two in Kasaï-Central and one in Sud-Kivu.
- **472 pregnant women** reached, **92 received ANC services**, and **64 were treated for malaria** as a result of a community champion campaign in Tanganyika.
- **34 mini-campaigns** organized that reached **229,083 people**

During Quarter 3, USAID IHP and Breakthrough action effectively started the joint implementation of VIVA, the multi pronged healthy family campaign and agile entertainment education program, co-designed under the technical leadership of Breakthrough Action and in collaboration with the Ministry of Health National Program on Social and Behavior Change Communication.

Under this umbrella formula, several activities take place, in continuity with earlier SBC activities and as new additions in support of achieving high prevalence of accelerator behaviors : the celebration of the World Malaria Day; the organization of mini-campaigns and community forums, the organization of awareness campaigns on the Ebola Virus Disease (EVD) and the prevention of COVID-19, the organization of SMS and IVR based campaigns and finally, the strengthening of collaborations with civil society organizations. USAID IHP continued to build networks of people committed to applying gender equality in practice.

IR 3.1: INCREASED PRACTICE OF PRIORITY HEALTHY BEHAVIORS AT THE INDIVIDUAL, HOUSEHOLD, AND COMMUNITY LEVELS

Support organization of World Malaria Day

Indirect: ✔ I2 ✔ I3 ✔ I4 ✔ I5 ✔ 2.3.1 ✔ 2.3.2 ✔ 3.1 ✔ 3.2.2

The DRC celebrated World Malaria Day under the theme "Zero Malaria Starts with Me." The Program technically and financially supported the celebration in five provinces: Haut-Katanga, Haut-Lomami, Kasaï-Central, Lualaba, and Sankuru. Due to COVID-19, no celebrations were organized in the other provinces). Celebrations took place in two phases: the first included the official kick-off by local political and administrative authorities; the second included an awareness campaign and referral of cases to health facilities and iCCM sites. In opening remarks, local political and administrative authorities (Bourgmestres and Territorial Administrators) insisted on prevention of malaria especially for the most vulnerable groups: pregnant women and children under 5. They issued a call to action for using ITNs, RDTs, and IPT for pregnant women and urged care-seeking for fever, especially for children under 5. Across the five provinces, the awareness campaign sensitized a total of 106,826 people. The Program supported the DPS and the ZS to brief RECO and deploy them into communities, where they conducted household visits to pregnant women and referred them to health facilities. Among the women reached, 1,276 attended ANC visits and received S/P. The campaign also referred 1,864 children under 5 with fever to the health centers, where 1,452 tested positive for malaria and received treatment.

Developed communication and media plans for VIVA campaign in collaboration with BA

Indirect: ✔ 2.2.1 ✔ 2.3.1 ✔ 2.3.2 ✔ 3.1.1 ✔ 3.1.2 ✔ 3.2.2 ✔ 3.3.1 ✔ 3.4.1

USAID IHP in collaboration with Breakthrough Action (BA) supported training of field staff in 18 ZS across five provinces. USAID IHP staff co-facilitated the training and supported drafting the training report. The Program held a training-of-trainers for 19 people (three women and 16 men) to carry out the VIVA campaign in six provinces: Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, Lualaba, and Sud-Kivu. The training strengthened the capacities of senior staff from the DPS and ZS by focusing on health aspects to be improved, interventions, essential family practices, and planning of VIVA campaign activities.

RECO sensitize a household in Kalenda Gare, Lomami. Credit: USAID IHP.

Concurrently, the Program trained 366 RECO (including 135 women) to use the awareness materials, data collection tools, and facilitation techniques. The training—implemented in six provinces (Kasaï-Central, Kasaï-Oriental, Lomami, Lualaba, Haut-Katanga, and Sud-Kivu)—will continue next quarter to cover all *aires de santé* in 18 targeted ZS. This training aimed to empower RECO to effectively promote essential family practices in the community, raise awareness, and sensitize the population on use of health services. The training also enabled review and ZS validation of action plans to optimize human and financial resources and set timelines for communication activity. Multisector mobilization committees were established and placed under the responsibility of the ZS community activity leaders to monitor implementation of the campaign in the targeted *aires de santé*. This training was facilitated by the nine ECZS managers, with technical support from three DPS managers, supported by BA and USAID IHP. Members of the provincial Communication Task Force (including the DPS Communication Officer and the civil society representative) helped explain how the community participation bodies should function.

Trained journalists and community agents to use multimedia in exclusive breastfeeding

Indirect: ✔ 2.1.7 ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 3.2

USAID IHP provided technical and financial support for training 33 journalists (8 women and 25 men) on awareness materials for exclusive breast feeding and IYCF in Lomami and Sud-Kivu. In Sud-Kivu, the training included 10 RECO, five registered nurses, three ECZS staff, and five Family Health International

staff. PRONANUT facilitated the training in both provinces, followed by translation of key messages on exclusive breastfeeding in local languages (Swahili, Tshiluba, Kisonge, Kanyoka, and Mashi), which were then broadcast via several radio channels. In Lualaba, the Program participated in the pilot test of exclusive breastfeeding prototype with Breakthrough Action using the behavioral economics approach. Various interviews conducted in the community revealed that engaging mothers, fathers, service providers, community leaders, village chiefs, and religious leaders was essential for parents and relatives to adopt and sustain exclusive breastfeeding.

Supported dissemination of radio messages to raise awareness about COVID-19

Indirect: ✔ 3.2.2 ✔ Indicators to track progress on COVID-19 prevention and control are pending USAID approval.

During Quarter 3, the Program supported DPS efforts to strengthen the COVID-19 disease prevention and response action plan in all nine provinces by improving people's attitudes and priority behaviors, including social distancing and good hygiene practices. The DPS led workshops for translating COVID-19 awareness materials into local languages in all provinces. Community members, public radio station managers, and members of civil society attended these workshops. The Program also supported printing and distribution of 5,500 leaflets and 1,180 posters and broadcast awareness messages through community and public radio stations. The DPS trained 315 RECO to act as town criers and 26 journalists to spread messages about the risks of contamination and methods of prevention.

Additionally, in Sud-Kivu, USAID IHP supported 24 community forums on COVID-19 in six ZS for 159 people, including 73 women. These forums focused on transmission modes, consequences, and preventive measures. Participants then spread these messages to 1,945 people, including 758 women.

Continued implementation of the community champions model

Indirect: ✔ 1.2 ✔ 1.3 ✔ 1.4 ✔ 1.5 ✔ 2.4 ✔ 2.5 ✔ 2.1.2 ✔ 3.1.1 ✔ 3.1.2 ✔ 3.2.2 ✔ 3.3.1

In Quarter 3, USAID IHP supported the relaunch of three community champion initiatives—two in Kasaï-Central and one in Sud-Kivu—and supported ongoing activities in Lualaba and Tanganyika. In Sud-Kivu, an eight-member transitional committee of five men and four women was established in the presence of the representative of the territorial administrator. Following this, 6,987 people (2,903 men and 4,084 women) were sensitized on ANC, with 414 pregnant women using ANC services and 34 children under 5 with fever referred to health centers. In Kasaï-Central, steering committees for two community champions developed new action plans to resume awareness activities and referral of cases of malaria, ANC, and TB to health facilities. In Tanganyika, the community champions raised the awareness of 472 pregnant women and referred 186 to health facilities; 92 of them received ANC and S/P and 64 tested positive for malaria and were treated. In Lualaba, the Program supported six champion communities to organize awareness sessions for 3,281 people (2,133 women and 1,148 men) on the importance of ANC and malaria prevention; these sessions also referred 112 pregnant women to health facilities for appropriate care.

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

Provide support to Q&A games competitions in secondary schools

Indirect: ✔ 3.1.1 ✔ 3.2.2 ✔ 3.3.1

USAID IHP provided financial and technical support to a quiz competition for 130 students (68 boys and 62 girls) in Tanganyika. This activity promoted components of adolescent and youth sexual and reproductive health: sexual responsibility, contraception, prevention of STIs and HIV, prevention of youth violence, and avoidance of harmful sexual behaviors. A group interview facilitation technique allowed all participants to express opinions based on a pre-defined questionnaire. At the end of the activity, the majority of the young people stated it was important to avoid any form of violence, including sexual violence. They acknowledged the importance of contraceptive products and demonstrated knowledge of how to avoid STI/HIV. The next steps will be to intensify awareness of adolescent and youth sexual and reproductive health and support facilitation of sessions by youth peer educators.

Provided technical and financial assistance for mini-campaigns in malaria, FP, TB, nutrition, childbirth, diarrhea, and WASH

Indirect: ✔ 2 ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.4 ✔ 2.5 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 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 ✔ 3.1 ✔ 3.1.1 ✔ 3.1.3 ✔ 3.2.2 ✔ 3.3.1

The Program supported 34 mini-campaigns in eight provinces (Haut-Katanga, Haut-Lomami, Lualaba, Kasaï-Central, Kasaï-Oriental, Sankuru, Sud-Kivu, and Tanganyika) on malaria, family planning, TB, nutrition, childbirth, diarrhea, and WASH. Of the 229,083 people sensitized on these themes (including 140,656 women and 88,427 men), 15,812 people were referred to health facilities and 7,538 used the different health services. The Program also supported community champions in three provinces (Sud-Kivu, Tanganyika, and Kasaï Central) to raise awareness on malaria and ANC, which sensitized 29,333 people. In Sud-Kivu, RECO and five community champions implemented malaria awareness activities.

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

Organized focus group discussions

Indirect: ✔ 2 ✔ 3 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.1.1 ✔ 3.1.1 ✔ 3.2.2 ✔ 3.3.1

USAID IHP supported the organization of 56 focus groups to gather opinions of 679 young people, including 248 girls and 431 boys, on the low use of sexual and reproductive health services in Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Sud-Kivu, and Tanganyika. In Lualaba, community forums facilitated by ECZS and DPS managers focused on socio-cultural barriers to using ANC services. They were attended by 300 adults (162 men and 138 women). In Sud-Kivu, the Program supported four community forums that brought together 50 young people, including 27 girls and women. These open exchange and discussion sessions on youth health issues led to the identification of priority youth health problems in the targeted *aires de santé*, namely STIs, early marriage, early pregnancy, sexual violence, induced abortion, and birth spacing.

Community forum in Lualaba. Credit: Patrick N'duwa, MOH for USAID IHP.

Supported ECZS to map key influencers and develop an engagement plan

Indirect: ✔ 3.2.2

In Quarter 3, USAD IHP supported the Haut-Katanga DPS to organize exchange sessions with 350 community, religious, and traditional leaders and other influential community members (including 132 women and 218 men) to identify priority health problems. Based on the synthesis of the exchanges with participants, the following priority problems emerged: high costs for care, poor access to drinking water, low use of ANC and post-natal care services, poor household waste management, and poor detection rates for TB. The DPS developed an engagement plan to share with the ZS for further improvement.

IR 3.4: INCREASED COLLABORATION BETWEEN THE CENTRAL AND DECENTRALIZED LEVELS THROUGH THE SHARING BEST PRACTICES AND CONTRIBUTIONS TO THE POLITICAL DIALOGUE

Organized coordination and collaboration meetings with Breakthrough Action

Indirect: ✔ 2.7.1 ✔ 3.1.1 ✔ 3.2.2 ✔ 3.3.1 ✔ 3.4.1

In Quarter 3, USAID IHP and Breakthrough Action held three coordination meetings in three provinces (Kasaï-Central, Kasaï-Oriental, and Sud-Kivu) on VIVA campaign implementation strategies, including plans for training of trainers and development of communication activities. The Program provided support for strategic roll-out input and continued refinement of potential SBC materials. Participants

incorporated prototype testing feedback into the "Health Boardgame" and shared design adjustments to the radio drama and "Health Game." In Kasaï-Central, the workshop focused on harmonzing terms of reference for training registered nurses in three ZS, to be approved by the DPS. In Kasaï-Oriental, the workshop assigned responsibilities for organizing community stakeholder briefings on the VIVA campaign and developed the joint implementation plan for SBC activities in six ZS. In Sud-Kivu, the workshop focused on harmonizing perspectives on implementation of VIVA campaign strategies, in particular training of trainers from the DPS and ZS in two pilot ZS, 25 people participated, including 16 men and nine women. In Sud-Kivu, staff also covered implementation strategies of the VIVA campaign, to begin in Quarter 4 with DPS training-of-trainers, followed by training stakeholders in two pilot ZS.

Supported *équipe cadre provinciale* and ECZS to document good practices and present them as success stories

Indirect: ✔ 2.7.1 ✔ 2.7.2 ✔ 2.7.3

During Quarter 3, USAID IHP supported two experience-sharing meetings with the DPS and civil society in Sud-Kivu and Tanganyika. The objective of the activity was to strengthen the capacities of the DPS and ECZS managers to document interventions successfully implemented in the ZS. In Tanganyika, this activity helped participants understand and master the process of writing a success story. ANC benefits in Kalemie ZS were selected for next quarter's success story. Nineteen ANC and ECZS managers—16 men and three women—joined in these sharing meetings and practice sessions.

Organized communities of practice on gender

Indirect: ✔ 24 ✔ 2.1.27 ✔ 2.7.1 ✔ 3.3.1

The Program supported organization of exchange meetings with the DPS on gender mainstreaming in Sud-Kivu, Sankuru, and Tanganyika. In Sud-Kivu, these meetings encouraged DPS managers to integrate the gender dimension in deployment of human resources. The head of the Health Division of Sud-Kivu, DPS members, the Gender and Family Division, and the civil society representative of Sud-Kivu reiterated individual and collective commitments to lead advocacy for gender mainstreaming in recruitment of DPS human resources. In Sankuru, two sessions were facilitated by two PNSR managers in the presence of the Territorial Administrator of Lodja and the Head of the Sector. Participants included 13 women and 21 men, representing local associations working on gender promotion. In Tanganyika, 19 participants, including 13 women and six men, attended the PNSR's experience exchange meeting on gender mainstreaming in communities by and through the CBOs and the ZS.

LESSONS LEARNED

- World Malaria Day provided an opportunity to remind pregnant women, husbands/partners, and the community of the benefits of ANC so they can receive malaria prevention services and seek care for children under 5 who are suffering from fever.
- Participants appreciated new communications prototypes, including the baby basket and quizzes in the markets. Each ZS developed its VIVA campaign action plan with the new awareness materials for behavior change and promotion of essential family practices.
- During the training, engaging journalists in the translation of local messages helped them understand the relevance of exclusive breastfeeding, resulting in dissemination of messages at no extra cost.

NEXT STEPS

- Organize the VIVA campaign in collaboration with Breakthrough Action in the ZS of Kanda Kanda, Luputa, and Mwene Ditu; kick off VIVA campaign and monitor its implementation.
- Contract with more community radio stations for wider dissemination and broadcast of messages on exclusive breastfeeding. Follow up on the dissemination of messages and broadcasts of program.
- Support meetings in champion communities on a rotating, regular basis in the *aires de sante*. Support the analysis of the champion communities' activity reports produced with the registered nurses of the *aires de santés*.

7. REPORTING ON ADDITIONAL AREAS

GENDER

USAID IHP continued to implement gender activities during FY2020 Quarter 3, despite challenges resulting from the COVID-19 pandemic. The Program adapted certain activities due to the Government of the DRC (GDRC)-imposed social distancing requirements: these included the gender audits and gender champion network awareness-raising activities. To accommodate COVID-19-related requirements, the Program reduced the number of participants for certain meetings/trainings, moved meetings/trainings to a virtual format when possible, and in certain cases, postponed activities to a future date. The development of the MOH gender audit survey protocol and subsequent data collection, which was to be conducted in collaboration with the Ministry of Gender, Family, and Children, was delayed due to COVID-19 travel restrictions from Kinshasa to the provinces.

USAID IHP established five gender champions networks in Haut-Katanga, Haut-Lomami, and Sankuru, consisting of men and women committed to promoting gender equality. The Program also supported the implementation of action plans for the previously established gender champions networks (in Tanganyika, Kasaï-Oriental, Sankuru, and Lomami). These action plans focused on changing behavior to ensure equal access to health services and other resources at the community level.

USAID IHP also provided technical and financial support for the revitalization of CAC in four ZS in Kasaï-Oriental and two ZS in Kasaï-Central (see IR 1.3). The Program integrated modules on gender and women's rights and supported the DPS in Tanganyika and Lualaba to orient their senior staff on gender integration in their human resource deployment plan.

To ensure sexual and gender based violence (SGBV) victims' access to basic social services, in particular mental and physical health services, USAID IHP supported the training of ZS service providers in Tanganyika, Sankuru, Lualaba, and Lomami. At the provincial level, the Program continued to support community review meetings on gender to facilitate sharing, learning, and networking on gender inclusion in program implementation.

Finally, USAID IHP supported a rapid impact analysis of COVID-19 containment measures on domestic, sexual and gender-based violence.

Fostered monthly community reviews on good gender integration practices

To address the lack of gender sensitivity in the day-to-day operations of most of state-run and private health structures and CBOs, USAID IHP continued with monthly practice community sessions in three ZS in Sankuru, two ZS in Tanganyika, two ZS in Haut-Lomami, one ZS in Kasaï-Oriental, and one in Lomami. These sessions had the following objectives:

- Increase gender sensitivity of actors at the personal, interpersonal, and community levels within their respective organizations by clarifying key gender concepts;
- Analyze the gender equality situation in organizations and structures; and
- Share good practices and examples of experiences that integrate gender sensitivity into work with survivors of gender-based violence, including sexual violence.

These sessions allowed participants to share experiences and discuss social norms, positive masculinity, and gender equality, and their influence on attitudes and relations among community members.

Set up gender champions networks

The gender champions model seeks to integrate a network of gender champions in communities within ZS to increase the representation of women in public and community institutions. The purpose of establishing gender champions networks and training their members is to improve priority health attitudes and behaviors at the individual, family, and community levels.

Photo: USAID IHP

Gender champion network member during a USAID IHP-supported training in Kilwa ZS.

USAID IHP piloted the gender champions network model in two ZS in FY2020 Quarter 1, expanded it to two additional provinces in Quarter 2, and expanded it to five more provinces during Quarter 3. The model allows for a better understanding of the benefits of respecting the rights of others, especially the rights of women, and the importance of women's participation in decision-making processes, including decisions on access to health care.

During this quarter, USAID IHP established five additional gender champions networks: one in Kilwa ZS in Haut-Katanga, one in Kamina ZS in Haut-Lomami, one each in the Lomela, Wembonyama, and Katako ZS in Sankuru. The Program also supported the election of steering committee members for each network.

Conducted Impact Analysis of Covid-19 Containment Measures on Domestic, Sexual and Gender-Based Violence

To mitigate if not limit the spread of COVID-19 in the DRC, the GDRC's regulatory order of March 24, 2020, established a state of emergency. Several measures were put in place to guarantee public health order, and the pandemic forced many members of Congolese communities to remain confined in one place. This has led to a resurgence of domestic violence between spouses or partners because their habits and customs have been altered to the point where disagreements and disputes have resulted in physical violence, ranging from willful assault and battery to sexual violence in some cases.

Other achievements

- Seven provincial USAID IHP gender focal points participated in five webinar sessions on USAID IHP's gender strategy

Lessons Learned

- Community review meetings have helped increase women's leadership roles in CBOs and community structures at the ZS level. Specifically, they have allowed more women to be elected and to participate as elected members of steering committees. This is a direct result of the Program's support for the revitalization of CAC and CODESA and established champion communities.
- USAID IHP's engagement in the humanitarian and protection coordination mechanism in Tanganyika presents an opportunity to further identify needs for service provider training on SGBV support.
- After Kasaï-Oriental incorporated the module on the roles and responsibilities of men and women in the community, the number of women occupying leadership positions in CAC increased from 115 to 251 (Table 38). This helped improve results for USAID IHP Indicator #1.3.3 (Number of community service organizations (CSOs)/health area development committees (CODESA) supported by the program that are woman-led or with a mission focus on gender equality and/or GBV).

Table 38. Number of Women Occupying Leadership Roles at CAC Level by the end of Quarter 3 (Kasaï-Oriental)

ZS	Officials who participated in establishing new CODESA leadership		Elected members of newly established CAC	
	Male	Female	Male	Female
Bibanga	10	8	185	75
Cilundu	15	0	145	45
Dibindi	8	5	92	50
Mpokolo	7	8	123	81
Total	**30**	**21**	**545**	**251**

Next Steps

- Support the MOH gender unit in finalizing its action plan;
- Continue with the implementation of gender champions networks in Haut-Lomami, Kasaï-Central, Lualaba, Haut-Katanga, and Sud-Kivu; and
- Organize a gender audit in the nine DPS offices and selected ZS

CONFLICT SENSITIVITY

During this quarter, USAID IHP analyzed the data from the Progam's second conflict sensitivity analysis (CSA). Building on lessons learned from the first CSA, the second analysis builds on data collected from 313 key informants and participants in 64 focus group discussions, and from 49 participants in the perception survey conducted in Quarters 2 and 3. The analysis also served as an opportunity to evaluate the first CSA and develop the second conflict sensitivity implementation strategy. Key findings include the following:

Stakeholder perception survey

- ***For the conflict-sensitivity integration and community acceptance dimension.*** (1) Project staff self-reported their comprehension and their application of conflict sensitivity principles in their work: The vast majority of staff reported that project leadership and project staff understand and support/apply conflict-sensitivity in their work (87 percent agreed for leadership and 96 percent for

project staff). Most also agreed that staff are encouraged to report negative impacts of the project (83 percent) signaling that opportunities exist to discuss conflict-sensitivity at the field level. (2) Respondents self-reported community acceptance of USAID IHP: Respondents reported overwhelmingly that staff have positive relationships with local organizations and acceptance by communities. This highly positive response occurs despite lower scores for systematic engagement with communities; for example, only 38 percent agreed that community feedback was regularly collected and analyzed and 41 percent agreed that communities were oriented on Do No Harm and reported easily to the project on impact of project on conflict.

- ***For the resource transfers dimension.*** (1) Respondents agreed that USAID IHP is strengthening health services, but responses were mixed on whether those efforts led to more engaged local heath staff: Project staff strongly believe the project is strengthening the health system and not delivering parallel services (91 percent of respondents in agreement), however respondents were mixed on whether health staff are more or less engaged than before the project (only 52 percent of respondents agreeing that health staff are more engaged than before the project). On this question, respondents were split nearly down the middle as to whether the local health staff (not part of the project) were more engaged in delivering services than before the project. (2) Respondents perceived USAID IHP did not negatively impact existing community tensions: Project staff generally did not perceive the project to have reduced tensions between groups (29 percent of respondents believing tensions had been reduced) or they did not know if there had been an impact on the reduction of violence (36 percent of respondents). Very few project staff (7 percent of respondents) reported the project had caused an increase on tensions in the community.
- ***For the implicit ethical messages dimension.*** (1) Staff reported relatively positive engagement and behaviors when interacting with beneficiaries and communities: Overall, staff reported quite positive engagement and behaviors when interacting with beneficiaries and communities. The majority of respondents (95 to 100 percent of respondents) reported treating clients in a respectful and fair manner. They also noted that staff work well together and use the resources of the project in a responsible manner. (2) Staff reported consistently high responses for the behavior and actions of the EEI: This series of questions pertains to how project EEI teams' behaviors and actions may reinforce or reduce tensions between groups in the community. Overall, responses were consistently high for the behavior and actions of the EEI. The lower scores were similar to staff survey in terms of transparency of information with communities along with representativeness of project staff. Similar to the above, these answers may have been affected by desirability bias.

Focus group discussions and key informant interviews

- ***Eastern Congo region.*** In Sud-Kivu, findings suggested the most important conflict involved customary power and tensions between farmers and cattle breeders from different ethnic groups. This high-level conflict manifested in kidnapping and armed groups aligning themselves with one of the main ethnic groups. In Tanganyika, findings documented tensions between the Bantu and Twa/Pygmee ethnic groups, sometimes escalating to open violence.
- ***Kasaï region.*** Kasaï-Central findings suggested two key conflicts: customary conflict and tensions between returning Congolese refugees from Angola and the host population. Informants reported conflicts involving land, fishing, mining, religion, and the problematic administration of the health sector, although they also reported that these conflicts are generally localized and resolved peacefully. Findings from Kasaï-Oriental demonstrated three main conflicts that have increased community tensions: problematic administration of the health sector, customary conflict pertaining

to land and mining, and the multiplicity and inconsistency of road taxes for motorbikes and bicycles plus the increase in illicit taxation barriers. Lomami data revealed three conflicts, the main one being between two major ethnic groups (Bakete and Baluba), linked to complex customary power arrangements and the location of certain health services. Informants in Sankuru reported no significant conflicts linked to ethnicity, geography, or land.

- ***Katanga region.*** Lualaba findings suggested customary conflicts, linked to family heritage/lineage, as the main source of tension in communities, which occasionally transforms into localized violence. In Haut-Lomami, the key source of community tensions was the origin of individuals (shore of the river/lake and land). Informants also cited customary conflicts and targeted kidnapping. In Haut-Katanga, informants identified various localized community conflicts such as unequal distribution of power between the Bantu and the Twa, permanent and recurrent hostility between people from Kasaï and Luba Kat, and permanent conflict between southerners and northerners in greater Katanga. However, those localized conflicts do not result in broader community tensions.

Implementation strategy. Analysis findings suggested that USAID IHP needs to adopt the measures below to improve conflict sensitivity and Do No Harm practices of Program and health sector staff:

- ***Program and health staff capacity.*** (1) Establish a Program-wide Community of Practice—a virtual space to exchange ideas and strategies to decrease community tension. (2) Increase USAID IHP focal point training opportunities on conflict sensitivity, Do No Harm, and gender transformation to ensure sufficient capacity to analyze context and behavior. (3) Introduce routine practices in conflict resolution, negotiation, and Do No Harm to promote conflict sensitivity champions.
- ***Project management processes.*** (1) Enhance focus on the collection and analysis of community feedback, and take action based on that feedback, to ensure that USAID IHP programming and staff are responsive to the Congolese population and health sector staff. (2) Strengthen community feedback mechanisms to provide a way for the Congolese population to constructively engage with USAID IHP staff to proactively address misperception and tensions. (3) Develop and implement a conflict and Do No Harm monitoring tool and dashboard to continuously capture community tensions and conflicts that may impact USAID IHP results and that the Program may inadvertently impact.
- ***Do No Harm training of trainers.*** USAID IHP identified all Program staff and partner participants for a virtual Do No Harm training of trainers. The training will increase participants' understanding of contextual risk factors in local implementation settings and ensure that the Program supports Do No Harm behaviors and practices. The training will also address critical technical gaps identified in the second conflict sensitivity analysis. USAID IHP will implement this training in FY2021.

ENVIRONMENTAL MITIGATION AND MONITORING

During this quarter, USAID IHP carried out three major activities that had environmental mitigation and monitoring were at the forefront: the clean clinic approach, the design of supply chain training, and the rehabilitation of gravity flow water distribution systems. In addition, the Program employed and promoted COVID-19 risk mitigation measures, including social distancing, mask-wearing, and work-from-home measures for staff in affected areas. The Program also supported improved IPC measures and provided PPE.

Under the framework of clean clinic approach activities, USAID IHP continued training of trainers and providers in Sud-Kivu and Kasaï-Central. In Quarter 3, USAID IHP trained 185 providers (60 in Sud-Kivu and 125 in Kasaï-Central) on various topics, including a module on WASH in health care settings (see section on WASH in Chapter 3). Through this module, providers learned necessary measures for managing medical and biomedical waste and other aspects requiring compliance with environmental regulations.

In addition, USAID IHP and the ECZS supported the providers who took the clean clinic training to self-assess their facilities to identify and analyze WASH issues. Based on those results and the results of the Program's complementary Knowledge, Attitudes, and Practices survey, providers developed plans to address their WASH infrastructure needs.

A part of the clean clinic approach, USAID IHP helped establish 37 health and hygiene committees (12 in Sud-Kivu and 25 in Kasaï-Central). These committees ensure sound WASH management practices, including:

- Ensuring water supply (e.g., quantity, availability, and quality of water);
- Management of latrines, showers, hand hygiene, and hand-washing stations;
- Sanitation (e.g., management of waste water from latrines and showers);
- Management of outdoor garbage cans, garbage pits, and incinerator ash pits;
- Management of the external environment (e.g., weeding, lawn maintenance, painting, fencing);
- Management of exterior lights and/or generator sets;
- Cleaning and disinfection of premises;
- Monitoring of the wearing of PPE; and
- Management of biomedical waste (minimization, sorting, collection, transport, and treatment and elimination).

USAID IHP designed a supply chain management training course during the quarter, including a module on the management of pharmaceutical waste. Once this course is finalized, USAID IHP will support training of management teams (MCZS and pharmacists) in all USAID IHP-supported ZS. The Program will supplement training by developing and distributing a poster that summarizes key messages in biomedical and pharmaceutical waste management to health facilities.

Lastly, as part of rehabilitation of the gravity flow water distribution systems in Lwiro and Kabamba in Sud-Kivu, USAID IHP developed and distributed a checklist of environmental mitigation measures to local stakeholders as recommended in the Environmental Mitigation and Monitoring Plan (EMMP).

8. ACTIVITY RESEARCH, MONITORING, AND EVALUATION

Evaluated and reviewed fee and Project Monitoring Report indicators

As USAID IHP implements the program and report on activities using the AMEP, the Program has been documenting difficulties that arise as staff report indicator data. The program indicators and performance indicator reference sheets (PIRS) were approved in Nov 2018, and many definitions need to be updated to better reflect the reality of data collection.

This quarter, USAID IHP began a robust evaluation process to review indicators to better reflect the intention, desired results and achieved results of program implementation. The Program organized a workshop that split the technical teams into result areas, led by the RM&E team. The teams used specially developed tools to review and document aspects of each indicator that is measured using the program monitoring report (PMR). These indicators are unique to USAID IHP, and no other source of data collection exists. The teams assessed the PMR indicators for usefulness and progress toward desired results. The teams then evaluated program performance and discussed whether the current definitions of program indicators allow the Program to accurately measure performance, and proposed changes in instances where definitions did not.

During the next quarter, teams will validate the proposed changes to indicators and submit them to USAID for overall review and approval, in tandem with the Year 3 work planning process.

Updated the Service Delivery Mapping and Household Survey reports

During Quarter 3, USAID IHP continued to refine and finalize the two baseline reports: the service delivery mapping report and the household survey report. For each report, USAID IHP details major points of progress toward finalization below:

Service delivery mapping report

1. **Updated data analyses, integration, and interpretation**: USAID IHP has updated all available data, formulating comments and monitoring the integration of feedback by the Consultant working on the report.
2. **Addition of new sections**: USAID IHP has added details and clarifications on the limitations, conclusions, recommendations and next steps.
3. **Finalization of the ZS report model**: USAID IHP developed a report model for use at the provincial and ZS levels, to facilitate further use of the mapping data to inform planning as USAID IHP provides TA, particularly at the DPS/provincial level.

   The refinement, translation and formatting exercise will continue during the next quarter and the final report should be shared with USAID in August for final validation.

Household survey report

1. **Updated data analyses and interpretation**: USAID IHP has updated the preliminary report to address the comments made by USAID on the first report submitted.
2. **Addition of SBC analyses and data**: USAID IHP has collaborated with Breakthrough Action to identify priority areas for further SBC analyses, and USAID IHP has refined the draft analysis by Breakthrough Action and incorporated it into the report.
3. The addition of final analyses from Breakthrough Action, refinement and formatting will continue into the third quarter for submission to USAID in August for final validation.

Supported GeoPoll to prepare and present the results of the Community Health Services Survey

USAID IHP planned and conducted activities to share results of the Community Health Services Survey—finalized with partner Geopoll during the previous quarter—with USAID IHP stakeholders for use in formulating intervention strategies and approaches.

USAID IHP held an introductory session on June 17, 2020, bringing together the Abt Associates headquarters team and the technical and RM&E team. During this exercise, the Program shared the survey methodology, target, sampling, results and recommendations on how best to use the findings. Geopoll and the RM&E team also gathered observations and feedback from participants, which focused on details of the methodological and sampling aspects. Geopoll and the RM&E team will use that feedback to enrich the presentation for future dissemination.

The RM&E team also identified additional research questions in different health areas—including Malaria, Maternal and Child Health, Nutrition, Family Planning/Reproductive Health, Tuberculosis and WASH—for which the Program will develop rapid surveys.

By the end of Quarter 3, Geopoll and the RM&E team finalized concept note drafts for each health area's research questions. The concept notes described the proposed background, study objectives, research questions, methodology and sampling aspects. Technical team review and discussions on implementation will continue over the next quarter.

Changes requested by the Institutional Review Board as a result of COVID-19

Several ongoing USAID IHP studies were subjected to review and increased IRB scrutiny to ensure that data collectors are kept safe from COVID-19. Accordingly, USAID IHP headquarters began organizing a remote workshop for the RM&E team to ensure measures are implemented correctly, and that there are no unnecessary delays that will result from improved guidance on data collection methods.

9. ADDITIONAL LESSONS LEARNED

COVID-19 transmission seems to be slowing in the DRC, thanks to successful mitigation measures and lessons learned by health authorities and partners in previous disease outbreaks.

The Program observed how country-wide travel restrictions, the lockdown of Gombe in Kinshasa, and the systematic application of contact tracing resulted in a gradual slowing of the pandemic in DRC. At the same time, often-contradictory information about the pandemic and ways to control it constantly circulates. USAID IHP salutes the central, provincial, ZS, and health facility teams and health workers for their efforts to mitigate the impact of COVID-19 in DRC.

The availability of technology has radically changed the way USAID IHP conducts business.

Person-to-person contact remains important, but amid the limited resources available to ZS, DPS, and IPS, and the logistical challenges created by the pandemic, technology offers opportunities to remotely conduct meetings, trainings, planning sessions, dissemination, and even supervision and coaching. USAID IHP needs to flexibly embrace the "affordable, allocable, and reasonable" approach when dealing with such activities, and aggressively design alternative, cost-effective strategies. For example, USAID IHP found opportunities to adjust the costs of central-level facilitator support (for example, by providing internet connection credit rather than paying for transport, food, and per diem) to continue training at a distance, safely.

COVID-19 has reminded all public health actors that a minimum service delivery platform needs to be in place, funded by public resources, and staffed by the best available human resources.

Even though it is weakly endowed, Congo's health system has been able to address a novel threat in COVID-19, having contained the pandemic's effects to 14 provinces, 7,122 cases, and 175 deaths by the end of the reporting period. Of particular note, GDRC launched a COVID-19 Multisectoral Emergency Mitigation Program to ensure multisectoral engagement to mitigate social and economic effects of COVID-19. The nation also leveraged lessons learned from EVD to launch contact tracing in affected areas of the country, and to ramp up testing in areas most affected. In addition, the MOH assumed leadership to coordinate technical and financial partners, their resources, and their programming to address specific health system needs related to COVID-19. Imagine the pride of country leadership if this resilience had taken place thanks to domestic resources committed to the health sector.

USAID IHP is putting in place measures to address challenges that have impeded the ability to achieve results.

USAID IHP progress has yet to reach planned levels of intervention and has not always been responsive to the sense of urgency of the Program's key counterparts in the MOH, provinces, health facilities, and communities. Many appreciate the Program's interventions, but overall progress has been slower than expected. Also, some Program promises are yet to be fulfilled, including equipment for facilities, motorbikes for ZS, funding for supervision and quality improvement visits, and treatment of MDR-TB. Following the conduct of the baseline service delivery mapping and household surveys and also strategic planning within the Program, USAID IHP has embarked on a process to rejuvenate and rebalance Program interventions across target ZS, which will yield results in future quarters.

ANNEX A: PERFORMANCE INDICATORS, TARGETS, AND ACHIEVEMENTS (FY2020 Q3)

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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†										Data will come from the DHS or MICS survey. Data from the 2017-2018 MICS is not yet available.
		Kasaï										
		Katanga										
		E. Congo										
2	FP: Percentage of married women using any modern method of contraception	Outcome	10.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	10.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	14.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	5.3%	N/A	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	848549	900226	225056	337458	149.9%	N/A	N/A	DHIS 2	We did CBD trainings in line with local norms, community-level counseling, provider trainings on FP and post-partum FP, mini-campaigns led by CBDs, and follow-up home visits to help	To maintain this progress, USAID IHP will continue to supply health facilities with FP inputs, provide ZS with management tools and registers, carry out post-training follow-up for providers and CBDs, and
		Kasaï	368326	390757	97689	136071	139.3%	N/A	N/A	DHIS 2		
		Katanga	272927	289548	72387	127806	176.6%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	207296	219921	54980	73581	133.8%	N/A	N/A	DHIS 2	new acceptors adhere to FP methods.	provide CBDs with kits for service delivery.
4 Fee	MNCH: Percentage of children 0-59 months of age for whom treatment/advice was sought for acute respiratory infection	Outcome	53.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	48.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	54.4%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	76.9%	N/A	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 received treatment for an acute respiratory infection from an appropriate provider	Outcome	1143154	1212772	303193	323543	106.7%	N/A	N/A	DHIS 2	We exceeded our target this quarter. The Katanga region reached 121.2% of its target. Lualaba and Tanganyika reached 142.4% and 157.5% of their targets, respectively, due to a steady supply of medicines and support from partner IRC. Sankuru had the lowest achievement (72.3%) due to	To improve this indicator, USAID IHP plans to support supply chain missions, collaborate closely with GHSC-TA to ensure that medicines are available at regional distribution centers, and organize supervision and monitoring activities by the ECDPS. We are also going to
		Kasaï	569695	604389	151097	156118	103.3%	N/A	N/A	DHIS 2		
		Katanga	229925	243927	60982	73935	121.2%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	343534	364456	91114	93490	102.6%	N/A	N/A	DHIS 2	low availability of ORS+zinc.	review targets for year 3.
6 Fee	MNCH: Percentage of children 0-59 months for whom treatment/advice was sought for diarrhea	Outcome	58.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	55.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	63.6%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	64.1%	N/A	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	1041286	1104700	276175	254553	92.2%	N/A	N/A	DHIS 2	This indicator did not reach its target overall, due to a significant shortage of medicines and antibiotics resulting from COVID-19 movement restrictions However, the Katanga region did reach its goal, punctuated by high achievement in	To improve this indicator, USAID IHP plans to support supply chain missions, collaborate closely with GHSC-TA to ensure that medicines are available at regional distribution centers, and organize supervision and monitoring
		Kasaï	476895	505938	126484	100646	79.6%	N/A	N/A	DHIS 2		
		Katanga	239799	254402	63601	76176	119.8%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	324592	344360	86090	77731	90.3%	N/A	N/A	DHIS 2	Haut-Lomami (121.3%) and Lualaba (135.2%).	activities by the ECDPS.
8 Contract	MNCH: Percentage of children age 12-23 months who received all basic vaccinations	Outcome	44.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	40.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	45.4%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	52.2%	N/A	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	1157027	1227490	306873	341505	111.3%	N/A	N/A	DHIS 2	The Katanga region performed particularly well (120%) and Haut-Katanga reached 129.9%. Strong performance was due to USAID IHP's support for the improved supply of and demand for immunization services, including support for CACs and community leaders, efforts to reach	Next steps to further improve this indicator include activities to "recover" unvaccinated children, support to the vaccine supply chain and hard-to-reach aires de sante, support to maintain the cold chain, and post-training monitoring for trained providers.
		Kasaï	479997	509229	127308	145879	114.6%	N/A	N/A	DHIS 2		
		Katanga	344494	365474	91368	110544	121.0%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	332536	352787	88197	85082	96.5%	N/A	N/A	DHIS 2	unvaccinated children, and support to maintain cold chain equipment.	
10	MNCH: Number of children less than 12 months of age who received measles vaccine from USG-supported programs	Outcome	1115918	1183877	295968	341419	115.4%	N/A	N/A	DHIS 2,	The Katanga region performed well (127.4%) and Haut-Katanga and Lualaba performed highest (140.8% and 132.5% respectively). Strong performance was due to USAID IHP's support for the improved supply of and demand for immunization services, including support for CACs and community	Next steps to further improve this indicator include activities to "recover" unvaccinated children, support to the vaccine supply chain and hard-to-reach aires de sante, support to maintain the cold chain, and post-training monitoring for trained providers.
		Kasaï	478162	507282	126820	147253	116.1%	N/A	N/A	DHIS 2,		
		Katanga	330445	350569	87642	111616	127.4%	N/A	N/A	DHIS 2,		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	307311	326026	81506	82550	101.3%	N/A	N/A	DHIS 2,	leaders, efforts to reach unvaccinated children, and support to maintain cold chain equipment.	
11	MNCH: Percentage of children less than 12-23 months of age who received measles vaccine from USG-supported programs	Outcome	64.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	61.6%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	58.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	75.6%	N/A	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	30.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	28.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	37.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	24.6%	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	825831	206457	251283	121.7%	N/A	N/A	DHIS 2	Performance may be attributed to support for community champions and RECO, ANC/FP mini-campaigns, and World	In the next quarter, USAID IHP will continue to provide support for mini-campaigns on the use of ANC services.
		Kasaï	418461	443945	110986	128511	115.8%	N/A	N/A	DHIS 2		
		Katanga	174119	184723	46180	62150	134.6%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	185845	197163	49291	60622	123.0%	N/A	N/A	DHIS 2	Malaria Day activities	
14 Fee	MALARIA :Percent of children under 5 years of age for whom treatment/advice was sought for fever	Outcome	80.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	76.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	90.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	83.6%	N/A	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	3043580	760894	911266	119.8%	N/A	N/A	DHIS 2	This indicator's high performance (119.8% of target) can be attributed to: provider trainings on blood transfusion for children under 5, refresher trainings on correct diagnosis and case management, the organization	We will continue to implement activities to maintain our targets.
		Kasaï	1397311	1482407	370602	452633	122.1%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	681602	723112	180777	255882	141.5%	N/A	N/A	DHIS 2	of World Malaria Day activities in five provinces, continued implementation of the community champions model, and mini-campaigns on malaria prevention and treatment.	
		E. Congo	789953	838061	209515	202751	96.8%	N/A	N/A	DHIS 2		
16 Fee	MALARIA :Proportion of children 0-59 months who slept under an Insecticide treated net (ITN) the previous night	Outcome	65.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	71.2%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	55.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	62.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
17 Fee Proxy	MALARIA: Number of insecticide-treated nets (ITN)	Process	1163227	1222086	305522	407910	133.5%	N/A	N/A	DHIS 2	We far exceeded our targets this quarter. USAID IHP supported	We will continue to implement activities to maintain our targets.

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	distributed during antenatal and/or child immunization visits (PROXY)	Kasaï	552961	580941	145235	200031	137.7%	N/A	N/A	DHIS 2	mini-campaigns that raised awareness about malaria prevention and the use of ITNs and their availability at health facilities during ANC/child immunization visits.	
		Katanga	217673	228687	57172	101197	177.0%	N/A	N/A	DHIS 2		
		E. Congo	392593	412458	103115	106682	103.5%	N/A	N/A	DHIS 2		
18 Fee	Improved satisfaction by clients/citizens with the services they receive: % of individuals reporting satisfaction with health center services	Outcome	66.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	69.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	70.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	56.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
19 Fee	Number of Basic Emergency Obstetric and Neonatal Care (BEmONC) or Comprehensive Emergency Obstetric Care (CEmONC) sites available in each province	Output	410	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	99	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	218	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	93	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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	project monitoring report	No publications were expected for this quarter.	We are presenting findings from the household and mapping survey this year and will produce articles for publication.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
21 Fee	Conflict Sensitivity Analysis and Implementation Strategy	Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator has been completed. The revised Conflict Sensitivity Analysis and Implementation Strategy was submitted October 19, 2018, and approved by USAID on October 24, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
22 Fee	Percent of targeted facilities with quality improvement action plans	Outcome	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator is reported annually. This activity will begin this year,	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	documented and being implemented	Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report	so there is no baseline yet	
		E. Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
23 Fee	Capacity Development Approach	**Output**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator has been completed. The Capacity Development Approach was submitted October 5, 2018, and approved by USAID on November 11, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
24 Fee	Gender Analysis and Gender Implementation Strategy	Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator has been completed. The Gender Analysis and Implementation Strategy was submitted November 2, 2018, and approved by USAID on December 10, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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									project monitoring report	This indicator is reported annually.	N/A
										project monitoring report		
										project monitoring report		
										project monitoring report		
1.2	Percent of annual Provincial action plans and budgets aligned with National action plans and budgets (expected contract result)	Outcome	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	20.0%	N/A	N/A	N/A	N/A	N/A	project monitoring report	This indicator is reported annually.	N/A
		Kasaï	N/A	20.0%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	20.0%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	20.0%	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	project monitoring report	Per the updated PWS dated 13 June 2020, we will no longer do this activity.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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	2.3	3.3	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator is reported annually.	N/A
		Kasaï	2.3	3.3	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	3.0	4.0	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	2.0	3.0	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.2.2	PICAL assessment accountability sub-domain score for provinces and health zones receiving USG assistance (contract deliverable)	Output	2.0	3.1	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator is reported annually.	N/A
		Kasaï	1.8	2.8	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	2.0	4.0	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	2.5	3.5	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.2.3	Percentage of DPS and Health Zones supported by the program that are audited with USAID IHP DRC technical and/or financial	Output	N/A	25.0%	25.0%	15.1%	60.3%	27	179	Project monitoring report	We did not meet our targets this quarter. Contributing to this indicator's performance was USAID IHP support to	We have looked at this indicator and corresponding targets and will focus on them in Y3.
		Kasaï	N/A	25.0%	25.0%	18.2%	72.7%	14	77	Project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	support (contract deliverable)	Katanga	N/A	25.0%	25.0%	15.8%	63.2%	9	57	Project monitoring report	quarterly trips of IPS for audits and oversight of ZS in Sankuru, Kasaï-Oriental, Lomami, Haut-Lomami, and Lualaba.	
		E. Congo	N/A	25.0%	25.0%	11.1%	44.4%	5	45	Project monitoring report		
1.2.4	Number of tickets on the fraud and complaints hotline issue tracker (expected contract result)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This activity has not yet begun.	Finalize the technical development with Viamo for the implementation of the activity in Kasaï-Central and Lomami
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
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/CODES As in health zones fully supported by the program, which receive financial support (contract deliverable)	Output	N/A	5.0%	N/A	0	0.0%	0	3200	Project monitoring report	We did not collect data for this indicator.	Finalize the evaluation of the financial management of the DPS
		Kasaï	N/A	5.0%	N/A	0	0.0%	0	1316	Project monitoring report		
		Katanga	N/A	5.0%	N/A	0	0.0%	0	971	Project monitoring report		
		E. Congo	N/A	5.0%	N/A	0	0.0%	0	913	Project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
1.3.2	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	100.0%	N/A	0	0.0%	0	3200	Project monitoring report	This activity has not yet begun.	Finalize the evaluation of the financial management of the DPS
		Kasaï	N/A	100.0%	N/A	0	0.0%	0	1316	Project monitoring report		
		Katanga	N/A	100.0%	N/A	0	0.0%	0	971	Project monitoring report		
		E. Congo	N/A	100.0%	N/A	0	0.0%	0	913	Project monitoring report		
1.3.3 Fee (Standard: CDCS-#)	Number of community service organizations (CSOs)/Health Area Development Committees (CODESAs) supported by the program that are woman-led (contract deliverable)	Outcome	217	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	68	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	105	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	44	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	Output	41.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with
		Kasaï	44.6%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	their views are reflected in planning/policy processes	Katanga	40.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		the household survey.
		E. Congo	37.2%	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	100%	100%	48.3%	48.3%	115	238	Project monitoring report	We did not meet our targets for this indicator. This indicator was indirectly affected by high-impact preparatory activities, such as surveys to collect primary data before the official launch of the fraud hotline in Kasaï-Central and Sankuru.	We anticipate that we will be able to improve performance simply by catching up with the work plan in Q4.
		Kasaï	N/A	100%	100%	60.0%	60.0%	3	5	Project monitoring report		
		Katanga	N/A	100%	100%	33.3%	33.3%	1	3	Project monitoring report		
		E. Congo	N/A	100%	100%	48.3%	48.3%	111	230	Project monitoring report		
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-	Output	0.86	1.9	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator is reported annually.	N/A
		Kasaï	1.75	1.8	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	2.00	2.0	N/A	N/A	N/A	N/A	N/A	Project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	making and implementation (contract deliverable)	E. Congo	2.00	2.0	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
IR 1.5: Improved disease surveillance and strategic information gathering and use												
1.5.1	Annual PICAL score of sub-national level health divisions assessed for information management capacity to monitor and inform their strategies (contract deliverable)	Output	1.4	2.4	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator is reported annually.	N/A
		Kasaï	2.4	2.4	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	2.2	2.2	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	2.6	2.2	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.5.2	Percentage of USG supported provinces and health zones with MAPEPI DHIS2 reporting rates > 95% (expected contract result)	Output	16.2%	20.2%	20.2%	22.3%	110.6%	40	179	DHIS 2	This indicator passed its target at 110.6%, although the Katanga region only reached 44.3% with 0% for both Haut-Lomami and Lualaba, although USAID IHP held six MAPEPI monitoring meetings for Haut-Lomami.	Initial investigations into this performance were inconclusive and we want to investigate this indicator further given the wide variation in performance.
		Kasaï	18.2%	22.2%	22.2%	36.4%	163.8%	28	77	DHIS 2		
		Katanga	15.8%	19.8%	19.8%	8.8%	44.3%	5	57	DHIS 2		
		E. Congo	13.3%	17.3%	17.3%	15.6%	89.9%	7	45	DHIS 2		
1.5.3	Percentage of targeted DPS, ECZS and FOSA	Output	N/A	100%	100%	0%	0%	0	179	Project monitoring report	We have not yet started this activity.	N/A

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	teams that use real-time data dashboards in routine management tasks (contract deliverable)	Kasaï	N/A	100%	100%	0%	0%	0	77	Project monitoring report		
		Katanga	N/A	100%	100%	0%	0%	0	57	Project monitoring report		
		E. Congo	N/A	100%	100%	0%	0%	0	45	Project monitoring report		
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	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Push on the consensus between USAID and MoH on the approach.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.6.2	Number of DPS/ECZS health workers trained in Human Resources Management using iHRIS (expected contract result)	Output	N/A	188	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Consultation with the Ministry for the programming of the activity
		Kasaï	N/A	81	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	60	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	47	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.6.3	Number of ECDPs who have been	Output	N/A	9	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Consultation with the Ministry for the

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	coached according to Ministry of Health guidelines for Human Resources Management (expected contract result)	Kasaï	N/A	4	N/A	N/A	N/A	N/A	N/A	Project monitoring report		programming of the activity
		Katanga	N/A	3	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	2	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
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	NA	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Finalize the technical development with Matchboxology for the implementation and find consensus with MoH
		Kasaï	N/A	NA	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	NA	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	NA	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
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%	67.7%	67.7%	44.7%	134.0%	2911	6517	DHIS 2	The indicator exceeded the fixed target of 34.0% that means beyond the fixed target there was a gain of 66 structures that did not experience any stockouts during the period. All regions improved. A few	Continue to make tracer commodities available in health facilities to prevent stock shortages.
		Kasaï	77.9%	73.9%	73.9%	55.1%	125.5%	1446	2626	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	61.4%	57.4%	57.4%	31.2%	145.6%	782	2506	DHIS 2	factors impacted this trend: low availability of MNCH products at upstream levels, longer delivery times due to COVID-19 restrictions, insecurity in Sud-Kivu, and deteriorating road conditions.	
		E. Congo	76.0%	72.0%	72.0%	49.3%	131.5%	683	1385	DHIS 2		
1.7.2	Percent of USG supported health zones with LMIS reporting rates > 95% (expected contract result)	Output	32.4%	36.4%	36.4%	16.2%	44.5%	29	179	DHIS 2	We did not achieve our targets in any province, with a wide variation in performance. Toutes les provinces ont des taux < au target de 95% sauf la provinces de sankuru avec un taux de 110.1%.	We believe performance is strongly tied to training and network accessibility and we will continue to train staff to improve reporting rates.
		Kasaï	42.9%	46.9%	46.9%	15.6%	33.2%	12	77	DHIS 2		
		Katanga	31.6%	35.6%	35.6%	15.8%	44.4%	9	57	DHIS 2		
		E. Congo	15.6%	19.6%	19.6%	17.8%	90.7%	8	45	DHIS 2		
1.7.3	Percent of supported sub-national level health divisions with a documented and	Output	N/A	60%	60%	35.2%	58.7%	63	179	Project monitoring report	We did not achieve our targets in any region but we did report that Kasia Central	We need to verify the data and ensure improvements.
		Kasaï	N/A	60%	60%	46.8%	77.9%	36	77	Project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	budgeted distribution plan (expected contract result)	Katanga	N/A	60%	60%	36.8%	61.4%	21	57	Project monitoring report	achived 166.7% of the Quarter 3 target.	
		E. Congo	N/A	60%	60%	51.1%	85.2%	23	45	Project monitoring report		
1.7.4	Percentage of Health Zones with improved conditions of medicines storage according the planned renovation (expected contract result)	Output	1.3%	N/A	N/A	N/A	N/A	N/A	179	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	77	EDL 2019		
		Katanga	1.8%	N/A	N/A	N/A	N/A	N/A	57	EDL 2019		
		E. Congo	2.4%	N/A	N/A	N/A	N/A	N/A	45	EDL 2019		
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	9	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We did not do this activity this quarter.	N/A
		Kasaï	N/A	4	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	3	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	N/A	2	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
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	1061334	265335	332974	125.5%	N/A	N/A	DHIS 2	The indicator exceeded its target, although there were significant	To further improve indicator 2.1, USAID IHP will continue to

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Kasaï	383,777	407148	101788	112214	110.2%	N/A	N/A	DHIS 2	variations by province. The E. Congo region, performing best (140.4%), due to high availability of FP inputs, CBD trainings, and FP mini-campaigns. In the Kasaï region (102.2%) there was joint support from E2A. In the Katanga region, Haut-Katanga's CYP achievement decreased (to 98.5%), due to less integration of FP activities in some ZS.	retrain providers in administering clinical FP methods, support integrating FP in collaboratoin with other partners, supply health facilities with FP inputs, and organize targeted SBC campaigns in urban areas.
		Katanga	329,122	349165	87291	113689	130.2%	N/A	N/A	DHIS 2		
		E. Congo	287,511	305021	76256	107071	140.4%	N/A	N/A	DHIS 2		
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	994843	248711	307223	123.5%	N/A	N/A	DHIS 2	The indicator exceeded the target, reporting 123.5%, the Katanga and Eastern regions have rates> 120%.	We will continue to implement as planned to maintain achievements.
		Kasaï	360,468	382421	95605	102941	107.7%	N/A	N/A	DHIS 2		
		Katanga	303,164	321626	80407	102317	127.2%	N/A	N/A	DHIS 2		
		E. Congo	274,103	290796	72699	101965	140.3%	N/A	N/A	DHIS 2		
2.3	FP: Number of counseling visits for FP/ RH as	Output	192,080	1125282	281321	2622	0.9%	N/A	N/A	DHIS 2	We did not achieve our	We need to ensure the availability of the

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	result of USG support	Kasaï	150,200	488446	122112	1151	0.9%	N/A	N/A	DHIS 2	targets for this indicator.	data management tools for this indicator to ensure it will be reported accurately through the module complementaire.
		Katanga	26,796	361935	90484	1471	1.6%	N/A	N/A	DHIS 2		
		E. Congo	15,084	274901	68725	0	0.0%	N/A	N/A	DHIS 2		
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%	75.4%	94.2%	314429	417238	DHIS 2	The DRC health system achieved 94.2 of this indicator's target (74.5% of pregnant women benefiting from S/P in target ZS). Only the Kasaï region achieved 100% of its target. Good performance in this region was supported by the implementation of additional activities supplying treatments and	We believe that training and supervisory visits will improve our performance.
		Kasaï	70%	80%	80%	80.0%	100.0%	139019	173743	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	64%	80%	80%	69.5%	86.9%	94916	136575	DHIS 2	supplies to ZS and promoting the use of ANC services to pregnant women by community champions. Sankuru (73.4%), Haut-Katanga (79.6%), and Lualaba (82.6%) pulled down the overall average, though all other provinces achieved at least 90% of their targets.	
		E. Congo	62%	80%	80%	75.3%	94.1%	80494	106920	DHIS 2		
2.5 (Standard: CDCS)	Percentage of population who use selected facilities	Outcome¥	42.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	43.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	43.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	36.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
2.6	Percentage of Health centers supported by the USG implementing interventions to support the minimum package of activities (contract deliverable)	Outcome¥	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	0.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.7	Percentage of hospitals supported by the USG implementing interventions to support the complementary package of activities. (expected contract result)	Outcome	0.70%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	0.50%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	1.40%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	0.50%	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	16.8%	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not started this activity.	N/A
		Kasaï	13.7%	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	22.3%	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		E. Congo	14.9%	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
2.9 (Standard: CDCS)	Percentage of population reporting improved availability of selected services	Outcome¥	25.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	27.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	27.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	17.3%	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	60.6%	63.0%	N/A	N/A	N/A	N/A	N/A	DHIS 2	This indicator is reported annually.	N/A
		Kasaï	58.2%	65.9%	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		Katanga	53.8%	58.5%	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		E. Congo	75.6%	77.6%	N/A	N/A	N/A	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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%	99.9%	99.9%	417238	417596	DHIS 2	Strong performance in the Kasaï/Katanga regions was related to provider supervision and coaching, capacity building of providers in BEmONc, the availability of medicines and other inputs, raised awareness, and champion community activities.	In the next quarter, USAID IHP will continue to provide support for mini-campaigns on the use of ANC services.
		Kasaï	96.3%	100%	100%	100.8%	100.8%	173743	172320	DHIS 2		
		Katanga	91.3%	100%	100%	102.2%	102.2%	136575	133626	DHIS 2		
		E. Congo	100.1%	100%	100%	95.8%	95.8%	106920	111650	DHIS 2		
2.1.3	MNCH: Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Outcome	75.4%	90.0%	90.0%	84.9%	94.4%	354622	417596	DHIS 2	Only Kasaï-Central et Lualaba met their targets. Tanganyika had the lowest performance, reporting, 54.9%. Haut-Katanga declined from Q2 largely due	In the next quarter, USAID IHP plans to provide data management tools to HFs to improve data collection, organize coaching for providers, and hold mini-campaigns that
		Kasaï	82.6%	90.0%	90.0%	88.9%	98.8%	153238	172320	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	69.6%	90.0%	90.0%	87.9%	97.6%	117400	133626	DHIS 2	to a lack of providers in EmONC. There was also under-collecting of data caused by challenges in collection and use of management tools at HFs.	emphasize the importance of delivery in a health facility.
		E. Congo	70.7%	90.0%	90.0%	75.2%	83.6%	83984	111650	DHIS 2		
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	242341	60586	42191	69.6%	N/A	N/A	DHIS2	Each province underperformed in this indicator. This was due to low availability of uterotonics/oxytocin in the health facilities, data collection challenges/under reporting, an absence of maternity wards in facilities, and local women's low awareness about skilled birth attendance.	In the next quarter, USAID IHP plans to provide data management tools to HFs to improve data collection, organize coaching for providers, and ensure the regular supply of essential generic medicines at health facilities.
		Kasaï	19244	33321	8330	7030	84.4%	N/A	N/A	DHIS2		
		Katanga	37395	67366	16842	13110	77.8%	N/A	N/A	DHIS2		
		E. Congo	83819	141654	35414	22051	62.3%	N/A	N/A	DHIS2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.1.5 (Standard/ PPR)	MNCH: Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Output	33509	35550	8889	8438	94.9%	N/A	N/A	DHIS 2	Of all regions, only E. Congo reached its target this quarter, though this indicator did improve overall from Quarter 2. USAID IHP has supported 450 clinical actors in 32 ZS to master techniques in BEmONC, essential newborn care, and newborn resuscitation. Low performance in a few provinces was largely due to a lack of capacity building and support from other partners. 4 provinces ont atteint ou depasser leur cibles ils s'agit de Kasaï-Oriental 108.6%, Haut-Lomami 128.8%,	To improve this indicator, USAID IHP will focus on equipping ZS maternity wards with Helping Baby Breathe (HBB) equipment, organizing trainings for maternity and pediatric providers in pediatric emergencies, briefing providers on resuscitation, and supporting clinical mentoring for providers in ZS with high newborn mortality.
		Kasaï	9818	10416	2605	2263	86.9%	N/A	N/A	DHIS 2		
		Katanga	14450	15330	3833	3640	95.0%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	9241	9804	2451	2535	103.4%	N/A	N/A	DHIS 2	Tanganyika 106.9%, Sud-Kivu 102.7%.	
2.1.6	MNCH: Number of postpartum/new born visits within three days of birth in USG-supported programs	Output	1121703	1190014	297504	354117	119.0%	N/A	N/A	DHIS 2	This performance was due to provider trainings in EmONC, CEmONC, post-abortion care, and MDSR; support and supervision for providers; and increased supply of nine of the 13 life-saving drugs for mothers and their children. Lualaba province stands out with a 139.3 completion rate of the indicator, largely due to increased follow-up visits.	. We will continue to support the monitoring of early newborn care providers and provide post-training follow-up in BEmONC.
		Kasaï	525049	557024	139256	154319	110.8%	N/A	N/A	DHIS 2		
		Katanga	336949	357469	89368	118915	133.1%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	259705	275521	68880	80883	117.4%	N/A	N/A	DHIS 2		
2.1.7 (CDCS)	MNCH: Number and percentage of newborns receiving essential newborn care through USG-supported programs	Output	91.5%	100%	100%	94.5%	94.5%	340803	360490	DHIS 2	We did not achieve our target for this indicator, and none of the regions or provinces met their targets either. There was a lack of resuscitation materials and equipment and there was a lack of trained providers in many of the ZS. Lomami had the lowest completion rate (88.5%) due to a lack of trained providers in the most populated ZS.	To improve this indicator in the next quarter, USAID IHP will organize post-training follow-up in BEmONC, provide clinical care monitoring for care providers in ZS with high neonatal mortality, and support the monitoring of early newborn care providers.
		Kasaï	91.8%	100%	100%	93.6%	93.6%	145689	155578	DHIS 2		
		Katanga	89.7%	100%	100%	94.6%	94.6%	114447	120947	DHIS 2		
		E. Congo	93.2%	100%	100%	96.1%	96.1%	80667	83965	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.1.8 (PPR)	MNCH: Number of newborns receiving antibiotic treatment for infection from trained health workers through USG-supported programs	Output	212375	225309	56328	44853	79.6%	N/A	N/A	DHIS 2	We did not achieve our target this quarter in any region. Only Sud-Kivu met its target.	We plan to conduct trainings for this service.
		Kasaï	98016	103985	25997	18084	69.6%	N/A	N/A	DHIS 2		
		Katanga	89734	95199	23799	21243	89.3%	N/A	N/A	DHIS 2		
		E. Congo	24625	26125	6532	5526	84.6%	N/A	N/A	DHIS 2		
2.1.9	MNCH: Drop-out rate in DTP-HepB-Hib3 among children less than 12 months of age	Output	5%	4.0%	4.0%	5.3%	68.0%	19041	360546	DHIS 2	We only achieved our target in Katanga region and in the following provinces: Kasaï-Central, Kasaï-Oriental, Sankuru et Haut-Lomami. However, this was not enough to reach our overall goal.	We plan to conduct trainings for this service.
		Kasaï	5%	4.0%	4.0%	3.5%	112.1%	5316	151195	DHIS 2		
		Katanga	7%	5.0%	5.0%	6.8%	63.2%	8115	118659	DHIS 2		
		E. Congo	5%	4.0%	4.0%	6.2%	45.4%	5610	90692	DHIS 2		
2.1.10 (Standard /PPR)	NUTRITION: Number of individuals receiving nutrition-related professional training through USG supported	Outcome	N/A	3695	927	1597	172.3%	N/A	N/A	Project monitoring report	In Sankuru and Lualaba, USAID IHP trained providers who had not been trained in past quarters. Despite many trainings being delayed because	We plan to conduct trainings for this service.
		Kasaï	N/A	1739	438	812	185.4%	N/A	N/A	Project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	nutrion programs	Katanga	N/A	1135	284	607	213.7%	N/A	N/A	Project monitoring report	of inavailability of provincial facilitators, which contributed to lower achievement. Only Lualaba achieved its goals this quarter.	
		E. Congo	N/A	821	205	178	86.8%	N/A	N/A	Project monitoring report		
2.1.11 (Standard /PPR)	NUTRITION: Number of children under-five (0-59 months) reached by USG-supported nutrition programs	Outpiut	520956	2226517	N/A	N/A	N/A	N/A	N/A	DHIS 2	This indicator is reported annually.	N/A
		Kasaï	175472	987119	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		Katanga	133310	620767	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		E. Congo	212174	618631	N/A	N/A	N/A	N/A	N/A	DHIS 2		
2.1.12 (Standard)	NUTRITION: Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs	Outcome	620698	775872	N/A	N/A	N/A	N/A	N/A	DHIS 2	This indicator is reported annually.	N/A
		Kasaï	294527	368158	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		Katanga	143759	179699	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		E. Congo	182412	228015	N/A	N/A	N/A	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.1.13 (Standard /PPR)	NUTRITION: Number of pregnant women reached with nutrition interventions through USG-supported programs	Output	1432281	1519511	379877	417238	109.8%	N/A	N/A	DHIS 2	This indicator's Q3 achievement may be due to a few factors: the availability of iron-folic acid, VIVA campaigns and mini-campaigns to recruit women to start antenatal care and prevent malaria, support for champion communities (Lualaba sensitized 3,281 people), and outreach by RECO.	To improve this indicator further next quarter, USAID IHP will support supervision of ZS by PRONANUT on nutrition, advocate for the supply of nutritional inputs, support follow-up of RECO, and support more mini-campaigns on ANC in all nine provinces.
		Kasaï	603904	640681	160170	173743	108.5%	N/A	N/A	DHIS 2		
		Katanga	432196	458517	114630	136575	119.1%	N/A	N/A	DHIS 2		
		E. Congo	396181	420313	105077	106920	101.8%	N/A	N/A	DHIS 2		
2.1.14	MALARIA: Number of health workers trained in IPTp with USG funds	Output	N/A	2000	353	202	57.2%	N/A	N/A	project monitoring report.	Low performance is largely due to the fact that Haut-Katanga and Sud-Kivu could not plan the refresher training activity due to lack of funds. There were also challenges in Tanganyika with accessing health facilities in	Haut-Katanga, Tanganyika, and Kasaï-Oriental plan to conduct this activity in Q4 to reach their target.
		Kasaï	N/A	860	111	93	83.8%	N/A	N/A	project monitoring report.		
		Katanga	N/A	637	164	95	57.9%	N/A	N/A	project monitoring report.		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	N/A	503	78	14	17.9%	N/A	N/A	project monitoring report.	remote ZS due to flying restrictions in certain routes from COVID-19.	
2.1.15	MALARIA: Number of health workers trained in case management with ACTs with USG funds	Output	N/A	2500	391	351	89.8%	N/A	N/A	project monitoring report.	Haut-Katanga has unable to hold this training due to COVID-19, explaining its low performance (0%). Huat-Lomami and Sud-Kivu have already achieved their targets for the year.	Continue training in low-performing provinces. Maintain knowledge through supportive supervision. Do post-training follow-ups
		Kasaï	N/A	1081	225	279	124.0%	N/A	N/A	project monitoring report.		
		Katanga	N/A	786	102	40	39.2%	N/A	N/A	project monitoring report.		
		E. Congo	N/A	633	64	32	0.0%	N/A	N/A	project monitoring report.		
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	2500	391	351	89.8%	N/A	N/A	project monitoring report.	Huat-Lomami and Sud-Kivu have already achieved their targets for the year.	Continue training in low-performing provinces. Maintain knowledge through supportive supervision. Do post-training follow-ups
		Kasaï	N/A	1081	225	279	124.0%	N/A	N/A	project monitoring report.		
		Katanga	N/A	786	102	40	39.2%	N/A	N/A	project monitoring report.		
		E. Congo	N/A	633	64	32	50.0%	N/A	N/A	project monitoring report.		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.1.17	TB: TB notification rate through USG-supported programs	Output	126	150	150	139.5	93.0%	11977	8588004	DHIS 2	Haut-Lomami, Lualaba, Tanganyika, Kasaï-Oriental, and Haut-Katanga surpassed their targets, largely due TB case tracing activities among at-risk populations. Sud-Kivu's performance (54.1% of target) was lowest, due in part to its terrain and zones of conflict that are rarely supplied to perform TB screenings and laboratory diagnostics.	Continue training in low-performing provinces. Maintain knowledge through supportive supervision. Do post-training follow-ups
		Kasaï	126	150	150	115.4	76.9%	4542	3935943	DHIS 2		
		Katanga	156	150	150	212.2	141.5%	5120	2412826	DHIS 2		
		E. Congo	94	150	150	103.4	68.9%	2315	2239235	DHIS 2		
2.1.18 PPR	TB: Number of patients diagnosed with TB that have initiated first-line treatment. (PPR)	Output	61974	TBD	19832	19057	96.1%	N/A	N/A	DHIS 2	Tanganyika and Lualaba underperformed in this indicator, achieving 84% and 89% respectively. This was caused by prolonged stock-outs of first-line TB drugs	To improve availability of anti-TB drugs, partner i+Solutions is working to collaborate with CONRAID and Chemonics, who manage the supply chain.
		Kasaï	28508	TBD	8591	8585	99.9%	N/A	N/A	DHIS 2		
		Katanga	21823	TBD	7638	7125	93.3%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	11643	TBD	3603	3347	92.9%	N/A	N/A	DHIS 2	exacerbated by limited air and road traffic due to COVID-19.	
2.1.19	TB: Therapeutic success rate through USG-supported programs	Output	64.7	95	95	91.9	96.7%	9603	10454	DHIS 2	The availability of anti-TB drugs in the high-performing provinces of Haut-Lomami, Lomami, Haut-Lomami, and Kasaï-Oriental improved this indicator. The Kasaï region improved from Q2 (from 95% to 97% therapeutic success rate) as well as the E. Congo region (88% to 90%).	To reverse the Katanga region's downward trend, USAID IHP will work to improve coordination in the supply chain and find a better mechanism to ensure the transportation of drugs and laboratory equipment from the ZS to CSDTs
		Kasaï	55.5	95	95	96.6	101.7%	3713	3844	DHIS 2		
		Katanga	76.7	95	95	88.5	93.2%	3890	4393	DHIS 2		
		E. Congo	63.7	95	95	90.2	95.0%	2000	2217	DHIS 2		
2.1.20 (Standard)	TB: HL.2.4-1 Number of multi-drug resistant (MDR) TB cases detected	Outcome	405	180	180	87	48.3%	N/A	N/A	DHIS 2	Overall poor performance for many provinces can be explained by low coverage of CPLTs with Xpert diagnostic sites, frequent stock-outs of test cartridges, and disruptions in transportation	USAID IHP is working to develop a financial mechanism to support transportation costs to prevent stock-outs and efficiently transport sputum samples. The project will also
		Kasaï	190	72	72	34	47.2%	N/A	N/A	DHIS 2		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	158	77	77	37	48.1%	N/A	N/A	DHIS 2	of sputum samples due to difficulties reimbursing transportation costs in remote ZS.	support the transportation of suspected MDR-TB samples with the help of community workers and prioritize the screening of family and regular contacts of patients to detect cases in coming quarters.
		E. Congo	57	31	31	16	51.6%	N/A	N/A	DHIS 2		
2.1.21	TB: Number of multi-drug resistant TB cases that have initiated second line treatment	Outcome	237	78	87	75	86.2%	N/A	N/A	DHIS 2	We did not achieve our targets this quarter but we have improved upon Q2.	We will continue to implement our work plan and seek definitive approaches to improve our performance.
		Kasaï	130	43	34	27	79.4%	N/A	N/A	DHIS 2		
		Katanga	77	27	37	35	94.6%	N/A	N/A	DHIS 2		
		E. Congo	30	8	16	13	81.3%	N/A	N/A	DHIS 2		
2.1.22	TB: Therapeutic success rate for RR-/MDR-TB through USG-supported programs	Output	TBD	75%	75%	77.4%	103.1%	41	53	DHIS 2	We achieved our overall goal through exceptional performances in Katanga and the East.	We will look into why our performance was so low in Kasaï and maintain our achievements in the other regions.
		Kasaï	TBD	75%	75%	25.0%	33.3%	1	4	DHIS 2		
		Katanga	TBD	75%	75%	79.4%	105.9%	27	34	DHIS 2		
		E. Congo	TBD	75%	75%	86.7%	115.6%	13	15	DHIS 2		
2.1.23	TB: Percentage of under five children who received (or are receiving) INH prophylaxis	Output	5717	TBD	100%	77.8%	77.8%	4019	5168	DHIS 2	This indicator's target was not met and the proportion of children under 5 on INH	To improve this indicator, USAID IHP will collaborate with the CPLT and other

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	through USG-supported programs	Kasaï	2713	TBD	100%	88.3%	88.3%	1504	1703	DHIS 2	prophylaxis is low due to stock-outs of the pediatric form of INH and delays in supply of RDCs. However, Kasaï-Central (100%), Haut-Lomami (100%), and Lomami (99%) performed well due to strong guidelines for managing pediatric TB supported by the TB Challenge Project until March 2018.	stakeholders at the DPS level.
		Katanga	1784	TBD	100%	78.4%	78.4%	1822	2325	DHIS 2		
		E. Congo	1220	TBD	100%	60.8%	60.8%	693	1140	DHIS 2		
2.1.24	TB: Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis	Output	54	100%	100%	74.1%	74.1%	4801	6479	DHIS 2	This indicator underachieved with only a 54% achievement rate overall, with Haut-Lomami, Haut-Katanga, and	USAID IHP will continue supporting monthly meetings of the provincial TB/HIV task force and provide support to

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	through USG-supported programs	Kasaï	48	100%	100%	82.2%	82.2%	905	1101	DHIS 2	Tanganyika showing poorest performance. INH stock-outs at TB/HIV care sites partly explain this, caused by disruption of supply from the national to provincial level. Good performance in the Kasaï region is largely explained by collaborative activities between the PNLT and PNLS programs and support from other partners on HIV-related efforts.	PNLTs/PNLS to coordinate activities at the facility level throughout the nine provinces.
		Katanga	59	100%	100%	73.6%	73.6%	3525	4791	DHIS 2		
		E. Congo	44	100%	100%	63.2%	63.2%	371	587	DHIS 2		
2.1.25	TB: Percentage of new-enrolled HIV-positive patients screened for TB through USG-supported programs	Outcome	64.7	TBD	100%	75.1%	75.1%	14785	19676	DHIS 2	We did not meet our target in this indicator.	We will continue to work with the MOH to support their efforts in this area.
		Kasaï	55.5	TBD	100%	62.1%	62.1%	5330	8580	DHIS 2		
		Katanga	76.7	TBD	100%	89.8%	89.8%	6763	7527	DHIS 2		
		E. Congo	63.7	TBD	100%	75.4%	75.4%	2692	3569	DHIS 2		
2.1.26	TB: Number of individuals trained in any	Output	N/A	1640	23	23	100.0%	N/A	N/A	project monitoring report.	We achieved our overall goal through a	We will continue to coordinate with the MOH to

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	component of the World Health Organization Stop TB strategy with USG funding.	Kasaï	N/A	801	0	0	0.0%	N/A	N/A	project monitoring report.	successful performance in Katanga.	help them meet their training targets.
		Katanga	N/A	599	23	23	100.0%	N/A	N/A	project monitoring report.		
		E. Congo	N/A	240	0	0	0.0%	N/A	N/A	project monitoring report.		
2.1.27 (PPR)	GBV: Number of women treated for gender-based violence. PPR.	Outcome	8318	6932	1734	2606	150.3%	N/A	N/A	DHIS 2	The indicator exceeded the target by 50.3%, all regions exceeded their target even though the following provinces did not meet their quarterly targets, namely: Kasaï Oriental, Lomami and Lualaba.	We will continue to work with the MOH to ensure that they can meet demand for these critical services.
		Kasaï	2056	1714	429	788	183.7%	N/A	N/A	DHIS 2		
		Katanga	599	499	125	141	112.8%	N/A	N/A	DHIS 2		
		E. Congo	5663	4719	1180	1677	142.1%	N/A	N/A	DHIS 2		
2.1.28	GBV: Number of surgical fistula repairs provided with USG-assistance	Output	N/A	100	0	0	0%	N/A	N/A	project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	20	0	0	0%	N/A	N/A	project monitoring report		
		Katanga	N/A	20	0	0	0%	N/A	N/A	project monitoring report		
		E. Congo	N/A	60	0	0	0%	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
2.1.29	GBV: Number of surgical fistula repairs provided with USG-assistance that remained closed after discharge	Output	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		Katanga	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		E. Congo	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
IR 2.2: Increased availability of quality, integrated community-based health services												
2.2.1 (Standard PPR)	FP: Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year	Output	N/A	2400	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)	This data is not yet available. The module complementaire was delayed due to COVID-19	N/A
		Kasaï	N/A	855	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		Katanga	N/A	600	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		E. Congo	N/A	945	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
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	19.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	21.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	22.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	11.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
2.2.3	Percent of citizens	Impact	58.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		This data is collected with

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	reporting improvement and equity in service delivery of local level institutions with USG assistance (contract deliverable)	Kasaï	59.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	the household survey.
		Katanga	63.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	49.0%	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	1825	N/A	1619	442	27.3%	N/A	N/A	EDL 2019	We did not meet our targets in any regions.	We will emphasize this work in the future to ensure we meet annual targets.
		Kasaï	889	N/A	892	286	32.1%	N/A	N/A	EDL 2019		
		Katanga	476	N/A	476	109	22.9%	N/A	N/A	EDL 2019		
		E. Congo	460	N/A	251	47	18.7%	N/A	N/A	EDL 2019		
2.2.5	Proportion of supervisory visits performed during the quarter to relais	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	DHIS 2	This indicator is reported annually.	This data is collected with the mapping survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	DHIS 2		
		E. Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	DHIS 2		
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	63500	15874	14882	93.8%	N/A	N/A	project monitoring report	We have wide variation in performance, just missing our target overall. Tanganyika had a very low performance of 25.2%.	We will work with the MOH to help them meet their targets in this area. This may in fact be subject to the data source and reporting mechanism,
		Kasaï	33073	34409	8602	10042	116.7%	N/A	N/A	project monitoring report		
		Katanga	8286	8621	2155	2236	103.8%	N/A	N/A	project monitoring report		
		E. Congo	19675	20470	5117	2604	50.9%	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	Corrective Actions
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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**											
2.3.2	Number of individuals referred by relais/CBDs that were received by supported health facilities (completed referrals) (expected contract result)	Output	350457	371800	92949	128729	138.5%	N/A	N/A	DHIS 2	The indicator reached and exceeded the set target of 38.5%, all regions exceeded the target. All provinces have rates above 100%	We will continue to work with the MOH to help them meet their targets in this area.
		Kasaï	241407	256109	64026	79352	123.9%	N/A	N/A	DHIS 2		
		Katanga	44385	47088	11772	26769	227.4%	N/A	N/A	DHIS 2		
		E. Congo	64665	68603	17151	22608	131.8%	N/A	N/A	DHIS 2		
2.3.3	Number of women transported for facility delivery (contract deliverable)	Output	TBD	2400	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)	This data is not yet available. The module complementaire was delayed due to COVID-19.	N/A
		Kasaï	TBD	855	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		Katanga	TBD	600	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		E. Congo	TBD	945	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
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	project monitoring report	This activity has not yet begun.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
2.4.2		Output	55	40	N/A	N/A	N/A	N/A	N/A	EDL 2019		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	Corrective Actions
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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**											
	Number of supported facilities offering a package of youth-friendly family planning services (contract deliverable)	Kasaï	7	25	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Katanga	21	15	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	27	0	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	149	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	60	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	29	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		E. Congo	60	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	TBD	0	0	0%	N/A	N/A	project monitoring report	Activity not yet started due to lack of concession with USAID and MoH.	N/A
		Kasaï	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		Katanga	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		E. Congo	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
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	Outcome	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	Corrective Actions
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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**											
	equipment support	Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	7500	N/A	N/A	N/A	N/A	N/A	project monitoring report	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	2500	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	5000	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	930	N/A	N/A	N/A	N/A	N/A	project monitoring report	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	930	N/A	N/A	N/A	N/A	N/A	project monitoring report		
2.6.4 (Standard /PPR)	WASH: HL.8.2-4 Number of basic sanitation facilities provided in institutional	Outcome	N/A	340	N/A	N/A	N/A	N/A	N/A	project monitoring report	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	180	N/A	N/A	N/A	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
	settings as a result of USG assistance	Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	160	N/A	N/A	N/A	N/A	N/A	project monitoring report		
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	project monitoring report	This activity is implemented by demand of the MOH.	We will work to increase demand for knowledge sharing workshops.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	project monitoring report		
2.7.2	Number of strategies / policies that have been updated from good practices and lessons learned	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report	We have not been able to do this yet.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		
		E. Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	project monitoring report		
2.7.3	Number of success stories developed	Output	N/A	36	9	11	122.2%	N/A	N/A	project monitoring report	The indicator exceeded the fixed target of	We will continue to report success stories as we

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Kasaï	N/A	16	4	4	100.0%	N/A	N/A	project monitoring report	22.2% for the quarter, the Kasaï and Eastern regions have reached or exceeded their target.	become aware of them.
		Katanga	N/A	12	3	2	66.7%	N/A	N/A	project monitoring report		
		E. Congo	N/A	8	2	5	250.0%	N/A	N/A	project monitoring report		
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	8.6%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	10.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	9.4%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	4.1%	N/A	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	Outcome	76.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	81.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	71.2%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		E. Congo	73.2%	N/A	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	7.3%	4.6%	3.9%	85.1%	126	3200	project monitoring report	The indicator did not reach the target 85.1%, the Kasaï region reached the fixed target during the period.	In Y3 we will ramp up Campaign VIVA.
		Kasaï	N/A	12.7%	4.6%	4.6%	100.0%	61	1316	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		Katanga	N/A	6.4%	3.9%	2.6%	65.8%	25	971	project monitoring report	Kasaï-Central and Haut-Lomami have zero rates. Kasaï-Oriental, Sankuru, Lualaba and Tanganyika have reached the fixed target.	
		E. Congo	N/A	5.2%	5.4%	4.4%	81.6%	40	913	project monitoring report		
3.1.2	Percentage of trained community mobilizers active at community level (contract deliverable)	Output	0	100%	100%	87.6%	87.6%	641	732	project monitoring report	The indicator did not reach the 87.6% target, the Kasaï region did not reach its target. Kasaï-Oriental, Haut-Katanga and Sud-Kivu have reached the quarterly target. The following provinces have a zero rate: Lomami, Sankuru, Haut-Lomami and Lualaba.	We will continue to support the MOH's training agenda.
		Kasaï	0	100%	100%	79.3%	79.3%	349	440	project monitoring report		
		Katanga	0	100%	100%	100.0%	100.0%	64	64	project monitoring report		
		E. Congo	0	100%	100%	100.0%	100.0%	228	228	project monitoring report		
3.1.3	Number of facilities providers trained in interpersonal communication skills	Output	N/A	648	0	0	0.0%	N/A	N/A	project monitoring report	We did not do this activity this quarter.	We met our targets in Q2 and are confident that we will meet future targets.
		Kasaï	N/A	354	0	0	0.0%	N/A	N/A	project monitoring report		
		Katanga	N/A	177	0	0	0.0%	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
		E. Congo	N/A	117	0	0	0.0%	N/A	N/A	project monitoring report		
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	TBD	0	0	0%	N/A	N/A	project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		Katanga	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
		E. Congo	N/A	TBD	0	0	0%	N/A	N/A	project monitoring report		
3.2.2	Number of awareness campaigns designed, implemented, and evaluated with community participation. (contract deliverable)	Output	TBD	108	27	24	88.9%	N/A	N/A	project monitoring report	Although this indicator achieved 88.9% of its target, the Kasaï region had the lowest performance at just 63.9 of its target. Kasaï-Central and Lomami did not make any progress towards their targets (we do not report any mini-campaigns in these provinces), and Sud-Kivu only reached 57.1%.	We will continue to work with the MOH and communities to meet their needs for health campaigns.
		Kasaï	TBD	48	11	7	63.6%	N/A	N/A	project monitoring report		
		Katanga	TBD	36	6	7	116.7%	N/A	N/A	project monitoring report		
		E. Congo	TBD	24	10	10	100.0%	N/A	N/A	project monitoring report		

Technical Areas, Illustrative Indicators		Region*	Baseline	FY 2020 Annual Target	Target Quarter 3	Achieved Quarter 3	% Achieved Quarter 3	Percentage		Sources	Explanation of Performance Level	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**											
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	33.0%	0	0	0.0%	0	0	project monitoring report	We did not conduct any campaigns directed towards vulnerable populations this quarter.	N/A
		Kasaï	N/A	33.0%	0	0	0.0%	0	0	project monitoring report		
		Katanga	N/A	33.0%	0	0	0.0%	0	0	project monitoring report		
		E. Congo	N/A	33.0%	0	0	0.0%	0	0	project monitoring report		
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	100.0%	100%	35.6%	35.6%	16	45	project monitoring report	We did not meet our targets this quarter.	We will continue to work with the MOH and CSOs to support this activity.
		Kasaï	N/A	100.0%	100%	60.0%	60.0%	12	20	project monitoring report		
		Katanga	N/A	100.0%	100%	20.0%	20.0%	3	15	project monitoring report		
		E. Congo	N/A	!00%	100%	10.0%	10.0%	1	10	project monitoring report		

* The Kasaï region includes the following provinces: Kasaï-Central, Kasaï-Oriental, Lomami, and Sankuru.

* The Katanga region includes the following provinces: Haut-Katanga, Haut-Lomami, and Lualaba.

* The Eastern Congo region includes the following provinces: Sud-Kivu and Tanganyika.

Please refer to the approved AMEP and PIRS for precise indicator definitions. This Annex documents specifications or changes to those definitions as identified and needed through the routine data collection and reporting processes. USAID IHP will submit an updated AMEP with updated PITT and PIRS in Y2 to better define program indicators.

1.1, 1.2.1, 1.2.2, 1.4.3: for PICAL indicators, we used the average of the first evaluation scores from Y1 and the predecessor, HFG project) for the baselines.

1.3.1: The denominator was determined by assuming one CODESA for each aire de santé.

1.5.2, 1.7.1, and 1.7.2: In the annual report, the data in the Mission Standard Reporting Template for these indicators is the average of the quarters. All other data is cumulative unless otherwise defined in the PIRS.

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.

2.1.9: this data was intended to come from the household survey but we identified a DHIS2 indicator, *Taux d'abandon Penta 1-Penta 3*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.

2.1.12: this data was intended to come from the household survey but we identified a DHIS2 indicator, *B 8.1 Enfants dont les mères ont reçu ANJE*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.

2.1.13: this data was intended to come from the household survey but we identified a DHIS2 indicator, *CPN1*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.

2.1.17–2.1.26: The PNLT has not yet validated the data. Therefore it has not been made available to us. We will update this table when the data is available.

2.1.23: PNLY is reporting this as a number and not a percentage. We have requested to report this as a number instead of a percentage to align with their data.

2.1.28- 2.1.29: This data comes directly from the hospital and was not shared at the time the report was submitted. We will update the MECC as soon as it is made 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.

2.6.1- 2.6.4 will be collected through project monitoring reports because the Household survey could not capture the information as defined.

ANNEX B: NOTES ON ANNEX A FY2020 QUARTER 3 REPORT DATA

USAID IHP's Activity Monitoring and Evaluation Plan (AMEP) includes 118 indicators, of which 71 are reported quarterly. The Mission Standard Reporting Template (MSRT) in Annex A is an edit of the complete, disaggregated data set captured by the Performance Indicator Tracking Table (PITT) and described by the PIRS. The PIRS and PITT, which were approved by USAID in December 2018, are the primary reference documents for program indicators. The data presented in the MSRT is aligned with the PIRS except where noted in the footnotes to the table and this chapter. We made changes to adapt the data to the constraints of the table, but the full data set is available for additional analyses as needed. We expect that in Quarter 4, an expanded data tables will be made available on the program platform.

The MSRT table is populated with data that is available through existing data information systems such as DHIS2 or as a direct result of Program activities, particularly the baseline, mid-line, and end-line surveys and Project Monitoring Reports (PMRs). In addition, data on some of the indicators is not yet available because the corresponding activities have not yet started. This has been noted in the Observations column for these indicators.

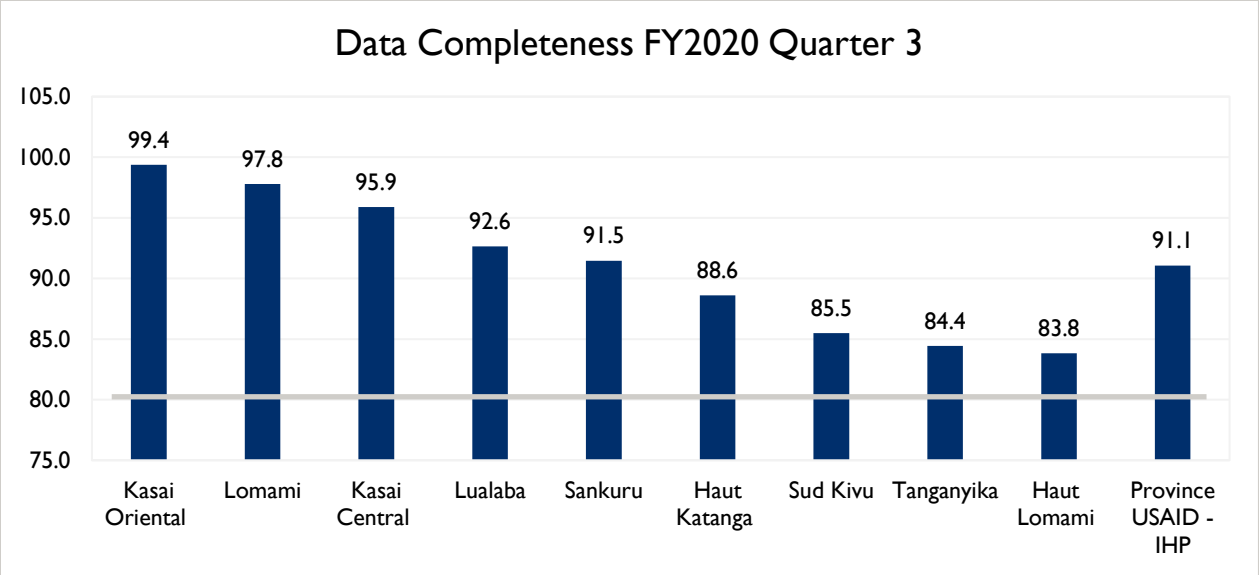
We extracted data in this table from DHIS2 on July 23, 2020; they represent FY2020 Quarter 3 (April-June 2020). The data was originally disaggregated by province. We reorganized the data into the regions for this table. The province data will be entered into the Monitoring, Evaluation and Coordination Contract (MECC) database.

Since the start of the project, the MOH's health information system has recorded 179 ZS in Program provinces, which adds one ZS to the number counted in the proposal and contract. The additional zone is Kowe in Haut-Katanga. The program has always operated in all 179 health zones.

DATA COMPLETENESS--MECC AND MSRT DATA TABLES

As noted in the Research, Monitoring, and Evaluation (RME) chapter of this report, we have identified some issues related data completeness for the data that comes from the MOH's DHIS2. Official data completeness figures as reported through the Health Management Information System (HMIS) have systematic errors. Facility or data entry clerks can submit data "on time" by simply clicking a button on the data entry page—they do not need to enter any data at all. There are many reasons why they might do this: for example, someone responsible for data entry may "submit" an empty data form so the data is counted "on time" even if it is not. We expect that future data quality activities with the MOH will investigate the reasons for this to improve true reporting rates. Ultimately, this challenge means the reporting rates reported in USAID IHP reports are inflated.

Because of this systemic flaw, USAID IHP has developed as part of the Performance Dashboard and monitoring and evaluation (M&E) platform a "true" data completeness and timeliness measure. The data completeness dashboard looks at the status of data fields submitted. If any required fields are empty or incomplete when submitted, the data completeness dashboard will not count that the data as complete and on time.



Source: DHIS2, accessed July 23, 2020, basic services data set. Monthly *Système National d'Information Sanitaire* (SNIS, National Health Information System) *canevas*.

To qualify as "complete," at least 50 percent of the data must be entered into DHIS2. The data completeness dashboard collects passive data to ensure that at least 50 percent of the data elements have been entered.

MOH standards require data to be entered by the 23rd of the following month and stipulate that 80 percent of facilities is the acceptable reporting rate. Data completeness and timeliness are key elements of data quality. If data are late, they cannot be used in real time to understand performance results and inform planning and budgeting. Missing data simply are not available for use. In sum, late and incomplete data are misleading and misrepresent performance results.

Furthermore, late and incomplete data create discrepancies between the annual data reported through MECC and the data in the MSRT tables in Annex A. USAID IHP produces the data for MECC and the MSRT by downloading the DHIS2 data disaggregated by province, which is then combined into regions for the MSRT in Annex A. These two data tables are standardized to one decimal place and checked for rounding errors. The MECC data is then entered into MECC and the MSRT table is formatted and published in Annex A of the quarterly (or annual) report.

Table 39. Annual Datasets

Annual data Dataset	Distinguishing characteristic	Data source
MECC	Disaggregated by province	Static MECC data reported Q1, Q2, Q3, and Q4.
MSRT	Disaggregated by region	Dynamic data reported from DHIS2.

ADDITIONAL NOTES ABOUT THE DATA IN THE MSRT TABLE

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. We also use N/A to note data that isn't applicable due to the indicator definitions, for example, for indicators measuring numbers, we fill the numerator and denominator with N/A. We also use N/A to note data that should be coming from the supplementary

module (the *module complementaire*). There is no reliable way to collect this information until the system is operational, in Year 2.

Furthermore, not all data have been integrated into the platform; some indicators are collected through the HMIS but not reported through DHIS2. During FY2019, USAID IHP worked with MOH partners to add additional modules to DHIS2 to capture these data. The MOH has started data entry training for these data and we expect to see the data in the Program' next quarterly report.

DETERMINATION OF BASELINE, TARGETS, AND QUARTER I DATA REPRESENTED IN THE MSRT TABLE

Determination of Baseline Values

Baselines have been determined according to the sources of the indicator data. These include:

- The USAID IHP service delivery mapping survey (noted in the table as EDL, for *enquête d'état des lieux*) 2019, these baselines have been updated with the data prepared for the resubmission with the complete dataset. This report will be resubmitted in Quarter 3.
- The USAID IHP household survey (noted in the table as EDM, for *enquête de menages*) 2019
- DHIS2
- The internal USAID IHP Performance Monitoring Report (PMR)
- The *Enquête Démographique sur la Santé* (EDS, Demographic and Health Survey)/Multiple Indicator Cluster Survey (MICS)

The EDS 2013–2014 report served as the basis for the baseline data for indicators with the data source listed as the EDM 2019 and EDL 2019 surveys in previous report up to and including the Y1 annual report. The data in EDS 2013–2014 are presented according to the former configuration of provinces, they were recalculated to reflect the USAID IHP regions.

Since the Year 2 Quarter 1 report, however, baselines have been updated using the service delivery mapping and household survey data reported in the first submission of these reports. We have also used PMR data when possible. The baselines originating from the mapping and household surveys will be updated when data collection and cleaning is finalized for resubmission in Quarter 3.

Where the activity is based on program activity and the source is the project monitoring report, we have updated the table to read "0" because the program was not active before Year 1.

Determination of Targets

For the indicators for which we originally used EDS/MICS to determine baselines, we increased the targets from 2 to 3 percent, per USAID request for the FY2019 Quarter 3 report and moving forward.

For the indicators derived from HMIS, specifically DHIS2, we applied PNDS 2019–2022 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. Some indicators do not have targets because we are responding to MOH and GDRC needs.

We have begun to apply targets to indicators collected from the service delivery mapping and household surveys and PMR indicators, based on baselines. We expect to discuss and finalize these with USAID and government partners in Quarter 3.

Quarterly targets are noted as N/A if an indicator is reported annually. Annual targets are noted as N/A for data that is reported only in Years 4 and 7, through service delivery and mapping survey data collection.

ANNEX C: SUCCESS STORIES

1. Boosting malaria prevention for pregnant women
2. Training to monitor and address child malnutrition
3. Nine months after, MDR-TB outbreak is under control
4. Men's support is key to exclusive breastfeeding
5. Revitalized community care sites: linchpins for lowering child mortality
6. Knowing the danger signs for pregnant women and young children
7. Counteracting harmful beliefs for pregnant women
8. Practical measures to cost-effectively fight COVID-19
9. Hospital hygiene committee tackles sanitation issues

SUCCESS STORY

Boosting malaria prevention for pregnant women

In Haut-Lomami, USAID training increases pregnant women's access to intermittent preventive therapy to combat malaria.

Photo: Emile Nkulu, Ministry of Health for USAID IHP

Bernadette Kitenge taking a dose of S/P supervised by the registered nurse at the Kalunga Health Center.

"I have never had the fourth dose of S/P before, and my children have had health problems, and I had a miscarriage during a previous pregnancy. But this time… I received advice on drugs to prevent malaria. … From now on I encourage other pregnant women to go to ANC consultations early."

Bernadette Kitenge, mother of three

Malaria infection during pregnancy can lead to maternal and fetal anemia, premature delivery, low birth weight, and even the death of the newborn or the mother. To combat this scourge, the World Health Organization recommends that all pregnant women receive four doses of intermittent preventive therapy with sulfadoxine/pyrimethamine (S/P) during antenatal care (ANC) visits.

In Haut-Lomami province in the Democratic Republic of the Congo (DRC), the District Health Information System 2 showed in 2019 that 85 percent of women attending ANC visits took the first dose of S/P, 76.7 percent took the second dose, 58 percent took the third dose, and 33 percent took the fourth dose. Results in the province's Baka military health zone were even worse—only 20 percent of women there completed a fourth dose of S/P. Many pregnant women and providers simply lacked knowledge about the ANC visit schedule.

To reverse this trend, the USAID Integrated Health Program (USAID IHP) supported the Haut-Lomami provincial health district to organize a five-day training in November 2019. The training for 13 female and 32 male health care providers—including those from the Baka health zone—focused on prevention and correct management of malaria in women, particularly supervised intake of S/P during pregnancy and the need to follow the ANC visit schedule. The providers subsequently raised awareness during ANC visits at health facilities, while community health workers went door-to-door to reach households. USAID IHP also equipped all Baka health facilities with filters and cups to facilitate supervised intake of S/P.

In the Kalunga health area of the Baka health zone, S/P intake by pregnant women increased from 51 percent from October to December 2019 to 95.7 percent from January to March 2020, while women taking the fourth dose of S/P at the 36th week of pregnancy increased from 25 percent to 76.9 percent for the same period.

"Although the national standard is 80 percent, that is a remarkable improvement," said Emile Nkulu, Supervisory Nurse in Baka. "We are going to continue to achieve the standard."

With support from the President's Malaria Initiative, USAID IHP is supporting S/P intake and other strategies for reducing malaria in Baka and 178 other health zones in the DRC.

SUCCESS STORY

Training to monitor and address child malnutrition

USAID-supported training dramatically increased attendees of preschool consultations in Haut-Katanga Province.

Photo: Gaston Muvudi, IRC for USAID IHP

Registered nurse Louis Heradi Saidi meets with a mother and child during a revitalized preschool consultation session.

"This is a success for the whole Kikula health zone, and we say thank you to USAID IHP for supporting this training."

Dr. Blaise Musoya,

Kilula Health Zone Chief Medical Officer

The Democratic Republic of the Congo (DRC) relies on a program of revitalized preschool consultations (CPSr) to reach children under 5 with nutrition and vaccination interventions. Louis Heradi Saidi, a registered nurse in Haut-Katanga Province since 2004, has been responsible for CPSr but lacked the knowledge to ensure quality care.

"Preschool consultations are an activity that boils down to vaccination of children in the 0–11 month age group and weighing them," Mr. Saidi said. "I did not know how to interpret the growth curve on the preschool consultation sheet or read the World Health Organization's unisex weight-for-height table to classify malnutrition."

In April 2020, Mr. Saidi participated in a training on CPSr organized by the Haut-Katanga provincial health district, joined by 17 other nurses and health zone management team members. The USAID-funded Integrated Health Program (USAID IHP) supported the training as part of ongoing backing for the National Nutrition Program's efforts to reduce the prevalence of chronic malnutrition.

"[T]hanks to this training, I can read the unisex weight-height table of the World Health Organization to classify malnutrition and interpret the growth curve of the child," Mr. Saidi said. "I started to put this into practice to improve the quality of care."

Following the training, Louis saw CPSr monthly attendance increase significantly in the Kikula health zone, home to an estimated population of 42,732. In March 2020, 339 children attended CPSr sessions. That number rose to 740 in April, 807 in May, and 1,117 in June—a 229 percent increase over a three-month period.

"The training of providers in revitalized preschool consultation has allowed us to improve not only our performance but also our learning about [CPSr] strategies," said Dr. Blaise Musoya, the Kikula Health Zone Chief Medical Officer. "This enabled us to reach all the children eligible for a preschool consultation, which was difficult to do before."

SUCCESS STORY

Nine months after, MDR-TB outbreak is under control

USAID's August 2019 campaign, testing and follow-up in Sankuru province identified dozens of cases and funded months of treatment.

Blaise Ekofo Abt Associates for USAID IHP

Constantin Esema and his daughter during post-treatment evaluation at the Bena Dibele Diagnosis and Treatment Health Center.

"I no longer feel pains in my back and chest, and I even have the impression of having increased weight. My daughter and I finished the cure, and our last sputum test was normal."

Constantin Esema, former MDR-TB patient, Bena Dibele

In mid-2019, an outbreak of multi-drug resistant tuberculosis (MDR-TB) spiked in Sankuru province in the Democratic Republic of the Congo. This outbreak rang alarm bells, as this form of TB can develop into an ultra-resistant form. To tackle this challenge, the USAID Integrated Health Program (USAID IHP) supported the Sankuru provincial health district to organize an awareness mini-campaign on TB in five health zones, including Bena Dibele. Nine months later, patients with identified MDR-TB have responded successfully to treatment.

The initial August 2019 effort combined a door-to-door campaign, an active search for TB cases, and sputum transport for people with signs of the disease. Of 977 presumed TB cases who submitted sputum samples during the mini-campaign, 159 tested positive for drug-sensitive TB, and 27 tested positive for MDR-TB.

One of the MDR-TB patients was Constantin Esema, a farmer with three children in Bena Dibele, who had been battling a cough, fever, and chest pain for a long time. Following an interview with a community health worker, he gave a sputum sample and received a diagnosis of MDR-TB with instructions to visit the Bena Dibele Diagnosis and Treatment Health Center.

"I started to go to the health center daily for treatment, but I did not believe in modern medicines, so I stopped the treatment and… left the village," Mr. Esema said.

Noticing his patient's absence, Augustin Nkoy, a registered nurse at the center, followed up.

"I went to his home to meet him and took the opportunity to screen the whole family," Mr. Nkoy said. Mr. Esema's 6-year-old daughter also tested positive for MDR-TB in September 2019. With USAID IHP support, she received treatment, food, and US$30 in cash for transportation to the health center—news that reached her father in a neighboring village.

"A month later I returned and found that my daughter's health had improved," Mr. Esema said. "This prompted me to resume taking the medication regularly, as my daughter was proof to me that I could be cured."

Constantin and his daughter are among 23 MDR-TB patients identified during the August 2019 mini-campaign who have finished a nine-month course of treatment and are awaiting national-level sputum culture results to confirm they are cured.

SUCCESS STORY

Men's support is key to exclusive breastfeeding

USAID IHP supported World Breastfeeding Week activities that helped mothers and their male partners understand the importance of exclusive breastfeeding.

Photo: Anny Kaja, Pathfinder for USAID IHP

Marie Beya and Charles Ntumba brought their baby to a preschool consultation for vaccination.

"The advice received during the forums and through home visits from community health workers helped us a lot, we have noticed, because we are not worried about the baby and her weight is only increasing each month. I have resolved to advise other men to do like me."

Charles Ntumba, husband of Marie Beya

Every August, World Breastfeeding Week promotes key practices for exclusive breastfeeding to improve babies' growth and health. In August 2019, the USAID Integrated Health Program (IHP) supported seven provincial health districts to carry out awareness mini-campaigns, including through door-to-door visits, appearances in maternity wards and during antenatal care visits, preschool consultations, radio campaigns and testimonials.

In October 2019, a USAID IHP household survey found that 77.5 percent of children under six months in its target nine provinces were exclusively breastfed. However, this varied among provinces, from a high of 90.9 percent in Sankuru to a low of 59.8 percent in Tanganyika.

A key tactic in 2019 was supporting community leaders and the local infant and young child feeding (IYCF) groups to persuade fathers and partners to support exclusive breastfeeding—particularly within patriarchal cultures where men do not traditionally get involved in family health.

In Kasaï-Central province, Marie Beya was counseled during childbirth and started breastfeeding within the first hour. During follow-up home visits, Marie's husband, Charles Ntumba, was encouraged to support her to breastfeed exclusively until their baby was six months old. By July 2020, her 11 month-old daughter weighed 10 kilograms.

"Without my husband's involvement, my baby would have been susceptible to illness and might even have died. I would not have had the courage to breastfeed exclusively," Marie said. "But my husband monitored and ensured I followed the guidance, and I benefitted from visits from the IYCF support group."

In Lomami province, Sylvie Musau said her husband encouraged her to exclusively breastfeed their seventh child for the first six months after learning of its importance during the 2019 campaign.

"[T]his baby didn't get sick like the other six," Ms. Musau said in July 2020 of her son, then seven months and 9.5 kilograms, "Now I raise awareness among other women about exclusive breastfeeding."

The 2019 campaigns reached a total of 17.067 pregnant women and 28,065 nursing mothers—along with 29,554 male partners. During World Breastfeeding Week in 2020, USAID IHP is again supporting mini-campaigns to reach both mothers and fathers, this time in all nine provinces.

SUCCESS STORY

Revitalized community care sites: linchpins for lowering child mortality

After receiving USAID training and essential supplies, community care sites in Sud-Kivu Province are once again vital resources for remote villages.

Dieudonne Cigajira, IRC for USAID IHP

"It is thanks to the care offered by our site that my son Muzusa survived," said Agnes N'shamamba of the Nabishaka community care site.

"Really, these are simple but life-saving gestures: Training and supplying inputs. USAID IHP support has substantially helped the population in reducing child deaths."

Jean-Baptiste Baharanyi
Community health worker
Nabishaka

On the third day of her 3-year-old son's diarrhea, Agnès N'shamamba took him to seek medical attention. It was 10 pm on a Thursday in April 2020, and the nearest health center in the Kaniola health zone of Sud-Kivu Province was 90 minutes away through the mountainous Mugaba Forest, along a path where violent crime was resurging.

Ms. N'shamamba was able to instead visit the newly revitalized Nabishaka community care site in her village and woke up its community health worker, Jean-Baptiste Baharanyi. He gave her son a glass of oral rehydration solution and tablets of zinc and Mebendazole—as well as packets of all treatments to take home.

Community care sites, established by the Ministry of Health, ensure the health of remote populations, including young children. In the Democratic Republic of the Congo, every hour, 30 children under 5 die, often due to treatable conditions like diarrhea.

For years, the Nabishaka community care site was non-functional due to a lack of supplies and frequently changing community health workers. In August 2019, the USAID Integrated Health Program targeted this site and seven others in the Kaniola health zone for revitalization to improve communities' access to health services.

With USAID IHP funding, Sud-Kivu's provincial health division trained 16 community intermediaries from eight sites, eight nurses, and three members of the Kaniola health zone's management team. The August 10-12 training covered correct care of sick children, management of community care sites, and use of tools such as the consultation register, medication use register, order book and monthly report template.

Following the training, the project provided the eight sites with essential materials, including tape to measure Middle Upper Arm Circumference—a prime way to spot underweight children—as well as care sheets, supervision sheets, flashlights, washbasins, cups, tables and cupboards. USAID IHP also finances supervision of the sites by nurses from the closest health centers.

Since the Nabishaka community care site became fully functional in October 2019, it has treated 49 children—averaging six per month—and referred five to the health center for severe acute malnutrition and severe dehydration with pneumonia, Mr. Baharanyi said.

SUCCESS STORY

Knowing the danger signs for pregnant women and young children

USAID-supported training boosts community health workers' outreach capacity and increases the number seeking treatment at health facilities.

Patrick Nduwa, IRC for USAID IHP

Community health worker Viviane Kateba meets with families during household visits to raise awareness about health danger signs and the need to seek qualified treatment at health facilities.

"The [community health workers' visits] got heads of households and parents to pay attention to the risks of neglecting early consultations at the health center and trying self-medication, and pushed them to visit the health centers."

Viviane Kateba, community health worker Dipeta II health area

Pregnant women and children under 5 are particularly vulnerable to disease and infection, so is vital they seek prompt, professional treatment when they develop danger signs such as fever. In the Democratic Republic of the Congo, this means identifying these vulnerable populations, flagging any danger signs, and referring them to the nearest health facility.

The USAID Integrated Health Program supported the Lualaba provincial health district to train 23 community health workers on this approach on June 6-7, 2020. The participants—from four health areas in the Fungurume health zone—improved their interpersonal communication skills and learned how to identify danger signs and refer people to health facilities.

In the Dipeta II health area, the newly trained community health workers combined theory and practice by fanning out to conduct home visits over a one-day period. They urged pregnant women and parents and guardians of children to pursue care at health facilities rather than resort to self-treatment with medicinal plants or seek recourse from traditional healers.

Out of 105 households visited over the course of the day, community health workers found 42 pregnant women, including 17 (40.5 percent) with identified danger signs. They also recorded 49 children under 5, including 13 children with danger signs (26.2 percent). All were referred to the nearest health center.

"The households in the Dipeta II health area confirmed that… community health workers encouraged them to go to the nearest health center to receive appropriate care to treat danger signs in pregnant women, infants, and children under 5," said Viviane Kateba, a community health worker.

Following the training and home visits, the number of pregnant women in the Dipeta II health area who attended their first antenatal care visit, another important means of monitoring women's health, rose from 59 in April 2020 to 82 in June 2020, a 39 percent increase.

SUCCESS STORY

Counteracting harmful beliefs for pregnant women

USAID behavior change campaigns in Sud-Kivu Province promote antenatal care visits for healthy mothers and babies.

Josue Mabaya, IRC for USAID IHP

Ferdinand Siyajali initially believed that antenatal care visits could cause her to lose her baby.

"I will also sensitize friends and other women who believed like me in the community."

Ferdinand Siyajali
Expectant mother
Kilomoni heath area

In the 26th week of her third pregnancy, Ferdinand Siyajali finally agreed to attend an antenatal consultation (ANC), well after the 12-week threshold recommended by the World Health Organization. The 26-year-old from Kilomoni health area in Sud-Kivu province had avoided doing so before because she believed it might lead to miscarriage

"[O]ur grandmother told us to hide the pregnancy during the period of up to six months for fear that it—this does not disappear," she said.

Many women in rural health areas continue to hold similar beliefs that are socio-cultural barriers to the use of health services. To remedy this, USAID through its Integrated Health Program supports the Ministry of Health to encourage adoption of healthy behaviors through social and behavioral change communication campaigns.

A mini-awareness campaign in the Kilomoni health area, May 27-31, 2020, promoted the advantages of ANCs to identify any potential problems and to help prevent malaria in pregnant mothers and their unborn children. USAID IHP also supported the provincial health division to organize a briefing two days in advance on these topics for 14 community health workers and 24 other members of the community.

This mini-campaign reached more than 4,000 people, including through home visits by community health workers and "champion community" members, and through town criers to relay mass messages. During the home visits, community health workers met Ms. Siyajali and her family and eventually persuaded her to attend an ANC.

"It took nearly 45 minutes for discussions with Ferdinand and her husband, insisting on the fact that by going to the ANC, we protect the pregnancy and the mother more than by staying at home, because (there) we run the risk of a death," said Kabika Janda, community health worker.

"Really, I commit to follow any sessions that remain, and now I will be at the prenatal consultation from the 16th week of all pregnancies," Ms. Siyajali said. "I will also sensitize friends and other women who believed like me in the community."

SUCCESS STORY

Practical measures to cost-effectively fight COVID-19

USAID supported briefings on ways to control spread of coronavirus in Kasaï-Central Province.

Photo: Germaine Sombamanya, Pathfinder for USAID IHP

Mask-making lessons in Kasaï-Central Province

"I am making the decision today to talk about barrier measures to my community to fight against COVID-19."

Dorcas Sakulu
Warden head and community intermediary
Luiza health zone

As around the world, COVID-19 is spreading in the Democratic Republic of the Congo. Between March 10 and August 17, 2020, the country recorded 9,721 cases of COVID-19, including 243 deaths. The national Ministry of Health and development partners have set up a national crisis unit to monitor the pandemic and put in place effective measures to control it—including events to raise public awareness.

In Kasaï-Central Province, the USAID Integrated Health Program supported the provincial health district to conduct briefings on COVID-19, piggybacking on an already planned evaluation of a family planning campaign. In June and July 2020, these briefings in Luiza, Ndekesha, and Yangala health zones covered common symptoms, modes of contagion, and prevention of COVID-19. Participants included 36 community health workers (31 men and five women), six registered nurses (all men), and six members of the management team (all men) of the three health zones.

These briefings were accompanied by the distribution and placement of 1,500 leaflets and posters, as well as provision of prevention kits, including gloves, handwashing materials, disinfectant and garbage cans. These efforts have helped sensitize more than 73,000 people, including 40,469 women, to COVID-19 control measures.

"I, who did not know the correct technique of hand washing, who was not informed about all the barrier measures of COVID-19, at times I wondered how I could help my community on how to protect itself against COVID-19," said Dorcas Sakulu, a warden head and community intermediary in the Luiza health zone. "Thanks to USAID IHP, I feel able to educate my community on COVID-19, as a neighborhood manager and community health worker."

Given the infeasibility of buying masks in rural areas—if they are available, they can cost as much as 3,000 FC (US$1.40)—the Program also showed participants how to make masks during a hands-on tutorial with materials that cost around 500 FC ($.24).

"I am delighted with this effort to show us how to make masks, because the community is incapable of buying masks that cost 3,000 FC or even 1,500 FC," said Emango Tshimanga, provincial supervisor of the national program for reproductive health.

SUCCESS STORY

Hospital hygiene committee tackles sanitation issues

In Haut-Katanga hospital, post-operative infections have plummeted to zero since committee launched to oversee and carry out cleaning, maintenance and sterilization.

Photo: Josue Kasongo, MOH for USAID IHP

Sanitation committee members and supporters following a cleanup of hospital grounds.

"All this information in terms of hygiene and public sanitation standards as well as the installation of the committee has enabled us to significantly reduce the occurrence of infections contracted in the healthcare environment."

Dr. Josué Kasongo
Physician Director
Kilwa General Hospital

The general hospital in Kilwa health zone in Haut-Katanga province has 100 beds and serves an estimated population of 207,154. In late 2019, data showed it had an unacceptably high level of post-operative infections—30 out of 57 operations, or 52 percent—to which onsite unsanitary conditions likely contributed.

In January 2020, the USAID Integrated Health Program supported Haut-Katanga's provincial health division to brief 28 hospital staff and four members of the Kilwa health zone's central office on hygiene and public health. The division's facilitator covered priorities like the correct management of biomedical waste, hospital grounds, garbage cans, ash pit, incinerator, and receptacles for disposing of placentas, as well as needed materials—and the roles of a health and hygiene committee.

At the end of the briefing, the hospital's medical director, Dr. Josué Kasongo, made a commitment to improve the situation and set up a hygiene and sanitation committee made up of seven people, including three women.

This dynamic committee includes a president, a vice-president and five heads to oversee five "cells": courtyard; sanitary facilities; structures and water management; rooms and offices; sterilization of equipment and laundry. In addition, this committee educates family members accompanying patients and bringing in food and dishes on how to follow guidelines for maintaining hygiene.

"All this information in terms of hygiene and public sanitation standards and the installation of the committee has enabled us to significantly reduce the occurrence of infections contracted in the healthcare environment," said Dr. Kasongo.

The committee has purchased basic materials—such as hoes and machetes to clear brush—and meet monthly to review progress. Between February and July, data shows there have been no post-operative infections at the hospital.

"Currently this committee has a duly developed work schedule and records of daily tasks to be performed," Dr. Kasongo said. "And in every cell today there is a marked improvement, and every month we are evaluating."

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 Dates:	May 26, 2018–May 29, 2025[6]
Contract/Award Number:	72066018C02001
Implementing Partner(s):	Abt Associates, International Rescue Committee, Pathfinder International, BlueSquare, Training Resources Group, Mobile Accord/Geopoll, i+Solutions, Viamo, Matchboxology
Tracking ID:	
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:	Rio MALEMBA
Date Prepared:	August 3, 2020
Submitted by:	USAID IHP
Date Submitted:	August 28, 2020

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

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 impose 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 IEE requirements over the preceding project implementation period. They are typically provided annually, but the frequency will be stipulated in the IEE or award document.

Generally, EMMRs are developed by the Implementing Partner (IP) (and updated at least annually) in conjunction with the Annual Report. Responsibility for ensuring IPs submit appropriate EMMRs rests with USAID CORs/AORs. These reports are an important tool in adaptive management and are used by Mission, Regional, and Bureau Environmental officers to ensure USAID interventions are implemented in compliance with 22 CFR 216 and mitigation measures are adequate.

SCOPE

The following EMMR documents the status of each required mitigation measure as stipulated in the associated Environmental Mitigation and Monitoring Plan (EMMP). It provides a succinct update on progress regarding the implementation and monitoring of mitigation measures implemented as detailed in the EMMP. It summarizes field monitoring, issues encountered, actions taken to resolve identified issues, outstanding issues, and lessons learned.

This EMMR includes the following:

1. A succinct narrative description of the EMMP implementation and monitoring system, any updates to the system, any staff or beneficiary trainings conducted on environmental compliance, lessons learned, and other environmental compliance reporting details.
2. EMMR table summarizing the status of mitigation measures, any outstanding issues relating to required conditions, and general remarks.
3. Attachments such as photos of mitigation measures and activities, waste disposal logs, water quality data, etc.

USAID REVIEW OF EMMR

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 [as required]	Date

DISTRIBUTION:

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 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, newborn, 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.

ENVIRONMENTAL COMPLIANCE MONITORING AND REPORTING

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

LESSONS LEARNED

USAID IHP will synthesize and report lessons learned alongside the annual report update to the EMMR.

EMMR TABLE FOR USAID IHP (FY2020 QUARTER 3)

Project/Activity/Sub-Activity	Mitigation Measure(s)	Summary Field Monitoring/Issues/Resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding Issues, proposed resolutions
Activity 1:			
Education, technical assistance, training to improve access to and delivery of health care.	1. Ensure that training/ curricula/ supervision addresses appropriate management practices concerning proper handling of medical waste. 2. Ensure that training addresses correct water and sanitation practices. 3. Ensure that capacity development addresses maintenance of health clinic grounds. 4. Ensure that training addresses prevention of transmission of HIV/AIDS and other blood-borne pathogens in health-care settings, including availability of post-exposure prophylaxis (PEP) and guidelines.	USAID IHP supported training on sanitation and biomedical waste management and other WASH-related aspects in line with the clean clinic approach framework in Kasaï-Central and Sud-Kivu. More specifically, the program trained 125 clinical and community providers (41 women) from 25 health centers in 3 ZS in Kasaï-Central and 60 providers (15 women) from 12 health centers in 3 ZS in Sud-Kivu. During the trainings, USAID IHP emphasized (i) the management of excreta, wastewater and rainwater, waste and the environment in relation to sanitation in a health center and (ii) logical sequence of the biomedical waste management process (minimization; separation; collection, handling and transport; storage / warehousing as well as treatment and disposal).	The majority of providers have knowledge gaps about the required measures for the management of the health facilities. Providers must adopt good practices to implement the mitigation measures in their health centers.
Activity 2:			
Procurement, storage, and management of public health commodities, including pharmaceuticals and supply chain strengthening activity.	1. Apply guidance on posting procedures on waste and storage management at health facilities. 2. Provide guidance manual on incinerator and waste pit operation to hygienists and operators. 3. Apply MOH guidance on	USAID IHP is designing a supply chain training that the project will conduct for pharmaceutical management teams (MCZ and pharmacists) of 178 USAID IHP-supported ZS. This training includes a module on pharmaceutical waste management. In addition to the training itself, USAID IHP will produce and distribute a poster summarizing key messages in the management of biomedical and pharmaceutical waste for health facilities.	

Project/Activity/Sub-Activity	Mitigation Measure(s)	Summary Field Monitoring/Issues/Resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding Issues, proposed resolutions
	remitting expired drugs.		
Activity 3:			
Provision of long-lasting insecticidal nets for vector control.	Train beneficiaries on proper use of bed nets, and on risks of improper use or disposal, especially in ecologically-sensitive areas, including lakes and rivers.	Currently, health facilities currently retrieve bed nets from the ZS offices. As USAID IHP supports local stakeholders in additional efforts to ensure delivery of bed nets at the health facility level, the program will provide training in the proper use of nets and the risks of inappropriate use or disposal in tangent with the distribution of nets.	
Activity 4:			
Construction and improvement of water and sanitation systems.	1. Submit water quality assurance plan (WQAP) to USAID when potable water systems are constructed. 2. Sensitize the community on hygiene as it relates to water handling and storage. 3. Use piping and water collector material of the recommended quality: PE, PVC, HDPE. 4. Ensure water conservation measures: efficient taps, reduced leakages due to use of high quality high density polyethylene (HDPE) fittings. 5. Install safety taps at all water supply points: valve chambers built to section off segments of the pipelines in case pipes burst, safety valves at water reservoirs. 6. Conduct proper maintenance of pipes and storage tanks.	USAID IHP launched the ongoing implementation of gravity water system rehabilitation works within two ZS of Sud-Kivu: Kalengo, Miti-Murhesa ZS and Kabamba, Katana ZS. Notable actoins and observations were: -USAID IHP promoted community awareness on nature conservation and management of water as a finite resources. This contributes to the protection of water sources and integrated management of watersheds. -The Water Point Management Committees were set up to sensitize communities on hygiene with regard to the handling and storage of water. -PVC pipes of the recommended quality are being laid -Construction of standpipes is underway with attention paid to water conservation measures, such as ensuring that the taps are efficient and the fittings of high quality.	

Project/Activity/Sub-Activity	Mitigation Measure(s)	Summary Field Monitoring/Issues/Resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding Issues, proposed resolutions
	7. Exclude livestock from water points. 8. Employ water disinfection methods, which include chlorination, chloramination, ozone, solar, and ultraviolet disinfection. 9. Conduct water testing and treatment via a competent water specialist using standard methods for nitrate, bacteria, arsenic, and other suspected contaminants 10. Monitor water quality at system start-up, after 1 month, and annually after that. 11. Post signage at water points with messages on sustainable use of water.		
Activity 5:			
Office management and supply.	1. Ensure careful planning and implementation of sustainable practices for resource usage and waste minimization: 2. Use electricity wisely. 3. Reduce, reuse, recycle. 4. Use environmentally friendly office products. 5. Use non-toxic cleaning products. 6. Make eco-friendly food choices.	During Quarter 3, USAID IHP continued to enforce social distancing measures and enforced restrictions in accordance with DRC government and Abt Associates guidelines. In addition, the project has allowed staff to work from home, i.e., telework, as a preventive measure against the spread of COVID-19. The latter decision especially has helped to minimize the use of paper, waste production and electricity at the Kinshasa office mainly but also somewhat in the provincial offices.	

Project/Activity/Sub-Activity	Mitigation Measure(s)	Summary Field Monitoring/Issues/Resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding Issues, proposed resolutions
	7. Allow staff to sometimes work from home. 8. Aim for paperless office.		
Activity 6:			
Transportation of personnel and supplies.	1. Adjust mobility of staff concepts, include walking short distances versus being dropped at destination. 2. Purchase fuel-efficient vehicles, planning to avoid unnecessary trips, management of order quantities.	USAID IHP staff teleworking practices to mitigate the spread of COVID-19 resulted in reduced vehicle usage and fuel consumption, particularly in Kinshasa.	
Activity 7:			
Funding private sector acquisition of diagnostic and treatment equipment.	1. Ensure due diligence investigation of the environmental record and practices of each private party. 2. Ensure training recipients on proper use and disposal of equipment at end of life, and on the risks of improper use and disposal. 3. Ensure training recipient on the environmental risk related to the activity.	As part of USAID IHP provider training described under Activity 1 above, the project trained 60 providers in Sud-Kivu and 125 providers in Kasaï-Central in the management of biomedical waste. Biomedical waste is waste resulting from diagnostic, monitoring, preventive, curative or palliative treatment. The training detailed the five stages of waste management: 1. minimization, 2. sorting / separation, 3. collection / transport, 4. storage, and 5. treatment / disposal.	
Activity 8:			
Very small-scale construction or rehabilitation (less than1000m^2 total disturbed area) with no complicating factors.	No mitigation measures required as there was no such activity in Quarter 3.		
Activity 9:			

Project/Activity/Sub-Activity	Mitigation Measure(s)	Summary Field Monitoring/Issues/Resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding Issues, proposed resolutions
Small-scale construction.	No mitigation measures required since as there were no small scale construction in Q3.		
Activity 10:			
Sub-grant activities.	No mitigation measures are required as there were no sub-grant activities for Q3.		
Activity 11:			
Activity 12:			

ADDITIONAL COMMENTS

ATTACHMENTS

USAID REVIEW OF EMMR

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 [***as appropriate***]	Date

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