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USAID'S INTEGRATED HEALTH PROGRAM

Fiscal Year 2021 Quarterly Report 2 (January 1 through March 31, 2021)

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Cover Photo: A nurse weighs a child during an after-birth visit at the Crina health center in Kamalondo ZS, Haut-Katanga. Photo by Jean Manassé Tshibamba, freelance photographer for USAID IHP.

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USAID'S INTEGRATED HEALTH PROGRAM

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Contract No.: 72066018C00001

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based combination therapy
ADF	Allied Defense Forces
AMEP	Activity Monitoring and Evaluation Plan
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ARI	Acute respiratory infection
BCZS	*Bureau central de la zone de santé* (Central office of the health zone)
BEmONC	Basic emergency obstetric and newborn care
CA	*Conseil d'Administration* (Administrative Council)
CAC	*Cellules d'animation communautaire* (Community action groups)
CBD	Community-based distributor (of contraceptives)
CBO	Community-based organization
CBS	Community-based surveillance
CODESA	*Comités de Développement de l'Aire de Santé* (Health Area Development Committees)
COGE	*Comité de Gestion* (Management Committee)
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	*Consultation préscolaire redynamisée* (Revitalized preschool consultation)
CSDT	*Centres de santé de diagnostic et traitement* (Diagnosis and treatment health centers)
CSO	Civil society organization
CTMP-PF	*Comité Technique Multisectoriel Permanent de Planification Familiale* (Multisectoral Technical Committee for Family Planning)
CYP	Couple years of protection
D&F	Determination and Finding
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	Medroxyprogesterone acetate
DOT	Directly observed therapy
DOTS	Directly observed therapy – short course
DPS	*Divisions Provinciales de Santé* (Provincial Health Districts)
DQI	*Démarche de Qualité Intégré* (Integrated Quality Improvement)
DRC	Democratic Republic of the Congo (*République démocratique du Congo*)
DR-TB	Drug-resistant TB
DSSP	*Direction des Soins de Santé Primaires* (Directorate for Primary Health Care)
ECDPS	*Equipe Cadre de la DPS* (Executive Team of the Provincial Health District)
ECZS	*Equipe Cadre de la Zone de Sante* (Health Zone Mangement Team)
EDS	*Enquête Démographique sur la Santé* (Demographic and Health Survey)
EGM	Essential generic medicines

EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency obstetric and neonatal care
EPI	Expanded Program on Immunization
EPP	*Encadreur provincial polyvalent* (Multidisciplinary provincial supervisor)
FP	Family planning
FY	Fiscal Year
GAS	*Gestion des approvisionnements et des stocks* (Management of supplies and stocks)
GHSC-TA	Global Health Supply Chain-Technical Assistance
GTM	*Group de Travail Médicament* (Essential Drugs Working Group)
HMIS	Health Management Information System
HNQIS	Health Network Quality Information System
HRH	Human resources for health
iCCM	Integrated community case management
IGS	*Inspection Générale de la Santé* (General Health Inspectorate)
IMNCI	Integrated management of newborn and childhood illness
INH	Isoniazid
IPC	Infection prevention and control
IPS	*Inspection Provinciale de la Santé* (Provincial Health Inspectorate)
IPT	Intermittent preventive treatment
IPTp	Intermittent preventive treatment in pregnancy
IRC	International Rescue Committee
iHRIS	Integrated Human Resources Information System
ITN	Insecticide-treated net
IT	Infirmier titulaire (Registered nurse)
IUD	Intrauterine device
IYCF	Infant and young child feeding
LAM	Lactational amenorrhea method
LDHF	Low Dose High Frequency
LMIS	Logistics Management Information System
LLIN	Long-lasting insecticidal nets
MAPEPI	*Maladies à potential epidémique* (Diseases with epidemic potential)
MDR-TB	Multi-drug resistant TB
MDR-TB/RR-TB	Multi drug-resistant/rifampicin-resistant TB
M&E	Monitoring and Evaluation
MECC	Monitoring, Evaluation, and Coordination Contract
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MSRT	Mission Standard Reporting Template
MVA	Manual intrauterine vacuum aspiration
NMCP	National Malaria Control Program
ORS+zinc	Oral rehydration salt + zinc sulfate
OSQD	*Supervision de la Qualité des Données* (Data Quality Supervision Tool)
PAO	*Plan d'Action Opérationnel* (Annual Operation Plan)
PDSS	*Projet de Développement de Système de Santé* (Health Care System Development Project)

PICAL	Participatory Institutional Capacity Assessment and Learning
PIRS	Performance indicator reference sheets
PITT	Performance Indicator Tracking Table
PMR	Project Monitoring Report
PNAM	*Programme National d'Approvisionnement en Médicaments* (National Drug Supply Program)
PNECHOL-MD	*Programme National d'Elimination du Choléra et de lutte contre les autres Maladies Diarrhéiques* (National Program for the Elimination of Cholera and Other Diarrheal Diseases)
PNIRA	*Programme National de lutte contre les Infections Respiratoires Aigues* (National Program for the Fight Against Acute Respiratory Infections)
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)
PPDRHS	*Plan Provincial de développement des ressources humaines pour la santé* (Provincial Plan for the Development of Human Resources for Health)
PRODS	*Programme de Renforcement de l'Offre et Développement de l'Accès aux Soins de Santé* (Program for Strengthening of Supply and Development of Access to Health Care) (European Union Program)
PRONANUT	*Programme National de Nutrition* (National Nutrition Program)
PwC	PricewaterhouseCoopers
RDQA	Routine data quality assessment
RDT	Rapid diagnostic test
RECO	*Relais communitaires* (Community health workers)
RH	Reproductive health
RME	Research, monitoring, and evaluation
SBC	Social and behavior change
SDM	Standard days method
SDMPR	*Surveillance des décès maternels et périnatals et riposte* (Maternal and perinatal death surveillance and response)
SGBV	Sexual- and gender-based violence
SNIS	*Système national d'information sanitaire* (National Health Information System)
SNSAP	*Système nutritionnel de surveillance et d'alerte précoce* (Nutritional surveillance and early warning system)
S/P	Sulfadozine-pyrimethamine
SRH	Sexual and reproductive health
Sub-Q DMPA	Subcutaneous medroxyprogesterone acetate
TB	Tuberculosis

TETU	*Triage, évaluation et traitement d'urgence* (Emergency triage, evaluation, and treatment)
TP+	Bacteriologically-confirmed pulmonary TB
TRG	Training Resources Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID IHP	USAID's Integrated Health Program
USG	U.S. government
V-SAT	Very-small aperture terminal
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
WQAP	Water Quality Assurance Plan
XDR-TB	Extensively drug-resistant TB
ZS	*Zone de santé* (Health zone)

EXECUTIVE SUMMARY

In the second quarter of fiscal year 2021, USAID's Integrated Health Program (USAID IHP) in the Democratic Republic of the Congo (DRC) accelerated momentum of various interventions that enable Congolese institutions and communities to deliver quality integrated health services (see Snapshot at right). As COVID-19 cases rose and fell, intra-country travel resumed, but bottlenecks remained in the availability of Ministry of Health (MOH) and other government partners for activities to sustainably improve the health of men, women, and children in target provinces. USAID IHP pivoted to some virtual trainings and invited more clinicians to become trainers in malaria interventions, an approach with potential to expand to other program areas. The Program also leveraged its integrated nature, cross-training health care providers and community mobilizers (via the VIVA behavior change campaign) in malaria prevention, antenatal care, and nutrition for pregnant women.

Several initiatives launched in Quarter 2, including a fraud-reporting accountability hotline pilot in Lomami and Kasaï-Central, the Low Dose High Frequency clinical mentoring approach for service providers in Tanganyika, and new gender units within the *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) of Haut-Katanga, Lualaba, and Tanganyika. The Program made the first mobile money payments for last-mile health commodity deliveries and explored other ways to bridge supply chain gaps at the zonal and facility levels. These included engaging community agents for deliveries, sharing information during quarterly data validation meetings, and coordinating with upcoming mini-campaigns that spur demand for health supplies.

USAID IHP at a glance

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

Structure

The Program works in 179 *zones de santé* (ZS, health zones) across nine provinces within three regions: Eastern Congo, Kasaï, and Katanga. USAID IHP builds on previous Agency 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). The Program also implements vital cross-cutting approaches in health systems strengthening, gender integration, conflict sensitivity, and environmental monitoring and mitigation.

Quarterly highlights by program area and in health systems strengthening follow.

Malaria. The Program supported the MOH with training for health care providers; supply of sulfadoxine/pyrimethamine (S/P) for intermittent preventive treatment for pregnant women; and distribution of insecticide-treated nets (ITNs). The MOH's key results included:

- Training and retraining 1,122 providers on prevention and management of malaria in pregnant women, with an emphasis on interpersonal communication skills to promote adherence to S/P follow-up. In Lomami, provincial training incorporated DPS and ZS leadership.
- Distribution of 473,373 ITNs out of 314,687 planned—150 percent of the target—via antenatal care (ANC) and well-child visits across all nine provinces.

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

- All nine provinces held monthly maternal and perinatal death surveillance and response committee meetings, and three provinces reviewed at least 50 percent of maternal deaths, a key opportunity to identify risk factors and develop response plans.
- Program staff joined registered nurses and ZS management team members to conduct supervisory visits at 710 integrated community case management (iCCM) sites; iCCM sites also treated 75,399 sick children for pneumonia, diarrhea, and malaria.
- USAID IHP supported implementation of the Mashako Plan in eight of nine USAID provinces, in collaboration with the International Red Cross, Save the Children and UNICEF, resulting in 359,845 children vaccinated with pentavalent-3 and 349,247 children vaccinated against measles.

Nutrition. USAID IHP equipped providers, *relais communautaires* (RECO, community health workers), and community members with information on preventing malnutrition and promoting good nutrition, especially for pregnant and breastfeeding women and children under 5. This quarter, the Program:

- Trained 617 providers in nutrition-related interventions, including revitalized pre-school consultations, infant and young child feeding (IYCF), and malnutrition.
- Helped establish 60 IYCF support groups in four provinces and supported activity monitoring and coaching of 139 established IYCF support groups in 41 ZS in four provinces.

Reproductive health and family planning. USAID IHP supports DRC 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, CTMP-PF); and promotion of SBC campaigns. Key results included:

- Supported supply of FP inputs and modern contraceptive methods to the ZS, as well as seven mini-campaigns and CTMP-PF meetings to strengthen coordination of FP interventions among all stakeholders in the provinces.
- First-time users of modern contraceptive methods included 344,831 women, a 101 percent achievement rate.

Tuberculosis. Program activities to improve the quality of TB management services and care in all 179 target ZS prioritized detection and treatment, improved data, active screening, and directly observed therapy. The provinces achieved the following results:

- During World Tuberculosis Day celebrations, USAID IHP presented to key decision-makers a study on drug-resistant TB to set the stage for a policy review.

- Among 12,529 new and relapsed TP+ patients—those who started treatment in the corresponding quarter one year earlier—11,322 patients were reported cured, and 475 patients completed treatment—a 94 percent success rate. All three regions performed well against the World Health Organization (WHO) success threshold of 90 percent or higher.

WASH. The Program continued its transition to the clean clinic approach while completing rehabilitation of community-based WASH infrastructure in Sud-Kivu and construction of boreholes in Kasaï-Oriental. In this quarter, the Program:

- Supported the establishment of hospital hygiene committees in 10 general reference hospitals while 14 new target clean clinic sites completed the preliminary clean clinic approach steps and are ready for improvements upon receipt of USAID guidance on clean clinic construction and minor rehabilitation.
- Conducted water quality tests at four village wells constructed with USAID IHP assistance, one of which has given its community access to potable water for the first time.

Health system strengthening. In Quarter 2, USAID IHP supported all nine provinces to develop *contrats uniques* with provincial stakeholders and partners, with two signed in Kasaï-Oriental and Haut-Katanga. The Program trained providers on the Pathways to Change tool to facilitate behavior change for better health outcomes and disseminated the DRC's new Community Health National Strategic plan in all nine provinces to connect national, provincial, and local efforts to bolster health system monitoring and ultimately improved health services. The Program also provided technical and financial support to train 236 stock managers from 163 ZS so they can more accurately monitor drug availability and prevent stockouts. USAID IHP facilitated supervisory visits from six national specialized programs to strengthen provincial managers' ZS monitoring skills, while results from a *Démarche de Qualité Intégré* (Integrated Quality Improvement) assessment of facilities in Lualaba showed improved service provision, particularly in training and availability of essential drugs. The Program supported 29 mini-campaigns this quarter on malaria, family planning, TB, ANC, pneumonia and vaccinations that reached more than 18,600 people, and referred 5,823 children with fever and 682 pregnant women to health centers. USAID IHP completed trainings on the Community Health data collection tool that will enable the MOH to better track service delivery performance at the community level. USAID IHP also continued routine surveys to collect information about health services supply and demand to improve implementation planning.

Looking forward. Next quarter, USAID IHP will support finalization and monitoring of *Division Provincial de Santé* (DPS, Provincial Health District) organizational vision and value statements and expand provincial gender units to all nine provinces, The Program will continue building the capacity of the *Inspection Générale de la Santé (*IGS, General Health Inspectorate) and *Inspection Provinciale de la Santé (*IPS, Provincial Health Inspectorate) to analyze and respond to alerts from the accountability hotline to boost health system transparency. The Program will steadily grow its mobile money network to fill supply chain and other gaps in hard-to-access locations and expand use of the Pathways to Change tool and the VIVA roadmap to develop the capacity of providers. Within program areas, USAID IHP will continue organizing integrated activities to promote ANC and intermittent preventive treatment for pregnant women and expand the Low Dose High Frequency clinical mentoring approach to other ZS. The Program will intensify collaboration with community-based organizations in active TB case-finding activities and continue supporting quarterly TB-HIV task force meetings to strengthen the collaboration framework and expand the "One Stop Shop" strategy to other health facilities. Upon receipt of USAID guidance, the Program will launch facility WASH construction and rehabilitation and continue preparing health centers to advance in the clean clinic approach step-by-step process.

1. INTRODUCTION

This report describes implementation of USAID's Integrated Health Program (USAID IHP) during Quarter 2 of USAID's fiscal year (FY) 2021 (January 1, 2021–March 31, 2021). 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) in tackling 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 nine provinces—organized into three regional province clusters—Eastern Congo, Kasaï, and Katanga—with 179 ZS,[1] 168 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 in stewarding 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 corridors as defined in the Country Development Cooperation Strategy, high mortality rates, and/or baseline level of MNCH service offerings already available. The strategic selection of the 60 ZS also considered the presence of other technical and financial partner support so that 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**
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	27	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
Eastern Congo	Sud-Kivu	34	641	38	622	157	7,703,971
	Tanganyika	11	267	7	243	867	3,246,186
Total		**179**	**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 three core contract partners—the International Rescue Committee (IRC), Pathfinder International, and i+ Solutions—and five niche contract partners—Bluesquare, Matchboxology, Mobile Accord/Geopoll, Training Resources Group (TRG), and Viamo. During Quarter 2, 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 lutte contre les Infections Respiratoires Aigues* (PNIRA, National Program for the Fight Against Acute Respiratory Infections), *Programme National d'Elimination du Choléra et de lutte contre les autres Maladies Diarrhéiques* (PNECHOL-MD, National Program for the Elimination of Cholera and Other Diarrheal Diseases), Expanded Program on Vaccination (EPI), *Programme National de la Lutte Contre la Tuberculose* (PNLT, National Program to Combat Tuberculosis), *Programme National de Santé de la Reproduction* (PNSR, National Program for Reproductive Health) *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) *Programme National d'Approvisionnement en Médicaments* (PNAM, National Drug Supply Program), *Programme national pour la santé de des adolescents* (PNSA, National Program for Adolescent Health),*Ministre de Genre et Famille,* and the Rural Health Program.

USAID IHP also carried out activities in collaboration with other partners to expand our scope and impact. The Program worked with Breakthrough Action on social and behavior change (SBC), with the World Bank-funded *Projet de Développement de Système de Santé* (PDSS, Health Care System Development Project) and Jhpiego for MNCH activities; and with the International Red Cross and Save the Children on the implementation of the Maskaho Plan for immunization activities. 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 to improve the supply chain. We worked with the President's Malaria Initiative to strengthen malaria case management and collaborated with the Food for Peace-funded Budikadidi project, the Development Food Security Activities on nutrition and WASH activities, and with the United Nations Children's Fund (UNICEF) on nutrition and immunization.

2. PROGRAM MANAGEMENT

IMPLEMENTATION AND MANAGEMENT

Work plan implementation

USAID IHP completed 979 provincial-level activities out of 1,958 scheduled for the quarter. This represents a completion rate of 50 percent. This quarter, several constraints impacted USAID IHP's ability to implement activities at the DPS and ZS levels. In January, several national holidays and associated leave/absences on the part of MOH staff, as well as the high number of activities scheduled for that month, resulted in a lower completion rate. In February, the level of implementation improved, but challenges included mandatory training of DPS staff that impacted their ability to participate in the Program's activities. Other challenges are the insufficiency of MOH human resources at the provincial level to cover all activities planned, the non-payment of salaries for health providers which affect their engagement to fulfill their responsibilities for services. USAID IHP continues to address planning and coordination bottlenecks with the MOH, with the DPS and ZS, and across MOH divisions to ensure the Program can maintain a continued level of activity implementation and continue to meet targets.

Overall travel between Kinshasa and the provinces was not hindered this quarter; however, some international travel and short-term technical assistance was impacted. One example was consortium partner TRG's leadership, management, and coaching workshop. Due to COVID-19 restrictions, international travel by U.S.-based team members Dee Hertzberg and Graeme Frelick was not possible. To mitigate this constraint, and to ensure that the FY2021 work plan activity could continue as planned, the TRG team pivoted to provide a virtual training-of-trainers event. The workshop itself was rescheduled to late April 2021 without the in-person participation of the U.S.-based TRG team members. It should be noted that none of the nine provinces reported COVID-19 as an issue for activities being delayed or cancelled.

The availability of provincial-level trainers has been an ongoing problem. Without trainers, training activities the Program has planned cannot take place. To address this, the USAID IHP malaria team trained additional trainers during this Quarter 2. As a part of this effort, more clinicians were invited to become trainers. The Program has found clinicians have a greater interest and an easier time integrating the trainings into their existing schedule than some DPS administrators. For more about this please see the Malaria Program Area section of this report. USAID IHP will see how this strategy can be adapted to other program areas during Quarters 3 and 4.

COVID-19

OVID-19 reports showed a marked decline in the number of cases reported during the quarter compared to the previous quarter. Within Quarter 2, COVID-19 cases increased in January (with the majority concentrated in Kinshasa) but began dropping again in February. Overall, the Democratic Republic of the Congo (DRC)'s incidence rate and case-fatality ratio remained relatively low in Quarter 2. During the reporting period, USAID IHP continued to support the Government of the DRC (GDRC)'s COVID-19 response plan at the provincial level particularly in support of populations already considered vulnerable: mothers, infants, and children. Activities focused on three objectives: (1) strengthening capacities for surveillance and investigation of cases, (2) improving infection prevention and control (IPC) and WASH in all health facilities and the community, and (3) strengthening risk communication and community engagement. Some specific examples include:

- Inclusion of COVID-19 prevention information in awareness-raising and sensitization activities for antenatal care (ANC) and WASH at the community level, and updates to community action plans to address COVID-19 prevention measures.
- Support to providers in complying with national COVID-19 guidelines and implementing directives across the program areas.
- Continued adherence to health and safety protocols as far as restricting the number of participants in meetings, trainings, and other events, and continued to hold some meetings and trainings virtually.

Determination & Findings (D&F)

In Quarter 2, Pricewaterhouse Coopers (PwC) completed its assessment report for the nine DPS supported by USAID IHP, which focused on their capacity to receive U.S. government (USG) funds via a subcontract. The report, which marks the first step in the Determination and Findings (D&F) process, was submitted for USAID feedback. PwC and Abt also adapted a version of the report for the MOH, focused on recommendations and next steps for addressing capacity gaps identified during the assessment. PwC's assessment found that that none of the DPS have a sufficient level of maturity to sign a subcontract in compliance with USAID rules. Although some DPS can mitigate the high risks observations quicker than others, all DPS must have the prerequisites in place to reach an acceptable level of maturity. PwC identified areas for improvement to bring the DPS up to the required level of maturity in terms of organizational, financial and management capacity and enable USAID to approve the award of subcontracts to the DPS by the Program in accordance with USAID regulations. USAID IHP awaits further feedback from USAID/DRC regarding next steps resulting from the D&F process.

PROGRAM STAFFING

During the period of January to March 2021, three Abt staff members left the USAID IHP team, and nine Abt staff were hired, leaving the staff count at 248 (159 Abt staff and 89 subcontractor staff).

In the Kinshasa office, the new Program Chief of Party Dr. Houleymata Diarra started working for the Program in January 2021. In addition, Abt hired several positions in Kinshasa, including a Subcontract/Grant Officer, an Operations Officer, and an Operations Assistant. Additionally, Abt hired a Bookkeeper in Mbuji Mayi and in Kananga, an Administrative Assistant in Kamina, and a Finance Assistant in Kabinda.

PROGRAM OPERATIONS

Mobile Money

Mobile money's benefits include a) efficient and timely payments to project beneficiaries, which will accelerate activity implementation; and b) easier means to track, process and account for payments, which will reduce potential for fraud. During Quarter 2, the Program finalized the mobile money set-up for last-mile supply chain deliveries and other USAID IHP interventions, operationalizing contracts for two mobile money provider contracts (TMB-Pepele and Vodacash-M-Pesa) and a fund transfer company, Soficom. Mobile money will be integrated into the established payment procedures to strengthen financial capacity to meet the vast breadth and scope of the USAID IHP project. To prepare for the system roll-out, the Program Finance team reviewed their roles and responsibilities in the mobile money context and formalized process documents to ensure system functionality. Initial payments were made by the end of Quarter 2, and the Program will steadily scale-up this system through Quarters 3 and 4. A

more efficient payment process will result more Congolese people receiving essential medicines and health commodities.

Revised Per Diem Guidance

A revised per diem table for USAID IHP staff and national- level government partners was approved internally by Abt. French and English translations have been circulated. We expect that updates to the USAID IHP per diem table will provide clearer guidance and the revised rates will help to ensure participation of MOH officials in USAID activities.

Standard Operating Procedures Manual

During Quarter 2, the home office team spent time reviewing sections of the Program's standard operating procedures with members of the Operations, Finance and Program team to consider inputs. The home office will work with subcontractors to ensure their inputs have been incorporated and relevant guidance has been shared with them. In some cases where guidance already exists, this has been an opportunity to re-share information related to existing policies. The standard operating procedures aim to ensure consistent understanding and application of USAID IHP's processes and procedures across the team and different Program locations.

Procurement Update

During Quarter 2, the Program worked to accelerate the procurement of medical equipment and finalize the process for the TB grants. The Program prioritized efficiency but also worked to ensure fiscal responsibility and quality. In addition, progress was made on awarding grants for USAID IHP's TB Program. The Program finalized procurement processes to select local subcontractors to carry out rehabilitation and very small-scale construction of WASH infrastructure in select health facilities though paused on implementation following USAID request for more information. For details related to WASH infrastructure improvement activities, please see the WASH Program Area section of this report (section 3).

Medical Equipment Procurement: The medical equipment procurement was bundled into several smaller procurements to promote efficiencies. This included a procurement for fridges; TB diagnostic equipment (PCR, Humalzer, and ECG EDAN); teaching materials; and a comprehensive packet of materials and equipment to meet the basic service delivery needs of health centers.

The USAID IHP technical team conducted a rigorous field review of the equipment and material list to ensure the materials selected most appropriately met the need of the health centers. Abt has engaged its home office procurement team to support this process. During Quarter 2, four RFQs were issued for these items during this period with international suppliers who can ensure quality products and ensure the most efficient delivery as possible. The Program is looking into warehousing facilities to receive and safely store materials before they are routed to their destination. Controls have been in place throughout every step of this procurement to ensure compliance with USAID's regulations and financial accountability. A Microsoft Access database has been developed to track each of these items for each step until they reach the delivery site. The large materials and equipment will be assembled in a kit for each health center to ensure each health facility receives their complete packet of equipment and materials. It is anticipated that these items will be shipped to DRC between July and August 2021.

TB grants: During Quarter 2, the USAID IHP Operations, Financial and Technical team worked to assemble a panel to review the proposals submitted in response to the RFPs submitted. The proposals received a rigorous financial and technical review. The Program worked to finalize the selection memo

during Quarter 2. During Quarter 3 all materials including the selection memo and pre-award responsibility determination will be finalized, and all organizations will be notified of the results of the RFP. USAID IHP anticipates the complete packet of information will be ready to submit to USAID before the end of Quarter 3.

SECURITY

During the quarter, USAID IHP continued to mitigate impacts of COVID-19 while closely monitoring and minimizing impacts of political, conflict, and disease threats where possible. Overall, while the COVID-19 pandemic remained an issue in DRC, the reported positive test rate nationwide reduced significantly during the reporting period. The Program's response to the risk of the disease remained proactive, flexible, and responsive based on the epidemiological risk in each province as well as the direct impact of the disease on each office. Some USAID IHP offices (e.g., Sankuru) were never impacted by COVID-19. In others, like Kinshasa and Sud-Kivu, the Program responded to confirmed COVID-positive cases among staff through reduced office occupancy, deep cleanings, recommended staff testing, and other precautionary measures[2] to reduce the risk of infection among other staff in such offices.

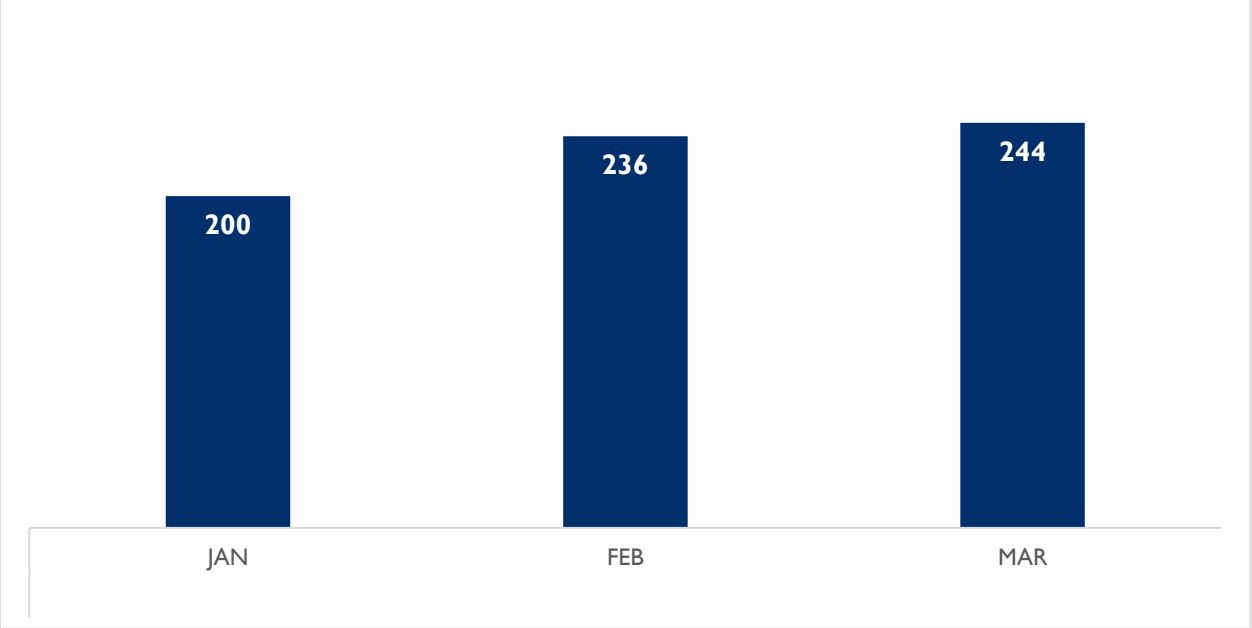
Political and military events in Eastern Congo constituted the second main challenge for security during the period. There, political and military strategies to combat Mai groups and the Allied Defense Forces (ADF) have been prevalent, while armed conflict and effects on accessibility persisted as the main security challenges in the region. Though many of these challenges centered in the non-Program province of North Kivu, USAID IHP monitored them closely to mitigate any impact on our program, staff, and stakeholders.

General Security Trends

Compared to previous Program years and Quarter 1, the security picture in Kinshasa was subdued, though security incidents in the east of the country tended to heavily influence the overall analysis of security incident reports. Across the Program, there was a slight uptick in security incidents from month to month (Figure 1) during the quarter, though total and region-specific security incidents in Quarter 2 trended significantly downward compared to the same period in FY2020 for USAID IHP intervention provinces.

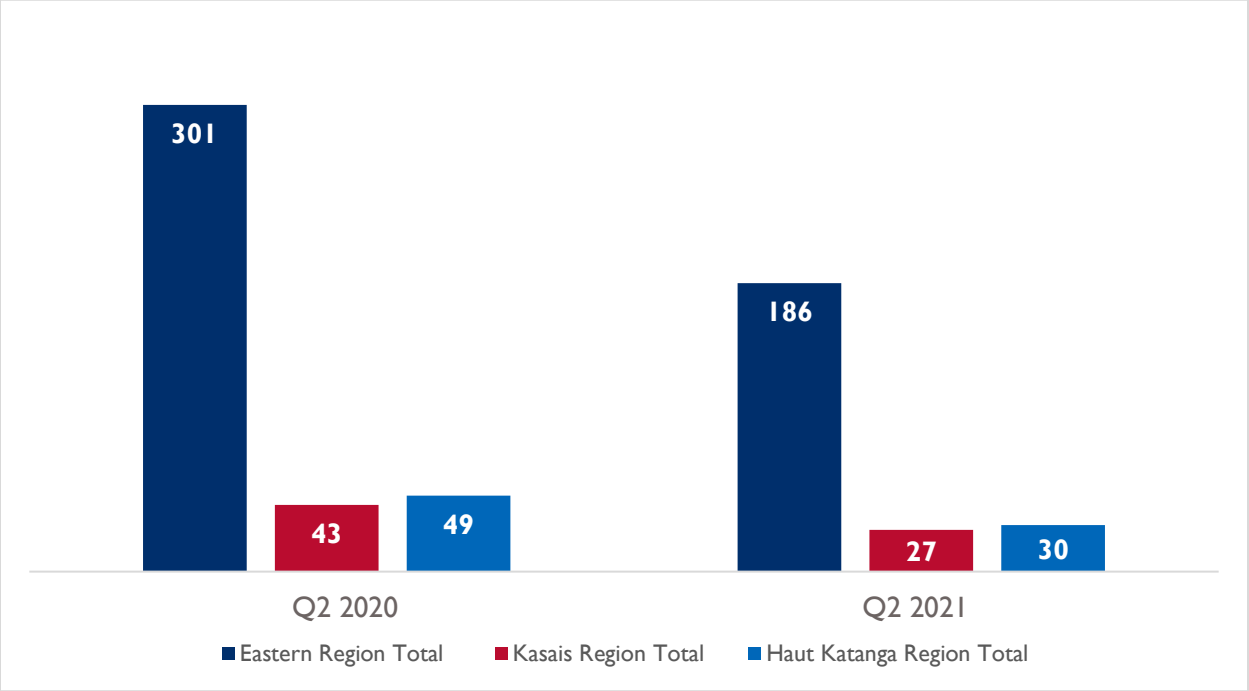
[2] Per the Centers for Disease Control (CDC) and Abt Global COVID-19 Preparedness Team guidance.

Figure 1. Total security incidents reported: Jan-March 2021



Source: USAID IHP Security Office metrics

Figure 2. Comparison of total security incidents reported by USAID IHP by region in Q2 FY2020 & FY2021



Source: USAID IHP Security Office metrics

Politics. The anticipated reorganization of the DRC government continued to cause tensions among political parties at the national level. At the provincial level, heightened tensions in North Kivu somewhat subsided following a series of violent demonstrations protesting the lack of security in

Eastern Congo following the death of the Italian Ambassador to DRC, several attacks by the ADF in North Kivu, and armed conflict. The Program responded to the proximity of demonstrations (within 300 meters) to the airport and harbor by instituting a security team review of each request for travel between Kinshasa and Sud-Kivu and/or through Goma and minimizing stopovers in Goma.

Armed conflict. Martial law was declared in the Eastern Congo province of North Kivu to directly respond to the threat of militias in the area. Along with this announcement, the profile of the United Nations Organizations Stabilization Mission in the Democratic Republic of the Congo rose significantly with the use of aerial attacks on ADF positions in the province. As noted above, these have had no direct impact on the Program, though we monitored developments closely since many staff transit through Goma in North Kivu *en route* to or from Bukavu in USAID IHP-supported province Sud-Kivu.

Disease. COVID-19 reports showed a marked decline in the number of cases of COVID reported during the quarter. As a result, the Government of DRC lifted provincial curfews and reduced the curfew hours in Kinshasa to 10 p.m.–4 a.m. every night, although anecdotally few measures are currently being respected outside the office in Kinshasa.

During the quarter, USAID IHP responded to four COVID-19-related incidents among Program staff and offices, summarized below:

- On January 10, two staff members tested positive for COVID-19 in the Kinshasa office. The office was closed for deep cleaning on January 11-12, 2021, and following the cleaning, the office remained opened at 20 percent level of occupancy pending review by the Abt Preparedness Team.
- On February 24, following review of epidemiological risk and implemented mitigation, barrier, and sensitization measures, the Abt Preparedness Team determined that the Kinshasa office reopening plan was sufficient to increase staff occupancy to 75 percent, effective February 25. The office adopted a risk management approach to the disease with varying levels of occupancy to encourage social distancing according to the number of cases confirmed in each office location, Priority for occupancy was divided between the operations and finance teams to best support USAID IHP technical teams pursuing their workplan activities.
- On March 1, one staff member was confirmed as being in contact with a COVID-positive person (who subsequently died) during an activity in Kipushi, 70 km outside Lubumbashi, on February 26 and 27. The staff member self-isolated and was monitored and tested per USAID IHP procedures and subsequently recovered.
- On March 10, one staff member who attended a workshop with other technical staff in Lubumbashi tested COVID positive in Kinshasa. The staff member self-isolated and was monitored and tested per USAID IHP procedures, and subsequently recovered.

Program incidents. Table 2 shows six Program-related incidents reported in FY2021 Quarter 2, including an increase in road traffic collisions during the rainy season and four incidents of theft.

Table 2. Program-related incidents reported in FY2021 Quarter 2

Date	Category	Region	Province	Office	Details
1/25/2021	Theft	Eastern Congo	Sud-Kivu	Bukavu	Theft/loss of computer
1/29/2021	RTC	Katanga	Lualaba	Kolwezi	RTC
1/30/2021	RTC	Katanga	Lualaba	Kolwezi	RTC
3/1/2021	Medical	Katanga	Haut-Katanga	Lubumbashi	COVID-19

Source: USAID IHP Security Office metrics

It has been noted that the incidence of road traffic collisions is high, and the operations team has organized driver and first aid refresher training for all USAID IHP drivers and operations staff.

The security team maintains databases on several security metrics. Internal incidents are those that have a direct impact on the Program and are reported directly to the home office and client. External incident data are gathered from verified sources to give context to the overall security situation throughout the country, and the data are used as a basis for carrying out security evaluations for any specified area. Metrics are made available on request, and a dashboard of security incidents is maintained as shown in Figure 1 and Figure 2. These data inform the security team's decision making at all levels of the Program and organization so that all relevant information is considered.

3. PROGRAM AREAS

A nurse sets up an insecticide treated bed net for a mother and her newborn, Fuamba health center, Kasaï Central, Photo by Aimé Tshibanda, Pathfinder for IHP.

- **101% of the target number of pregnant women** attended at least one ANC visit with a USG-supported facility and **98.9%** attended at least four.
- **434,720 pregnant women** received iron-folic acid supplementation.
- **6,523 eligible children under 5** were placed on INH prophylaxis.
- **359,845 children** vaccinated with pentavalent-3 and **349,247 children** vaccinated against measles.

- **473,373 ITNs** distributed during antenatal and child immunization visits.
- **1,122 providers** trained and retrained to support prevention and management of malaria in pregnant women
- **787,920 confirmed cases of malaria for children under 5** treated.

MALARIA

USAID IHP supports the implementation of the President's Malaria Initiative through the activities described in its annual Malaria Operation Plan (MOP) in all 179 ZS in nine supported provinces. All activities technically and financially supported through USAID IHP are also aligned with the priorities of the *Programme National de Luttre Contre le Paludisme* (National Malaria Control Program, NMCP). Key activities relate to the training support for providers, trainers, and provincial supervisors on the malaria treatment and care package and the Health Network Quality Information System (HNQIS) supervision tool. The Program also worked to ensure access to essential commodities such as sulfadoxine/pyrimethamine (S/P) for intermittent preventive treatment (IPT), insecticide-treated nets (ITNs) and artemisinin-based combination therapies (ACTs). In addition to implementing routine activities, USAID IHP invested in developing long-term solutions to problems. During Quarter 2, USAID IHP worked to address a shortage of trainers and developed new strategies to deliver ITNs to remote *aires de santé*. The Program also worked to emphasize the importance of ANC visits as a way to prevent malaria in pregnancy.

Trained health workers to integrate malaria prevention during ANC visits

A total of 1,122 providers were trained and retrained through USAID IHP's technical and financial support on the prevention and management of malaria in pregnant women. The target was exceeded for Quarter 2 with an achievement rate of 117.6 percent. Key themes for these capacity-building efforts included the components of antenatal care, intermittent preventive treatment in pregnancy (IPTp), the identification of the signs of malaria, and preparation for pregnancy and childbirth. To increase rates of IPTp among pregnant women, interpersonal communication skills to promote IPTp, particularly adherence to the calendar for S/P among pregnant women, were emphasized. Providers as well as staff from the ZS and DPS central offices were trained to administer S/P by introducing the directly observed therapy (DOT) strategy for S/P during ANC sessions, as well as ITN use and the correct dosage of artemether + lumefantrine (AL) and artesunate/amodiaquine in pregnant women for cases of uncomplicated and severe malaria and strategies for identification in the community and referral of pregnant women to health facilities in time to reduce delays in the first ANC visit.

All nine DPS of the Program planned and carried out training and retraining of providers on the prevention of malaria in pregnant women with financial and technical support from the USAID IHP provincial offices. Lomami, Haut-Lomami, and Tanganyika were the provinces with the lowest

performance; this was mostly due to the trainers' being unavailable. All of the provincial trainers in Haut-Lomami were occupied with the mass distribution campaign of ITNs in all ZS throughout Quarter 2. This activity has now been postponed to Quarter 3. In Lomami and Tanganyika, the DPS trainers were busy during Quarter 2 with the annual review of the province and the training on primary health care as well as the ITN mass distribution campaign. The other regions exceeded their targets. The Program provided financial support for Sud-Kivu to carry out post-training follow-ups in the three ZS. The positive performance in these provinces was mainly due to the availability of provincial trainers during this period. To address the challenges related to the lack of provincial trainers, USAID IHP technically and financially supported the training of 14 provincial trainers in Lomami on malaria-related prevention and care of pregnant women. In addition, DPS and ZS leadership were incorporated as a part of a strategy to build their capacity so they will eventually be able to support training efforts.

Table 3. Number of health workers trained in IPTp with USG funds (Indicator #2.1.14)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	165	165	100%
	Kasaï-Oriental	60	178	296.7%
	Lomami	140	0	0%
	Sankuru	25	117	468%
Total Kasaï		**390**	**460**	**117.9%**
Katanga	Haut-Katanga	120	148	123.3%
	Haut-Lomami	87	53	60.9%
	Lualaba	19	19	100%
Total Katanga		**226**	**220**	**97.3%**
Eastern Congo	Tanganyika	44	31	70.5%
	Sud-Kivu	294	411	139.8%
Total Eastern Congo		**338**	**442**	**130.8%**
Grand Total		**954**	**1,122**	**117.6%**

Source: USAID IHP Project Monitoring Report

Women who received doses of sulfadoxine/pyrimethamine (S/P) for Intermittent Preventive Treatment (IPT) during ANC visits

In addition to the correct use of ITNs, IPT with S/P for pregnant women is a top priority for the NMCP. During Quarter 2, with financial and technical support from USAID IHP, 213,612 pregnant women received doses of S/P during antenatal visits, which represents an achievement rate of 61.4 percent. The Katanga region had the best performance. The province of Sankuru had a downward influence on the provincial and global average. Sankuru's underperformance could be due to several factors. First, the shortage of S/P stocks has had an impact in several provinces. Tanganyika reported a total stockout during Quarter 2, Sankuru experienced shortfalls in the ZS of Tshudi Loto and Kole from the Sankuru regional distribution center, Sud-Kivu reported problems in a few difficult-to-reach *aires de santé*, and Kasaï Central had shortages in January and early February but received a supply before the end of Quarter 2. In addition, the low rate of training of providers on IPT (particularly in Lomami, Haut-Lomami, and Tanganyika) had an impact on this indicator.

Table 4. 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 (%)	Q2 Achievement (%)	Number of Women
Kasaï	Kasaï-Central	80%	61.5%	34,882

Region	Province	Target (%)	Q2 Achievement (%)	Number of Women
	Kasaï-Oriental	80%	63.4%	34,482
	Lomami	80%	58.0%	26,671
	Sankuru	80%	30.6%	8,103
Total Kasaï		**80%**	**53.4%**	**104,138**
Katanga	Haut-Katanga	80%	63.6%	40,019
	Haut-Lomami	80%	76.5%	31,296
	Lualaba	80%	66.0%	21,940
Total Katanga		**80%**	**68.7%**	**93,255**
Eastern Congo	Tanganyika	80%	50.7%	53,266
	Sud-Kivu	80%	64.9%	16,219
Total Eastern Congo		**80%**	**64.9%**	**16,219**
Grand Total		**80%**	**61.4%**	**213,612**

Source: District Health Information System 2 (DHIS2), Accessed April 23, 2021

Distributed insecticide-treated nets to prevent malaria transmission

During Quarter 2, USAID IHP financially and technically supported the distribution of 473,373 ITNs out of 314,687 planned, or 150.4 percent via ANC and well-child visits across all nine provinces. All provinces exceeded their target for this quarter. Kasaï Oriental, Lomami, Haut-Katanga, and Tanganyika had very high performances varying between 192.7 and 313.5 percent. This was due to the availability of long-lasting insecticidal nets (LLINs) at the ZS level. In addition, the remainder of ITNs from mass distribution campaigns contributed to the availability of routine distribution at ANC and well-child visits. All nine provinces benefitted from VIVA campaign activities, which promoted the use of ITNs among the key messages communicated. For more about how these activities supported ITN use, please see the Objective 3 section of this report. In addition, IHP collaborated with other partners (in particular Impact Malaria) in Kasaï Oriental and Haut-Katanga to hold regular meetings to monitor and analyze malaria data and the good management of existing ITN stocks in some ZS.

Table 5. Number of insecticide-treated nets (ITNs) distributed during antenatal and/or child immunization visits (Indicator #17)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	57,079	74,635	130.8%
	Kasaï-Oriental	29,688	84,414	284.3%
	Lomami	32,991	63,590	192.7%
	Sankuru	29,835	31,907	106.9%
Total Kasaï		**149,593**	**254,546**	**170.2%**
Katanga	Haut-Katanga	14,078	44,140	313.5%
	Haut-Lomami	26,826	23,090	86.1%
	Lualaba	17,982	24,668	137.2%
Total Katanga		**58,886**	**91,898**	**156.1%**
Eastern Congo	Tanganyika	15,256	38,184	250.3%
	Sud-Kivu	90,952	88,745	97.6%
Total Eastern Congo		**106,208**	**126,929**	**119.5%**
Grand Total		**314,687**	**473,373**	**150.4%**

Source: DHIS2, Accessed April 23, 2021

Equip health facilities with water filters and cups that allow direct observed therapy of adherence to IPTp (presumptive treatment in pregnant women)

During Quarter 2, USAID IHP supported the distribution of DOT kits to 61 health centers in Tanganyika. Tanganyika has increased the number of health facilities that have received DOT kits from 112 to 173.

Trained health workers to improve case management and trained health workers in malaria laboratory diagnostics

Training was planned on NMCP-approved correct care and treatment for simple and severe malaria in children under 5 and adults, including pregnant women, in all nine provinces. Of the nine DPS that planned this activity, eight (89 percent) carried it out with the financial and technical support of USAID IHP during Quarter 2. A total of 1,167 providers, or 56.4 percent, benefited from this training in 24 ZS across the eight provinces (all but Haut-Lomami). This training did not take place in Haut-Lomami in Quarter 2 because all trainers were mobilized for the ITN mass distribution campaign. The Program plans to catch up in Quarters 3 and 4. Lomami and Tanganyika had faced challenges related to availability of trainers as well. During Quarter 2, all the training managers of the DPS were busy with the annual review of the province and the training in primary health care, which took 15 days. Provinces that performed well this quarter on this indicator succeeded because provincial trainers were available.

As a complement to training on malaria case management, during Quarter 2 a total of 47 DPS leaders from Haut-Katanga, Lomami, and Sud-Kivu were trained on use of the HNQIS supervision tool. USAID IHP financially supported the training of six central trainers including four from the NMCP and two from USAID IHP on this tool. USAID IHP believes that the HNQIS supervision tool will strengthen supportive supervision and improve the quality of malaria care and treatment overall.

Table 6. Number of health workers trained in case management with ACTs and USG funds (Indicator #2.1.16) and Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnostic Tests, RDT) or microscopy with USG funds (Indicator #2.1.15)

Region	Province	Target	Q1 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	**165**	**165**	100%
	Kasaï-Oriental	90	106	117.8%
	Lomami	118	35	29.6%
	Sankuru	75	95	126.7%
Total Kasaï		**448**	**401**	**81.7%**
Katanga	Haut-Katanga	250	98	39.2%
	Haut-Lomami	100	0	0%
	Lualaba	80	77	96.3%
Total Katanga		**430**	**175**	**40.7%**
Eastern Congo	Tanganyika	139	31	22.3%
	Sud-Kivu	150	86	57.3%
Total Eastern Congo		**289**	**117**	**40.5%**
Total		**1,167**	**693**	**56.4%**

Source: USAID IHP Project Monitoring Report

Supported treatment for malaria among children under 5 years

Children under 5 are a vulnerable group for malaria cases. During Quarter 2, 787,920 out of 924,765, or 85.2 percent of confirmed cases of uncomplicated malaria were treated according to national policy. The

regions of Eastern Congo and Katanga had the best performance with an achievement rate above 80 percent. The Kasaï Region did not perform as well (achievement rate of 78.8 percent). Three provinces (Haut-Katanga, Lualaba, and Sud-Kivu) exceeded their targets. These results were due to the series of training sessions for providers on the malaria care and treatment package and on malaria in pregnant women, the availability of key commodities (ACTs and RDTs), and community awareness activities.

Table 7. Number of children under 5 years of age (0-59 months) with confirmed malaria who received treatment for malaria from an appropriate provider in USG-supported areas (Indicator #15)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	161,176	141,218	87.6%
	Kasaï-Oriental	132,594	100,077	75.5%
	Lomami	104,267	66,110	63.4%
	Sankuru	56,052	50,557	90.2%
Total Kasaï		**454,089**	**357,962**	**78.8%**
Katanga	Haut-Katanga	82,386	82,898	100.6%
	Haut-Lomami	108,997	79,678	73.1%
	Lualaba	65,289	66,259	101.5%
Total Katanga		**256,672**	**228,835**	**89.2%**
Eastern Congo	Tanganyika	61,335	46,818	76.3%
	Sud-Kivu	152,669	154,305	101.1%
Total Eastern Congo		**214,004**	**201,123**	**106.4%**
Grand Total		**924,765**	**787,920**	**85.2%**

Source: DHIS2, Accessed April 23, 2021

Lessons learned

Training clinicians from hospitals and general referral hospitals in addition to DPS leadership to be trainers has had a positive impact. These groups often have greater availability to lead trainings. In addition, they can take on a leadership role in the implementation of the standards and guidelines for the prevention and correct management of malaria in their own health facilities.

Remote ZS require additional efforts to ensure ITN delivery to those areas. The Program supported delivery from the *Bureaux centraux de la zone de santé* (BCZS, Central office of the ZS) to the *aire de santé* during Quarter 2, which increased access to those areas. In the next quarter, USAID IHP will work to leverage existing trips that nurses and other providers take to remote *aires de santé* to transport small batches of ITNs.

Next Steps

- Organize integrated activities with the reproductive health team to advance strategies related to promoting access to ANC for women.
- Produce technical posters and reminders for adherence to the ANC and IPT calendar.
- Strengthen support for monthly meetings to monitor and analyze malaria data in ZS.

- **101% of the target number of pregnant women** attended at least one ANC visit, and **98.9%** attended at least four ANC visits with a skilled provider from USG-supported facilities
- **46,360 newborns** received essential care at birth
- **75,399 sick children** were treated at the iCCM sites
- **359,845 children** vaccinated with pentavalent-3 and **349,247 children** vaccinated against measles

MATERNAL, NEWBORN, AND CHILD HEALTH

MATERNAL AND NEWBORN HEALTH

The DRC is one of 24 USAID priority countries for MNCH. USAID IHP implements maternal, newborn, and child health interventions in support of MOH standards and guidelines in the nine provinces. During this quarter, USAID IHP supported its target provinces' implementation of MNCH interventions such as ANC visits, assisted deliveries and postnatal care visits, essential newborn care, emergency care, integrated management of childhood illness, and immunization according to MOH guidelines and standards.

ANC visits with a skilled provider

In the DRC, national standards and guidelines recommend at least four ANC consultation visits, starting with one in the first trimester, the second at 24-28 weeks of amenorrhea, and the last two visits in the last trimester. ANC visits offer opportunities for providers to consult with pregnant women to identify potential risks, provide preventive care, and improve pregnancy outcomes; discuss the importance of giving birth in health facilities with the assistance of a skilled provider; and review the delivery plan (e.g., identifying a blood donor, saving for unexpected costs during delivery). In addition, they are opportunities to educate women and their families about danger signs during pregnancy and provide information about family planning, an important factor in improving maternal and newborn health.

Table 8 shows that average ANC-1 coverage in USAID IHP-supported provinces during Quarter 2 was 101 percent of the target, a slight increase from 98.7 percent in Quarter 1. Lualaba, Kasaï-Central, Lomami, Sud-Kivu, Kasaï-Oriental, and Sankuru exceeded 100 percent of target; while Tanganyika, Haut-Lomami, and Haut-Katanga fell short. However, Tanganyika improved its coverage from 80.9 percent in Quarter 1 to 97 percent in Quarter 2.

A team of nurses working at the Crina health center in ZS Kamalondo, Haut-Katanga, a facility that provides well child check-ups. Photo by Jean Manassé, Freelance photographer for USAID IHP.

Strong performance for indicator #2.1.2 is linked to the following USAID IHP-supported activities:

- Six mini-campaigns encouraging pregnant women to use antenatal care visits in Tanganyika, Kasaï-Oriental, Lomami, Sankuru, Sud-Kivu, and Lualaba.
- Training of 303 RECO and community leaders in Tanganyika, Kasaï-Oriental, Lomami, Kasaï-Central and Haut-Lomami on best practices, including promotion of ANC and delivery in health facilities.
- Monthly committee meetings for *surveillance des décès maternels et périnatals et riposte* (SDMPR, maternal and perinatal death surveillance and response) in all nine provinces, and approximately 65 ZS, which highlighted the importance of attending all four ANC visits to prevent maternal and perinatal deaths. (See section below on maternal death surveillance and response for more details).
- Consistent availability of inputs (iron-folic acid, ITNs, tetanus vaccine), distributed free of charge in the ZS, a motivating factor for pregnant women to seek ANC services in all provinces.

Haut-Katanga and Haut-Lomami in particular performed poorly this quarter for Indicator #2.1.2, due in part to the following factors:

- Low performance of clinical providers (nurses and midwives) due to non-payment of premiums for services by the World-Bank funded PDSS project[3] in Haut-Lomami and Haut-Katanga.
- Chronic geographical barriers within some ZS in Tanganyika, Haut-Lomami, and Lomami—including natural obstacles such as rivers and swampy terrain, as well as insecurity—making it difficult for pregnant women to travel.

For Indicator #13 (Table 9), USAID IHP had an achievement rate of 98.9 percent in ANC-4 in Quarter 2. Provinces in Kasaï region reached or exceeded all targets. Katanga region recorded the weakest performance, with Haut-Katanga province pulling down the average with an achievement rate of 66.9 percent (mainly due to the BCZS internet connection issue, which impacted data reporting). USAID IHP activities described above for ANC-1 contributed to the strong achievement of targets for ANC-4. In addition, 1,122 providers across all provinces were briefed on the prevention and management of malaria in pregnant women and early attendance at ANC visits. Monitoring of ANC-1 data was conducted at week 16 with the recovery plan for pregnant women by the community action groups (CACs) and other pregnant women in Kasaï-Oriental, Kasaï-Central, and Sankuru.

Table 8. Percentage of pregnant women attending at least one antenatal care (ANC-1) visit with a skilled provider from USG-supported health facilities (Indicator #2.1.2)

Region	Province	Target (%)	Numerator	Denominator	Q2 Achievement
Kasaï	Kasaï-Central	100%	56,700	52,611	107.8%
	Kasaï-Oriental	100%	54,393	54,186	100.4%
	Lomami	100%	46,024	43,377	106.1%
	Sankuru	100%	26,439	25,941	101.9%
Total Kasaï		**100%**	**183,556**	**176,115**	**104.2%**
Katanga	Haut-Katanga	100%	62,928	72,357	87.0%
	Haut-Lomami	100%	40,906	43,428	94.2%
	Lualaba	100%	33,234	29,246	113.6%
Total Katanga		**100%**	**137,068**	**145,031**	**94.5%**
Eastern Congo	Sud-Kivu	100%	82,108	80,626	101.8%
	Tanganyika	100%	31,988	33,165	96.5%
Total Eastern Congo		**100%**	**114,096**	**113,791**	**100.3%**
Grand Total		**100%**	**434,720**	**434,937**	**100.0%**

Source: DHIS2, Accessed April 23, 2021

Table 9. Percentage of pregnant women attending at least four antenatal care visits with a skilled provider (Indicator #13)

Region	Province	Target	Numerator	Denominator	% Achieved Q2
Kasaï	Kasaï-Central	34,446	45,625	52,611	132.5%
	Kasaï-Oriental	33,676	37,322	54,186	110.8%
	Lomami	27,342	30,349	43,377	111.0%
	Sankuru	16,477	20,622	25,941	125.2%
Total Kasaï		**111,941**	**133,918**	**176,115**	**119.6%**

[3] Katanga region's provider-payment structure is performance-based. Therefore, delays in payment of salary premiums by PDSS have a direct impact on performance of staff who collect their income from the premiums (they do not earn a salary). The result of the non-payment of salary premiums to the providers is that the providers did not implement approaches to reach pregnant women.

Region	Province	Target	Numerator	Denominator	% Achieved Q2
Katanga	Haut-Katanga	38,565	25,793	72,357	**66.9%**
	Haut-Lomami	27,274	25,751	43,428	**94.4%**
	Lualaba	20,955	15,920	29,246	**76.0%**
Total Katanga		**86,794**	**67,464**	**145,031**	**77.7%**
Eastern Congo	Tanganyika	18,028	18,110	18,110	**100.5%**
	Sud-Kivu	52,679	46,923	46,923	**89.1%**
Total Eastern Congo		**70,707**	**65,033**	**65,033**	**92.0%**
Grand Total		**269,442**	**266,415**	**434,937**	**98.9%**

Source: DHIS2, Accessed April 23, 2021

Delivery with a skilled birth attendant and proper administration of uterotonics

According to Table 10, in Quarter 2, 92.1 percent of pregnant women gave birth at a health facility in all USAID IHP-supported provinces (Indicator #2.1.3), up from 83.7 percent in Quarter 1. This improvement stemmed from the integration of basic emergency obstetric and newborn care (BEmONC) in more than 65 priority ZS with USAID IHP support since Program inception for training, post-training follow-up, and clinical mentoring.

In Quarter 2, Lualaba and Kasaï-Central reached or exceeded the Program's targets, while Haut-Lomami, Haut-Katanga, Kasaï-Oriental, Lomami, and Sud-Kivu provinces achieved at least 80 percent of the target. Tanganyika pulled down the average; however, its performance improved from the previous quarter (54.2 percent in Quarter 1; 59.4 percent in Quarter 2). USAID IHP implemented the following activities to improve deliveries at a health facility with a skilled birth attendant:

- Post-training follow-up of 153 providers (including 54 women) on essential and emergency obstetric care, and essential and emergency neonatal care in six ZS and two provinces: Kasaï-Oriental and Haut-Lomami.
- Clinical mentoring in Tanganyika using the *Low Dose High Frequency* approach[4] in five ZS as well as UNICEF-supported clinical mentoring in Sud-Kivu.
- Integration of BEmONC in 10 additional ZS through the training of 242 providers in Sud-Kivu, Kasaï-Central, Lomami, Haut-Katanga, and Tanganyika.
- Community mobilization activities carried out during VIVA awareness sessions, as described in the ANC section.
- Monthly SDMPR meetings in 65 ZS to encourage community leaders, community-based organizations, and providers to promote delivery in health facilities.

Although performance for this indicator was still low in Tanganyika for Quarter 2, the above activities led to improvement over the previous quarter. In Haut-Katanga and Haut-Lomami, the delay in the payment of premiums to providers and community members by the PDSS project unfavorably impacted deliveries in the health facilities, thereby affecting USAID IHP performance in these provinces for Indicator #2.1.3. Incomplete data were also an issue in Haut-Katanga, where 30 percent of health

[4] USAID IHP introduced the Low Dose High Frequency (LDHF) clinical mentoring approach developed by Jhpiego in five sites in five ZS in Tanganyika. This variation of the competency-based approach builds provider capacity by promoting maximum retention of clinical knowledge, skills, and behaviors/attitudes through short, focused, simulation-based learning activities spaced over time, reinforced by ongoing practical sessions in the workplace.

facilities did not report in March. Finally, insecurity and long distances to health facilities led many mothers in Haut-Lomami, Tanganyika, and Lomami to deliver at home.

Table 10. Percentage of deliveries with a skilled birth attendant in USG-supported facilities (Indicator #2.1.3)

Province		Target	Numerator	Q2 Achievement (%)
Kasaï	Kasaï-Central	99.8%	52,515	110.9%
	Kasaï-Oriental	86.1%	46,649	95.7%
	Lomami	81.9%	35,544	91%
	Sankuru	90.4%	23,441	100.4%
Total Kasaï		**89.8%**	**158,149**	**99.8%**
Katanga	Haut-Katanga	72.5%	52,425	80.5%
	Haut-Lomami	78.3%	33,987	87%
	Lualaba	100.3%	29,330	111.4%
Total Katanga		**79.8%**	**115,742**	**88.7%**
Eastern Congo	Tanganyika	59.4%	19,713	**66%**
	Sud-Kivu	82.8%	66,742	**92%**
Total Eastern Congo		**76%**	**86,455**	**84.4%**
Grand Total		**82.9%**	**360,346**	**92.1%**

Source: DHIS2, Accessed April 23, 2021

Essential newborn care and postpartum visits

The postnatal period is a crucial phase in the life of a mother and her newborn: Most maternal and neonatal deaths occur during the first month after delivery, more than half of them within the first 24 hours and the first week. USAID IHP activities focus therefore on follow-up and monitoring of mother and newborn immediately after delivery.

During the quarter, postpartum visits (Table 11) averaged 103 percent, an improvement over 101 percent in Quarter 1. In Quarter 2, all provinces met or exceeded the threshold except Lualaba and Katanga. Compared to the number of births this period, 99.6 percent (358,971 out of 360,346) mothers with newborns were visited in the three days after birth. Capacity-building sessions for providers in emergency obstetric and neonatal care (EmONC), post-training follow-up, and clinical mentoring have contributed to the strong performance for this indicator. In addition, 9,339 home visits for newborn follow-up by the RECO helped to ensure essential newborn care.

During the quarter, 346,360 newborns received essential care at birth (Indicator #2.1.7), which represents 94.1 percent of the target, a decline from Quarter 1's 95.4 percent. The lack of training, post-training follow-up, and clinical mentoring in certain ZS and the stockouts of certain inputs/drugs (twine, pliers for cord ligation, 7.1 percent chlorhexidine, and eye drops for essential newborn care) negatively impacted the performance in the coverage of newborns who received essential newborn care.

Table 11. Number of postpartum/newborn visits within three days of birth in USG-supported programs (Indicator #2.1.6) and Number of newborns receiving essential newborn care through USG-supported programs (Indicator #2.1.7)

Province		Newborns Receiving Essential Newborn Care through USG-Supported Programs			Postpartum/Newborn Visits within Three Days of Birth in USG-Supported Programs		
		Target %	Q2 Achievement	Numerator	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	100%	98.6%	51,885	49,074	52,411	106.8%
	Kasaï-Oriental	100%	96.7%	45,458	44,754	46,830	104.6%

Province		Newborns Receiving Essential Newborn Care through USG-Supported Programs			Postpartum/Newborn Visits within Three Days of Birth in USG-Supported Programs		
		Target %	Q2 Achievement	Numerator	Target	Q2 Achievement	Achievement Rate (%)
	Lomami	100%	88.4%	33,207	35,277	36,329	103.0%
	Sankuru	100%	90.0%	21,383	22,311	23,647	106.0%
Total Kasaï		**100%**	**93.4%**	**151,933**	**151,416**	**159,217**	**105.2%**
Katanga	Haut-Katanga	100%	94.1%	50,359	52,114	53,201	102.1%
	Haut-Lomami	100%	92.5%	33,406	34,667	34,347	99.1%
	Lualaba	100%	91.7%	28,205	30,124	29,157	96.8%
Total Katanga		**100%**	**92.8%**	**111,970**	**116,905**	**116,705**	**99.8%**
Eastern Congo	Tanganyika	100%	87.0%	18,151	16,467	19,784	120.1%
	Sud-Kivu	100%	97.8%	64,306	62,882	63,265	100.6%
Total Eastern Congo		**100%**	**97.8%**	**82,457**	**79,349**	**83,049**	**104.7%**
Grand Total		**100%**	**94.1%**	**346,360**	**347,670**	**358,971**	**103.3%**

Source: DHIS2, Accessed April 23, 2021

Number of newborns resuscitated

During the quarter, a total of 7,746 newborns not breathing at birth were resuscitated with USAID IHP support in the nine provinces. This represents 84.6 percent of the target (Table 12), which is a decrease compared to the previous quarter (when the Program achieved 89.1% of its target). As more quality services are available for pregnant and delivering women, fewer newborns need resuscitation. Only Haut-Lomami reached the target with a 102.2 percent achievement rate). Six provinces recorded a performance above 80 percent, as a result of provider capacity-building sessions in EmONC, post-training follow-up in essential and emergency newborn care, and clinical mentoring. Kasaï-Central and Sud-Kivu recorded poor performances. Insufficient provider coaching in newborn emergency care, as well as scarce or obsolescent materials for neonatal resuscitation, negatively impacted the performance of this indicator.

Table 12. Number of newborns not breathing at birth who were resuscitated in USG-supported programs (Indicator #2.1.5)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	911	669	73.4%
	Kasaï-Oriental	757	719	95.0%
	Lomami	724	586	80.9%
	Sankuru	290	240	82.8%
Total Kasaï		**2,682**	**2,214**	**82.6%**
Katanga	Haut-Katanga	2,092	1,699	81.2%
	Haut-Lomami	945	966	102.2%
	Lualaba	911	870	95.5%
Total Katanga		**3,948**	**3,535**	**89.5%**
Eastern Congo	Sud-Kivu	2,075	1,598	77.0%
	Tanganyika	449	399	88.9%
Total Eastern Congo		**2,524**	**1,997**	**79.1%**
Grand Total		**9,154**	**7,746**	**84.6%**

Source: DHIS2, Accessed April 23, 2021

Maternal death surveillance and response

As shown in Table 13, USAID IHP provinces reviewed 32.5 percent of notified maternal deaths (209 deaths out of 643) in Quarter 2. This rate is low, since in theory all reported deaths should be reviewed to develop a response plan. Nevertheless, it marks a significant improvement compared to the previous quarter. Kasaï-Central, Sankuru, and Tanganyika reviewed at least 50 percent of deaths.

Across the nine provinces, integration of the SDMPR committees in 65 ZS, monthly maternal death review meetings, and quarterly provincial SDMPR meetings have contributed to this improvement. During this quarter:

- 12 ZS set up SDMPR committees
- 27 ZS revitalized their SDMPR committees and held monthly SDMPR meetings
- Five provinces (Sankuru, Lomami, Central-Kasaï, Sud-Kivu, and Lualaba) organized quarterly SDMPR meetings

These reviews identified postpartum hemorrhage, particularly after emergency caesarean sections, as a cause of maternal death. Among the risk factors, USAID IHP identified delayed decisions to seek care at the health facility and too many pregnancies. Most maternal deaths in the community were not reviewed due to late notification and lack of skills to conduct these reviews.

Table 13. Number of maternal deaths and maternal death reviews by province (Q2)

Province		October to December 2020			January to March 2021		
		Maternal Deaths	Reviewed Maternal Deaths	Maternal Deaths in the Community	Maternal Deaths	Reviewed Maternal Deaths	Maternal Deaths in the Community
Kasaï	Kasaï-Oriental	11	6	44	6	5	8
	Kasaï-Central	15	14	14	26	23	16
	Lomami	20	18	32	64	26	19
	Sankuru	15	14	23	33	26	17
Total Kasaï		**61**	**52**	**113**	**129**	**80**	**60**
Katanga	Haut-Katanga	47	29	15	55	23	43
	Haut-Lomami	40	24	151	45	33	136
	Lualaba	27	23	7	21	13	20
Total Katanga		**114**	**76**	**173**	**121**	**69**	**199**
Eastern Congo	Sud-Kivu	34	23	17	46	31	37
	Tanganyika	16	14	32	34	29	17
Total Eastern Congo		**50**	**37**	**49**	**80**	**60**	**54**
Grand Total		**225**	**165**	**335**	**330**	**209**	**313**

Source: DHIS2, Accessed April 23, 2021

Organize clinical mentoring of ZS in EmONC

To improve quality at the point of service delivery and to enhance providers' skills in applying standards and procedures of care, USAID IHP introduced LDHF clinical mentoring in five sites in five ZS in Tanganyika. Table 14 below shows the scores of 30 nurses and midwives in two sites before and after they received coaching on maternal and neonatal care packages and postpartum family planning by provincial coaches and USAID IHP. Coaching covered five essential interventions: eutocic delivery with active management of the third stage of delivery, artificial delivery in case of placental retention, resuscitation of newborns with asphyxia, and postpartum family planning with intrauterine device (IUD)

insertion and Implanon NxT implantation. Partner Jhpiego provided materials that enabled simulation exercises. For these 30 providers in the maternity wards, the minimum acceptable level of performance varied from 75 to 89 percent for the different interventions. For example, for IUD insertion, the average increased from 3 to 84 percent—a gain of 81 percent after four months of coaching.

Table 14. Evaluation of clinical mentoring with LDHF in two ZS: Kalemie and Nyemba Tanganyika

Location	Eutocic Delivery		Artificial Delivery of the Placenta		Newborn Resuscitation		Insertion of IUDs		Insertion Implanon NXT	
	Pre-Test Nov. 2020	Post Test after Coaching March 2021	Pre-Test Nov. 2020	Post Test after Coaching March 2021	Pre-Test Nov. 2020	Post Test after Coaching March 2021	Pre-Test Nov. 2020	Post Test after Coaching March 2021	Pre-Test Nov. 2020	Post Test after Coaching March 2021
Nyemba ZS	37%	80%	15%	75%	21%	82%	3%	84%	10%	89%
Kalemie ZS	17%	90%	43%	87	23%	84%	54,8%	81,4%	69,5%	89%

Source: USAID IHP Project Monitoring Report

Organize training and post-training follow-up for providers in EmONC, emergency obstetric care, post-abortion care, SMR

In Sud-Kivu, USAID IHP provided technical and financial support to train 80 providers (nurses and midwives) in five ZS in BEmONC. The training covered manual intrauterine vacuum aspiration (MVA), artificial delivery, and administration of magnesium sulfate in cases of severe preeclampsia and eclampsia, neonatal resuscitation, and active management of third stage of labor (AMTSL). As shown in Table 15, providers clearly improved their skills between the initial and final evaluations of the different functions of BEmONC. The lowest score started at 3.9 percent and rose to 43 percent at the end of the training. The lowest average of 22 percent rose to 67.2 percent, a 45 percent increase.

Table 15. Evaluation of providers' skills in BEmONC in Sud- Kivu

Score	Shabunda		Nundu		Kadutu		Fizi		Bunyakiri	
	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test
Minimum	3.9%	43%	25%	50%	14.2%	31.1%	16%	51%	8%	30%
Maximum	46%	81.4%	50%	85%	59%	79%	70%	84%	57%	73%
Average	22%	67.2%	35%	70%	36.1%	55.1%	49%	70%	29%	54%

Source: USAID IHP Project Monitoring Report

USAID IHP also conducted a post-training follow-up of 130 providers in three Kasaï-Oriental ZS. Observation of the providers during their work revealed clear improvement in their skills for certain routine practical procedures, either on real cases or in simulation. However, low-volume cases such as MVA remain a challenge due to lack of coaching or lack of materials. Several practice sessions with the coaches helped some providers unfamiliar with uterine compression and MVA to improve performance.

Challenges encountered by providers in implementing BEmONC, include: (1) insufficient or lack of real cases to apply certain interventions, (2) low attendance by pregnant women at the facilities, and (3) few instructional materials for ongoing practical simulation exercises *in situ*. Finally, irregular supervision and coaching affects the quality of learning in health facilities.

Table 16. Evaluation of the skills of providers in Kasaï-Oriental during post-training follow-ups in EmONC

Parameters	MVA		AMTSL		Uterine Compression		Artificial Delivery		Neonatal Resuscitation	
	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test	Pre-test	Post test
Minimum	0.0%	17.2%	16.7%	66.7%	0.0%	64.3%	7.7%	69.2%	10.0%	50.0%
Maximum	86.2%	96.6%	75.0%	100.0%	78.6%	100.0%	84.6%	96.2%	56.7%	83.3%
Average	46.6%	77.2%	45.8%	86.7%	47.9%	87.1%	54.6%	85.0%	32.7%	65.7%

Source: USAID IHP Project Monitoring Report

Lessons learned

- Regular mini-campaigns improve use of ANC services and delivery at health facilities.
- Building providers' skills improves the management and quality of maternal and newborn care during labor, delivery, and postpartum.
- Clinical mentoring significantly improves provider skills for the survival of women and children, but to be most effective, it must be supported by regular follow-up activities and training materials.

Next steps

- Proceed with raising community awareness about the four ANC visits and delivery services, especially in Haut-Lomami, Lomami and Tanganyika.
- Organize EmONC trainings in Lualaba, Lomami, Sud-Kivu, and Tanganyika.
- Expand the clinical mentoring approach to other ZS.
- Organize post-training follow-up in maternal health for ZS in Lualaba and Kasaï-Central.
- Proceed with monthly and quarterly SDMPR meetings.
- Focus on increasing sensitization sessions on use of ANC services and delivfery. reinvigorating support for SDPMR and ensuring post-training on BEmONC for trained providers in Haut-Lomami
- Explore the possibility of expanding the IPT approach and early ANC initiation (briefing of providers) in other provinces.
- Procurement is underway for training materials to support EmONC, and delivery of these materials is expected before the end of FY2021 Quarter 4.

IMMUNIZATION

Immunization of women and children is a priority area of the GDRC's program. The Expanded Program on Immunization aims to increase immunization coverage to a rate above 90 percent for the pentavalent-3 (DPT-HepB-Hib3) vaccine, reduce the gap in DPT3 immunization coverage between the richest and poorest quintiles, and reduce morbidity and mortality due to vaccine-preventable illnesses. The analysis of the immunization situation, conducted by EPI, reveals that there are still many unvaccinated children, unreliable availability of vaccines at the operational level, and continued risk of internal spread of wild poliovirus and circulating vaccine-derived poliovirus.

A newborn receives care during a well-child visit at the Crina health center in Kalamondo ZS, Haut-Katanga. Photo by Jean Manassé Tshibamba, freelance photographer for USAID IHP.

The Reach Every Child approach, implemented in the DRC since 2004, has proven crucial for the successful strengthening of vaccination systems and the sustainable and equitable increase in the immunization coverage rate. Since 2018, the DRC has implemented the Emergency Plan for the relaunch of routine vaccination in the DRC (called the "Mashako Plan"). The essential components for strengthening immunization activities within the framework of the Mashako Plan are: coordination and financing, service delivery (immunization sessions), availability of vaccines and operation of the cold chain, monitoring and supervision, community dynamics and performance evaluation.

The Mashako Plan is currently being implemented in eight of the nine USAID IHP provinces (not in Lualaba). To date, three of the eight USAID IHP supported provinces (Haut-Katanga, Haut-Lomami and Tanganyika) have already integrated Mashako Plan activities and five (Lomami, Sankuru, Kasaï-Oriental, Kasaï-Central, and Sud-Kivu) began integrating the strategy in early 2021. During Quarter 2, USAID IHP provided financial and technical support to Lomami in its implementation of the Mashako Plan, in collaboration with the International Red Cross, Save the Children and UNICEF. In the other provinces, USAID IHP contributed technical support.

Implementation of service delivery and quality activities for immunization

For Indicator #9 (number of children less than 12 months of age who received three doses of pentavalent vaccine from USG-supported programs), Figure 3 shows that USAID IHP had an achievement rate of 97.2 percent, or 359,845 children vaccinated with pentavalent-3 out of 370,022 children expected for this quarter. Eight provinces (Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru,

Haut-Katanga, Haut-Lomami, Sud-Kivu, and Tanganyika) out of nine achieved an immunization rate above 90 percent, while Lualaba did not achieve this rate.

For Indicator #10 (number of children less than 12 months of age who received measles vaccine from USG-supported programs), Figure 4 shows that USAID IHP had an achievement rate of 94.4 percent, or 349,247 children vaccinated against measles. Seven out of nine provinces achieved vaccination rates of 90 percent or higher, while two provinces (Lualaba and Sankuru) did not achieve this target.

Generally, USAID IHP noted a slight increase in immunization coverage rates between FY2021 Quarter 1 and Quarter 2 of 1.1 percent for pentavalent-3 and 0.5 percent for measles. However, despite good immunization coverage in certain provinces, there are disparities in performance among the ZS within these provinces. USAID IHP specifically contributed to this area by supporting the following activities.

Training

- Training of 117 providers (112 men and 15 women, all nurses) in Lomami and Sud-Kivu in vaccine management, vaccination practices, and post-vaccine follow-up.
- Training of 104 RECO—92 men and 12 women—in five ZS in Sankuru. USAID IHP trained the RECO in community-based surveillance (CBS), reproduced 360 modules of the updated CBS guide, and distributed them to the ZS of Lomela, Lodja, Dikunku, Katakokombe, and Wembonyama.

Logistics

- Transport of vaccines and EPI inputs from the EPI site to 13 BCZS in two provinces (Sankuru, and Lualaba). USAID IHP contributed by purchasing 1,290 liters of fuel oil, 4,560 liters of oil, and 360 liters of gasoline (for the conservation of vaccines in three ZS in Sankuru).
- Contribution to the preventive and corrective maintenance of cold chain equipment.

Supervision

- DPS executives' supervision of the ZS to identify reasons for poor performance and supervise the actors involved in immunizations (including nurses and RECO).
- Technical and financial support of integrated epidemiological supervision meetings covering both *Maladies à potentiel epidémique* (MAPEPI, diseases with epidemic potential) and COVID-19 in Kasaï-Central (three meetings; reproduction of updated CBS tools), Lomami (one meeting), and Sankuru (two meetings).

Monitoring and Evaluation (M&E)

- Quarterly close monitoring through electronic supervision[5] (see more below) which is standard throughout all ZS in Haut-Katanga, and organization of performance analysis meetings in which USAID IHP staff also participate. These meetings are reviews with the ZS and a meeting of the *Comité de Coordination Inter-agences* (Inter-agency Coordinating Committee).

[5] The Mashako Plan's electronic supervision tool is a numeric tool to reinforce quality services for immunization. It uses a numerical checklist for simplified entry for the components: vaccine availability, cold chain functionality, and the number of routine immunization sessions carried out based on the health pyramid. The tool instantly analyzes collected data to help provincial teams make quick decisions.

Planning

- Organization of Periodic Intensification of Routine Vaccination activities in the *aires de santé* with low coverage to recover unvaccinated children in Kasaï-Central, Lomami, and Sud-Kivu. This activity allowed the recovery of 3,642 children for all antigens combined and of 79 pregnant women in Lomami with involvement of the CACs.
- Support for the outreach activities in Kasaï-Central, Lomami, and Sud-Kivu.

The following are factors that explain the underperformance in certain provinces:

Lualaba:

- The severe disrepair of the roads to Mutshatsha, which makes it difficult to supply vaccines to all the health facilities that have integrated the immunization activity.
- Stockouts of dry inputs at the central level, affecting the dosage for BCG vaccine during the first two months of the quarter.
- Poor coverage of activities related to the recovery of unvaccinated children.

Sankuru:

- Skill levels in EPI management and follow-up that have not been updated since 2015.
- Inadequate means of transport for the Lodja EPI site to the ZS in the province.

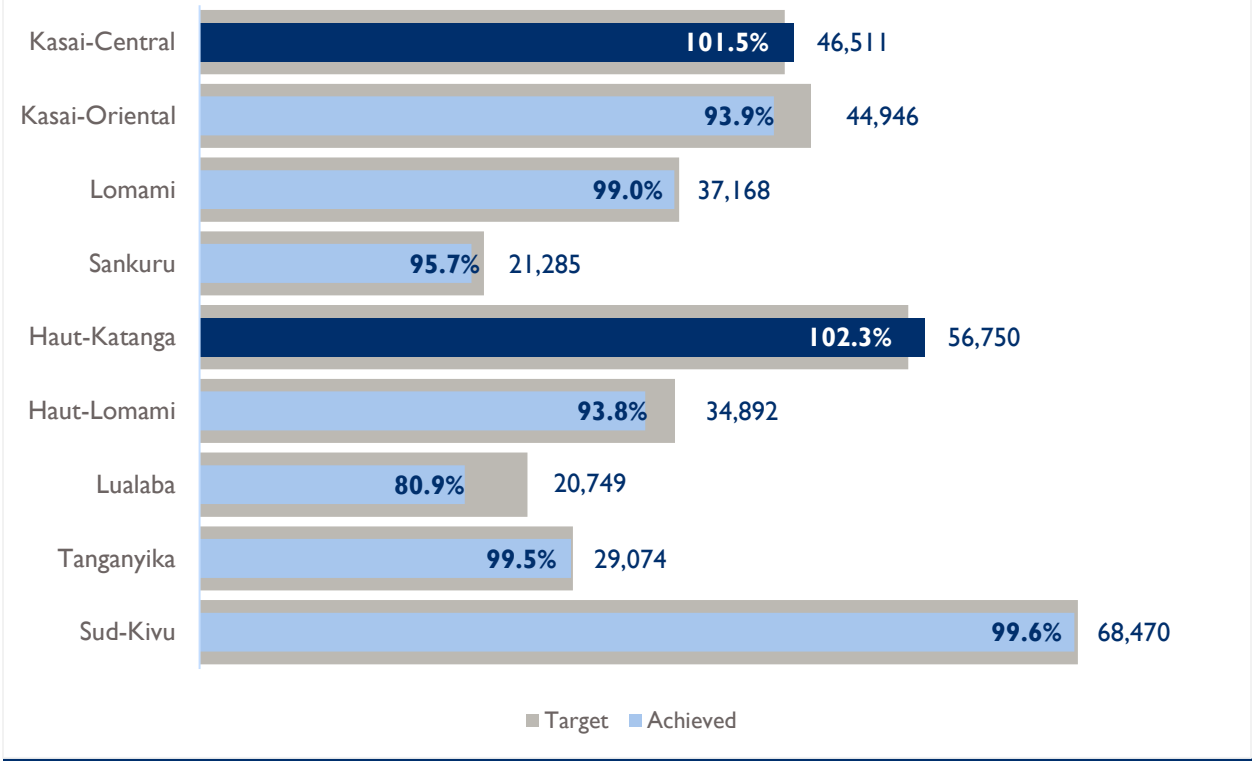
Haut-Lomami:

- Incomplete ZS-level data in DHIS2.
- Poor data analysis due to the lack of mastery of DHIS2 by most EPI supervisors and some ZS Chief Medical Officers.
- Inconsistencies between DHIS2 immunization data and those produced by the health facilities: F1 and *Système national d'information sanitaire* (SNIS, National Health Information System).
- Low completion rate of planned immunization sessions in low-performing ZS following bad weather (flooding made it difficult to access some ZS).

Sud-Kivu:

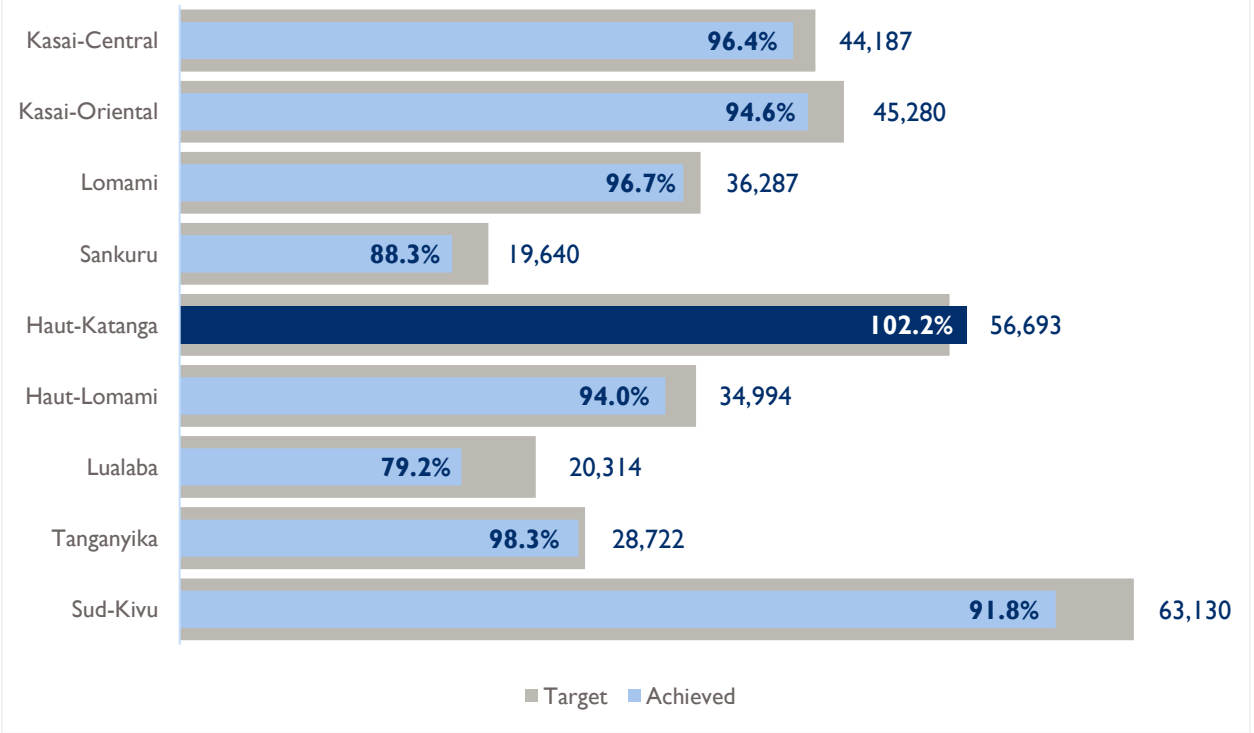
- Insecurity and ongoing conflict between communities in the ZS of Hauts-Plateaux d'Uvira and Itombwe which made it difficult to supply the vaccines and recover vaccinations.
- The current rainy season, which has made roads impassable, resulting in stockouts of vaccines and other EPI inputs. This has been the case in Kamituga, Kitutu, Mulungu, and Kalole.

Figure 3. Vaccination coverage in DPT-HepB-Hib3 by province (Indicator #9)



Source: DHIS2, Accessed April 23, 2021

Figure 4. Measles vaccination coverage by province (Indicator #10)



Source: DHIS2, Accessed April 23, 2021

USAID IHP support to Mashako Plan activities

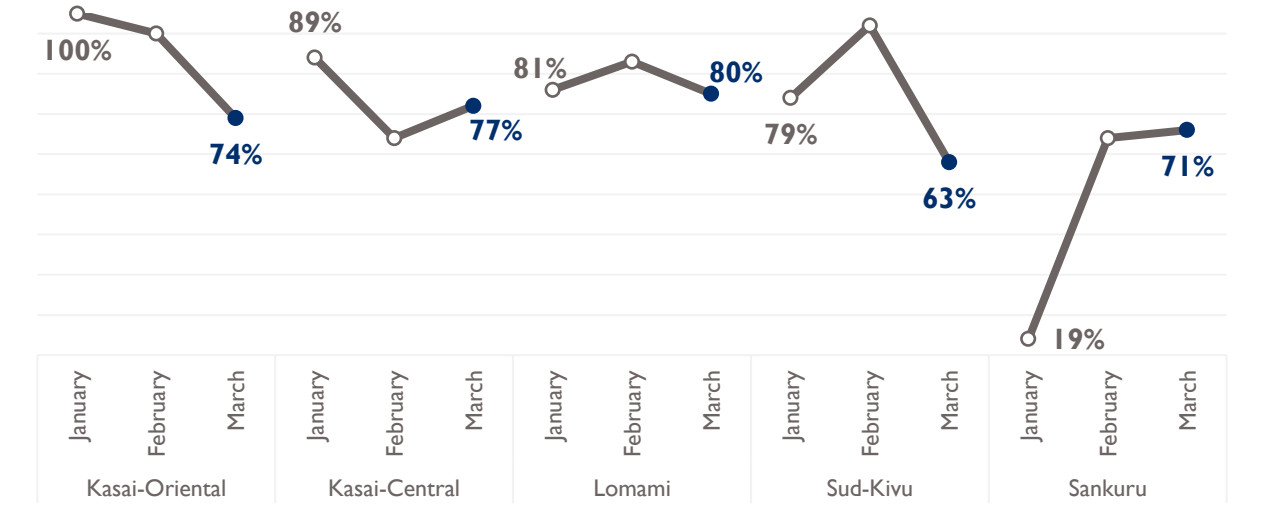
USAID IHP analyzed supervisory scores for the five provinces that have just begun integrating the Mashako Plan strategy. Kasaï Oriental, Kasaï Central and Lomami maintained scores of 80 percent or higher in Quarter 2. Sankuru showed the greatest improvement from 19 percent to 71 percent. Sud-Kivu's scores decreased from 79 percent in January to 63 percent in March (see Figure 5).

USAID IHP also conducted an analysis of data for five indicators over the past quarter for the three provinces that have already integrated the Mashako Plan strategy. As shown in Figure 6, the data shows a satisfactory rate of DPS supervision of ZS and AS and vaccination sessions in Haut-Katanga and Haut-Lomami. The weak performance in Tanganyika is linked to the distribution of LLINs and logistical issues preventing access of airplanes to the ZS. The functioning of the cold chain and availability of vaccines was good in all three provinces.

Data Quality and Other Support Activities for Vaccination

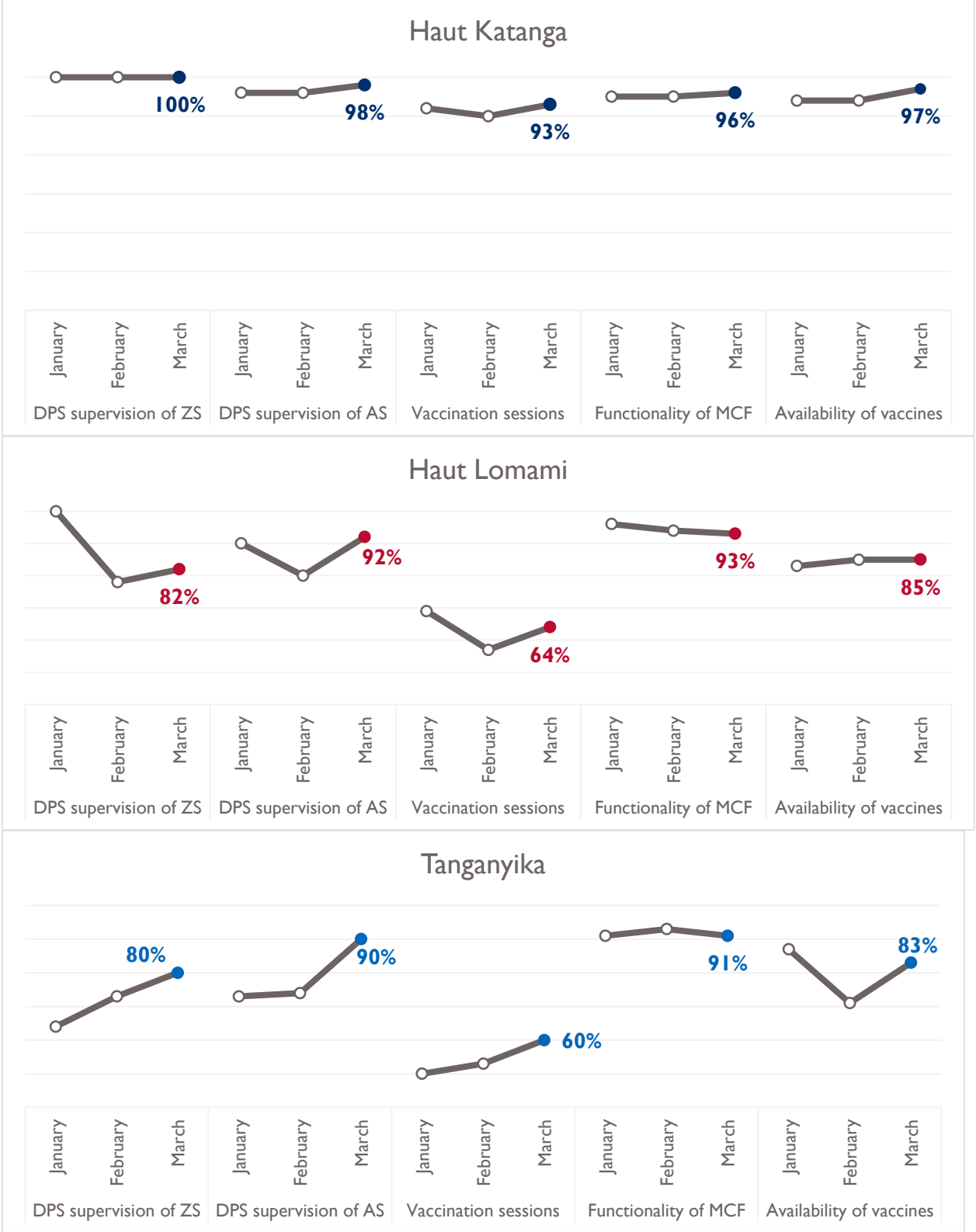
USAID IHP supported implementation of data quality self-assessments in the Kalenda ZS, Lomami province, to evaluate the quality of immunization data. A total of four organizations (one BCZS and three health centers) were involved in this activity. At the end of the data quality audit in the Kalenda ZS, the main weakness identified in the structures visited was the inconsistency of EPI data between the different management tools (Form 1, Form 2, scorecards, and vaccination record). USAID IHP will support the health facilities to organize vaccination sessions to better define the flow of children and to improve reporting.

Figure 5. Supervision score for the USAID IHP supported five provinces that are newly integrating the Mashako Plan (FY2021 Q2)



Source: USAID IHP Project Monitoring Report

Figure 6. Mashako Plan indicators in 3 provinces previously supported by USAID IHP (FY2021 Q2)



Source: USAID IHP Project Monitoring Report

Lessons learned

- Strengthening of routine EPI by implementing the Reach Every Child approach to recover all cases lost to follow-up helped to improve vaccine coverage in the ZS.
- The involvement of RECO in routine community EPI activities in ZS health facilities allowed the recovery of children lost to follow-up and children who have missed their vaccinations.

Next steps

- Support providers in recovering children who have not received pentavalent-3.
- Update all data in DHIS2 in real time.
- Continue to support the vaccine supply chain of the EPI sites in reaching BCZS and far-away *aires de santé.*
- Support maintenance of cold chain equipment.
- Ensure post-training follow-up for providers who have received training.
- Continue financial support to ZS to reinforce their routine EPI activities.

CHILD HEALTH

Integrated management of newborn and childhood illness

In the Quarter 2 of FY2021, USAID IHP continued to support the MOH in reducing the morbidity and mortality of children under 5 years of age caused by childhood killer diseases, particularly pneumonia, diarrhea, malaria, and malnutrition. The Program provided this support through the integrated care of sick children as well as the rational prescription of essential medicines.

The areas benefiting from this support were the iCCM of newborn and childhood illness (IMNCI); clinical flowcharts on IMNCI for health centers; and *triage, évaluation et traitement d'urgence* (TETU, emergency triage, evaluation, and treatment) for general referral hospitals through training, follow-up, supervision, printing and distribution of job aids and management tools, and coaching. The following activities were implemented:

- Training of 61 service providers and ZS officials (54 men and seven women) in Lualaba and Sankuru on the IMNCI flowchart, broken down as follows: 12 members of the *Equipe cadre de la zone de santé* (ECZS, ZS Management Team), two representatives of GRHs, and 47 registered nurses/assistant registered nurses.
- Training of trainers: 27 DPS officials and general referral hospital clinicians in Haut-Lomami and Kasaï-Oriental (all men; 15 from Haut-Lomami and 12 from Kasaï-Oriental) were trained as trainers in TETU; out of 15 from Haut-Lomami, 11 were certified as trainers.
- TETU training: 203 participants (145 men and 58 women) from Haut-Lomami, Lualaba, and Sud-Kivu were trained in TETU as follows: 135 providers (94 men and 41 women, pediatric doctors and nurses specializing in pediatrics, delivery and emergencies) and 72 administrative staff (54 men and 18 women working in administration, reception and those focused on triage, lab and radiology). In Sud-Kivu, providers were trained by pediatric specialists and improved their competencies in management of pediatric emergencies: a pre- and post- evaluation showed that they improved their competencies by 33 percent.

- Printing and distribution of 5,000 IMNCI flow charts, 25 posters, and 70 TETU technical sheets in Kasaï-Central and 1,152 TETU technical sheets in Lualaba.
- Support for TETU coaching missions in 10 general referral hospitals in the ZS of Sud-Kivu to identify obstacles and weaknesses of providers and organization of services in general referral hospitals; to reinforce personnel knowledge and skills in practice and management; and to develop an improvement plan for each general referral hospital.
- Mini-campaign on the promotion and use of oral rehydration salts plus zinc (ORS+zinc) for the treatment of diarrhea, in Kasaï-Central, Lualaba, and Haut-Lomami.
- Mini-campaign for detecting and referring sick children in Kasaï-Central, Kasaï-Oriental, and Lualaba: detection, referral, and treatment of 10,528 sick children, presenting with ARI/pneumonia.
- Supervisory visits by PNIRA and PNECHOL-MD national-level executives to Kasaï-Central and Lomami provinces for supervision and assessment of the level of integration of PCIMNE, TETU and PCIMNE approaches; community care sites in 3 ZS visited show that systematic care according to the PCIMNE approach (assess and classify, advise, when to return) is effective in more than 70 percent of the training courses conducted.

With regard to Indicator #5 (Number of children under 5 that received treatment for an acute respiratory infection from an appropriate provider), a total of 367,634 children with ARI/pneumonia were treated, which represents an achievement rate of 108.5 percent for the quarter. With the exception of Haut-Lomami, all provinces achieved and even surpassed the target. This strong performance can be explained by the availability of dispersible amoxicillin in all health facilities, the integration of the TETU approach in 22 additional hospitals, training in TETU, IMNCI flowchart in the ZS, and supervision of iCCM sites.

For Indicator #7, 278,776 children with diarrhea were treated (98 percent of the target). The Katanga region had the highest performance with 113.3 percent, followed by Eastern Congo with 98 percent and Kasaï with 96.4 percent. In terms of the provinces, Kasaï-Central had the highest rate (113.3%) as a result of the mini-campaigns promoting ORS+zinc and on referring sick children that presented with an episode of diarrhea. In addition, the integration of the complete IMNCI package (community, clinical and TETU) in the same ZS facilitated integrated care and optimal care at multiple levels of the health system. Sankuru exhibited the weakest performance following the lengthy ORS+zinc stockout at health facilities and iCCM sites. As for Sud-Kivu, 231 out of 1,066 health facilities (21.6%) experienced artificial shortages of ORS+zinc even though the medicines were available at the central offices of the ZS, because registered nurses refused to requisition this medicine. This refusal was due to the central office's cost recovery for this item.

Table 17. Number of children under 5 years of age (0-59 months) 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 years of Age that Received Treatment for an Acute Respiratory Infection from an Appropriate Provider			Number of Cases of Child Diarrhea Treated in USG-Supported Programs		
		Target	Q2 Achievement	Achievement Rate (%)	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	69,740	79,192	113.6%	48,355	59,471	123.0%

Region	Province	Number of Children under 5 years of Age that Received Treatment for an Acute Respiratory Infection from an Appropriate Provider			Number of Cases of Child Diarrhea Treated in USG-Supported Programs		
		Target	Q2 Achievement	Achievement Rate (%)	Target	Q2 Achievement	Achievement Rate (%)
	Kasaï-Oriental	39,400	41,967	106.5%	30,942	25,824	83.5%
	Lomami	38,173	49,115	128.7%	30,021	27,455	91.5%
	Sankuru	16,701	17,363	104.0%	20,962	12,890	61.5%
Total Kasaï		**164,014**	**187,637**	**114.4%**	**130,280**	**125,640**	**96.4%**
Katanga	Haut-Katanga	25,434	25,363	99.7%	23,229	24,733	106.5%
	Haut-Lomami	23,761	22,969	96.7%	26,250	30,233	115.2%
	Lualaba	26,007	26,641	102.4%	16,030	18,143	113.2%
Total Katanga		**75,202**	**74,973**	**99.7%**	**65,509**	**73,109**	**111.6%**
Eastern Congo	Tanganyika	24,335	26,611	109.4%	13,815	16,093	116.5%
	Sud-Kivu	75,331	78,413	104.1%	74,858	63,934	85.4%
Total Eastern Congo		**99,666**	**105,024**	**105.4%**	**88,673**	**80,027**	**90.2%**
Grand Total		**338,882**	**367,634**	**108.5%**	**284,462**	**278,776**	**98.0%**

Source: DHIS2, Accessed April 23, 2021

Lessons learned

- The integration of pediatricians in the implementation of the TETU approach in Sud-Kivu helped to facilitate their understanding and involvement in primary health care activities. It also helped to improve provider skills in the application of emergency procedures, in particular the management of the state of shock, and the use of oxygen in hospitals.
- The integration of community care sites, clinical IMCNI and TETU in the same health zone improves access, care, referrals and follow-up at different levels of the health system.

Next steps

- Ensure that providers in Tanganyika, Kasaï-Central, and Lomami receive training on the IMNCI clinical flowchart.
- Ensure post-training follow-up, including supportive supervision and coaching, for providers already trained in Haut-Lomami, Lualaba, Sankuru and Sud-Kivu..
- Collaborate with GHSC-TA to revise procedures for managing essential generic medicines (EGM), to ensure the consistent availability EGM at the last-mile of supply chain.
- Follow up on implementation of the general referral hospital improvement plans after the TETU coaching missions in Sud-Kivu.
- Supply health facilities with equipment and treatment tools for managing pediatric emergencies.

Integrated community case management

To reduce the mortality of children under 5, USAID IHP supported the implementation of the following activities at iCCM sites during Quarter 2:

- Established 62 new iCCM sites (50 in Kasaï-Central and 12 in Kasaï-Oriental) and trained 62 RECO (59 men and 3 women), 57 registered nurses (56 men and one woman), 13 members of ECZS (12 men and one woman), and 50 community action group presidents (all men).
- Supervised 710 iCCM sites by registered nurses, ECZS members and USAID IHP staff, made the supervisory visits. The supervisory visits followed a standard format consisting of a review of the site's tools, medicines, and equipment; observation of care; and interviews with the health worker, the parents, and community members. This also shows the mastery of algorithms and the correct treatment for malaria, despite the low availability of ORS+Zinc and amoxycillin. One of the main gaps in knowledge identified during these visits was data entry errors in the care register (discrepancies in particular between: complaints and evaluation; evaluation and classification; classification and treatment). To address this, supervisor feedback was provided in order to reinforce strengths and correct weaknesses.
- Retraining of 513 RECO in Haut-Katanga, Kasaï Central, Lualaba and Tanganyika. Follow-up for groups or RECOs with their ITs (assessment of competencies for treatment observation, document review, etc) in Kasaï-Central, Haut-Katanga, Lualaba, and Tanganyika. In Lualaba for example, the results from the follow-up showed adherence to care protocols for treatment of malaria, pneumonia, diarrhea and malnutrition.

In total, 75,399 sick children were treated at the iCCM sites (12,691 for pneumonia, 14,540 for diarrhea, and 48,168 for malaria) (Table 18). Compared to last quarter, we note a slight reduction in the total number of cases treated (which was 77,927 in FY2021 Q1). This can be explained by the unavailability of medicines especially at the iCCM sites, for cases referred to the health centers for treatment.

Strongest performance was in Kasaï-Central, Sankuru and Sud-Kivu as a result of: follow-up group activities, availability of ORS+Zinc, and the set-up of new SSCs. In Tanganyika province, the DPS signed a circular for the supply of ORS-Zinc and other products for community care sites. For the other provinces, the recommendation is integrated into the procedures for managing drugs under review.

Table 18. Management of pneumonia, diarrhea, and malaria at iCCM sites

Region	Province	Number of Pneumonia Cases Treated	Number of Diarrhea Cases Treated	Number of Malaria Cases Treated	Total Cases Treated
Kasaï	Kasaï-Central	3,515	4,306	9,285	17,106
	Kasaï-Oriental	2,089	2,645	7,178	11,912
	Lomami	2,193	1,652	4,713	8,558
	Sankuru	703	797	5,098	6,598
Total Kasaï		**8,500**	**9,400**	**26,274**	**44,174**
Katanga	Haut-Katanga	365	489	2,169	3,023
	Haut-Lomami	654	1,278	3,552	5,484
	Lualaba	515	599	2,185	3,299
Total Katanga		**1,534**	**2,366**	**7,906**	**11,806**
Eastern Congo	Sud-Kivu	1,887	1,867	7,926	11,680
	Tanganyika	770	907	6,062	7,739
Total Eastern Congo		**2,657**	**2,774**	**13,988**	**19,419**
Grand Total		**12,691**	**14,540**	**48,168**	**75,399**

Source: DHIS2, Accessed April 23, 2021

Lessons learned

- Supervision allows: (1) the assessment of health centers' difficulties with the supply chain for medicines and the lack of availability of certain equipment, such as timers and service delivery tools and (2) improvement of weaknesses identified by the head of the RECO in order to strengthen iCCM workers' skills in case management and management of medicines.

Next steps

- Ensure post-training follow-up for RECO sites in newly established iCCM sites.
- Continue monthly supervision of RECO in all provinces
- Encourage the establishment of new iCCM sites in the remaining provinces (Lomami, Sud-Kivu, Haut-Katanga, Haut-Lomami, and Lualaba).
- Ensure follow-up on EGM supply at the established sites.
- Speed up the process of using the supervision of the SSC application developed by USAID IHP, to increase the number of supervised care sites in Lualaba, Sankuru, Kasaï Oriental and Tanganyika.
- Train provincial supervisors in the use of the site supervision application in Haut-Lomami, Lomami, Haut-Katanga, Sud-Kivu and Kasaï Central.
- Organize group follow-up with the RECO.

- **434,720 pregnant women** received iron-folic acid supplementation
- **617 providers** trained in nutrition-related interventions
- **60 IYCF support groups** established
- **139 IYCF support groups** supported through activity monitoring and coaching in 41 ZS

NUTRITION

USAID IHP supports the MOH in preventing malnutrition and promoting nutrition to pregnant and breastfeeding women and children under 5 years old through interventions largely focused on key points of care at the health facility and community levels. During Quarter 2, USAID IHP continued to (1) improve DPS executive team, provider, and RECO knowledge of nutrition-related interventions *consultation préscolaire redynamisée* (Revitalized preschool consultation, CPSr) and infant and young child feeding; (2) increase community engagement in good nutritional practices through IYCF coaching and support groups; and (3) reinforce nutritional interventions specifically geared toward women through mini-campaigns, ANC visits, and IYCF support group activities. During the quarter, USAID IHP also with consulted fellow USAID project Food for Peace to ensure good coordination of joint interventions in Kasaï-Oriental.

Reached providers and RECO with nutrition-related trainings

Direct: ✔ 2.1.10

USAID IHP supported nutrition-related trainings in CPSr, IYCF, the *Système nutritionnel de surveillance et d'alerte précoce* (SNSAP, the nutritional surveillance and early warning system), clinical IMNCI, iCCM, and child health for a total of 617 providers and RECO, or 32.3 percent of the target, in eight provinces during Quarter 2. These trainings provided participants with essential information on the assessment, classification, and management of moderately acute malnutrition, advice on feeding children, and the detection and referral of cases of malnutrition. Of particular note, out of the 617 people trained, the Program trained 183 individuals as part of the implementation of new iCCM sites in Kasaï-Central and Kasaï-Oriental, 100 individuals as part of the establishment of 50 new IYCF support groups in Sankuru, and 61 service providers and executives from Lualaba and Sankuru in clinical IMNCI.

Though trainings occurred in eight out of nine provinces, only Sankuru met or exceeded the quarterly target. Sankuru's high achievement rate was due to not only conducting provider trainings in nutrition but also aligning nutrition-related training with the establishment of IYCF support groups in the province. In contrast, no trainings were conducted in Lomami due to the non-availability of central-level trainers. In that province, there are no provincial trainers in nutrition and so it is not possible to implement trainings in the absence of available central-level trainers. However, the Program has already facilitated scheduling of trainings for provincial-level trainers in Lomami during Quarter 3.

Table 19. Number of individuals receiving nutrition-related professional training through USG-supported nutrition programs (Indicator #2.1.10)				
Region	**Province**	**Target**	**Q2 Achievement**	**Achievement Rate (%)**
Kasaï	Kasaï-Central	377	155	41.1%
	Kasaï-Oriental	423	41	9.7%
	Lomami	122	0	0%
	Sankuru	94	160	170.2%
Total Kasaï		**1,016**	**356**	**35%**
Katanga	Haut-Katanga	223	94	42.2%
	Haut-Lomami	87	26	29.9%
	Lualaba	123	18	14.6%
Total Katanga		**433**	**138**	**31.9%**
Eastern Congo	Sud-Kivu	324	92	28.4%
	Tanganyika	136	31	22.8%
Total Eastern Congo		**460**	**123**	**26.7%**
Grand Total		**1,909**	**617**	**32.3%**

Source: USAID IHP Project Monitoring Report

Nutrition interventions for women, including pregnant and breastfeeding women

Direct: ✔ 2.1.13 **Indirect:** ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12

In addition to the activities above, USAID IHP continued to support nutrition interventions for pregnant and breastfeeding women. Namely, the Program supported nutritional counseling, iron-folic acid supplementation, and deworming for pregnant women during ANC visits; awareness-raising of pregnant and breastfeeding women on nutrition during breastfeeding and ANC mini-campaigns; VIVA campaigns with couples' parties and quizzes at the market; and IYCF support group activities.

Table 20 shows that Program support resulted in 434,720 women (104.9 percent) receiving nutritional interventions during the quarter. All provinces exceeded their quarterly targets for this indicator, with the exception of Haut-Lomami, where 40,906 women (97.5 percent) received nutritional support. This high level of beneficiaries in Quarter 2 is primarily due to the availability of iron-folic acid in health facilities and USAID IHP's ANC mini-campaigns, which helped refer more women to ANC services.

Table 20. Number of pregnant women reached with nutrition interventions through USG-supported programs (Indicator #2.1.13)				
Region	**Province**	**Target**	**Q2 Achievement**	**Achievement Rate (%)**
Kasaï	Kasaï-Central	52,994	56,700	107%
	Kasaï-Oriental	51,810	54,393	105%
	Lomami	42,064	46,024	109.4%
	Sankuru	25,349	26,439	104.3%
Total Kasaï		**172,217**	**183,556**	**106.6%**
Katanga	Haut-Katanga	59,330	62,928	106.1%
	Haut-Lomami	41,960	40,906	97.5%
	Lualaba	32,239	33,234	103.1%
Total Katanga		**133,529**	**137,068**	**102.7%**
Eastern Congo	Sud-Kivu	81,045	82,108	101.3%
	Tanganyika	27,734	31,988	115.3%
Total Eastern Congo		**108,779**	**114,096**	**104.9%**
Total		**414,525**	**434,720**	**104.9%**

Source: DHIS2, Accessed April 23, 2021

Lessons learned

- Establishing SNSAP sites—aires de santé identified for monitoring of chronic malnutrition data based on the population's epidemiologic profile and well-child visits and antenatal care attendance—facilitates early detection of malnutrition cases and the identification of alert areas for intensive nutritional interventions.
- In addition to trainings and community-level interventions, nutritional coaching—during which DPS coaches in nutrition support the BCZS, health centers, and community with implementation, data collection and analysis, and reporting of nutritional activities—reinforces different stakeholders to improve the implementation of activities and produce quality results.
- The approach of coupling the establishment of IYCF support groups with high participation in nutrition-related training can be further promoted and reinforced via functional community action groups and involvement of local authorities, as in Sankuru.
- The establishment of IYCF support groups facilitates the promotion of nutritional interventions at the community level as well as diet monitoring for children under 5 years old and pregnant and breastfeeding women, both of which support healthy growth of children during their first 1,000 days.
- The availability of medicines, and iron-folic acid in particular, is critical to effective ANC care during which women attending ANC visits also receive advice about their nutrition and hygiene.

Next steps

- Conduct nutrition-related trainings in IMNCI (training of trainers, training of service providers, implementation of new iCCM sites) in Lomami.
- Find a mechanism to supply nurses with communications support (i.e., mobile data credit) to facilitate reporting for the old iCCM sites supported by UNICEF through the DPS in Kasaï-Oriental.
- Expand nutritional training to other ZS and establish iCCM sites in Kasaï-Oriental and Lualaba.
- Continue nutrition coaching by the DPS executive team in Sud-Kivu, Haut-Lomami, Lomami, Sankuru, and Haut-Katanga.
- Ensure follow-up with the providers and members of the IYCF support groups trained in Sankuru, Lualaba, and Haut-Lomami.
- Provide IYCF support groups with communication materials (counseling cards, picture boxes) and data collection tools.
- Continue establishing IYCF support groups in Tanganyika and Sud-Kivu
- Conduct trainings in IYCF counseling including training of trainers in Tanganyika, Haut-Lomami, and Kasaï-Oriental

- **79% achievement rate for couple years of protection** in USG-supported programs
- **344,831 women** accessed modern contraceptive methods for the first time
- Supported the **MOH's introduction of the peer education approach for adolescent and youth sexual and reproductive health** in Haut-Lomami, Kasaï-Oriental, and Tanganyika

REPRODUCTIVE HEALTH AND FAMILY PLANNING

This quarter, USAID IHP continued to support the MOH in implementing family planning and reproductive health activities by expanding access to information about voluntary FP products and quality FP services. Short- and long-term FP are an essential component of sexual and reproductive health. FP alone contributes to the reduction of maternal deaths by 30 percent,[6] neonatal and infant deaths by 37 percent, and the devastating and destructive effects on the environment by 120 percent, and FP is included in the list of pilot interventions to achieve the Sustainable Development Goals.[7]

Increased protection provided by family planning methods

During the quarter, USAID IHP had a 79 percent achievement rate for Indicator #2.1 (couple years of protection in USG-supported programs). As shown in Table 21, the Katanga region provided the most couples with modern contraceptive methods and reached an achievement rate of 87.2 percent, followed by the Kasaï region (82.2 percent), and then the Eastern region (66.5 percent).

Results in the Katanga region this quarter can be explained by the following factors:

- Strong performance in Lualaba (96.6 percent) and Haut-Katanga (88.4 percent) due to USAID IHP's support for: (1) organizing FP mini-campaigns; (2) organizing the community-based distributor (CBD) monitoring meetings; (3) supplying FP commodities to the ZS, especially contraceptives with a high coefficient (injectables, implants, and cycle beads); and (4) organizing CTMP-PF meetings, which helped ensure coordination of FP interventions.
- The weak performance observed in Haut-Lomami (77.4 percent) can be attributed to the fact that FP is less integrated in the health facilities there. Furthermore, only 47 providers of the expected 120 were trained in five of the 16 ZS. The remaining providers will be trained in Quarter 3.

In the Kasaï region:

- Lomami province reached an achievement rate of 105.5 percent. Several activities contributed to this result; namely: (1) training trainers on FP; (2) briefing providers and ECZS members in two ZS on subcutaneous medroxyprogesterone acetate (sub-Q DMPA) self-injection; (3) conducting post-training follow-up for FP; (4) routine distribution of contraceptive methods by clinical providers and

[6] https://pubmed.ncbi.nlm.nih.gov/12157688/
[7] Source: Closing Plenary, "Cementing the Connection between FP and UHC," Not Without FP Forum, February 2021

CBDs in eight ZS; (5) organizing CBD monthly monitoring meetings in the 17 *aires de santé* of five ZS; and (6) organizing two meetings for the CTMP-PF provincial coordinating members.

- Kasaï Oriental's weak performance (achievement rate of 71.3 percent) can be explained by: (1) the non-integration of FP in many of the nine non-priority ZS; (2) the non-availability of FP commodities for newly trained CBDs and clinical providers in January 2021 (because health facilities did not submit orders for commodities); and (3) the fact that the most widely distributed methods were those with a low conversion factor, leading to a weaker outcome in contraceptive protection.
- In Kasaï Central (achievement rate of 77.8 percent), the non-priority ZS weakened overall results of the province due to: (1) a shortage of FP commodities in four ZS; (2) lack of FP commodities for providers in three ZS supported by the NGO Malteser (which did not submit orders); (3) absence of trained FP providers in one ZS; and (4) the lack of integration of FP activities into the PRODS support package with the results-based financing in the six ZS of Kasaï-Central.
- Sankuru reached an achievement rate of 89.5 percent as a result of the following USAID IHP supported activities: (1) training 120 FP/postpartum providers (26 ECZS, 18 general referral hospital doctors, and 76 *aires de santé* nurses) in the 80 health facilities of eight ZS in Lodja and CBDs in three ZS; (2) the provincial trainers' support for ZS during supervision missions; (3) implementing the CBD approach for the promotion and provision of FP services in eight ZS; (4) integrating FP services in 33 health facilities; and (5) organizing two FP mini-campaigns in three ZS.

The Eastern region showed a very low performance of 66.5 percent in two provinces:

- In Sud-Kivu**,** the low performance of 73 percent can be explained by: (1) the fact that most non-priority ZS providers have not received FP training, and (2) lack of access to FP services in certain ZS due to populations displaced by insecurity.
- The achievement rate of 51.5 percent in Tanganyika is attributable to: (1) non-integration of FP services in all health facilities; (2) low proportion of trained providers in facilities; (3) low proportion of trained CBDs (68 out of 200 planned) due to non-availability of the PNSR; (4) lack of geographic access to FP services; (5) an uptake of low-coefficient contraceptive methods by acceptors in four ZS; and (6) rumors that FP may cause infertility.

Table 21. Couple years of protection (CYP) in USG-supported programs (Indicator #2.1)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	42,380	32,958	77.8%
	Kasaï-Oriental	34,921	24,903	71.3%
	Lomami	18,665	19,686	105.5%
	Sankuru	19,113	17,102	89.5%
Total Kasaï		**115,079**	**94,649**	**82.2%**
Katanga	Haut-Katanga	57,444	50,753	88.4%
	Haut-Lomami	35,582	27,550	77.4%
	Lualaba	29,948	28,918	96.6%
Total Katanga		**122,974**	**107,221**	**87.2%**
Eastern Congo	Sud-Kivu	76,881	56,101	73%
	Tanganyika	33,056	17,017	51.5%
Total Eastern Congo		**109,938**	**73,118**	**66.5%**
Grand Total		**347,991**	**274,988**	**79%**

Source: DHIS2, Accessed April 23, 2021

As shown in Table 22, for Indicator #2.2 (couple years of protection after exclusion of lactational amenorrhea method (LAM) and standard days method (SDM) for FP in USG-supported programs), USAID IHP recorded a 76.8 percent achievement rate for the quarter. Katanga led the way with an achievement rate of 86.2 percent followed by Kasaï (79.9 percent). In both regions, the performance was due to: (1) the organization of FP mini-campaigns at the ZS level; (2) the organization of CBD monitoring meetings; and (3) supply of FP commodities to health facilities, particularly in the provinces of Lomami and Lualaba. In Kasaï-Central**,** the poor performance (74.6 percent) is attributable to the fact that, after the training, the providers did not order FP commodities and other inputs in a timely manner, particularly for certain ZS facilities that receive PRODS support. Also, in these ZS, the number of trained CBDs is insufficient, and there is a lack of involvement of provincial leadership in FP activities. In Kasaï-Oriental (69.9 percent), the poor performance was due to: (1) the non-integration of FP in the nine non-priority ZS and (2) the fact that the mostly commonly distributed contraceptive methods had a low coefficient of conversion. In Eastern Congo**,** there was a sharp decline in this indicator; overall, the region averaged 63.6 percent this quarter compared to 82.9 percent last quarter. This decline was mainly due to poor performance in Tanganyika**,** which achieved 49.3 percent because of geographic inaccessibility and insecurity that hinders access to FP services. Results in Sud-Kivu (70 percent) are explained by the fact that most non-priority ZS do not have providers trained in FP. Finally, people displaced as result of general insecurity are not able to easily renew their methods.

Table 22. Couple years of protection (CYP) after exclusion of LAM and Standard days methods (SDM) for FP in USG-supported programs (Indicator #2.2)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	40,488	30,206	74.6%
	Kasaï-Oriental	32,318	22,582	69.9%
	Lomami	17,200	18,094	105.2%
	Sankuru	16,484	14,232	86.3%
Total Kasaï		**106,491**	**85,114**	**79.9%**
Katanga	Haut-Katanga	52,351	46,009	87.9%
	Haut-Lomami	32,303	24,165	74.8%
	Lualaba	27,935	26,910	96.3%
Total Katanga		**112,589**	**97,084**	**86.2%**
Eastern Congo	Sud-Kivu	72,153	50,476	70%
	Tanganyika	32,487	16,027	49.3%
Total Eastern Congo		**104,640**	**66,503**	**63.6%**
Grand Total		**323,720**	**248,701**	**76.8%**

Source: DHIS2, Accessed April 23, 2021

New acceptors of modern contraceptive methods

During the quarter, all provinces recorded a strong enrollment rate for new acceptors of modern contraceptive methods. As shown in Table 23 (Indicator #3), 344,831 new women accessed modern contraceptive methods out of out of a target of 340,063 first-time acceptors, an achievement rate of 101.4 percent. The Kasaï region had the strongest performance with an achievement rate of 107.2 percent. Analysis of performance by region and province is included below:

- In the Kasaï region, all the provinces performed well, with Sankuru exceeding the expected performance by enrolling 35,765 new acceptors out of a target 26,113 (137 percent). This was due to: (1) training providers in 80 health facilities in eight ZS; (2) supportive supervision; (3)

implementing the CBD approach in eight ZS; (4) integrating FP services into 33 health facilities; (5) training CBDs; and (6) organizing mini-campaigns in three ZS.

- In the Katanga region, 121,178 women used modern contraceptive methods for the first time (out of a target of 123,639), representing an achievement rate of 98 percent. This performance was a result of the following activities in three provinces: (1) organizing mini-campaigns in the ZS; (2) organizing monthly CBD monitoring meetings; (3) supplying FP inputs to the ZS; (4) USAID IHP support in organizing CTMP-PF meetings to strengthen coordination of FP interventions; and (5) organizing FP awareness-raising sessions during which new acceptors were enrolled.
- In the Eastern Congo region**,** Tanganyika province enrolled the lowest number of new acceptors (12,757 compared to a target of 17,535), weaking performance for the region overall. The achievement rate of 72.8 percent can be explained by: (1) non-integration of FP services in all health facilities; (2) low proportion of trained providers in facilities; (3) low proportion of trained CBDs (68 out of 200 planned); (4) poor geographic accessibility; and (5) circulating rumors that FP encourages infidelity. Sud-Kivu's strong performance and achievement rate of 103.4 percent was due to: (1) availability of FP inputs in the ZS; (2) provider and CBD training in ZS; (3) improvement of the CTMP-PF coordination function; (4) monthly monitoring meetings for CBDs in the ZS; and (5) the organization of FP mini-campaigns.

Table 23. Number of new acceptors using modern contraceptive methods in USG-supported facilities (Indicator #3)

Region	Province	Target	Q2 Achievement	Achievement Rate (%)
Kasaï	Kasaï-Central	51,006	51,602	101.2%
	Kasaï-Oriental	36,181	35,256	97.4%
	Lomami	26,163	26,822	102.5%
	Sankuru	26,113	35,765	137%
Total Kasaï		**139,463**	**149,445**	**107.2%**
Katanga	Haut-Katanga	41,272	45,202	109.5%
	Haut-Lomami	47,290	43,759	92.5%
	Lualaba	35,077	32,217	91.8%
Total Katanga		**123,639**	**121,178**	**98%**
Eastern Congo	Sud-Kivu	59,426	61,451	103.4%
	Tanganyika	17,535	12,757	72.8%
Total Eastern Congo		**76,961**	**74,208**	**96.4%**
Grand Total		**340,063**	**344,831**	**101.4%**

Source: DHIS2, Accessed April 23, 2021

Lessons learned

- The implementation of the CBD approach in the *aires de santé* supports the promotion and use of FP services in the community. This aligns with the national guidelines that at least three *aires de santé* in each ZS must offer FP services.
- The synergy with other partners (*Association pour le Bien-Etre Familial* and DKT) in Lomami helps to improve CYP through coordination of provider and CBD trainings, supervision, and support for monitoring meetings.

Next steps

- Provide management tools (including registers for CBD services, registers for input management, summary tables, client cards, and client orientation materials).
- Continue and intensify awareness-raising sessions during mini-campaigns to create demand for FP services and to increase the rate of use of services in the target *aires de santé*.
- Equip CBDs with kits and bicycles for them to reach the acceptor's workplace (field, office, home).
- Organize post-training FP follow-up, especially in the lowest-performing ZS.
- Consider facilitating training for providers in non-priority ZS to increase the critical mass of FP providers in each province and contribute to the improved performance of quality FP service.
- Continue FP mini-campaigns in targeted ZS.
- Assist ZS that have recorded declines in performance through the following interventions: training clinical and community providers, supporting supervision and post-training follow-up, providing kits and tools for CBDs, procuring FP commodities based on need, and supporting monitoring meetings at the *aires de santé*.
- Continue to retrain providers in administering clinical FP methods, including long-acting FP, postpartum, and sub-Q DMPA.
- Support the integration of FP in collaboration with the other partners for complete coverage of outreach in all ZS.
- Supply health facilities with FP commodities as needed.
- Organize CBD monitoring meetings in the *aires de santé* with active CBDs.
- Raise community awareness on the use of long-acting methods (in Tanganyika, Kasaï-Central, and Kasaï-Oriental) to increase demand for and use of FP services.
- Organize community discussions on the use of FP services and benefits.

- **13,044 bacteriologically confirmed pulmonary TB (TP+) cases** reported out of over 17,000 in USAID IHP supported provinces.
- **22,788 TB patients** put on first-line treatment out of a cohort of 22,876
- **11,322 TP+ patients** reported cured as a result of supply chain improvements for anti-TB drugs.

TUBERCULOSIS

Tuberculosis remains a major public health problem in the DRC. To achieve the DRC's goal of reducing TB morbidity and mortality, USAID IHP supports the National Tuberculosis Control Program in implementing the World Health Organization (WHO)'s "End TB" strategy by 2035 by supporting political commitment and providing funding to fight the disease. As outlined in the 2021-2023 National Strategic Plan for TB Control, USAID IHP supports the PNLT to improve quality of TB care and services in 179 ZSs in nine provinces.

USAID IHP supports implementation of TB strategies and activities that reflect USAID and PNLT priorities, encouraging synergies with other PNLT partners and the participation of community and civil society in this fight. These strategies and activities include: (1) universal access to TB diagnosis and treatment, (2) improved management of TB/HIV co-infection, (3) programmatic management of drug-resistant TB, improved clinical and biological monitoring of patients with this form of TB and their nutritional support, (4) strengthening provincial capacity to collect, analyze and use data for decision-making, (5) improving TB diagnosis and treatment capacity in children aged 0-14, and (6) improving tuberculosis infection prevention and control. In addition to routine activities, the Program participated in World Tuberculosis Day celebrations this quarter. At this event, the Program presented a study: "In a ZS, is the incidence of drug-resistant TB related to the therapeutic success of bacteriologically confirmed pulmonary TB? A comparative study in the ZS supported by USAID IHP in DRC". The study draws the conclusion that the incidence of drug-resistant TB (DR-TB) was strongly related to the cure rate of bacteriologically-confirmed pulmonary TB (TP+), but only weakly related to treatment success rate—even though the current PNLT policy focuses on treatment success rate as the primary performance and quality criterion. This was a good opportunity to share these findings to decision makers to set the stage for a future policy review.

A lab technician processes samples of potential tuberculosis cases at the Crina health center in Kamalondo ZS, Haut-Katanga. Photo by Jean Manassé Tshibamba, freelance photographer for USAID IHP.

Improved TB notification rates

Out of 17,718 TP+ cases in Quarter 2, 13,044 cases (new patients and relapses) of bacteriologically confirmed TP+ were reported for a population of more than 36 million covered by the directly observed therapy short course (DOTS) program in the nine provinces—a BP+ notification rate of 142 per 100,000 people (Table 24). Similar to the previous two quarters, the provinces of Lualaba, Kasaï Oriental, Haut-Lomami, Tanganyika, and Lomami recorded a notification rate greater than or equal to the target of 150 per 100,000 inhabitants. This performance can be explained by active TB case detection activities supported by USAID IHP among at-risk populations, particularly prisoners and people working in artisanal mines. Sud-Kivu underperformed with a notification rate of 78 per 100,000 inhabitants, similar to its performance in the previous two quarters. Various factors explain this persistent underperformance, including difficult geographical accessibility of 13 of the 34 health zones, which limits regular supply of laboratory reagents (such as alcohol and fuscine) necessary for diagnosing TB; and insecurity related to armed conflicts, which reduces community agents' mobility for active TB screening in these health zones.

To maintain above-target notification rates, USAID IHP is collaborating with the provincial CPLTs to intensify and expand innovative active TB case-finding strategies. These include identifying coughing cases presenting in health care facilities by intensifying collaboration with other health care services (pediatrics, HIV, diabetology, pulmonology and nutrition rehabilitation), and investigating contacts of TB patients by systematically involving community agents (RECOs and members of community-based

organizations) in sensitization, referral of suspected patients, safe transport of sputum samples, and laboratory inputs to the *centres de santé de diagnostic et traitement* (diagnostic and treatment health centers, CSDT).

Table 24. TB notification rate through USG-supported programs (Indicator #2.1.17)

Region	Province	Incident TB Cases				# Pulmonary TB Cases	# TP+ Incident Cases	TP+ Notification Rate per 100k People		
		F	M	Total	0-14 years			Actual	Target	Achieved (%)
Kasaï	Sankuru	891	850	1,741	166	1,373	872	138	150	92
	Kasaï-Oriental	2,650	2,708	5,358	661	3,954	2,478	190	150	126
	Kasaï-Central	920	880	1,800	218	1,747	1,509	114	150	76
	Lomami	1,235	1,329	2,564	453	2,075	1,417	159	150	106
Kasaï		**5,696**	**5,767**	**11,463**	**1,498**	**9,149**	**6,276**	**151**	**150**	**101**
Katanga	Haut-Katanga	1,563	2,153	3,716	369	2,677	2,048	148	150	99
	Lualaba	652	910	1,562	205	1,338	1,102	203	150	135
	Haut-Lomami	1,010	933	1,943	223	1,490	1,316	193	150	128
Katanga		**3,225**	**3,996**	**7,221**	**797**	**5,505**	**4,466**	**171**	**150**	**114**
Eastern Congo	Sud-Kivu	820	1,379	2,199	276	1,888	1,424	78	150	52
	Tanganyika	751	660	1,411	118	1,176	878	150	150	100
Eastern Congo		**1,571**	**2,039**	**3,610**	**394**	**3,064**	**2,302**	**96**	**150**	**64**
Total		**10,492**	**11,802**	**22,294**	**2,689**	**17,718**	**13,044**	**142**	**150**	**95**

TP includes pulmonary tuberculosis that has been confirmed (either bacteriologically or clinically).

TP+ incident cases refer specifically to the rate of cases that have been confirmed by bacteriological diagnostic tests.

Source: TB DHIS2 validated for FY2021 Q2 by CPLT

First-line treatment for patients diagnosed with TB and under 5 children who received (or are receiving) is isoniazid (INH) prophylaxis

Out of a cohort of 22,876 TB patients registered in Quarter 2, 99.6 percent were put on first-line treatment. This positive performance largely reflects improved supply of first-line anti-TB drugs to the CSDT. Five provinces (Sud-Kivu, Haut-Lomami, Kasaï Oriental, Haut-Katanga and Lomami) treated 100 percent of the TB patients detected, while Tanganyika increased treatment from 88 percent in Quarter 1 to 98 percent in Quarter 2. This situation in Tanganyika is related to stockouts of first-line TB drugs in 28 CSDTs located in hard-to-reach areas that face insecurity due to armed groups. To improve the availability of anti-TB drugs in health zones with a drug shortage of seven days or more, USAID IHP plans to use reliable community agents to transport anti-TB drugs.

Out of a total of 7,217 children aged 0-5 declared eligible for INH prophylaxis, 6,523 were put on prophylaxis (90 percent) after exclusion of the active form of TB. This continuous improvement trend is due to implementation of PNLT guidelines to prevent latent TB in children under 5 in contact with a TB case. USAID IHP supported capacity-building sessions for health care providers in all nine provinces during the previous three quarters. Best-performing provinces were Haut-Lomami, Sankuru, and Lomami, with 100 percent, and Central Kasaï with 96 percent of children put on INH. Haut-Katanga recorded one of the lowest percentages (77 percent), but still showed steady improvement (from 10 percent in Year 1 Quarter 2 to 35 percent in Year 2 Quarter 3 and 47 percent in Year 3 Quarter 1). This province still insufficiently implements guidelines on TB prevention in children. To reverse the

trend, USAID IHP will support provider capacity building using more practical approaches such as mentoring and demonstration sessions during formative supervision visits.

Table 25. 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

Region	Province	Recorded TB Cases				CSDT with Stockouts of 1+ Tracer Products for 7+ Days	Children 0-5 years			
		Total	# Receiving Treatment	% Receiving Treatment	Targets		# Eligible for INH Treatment	# Put on Treatment	% Put on Treatment	Targets
Kasaï	Sankuru	1,742	1,729	99.3	100	0	822	819	99.6	100
	Kasaï Oriental	5,362	5,362	100	100	0	795	738	92.8	100
	Kasaï Central	2,007	1,994	99.4	100	0	658	630	95.7	100
	Lomami	2,620	2,619	100.0	100	0	1,323	1,323	100	100
Kasaï		**11,731**	**11,704**	**99.8**	**100**	**0**	**3,598**	**3,510**	**97.6**	**100**
Katanga	Haut-Katanga	3,793	3,792	100.0	100	21	1,010	776	76.8	100
	Lualaba	1,565	1,546	98.8	100	0	731	570	78.0	100
	Haut-Lomami	1,944	1,944	100	100	10	823	823	100	100
Katanga		**7,302**	**7,282**	**99.7**	**100**	**31**	**2,564**	**2,215**	**86.4**	**100**
Eastern Congo	Sud-Kivu	2,214	2,208	99.7	100	7	548	401	73.2	100
	Tanganyika	1,629	1,594	97.9	100	28	507	443	87.4	100
Eastern Congo		**3,843**	**3,802**	**98.9**	**100**	**35**	**1,055**	**844**	80	**100**
Total		**22,876**	**22,788**	**99.6**	**100**	**66**	**7,217**	**6,523**	**90.4**	**100**

Source: TB DHIS2 validated for FY2021 Q2 by CPLT

Sharpened detection of multi-drug resistant TB cases and second-line treatment for multi-drug resistant TB cases

During Quarter 1, 117 rifampicin-resistant (RR)/MDR-TB cases were recorded, an achievement rate of 65 percent, and no extensively drug-resistant (XDR)-TB cases were detected. Haut-Katanga and Kasaï Oriental, the "hot spot" provinces for MDR-TB among the nine USAID IHP provinces, recorded more cases during the quarter (43 and 51 respectively). As in the previous quarter, Kasaï Oriental recorded the best performance (128 percent or 51 confirmed cases out of 40 expected cases), thanks to case-finding activities, including contact investigation and mini-campaigns.

All nine provinces still have a low overall achievement rate of 64 percent, largely due to limited coverage of CPLTs with Xpert diagnostic sites (GeneXpert machine) and by dysfunctional transport circuits for sputum samples from presumed sick persons to diagnostic sites. As this dysfunction stems from inabilities to reimburse transport costs in difficult-to-access ZS, USAID IHP will work with community-based organizations involved in the fight against TB to facilitate payment of transportation costs for samples. Of the 117 MDR-TB/RR cases recorded during the quarter, 95 started second-line TB treatment, or 81 percent compared to 39 percent in Quarter 1. This improvement stems from reduced time to start treatment for DR-TB patients—particularly in the two "hot spot" provinces—due to rapid completion of pre-treatment clinical and biological assessments of patients and pre-positioning of second-line anti-tuberculosis treatments at CPLTs. Rapid transport of treatment courses from CPLTs to treatment sites for DR-TB patients will further slim this delay, which USAID IHP has committed to in collaboration with CPLT and other supply chain partners.

Table 26. Number of multi-drug resistant TB (MDR-TB) cases detected (Indicator #2.1.20) and Number of those who have initiated second-line treatment (Indicator #2.1.21)

Region	Province	Confirmed RR/MDR-TB Cases		Confirmed XDR-TB Cases		Total	Target # MDR TB/RR	Achieved (%)	RR/MDR/ XDR-TB Cases Receiving Treatment			
		M	F	M	F				M	F	Total (#)	Total (%)
Kasaï	Sankuru	0	1	0	0	1	8	13	0	1	1	100
	Kasaï-Oriental	31	20	0	0	51	40	128	30	20	50	98
	Kasaï-Central	4	0	0	0	4	12	33	4	0	4	100
	Lomami	1	0	0	0	1	12	8	1	0	1	100
Kasaï		**36**	**21**	**0**	**0**	**57**	**72**	**79**	**35**	**21**	**56**	**98**
Katanga	Haut-Katanga	25	18	0	0	43	61	70	17	9	26	60
	Lualaba	4	1	0	0	5	12	42	4	1	5	100
	Haut-Lomami	0	0	0	0	0	4	0	0	0	0	-
Katanga		**29**	**19**	**0**	**0**	**48**	**77**	**62**	**21**	**10**	**31**	**65**
Eastern Congo	Sud-Kivu	3	0	0	0	3	19	16	2	0	2	67
	Tanganyika	9	0	0	0	9	12	75	6	0	6	67
Eastern Congo		**12**	**0**	**0**	**0**	**12**	**31**	**39**	**8**	**0**	**8**	**67**
Total		**77**	**40**	**0**	**0**	**117**	**180**	65	**64**	**31**	**95**	**81**

Source: TB DHIS2 validated for FY2021 Q2 by CPLT.

Boosted therapeutic success rates for TB and RR/MDR-TB

Among 12,529 new and relapsed TP+ patients evaluated during Quarter 2 (representing those who started treatment in the corresponding quarter a year earlier), 11,322 patients were reported cured, and 475 patients completed treatment—a treatment success rate of 94 percent. All three regions performed well against the WHO performance threshold of 90 percent or higher. Availability of first-line anti-TB drugs in the SDAs and CSDTs contributed to this overall performance. In addition, out of a total of 81 RR-/MDR-TB cases treated during Quarter 2, four patients were declared cured and 56 completed their treatment, for a treatment success rate of 74 percent against a target of 75 percent.

Sud-Kivu recorded an underperforming RR-/MDR-TB treatment success rate of 17 percent. Follow up of patients is irregular in this province due to difficulty accessing the three ZS where five out of eight DR-TB cases were recorded during Quarter 2. The situation calls for several solutions: general reference hospitals require automated equipment (spectrophotometers) for biological assessment, clinicians in these hospitals need trainings to manage MDR-TB cases, and providers at CSDT and TB treatment centers should exchange information on follow-up of MDR-TB patients during their quarterly monitoring meetings and collaborate more with community agents on DOTS and recovery of irregular and lost-to-follow-up patients. USAID IHP will work on implementing these solutions throughout FY2021 Q3 and FY2021 Q4. In addition, by contracting with TB community-based organizations (CBOs), USAID IHP will provide essential support in improving follow-up of MDR-TB patients.

Table 27. Therapeutic success rate for TB through USG-supported programs (Indicator #2.1.19)							
		New and Relapsed TP+ Patients					
Region	Province	# Y2 Q2	# Cured	# Who Finished Treatment	Therapeutic Success Rate (%)	Target (%)	Achieved (%)
Kasaï	Sankuru	955	916	20	98	95	103
	Kasaï Oriental	2,072	1,888	118	97	95	102
	Kasaï Central	1,207	1,083	45	93	95	98
	Lomami	1,106	1,041	29	97	95	102
Kasaï		**5,340**	**4,928**	**212**	96	**95**	**101**
Katanga	Haut-Katanga	1,899	1,577	129	90	95	95
	Lualaba	993	889	17	91	95	96
	Haut-Lomami	2,088	2,041	9	98	95	103
Katanga		**4,980**	**4,507**	**155**	94	**95**	**99**
Eastern Congo	Sud-Kivu	1,314	1,108	76	90	95	95
	Tanganyika	895	779	32	91	95	95
Eastern Congo		**2,209**	**1,887**	**108**	90	**95**	**95**
Total		**12,529**	**11,322**	**475**	**94**	95	**99**

Source: TB DHIS2 validated for FY2021 Q2 by CPLT.

Table 28. Therapeutic success rate for RR-/MDR-TB through USG-supported programs (Indicator #2.1.22)							
		RR/MDR-TB Patients					
Region	Province	# Y2 Q2	# Cured	# Who Finished Treatment	Therapeutic Success Rate (%)	Target (%)	Achieved (%)
Kasaï	Sankuru	17	0	17	100	75	133
	Kasaï Oriental	20	0	17	85	75	113
	Kasaï Central	5	0	2	40	75	53
	Lomami	2	2	0	100	75	133
Kasaï		**44**	**2**	**36**	**86**	**75**	**115**
Katanga	Haut-Katanga	21	2	12	67	75	89
	Lualaba	3	0	2	67	75	89
	Haut-Lomami	0	0	0	-	75	-
Katanga		**24**	**2**	**14**	**67**	**75**	**89**
Eastern Congo	Sud-Kivu	8	0	1	13	75	17
	Tanganyika	5	0	5	100	75	133
Eastern Congo		**13**	**0**	**6**	**46**	**75**	62
Total		**81**	**4**	**56**	**74**	**75**	**99**

Source: TB DHIS2 validated for FY2021 Q2 by CPLT.

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

In Quarter 2, out of 8,759 newly enrolled PLWH in whom TB was excluded and eligible for INH prophylaxis, 7,404 PLWH (85 percent) were started on INH. This result is almost the same as last quarter (87 percent) and shows a steady increase from the previous two quarters—75.6 percent and 74 percent respectively—following a big jump from 54 percent in Quarter 2. This trend is largely due to improved collaboration between the PNLT and the PNLS via two measures supported by USAID IHP: quarterly "TB-HIV Task Force" meetings and extending the "One Stop Shop" strategy of integrating interventions for TB and HIV into services offered at health centers.

Nevertheless, this overall result still falls short of the 100 percent target, and Tanganyika and Haut-Lomami recorded the lowest percentages of 64 percent and 68 percent, respectively—generally due to weak application of guidelines for prevention of latent TB. In addition, out of 22,294 incident cases of all forms of TB registered during Quarter 2, 18,063 were tested for HIV, (81 percent), of which 946 were HIV positive. Of the 946 coinfected patients, 913 were put on ARV treatment, (97 percent). To improve the percentage of PLWHA put on INH, the Program will strengthen the collaboration framework between the PNLT and the PNLS and promote further extension of the "One Stop Shop" strategy to other health facilities at the operational level.

Table 29. Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG- supported programs (Indicator #2.1.24)

Region	Province	# people living with HIV					TB Incident Cases				Co-Infection Cases put on ARV
		Tested for TB	TB Ruled Out	TB Ruled Out and put on INH (#)	TB Ruled Out and Put on INH (%)	Target	Total Cases	Tested for HIV (#)	Tested for HIV (%)	HIV+	
Kasaï	Sankuru	94	86	86	100	100	1,741	1,682	97	54	48
	Kasaï-Oriental	788	762	680	89	100	5,358	2,723	51	111	108
	Kasaï-Central	200	166	148	89	100	1,800	1,608	89	102	93
	Lomami	117	101	95	94	100	2,564	2,150	84	28	28
Kasaï		**1,199**	**1,115**	**1,009**	**90**	**100**	**11,463**	**8,163**	**71**	**295**	**277**
Katanga	Haut-Katanga	5,044	5,147	4,318	84	100	3,716	3,686	99	344	340
	Lualaba	1,679	1,514	1,354	89	100	1,562	1,219	78	101	100
	Haut-Lomami	532	530	359	68	100	1,943	1,683	87	32	31
Katanga		**7,255**	**7,191**	**6,031**	**84**	**100**	**7,221**	**6,588**	**91**	**477**	**471**
Eastern Congo	Sud-Kivu	347	296	264	89	100	2,199	1,839	84	130	121
	Tanganyika	166	157	100	64	100	1,411	1,473	104	44	44
Eastern Congo		**513**	**453**	**364**	**80**	**100**	**3,610**	**3,312**	**92**	**174**	**165**
Total		**8,967**	**8,759**	**7,404**	**85**	**100**	**22,294**	**18,063**	**81**	**946**	**913**

Source: TB DHIS2 validated for FY2021 Q2 by CPLT.

Lessons learned

- Available first- and second-line anti-TB drugs at the facility level (CSDT) reduce the time to treatment and improve treatment success by reducing adverse treatment outcomes. During Quarter 2, the Program advanced strategies for ensuring commodities reached remote areas such as leveraging community agents to transport anti-TB drugs. In the coming quarters, USAID IHP will continue to apply creative delivery strategies, particularly in remote areas.
- Collaboration between TB and HIV partners at the intermediate (provincial) level of the health system enables better coordination of interventions at the operational level. USAID IHP supports quarterly meetings of the TB/HIV Task Force at the provincial level.
- Identifying and implementing program improvements are further limited by local decision makers unaccustomed to using data for decision-making. Presenting research findings at the World TB Day event was a contextually appropriate strategy to present findings to government partners and lay groundwork for a potential policy review.

Next steps

- Intensify collaboration with community-based organizations in active TB case-finding activities (contact investigation, sputum sample transport, and mini-campaigns among at-risk populations) to improve detection of susceptible and DR-TB cases.
- Support the CPLT in formative supervision visits of health care providers to use nebulizers for children under 5.
- Team with community organizations to carry out activities that lagged in implementation because of the direct payment constraint.
- Support quarterly monitoring meetings of TB activities by providers at the operational level (CSDT and TB treatment centers) to improve day-to-day TB management.
- Coordinate with Chemonics and the CPLTs to harmonize how CSDT-MDR-TBs receive second-line anti-TB drugs to reduce time to start treatment for patients with DR-TB.
- Continue to support quarterly TB-HIV task force meetings to strengthen the collaboration framework between the PNLT, PNLS and other partners involved in HIV and expand the "One Stop Shop" strategy to other health facilities.

- **10 hospital hygiene committees** established in 10 general referral hospitals
- **4 village wells** constructed with Program assistance had water quality confirmed by USAID IHP testing
- **14 new target clean clinic sites** completed the preliminary clean clinic approach steps and are ready for improvements

WATER, SANITATION, AND HYGIENE

DRC is one of 20 USAID priority countries for WASH, and USAID IHP comprises one of USAID's main strategies for improving WASH in the DRC. The Program promotes improved quality of care and infection prevention at health facilities through improved WASH practices and infrastructure. In FY2021, USAID IHP will continue to implement the clean clinic approach in health centers across four provinces: Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central. The clean clinic approach consists of capacity building, the establishment of hospital hygiene committees, and facility-based WASH interventions—including rehabilitating water supply systems, rehabilitating, or constructing adequate latrines, showers, and other key WASH infrastructure. In addition, USAID IHP will complete discrete, community-based WASH interventions originally programmed in FY2020.

While the Program continued implementation of in-progress community WASH activities in Kasaï-Oriental and clean clinic approach support to 82 health centers in four provinces, the Program did not achieve planned WASH targets during Quarter 2. Early in the quarter, USAID approved USAID IHP's Water Quality Assurance Plan (WQAP), thereby approving the new FY2021 WASH workplan; this allowed the Program to engage an additional 60 health centers targeted to receive clean clinic approach support in FY2021. USAID IHP also finalized procurement processes to select local subcontractors to carry out clean clinic approach improvements (rehabilitation and very small-scale construction of WASH infrastructure) in the initial 82 health centers. Prior to launching the improvements, and at USAID request, USAID IHP submitted all procurement and planning materials to USAID for detailed review of planned facility WASH activities in the 82 health centers. USAID took this step to verify compliance with the procurement process and the Program's Environmental Monitoring and Mitigation Plan (EMMP) and also availability of sufficient funds to implement facility WASH to completion in the initial target health centers. This review continued beyond the end of the quarter.

Installation of a standpipe in Kasansa ZS, Kasaï-Oriental. Photo by Michel Dibwe, Abt Associates for USAID IHP.

Rehabilitated WASH facilities in communities

Direct: ✔ 2.6.2

During Quarter 2, USAID IHP accelerated preparation of boreholes for pump installation and community use in four villages (Tshistshimu, Ntendu, Lac Lomba, and Katoto) in Kasansa ZS, Kasaï Oriental. Prior to pump installation, the Program tested turbidity by submerging the pumps for two to three days—based on the level of turbidity of each borehole—and pumping water until the water ran clear (see images below). Next, the Program conducted water flow tests to determine the water production capacity of each borehole; this confirmed that flows increased after borehole drilling in three of the villages. In the case of Lac Lomba, the water column fell by three meters. After pump installation, USAID IHP provided financial support to the DPS to submit water samples for laboratory-based testing of drinking water quality. Results indicated that the water at two of the sites were of good quality while that of the other two was of good physicochemical quality but required bacteriological monitoring. USAID IHP recommends a third laboratory analysis to confirm any necessary corrective measures for the sites prior to authorizing water consumption for the local population. To guarantee a permanent water supply of adequate quality, USAID IHP will sensitize the local communities on the importance of maintaining a clean environment and ensuring good practices around the watershed.

USAID IHP also reviewed the technical specifications of the Program's fifth borehole constructed in the Kasansa ZS village of Bena Yombo given it became dry within two weeks of pump installation. The Program evaluated the feasibility of several options to ensure potable water access for the village, which continued in Quarter 3.

Water from the Lac Lomba borehole at the beginning of pumping

Water from the Lac Lomba borehole 20 minutes into pumping

HPV 30 pump in Ntendu

HYDRO INDIA 60 pump in Tshitshimu

Implemented the clean clinic approach

Direct: ✔ 2.6.4

USAID IHP launched the clean clinic approach step-by-step process in 60 health centers across eight priority ZS in Sud-Kivu, Kasaï-Oriental, Lomami, and Kasaï-Central. The activities focused mainly on the baseline mapping and mutual commitment for WASH needs in health centers in Lomami, Kasaï-Central, and Kasaï-Oriental. In Sud-Kivu, 14 health centers were newly ready for facility WASH improvements, while eight were planning for improvements, and six were pre-planning for improvements.

Lessons learned

- Community enthusiasm for the borehole after the installation of the hand pump is proof that drinking water remains a challenge in this region.
- Involving the community in all meetings and decisions on the water access point helps prevent conflict and ensure the sustainability of the borehole.
- Field team monitoring indicated overuse of the pumps in the villages of Tshishimu, Ntendu, and Katoto because of the population density in those areas.

Next steps

- Conduct quarterly monitoring of the water quality by the DPS/ECZS according to the WQAP, renewing the bacteriological analysis and disinfection if necessary.
- Support water management committees in developing maintenance and repair plans and monitor plan implementation to ensure that these installations continue to function, and advocate for the construction of autonomous solar water stations or mini networks for the boreholes of Tshitshimu, Ntendu, and Katoto.
- Following USAID guidance, launch facility WASH construction.
- Continue supporting 60 health centers to advance in the clean clinic approach step-by-step process and prepare for facility WASH improvements.

4. OBJECTIVE 1

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

Participants in the Strategic Community Health Plan workshop in Lubumbashi ZS, Haut-Katanga. Photo by Jean Manassé Tshibamba for USAID IHP.

- **Supported DPS and IPS to develop their mission statements, visions, and values which they will govern**
- **Trained 130 providers** on use of the Pathways to Change tool for behavior change
- Disseminated the DRC's new **National Community Health Strategic plan** in all **nine provinces**
- **Supported 2 DPS** (Kasaï-Oriental and Haut-Katanga) to obtain government, partner, and donor signatures for their **2021 *contrats uniques***
- **Coached 2 ECDPS** in human resources management

In Quarter 2, USAID IHP continued to support health systems strengthening in the DRC by: (1) disseminating the community strategic plan in all nine provinces and training managers of all nine DPS as well as ZS stakeholders on the *Pathways to change* tool for behavior change; (2) providing technical and financial assistance to DPS and ZS managers for the adoption and validation of the 2021 *Plan d'action operationnel* (PAO, Operational Action Plan) in all nine DPS and 179 ZS; (3) improving health sector transparency through the *Inspection General de la Santé* (IGS, Inspectorate General of Health) launch of the accountability, abuse and fraud reporting hotline in two pilot provinces (Lomami and Kasaï Central) and the routine missions of the *nine Inspection Provinciale de la Santé* (IPS, Provincial Health Inspectorate); (4) implementing the community scorecard to support community-based organizations in their local-level efforts to strengthen the health system; (5) continuing the primary health care management training for remaining *Equipe cadre de la Division Provinciale de la Santé* (ECDPS, Executive Team of the Provincial Health District) and ECZS; and (6) providing assistance to the various health system governance stakeholders for consultation, monitoring, and reviews of the health system.

This quarter, USAID IHP implemented 316 (60%) out of 525 activities planned under Objective 1 in Kinshasa and the provinces. This represents an 11 percent increase in Objective 1 activity completion compared to the previous quarter. USAID IHP's strategy of promoting ownership and sustainability of Program achievements by involving the central-level MOH was key to this increase. During the Quarter, the central-level MOH was engaged in both promoting and monitoring the implementation of provincial-level activities.

IR 1.1: ENHANCED ABILITY TO PLAN, IMPLEMENT AND MONITOR SERVICES AT THE PROVINCIAL, ZS, AND HEALTH FACILITY LEVELS

During Quarter 2, USAID IHP activities reinforced the capacity of the ECDPS and ECZS to effectively plan, implement, and monitor health services. Of note, USAID IHP supported the completion of the PAO 2021 process in all nine target DPS. In addition, the Program continued to implement institutional capacity building activities in line with the Participatory Institutional Capacity Assessment and Learning (PICAL) tool analyses. In particular, USAID IHP completed the first round of leadership, management, and coaching trainings in all nine target DPS, and the Program continued implementation of primary health care management training seven remaining target DPS, following completion of two in a previous quarter.

Supported the 2021 PAO process at the national, DPS, and ZS levels in collaboration with other stakeholders

Indirect: ✓22 ✓1.2 ✓1.3 ✓1.1.1 ✓1.1.2

At the outset of Quarter 2, all nine USAID IHP-supported provinces had finalized their PAOs at the DPS, IPS and ZS levels, leaving the management-level (the provincial steering committees for the DPS PAOs and the CA for the ZS PAOs) validation and adoption of the PAO as the final step in the process. This was especially true of the CPP-SS for the DPS and the *Conseil d'Administration* (CA, Administrative Council) for the ZS. While the orientation of the final step remained in progress in most provinces by the end of Quarter 2, in Haut-Katanga, the validation process began in December 2020 with USAID IHP support for the development and consolidation of PAOs in 27 ZS, followed by consolidation at the provincial level. In January 2021, USAID IHP supported a meeting of the provincial steering committee resulting in their adoption of the 2021 PAO; by the end of Quarter 2, Haut-Katanga's DPS had full approval to implement its 2021 PAO.

A major challenge in realizing approved PAOs is limited mobilization of local resources to finance PAO activities. Thus far, only 20 to 30 percent of PAO activities are financed with local resources, while the rest depends on financing from external donors.

Technically and financially supported the organization of team building workshops in the DPS

Indirect: ✔ 1.1 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.4.3

USAID IHP supported six provinces (Lualaba, Kasaï-Oriental, Sankuru, Lomami, Kasaï-Central, and Haut-Katanga) to organize ECDPS team building workshops in Quarter 2[8]. In total, 146 DPS and IPS executives—including 14 women—and four participants from the PRODS project learned teamwork techniques and the advantages of a team-based approach. For example, participants learned how a team can benefit from the different skills across each team member, and how to leverage such skills as well as a sense of individual responsibility to achieve team objectives. The workshop also highlighted how working in isolation can be counterproductive.

Supported training in leadership, management, and coaching

Indirect: ✔ 1.1 ✔ 1.1.2 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.4.3

During Quarter 2, USAID IHP conducted the first series of leadership, management, and coaching training in Tanganyika, completing these trainings in all nine provinces[9]. In Tanganyika, 18 people—including five DPS executives, three IPS executives and two women—learned key tenants based the results of their PICAL analyses. The training enabled the DPS to begin mapping out provincial stakeholders and drafting their vision and values for the next five years; beyond the training, the DPS team will seek out mutual agreement with stakeholders. Training exercises like with the agility compass and diversity wheel showcased the importance of routine and quick adaptation to different situations and reinforced the value of harmonious teamwork.

Provided technical and financial support for ECDPS training in primary health care management

Indirect: ✔ 2.6 ✔ 2.7 ✔ 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 ✔ 2.1.27 ✔ 2.1.28 ✔ 2.1.29

To improve the quality of the health services offered to the population, USAID IHP supported ECDPS and ECZS management team training in primary health care management. The trainings aimed to strengthen the DPS and BCZS executives' technical and managerial capacities toward the achievement of universal health coverage and the sustainable development goals. During the quarter, USAID IHP helped conduct these training in six ECDPS and 76 ZS across the provinces of Tanganyika, Haut-Katanga, Haut-Lomami, Kasaï-Oriental, Kasaï-Central, and Sankuru. Inclusive of FY2020 trainings, the Program has trained all nine DPS and a total of 101 ZS to-date. USAID IHP has also enabled the establishment of provincial primary health care management trainers at each DPS, and they will carry out primary health care management trainings in the remaining 78 ZS with program support as needed.

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[8] Note: The Program supported Haut-Lomami to implement this activity in Quarter 1 and both Tanganyika and Sud-Kivu have planned their ECDPS team building workshops for April 2021.
[9] USAID IHP previously conducted leadership, management, and coaching trainings in Kasaï-Central and Sankuru (FY2021, Quarter 1) and Kasaï-Oriental, Lomami, Haut-Katanga, Haut-Lomami, Lualaba and Sud-Kivu in FY2020.

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

Indirect: ✔ 1.3 ✔ 1.1.1 ✔ 1.1.2

USAID IHP supported six DPS (Haut-Lomami, Lualaba, Sud-Kivu, Sankuru, Tanganyika, and Haut-Katanga) to conduct supervision missions in 54 ZS during the quarter. During these missions, *Encadreurs provincial polyvalent* (EPPs, Multidisciplinary provincial supervisors) supported each ZS to resolve specific issues identified during routine supervision. For instance, in Sankuru, 11 EPPs supported 11 ECZS to finalize plans linked to their 2021 PAO, including communications plans, human resources for health (HRH) development plans, and contingency plans. EPPs also participated in their assigned ZS's CA during the supervision missions. In Tanganyika, the EPPs showed ECZS how to develop dashboards to monitor key PNDS 2019-2022 performance indicators. They also demonstrated how to use the Routine data quality assessment (RDQA) tool and briefed the staff on routine data analysis.

Supported ZS supervision of facilities and communities

Indirect: ✔ 2.2.5

USAID IHP supported ECZS from 142 ZS (or 79.3 percent of the target) across all nine provinces to conduct supervision missions. During these supportive supervision missions, ECZS provide providers with hands-on, technical support in: (1) data analysis with an emphasis on routinely updating data management tools to minimize transcription errors on data forms from SNIS; (2) compliance with national protocol for managing certain diseases in children under 5; and (3) the display of monitoring trends for key indicators.

During the quarter, the Program piloted mobile money as a mechanism to transfer funds for the supervision visits to ZS managers in Sud-Kivu; the pilot successfully enabled the ECZS to reach and support all 34 ZS.

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

Indirect: ✔ 1.1.1 ✔ 1.1.2

The Program supports the DPS and ZS of all nine USAID IHP-supported provinces to optimize the functioning of their offices, in turn enabling them to embody their leadership role, improve governance, produce and archive various reports, and maintain good logistics. During Quarter 2, the Program supported operating costs in six provinces (Kasaï-Central, Lualaba, Kasaï-Oriental, Sud-Kivu, Tanganyika and Haut-Lomami).

USAID IHP also directly funded needs-based goods and services—including office supplies, fuel, computer and equipment maintenance—for 150 ZS across eight provinces (Lualaba, Sankuru, Haut-Katanga, Sud-Kivu, Tanganyika, Haut-Lomami, and Kasaï-Central, and Lomami).

The program observed some considerable challenges through this support:

- The actual operating costs of the DPS and ZS are higher than the contributions budgeted through USAID IHP, the latter of which were established to contribute to, versus wholly assume 100 percent of, operating costs, along with other technical and financial partners.
- The transportation in-kind goods and services to ZS that are difficult to access and/or affected by insecurity (i.e., seven of the 11 target ZS in Tanganyika are only reliably reached via air transport) far exceed the planned contributions of USAID IHP. Further, these same challenges sometimes result in difficulty delivering purchased goods and services.

- The end or suspension of several technical and financial partner programs across provinces creates a financial gap for DPS and ZS operational funding needs relative to planned USAID IHP contributions. This is particularly true in Kasaï-Central where USAID IHP will soon be the only implementing partner providing such support. In the absence of contributions from other partners, this could present a considerable challenge for the conduct of DPS activities in particular, including those supported through USAID IHP.

Provided financial support to the functioning of the CPLT

Indirect: ✓ 1.1.1 ✓ 1.1.2 ✓ 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 directly purchased goods and services for CPLT operations in all five planned provinces (Sud-Kivu, Lomami, Kasaï Central, Kasaï-Oriental, and Sankuru). The Program provided each CPLT with in-kind office supplies, fuel and lubricant for office generators and motor vehicles, protective equipment against COVID-19, cellular cards, and internet subscriptions up to the equivalent of $2,000.

Lessons learned

- As institutions, the DPS and IPS work in groups and not as teams, without any common vision or shared values.
- Shifting from group work to teamwork is a process and implies a collective commitment toward common objectives of the institution. With technical support from USAID IHP, the DPS and IPS developed their missions, visions and values which they will share and reinforce from now on.
- The DPS and IPS developed their missions, visions and the values that they will share from now on.
- Supporting office operations raises the Program's visibility in the ZS.
- Providing the CPLT with office supplies and consumables improved administrative management, especially the archiving system, and contributed to the proper functioning of supported CPLTs (including activity and patient monitoring, internet connectivity, vehicle maintenance, and hygiene measures at the coordination office).

Next steps

- Support DPS and IPS to finalize and share organizational vision and values with their teams under the leadership of the Head of Division.
- Monitor DPS implementation of their organizational vision and values to help promote teamwork.
- Provide technical support to the DPS of Sankuru, Lomami, and Kasaï-Central as they plan to implement nine ZS-level institutional analyzes in Quarter 3.
- Launch the second series of leadership, management and coaching trainings at the central level and in all nine provinces.
- Ensure provincial trainers complete remaining ECZS trainings with technical support, as needed, from the central level.
- Organize post-training follow-up in Quarter 4 to improve performance of trained ECDPS and ECZS.
- Extend USAID IHP support of ZS-level operating costs to all 179 ZS.
- Continue to provide quarterly support for the functioning of the DPS and CPLT.

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

The Program supported improved transparency, financial management, and management at the DPS, ZS, health facility and community levels. USAID IHP focused on technical and logistical support for the quarterly inspection and control missions by the IPS to the ZS and health facilities. USAID IHP technical assistance for effective audit missions promoted greater transparency by building trust and sharing responsibility among decision-makers, providers and beneficiaries of health services. In addition, USAID IHP collaborated effectively with the IGS and IPS of Lomami and Kasaï Central to launch the accountability hotline in the two pilot provinces.

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

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

USAID IHP provided financial support to seven IPS to conduct audit and control missions in 30 DPS and ZS across Kasaï-Oriental, Lomami, Sankuru, Haut-Lomami, Lualaba, Tanganyika, and Sud-Kivu. This represents 67 percent of the target, the achievement of which was affected by scheduling conflicts for ZS and health facilities as they launched implementation of their 2021 PAO during the reporting period. In each ZS, the IPS visited four functional units: the BCZS, the general reference hospital, and two additional health facilities. These visits helped assess traceability of technical and financial partner financing at the functional unit level as well as the uniform management of human, material and financial resources and compliance with health care delivery standards and policies at the facility level.

During Quarter 2, IPS audits and ZS oversight noted the following key findings:

- Poor recovery and mismanagement of funds generated from selling medications (drug credit line allocated by USAID IHP)
- Outdated accounting documents in some ZS
- Several health facilities were not able to provide complete administrative files
- Several health facilities appeared to have a random allocation of human resources for health (HRH) that did not take into account relevant norms

Table 30. Percentage of DPS and ZS supported by the Program and that have been audited with technical and/or financial support from USAID IHP (Indicator #1.2.3)

	Provinces	Target Q2	Numerator	Denominator	Achieved Q2	% Achieved Q2
Kasaï	Kasaï-Central	25%	0	26	0%	0%
	Kasaï-Oriental	25%	7	19	36.8%	147.4%
	Lomami	25%	4	16	18.8%	75%
	Sankuru	25%	4	16	25%	100%
Kasaï total		**25%**	**14**	**77**	**18.2%**	**72.7%**
Katanga	Haut-Katanga	25%	0	27	0%	0.0%
	Haut-Lomami	25%	3	16	18.8%	75%
	Lualaba	25%	3	14	21.4%	85.7%
Katanga total		25%	**6**	**57**	**10.5%**	**42.1%**
Eastern Congo	Tanganyika	25%	2	11	18.2%	72.7%
	Sud-Kivu	25%	8	34	23.5%	94.1%
Eastern Congo total		25%	**10**	**45**	**22.2%**	**88.9%**
Total		**25%**	**30**	**179**	**16.8%**	**67.0%**

Source: USAID IHP Project Monitoring Report

Provide financial support to running costs of the IPS

Indirect: ✔ 1.2.1 ✔ 1.2.2

USAID IHP directly purchased goods and services to support the operating costs of all nine IPS including office supplies, spare parts and fuel for vehicles, motorcycles, and generators up to an average monthly value of $250. In addition, USAID IHP covered communication costs for provincial inspectors so they could monitor routine alerts from health facilities.

Set up the accountability hotline

Indirect: ✔ 1.2.1 ✔ 1.2.2 ✔ 1.2.4

Following Program-supported training to the IGS coordination team and provincial line managers and supervisors in Lomami and Kasaï-Central, USAID IHP, led by partner Viamo, supported the IGS to launch the hotline for accountability and reporting of fraud and abuse pilot in Lomami and Kasaï-Central. These launches, both held in early March, were met with enthusiasm by the population and strong ownership of the approach by provincial authorities, the latter of whom have adopted the hotline as their tool for improving transparency in the management of allocated health resources. The provinces' governors issued a strong call to their respective populations to use the hotline to discourage bad practices. By the end of the quarter, the hotline generated more than 3,000 alerts, and the Program supported the Inspector General of Health to organize a central-level meeting around the hotline's functionality. Through the meeting, the following action steps were agreed upon:

1. Provide a short number easy to memorize by the population for making calls easily.
2. Provide short, direct questions between the whistleblower and the hotline (the script looks long and the caller can get lost).
3. Provide the IPS and IGS with computer kits, modems, credits and a power source
4. Form a group of RECOs to build community capacity to use the toll-free number.

Launch of the accountability hotline in Kasaï-Central

First phase: Training for key stakeholders

USAID IHP supported an online workshop from January 27-28 for eight IPS executives—including two women—on the Green Line, an accountability hotline for complaints and fraud reporting. The workshop's main stakeholders were the four executives from the Kasaï-Central IPS: the *Médecin Inspecteur Provincial* (MIP, Provincial Health Inspector), two heads of offices and the Pharmacist Inspector. The MIP will serve as the group supervisor and moderator, responsible for checking received alerts (tickets), approving or rejecting them, assigning tickets, adding notes to the ticket, and sending responses to callers.

During the workshop, USAID IHP conducted a test with the workshop participants—using the number +243 99 603 41 08—to ensure system functionality and reinforce the confidentiality measures required to protect contacts throughout use of the accountability hotline. At the IGS/IPS level, anonymity is maintained as the Ministry does not receive caller numbers or names.

Second phase: Official launch

On March 2, His Excellency the Governor a.i. of Kasaï-Central, Mr. Tharcisse Kabatusuila Mbuyama, with USAID IHP support, officially launched the Green Line in the provincial capital of Kananga. Entities represented at the event included the provincial assembly, the provincial executive, the DPS, local press and civil society, private sector and health facilities. Following four dissemination sessions organized with local target groups, the Green Line became operational with more than 100 calls during the test phase.

By the end of the Quarter, the IGS and IPS launched the hotline with USAID IHP support in the city of Kananga, as well as three other sites: Bilomba, Luiza, and Tshimbulu. The hotline's participatory approach aims for maximum stakeholder involvement and support through consultation meetings and dissemination sessions; the hotline will also generate statistics showing people contacted. The IGS will regularly mentor and supervise the IPS to run the hotline independently.

Lessons learned

- Direct financing of activities through beneficiaries can affect traceability of financial resources and necessitate appropriate monitoring and audit systems.
- Routine in-kind financial support to the IPS for communications allowed inspectors to conduct essential missions and gradually establish trust and transparency between health facilities managers and the population. This was particularly important for the IPS of Lomami and Kasaï-Central where the accountability hotline pilot launched.

Next Steps

- Support the IGS and pilot IPS to monitor and investigate alerts and establish responsibilities for investigations underway.
- Conduct an evaluation of the hotline pilot.
- In FY2022, scale up the hotline to all nine provinces.

IR 1.3: CAPACITY BUILDING FOR COMMUNITY SERVICE ORGANIZATIONS AND COMMUNITY ORGANIZATIONS TO PROVIDE HEALTH SYSTEM MONITORING

USAID IHP strengthens community organizations to ensure effective functioning of local health services. The Program launched effective use of the community scorecard with 23 CACs in Sud-Kivu following its training of DPS and ZS officials. The community scorecard—being implemented in revitalized CACs in all nine provinces with USAID IHP support—targets more accountability and control of community activities to support local health system improvements. The Program also supported the MOH through the DGOGSS to disseminate the DRC's new National Community Strategic Plan in all nine provinces. Moreover, USAID IHP supported the revitalization of 217 CACs in five provinces. Finally, the Program provided financial support to 170 CODESA across seven provinces to conduct community meetings.

Implement the Community Score Card in ZS covered by revived CACs

Direct: ✔ 1.3.2

USAID IHP launched community scorecard implementation in Sud-Kivu in addition to providing ongoing implementation support in the remaining eight provinces. The Sud-Kivu launch consisted of training 44 participants from the DPS, ZS, provincial task force, and the Red Cross on the approach and working with revitalized CACs to start using the tool. By the end of the quarter, 23 CACs were using the community scorecard.

Provided technical and financial support for the organization and monthly holding of CODESA meetings in a few ZS

Direct: ✔ 1.3.1 **Indirect:** ✔ 1.3.2

The Program provided technical and/or financial support to 376 CODESA in seven provinces (Kasaï-Oriental, Lomami, Sankuru, Haut-Katanga, Haut-Lomami, Lualaba, Tanganyika, and Sud-Kivu). USAID IHP support enabled the CODESA to organize monthly meetings to monitor and evaluate the community services, a key activity in stimulating community-led accountability of health service delivery. With the already launched community scorecard, community dynamics bolstered by regular CODESA meeting will certainly improve.

Table 31. Percentage of active CSOs/CODESA that receive financial support in USG supported health zones (Indicator #1.3.1)

Provinces		Q2 Target	Numerator	Denominator	Achievement Q2	% Achievement Q2
Kasaï	Kasaï-Central	50%	0	449	0%	0%
	Kasaï-Oriental	50%	60	320	19%	38%
	Lomami	50%	56	316	18%	36%
	Sankuru	50%	14	248	6%	12%
Kasaï Total		**50%**	**130**	**1,333**	**9.8%**	**19.5%**
Katanga	Haut-Katanga	50%	56	398	14.1%	28.1%
	Haut-Lomami	50%	3	333	0.9%	1.8%
	Lualaba	50%	30	240	12.5%	25%
Katanga Total		**50%**	**89**	**971**	**9.2%**	**18.3%**
Eastern Congo	Tanganyika	50%	60	267	22.5%	44.9%
	Sud-Kivu	50%	97	656	14.8%	29.6%
Eastern Congo Total		**50%**	**157**	**923**	**17%**	**34%**
Total		**50%**	**376**	**3,227**	**11.7%**	**23.3%**

Source: USAID IHP Project Monitoring Report

Provided support to revitalizing CACs in a few ZS with integration of gender and promotion of positive masculinity

Direct: ✔ 1.3.1 **Indirect:** ✔ 1.3.2 ✔ 1.3.3

USAID IHP provided technical and financial support for revitalizing 217 CACs in five provinces (Sud-Kivu, Haut-Katanga, Kasaï-Oriental, Haut-Lomami, and Tanganyika). Across these CACs, USAID IHP support resulted in training 550 RECOs (nearly 30 percent women) in their roles and responsibilities. Furthermore, the communities selected several candidates to represent their CACs at the CODESA level.

Next steps

Follow-up with CACs implementing the community scorecard and any related improvements.

IR 1.4: IMPROVING THE EFFECTIVENESS OF STAKEHOLDER COORDINATION AT THE PROVINCIAL AND ZS LEVELS

In a context of limited resources, effective coordination of activities requires optimal management of the funds allocated to health priorities. During Quarter 2, USAID IHP continued to support existing consultation frameworks within the MOH so that they can work better. Specifically, the program provided technical and financial support for the organization of monthly monitoring meetings and quarterly health sector reviews for information sharing among stakeholders. The program also strengthened the *contrat unique* process in all provinces for greater transparency, accountability and stakeholder engagement.

Supported the implementation of the *Contrat unique* in the DPS

Direct: ✔ 1.4.2

The *contrat unique* aims to establish, in a transparent and collegial way, consolidated structural financing and enhanced accountability through a performance framework for effective implementation of DPS activities. It serves as a tool for consolidating funding commitments from technical and financial partners and provincial stakeholders while formalizing their commitment to timely disbursement of funds. During Quarter 2, USAID IHP supported all nine DPS to finalize their *contrats uniques* and worked with the DPS

of Kasaï Oriental and Haut-Katanga to fully sign theirs. In the remaining seven DPS, scheduling of signing ceremonies depends on the agenda and protocol of each provincial governor and the Program will continue to support each DPS to sign contrats uniques for 2021.

Sources of provincial financing from the DPS Lomami *contrat unique*

Each province has specific funding needs, technical and financial partners, and local stakeholders, as well as local resources that contribute to provincial health system financing as detailed in each *contrat unique*. Lomami's 2021 *contrat unique* contains the following sources and financing:

Sources	Financial Commitment	Level of Funding
Central government	$299,927.58	25%
Provincial government	$30,993.11	3%
USAID IHP	$410,177.00	34%
UNICEF	$170,463.00	14%
CHEMONICS	$13,764.50	1%
European Union	$237,450.60	20%
E2A	$7,450.00	1%
BDOM Mwene Ditu et Kabinda	$6,000.00	1%
Save the Children	$21,643.64	2%
TOTAL	$1,197,869.43	100%

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

Indirect: ✔ 1.4.2

USAID IHP provided technical and financial support for COVID-19 assessment meetings in all nine provinces. These meetings allowed health sector actors to share COVID-19 mitigation strategies and promote solidarity in the fight against COVID-19. Stakeholders were encouraged to continue sensitizing the population to strictly comply with barrier measures to contain the spread of the disease despite cases trending downward towards the end of the quarter.

Provide technical and financial support for the semi-annual CPP meeting of the DPS

Indirect: ✔ 1.5.1

In line with PNDS 2019-2022 recommendations, the Program supports semi-annual CPP-SS meetings to coordinate interventions through management of the health sector and monitoring and evaluation at all levels of the health pyramid. During the quarter, which corresponds with Quarter 1 of the MOH's fiscal year, USAID IHP supported six provinces (Tanganyika, Lomami, Kasaï Central, Kasaï Oriental, Sud-Kivu and Haut-Katanga) to host their CPP-SS meeting under the leadership of the provincial governors. These meetings resulted in adoption of 2021 provincial PAOs, reviews of health interventions and their real impacts on the population, and recommendations for health system improvements based on province-specific needs and

Sample of resolutions from the semi-annual CPP-SS meeting in Kasaï-Central

- After review and amendment, the CPP-SS adopted the:
  - DPS and IPS 2021 PAOs; and
  - the DPS Investment Plan.
- The Provincial Government with the DPS, its technical entity, asked health system technical and financial partners to allocate a substantial budget for the supply of essential medicines.
- The Provincial Government committed to:
  - make valuable printed documents (e.g., certificate of physical fitness, good health, grade sheet from educational establishments, badge, etc.) available to the DPS;
  - protect health workers who oversee private health facilities, pharmacies and health science training schools, against influence peddling;
  - rationalizing human resources for health across ZS to address the lack of doctors and ensure between eight to ten agents in health centers.

challenges. The textbox below lists illustrative outcomes of a CPP-SS based on the meeting in Kasaï-Central.

Lessons learned

- In general, evaluations of previous *contrats uniques* show a low rate of disbursement of the funding declared by stakeholders. The causes of this low disbursement rate are primarily linked to administrative procedures of certain organizations that are poorly appropriated and/or poorly exploited by the main beneficiaries (ECDPS); this sometimes limits access at funding when needed.

Next steps

- Support efforts to sensitize the population on COVID-19 barrier measures and compliance and to reinforce vigilance of monitoring teams at the airport and border checkpoints in order to prevent any positive cases from entering the country.

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

As part of the implementation of the Year 3 work plan, USAID IHP has continued efforts to build the capacity of DPS, ZS and health facility providers to improve disease surveillance and the collection and use of strategic information. In particular, the program's support focuses on sustained attention to data collection, analysis, reporting and evidence-based decision making. To this end, USAID IHP is guiding interventions with a particular emphasis on activities related to data availability and quality. To ensure the availability of quality data for rational decision making and planning, the Program continued to plan logistical and technical support to DPS, ZS, and provider managers to frequently organize data analysis and validation meetings, to conduct regular missions and meetings for data quality control, quality assurance and to ensure data availability.

In general, USAID IHP supports (1) capacity building of providers to ensure evidence-based surveillance, (2) data availability for good planning, and (3) data quality.

DATA CAPACITY

During Quarter 2, USAID IHP supported training to give DPS and ECZ managers the skills to ensure data processing and quality control by using appropriate tools—particularly DHIS2 and the *Outil de Supervision de la Qualité des Données* (OSQD, Data Quality Supervision Tool), to improve the quality of care and services offered in technical and administrative structures, as well as in health care facilities. To guarantee quality intermediate support to ZS and health facilities, USAID IHP will continue to support capacity-building for DPS and ZS managers as well as providers in the following areas. as indicated in Table 32.

Table 32. USAID IHP-supported trainings to improve data quality in Quarter 2

Training topics	DPS cadre trainings in OSQD Tool	ECZS trainings in SNIS complementary module	iCCM supervisor trainings on collecting supervision data using tablets with an app
Contribution	(1) Encoded data collected by the OSQD tool in the DHIS2. (2) Familiarized participants with data quality control tools: data quality supervision	(1) Improved the monitoring of data quality in DHIS2 for the main data sets ("Basic services", "Secondary services", "Hospital services", "LMIS health facility", "LMIS BCZS", "PNLT", "Blood	(1) Built the team of provincial trainers on the supervision tool for iCCM sites. (2) Management of the health pyramid/addition of a

Training topics	DPS cadre trainings in OSQD Tool	ECZS trainings in SNIS complementary module	iCCM supervisor trainings on collecting supervision data using tablets with an app
	tool, RDQA, DHIS2 Data Quality Tools, (3) Taught techniques for organizing data analysis and validation meetings at both the *aire de santé* and ECDPS levels.	Bank", "PNLS", and complementary modules). (2) Improved management of information on health facilities.	community care site, (3) Management of stocks, and (4) Management of cases received at the iCCM sites.

Source: USAID IHP Project Monitoring Report

DATA AVAILABILITY

During Quarter 2, USAID IHP continued to support internet connectivity at DPS and ZS offices to ensure data availability and to enable complete and timely data entry and transmission of health data generated by health facilities into DHIS2.

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

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

USAID IHP paid very small aperture terminal (VSAT) subscription fees as well as preventative maintenance of the VSATs for all nine DPS and 167[10] ZS. This support enabled users to maintain DHIS2 data completeness and timeliness at more than 93 percent and 86 percent, respectively, as shown below.

Table 33. Completeness and timeliness of data in DHIS2

Period	January 2021		February 2021		March 2021		Q2 Total	
Province	% Reported	% Reported on Time	% Reported	% Reported on Time	% Reported	% Reported on Time	% Reported	% Reported on Time
Kasaï Oriental	89.7	83.7	90	82.5	85.8	83.9	88.5	83.4
Kasaï Central	85.5	59.6	88.3	69.6	87.1	86.7	87.0	72.0
Lomami	96.1	88.6	95.6	86.6	95.4	95	95.7	90.1
Sankuru	86.3	79.9	88.2	83.9	95.3	94.7	89.9	86.2
Haut-Katanga	92.9	92.3	90.2	76.2	86	84.9	89.7	84.5
Haut-Lomami	99.9	99.3	99.7	98.4	99.3	99.3	99.6	99.0
Lualaba	93.3	75.4	92.9	79.2	89.6	88.3	91.9	81.0
Sud-Kivu	100	96.1	100	89.4	100	99.8	100.0	95.1
Tanganyika	95.1	80.8	97.1	95.4	94.1	93.5	95.4	89.9
USAID IHP	**93.2**	**84.0**	**93.6**	**84.6**	**92.5**	**91.8**	**93.1**	**86.8**

Source: DHIS2, Accessed April 23, 2021

Overall in Quarter 2, completeness was 93.1 percent compared to 92.0 percent in the first quarter, and all provinces had reporting rates that could be analyzed (i.e., completeness above 80 percent) according to standards. There was also a noticeable improvement in timeliness rate, which was 86.8 percent in Quarter 2 compared to 82.0 percent the previous quarter.

[10] USAID IHP provided this support in all targeted ZS save 12 ZS in Kasaï-Central that are instead supported via a European Union-funded project.

In addition to overall rates of DHIS2 data completeness and timely data entry, USAID IHP support resulted in 40 ZS, or 100.7 percent of the overall target, achieving MAPEPI DHIS2 reporting rates greater than 95 percent (Table 34). While the Program slightly exceeded the target overall, there was notable variation across provinces with Haut-Lomami and Tanganyika reporting zero MAPEPI surveillance during Quarter 2. Underperforming provinces were offset by high performance in the provinces of the Kasaï region, especially Lomami.

Table 34. Percentage of USG supported provinces and health zones with MAPEPI DHIS2 reporting rates > 95% (Indicator #1.5.2)

Region	Province	Target	Q1 Achieved	Numerator	Denominator	Achievement Rate (%)
Kasaï	Kasaï-Central	25.2%	34.6%	9	26	137.4%
	Kasaï-Oriental	32.3%	31.6%	6	19	97.8%
	Lomami	12.3%	62.5%	10	16	508.1%
	Sankuru	24.8%	18.8%	3	16	75.6%
Kasaï Region		**23.7%**	**36.4%**	**28**	**77**	**153.8%**
Katanga	Haut-Katanga	35.6%	11.1%	3	27	31.2%
	Haut-Lomami	12.3%	0.0%	0	16	0.0%
	Lualaba	6.0%	14.3%	2	14	238.1%
Katanga Region		**18.0%**	**8.8%**	**5**	**57**	**48.8%**
Eastern Congo	Sud-Kivu	14.8%	20.6%	7	34	139.1%
	Tanganyika	33.3%	0.0%	0	11	0.0%
Eastern Congo Region		**24.1%**	**15.6%**	**7**	**45**	**64.7%**
Total		**22.2%**	**22.3%**	**40**	**179**	**100.7%**

Source: USAID IHP Project Monitoring Report

DATA QUALITY

Provided support to data quality control field visits

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

To improve the quality of the data collected, USAID IHP supported data quality control missions in seven intervention provinces, namely Sud-Kivu, Kasaï Central, Kasaï Oriental, Tanganyika, Haut-Lomami, Haut-Katanga and Lualaba.

In these nine provinces, the DPS, with technical support from USAID IHP, selected 39 health zones and 138 health facilities (BCZS, general reference hospitals, and health centers) to undergo quality control of data that each selected institution had entered into DHIS2 and reported or followed up on the improvement of data quality. Through USAID IHP technical assistance, the DPS identified three major problems: (1) the weak application of prior measures in data quality assurance at all levels (BCZS and health facilities), (2) the poor mastery by providers of the instructions for filling out SNIS tools, and (3) the inadequacy of data collection and transmission tools in the health facilities. Action steps identified to address these issues were: (1) To support the support missions for the implementation of the recovery plans developed as a result of these missions, (2) to plan these missions in Q3Y3 in the other health authorities of the health zones visited, and (3) to support the revitalization of the process of updating the health pyramid of the supported provinces.

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

Indirect: ✓ 1.1.1 ✓ 1.5.1 ✓ 1.5.2 ✓ 1.5.3 ✓ 1.7.2

During Quarter 2, six provinces—Sankuru, Kasaï Oriental, Lomami, Haut-Lomami, Haut-Katanga and Lualaba—held integrated data validation meetings. A total of 140 participants, including 11 women, from the DPSs and health zones, attended. The validated data from DHIS2 concerned encompassed covered availability, correctness accuracy and consistency. However, the validation meetings revealed the persistence of persistent inconsistencies between the data from DHIS2, SNIS, those contained in the registers and those in the Excel file. USAID IHP shared This situation is shared with Directorate of the SNIS to develop an improvement plan that will require sharing with the DPSs the violated rules, the inconsistencies and the outliers.

Provided technical and financial support to monthly monitoring meetings at the ZS level

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

USAID IHP continued to provide technical and financial support for monthly monitoring meetings at two provincial levels: (1) health zones, including BCZ offices and (2) *aires de santé* in the ZS. USAID IHP supported a total of 131 ZS and 271 *aires de santé* in nine provinces.

In general, these meetings have allowed the DPS and ZS to share feedback on data, identify areas in for strengthening provider capacity, and make regular use of the dashboards for analysis and decision-making.

Provided technical and financial support to various RDQA field visits

Indirect: ✔ 1.1.1 ✔ 1.5.1

The national health information system contributes to monitoring and evaluation, decision making, improved governance and stronger leadership in the health sector. However, it still faces problems, particularly related to the quality of the data produced and their use at all levels of the health pyramid. Improving the quality of routine data and analysis is a priority for the MOH, considering implementation of DHIS2 software in all ZS since the end of 2016 with more than 90 percent completeness, updating the tools, provision of computer equipment and internet connectivity, and development of the 2018-2020 strategic plan for the strengthening the SNIS.

In view of this, the quality of PNDS implementation is closely linked to the quality of the data generated through SNIS as well its analysis and use. Within this framework, USAID IHP has supported the Directorate for Primary Health Care to organize RDQA missions in the nine provinces to improve routine data quality at health facilities. This is done by:

- Assessing the quality of contractual data from MOH priority programs in health facilities;
- Analyzing the capacity of the data management systems at the DPS, BCZ and health facilities;
- Developing individualized remediation plans (recovery plans) to strengthen the routine data management and reporting system; and
- Producing the baseline as a reference framework for data quality in the targeted provinces

Based on an audit sampling four indicators, the two-person team (a public health specialist and a computer specialist) assigned to conduct RDQAs in at least three ZS in each province: (1) assessed the quality of the data, (2) analyzed the capacity of the data management systems in place at the DPS, BCZ and health facilities, and (3) produced the baseline reference framework for data quality in the DPS was produced.

Supported monitoring missions of the SNIS normative Framework

Indirect: ✔ 1.1.1 ✔ 1.5.1

USAID IHP supported the *Direction des Soins de Santé Primaires* (DSSP, Directorate for Primary Health Care) to conduct monitoring missions of the SNIS normative framework in all nine provinces. The monitoring missions assisted the DSSP to identify bottlenecks and enable actors at the intermediate and operational levels to improve the timely availability, completeness, quality, and use of data. Improvements are critical to SNIS functioning as a tool that provides data for planning, monitoring and evaluation, decision-making and improved governance and leadership of the health sector at all levels of the health pyramid.

During monitoring missions, monitoring teams:

- Evaluated the level of implementation of the recommendations of previous missions in the same framework;
- Evaluated the level of implementation of the SNIS (collection, analysis, processing, interpretation and use of data) while identifying the bottlenecks to its proper functioning; and
- Established a mechanism for monitoring data quality (i.e., correction of validation rules) and documenting violated rules (i.e., correctly filling out the error register and error correction guide) by DPS, ZS and health facilities.

Monitoring missions resulted in two primary outcomes: (1) improved data entry, analysis and interpretation of the data generated by their health facilities under DPS supervision and (2) improved data availability and quality for decision making.

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

During Quarter 2, the Program assisted the first Directorate of the MOH to prepare and brief MOH experts and data managers who will support the *Plan Provincial de développement des ressources humaines pour la santé* (PPDRHS, Provincial Plan for the Development of Human Resources for Health) development process in the eight remaining provinces[11]. In addition, USAID IHP supported disseminating legal and regulatory texts for better health institution functioning; training BCZS and general reference hospital managers on the *Organisation Pour L'Harmonisation en Afrique du Droit des Affaires* (Organization for the Harmonization of Business Law in Africa) accounting software; training DPS and ZS executives on the *Pathways to Change* tool. Finally, USAID IHP continued to support the creation of gender units within DPS.

Supported technically and financially the popularization of legal and regulatory texts concerning the functioning of the public administration

Indirect: ✔ 1.3.1 ✔ 1.3.2 ✔ 1.3.3

USAID IHP supported the MOH through the DGOGSS to popularize the new National Community Health Strategic Plan[12] in all nine provinces to address major challenges in community health

[11] USAID IHP supported completion in Tanganyika in a previous quarter.
[12] The strategic plan defines a vision for community health, orientations for community health development, and an integrated coordination and implementation model that will serve as a framework for interventions and the mobilization of the necessary resources to achieve defined objectives.

development[13]. The Director General of the DGOGSS launched the activity in Haut-Katanga and Tanganyika with each province's Provincial Minister of Health, Communications Director, and other stakeholders; roll out followed in the remaining provinces. Across all nine provinces, 197 participants—including 29 women—from the DPS specialized programs and IPS worked through the various analytical, strategic, implementation, and monitoring and evaluation elements of the plan.

Supported the process of setting up provincial gender units and training their members

Indirect: ✔ 24 ✔ 1.3.3

USAID IHP technically and financially supported Lualaba to organize of a workshop to set up the Provincial Gender Unit. Delivered by two central-level experts from the Ministry of Gender and the MOH, 10 men and 10 women from the DPS, IPS, the ZS of Dilala and Manika, and specialized programs including the CPLT, PNSR, and PNLS participated. The main objective of the five-day workshop was to promote equal rights between women and men as well as equitable sharing of resources and responsibilities in the DPS.

At the end of the workshop, participants developed a 2021 PAO for the Provincial Gender Unit and, over the following two days, officially established the Unit.

Organized a training of trainers workshop on the use of the Pathways to change tool

Indirect: ✔ 1.6.4

USAID IHP supported a series of trainings on the Pathways to Change tool, first, through central-level training of trainers and then cascade training in the nine provinces; in total, 266 providers—including 50 women—benefitted from these trainings. The training addressed adult learning techniques combined with participatory and experiential training methodologies. This training helped: (1) improve participant knowledge and skills in behavior change communication and how communities are often affected by various personal, social, and environmental factors which can reinforce and support unwanted behavior; (2) increase knowledge and skills to promote avenues for change; (3) better understand participants' perceptions of barriers and enabling factors; (4) increase self-efficacy in promoting behavior change in different program areas by equipping communities with self-reflection and reflection tools through the Pathways to Change game; and (5) improve the capacity of peer educator supervisors (providers and Presidents of CODESA) to ensure formative supervision of the *RECO* and other community outreach agents.

Lessons learned

- Behavior change is a result of enabling factors and obstacles that can be individual, social, and environmental. Any communication plan for behavior change must take this into account.
- Participants discovered that the Pathways to Change game enables deeper problem analysis as well as identification of barriers and enablers that influence behavior change and setbacks that cause individuals or communities to abandon good practices and revert to where they started.

[13] The main challenges that the community health development is facing in the DRC include: (1) low equity in the supply of health services; (2) low motivation of community health actors; (3) Low use of services because of the limited access to information; (4) Poor coverage of community-based interventions; (5) Poor integration of community health into the health system. The National Community Health Strategic Plan addresses these challenges through a holistic and participatory approach based on community engagement through CACs.

Next steps

- Support dissemination of legal and regulatory texts consistent with the functioning of the public administration to all ZS.
- Continue to support monthly meetings of the Lualaba Provincial Gender Unit and establish gender units in the remaining provinces.
- Organize a workshop on the Pathways to Change tool to stimulate behavior and attitude change among providers at the health facility level across the 179 target ZS.

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

USAID IHP works closely with PNAM, the DPS, and USAID-supported ZS to ensure better availability of drugs at the last mile of the supply chain. Despite COVID-19, the Program's supply chain management activities continued during the quarter, including holding coordination meetings with stakeholders from nine supported provinces, holding *Group de Travail Médicament* (GTM, Essential Drugs Working Group) meetings, *Gestion des approvisionnements et des stocks* (GAS, Management of supplies and stocks) activities, conducting reviews of pharmacists from ZS, printing and distributing logistics management tools to health facilities, supporting transport of products at the last kilometer of the logistics chain, and supply chain management support for health facilities and BCZ.

In addition to these province level activities, the Program participates in bi-weekly technical supply chain meetings with other USAID implementing partners. During Quarter 2, SC disruptions for malaria treatment, ACT, and S/P, and overstock of FP products were the primary concerns. Longer international delivery times caused by COVID-19 and deteriorating road infrastructure in the DRC largely explain the low availability of products for Malaria and MNCH at all levels (regional distribution centers, BCZS, and health facilities). Poor coordination of actors in the field and the small number of providers trained to offer clinical methods led to an overstock of FP commodities. GHSC-TA borrowing products to partners and USAID IHP's support for reallocation of surplus stocks helped resolve this issue. USAID IHP also supported PNAM to organize a workshop with 10 MOH leaders and USAID IHP staff who collaborated to adapt the content of DRC Logistics Academy's training modules, and internal discussions are underway for technical and financial handover of the online tool at the Ministry. PNAM plans to integrate the online tool into training and retraining strategies in supply chain management for MOH staff at all levels. By the start of FY2022, this online tool will be available for any retraining of stock managers in ZS and DPS in provinces supported by USAID.

Provided Technical and Financial Support to the GTM and GAS activities

Indirect: ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

In the nine DPS supported by USAID IHP, GHSC-TA continues to hold monthly coordination meetings and GTM continues to hold quarterly meetings. During Quarter 2, USAID IHP supported the first pharmacist meetings organized in the nine DPS partners.

Meetings with GHSC-TA and GTMs mainly focused on monitoring the completeness and quality of data in the LMIS and on analyzing stock status in the provinces at all levels (global pipeline, CDR, BCZ, and health centers).

USAID IHP observed the following:

1. There is a need to improve the completeness of LMIS reports for both BCZ and health centers. Despite recurring complaints of very-small aperture terminal (V-SAT) failures (which cause internet

connection problems), lack of computer hardware, low availability of electricity, and delayed modifications to the reporting frameworks, the completeness rates of InfoMED reports have remained above 80 percent in the majority of ZS.

2. Near-shortage of stocks of antimalarials (ACT and SP) at CDR and ZS and understocking in the health centers of the supported DPS. The two-month supply GHSC-TA borrowed from the Rural Health Program was not sufficient to meet ZS needs during the quarter. GHSC-PSM anticipates that new stocks are planned to arrive in FY2021 Quarter 3.
3. Overstock of FP materials reported early in the year has been significantly reduced with the rationalization activity carried out in the nine provinces. Significant quantities of IUDs, DMPA-Sayana Press, female condoms, and cycle necklaces overstocked in three provinces (Sankuru, Lualaba, and Kasaï-Central) must still be redeployed in ZS in need or returned to the CDRs. USAID IHP is working to absorb the surplus stocks through the organization of mass FP campaigns and training providers in available clinical methods and community-based distributions efforts.
4. Delays in CDR deliveries to ZS.

During the quarter, USAID IHP provided technical and financial support to workshop sessions with 236 stock managers from 163 ZS of eight DPS (excluding Sankuru). During these sessions, USAID IHP SC advisors collaborated with the DPS to train participants in the use of the tools, facilitate group work to compile ZS data, and analyze indicators. For the next sessions, USAID IHP will support the ZS to complete presentation outlines by analyzing data and indicators. The tools provide data visualization on commodity stock levels and will allow stock managers to more accurately monitor drug availability in health facilities that have access it.

There were low levels of data completion in Haut-Katanga, Tanganyika, Lomami, and Haut-Lomami in Quarter 2, mostly likely caused by failure of V-SATs in the ZS and instability of the DHIS2 database. USAID IHP leveraged creative solutions to address many of the challenges that might reduce data completion rates, including ensuring regular maintenance of the V-SATs, which contributes to more complete LMIS reports. Program staff communicate regularly with the ECZS to collect complaints related to DHIS2 and InfoMED to address errors in the system. USAID IHP also supports communication between provincial level stock managers to promote effective sharing of all information on InfoMED with PNAM and DPS leadership. Using the ZS delivery planning tool, USAID IHP supports delivery of products to hard-to-reach places through the submission of a delivery plan for the ZS.

Copy and distribute normative management tools LMIS (preferably digitally)

Direct: ✔ 1.7.2 **Indirect:** ✔ 1.7.3

In Quarter 2, USAID IHP produced and distributed 69,028 management tools to more than 800 health structures of four supported DPS (Kasaï-Oriental, Sankuru, Haut-Katanga, and Tanganyika). USAID IHP is actively involved in improving the compatibility between hard copies of tools and LMIS and InfoMED. The Program also contributes to provider capacity building in the correct use of management tools, which contributes to increased data availability and quality.

Technically and financially support the distribution of drugs to the "Last Mile"

Direct: ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3

During this quarter, 55.8 percent of the 6,867 health establishments in nine supported provinces reported stock-outs in at least one of six tracer products selected by the program. The Program exceeded its target for this indicator with an achievement rate of 106.8 percent. During Quarter 2, 966 health facilities from 51 difficult-to-access ZS in seven provinces (excluding Kasaï-Oriental and Lomami) benefited from USAID IHP-supported transport of health commodities. This represents an increase of

99.5 percent compared to FY2021 Quarter 1 and brings the Program closer to the goal of reaching 1,857 health centers by the end of FY2021. USAID IHP anticipates that scale-up of mobile money will help the Program reach this target.

Table 35. USG-assisted service delivery points that experienced a stock-out of selected tracer drugs* at any time during the reporting period

Region	Province	Target (%)	Q2 Achieved	# Facilities	Total Facilities	Achievement Rate (%)
Kasaï	Kasaï-Central	80%	63.9%	608	952	120.2%
	Kasaï-Oriental	53.1%	46.9%	284	605	111.7%
	Lomami	67%	72.3%	532	736	92.2%
	Sankuru	57%	81.4%	386	474	57%
Total Kasaï Region		**64.3%**	**65.4%**	**1,810**	**2,767**	**98.23 %**
Katanga	Haut-Katanga	36.1%	29.8%	461	1,548	117.5%
	Haut-Lomami	58.1%	51.6%	314	609	111.2%
	Lualaba	72.2%	45.8%	230	502	136.6%
Total Katanga Region		**55.5%**	**37.8%**	**1,005**	**2,659**	**131.86 %**
Eastern Congo	Sud-Kivu	58.9%	66.2%	749	1,132	87.6%
	Tanganyika	81.4%	87.7%	271	309	92.2%
Total Eastern Congo Region		**70.1%**	**70.8%**	**1,020**	**1,441**	**99.1%**
Total General		**59.9%**	**55.9%**	**3,835**	**6,867**	**106.8%**

Source: USAID IHP Project Monitoring Report

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

USAID IHP's mandate to strengthen collaboration between central and decentralized levels is essential for sharing lessons learned, new strategies and approaches. This collaboration helps to better inform the Program's interventions and contribute to the improvement of the Congolese health system. In Quarter 2, USAID IHP focused on organizing regular meetings of the Management Committee (COGE) at the ZS level and on strengthening collaboration between the Ministry of Gender, Family and des Infants and the MOH for the promotion of gender mainstreaming in health facilities.

Organized a monthly review of good practices for gender mainstreaming

Indirect: ✔ 1.8.1

USAID IHP supported Haut-Lomami and Lualaba to organize sharing sessions on gender mainstreaming best practices. In Haut-Lomami, the session—attended by 19 participants from the provincial taskforce, civil society, religious groups, media, schools, the DPS and USAID IHP—included a presentation of quarterly activity reports and working group discussions on areas of improvement for the following quarter. In Lualaba, the province shared best practices across two sessions where 22 participants, including 15 women, discussed promoting equal rights between women and men and equitable sharing of resources and responsibilities across the Lualaba DPS. Across the provinces, Program-supported sessions resulted in planned activities for April-June 2021 along with an agenda for activities in the following quarter.

Provided financial support for the organization of COGE meetings in a few ZS

Indirect: ✔ 1.8.1

During Quarter 2, USAID IHP provided financial support for 75 ZS COGE meetings in six provinces (Lomami, Haut-Lomami, Tanganyika, Lualaba, Kasaï-Central, and Haut-Katanga). These meetings focused on reviewing calendar year 2020 (the MOH's fiscal year) activities and evaluating the relevance of 2021 planned activities. In addition, the ECZS shared challenges to making resource management (personnel, financial, material) decisions, which enabled strengthened collaboration between stakeholders. Finally, stakeholders discussed needs related to local resource mobilization from decentralized territorial entities and local partners. Lessons learned from these ongoing meetings will help redefine strategies and harness support for ZS priorities.

Next steps

- Support eight DPS (apart from Tanganyika where this activity was conducted in a previous quarter) to conduct planned workshops for the development of their PPDRHS.
- Provide technical support to the DPS to use data from the gender mainstreaming mapping survey to inform future activities

5. OBJECTIVE 2

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

Staff take participants' blood pressure during a workshop demonstration in Luiza ZS, Kasai-Central. Photo by Jean Manassé Tshibamba, freelance photographer for USAID IHP.

- **Supported 2 provinces with the implementation of the DQI tool** to identify bottlenecks and propose solutions
- **Updated 20 existing audio job aids for frontline health workers on the 42502 service (10 on IPS and 10 on iCCM) and developed a pack of 15 audio job aids for MNCH**
- **193 men and 95 women sensitized** on the flat-rate pricing approach applied in health facilities

During Quarter 2, as in previous quarters, USAID IHP supported the MOH in conducting various activities in support of quality service provision in health facilities. Our intervention targeted the three levels of the health system pyramid: the national level, including specialized departments and programs; the DPS and ZS at the health facilities; and the community level.

The main activities implemented under Objective 2 in FY2021 Quarter 2 were: (1) the application of the *Démarche de Qualité Intégré* (DQI, Integrated Quality Improvement Approach) and associated tools in health facilities; (2) provider training in the six program areas supported by USAID IHP; (3) supervision at all levels; (4) clinical mentoring for maternal and child health; (5) transport of vaccines from central offices to hard-to-access *aires de santé*; (6) provider training and the provision of IPC materials; and (7) technical and financial support for meetings and data monitoring at different levels of the health system. This section of the report presents activities not related to the indicators described in the program areas.

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

Supported supervisory visits of executives from specialized directorates and programs at the national level to the DPS

Indirect: ✔ 2 ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.4 ✔ 2.1.1 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 2.1.14 ✔ 2.1.15 ✔ 2.1.26

- The MOH requires that the national level (specialized directorates and programs) conduct semi-annual supervisory visits to the provinces. In Quarter 2, USAID IHP supported six specialized programs[14] in conducting seven supervisory visits in six provinces (Sankuru, Lomami, Kasaï-Central, Haut-Katanga, Lualaba, and Sud-Kivu). These supervisory visits enabled national-level experts to strengthen the provincial managers' skills in supporting ZS and monitoring implementation while identifying challenges in the field. With USAID IHP support:
- PNIRA and PNECHOL-MD teams conducted supervisory visits to Kasaï-Central and Lomami to assess the level of integration of the IMNCI and TETU approaches at iCCM sites in the ZS that were visited. The results showed that: (1) systematic management based on the IMNCI approach (assess and classify, counsel, follow up) is effective in more than 70 percent of the facilities visited; (2) the PAO includes clinical IMNCI and TETU activities; (3) health facilities are supervised as part of the IMNCI package; and (4) IMNCI data are validated during monitoring meetings. However, many hospitals do not have an oxygen kit (extractor). Even at the Tshamala Hospital, which is equipped with this device, the extractor does not work because there is no electrical power.
- The PNLT supported the Kasaï-Central CPLT with information on and technical maintenance of the GeneXpert machines. The GeneXpert machine at the Kananga site benefited from maintenance and analysis.
- PRONANUT conducted supervisory visits in Haut-Katanga and Sankuru to ensure the quality of nutrition interventions: CPSr, community-based nutrition, IYCF, and integrated management of acute malnutrition. Reports from these visits revealed that nutrition activities are integrated in the

[14] National Program for PNIRA, PNECHOL-MD, PRONANUT, PNSR, PNLT, and the EPI.

DPS of Sankuru and Haut-Katanga; however, some integrated management of acute malnutrition and community-based nutrition components are poorly integrated into the health facilities (only 12 percent of health facilities in Sankuru and 24 percent in Haut-Katanga) due to lack of implementing partner support.

- The PNLP conducted supportive supervisory visits for the management of malaria cases in Lualaba and Sud-Kivu. The reports indicate that the health facilities use flowcharts for case management and in the majority of cases, perform RDTs for patients with a fever. There is also good traceability of data between the outpatient consultations register and the laboratory in the majority of health facilities. However, some health facilities do not analyze the medical history further. As part of the supervisory visit, the PNLP team distributed the paper version of the HNQIS tool to ZS in the two provinces.
- The EPI conducted a supervisory visit in Sankuru to support the province in the response to the measles epidemic. The team supported the Sankuru DPS in mapping affected localities, updating the contingency plan, and organizing the recovery of unvaccinated children for other antigens. The team led national advocacy efforts for emergency vaccine supply in Sankuru, which was out of stock.

Next step: Continue providing support to supervisory visits in the other aires de santé in the provinces.

Supported application of the Integrated Quality Approach (DQI) to identify bottlenecks and propose appropriate responses

Direct: ✔ 2.8 **Indirect:** ✔ 18 ✔ 1.1.1 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.4.3

The MOH uses the DQI tool to improve the package of services offered to the Congolese population. As shown in Table 36, two provinces (Haut-Lomami and Lualaba) supported the use of the DQI tool in 34 service and care facilities including 14 health centers, 10 hospitals/general referral hospitals, and 10 central offices across 10 ZS. The goal was to identify the bottlenecks and to propose solutions to these bottlenecks.

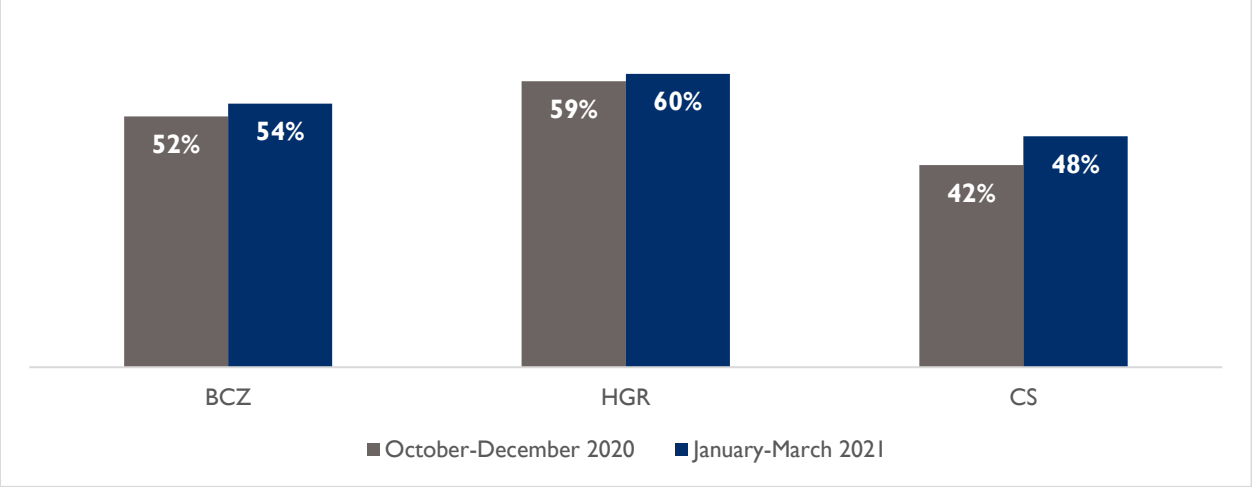
Table 36. Service and care facilities that have benefited from applying DQI during Quarter 2

Provinces	Health centers	General referral hospitals	BCZS	Grand Total	ZS
Haut-Lomami	8	4	4	16	Kamina, Kabongo, Kabondo dianda, Malemba nkulu
Lualaba	6	6	6	29	Kanzenze, Lualaba, Bukenya, Fungurume, Dilala, Manika,
Total	**14**	**10**	**10**	**34**	**10 ZS**

Source: USAID IHP Project Monitoring Report

- Figure 7 shows the results from the DQI assessment in 18 facilities in Lualaba (six BCZS, six HRG, and six health centers) and the changes in scores between Quarters 1 and 2 of FY2021. Overall, the facilities showed improvement in quality service provision compared to the previous quarter. At the health center level, there was an average 6 percent increase; the indicators that improved are the training and availability of essential drugs. At the hospital level the progress is not significant: although the Dipeta hospital achieved an 80 percent score, the score remains low for hospitals. The Bunkeya hospital's performance was poor compared to the previous quarter. All the facilities evaluated have implemented corrective plans developed by the DPS, BCZS, health center, and community teams, and they will be evaluated next quarter.

Figure 7. Average DQI evaluation score in facilities in Lualaba



Source: USAID IHP Project Monitoring Report

Lesson learned

- The evaluation of health facilities using the DQI tool and the establishment of the evaluation and quality improvement teams—to date, in all provinces except Tanganyika—has helped to increase stakeholder participation in identifying the gaps between the standards and their implementation of those standards; and thereby their engagement in improving quality of services and care at the facility level.

Next steps

- Train the trainers in Tanganyika on the DQI tool.
- Integrate the DQI database into the DHIS2 platform.
- Reassess the facilities assessed during this quarter.

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

Launched module of audio job aids focused on iCCM, IPC, and MNCH

Indirect: ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9

In Quarter 2, USAID IHP consortium partner Viamo updated 20 existing audio job aids for frontline health workers on the 42502 service: 10 on IPC and 10 on iCCM. Message updates were based on the need to improve the quality of messages as well as complement the existing messages with any new and emerging facts, such as recent updates to IPC messages that included COVID-19 considerations. The iCCM messages were updated and validated with the technical support of PNIRA and PNECHOL. For IPC messages, Viamo updated the messages and validated them with the Directorate of Public Hygiene and Public Health. Additionally, a pack of 15 audio job aids on MNCH went live. Examples of topics covered by the audio job aides include hygienic practice when treating respiratory illness, management of medical waste, and use of multi-dose vials when giving injections. A detailed breakdown of the traffic toward the content of these audio job aids for IPC, iCCM, and MNCH, ahead of the upload of the updated messages, can be found in the tables below. Finally, Viamo developed a pack of 15 key messages

on adolescent sexual and reproductive health (SRH) aimed at promoting responsible behaviors among youth. The messages were developed with the support of the PNSA. The message pack is currently being validated with the PNSA; translation and recording is expected early in Quarter 3. The new pack of messages about adolescent SRH delivers information about preventing sexually transmitted infections including HIV, expected physical and sociocultural changes during puberty, and risks associated with adolescent pregnancy.

Table 37. IPC audio job aids

Sub-theme	Total Number of Unique Listeners in Q1	Total Number of Unique Listeners in Q2
Hand washing	1,267	618
Personal protective equipment	1,708	1,059
Waste management	748	654
Management of sharp objects	910	898
Total	**4,633**	**3,229**

Source: USAID IHP Project Monitoring Report

Table 38. ICCM audio job aids

Sub-theme	Total Number of Unique Listeners FY2021 Quarter 1	Total Number of Unique Listeners FY2021 Q2
Prevention against childhood illness	1,340	968
Childcare	788	637
Prevention and care of the mother	1,237	1,118
Total	**3,425**	**2,723**

Source: USAID IHP Project Monitoring Report

Table 39. MNCH audio job aids

Sub-theme	Total Number of Unique Listeners in Q2
Prenatal consultation	79
Child/newborn health	36
Health of pregnant and breastfeeding women	76
Total	**191**

Source: USAID IHP Project Monitoring Report

Lessons learned

- The effectiveness of our mobile-based activities depends as much on the quality of the content as on the quality and size of the database of phone numbers available. In most cases, USAID IHP does not receive enough mobile numbers to reach the expected impact, and a significant proportion of those numbers are either not working or do not belong to the target population of the push. To mitigate this shortfall, USAID IHP is exploring various avenues to get access to the national Integrated Human Resources Information System (iHRIS) database of health workers.

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

During the quarter, USAID IHP consortium partner Viamo implemented improvements to the Referrals Tracking mHealth app. In addition, the Program received formal approval from the Secretariat General for the system's launch in the selected provinces of Kasaï Central, Haut-Katanga and Tanganyika. In February, USAID IHP organized a refresher training for RECOs as well as registered nurses and assistant registered nurses in Kasaï-Central, Haut-Katanga, and Tanganyika. The purpose of the refresher training was to introduce the changes to the mHealth app. Following the refresher training, RECOs and health centers were encouraged to use the mHealth app for their future patient referrals in parallel with the paper-based referral sheet and counter-referral coupon. The eventual goal is for the app to replace the paper-based form. Because these data are captured at the BCZS level, the system first needs to be stable and the data reliable, with mechanisms in place for filtering the information to each BCZS. For the time being, USAID IHP recommends that the two methods run in parallel throughout the pilot phase. Table 40 shows the number of calls made to the mHealth app in Quarter 2.

Table 40. Calls made to the mHealth app in FY2021 Quarter 2

	Jan 2021	Feb 2021	Mar 2021	Total Q2
Number of calls	40	245	192	**477**
Number of unique listeners	12	77	59	**148**

Source: USAID IHP Project Monitoring Report

Despite making considerable strides, several ongoing challenges remain, such as:

- The delay in obtaining the short code requires users to have minimum credit to be able to call the app and costs them a few cents of credit for each call.
- The lack of the counter-referral SMS notification interrupts the information flow and is a serious limitation in terms of sharing information with RECOs.
- The request for assistance functionality from the USAID IHP provincial focal point as the first point of contact for any technical support is not working as intended.
- Since many RECOs do not own a cellphone or have challenges charging them, Viamo has opened the system to allow RECOs or nurses to use any available cellphone. While this has solved one problem, it has created another problem linked to data validity.

Lesson learned

- For most mobile phone or platform-based activities, the intended users are not equipped with the required devices to effectively do their work. In order to access the mReferral app, some RECOs do not own a cellphone. Although the Program has opened the system as a workaround to allow RECOs to use any phone available, this approach comes with its own limitations. We will continue to monitor as we implement this activity to inform future implementation.

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

Established a provincial-level pool of trainers on gender-based violence, positive masculinity, and gender integration

Indirect: ✔ 2.1.27 ✔ 2.4.3

As part of the capacity building for provincial and ZS managers on sexual and gender-based violence (SGBV) case management, USAID IHP supported the training of trainers in Lualaba and Sankuru during Quarter 2. The purpose of this training was to increase the number of provincial trainers in SGBV management. The participants, most of whom are doctors, included DPS managers, ZS chief medical officers, and division gender managers, distributed as follows:

- Lualaba: 22 participants (20 men and two women) including 13 from the DPS and nine from the ZS.
- Sankuru: 20 managers from the DPS of Sankuru including 12 women from BATZ, PNSR, the Gender Division, PNLS, the National Multisectoral Program to Combat AIDS, and the Provincial Gender Unit.

Next step: Support provider training and post-training follow-up on medical and psychosocial care for survivors of SGBV in the two recently trained provinces and in the existing provinces.

Supported provider training and post-training follow-up on medical and psychosocial care for survivors of sexual and gender-based violence

Indirect: ✔ 2.1.27 ✔ 2.4.3

In Quarter 2, USAID IHP supported a provider training on medical and psychosocial care for survivors of SGBV in Lualaba and Haut-Katanga. This training helped enhance providers' case management capacities for SGBV cases. The participants were providers from various facilities, including doctors and nurses, as follows:

- Lualaba: 29 participants (20 men and nine women) from three ZS in Kolwezi
- Haut-Katanga: 75 participants (53 men and 23 women from seven ZS.

Next steps

- Extend the training to other ZS.
- Organize post-training follow-up for managers.
- Provide facilities with data collection tools.
- Organize supportive supervision visits.

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

Indirect: ✔ 2.4.2

USAID IHP provided technical and financial support for the training of 294 people in adolescent and youth sexual and reproductive health; this included 282 peer educators (162 boys and 120 girls), 10 ECZS, and two registered nurses from 103 aires de sante in nine ZS in Kasaï-Central, Tanganyika, and Kasaï-Oriental. The following subjects were covered: health and adolescent policies; relevant

information on peer educators; the meaning of adolescents in public health; information about sexually transmitted infections for adolescents; general information on HIV/AIDS; general information on family planning; adolescents' rights and needs; prevention of teenage pregnancy; pregnancy care and childbirth in adolescents; general information on gender-based violence; and adolescent-friendly services.

Next steps

- Support post-training follow-up and supervisory visits to the ZS.
- Supply the health centers with FP commodities and other inputs.
- Create the youth corner in the health facility and equip it with materials for their entertainment as well as SBC information.

IR 2.5: INCREASED AVAILABILITY OF INNOVATIVE FINANCING APPROACHES

Disseminated the flat-rate pricing strategy

Indirect: ✔ 2.5.1

During this quarter, USAID IHP supported the dissemination of the flat-rate pricing strategy in the *centres de santé* of nine ZS in Lualaba. A total of 193 men and 95 women received awareness training on the pricing applied in the health facilities.

Lead advocacy activities with decentralized institutions and the private sector in favor of greater mobilization of financial resources

Indirect: ✔ 2.5.1

The purpose of the mission conducted in the two ZS of Haut-Katanga was to implement advocacy activities with decentralized institutions and the private sector for greater mobilization of financial resources (i.e., in support of the provision of MNCH services).

The advocacy activity for maternal and child health took place in the capital of the Territory of Sakania and in the city of Kapolowe with the 52 participants (mayors, heads of districts, ECZS executives, health committee presidents, community leaders, and community health workers). The objectives of this activity were as follows:

- Integrate MNCH health activities into the action plan of two Decentralized Territorial Entities, Kapolowe and Sakania.
- Engage all stakeholders in the implementation of MNCH activities.
- Organize focus groups with representatives of the population (20 health committee presidents and community action leaders) to analyze bottlenecks causing low use of MNCH services.
- Prepare a corrective plan to improve the use of MNCH services.

Lessons learned

- Disseminating the flat-rate pricing strategy and involving the community in determining the cost of care has potential to improve the use of services at the community level. In this way, the population would not only validate the cost of the health service but also ensure its affordability.

- Engaging all social strata from a given entity facilitates the identification of the health challenges, especially in terms of maternal and child health.

Next steps

- Assess the applicability of the flat-rate pricing in the health facilities visited and identify new challenges.
- Conduct awareness-raising activities in additional provinces for activity #232.1.

IR 2.6: IMPROVEMENT OF BASIC INFRASTRUCTURE AND EQUIPMENT TO ENSURE QUALITY SERVICES

Rehabilitated WASH infrastructure in communities

Direct: ✔ 2.6.1

USAID IHP previously drilled boreholes to develop wells in four villages in Kasansa ZS, Kasaï-Oriental, and, during the last quarter, finalized plans to install motorized hand pumps and render four drilled wells functional. This will provide water access to approximately 2,000 members of the community. Following review and consultation with USAID, this work will be completed in Quarter 3.

Of note, the boreholes that USAID IHP constructed in Tshitshimu, Ntendu, and Katoto villages have flow rates of 3-4 m^3/h. While the Program workplan focuses on installing motorized hand pumps, USAID could consider replacing the motorized hand pumps with pumping systems such as solar or mini grid-powered autonomous water stations to enable these boreholes to provide water to more of the local population

Supported the establishment of Hospital Hygiene Committees

Indirect: ✔ 2.6.3 ✔ 2.6.4

USAID IHP worked through the Bureau of Hygiene and Public Sanitation to establish hospital hygiene committees in 10 general reference hospitals, five each in Kasaï-Oriental and Lomami. Once established, USAID IHP immediately facilitated trainings for committee members in both provinces, with 47—including 20 women—participating in Kasaï-Oriental and 60—including 15 women— in Lomami. Trainings focused mainly on local governance, the basics of nosocomial infections, and an introduction to IPC. The IPC section covered water supply; sanitation in health care settings; management of biomedical waste; hand hygiene; cleaning, disinfection; sterilization and personal protection equipment; and monthly, quarterly and weekly self-assessment. The Program supported each hospital hygiene committee to establish the appropriate structure and empower committee members to fulfill their roles. Each committee was structured into units, the number of which is determined by the workload and size of the health facility. At least three units must be created: (i) an external maintenance, water, and sanitation unit of the CS, (ii) the health facility internal sanitation and hygiene unit, and (iii) a sterilization and biomedical waste management unit. In addition, all committee and health facility members are responsible for communication—they must be point of contacts for WASH matters in the health facility and must ensure that all new staff members, patients, and caregivers are briefed on the key hygiene and sanitation best practices.

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

During this quarter, USAID IHP supported provider briefings on preventing the transmission of nosocomial diseases in the healthcare environment in Kasaï-Oriental. The Program also provided IPC kits in Kasaï-Central (four ZS), Kasaï-Oriental (two ZS), and Sankuru (five ZS). These kits include 17-liter trash bins, handwashing stations, masks, goggles, white coats, protective aprons, and detergent for cleaning surfaces.

Lessons learned

- The establishment of hospital hygiene committees in general reference hospitals played a catalytic role in the proactive involvement of technical services for the revitalization of WASH services in the health facilities.

Next steps

- Complete installation, follow-up water quality testing, and provincial acceptance of the four USAID IHP-constructed boreholes in Kasaï-Oriental
- Conduct a WASH mini survey in Kasaï-Oriental to quantify the number of people who benefit from potable water access at each USAID IHP-constructed borehole.
- Conduct post-training follow-ups in the newly established hospital hygiene committees and implement committee development and training activities in Kasaï-Central and Sud-Kivu.
- Provide the same materials at the ZS level in Kasaï-Oriental and train providers on the use and relevance of these materials

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

During the reporting period, USAID IHP provided financial or technical support to the organization of coordination meetings with the MOH, USAID, and other implementing partners. The MOH coordination meetings included meetings on family planning (national and provincial levels), malaria, tuberculosis, IMNCI, SGBV, and nutrition. Below is a summary of the key meetings held in Quarter 2.

Participated in meetings, workshops, and reviews of specialized MOH programs

Indirect: ✔ ✔2 ✔3 ✔8 ✔9 ✔10 ✔11 ✔14 ✔15 ✔16 ✔17 ✔2.1 ✔2.2 ✔2.3 ✔2.4 ✔2.6 ✔2.7 ✔2.1.1 ✔2.2.1 ✔2.4.2 ✔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 ✔2.7.1

Provided Financial Support to Activities of the CTMP-PF

USAID IHP provided technical and financial support for organizing meetings of the CTMP-PF in eight provinces (Lomami, Kasaï Oriental, Kasaï-Central, Sankuru, Lomami, Haut-Katanga, Lualaba, and Sud-Kivu) and at the national level. The provincial-level meetings help to coordinate engagement across several sectors (health, planning, gender, budget, civil society, and non-governmental organizations) and to advocate for family planning activities at all levels. The provincial-level meetings served to (1) review and assess progress against the CTMP-PF's 2020 action plan, (2) analyze the FP situation in light of the

COVID-19 pandemic, and (3) discuss the level of FP service provision, which does not currently match unmet need. The CTMP-PF also continued its efforts to improve the use of overstocks of FP inputs in the ZS. To achieve this, mini-campaigns were organized in Haut-Katanga, Lualaba, Haut-Lomami, Sud-Kivu, Lomami, Tanganyika, Kasaï-Central, Sankuru, and Kasaï-Oriental, and a rationalization plan was implemented for redistribution according to a plan approved by the CTMP-PF. (*See Chapter 3 on FP/RH in the report.*)

At the national level, the meetings focused on (1) the finalization and adoption of the CTMP rules of procedures document, (2) the review and finalization of work related to the evaluation of the National Health Plan for Family Planning 2014-2020 and the development of the new FP 2021-2025 strategic plan, and (3) the proposal of FP indicators to be integrated into the national health information system during the workshop on RH/FP indicators.

Next steps

- Engage all implementing partners in the coordination of FP activities (CTMP-PF) for full FP coverage in all USAID IHP provinces.
- Coordinate with all partners for the distribution of FP commodities to health facilities to prevent overstocking in the ZS.

Support technically and financially the TB/HIV Task Force quarterly meetings

USAID IHP provided technical and financial support to the PNLT/PNLS coordination meeting focusing on TB/HIV co-infection in Kasaï Central, Lomami, Haut-Katanga, and Sud-Kivu. This meeting, convened quarterly by the Head of the DPS Division, was also attended by other partners of the MOH (in particular, Cordaid/FM, Espoir pour la vie, UCOP+, FDSS, and CARITAS). In Kasaï-Central two new projects were presented during the meeting:

- **New Funding Model 3**: funded by Global Fund, this project targets prevention of mother-to-child transmission and HIV screening in all patients with all forms of TB. This project will be implemented by Cordaid and covers all 26 ZSs and will make available the Determine, Vikia, and Unigold tests; cotrimoxazole 480 mg tablets; and anti-retroviral therapies.
- **Tuberculosis Local Network**: funded by USAID, this project is being piloted by the Rural Health Project and focuses on communities and health facilities, working with local stakeholders. A total of six provinces are covered by the project: Kasaï Central, Kasaï Oriental, Sankuru, Tanganyika, Lomami, and Sud-Kivu.

Support IMNCI Coordination Meeting

USAID IHP provided technical and financial support to the organization of two IMNCI coordination meetings. These sessions served as an opportunity to discuss the scale-up of the supply of medical oxygen and pulse oximeters to the health facilities for the treatment of different lung conditions.

National Malaria Control Program

USAID IHP participated in the weekly meetings on malaria scientific days and in the Malaria Working Group meeting where the PNLP discussed extending the use of the HNQIS tool for supportive supervision activities (malaria service provision).

Nutrition Program

USAID IHP participated in two nutrition coordination meetings led by PRONANUT. Participants assessed the level of implementation of the PAO activities and collaboration across implementing partners.

Cluster SGBV

USAID IHP participated in meetings with the SGBV cluster in Sankuru and Kasaï-Central in order to ensure coordination of all implementing partner SGBV interventions at the provincial level.

Joint technical meetings between USAID and USAID IHP

USAID IHP participated in at least one meeting for each of the eight USAID/DRC technical groups, except for the Health Management Information System (HMIS) and health governance and financing technical groups, including PICAL.

Joint technical meetings USAID IHP and other USAID Partners

To improve activity coordination, USAID IHP held meetings with USAID implementing partners (Measure Malaria, Impact Malaria, GHSC-TA, Breakthrough Action, Food for Peace) and other partners at the national and provincial levels (Jhpiego and CARAMAL). Specifically, USAID IHP held coordination meetings on technical support for MNCH interventions based on the LDHF approach with Jhpiego.

6. OBJECTIVE 3

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

The Head of the Lomami DPS provides a welcome message during a campaign. Photo by USAID IHP.

- **5,823 children** with fevers referred to health centers via 29 mini-campaigns that reached 18,619 people with messaging on malaria, family planning, TB, and antenatal care.
- **379 pregnant women referred to start antenatal care at health centers as a result of the community champion awareness raising approach**
- **45 community forums** held with participation from **300 young people** and **240 adults**

During the quarter, USAID IHP used an integrated strategy to promote the adoption of health behaviors and the use of health services in health facilities. These included supporting the VIVA campaign with innovative interventions (market quiz, couple's meeting) as well as existing ones (mini-campaigns, community debates, community mobilization, school contests, and short messaging service (SMS) and interactive voice response (IVR) campaigns); celebrating world and national days; and strengthening collaboration with civil society organizations. The Program conducted these activities in all nine provinces, coordinating them with activities of Objective 2 to support health service delivery. USAID IHP also worked to strengthen its joint partnership plans with USAID implementing partner Breakthrough Action.

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

Provided technical and financial support for advocacy and celebrations of international days and weeks

Indirect: ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.26 ✔ 2.1.27 ✔ 2.1.28 ✔ 2.1.29

To highlight disease prevention and treatment and to promote healthy behaviors, USAID IHP supported the celebration of the following world days.

World Water Day. The Program joined other partners to fund and provide technical support to the Ministry of Health, through the Directorate of Water, Hygiene and Sanitation, to celebrate World Water Day. The day was celebrated in the context of the COVID 19 pandemic, under the theme "The place of water in our communities and how to protect it." A key objective of World Water Day was to support the achievement of Sustainable Development Goal 6: Safe and affordable drinking water for all by 2030. In Kasaï-Oriental, USAID IHP participated in the celebration day and provided technical support for the provincial authority's event organization, including raising the population's awareness. The mayor of Mbuji Mayi city invited citizens to follow the basic rules for treatment and use of drinking water. The ceremony was attended by 105 people including delegates from provincial ministries and their partners, members of the Provincial Assembly, and representatives from the University of Mbuji Mayi and civil society organizations. At the ZS level, eight advocacy visits and six community debates with 54 participants were carried out with government authorities and leaders. In addition, 68 community agents, churches, schools, media organizations, and market radio stations carried out awareness-raising activities. In total, 14,983 men and 18,165 women were reached. In the provinces, USAID IHP participated by supporting the logistical and technical organization.

World Tuberculosis Day. World Tuberculosis Day was celebrated in four provinces (Haut-Katanga, Lualaba, Sud-Kivu, and Tanganyika). In Kinshasa, USAID IHP contributed to the celebration of this day with a presentation titled "In a ZS, is the incidence of drug-resistant TB related to the therapeutic success of bacteriologically confirmed pulmonary TB? A comparative study in the ZS supported by USAID IHP in DRC." The initial results concluded that the incidence of DR-TB was strongly related to the cure rate of TP+, but only weakly related to the treatment success rate. It is important to understand the reasons for the emergence of DR-TB cases in the ZS to help improve TB control efforts. In the provinces, in addition to the official launch activities in which USAID IHP participated by supporting the logistical and technical organization, the awareness-raising activities focused on briefing 92 field actors (nurses and RECO) and getting them involved in raising awareness of suggestive signs, prevention measures, home visits, popular and group facilitation, and referral of suspected cases for

active screening in the health centers. Active TB screening campaigns were organized in ZS either with a high prevalence of multi drug-resistant TB, with special mining groups, or in the fishermen communities. A total of 3,723 people (2,025 women and 1,698 men) participated in awareness-raising activities. Of these, 155 suspected TB patients were referred to health centers, and 106 sputum samples and 17 cases tested positive. In Tanganyika two panel discussions were held at Kalemie University by the CPLT. There were 97 students and academic staff who participated in this activity. The theater group also put on a performance with messages on the signs of TB and the importance of early and active screening.

International Women's Day. During the quarter, USAID IHP provided technical and financial support for activities of the DPS and the Gender Division of four provinces (Haut-Katanga Kasaï-Central, Haut-Lomami, and Lualaba) to celebrate International Women's Day. Further details can be found in the Gender section of this report.

Supporting the VIVA campaign. During the quarter, USAID IHP in collaboration with Breakthrough Action supported activities related to the VIVA campaign, including training national-level actors, training/briefing ZS and *aires de santé* stakeholders, setting up steering committees, training journalists, and holding community awareness-raising events. Matchboxology participated in a meeting to discuss the VIVA campaign during a field visit. During this meeting it was agreed and discussed that Matchboxology will produce radio dramas for the campaign.

Trained DPS trainers to support trainings for ZS trainers on VIVA

Indirect: ✔ 3.1.1 ✔ 3.2.1 ✔ 3.2.2 ✔ 3.3.1

In Lubumbashi, USAID IHP technically and financially supported a training-of-trainers' workshop on the VIVA campaign implementation, monitoring, and evaluation. The workshop was an opportunity to allow USAID IHP and Breakthrough Action along with the DPS to have the same understanding of the VIVA campaign, mastery of all the implementation steps and capacity to supervise the staff and the community actors. This workshop was attended by 20 participants from three provinces including eight USAID IHP staff, four newly recruited Breakthrough Action staff, and six representatives from three DPS as well as two staff from the Haut-Katanga DPS who came to share the field experience. In Sud-Kivu and Kasaï-Central, the Program provided technical and financial support for the establishment of a VIVA campaign steering committee and VIVA campaign activity plan. The DPS has developed an activity plan that allows it to monitor the implementation of VIVA interventions in the ZS supported by Breakthrough Action and by USAID IHP.

Provide technical and financial support for briefing community actors and media professionals on VIVA

Indirect: ✔ 3.1.1 ✔ 3.2.1 ✔ 3.2.2 ✔ 3.3.1 ✔ 3.3.2 ✔ 3.3.3

In collaboration with the Sud-Kivu DPS, USAID IHP provided awareness-raising kits to community actors in the ZS supported by the Program. In Kasaï-Oriental, USAID IHP supported the training of 24 media professionals (12 journalists and 12 community radio managers) and six community activity leaders on the use of audiovisual aids in the VIVA campaign. In Kasaï-Central and Lomami, USAID IHP provided technical and financial support for the training of 192 RECO and seven nurses on the VIVA campaign. The training objectives were to strengthen the capacity of the RECO and nurses to promote essential health behaviors and access to health services in the community.

Support the establishment of the province-level steering committee of the VIVA campaign

Indirect: ✔ 3.1.1 ✔ 3.2.1 ✔ 3.2.2 ✔ 3.3.1

USAID IHP supported the establishment of a VIVA campaign steering committee in Kasaï-Central. This multi-sectoral committee consists of 15 members. Eighty people participated in the committee's launch ceremony, including government authorities, representatives of provincial ministries, members of civil society, and other stakeholders.

Provide technical and financial support for public awareness sessions

Direct: ✔ 3.3.1

During Quarter 2, USAID IHP provided technical and financial support for public awareness sessions in Sud-Kivu and Kasaï-Central. The objective of this activity was to promote essential family practices including the correct use of ITNs, early access to care for fever in children under 5 years old, exclusive breastfeeding, handwashing, and use of ANC and family planning services to contribute to the improvement of priority health-related attitudes and behaviors at the individual, family, and community levels and connect people to services. In Sud-Kivu, USAID IHP provided technical and financial support in the ZS as part of the VIVA campaign and in 20 *aires de santé* where the use of ANC and FP services and early access to care in case of fever in children under 5 are problematic. The public awareness sessions led by the nurses and community leaders reached 13,155 people. In Kasaï-Central, USAID IHP supported public awareness sessions on essential family practices related to FP, ANC/childbirth, diarrhea, fever, and acute respiratory infections (ARI). The Program conducted sensitization and referral activities for the use of services; these activities reached 6,873 people. Messages were shared through household visits and town criers. There were, 403 people for FP, 132 pregnant women for ANC visits or delivery, 105 children under 5 for diarrhea management, 552 children and pregnant women for malaria, 440 children under 5 for coughs and colds, and 123 children for malnutrition. There were 3,555 women and girls (including 2,136 women 18 years or older and 1,419 girls under 18 years) and 193 pregnant women who were reached about the correct use of ITNs.

Provided technical and financial support to mini-campaigns

Direct: ✔ 3.1.1 **Indirect:** ✔ 2 ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 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 ✔ 2.2.1 ✔ 3.2 ✔ 3.3.2 ✔ 3.3.3

During Quarter 2, 29 mini-campaigns were organized in nine provinces. The areas covered by these mini-campaigns are the following: four on malaria, seven on family planning, six on tuberculosis, six to encourage pregnant women to use ANC visits, four on pneumonia, and two on the recovery of unvaccinated children. Prior to the mini-campaigns, the targeted DPS worked with community members to identify relevant issues at the *aire de santé* level, which they used to plan achievable actions to carry out with appropriate interventions. They also examined the data to determine *aires de santé* with low rates for the use of health services among the different topics.

In collaboration with the DPS of Haut-Katanga, Kasaï-Oriental, Lomami, Lualaba, and Tanganyika, USAID IHP supported civil society facilities and community leaders in the organization of awareness-raising and community mobilization sessions. These actions focused on detecting sick children or children with fever and referring them to health facilities. These sessions reached 18,619 people. Following these

sessions, 5,823 children with fever, 402 children who did not complete their vaccinations, and 682 pregnant women as well as 543 women of childbearing age were referred to the health centers. Among this group, 1,914 children with fever tested positive for malaria and were treated, 358 children were vaccinated, and 656 pregnant women visited a health center, including 318 who benefited from the IPTp program. In addition, 265 women of childbearing age received postpartum counseling, and 981 new couples received FP counseling, and 858 new acceptors adopted a modern FP method. In addition to vaccination, 314 children under 5 received Vitamin A supplements, and 124 children aged 12-59 months were dewormed.

Revitalized and 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

USAID IHP supported 12 community champions in 8 ZS to carry out awareness-raising activities for attendance at ANC visits and curative and malaria services in Lualaba, Sud-Kivu, and Tanganyika. The findings reveal the low rates of women who attend all ANC visits, the low use of care by households for children under 5 in case of fever, and poor hygiene practices. During these awareness-raising activities, 25,581 people were reached by the target messages, including 1,212 pregnant women, 379 pregnant women who were referred to the health center to start ANC, and 833 who were advised to continue and complete ANC visits. In addition, 2,375 households were reached with malaria prevention messages, including 184 children under 5 referred for fever, of whom 53 tested positive for malaria. The same population was made aware of the correct use of ITNs and sanitation inside and near households. The community champions also took advantage of each meeting to share an information package on essential family practices and prevention of COVID-19.

Supported the broadcasting of radio spots to raise awareness about COVID-19

During Quarter 2, USAID IHP continued to support sensitization on COVID-19 through RECO, CBOs, and community radio stations in all provinces. Under the leadership of the DPS, technical meetings were held each month to ensure coordination of sensitization and awareness-raising activities in the provinces, particularly the dissemination of harmonized messages adapted to the local context. The messages were regularly disseminated in markets, schools, churches, and public places. During Quarter 2 a total of 20,348 community members and CBOs were briefed on COVID-19 prevention.

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

Trained RECO on communication techniques for essential practices and recognizing danger signs

Indirect: ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 14 ✔ 15 ✔ 3.1.2

During Quarter 2, USAID IHP supported training workshops for RECO on communication techniques, an integrated package of health messages, and danger signs in five provinces (Kasaï-Central and Kasaï-Oriental, Lomami, Lualaba, Sud-Kivu). The objective of this activity was to build the capacity of RECO and community health workers to enable them to independently conduct field activities. By the end of the workshops, 731 community workers had been trained. Awareness sessions were facilitated in Kasaï-Central and Kasaï-Oriental to promote these messages in households, women's centers, and community prayer groups. As a part of a briefing activity to prepare for these awareness sessions, RECO and nurses worked together to identify the messages to be used and how to best reach the target group based on

community needs. During these sessions, 19,282 households were visited, and 48,534 people were made aware of integrated health messages. These visits resulted in the following: 2,463 people were referred to health facilities; 4,073 households with a hygienic latrine were visited and advised to keep the latrine in a hygienic environment; 18,950 people participated in handwashing demonstration sessions; and 921 unvaccinated or insufficiently vaccinated children aged 0 to 11 months and pregnant women were referred for vaccinations.

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

Support community debates with young people and adults

Indirect: ✔ 2 ✔ 3 ✔ 2.1.1 ✔ 2.1.27 ✔ 2.1.28 ✔ 2.1.29 ✔ 2.2.1 ✔ 2.4.2 ✔ 2.4.3 ✔ 3.3.1 ✔ 3.3.2 ✔ 3.3.3

USAID IHP supported the organization of community debates to stimulate discussion among community members on health issues and the challenges they face, and to encourage everyone's participation in addressing them. The Program provided technical and financial support for the organization of 45 community discussions in three provinces (Haut-Lomami, Kasaï-Oriental, and Sud-Kivu). These discussions were held with 300 young people and 240 adults participating. They focused mainly on sexual and reproductive health among young people, unwanted pregnancies, sexually transmitted infections, sexual violence, HIV/AIDS, and the poor reception of patients at the health facilities. As a result of these discussions, the following resolutions were adopted: In Haut-Lomami and Kasaï-Oriental, young people requested capacity building in reproductive health from the ZS management teams to be better equipped and to organize awareness activities. In Sud-Kivu, young people discussed ways to prevent COVID-19 given the current threat of the pandemic.

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

Organized consultation and information meeting for community leaders

Indirect: ✔ 3.1.1 ✔ 3.2.1 ✔ 3.2.2

During Quarter 2, USAID IHP supported community influencers' experience sharing meetings in Haut-Katanga, Haut-Lomami, and Lualaba provinces. These meetings were attended by 235 participants and consisted of follow-up on activities and decisions made at previous meetings. Seven out of seven working meetings' minutes were read, amended, and adopted in each ZS. Eight advocacy visits out of 11 planned were carried out with village leaders. At the end of the meetings, the participants made a commitment to brief the influencers on the influence matrix, list and position each influencer according to their sphere of influence, and develop engagement plans. Following these meetings, 14 out of the 16 planned awareness-raising sessions on malaria, ANC visits, and vaccination were carried out among the mothers' groups. There were 358 pregnant women reached with messages on the benefits of following and completing ANC visits and respecting the vaccination schedule.

USAID IHP provided technical and financial support for the organization of meetings for community leaders to share information with local government and religious authorities. The meeting objectives were to encourage community leaders' involvement in the search for solutions to health problems in the ZS and to evaluate previous commitments in the provinces of Haut-Katanga and Haut-Lomami with

the support of the ZS management teams. These meetings were attended by 59 community leaders. At the end of the meetings, the members presented, their action plans approved by the participants. As part of the implementation of these action plans, 1,769 households were selected to receive targeted messages.

Supported the organization of meetings of the Communication Task Force

Direct: ✔ 3.4.1

During Quarter 2, the DPS of Kasaï-Central, Kasaï-Oriental, Lualaba, and Sud-Kivu received technical and financial support from USAID IHP for the organization of the Communication Task Force meeting. The objective of this activity was to share information on the fight against COVID-19 and to elaborate the community action plan. These meetings were attended by 77 people, all of whom were focal points of different sectoral ministries, media managers, and members of civil society organizations, as well as DPS partners' communication officers. At the end of the discussions, the participants decided to encourage community organizations to continue raising awareness about prevention of COVID-19. They also committed to finalizing the integrated communication plan for their respective provinces.

Lessons learned

- Community leader exchange meetings provide an advocacy opportunity for municipal authorities to report on the community's commitment to solving health problems in their jurisdiction and to encourage the efforts of leaders.
- Providing training to government partners (DPS members) and providers (nurses) to use data in targeting approaches has been a way to ensure that interventions are community-specific and focused on the most important health challenges. During this quarter, the Program used this strategy with the DPS to plan mini-campaigns and information technology to help screen for danger signs. The Program will continue to look for ways to continue to leverage data for strategic programming in the future.

Next steps

- Provide support to the trained staff to ensure the capacity building of the ZS actors according to the schedule proposed in the roadmap for the VIVA campaign. This roadmap was developed during the planning workshop held in Quarter 2.
- Help Haut-Lomami, Sankuru, and Tanganyika set up steering committees for the VIVA campaign at the beginning of the next quarter and to set up the national steering committee.
- Finalize and validate data collection tools for VIVA campaign activities.

7. REPORTING ON ADDITIONAL AREAS

GENDER

Last quarter, USAID IHP recruited a consultant to conduct a gender audit of the MOH at both national and provincial levels, with the objective of assessing the current status of gender mainstreaming throughout USAID IHP-implemented activities. In Quarter 2, the USAID IHP team conducted interviews of MOH cadres at all levels and USAID IHP staff (Abt, IRC, and Pathfinder) to assess their understanding and perceptions of gender issues, identify gaps, and make recommendations for integrating gender in all areas of program implementation. The team prepared for the deployment of nine technical experts from the Ministry of Gender (nominated by the General Secretary of Gender) to collect data in the nine provinces. The USAID IHP team and identified investigators validated the data collection tools developed by the consultant, although the deployment of the investigators did not take place during the reporting period as expected, since planned activities depended on revised USAID IHP per diem guidelines for MOH participants. These guidelines were finalized in mid-March 2021; USAID IHP then collaborated with the nine technical experts to establish an updated activity schedule with a new start date in the first week of April 2021. The gender audit is currently underway and will be completed by the end of Quarter 3.

USAID IHP continued to support the establishment of the Gender Units of the DPS in the provinces of Haut-Katanga, Lualaba, and Tanganyika. The coordinator of the MOH Gender Unit facilitated this activity in collaboration with an expert from the Ministry of Gender, with USAID IHP technical and financial support. In each of the three provinces, the two facilitators conducted a training of the Gender Unit staff and provided support for the development of their respective 2021 annual action plans for gender mainstreaming. The plans include four main objectives related to capacity building, advocacy with provincial political and administrative authorities, and social mobilization and sensitization. Remaining provinces will receive USAID IHP support to finalize the establishment of Gender Units next quarter.

USAID IHP continued to support quarterly community reviews on gender to facilitate sharing, learning, and networking on gender inclusion in program implementation, with the objective of promoting gender equality and equitable sharing of resources and responsibilities within the DPS. The provincial Gender Unit leaders now conduct these meetings in provinces where the Units have already been established (Sankuru, Lualaba, Tanganyika, and Haut-Katanga). Each session allowed participants to share their experiences and engage in meaningful discussions about social norms, positive masculinity, and gender equality, and their effect on attitudes and relationships within the community. The goal was to address the lack of gender sensitivity in the day-to-day operations of most state-run and private health structures and CBOs. The USAID IHP program team will continue to monitor awareness of gender aspects throughout implementation.

USAID IHP also supported implementation of action plans for previously established gender champions networks in four of the nine provinces. These networks consist of men and women committed to promoting gender equality in their communities, and their action plans focus on changing behavior to ensure equal access to health services and other resources at the community level. In Sankuru province, the program established a new gender champions network in Kole ZS.

Community members attend a gender-based violence prevention workshop in Kasai-Central. Photo by USAID IHP.

To increase awareness of gender and positive masculinity issues, USAID IHP also provided technical and financial support for the revitalization of CAC in Haut-Katanga, Kasaï-Central, Kasaï-Oriental, and Lomami. This activity involved local administrative authorities, traditional leaders, CODESA representatives, and male and female community members (Table 41). Increased proportion of women-led CACs may reflect a positive shift in gender perceptions in the supported communities. Notably, participants in meetings or trainings with CODESAs more frequently raise questions related to gender, especially around women's participation in community-led decision-making bodies and activities.

Table 41. USAID IHP support to revitalization of CACs by province/ZS in FY2021 Quarter 2

Province	ZS	# Revitalized CACs	# CACs Led by Women	% CACs Led by Women
Haut-Katanga	Kipushi	20	9	45%
Kasaï-Central	Luambo, Kalomba	102	19	19%
Kasaï-Oriental	Cilundu, Bibanga, Kabeya-Kamuanga, Bibanga, Bipemba, Mpokolo	742	237	32%
Lomami	Mwene-Ditu, Kalenda, Kanda-Kanda	119	19	16%
Haut-Lomami	Kabondo-Dianda, Malemba-Nkulu, Kabongo	30	0	0%
Sud-Kivu	Mwenga, Katana	90	7 (Mwenga only)	7%

Source: USAID IHP Project Monitoring Report

To celebrate the 2021 International Women's Day theme, "Women in Leadership: Achieving an Equal Future in a COVID-19 World," USAID IHP provided the DPS and the Gender Division of four provinces with technical and financial support for activities (Haut-Katanga Kasaï-Central, Haut-Lomami, and Lualaba). The event served to promote local adaption of this year's theme by organizing activities that brought women and men together by emphasizing fundamental shared values of respect for human

rights, female leadership, and positive masculinity. Sensitization sessions were conducted by the Provincial Division for Gender, Family, and Children. A total of 25,127 people were sensitized, including 13,855 women leaders of community-based organizations. About 70 male community leaders in Haut-Katanga were mobilized for positive masculinity and commitment to fight violence against women. During the five days, 7,398 pupils and students were sensitized. The actors visited 4,566 households and had discussions with couples where husbands were present. If not, they held discussions with women about their rights.

USAID IHP also supported the MOH's introduction of the peer education approach for adolescent and youth sexual and reproductive health in Haut-Lomami, Kasaï-Oriental, and Tanganyika, which aims to increase adolescent and youth knowledge, skills, and healthcare-seeking behaviors related to SRH through life skills counseling. To improve adolescent and youth access to SRH/FP services, the Program also supported community dialogue sessions (community-based activities like CAC meetings and champion community sessions) on sociocultural barriers to access of healthcare services, including those related to gender, in all nine supported provinces.

To accommodate COVID-19-related requirements, the Program continued to reduce the number of participants for meetings and sensitization activities and complied with all prevention measures.

Lesson learned

- Shifts in gender norms occur gradually but increases in the proportion of CACs led by women may reflect burgeoning healthier and more equitable perceptions around gender in the supported communities.

Next steps

- Complete the gender audit in the nine DPS offices and selected ZS.
- Continue to support the establishment of provincial-level Gender Units in the five remaining provinces.
- Continue the implementation of gender champions networks in Haut-Lomami, Lualaba, Haut-Katanga, and Sud-Kivu (preparation is currently underway for Haut-Lomami).
- Organize a one-day workshop on Gender and Communication to further strengthen the capacity of the Gender Unit in gender mainstreaming, communication, and advocacy on gender. This activity was delayed due to postponement of the gender audit.
- Conduct a national-level workshop on gender mainstreaming of community mobilization (following the workshop above).
- Conduct regular follow-up meetings with DGOGSS on gender mainstreaming. The agenda of the first meeting will include sharing and discussing the findings of the gender audit.

CONFLICT SENSITIVITY

During Quarter 2, USAID IHP, through partner IRC, conducted and planned several activities to raise conflict sensitivity awareness and promote do no harm practices in Tanganyika, Sud-Kivu, and provinces in the Kasaï and Katanga regions. Key activities included training and refresher training for regional trainers, training ZS, planning future activities, and provincial-level conflict sensitivity analyses. The Program also conducted three activities specifically resulting from FY2020 conflict sensitivity analysis

recommendations; they were: (1) training and briefing USAID IHP teams across the Kasaï region on the do no harm approach for FY2021, (2) supporting the community scorecard validation workshop, and (3) preparing for conflict sensitivity and do no harm activities and data collection for Quarter 3.

Prepared for provincial data collection on conflict sensitivity analysis

In Quarter 2, USAID IHP teams in all nine provinces prepared for conflict sensitivity analysis data collection to occur in Quarter 3. In particular, due to turnover among provincial and ZS stakeholders previously trained in do no harm and conflict sensitivity analysis, USAID IHP launched new staff and refresher trainings to occur in advance of data collection.

Trained ZS on the Do No Harm approach and conflict sensitivity

This Quarter, USAID IHP conducted a training of trainers on do no harm and conflict sensitivity with Program provincial staff and ECZS in the Kasaï region. Each trainer then began training health facility staff and ZS supervisors in do no harm and conflict sensitivity principles, which will continue in Quarter 3. Training participants learned the methodology for do no harm and conflict sensitivity analysis with emphasis on data collection and analysis methods. Participants also learned techniques in support of conflict sensitivity analysis and expanded training activities in Quarter 3. Training participants found discussion on the identification of connectors 'common ground' to be particularly valuable, especially in line with the need for increased social cohesion and integration between Twa and Bantu communities for shared health access and outcomes.

Supported community scorecard validation and implementation

During the Quarter, USAID IHP—as part of its support to the MOH in the dissemination of DRC's new National Community Health Strategic Plan—facilitated a workshop in Sud-Kivu to present and popularize the community scorecard among 44 ECDPS, ECZS, provincial taskforce and Red Cross DRC participants. As part of the workshop, the Program assisted participants to plan evaluation activities in two pilot *aires de santé,* ensure adoption of the community scorecard approach by CODESA, and improve upon the community scorecard with participants' inputs.

Lessons learned

- DPS, ECZS and CODESA will need additional training and operational support to ensure sustainable use of the community scorecard.

Next steps

- Collect conflict sensitivity and do no harm data in the province of Tanganyika in the three remaining areas where the Twa reside (Kalemie, Nyemba, and Manono).
- Compile and analyze conflict sensitivity and do no harm data collected in the seven ZS of Tanganyika.
- Expand data collection in the remaining eight provinces.
- Encourage the ownership and use of do no harm data by provincial decision-makers and the ownership of the approach for their routine practice.

ENVIRONMENTAL MITIGATION AND MONITORING

Water Quality Assurance Plan

In Quarter 2, USAID approved USAID IHP's Water Quality Assurance Plan (WQAP), which contains essential elements of the Program's Environmental Mitigation and Monitoring Plan (EMMP) for activities related to rehabilitation and construction of water and hygiene systems in communities and health facilities. The approval cemented the water quality measures that USAID IHP has and will continue to implement in all activities that involve water and hygiene systems. At the community level, USAID IHP adhered to WQAP measures during the rehabilitation and extension of water supply systems in Sud-Kivu and the construction of boreholes for potable water access in Kasaï-Oriental. USAID IHP equipped the four constructed boreholes in Kasaï-Oriental with motorized hand pumps and supported the DPS in water quality analyses. The analyses revealed that the water in two villages was of good quality while in the other two, the water was of good physiochemical but not bacteriological quality. USAID IHP will continue to support the DPS with further water quality testing and bacteriological quality monitoring in Quarter 3 and implement measures to eliminate coliforms if still detected in the water.

Environmental Mitigation and Monitoring Plan

The Program, following request from USAID, reviewed and updated USAID IHP's approved EMMP to ensure that EMMP mitigation measures reflected recommendations from USAID/DRC's Initial Environmental Examination (IEE). USAID IHP ensured that the updated EMMP clearly integrated IEE recommendations for the Program's activities in:

- Improving water and sanitation systems
- Small-scale constructing/renovating (under 1000 m^2 of total disturbed area) without complicating factors

Equipping hospital hygiene committees

During the Quarter, USAID IHP trained 107 members of hospital hygiene committees across ten general reference hospitals (five each in Kasaï Oriental and Lomami) in key areas of water, sanitation, and hygiene for health facilities. This activity followed USAID IHP's technical support to establish such committees, a key area of technical support to ensure the maintenance and sustainability of WASH improvement interventions at Program-supported health facilities and surrounding communities.

Medical waste management materials

USAID IHP, with the support of partner i+ Solutions, launched delivery of 8,000 posters highlighting principles of medical-chemical waste management to all nine provinces. By the end of the Quarter, the Program delivered posters to three provinces (Kasaï-Central, Kasaï-Oriental, Lomami) and supported the provinces to distribute their posters to ZS and health facilities.

Next steps

- Train management committees on protecting the vicinity surrounding the water structures including the immediate watershed and preventing water infiltration.
- Support water committee members in developing and monitoring a maintenance and upkeep plan for the water structures to ensure continued operation.
- Inform farmers in the neighboring area of the dangers of using fertilizers and pesticides in the immediate vicinity of the water structures.

8. ACTIVITY RESEARCH, MONITORING, AND EVALUATION

IMPLEMENTATION OF THE RESEARCH AND LEARNING AGENDA

During Quarter 2, the Research, Monitoring and Evaluation team continued efforts to implement the Research and Learning Agenda.

This quarter, several members of the program team developed research proposals including an (1) evaluation of professional practices: Clinical audit on the Treatment Observed in health centers, Diagnosis and treatment of tuberculosis in Health Zones supported by PROSANI USAID in the DRC and (2) an investigation of factors in the health of the mother and the child.

After preliminary examination and in order to allow the scientific committee to finalize the evaluation of the proposals, the researchers who presented the proposals were asked to provide a detailed concept note (the template is in the Annex of the approved Activity Monitoring and Evaluation Plan (AMEP)) that, if chosen, can be developed further into a research protocol. The TB concept note was the most completed and has been evaluated by the internal committee Using the evaluation grid, the technical committee had to evaluate a single proposal deemed completed in relation to the field of TB by formulating comments and observations that will be shared with the researcher for consideration and improved concept note.

IMPLEMENTATION OF THE FY2021 GENDER AUDIT

PROSANI USAID conducted a gender analysis during its first year, the results of which informed program partners of how gender norms influence approaches to achieve PROSANI USAID goals and recommend gender adaptation and transformation approaches to help the program achieve its goals. The analysis also clarified the differences in predominant gender norms and practices across geographic regions (East, Katanga and Kasaï).

In this quarter, we have started preparing for the midline of this survey which will continue the assessment of the understanding and perceptions of PROSANI USAID staff on gender and its implications for PROSANI USAID implementation. It will also assess the capacity of staff to effectively apply gender recommendations and implementation strategy to mainstream gender in implementation. This assessment will also examine the second year work plan and the extent to which gender is taken into account, and identify ways for improvement.

During this quarter, the consultant recruitment process, the development of the research protocol and the collection tools were finalized. We have also initiated contact with the general secretariat of the Ministry of Gender for the identification of experts who will facilitate and supervise the study in the provinces.

The process will continue during the third quarter with the training of national facilitators in Kinshasa, their deployment and organization of training sessions in the provinces. Data collection and the start of the reporting process is expected to begin in the third quarter.

ONGOING RESEARCH WITH GEOPOLL

USAID IHP partner Geopoll conducted four ongoing, crosscutting surveys this quarter: (1) Transparency and Oversight in Health Services Survey, (2) Evidence Gap of Civil Society Organizations (CSOs) Survey, and the (3) Healthcare Provider Survey, and 4, Client Satisfaction. These surveys are described in more detail below. The results from these surveys inform USAID IHP on healthcare

worker perceptions on transparency, gaps in CSO procedures and community practices, and provider perceptions on access to and quality of health services, respectively. Additionally, Geopoll implemented ad hoc surveys on Malaria and WASH to further inform program design and implementation.

The satisfaction survey aimed to measure the population's perception of the services offered as well as all the conditions related to the supply and demand of services. The results of this survey should help inform two indicators monitored by the program, (1) Indicator #2.5 Percentage of population who use selected facilities and (2) Indicator #2.9 Percentage of population reporting improved availability of selected services. The ad hoc survey on community perception of malaria focused on whether diagnosis and treatment of infections are detected in time and measures to prevent malaria during pregnancy and targeted the population in the community. Finally, the ad hoc WASH survey was designed to capture the target population's perception of WASH services, particularly access to borehole water and water management services.

USAID IHP launched the Transparency and Oversight in Health Services Survey with a sample of provincial workers in the targeted health zones. This cross-cutting survey under IR 1.2 evaluates provincial healthcare workers' perception on transparency and the need for accountability management. The survey also explores what performance management, policies and procedures exist for healthcare workers. The Program also launched the Evidence Gap of CSOs Survey this Quarter, under IR 1.3. The survey identifies gaps in CSO management procedures and practice efficiencies at the community level. Finally, during Quarter 2, GeoPoll continued the follow-up Healthcare Providers' Survey with a targeted sample of health zones. This survey assesses the perception, attitudes, and behaviors of healthcare workers related to access to quality and integrated health services under IR 2.2.

BEHAVIORAL ECONOMICS RESEARCH WITH VIAMO

During this quarter, the research, monitoring, and evaluation (RME) team with Viamo as focal point developed the scope and the subcontractor agreement with the Busara Center for Behavioral Economics for a research study to understand nuances of existing on-the-ground realities and optimizing remote training design for access and outcomes. This survey will be followed by light touch and rapid prototyping to provide feedback on planned interventions. The scope will investigate trainings in Years 2 and 3 and the study is scheduled to run for six months starting from the 1st of April.

M&E PLATFORM DEVELOPMENTS

USAID IHP's M&E Platform generates and compiles data for use and analysis for reporting. During Quarter 2, USAID IHP's RME team and partner BlueSquare developed a module on the M&E platform to support program implementation monitoring and data analysis. The team began using the tool to track Project Monitoring Report (PMR, internal system) indicators more efficiently.

9. SUMMARY OF LESSONS LEARNED

Strengthening linkages between *aires de santé* to reach pregnant women for high-impact health services

During Quarter 2, USAID IHP sought to strengthen linkages between *aires de santé* to reach pregnant women. For example, community mobilization activities during the VIVA campaign included briefings on IPTp and the importance of attending four ANC visits. Providers previously trained in prevention and management of malaria in pregnant women were also trained in strategies for identifying and referring pregnant women to health facilities to reduce delay of their first ANC visit. Providers trained in nutritional interventions for pregnant women shared nutritional guidance and provided iron-folate supplementation to pregnant women during ANC visits. These activities contributed to the strong performance of the Program's two ANC indicators for the quarter (see section 3, MNCH for more details).

Increase in representation of women in leadership positions at the community-level

During Quarter 2, USAID IHP noted an increase in the proportion of women-led CACs (*Cellules d'animation communautaires*) as well as representation of women RECO in CACs at the ZS level. In addition, issues related to gender, including participation of women in community-led decision-making bodies and in activities, are more often reported among the issues raised and discussed during meetings or trainings with CODESAs and other community-based activities. Shifts in gender norms occur gradually, but increases in the proportion of CACs led by women indicate healthier and more equitable perceptions around gender in Program-supported communities. USAID IHP will continue to track the gender breakdown of CAC leaders and the potential impact on community-level activities.

Leveraging community insights for more targeted health interventions

Gathering insights from the community can help to better target health interventions and increase local engagement. Community meetings enable participants to identify problems and needs and recommend solutions and actions, giving them ownership of disease control measures. During Quarter 2, USAID IHP leveraged this strategy for community mobilization efforts at the ZS, AS, and provincial levels. Community champions invited ZS providers to help develop and evaluate an action plan, starting with priority actions for challenges facing their community. One community champion focused on promotion of ITN use and ANC visits. In another community the CODESA was mobilized to accompany distribution of ITNs at the household level. The Program also tapped community engagement to plan mini-campaigns, working with community members to identify relevant issues at the AS level, achievable actions and appropriate interventions. They also examined data to determine AS health services and behaviors with low achievement rates. Complimenting local efforts, at the central and provincial levels, the DGOGSS spearheaded adoption of the new national strategic community plan in all nine provinces. The plan involves a participatory, community-led approach to address health inequities, engage community health actors, and integrate community health into the health system.

Innovative solutions for improved commodity delivery to remote ZS

With its nine provinces and 179 ZS, USAID IHP covers a vast geographic scope, and many ZS are in areas of DRC that are difficult to reach and face insecurity. During Quarter 2, the Program developed innovative delivery mechanisms to deliver essential commodities. In Tanganyika, 28 CSDTs are in hard-

to-reach areas that face insecurity due to the presence of armed groups, so the Program improved the availability of anti-tuberculosis drugs by engaging community agents for commodity delivery—specifically nurses and other providers who can transport small batches of ITNs when they return to their AS. The Program will provide financial support for these trips between the BCZS and health centers in these areas.

Leveraging improved communication channels to prevent stock-outs

Quarterly data validation meetings can be leveraged as a mechanism to prevent stock-outs as the health center staff (MCZS, nurses) share and document their drug stock status. If needed they can also carry back small amounts of necessary medicines to cover shortages before the next delivery. Mini-campaigns always create demand for commodities related to the health topic they cover, so the Program will help coordinate supply of relevant commodities to relevant sites before the mini-campaign takes place. The Program will continue to implement these strategies in the coming quarters and explore their applicability for other program areas.

ANNEX A: PERFORMANCE INDICATORS, TARGETS, AND ACHIEVEMENTS (FY2021 Q2)

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
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†	NA	NA	NA	NA	NA	NA	NA	NA	N/A	Data will come from the DHS or MICS survey. Data from the 2017-2018 MICS is not yet available.
		Kasaï	NA	NA	NA	NA	NA	NA	NA	NA		
		Katanga	NA	NA	NA	NA	NA	NA	NA	NA		
		Eastern Congo	NA	NA	NA	NA	NA	NA	NA	NA		
2 Fee	FP: Percentage of married women using any modern method of contraception	Outcome	UA	NA	NA	NA	NA	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	NA	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	NA	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	NA	NA	NA	HHS		
3 Fee Proxy PPR	FP: Number of acceptors new to modern contraception in USG-supported family planning service delivery points (PROXY)	Outcome	848549	1360253	340063	344831	101.4%	NA	NA	DHIS 2	Overall, the Program reached the target for number of new FP acceptors during the period. Kasaï and East regions did not reach the target, but showed good progress (respectively 98.0% and 96.4% achievement rates).	Tanganyika was the only province with performance <90% (72.8%). Next quarter we will focus on post-training FP follow-up, continuing FP mini-campaigns in targets ZS and supporting the integration of FP with other implementing partners to improve contraceptive coverage.
		Kasaï	368326	557853	139463	149445	107.2%	NA	NA	DHIS 2		
		Katanga	272927	494558	123639	121178	98.0%	NA	NA	DHIS 2		
		Eastern Congo	207296	307842	76961	74208	96.4%	NA	NA	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
4 Fee	MNCH: Percentage of children 0-59 months of age for whom treatment/advice was sought for acute respiratory infection	Outcome	UA	NA	NA	NA	NA	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	NA	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	NA	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	NA	NA	NA	HHS		
5 Fee Proxy PPR	MNCH: Number of children under five years of age that received treatment for an acute respiratory infection from an appropriate provider	Outcome	1143154	1355529	338882	367634	108.5%	NA	NA	DHIS 2	Overall, the program reached the target for this indicator in Q2. The Katanga region fell slightly short of its target but still achieved 99.7%.	Next quarter, conduct formative supervision and recovery plans for Haut-Lomami and Haut-Katanga, the only provinces that did not have 100% coverage in Q1.
		Kasaï	569695	656053	164014	187637	114.4%	NA	NA	DHIS 2		
		Katanga	229925	300811	75202	74973	99.7%	NA	NA	DHIS 2		
		Eastern Congo	343534	398665	99666	105024	105.4%	NA	NA	DHIS 2		
6 Fee	MNCH: Percentage of children 0-59 months for whom treatment/advice was sought for diarrhea	Outcome	UA	NA	NA	NA	NA	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	NA	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	NA	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	NA	NA	NA	HHS		
7 Fee Proxy (Standard /PPR)	MNCH: Number of cases of child diarrhea treated in USG- supported programs (PROXY)	Outcome	1041286	1137841	284462	278776	98.0%	NA	NA	DHIS 2	The Program did not reach the target set for the period. Specifically, Kasaï Oriental, Lomami, Sankuru and Tanganyika underperformed.	Intensify formative supervision in the weakest performing provinces and ensure that ORS + Zinc is available in all health facilities.
		Kasaï	476895	521117	130280	125640	96.4%	NA	NA	DHIS 2		
		Katanga	239799	262034	65509	73109	111.6%	NA	NA	DHIS 2		
		Eastern Congo	324592	354691	88673	80027	90.2%	NA	NA	DHIS 2		
8 Contract	MNCH: Percentage of children age 12-23 months who received all basic vaccinations	Outcome	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS	This indicator is reported in Y1, Y4, and Y7.	Baseline data for this indicator will come from MICS 2018 and midline and endline data will come from the HHS data is collected will be collected the household survey.
		Kasaï	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		
		Katanga	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Eastern Congo	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		
9 Fee Proxy PPR	MNCH: Number of children less than 12 months of age who received three doses of pentavalent vaccine (PROXY)	Outcome	1157027	1480089	370022	359850	97.3%	NA	NA	DHIS 2	Overall, the Program did not reach the target for DTP3 coverage this quarter. Only the provinces of Kasaï Central, Haut-Katanga, Tanganyika and Sud-Kivu reached the target.	Sensitize RECOs in recovering children who have not received pentavalent particularly in the provinces with the weakest performance. Continue to support the vaccine supply chain of the EPI sites in reaching BCZS and far-away aires de santé.
		Kasaï	479997	613786	153447	149915	97.7%	NA	NA	DHIS 2		
		Katanga	344494	474484	118620	112391	94.7%	NA	NA	DHIS 2		
		Eastern Congo	332536	391819	97955	97544	99.6%	NA	NA	DHIS 2		
10	MNCH: Number of children less than 12 months of age who received measles vaccine from USG-supported programs	Outcome	1115918	1480089	370022	349247	94.4%	NA	NA	DHIS 2	Although performance was satisfactory for this indicator, VAR coverage did not reach the target during the period. Only Haut-Katanga achieved the target.	Sensitize RECOs in recovering children who have not received VAR particularly in the provinces with the weakest performance. Continue to support the vaccine supply chain of the EPI sites in reaching BCZS and far-away aires de santé.
		Kasaï	478162	613786	153447	145394	94.8%	NA	NA	DHIS 2		
		Katanga	330445	474484	118620	112001	94.4%	NA	NA	DHIS 2		
		Eastern Congo	307311	391819	97955	91852	93.8%	NA	NA	DHIS 2		
11	MNCH: Percentage of children less than 12-23 months of age who received measles vaccine from USG-supported programs	Outcome	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS	This indicator is reported in Y1, Y4, and Y7.	Baseline data for this indicator will come from MICS 2018 and midline and endline data will come from the HHS data is collected will be collected the household survey.
		Kasaï	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		
		Katanga	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Eastern Congo	UA	NA	NA	NA	N/A	NA	NA	MICS 2018 (Baseline) and HHS		
12 Fee	MNCH: Percent of pregnant women attending at least four antenatal visits with a skilled provider from USG-supported health facilities	Outcome	UA	NA	NA	NA	N/A	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	N/A	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	N/A	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	N/A	NA	NA	HHS		
13 Fee Proxy	MNCH: Number of pregnant women attending at least 4 antenatal care visits with a skilled provider (PROXY)	Outcome	778425	1077766	269442	266415	98.9%	NA	NA	DHIS 2	Overall, the Program did not achieve its target for the CPN4 indicator during the period (98.9%). The provinces of Haut-Katanga, Lualaba and Sud-Kivu performed poorly.	Raise awareness among communities on the importance of ANC and schedule formative supervision, in particular in the provinces of Haut-Katanga (66.9%) and Lualaba (76.0%).
		Kasaï	418461	447764	111941	133918	119.6%	NA	NA	DHIS 2		
		Katanga	174119	347175	86794	67464	77.7%	NA	NA	DHIS 2		
		Eastern Congo	185845	282827	70707	65033	92.0%	NA	NA	DHIS 2		
14 Fee	MALARIA: Percent of children under 5 years of age for whom treatment/advice was sought for fever	Outcome	UA	NA	NA	NA	NA	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	NA	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	NA	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	NA	NA	NA	HHS		
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	3699060	924765	787920	85.2%	NA	NA	DHIS 2	Three provinces exceeded their targets for this indicator. This was due to the series of training sessions for providers, the availability of key commodities (ACTs and RDTs) and community awareness activities.	Additional supervision will be provided to the RECOs to be able to better seek out children under 5 with fever and connect them to treatment.
		Kasaï	1397311	1816358	454089	357962	78.8%	NA	NA	DHIS 2		
		Katanga	681602	1026688	256672	228835	89.2%	NA	NA	DHIS 2		
		Eastern Congo	789953	856014	214004	201123	94.0%	NA	NA	DHIS 2		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
16 Fee	MALARIA: Proportion of children 0-59 months who slept under an Insecticide treated net (ITN) the previous night	Outcome	UA	NA	NA	NA	NA	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	NA	NA	NA	NA	NA	NA	HHS		
		Katanga	UA	NA	NA	NA	NA	NA	NA	HHS		
		Eastern Congo	UA	NA	NA	NA	NA	NA	NA	HHS		
17 Fee Proxy	MALARIA: Number of insecticide-treated nets (ITN) distributed during antenatal and/or child immunization visits (PROXY)	Process	1163227	1258749	314687	473373	150.4%	NA	NA	DHIS 2	All provinces exceeded their target for this quarter. This was due to the availability of LLINs at the ZS level. In addition, the remainder of ITNs from mass distribution campaigns contributed to the availability of routine distribution at ANC and CPSs visits.	The Program will document the lessons learned from this success and use these strategies to maintain this positive performance.
		Kasaï	552961	598370	149593	254546	170.2%	NA	NA	DHIS 2		
		Katanga	217673	235547	58886	91898	156.1%	NA	NA	DHIS 2		
		Eastern Congo	392593	424832	106208	126929	119.5%	NA	NA	DHIS 2		
18 Fee	Improved satisfaction by clients/citizens with the services they receive: % of individuals reporting satisfaction with health center services	Outcome	N/A	NA	NA	NA	NA	N/A	N/A	PMR	We will begin collecting data for this indicator in Y3 with an SMS survey	We will begin collecting data for this indicator in Y3 with an SMS survey
		Kasaï	N/A	NA	NA	NA	NA	N/A	N/A	PMR		
		Katanga	N/A	NA	NA	NA	NA	N/A	N/A	PMR		
		Eastern Congo	N/A	NA	NA	NA	NA	N/A	N/A	PMR		
19 Fee	Number of Basic Emergency Obstetric and Neonatal Center (BEmONC) or Comprehensive Emergency Obstetric Center	Output	N/A	596	TBD	174	N/A	N/A	N/A	PMR	CMP, the #s in column L should be the overall targets for the fee indicator. I don't think we achieved anything for this indicator in Q2.	USAID IHP trained providers in BEmONC in Sud-Kivu and conducted post-training follow-up in Kasaï-Oriental. (RME team is
		Kasaï	N/A	250	TBD	39	N/A	N/A	N/A	PMR		
		Katanga	N/A	200	TBD	40	N/A	N/A	N/A	PMR		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
	(CEmONC) sites available in each province	Eastern Congo	N/A	146	TBD	95	N/A	N/A	N/A	PMR		confirming - keep red for now)
20 Fee	Documentation and publication of operational research in peer reviewed journal	Process	N/A	1	NA	NA	N/A	N/A	N/A	PMR	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	NA	NA	NA	N/A	N/A	N/A	PMR		
		Katanga	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
21 Fee	Conflict Sensitivity Analysis and Implementation Strategy	Process	N/A	1	NA	NA	N/A	N/A	N/A	PMR	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	NA	NA	NA	N/A	N/A	N/A	PMR		
		Katanga	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
22 Fee	Percent of targeted facilities with quality improvement action plans documented and being implemented	Outcome	N/A	100%	NA	NA	N/A	N/A	N/A	PMR	This indicator is reported annually. This activity will begin this year, so there is no baseline yet	N/A
		Kasaï	N/A	100%	NA	NA	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	NA	NA	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	NA	NA	N/A	N/A	N/A	PMR		
23 Fee	Capacity Development Approach	Output	N/A	1	NA	NA	N/A	N/A	N/A	PMR	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	NA	NA	NA	N/A	N/A	N/A	PMR		
		Katanga	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
24 Fee	Gender Analysis and Gender Implementation Strategy	Process	N/A	1	NA	NA	N/A	N/A	N/A	PMR	This target for this indicator has been achieved. The Gender Analysis and Implementation Strategy was submitted November 2, 2018, and approved by USAID on December 10, 2018.	N/A
		Kasaï	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
		Katanga	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	NA	NA	NA	N/A	N/A	N/A	PMR		
Result 1: Strengthened health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones												
1.1 Fee	Annual score derived from PICAL for USG-supported provincial health divisions	Output	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR		
1.2	Percent of annual Provincial action plans and budgets aligned with National action plans and budgets (expected contract result)	Outcome	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
1.3	Percentage of health zones with annual action plans and budgets that are aligned with provincial action plans and budgets (expected contract result)	Outcome	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
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	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
1.1.2	Percentage of targeted sub-national health level divisions that successfully implement 80% of resourced action plan activities (expected contract result)	Outcome	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
IR 1.2: Improved transparency and oversight in health service financing and administration at provincial, health zone, facility, and community levels												
1.2.1	Score for financial management sub-domains of the PICAL assessment for provincial health divisions (contract deliverable)	Outcome	N/A	2.84	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	2.76	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	3.75	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	2.50	N/A	N/A	N/A	N/A	N/A	PMR		
1.2.2	PICAL assessment accountability sub-domain score for provinces and health zones receiving USG assistance (contract deliverable)	Output	N/A	2.59	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	2.16	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	2.50	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	3.13	N/A	N/A	N/A	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
1.2.3	Percentage of DPS and Health Zones supported by the program that are audited with USAID IHP DRC technical and/or financial support (contract deliverable)	Output	N/A	100%	25%	16.8%	67.0%	30	179	PMR	All provinces underachieved relative to the target in Q2 for this indicator. This is primarily due to the period Jan-Mar corresponding to the first quarter of the Ministry of Health, during which the DPS and health zones launched their own annual operational plan activities. We anticipate stronger implementation in the remaining quarters of the year.	Work with the IPS in each province to schedule health zone audits.
		Kasaï	N/A	100%	25%	18.2%	72.7%	14	77	PMR		
		Katanga	N/A	100%	25%	10.5%	42.1%	6	57	PMR		
		Eastern Congo	N/A	100%	25%	22.2%	88.9%	10	45	PMR		
1.2.4	Number of tickets on the fraud and complaints hotline issue tracker (expected contract result)	Output	N/A	120	TBD	4026	N/A	N/A	N/A	PMR	This activity has not yet begun.	Finalize technical activity development with Viamo to implement this activity in Kasaï-Central and Sankuru
		Kasaï	N/A	120	TBD	4026	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
IR 1.3: Strengthened capacity of Community Service Organizations (CSOs) and community structures to provide health system oversight												
1.3.1	Percentage of active CSOs/CODESAs in health zones fully supported by the program, which receive financial support (contract deliverable)	Output	N/A	50%	50%	11.7%	23.3%	376	3227	PMR	USAID IHP provided technical and/or financial support to over 200 active CODESA in 25 ZS during Q2. The percentage of active CODESA remains low at less than 35% in each region.	Revitalize CODESA in all USAID IHP-supported provinces.
		Kasaï	N/A	50%	50%	9.8%	19.5%	130	1333	PMR		
		Katanga	N/A	50%	50%	9.2%	18.3%	89	971	PMR		
		Eastern Congo	N/A	50%	50%	17.0%	34.0%	157	923	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
1.3.2 Fee	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	50%	50%	11.5%	23.0%	23	200	PMR	During Q2, USAID IHP began implementing use of the community scorecard in Sud-Kivu, where the Program supported a relatively small percentage of active CSOs and CODESAs. Community scorecard implementation will be more widespread within Sud-Kivu as well as in the remaining 8 provinces in Q3.	Implement the community scorecard in CSOs/CODESAs in all USAID IHP-supported provinces.
		Kasaï	N/A	50%	50%	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	50%	50%	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	50%	50%	11.5%	23.0%	23	200	PMR		
1.3.3 (Standard CDCS	Number of community service organizations (CSOs)/Health Area Development Committees (CODESAs) supported by the program that are woman-led (contract deliverable)	Outcome¥	N/A	639	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	263	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	194	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	182	N/A	N/A	N/A	N/A	N/A	PMR		
IR 1.4: Improved effectiveness of stakeholder coordination at the provincial and health zone levels												
1.4.1	Percent of stakeholders who agree that their views are reflected in planning/policy processes	Output	N/A	TBD	N/A	N/A	N/A	NA	N/A	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	NA	N/A	HHS		
		Katanga	N/A	TBD	N/A	N/A	N/A	NA	N/A	HHS		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	NA	N/A	HHS		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
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	TBD	50%	40.2%	80%	115	286	PMR	The contrat unique serves as the major vehicle for reinforcing coalitions and networks to fulfill their mandates. In Q2, USAID IHP supported the signature of *contrats unique* in Kasaï Oriental and Haut-Katanga. USAID IHP supported the remaining 7 DPS to complete their *contrats unique* processes, with signatures expected in following quarters based on each provincial governor's protocol.	Complete the *contrat unique* signing in remaining USAID IHP-supported provinces.
		Kasaï	N/A	TBD	50%	36.4%	73%	4	11	PMR		
		Katanga	N/A	TBD	50%	40.0%	80%	2	5	PMR		
		Eastern Congo	N/A	TBD	50%	40.4%	81%	109	270	PMR		
1.4.3	Annual score of provincial level health divisions in PICAL sub-dimension 2.6 to assess for use of inclusive stakeholder feedback to inform decision-making and implementation (contract deliverable)	Output	N/A	1.11	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	0.96	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	1.25	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	1.25	N/A	N/A	N/A	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
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	N/A	1.40	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	1.40	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	1.20	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	1.60	N/A	N/A	N/A	N/A	N/A	PMR		
1.5.2	Percentage of USG supported provinces and health zones with MAPEPI DHIS2 reporting rates > 95% (expected contract result)	Output	16.2%	22.2%	22.2%	9.5%	42.8%	17	179	DHIS 2	Only 42.8% of target provinces and ZS reported >95% of the epidemiological survey data during the quarter. While greater than half of the ZS in Kasaï and Eastern Congo regions met or exceeded the reporting rate target, on-time reporting relative to the target was extremely low at 16.1% across the Katanga provinces. During the period only Lomami and Lualaba met or exceeded the target, however 0% of Haut-Lomami and Tanganyika ZS met the target reporting rate.	Encourage on-time reporting of ECZS epidemiological records. Provide technical and financial support to the MAPEPI surveillance meetings, in particular, those related to COVID-19. Support preventive maintenance missions of VSAT antennas and computer kits
		Kasaï	18.2%	24.2%	24.2%	13.0%	53.7%	10	77	DHIS 2		
		Katanga	15.8%	21.8%	21.8%	3.5%	16.1%	2	57	DHIS 2		
		Eastern Congo	13.3%	19.3%	19.3%	11.1%	57.6%	5	45	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
1.5.3	Percentage of targeted DPS, ECZS and FOSA teams that use real-time data dashboards in routine management tasks (contract deliverable)	Output	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR	This activity has not yet begun.	N/A
		Kasaï	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	100%	N/A	N/A	N/A	N/A	N/A	PMR		
IR 1.6: Improved management and motivation of human resources for health												
1.6.1	Average score of provinces and health zones assessed for HR management monitoring systems (contract deliverable)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR	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	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
1.6.2	Number of DPS/ECZS health workers trained in Human Resources Management using iHRIS (expected contract result)	Output	N/A	188	43%	0	0%	N/A	N/A	PMR	In Q2, workshops for the Provincial Plan for the Development of Human Resources for Health, which includes iHRIS training, only occurred in Kasaï Central. Kasaï Oriental completed the activity in Q1 and other provinces had not yet started this activity.	Provide technical and financial support for the HRH Development Plan Development Workshop, including iHRIS training, in remaining 7 provinces.
		Kasaï	N/A	81	43	0	0%	N/A	N/A	PMR		
		Katanga	N/A	60	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	47	N/A	N/A	N/A	N/A	N/A	PMR		
1.6.3	Number of ECDPs who have been coached according to Ministry of Health guidelines for Human Resources Management	Output	N/A	9	2	2	100%	N/A	N/A	PMR	The Program achieved the quarterly target for this activity.	Integrate activities in the Katanga region.
		Kasaï	N/A	4	1	1	N/A	N/A	N/A	PMR		
		Katanga	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
	(expected contract result)	Eastern Congo	N/A	2	1	1	N/A	N/A	N/A	PMR		
1.6.4	Number of providers who have benefited from using the Pathways to Change tool to improve their attitudes and behaviors (expected contract result)	Output	N/A	TBD	130	130	100%	N/A	N/A	PMR	The Program trained managers of all 9 DPS as well as ZS on the Pathways to change tool, achieving overall targets.	Continue supporting training and use of Pathways to Change tool.
		Kasaï	N/A	TBD	95	95	100%	N/A	N/A	PMR		
		Katanga	N/A	TBD	20	20	100%	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	15	15	100%	N/A	N/A	PMR		
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%	59.9%	59.9%	55.8%	106.8%	3835	6867	DHIS 2	Overall the target for this indicator was exceeded. All regions exceeded their target except for Eastern Congo.	The scale-up of mobile money will continue to reduce stock-outs and contribute to improved outcomes in remote areas (particularly in Eastern Congo).
		Kasaï	77.9%	66.1%	66.1%	65.4%	101.0%	1810	2767	DHIS 2		
		Katanga	61.4%	49.6%	49.6%	37.8%	123.7%	1005	2659	DHIS 2		
		Eastern Congo	76.0%	64.2%	64.2%	70.8%	89.7%	1020	1441	DHIS 2		
1.7.2	Percent of USG supported health zones with LMIS reporting rates > 95% (expected contract result)	Output	32.4%	38.4%	38.4%	40.2%	104.7%	72	179	DHIS 2	The rate of reporting in the LMIS is good (104.7%). Only the region of Katanga didn't reach their target.	Support coding of LMIS in the DHIS2 and do a post-training follow-up in Info Med.
		Kasaï	42.9%	48.9%	48.9%	55.8%	114.2%	43	77	DHIS 2		
		Katanga	31.6%	37.6%	37.6%	21.1%	56.0%	12	57	DHIS 2		
		Eastern Congo	15.6%	21.6%	21.6%	37.8%	174.9%	17	45	DHIS 2		
1.7.3	Percent of supported sub-national level health divisions with a documented and budgeted distribution plan (expected contract result)	Output	N/A	100%	44%	56.4%	127.8%	101	179	PMR	The overall target for this indicator was exceeded. Eastern Congo fell short slightly but still reached an achievement rate of 91.3%.	Provide follow-up to lower performing provinces to ensure they have the support needed to develop their plan.
		Kasaï	N/A	100%	53%	66.2%	124.4%	51	77	PMR		
		Katanga	N/A	100%	26%	50.9%	193.3%	29	57	PMR		
		Eastern Congo	N/A	100%	51%	46.7%	91.3%	21	45	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
1.7.4	Percentage of Health Zones with improved conditions of medicines storage according the planned renovation (expected contract result)	Output	N/A	TBD	N/A	N/A	N/A	N/A	179	EdL	This indicator is reported in Y1 and Y5.	This data is collected with the service provider mapping survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	77	EdL		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	57	EdL		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	45	EdL		
1.7.5	Average stockout rate of contraceptives at service delivery points by family planning method	Output	N/A	23.1%	25%	40.5%	38.7%	1471	3628	DHIS 2	The overall target for this indicator was exceeded overall.	The scale-up of mobile money will continue to reduce stock-outs and contribute to improved outcomes in remote areas (particularly in Eastern Congo).
		Kasaï	N/A	23.5%	26%	49.4%	6.6%	765	1550	DHIS 2		
		Katanga	N/A	19.2%	21%	35.3%	33.5%	397	1126	DHIS 2		
		Eastern Congo	N/A	28.3%	30%	32.5%	92.9%	309	952	DHIS 2		
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	18	N/A	N/A	N/A	N/A	N/A	PMR		
		Kasaï	N/A	8	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	6	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	4	N/A	N/A	N/A	N/A	N/A	PMR		
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	1391964	347991.1	274988.0	79.0%	N/A	N/A	DHIS 2	USAID IHP did not achieve the target for this indicator. Lomami was the only province to exceed its target. Haut-Katanga and Lualaba performed well. Performance in the other provinces was weak.	Continue providing support to the CBDs through monthly monitoring meetings, supportive supervision and post-training follow-up, provision of kits and tools and FP commodities based on need. Continue to
		Kasaï	383,777	460317	115079.3	94649.0	82.2%	N/A	N/A	DHIS 2		
		Katanga	329,122	491897	122974.2	107221.0	87.2%	N/A	N/A	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Eastern Congo	287,511	439750	109937.6	73118.0	66.5%	N/A	N/A	DHIS 2		integrate FP activities in all ZS supported by the Program.
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	1294879	323719.7	248701	76.8%	N/A	N/A	DHIS 2	USAID IHP did not achieve the target for this indicator. Lomami was the only province to exceed its target. Haut-Katanga and Lualaba performed well. Performance in the other provinces was weak.	Continue providing support to the CBDs through monthly monitoring meetings, supportive supervision and post-training follow-up, provision of kits and tools and FP commodities based on need. Continue to integrate FP activities in all ZS supported by the Program.
		Kasaï	360,468	425963	106490.7	85114	79.9%	N/A	N/A	DHIS 2		
		Katanga	303,164	450357	112589.2	97084	86.2%	N/A	N/A	DHIS 2		
		Eastern Congo	274,103	418559	104639.7	66503	63.6%	N/A	N/A	DHIS 2		
2.3	FP: Number of counseling visits for FP/ RH as result of USG support	Output	192,080	1125282	281320	26700	9.5%	N/A	N/A	DHIS 2	Performance for this indicator was very weak in Q2 (completion rate of 9.5%).	Reinvigorate the complementary module on FP/RH counseling in all the provinces.
		Kasaï	150,200	488446	122111	17583	14.4%	N/A	N/A	DHIS 2		
		Katanga	26,796	361935	90484	5253	5.8%	N/A	N/A	DHIS 2		
		Eastern Congo	15,084	274901	68725	3864	5.6%	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%	61.4%	76.7%	266878	434720	DHIS 2	The shortage of SP stocks had an impact on this indicator. Tanganyika reported the total rupture during Q2, Sankuru experienced shortfalls in several ZS, Sud-Kivu reported problems in a few difficult-to-reach AS and Kasaï Central had shortages in January and early February but received a supply before the	The Program is working with its partners to prevent stock-outs of this commodity. New trainers have been trained to help increase the rate of trainings.
		Kasaï	70%	80%	80%	56.7%	70.9%	104138	183556	DHIS 2		
		Katanga	64%	80%	80%	68.0%	85.0%	93255	137068	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Eastern Congo	62%	80%	80%	60.9%	76.1%	69485	114096	DHIS 2	end of quarter 2. The rate of training of providers on IPT is also low.	
2.5 (Standard: CDCS)	Percentage of population who use selected facilities	Outcome¥	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		
2.6	Percentage of Health centers supported by the USG implementing interventions to support the minimum package of activities (contract deliverable)	Outcome¥	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL	This indicator is reported in Y1 and Y5.	This data is collected with the service provider mapping survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
2.7	Percentage of hospitals supported by the USG implementing interventions to support the complementary package of activities. (expected contract result)	Outcome	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL	This indicator is reported in Y1 and Y5.	This data is collected with the service provider mapping survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EdL		
2.8	Percentage of supported health facilities using MOH QoC tool (contract deliverable)	Output	N/A	100%	100%	22.7%	22.7%	51	225	PMR	USAID IHP performed poorly against the target in Q2. None of the regions reached their target.	Continue to support facilities in using the MOH QoC tool in Q3.
		Kasaï	N/A	100%	100%	19.3%	19.3%	17	88	PMR		
		Katanga	N/A	100%	100%	45.3%	45.3%	34	75	PMR		
		Eastern Congo	N/A	100%	100%	0.0%	0.0%	0	62	PMR		
2.9 (Standard: CDCS)	Percentage of population reporting improved availability of selected services	Outcome¥	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	HHS		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
IR 2.1: Increased availability of quality, integrated facility-based health services												
2.1.1 (Standard)	FP: Percent of USG-assisted service delivery sites providing FP counseling and/or services	Output	N/A	75.3%	75.3%	61.9%	82.2%	4294	6942	DHIS 2	Percentage of USG assisted service delivery sites providing FP counseling and / or services still low (61.9%).	Integrate this activity in all health facilities
		Kasaï	N/A	70.2%	70.2%	58.9%	83.9%	1647	2795	DHIS 2		
		Katanga	N/A	74.8%	74.8%	58.0%	77.5%	1568	2705	DHIS 2		
		Eastern Congo	N/A	85.7%	85.7%	74.8%	87.3%	1079	1442	DHIS 2		
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%	100.0%	100.0%	434720	434937	DHIS 2	USAID IHP reached the target of 100.0% for the quarter, although Katanga fell short. The provinces of Haut-Katanga, Haut-Lomami and Tanganyika perform poorly.	Reinforce ANC activities (mini-campaigns encouraging pregnant women to use ANC visits), promotion of ANC and delivery in health facilities amongst RECOs and community leaders, in the provinces that fell short of their target.
		Kasaï	96.3	100%	100%	104.2%	104.2%	183556	176115	DHIS 2		
		Katanga	91.3	100%	100%	94.5%	94.5%	137068	145031	DHIS 2		
		Eastern Congo	100.1	100%	100%	100.3%	100.3%	114096	113791	DHIS 2		
2.1.3	MNCH: Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Outcome¥	75.4	90%	90%	82.9%	92.1%	360346	434937	DHIS 2	USAID IHP did not reach the target for assisted delivery in Q2. The Katanga and East regions showed average performance. Kasaï Central, Sankuru and Lualaba reached the target. Tanganyika had the weakest performance of 66.0%.	Continue implementing community mobilization activities as part of the VIVA awareness sessions; conduct post-training follow-up of providers on EmONC and clinical mentoring, particularly in Tanganyika.
		Kasaï	82.6	90%	90%	89.8%	99.8%	158149	176115	DHIS 2		
		Katanga	69.6	90%	90%	79.8%	88.7%	115742	145031	DHIS 2		
		Eastern Congo	70.7	90%	90%	76.0%	84.4%	86455	113791	DHIS 2		
2.1.4 (PPR)	MNCH: Number of women giving birth who received uterotonics in the third stage of labor	Output	140458	249611	62403	43592	69.9%	NA	NA	DHIS 2	The Program did not achieve its target in Q2 for this indicator. Only Haut-Lomami	Reinforce post-training follow-up on the complementary module in all provinces and
		Kasaï	19244	34322	8580	7733	90.1%	NA	NA	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
	(OR immediately after birth) through USG-supported programs	Katanga	37395	69386	17347	13212	76.2%	NA	NA	DHIS 2	province reached the target. Haut-Katanga, Lomami and Sud-Kivu had the weakest performance <70%.	particularly in Haut-Katanga, Lomami and Sud-Kivu.
		Eastern Congo	83819	145903	36476	22647	62.1%	NA	NA	DHIS 2		
2.1.5 (Standard/PPR)	MNCH: Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Output	33509	36616	9154	7746	84.6%	NA	NA	DHIS 2	The Program did not achieve the target this quarter (84.6% completion rate). Eastern region had the weakest performance of < 80%.	Reinforce Helping Babies Breathe activities (provider coaching, provision of materials for neonatal resuscitation) particularly in the provinces that the weakest performance (Kasaï-Central and Sud-Kivu)
		Kasaï	9818	10728	2682	2214	82.6%	NA	NA	DHIS 2		
		Katanga	14450	15790	3948	3535	89.5%	NA	NA	DHIS 2		
		Eastern Congo	9241	10098	2524	1997	79.1%	NA	NA	DHIS 2		
2.1.6 PPR	MNCH: Number of postpartum/newborn visits within three days of birth in USG-supported programs	Output	1121703	1390687	347670	358971	103.3%	NA	NA	DHIS 2	The Program achieved its target in Q2 with a completion rate of 103.3%. All provinces reached their target except for Haut-Lomami et Lualaba.	Reinforce activities in support of postpartum/newborn visits such as provider capacity building in EmONC, post-training follow-up and clinical mentoring, especially in Haut-Lomami et Lualaba.
		Kasaï	525049	605665	151416	159217	105.2%	NA	NA	DHIS 2		
		Katanga	336949	467624	116905	116705	99.8%	NA	NA	DHIS 2		
		Eastern Congo	259705	317398	79349	83049	104.7%	NA	NA	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%	94.1%	94.1%	346360	367933	DHIS 2	The Program did not achieve the target in Q2. None of the provinces achieved their target.	Focus on follow-up for providers and ensure availability of inputs/drugs for essential newborn care.
		Kasaï	91.8%	100%	100%	94.4%	94.4%	151933	160971	DHIS 2		
		Katanga	89.7%	100%	100%	93.0%	93.0%	111970	120351	DHIS 2		
		Eastern Congo	93.2%	100%	100%	95.2%	95.2%	82457	86611	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.8 (PPR)	MNCH: Number of newborns receiving antibiotic treatment for infection from trained health workers through USG- supported programs	Output	212375	178031	44508	40720	91.5%	NA	NA	DHIS 2	The Program did not reach the target in Q2. We observed good performance in the provinces of Kasaï Central, Haut-Lomami and Sud-Kivu.	Reinforce activities in support of essential newborn care in all provinces with weak performance.
		Kasaï	98016	72925	18232	15624	85.7%	NA	NA	DHIS 2		
		Katanga	89734	84352	21087	20073	95.2%	NA	NA	DHIS 2		
		Eastern Congo	24625	20754	5189	5023	96.8%	NA	NA	DHIS 2		
2.1.9 PPR	MNCH: Drop-out rate in DTP-HepB-Hib3 among children less than 12 months of age	Output	5%	4.0%	4.0%	4.8%	80.3%	18103	377953	DHIS 2	The Program did not reach its target for Q2. Good performances was observed in the provinces of Kasaï Oriental, Kasaï Central and Sud-Kivu.	Reinforce EPI activities in the provinces with the weakest performance.
		Kasaï	5%	4.0%	4.0%	2.9%	127.5%	4479	154394	DHIS 2		
		Katanga	7%	5.0%	5.0%	6.4%	71.2%	7733	120124	DHIS 2		
		Eastern Congo	5%	4.0%	4.0%	5.7%	57.6%	5891	103435	DHIS 2		
2.1.10 (Standard /PPR)	NUTRITION: Number of individuals receiving nutrition- related professional training through USG supported nutrition programs	Outcome	N/A	5391	1909	462	24.2%	N/A	N/A	PMR	Overall, performance was low at 24.2% for this indicator with most provinces training far less than the targeted number of providers and Lomami not conducting any such training in Q2. That said, Sankuru far exceeded the target with 160 providers (170.2%) trained in Q2.	Support training in provinces that underperformed in Q2, including supporting provinces with the availability of central-level trainers.
		Kasaï	N/A	2313	1016	201	19.8%	N/A	N/A	PMR		
		Katanga	N/A	2113	433	138	31.9%	N/A	N/A	PMR		
		Eastern Congo	N/A	965	460	123	26.7%	N/A	N/A	PMR		
2.1.11 (Standard /PPR)	NUTRITION: Number of children under-five (0-59 months) reached by USG-supported nutrition programs	Output	520956	2847748	NA	NA	NA	N/A	NA	DHIS 2	This indicator is reported annually	N/A
		Kasaï	175472	1495892	NA	NA	NA	N/A	NA	DHIS 2		
		Katanga	133310	569248	NA	NA	NA	N/A	NA	DHIS 2		
		Eastern Congo	212174	782608	NA	NA	NA	N/A	NA	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.12 (Standard)	NUTRITION: Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs	Outcome	2045125	827377	NA	NA	NA	N/A	NA	DHIS 2	This indicator is reported annually	N/A
		Kasaï	911389	422961	NA	NA	NA	N/A	NA	DHIS 2		
		Katanga	435344	182809	NA	NA	NA	N/A	NA	DHIS 2		
		Eastern Congo	698392	221607	NA	NA	NA	N/A	NA	DHIS 2		
2.1.13 (Standard /PPR)	NUTRITION: Number of pregnant women reached with nutrition interventions through USG-supported programs	Output	1432281	1658102	414525	434720	104.9%	N/A	N/A	DHIS 2	Overall, the target was exceeded for this indicator across all provinces and regionally. All but Haut-Lomami reached their provincial-level target.	Organize an RDQA
		Kasaï	603904	688867	172217	183556	106.6%	N/A	N/A	DHIS 2		
		Katanga	432196	534116	133529	137068	102.7%	N/A	N/A	DHIS 2		
		Eastern Congo	396181	435119	108779	114096	104.9%	N/A	N/A	DHIS 2		
2.1.14	MALARIA: Number of health workers trained in IPTp with USG funds	Output	N/A	1294	954	1122	117.6%	N/A	N/A	PMR	Overall the target for this indicator was exceeded however, several provinces failed to reach their individual targets. Lomami, Haut-Lomami and Tanganyika were the provinces with the lowest performance which was mostly due to the lack of availability of trainers. The provinces that performed well did mostly due to the fact that trainers were available.	The Program trained 14 provincial trainers in Lomami to increase the number of trainers available. The Program plans to continue to do this across all 9 provinces.
		Kasaï	N/A	436	390	460	117.9%	N/A	N/A	PMR		
		Katanga	N/A	420	226	220	97.3%	N/A	N/A	PMR		
		Eastern Congo	N/A	438	338	442	130.8%	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.15	MALARIA: Number of health workers trained in case management with ACTs with USG funds	Output	N/A	2161	1167	658	56.4%	N/A	N/A	PMR	This training didn't take place in Haut-Lomami because all trainers were mobilized for the ITN mass distribution campaign. Lomami and Tanganyika had faced challenges related to availability of trainers as well.	The Program is planning to train additional provincial level trainers to avoid the problem of a lack of trainer availability.
		Kasaï	N/A	774	448	366	81.7%	N/A	N/A	PMR		
		Katanga	N/A	640	430	175	40.7%	N/A	N/A	PMR		
		Eastern Congo	N/A	747	289	117	0.0%	N/A	N/A	PMR		
2.1.16	MALARIA: Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnosis Tests (RDT) or microscopy) with USG funds	Output	N/A	2161	1167	607	52.0%	N/A	N/A	PMR	This training didn't take place in Haut-Lomami because all trainers were mobilized for the ITN mass distribution campaign. Lomami and Tanganyika had faced challenges related to availability of trainers as well.	The Program is planning to train additional provincial level trainers to avoid the problem of a lack of trainer availability.
		Kasaï	N/A	774	448	401	89.5%	N/A	N/A	PMR		
		Katanga	N/A	640	430	175	40.7%	N/A	N/A	PMR		
		Eastern Congo	N/A	747	289	31	10.7%	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.17	TB: TB notification rate through USG-supported programs	Output	126	150	150	143.0	95.4%	13044	9119376	DHIS 2	Lualaba, Kasaï Oriental, Haut-Lomami, Tanganyika, and Lomami recorded a notification rate greater than or equal to the target. This is due to the increase in the detection of TB cases thanks to the active TB case detection activities among populations at risk. Underperformance in Sud-Kivu, can be explained by the difficult geographical accessibility of 13 of the 34 health zones, which limits the regular supply of laboratory reagents (alcohol, fuscine, etc.) necessary for diagnosing TB; and the reduced mobility of community agents for active TB screening in these health zones, due to insecurity.	Work with CPLTs to expand the implementation of innovative active TB case-finding strategies and involve RECO in the safe transport of sputum samples, and laboratory materials.
		Kasaï	126	150	150	152.5	101.7%	6276	4114269	DHIS 2		
		Katanga	156	150	150	171.3	114.2%	4466	2606823	DHIS 2		
		Eastern Congo	94	150	150	96.0	64.0%	2302	2398284	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.18 PPR	TB: Number of patients diagnosed with TB that have initiated first-line treatment. (PPR)	Output	61974	TBD	22876	22788	99.6%	N/A	N/A	DHIS 2	Out of a cohort of 22,876 TB patients registered 2, 22,788 (99.6%) were put on first-line treatment. This reflects the improvement in the supply of first-line drugs to the CSDT. Five provinces treated 100% of the TB patients detected; while Tanganyika province, despite the increase from previous quarters, performed the worst. This situation is related to stock-outs of first-line TB drugs in 28 CSDTs located in hard-to-reach areas that face insecurity due to the presence of armed groups.	To improve the availability of anti-tuberculosis drugs USAID IHP, through i+ Solutions, plans to use reliable community agents to transport anti-tuberculosis drugs.
		Kasaï	28508	TBD	11731	11704	99.8%	N/A	N/A	DHIS 2		
		Katanga	21823	TBD	7302	7282	99.7%	N/A	N/A	DHIS 2		
		Eastern Congo	11643	TBD	3843	3802	98.9%	N/A	N/A	DHIS 2		
2.1.19	TB: Therapeutic success rate through USG- supported programs	Output	64.7	95	95	94.2	99.1%	11797	12529	DHIS 2	All three regions performed well against the WHO performance threshold of a 90% or higher success rate. The availability of first-line anti-TB drugs in the CSDTs contributed to this overall performance.	The Program will continue to work with partners to ensure availability of first-line treatment.
		Kasaï	55.5	95	95	96.3	101.3%	5140	5340	DHIS 2		
		Katanga	76.7	95	95	93.6	98.5%	4662	4980	DHIS 2		
		Eastern Congo	63.7	95	95	90.3	95.1%	1995	2209	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.20 (Standard)	TB: HL.2.4-1 Number of multi-drug resistant (MDR) TB cases detected	Outcome	405	720	180	117	65.0%	N/A	N/A	DHIS 2	This underperformance can be explained, by the low coverage of the CPLTs with GeneXpert sites and by the dysfunction of the transport circuits for sputum samples.	The Program work with community-based organizations to facilitate the payment of transportation costs for samples.
		Kasaï	190	288	72	57	79.2%	N/A	N/A	DHIS 2		
		Katanga	158	308	77	48	62.3%	N/A	N/A	DHIS 2		
		Eastern Congo	57	124	31	12	38.7%	N/A	N/A	DHIS 2		
2.1.21 PPR	TB: Number of multi-drug resistant TB cases that have initiated second line treatment	Outcome¥	237	TBD	117	95	81.2%	N/A	N/A	DHIS 2	This performance is explained by the reduction in the time to start treatment for DR-TB patients, particularly in the two "hot spot" provinces. The rapid completion of pre-treatment clinical and biological assessments of patients and the pre-positioning of second-line anti-tuberculosis treatments at the level of the CPLTs largely explain the reduction in the time taken to start treatment.	Rapid transport of courses of treatment from the CPLT to the treatment sites for DR-TB patients will further reduce this delay. USAID IHP, through i+ Solutions, in collaboration with CPLT and other partners supporting the supply chain, including Chemonics, is committed to this.
		Kasaï	130	TBD	57	56	98.2%	N/A	N/A	DHIS 2		
		Katanga	77	TBD	48	31	64.6%	N/A	N/A	DHIS 2		
		Eastern Congo	30	TBD	12	8	66.7%	N/A	N/A	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.22	TB: Therapeutic success rate for RR-/MDR-TB through USG- supported programs	Output	TBD	75	75	74.1	98.8%	60	81	DHIS 2	All three regions performed well against the WHO performance threshold of a 90% or higher success rate. The availability of first-line anti-TB drugs in the SDAs and CSDTs contributed to this overall performance.	By contracting with TB CBOs, USAID IHP will provide important support in improving the follow-up of MDR-TB patients.
		Kasaï	TBD	75	75	86.4	115.2%	38	44	DHIS 2		
		Katanga	TBD	75	75	66.7	88.9%	16	24	DHIS 2		
		Eastern Congo	TBD	75	75	46.2	61.5%	6	13	DHIS 2		
2.1.23	TB: Percentage of under five children who received (or are receiving) INH prophylaxis through USG- supported programs	Output	5717	TBD	100%	90.4%	90.4%	6523	7217	DHIS 2	The positive performance reflects the improvement in the supply of first-line anti-tuberculosis drugs to the CSDT. Tanganyika province, despite the increase from PY3Q1 performed the worst. This situation in Tanganyika is related to stock-outs of first-line TB drugs in 28 CSDTs located in hard-to-reach areas that face insecurity due to the presence of armed groups.	To improve the availability of anti-tuberculosis drugs in the USAID IHP, through i+ Solutions, plans to use reliable community agents to transport anti-tuberculosis drugs.
		Kasaï	2713	TBD	100%	97.6%	97.6%	3510	3598	DHIS 2		
		Katanga	1784	TBD	100%	84.6%	84.6%	2169	2564	DHIS 2		
		Eastern Congo	1220	TBD	100%	80.0%	80.0%	844	1055	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.24	TB: Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG- supported programs	Output	54	100%	100%	84.5%	84.5%	7409	8764	DHIS 2	Improved collaboration between PNLT and PNLS favored by the regular holding of quarterly "TB-HIV Task Force" meetings and the extension of the "One stop shop" strategy of integrating TB-HIV aspects into the health care structures has led to a positive trend for this indicator overall, however Tanganyika and Haut-Lomami recorded the lowest percentages of 64% and 68%, respectively.	The Program will work to strengthen of the collaboration framework between the PNLT and the PNLS, as well as the extension of the "One Stop Shop" strategy in the other health facilities at the operational level.
		Kasaï	48	100%	100%	90.5%	90.5%	1014	1120	DHIS 2		
		Katanga	59	100%	100%	83.9%	83.9%	6031	7191	DHIS 2		
		Eastern Congo	44	100%	100%	80.4%	80.4%	364	453	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%	78.9%	78.9%	9235	11712	DHIS 2	Improved collaboration between PNLT and PNLS favored by the regular holding of quarterly "TB-HIV Task Force" meetings and the extension of the "One stop shop" strategy of integrating TB-HIV aspects into the health care structures has led to a positive trend for this indicator	The Program will work to strengthen of the collaboration framework between the PNLT and the PNLS, as well as the extension of the "One Stop Shop" strategy in the other health facilities at the operational level.
		Kasaï	55.5	TBD	100%	35.3%	35.3%	1204	3411	DHIS 2		
		Katanga	76.7	TBD	100%	98.7%	98.7%	7518	7615	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Eastern Congo	63.7	TBD	100%	74.8%	74.8%	513	686	DHIS 2	overall, however Tanganyika and Haut-Lomami recorded the lowest percentages of 64% and 68%, respectively.	
2.1.26 PPR	TB: Number of individuals trained in any component of the World Health Organization Stop TB strategy with USG funding.	Output	N/A	3691	1563	147	9.4%	N/A	N/A	PMR	Compared to the quarterly target of 1,563 people to receive training on one of the components of the WHO Stop TB Strategy, 908 providers were trained, for an achievement rate of 58.09%. The Kasaï region achieved the best rate with 88.49%, while that of Katanga was less efficient (33.38%). The context of the COVID-19 pandemic explains, in large part, this overall underperformance.	During the next quarter, the pools of trainers already set up in each province will continue training sessions for providers in the ZS while ensuring compliance with COVID-19 prevention measures.
		Kasaï	N/A	1606	556	82	14.7%	N/A	N/A	PMR		
		Katanga	N/A	1343	773	27	3.5%	N/A	N/A	PMR		
		Eastern Congo	N/A	742	234	38	16.2%	N/A	N/A	PMR		
2.1.27 (PPR)	GBV: Number of women treated for gender-based violence. PPR.	Outcome	8318	6932	1733	5427	313.2%	N/A	N/A	DHIS 2	The Program exceeded the target this quarter at a completion rate of 213%, although Kasaï Oriental and Lualaba did not achieve their target.	Revisit the targets for this indicator.
		Kasaï	2056	1714	428	2661	621.7%	N/A	N/A	DHIS 2		
		Katanga	599	499	125	215	172.0%	N/A	N/A	DHIS 2		
		Eastern Congo	5663	4719	1180	2551	216.2%	N/A	N/A	DHIS 2		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.1.28	GBV: Number of surgical fistula repairs provided with USG-assistance	Output	N/A	120	30	N/A	0%	N/A	N/A	PMR	No activities implemented in Q2.	The Program is working on MOUs with EngenderHealth and Jhpiego to collaborate on related activities next quarter.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	120	30	N/A	0%	N/A	N/A	PMR		
2.1.29	GBV: Number of surgical fistula repairs provided with USG-assistance that remained closed after discharge	Output	N/A	120	N/A	N/A	N/A	N/A	N/A	PMR	No activities implemented in Q2.	The Program is working on MOUs with EngenderHealth and Jhpiego to collaborate on related activities next quarter.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	120	N/A	N/A	N/A	N/A	N/A	PMR		
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	1752	638	644	100.9%	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	712	400	411	102.8%	N/A	N/A	DHIS2 (MC)		
		Katanga	N/A	640	38	38	100.0%	N/A	N/A	DHIS2 (MC)		
		Eastern Congo	N/A	400	200	195	97.5%	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	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		
		Katanga	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.2.3	Percent of citizens reporting improvement and equity in service delivery of local level institutions with USG assistance (contract deliverable)	Impact	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		
		Katanga	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	NA	NA	HHS		
2.2.4	Number of Integrated Community Case Management (iCCM) sites in USG-supported communities (expected contract result)	Output	N/A	2273	2273	2112	92.9%	N/A	N/A	DHIS 2	USAID IHP achieved 92.9% of the target. Kasaï and katanga exceeded targets but Eastern fell short.	Integrate activities at iCCM sites in the provinces with the weakest performance.
		Kasaï	N/A	878	878	1056	120.3%	N/A	N/A	DHIS 2		
		Katanga	N/A	371	371	467	125.9%	N/A	N/A	DHIS 2		
		Eastern Congo	N/A	1024	1024	589	57.5%	N/A	N/A	DHIS 2		
2.2.5	Proportion of supervisory visits performed during the quarter to RECO	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	DHIS 2	This indicator is reported annually.	N/A
		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		
		Eastern 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 RECO and CBDs (contract deliverable)	Output	61034	65405	16351	17811	108.9%	N/A	N/A	DHIS 2	The Program exceed this target with a completion rate of 108.9%, however the Eastern region had a weak performance of 53.9.	Reinforce referrals to health centers especially in Tanganyika.
		Kasaï	33073	35441	8860	12482	140.9%	N/A	N/A	DHIS 2		
		Katanga	8286	8880	2220	2487	112.0%	N/A	N/A	DHIS 2		
		Eastern Congo	19675	21084	5271	2842	53.9%	N/A	N/A	DHIS 2		
2.3.2	Number of individuals referred by RECO/CBDs that were received by supported health facilities (completed referrals) (expected contract result)	Output	350457	537328	134332	158370	117.9%	N/A	N/A	DHIS 2	The Program exceeded the target with a completion rate of 117.9%, however the provinces of Lomami et Haut-Lomami did not achieve the target.	Reinforce referral activities especially in Haut-Lomami and Lomami.
		Kasaï	241407	334429	83608	100904	120.7%	N/A	N/A	DHIS 2		
		Katanga	44385	109016	27253	26568	97.5%	N/A	N/A	DHIS 2		
		Eastern Congo	64665	93883	23471	30898	131.6%	N/A	N/A	DHIS 2		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.3.3	Number of women transported for facility delivery (contract deliverable)	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)		
		Eastern Congo	N/A	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	TBD	N/A	N/A	N/A	N/A	N/A	PMR	This activity has not yet begun.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
2.4.2	Number of supported facilities offering a package of youth-friendly family planning services (contract deliverable)	Output	N/A	N/A	N/A	N/A	0%	N/A	N/A	PMR	USAID IHP only conducted training of peer educators and providers in Q2.	Next quarter we will supply health centers with FP commodities and other inputs and create a youth corner in health facilities for youth-friendly SBC info on FP.
		Kasaï	N/A	N/A	N/A	N/A	0%	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	0%	N/A	N/A	PMR		
		Eastern Congo	N/A	N/A	N/A	N/A	0%	N/A	N/A	PMR		
2.4.3	Number of supported facilities offering a package of comprehensive SGBV services (contract deliverable)	Output	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR	USAID IHP conducted provider training on medical and psychosocial care for survivors of SGBV.	Next quarter we will provide health facilities with data collection tools and organize post-training follow-up for managers.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PMR		
IR 2.5: Increased availability of innovative financing approaches												
2.5.1	Number of innovative financing tools piloted (contract deliverable)	Output	N/A	4	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	1	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	2	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	1	N/A	N/A	N/A	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
IR 2.6: Improved basic facility infrastructure and equipment to ensure quality services												
2.6.1 (Fee, CDCS)	Number of targeted health care facilities receiving infrastructure and/or equipment support	Outcome	N/A	300	N/A	N/A	N/A	N/A	N/A	PMR	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	125	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	100	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	75	N/A	N/A	N/A	N/A	N/A	PMR		
2.6.2 (Standard /PPR)	HL.8.1-1 Number of people gaining access to basic drinking water services as a result of USG assistance	Outcome	N/A	7500	N/A	N/A	N/A	N/A	N/A	PMR	We did not conduct any corresponding activities during Q2.	N/A
		Kasaï	N/A	2500	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	5000	N/A	N/A	N/A	N/A	N/A	PMR		
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	1000	1000	N/A	N/A	N/A	N/A	PMR	We did not conduct any corresponding activities during Q2.	N/A
		Kasaï	N/A	TBD	TBD	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	TBD	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	TBD	N/A	N/A	N/A	N/A	PMR		
2.6.4 (Standard /PPR)	WASH: HL.8.2-4 Number of basic sanitation facilities provided in institutional settings as a result of USG assistance	Outcome	N/A	288	N/A	N/A	N/A	N/A	N/A	PMR	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	228	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	0	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	60	N/A	N/A	N/A	N/A	N/A	PMR		
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	8	N/A	N/A	N/A	N/A	N/A	PMR	This activity is implemented according to the needs of the MOH.	We will work to increase demand for knowledge sharing workshops.
		Kasaï	N/A	4	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	3	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	1	N/A	N/A	N/A	N/A	N/A	PMR		
2.7.2	Number of strategies / policies that have been updated from good practices and lessons learned	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR	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	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
2.7.3	Number of success stories developed	Output	N/A	9	2	2	100.0%	N/A	N/A	PMR	N/A	N/A
		Kasaï	N/A	4	1	1	100.0%	N/A	N/A	PMR		
		Katanga	N/A	3	NA	NA	NA	N/A	N/A	PMR		
		Eastern Congo	N/A	2	1	1	100.0%	N/A	N/A	PMR		
Result 3: Increased adoption of healthy behaviors, including use of health services, in target health zones												
3.1	Percentage of USG-supported health zones that demonstrate improvement in key accelerator behavior indicators	Outcome	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
		Katanga	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
3.2	Percentage of children under age 2 living with the mother who are exclusively breastfed, age 0-5 months	Outcomeβ	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
		Katanga	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	NA	NA	HHS		
IR 3.1: Increased practice of priority healthy behaviors at the individual, household, and community levels												
3.1.1	Number of health areas reached by Viva SBC campaigns	Output	N/A	612	153	274	179.1%	274	3227	PMR	This target was exceeded for this quarter which represents the fact that the VIVA campaign activities are beginning to scale-up.	Continue with this positive trend to roll-out this campaign.
		Kasaï	N/A	279	69	6	8.7%	139	1333	PMR		
		Katanga	N/A	215	54	20	37.0%	77	971	PMR		
		Eastern Congo	N/A	118	30	100	333.3%	58	923	PMR		
3.1.2	Percentage of trained community mobilizers active at community level (contract deliverable)	Output	N/A	100%	100%	34.1%	34.1%	731	2142	PMR	The percentage of active community mobilizers is below the target.	The Program will work to engage community mobilizers and ensure they have the support necessary.
		Kasaï	N/A	100%	100%	44.4%	44.4%	429	966	PMR		
		Katanga	N/A	100%	100%	6.3%	6.3%	48	756	PMR		
		Eastern Congo	N/A	100%	100%	60.5%	60.5%	254	420	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
3.1.3	Number of facilities providers trained in interpersonal communication skills	Output	N/A	875	275	45	16.4%	N/A	N/A	PMR	This indicator was not achieved this quarter because the trip scheduled for this activity was postponed to Q3. An increase in this indicator is anticipated for the next quarter.	Trainings are planned in Q3 which will increase the rate of achievement for this indicator.
		Kasaï	N/A	375	125	25	20.0%	N/A	N/A	PMR		
		Katanga	N/A	350	100	20	20.0%	N/A	N/A	PMR		
		Eastern Congo	N/A	150	50	0	0.0%	N/A	N/A	PMR		
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	N/A	N/A	N/A	N/A	N/A	PMR	We have not yet started this activity.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
3.2.2	Number of awareness campaigns designed, implemented, and evaluated with community participation. (contract deliverable)	Output	TBD	607	27	26	96.3%	N/A	N/A	PMR	Both Kasaï and Eastern Congo achieved their targets for this quarter. Katanga fell short with a rate of 87.5%	Overall the rate of achievement for this indicator has improved. Additional trainings will be organized in Katanga to increase the number of campaigns in the next quarter.
		Kasaï	TBD	275	9	9	100.0%	N/A	N/A	PMR		
		Katanga	TBD	215	8	7	87.5%	N/A	N/A	PMR		
		Eastern Congo	TBD	117	10	10	100.0%	N/A	N/A	PMR		
IR 3.3: Reduced socio-cultural barriers to the use of health services and the practice of key healthy behaviors												
3.3.1 Fee	Number of Viva SBC events with messages disseminated targeting youth and other vulnerable groups per year	Output	0	150	150	132	88.0%	N/A	N/A	PMR	During Quarter 2, the Program reached 132 health areas by VIVA campaign events and messages disseminated targeting youth and	Overall, the program achieved 88% of the quarterly target. In FY2021 quarters 3 and 4 more activities will be planned in the Kasaï and Katanga region to ensure the
		Kasaï	0	51	51	12	23.8%	N/A	N/A	PMR		

Indicator		Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
		Katanga	0	49	49	20	40.8%	N/A	N/A	PMR	other vulnerable groups. This exceeded the target for this quarter overall. The highest number of activities took place in the Katanga and Eastern Congo regions.	vulnerable groups from those provinces are reached as well.
		Eastern Congo	0	51	51	100	196.1%	N/A	N/A	PMR		
3.3.2 (Standard/PPR)	Percent of audience who recall hearing or seeing a specific USG-supported Family Planning/Reproductive Health (FP/RH) message	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
3.3.3 (Standard/PPR)	Cust: Number of individuals in the target population reporting exposure to USG funded Family Planning (FP) messages through/on radio, television, electronic platforms, community group dialogue, interpersonal communication or in print (by channel/# of channels)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR	This indicator is reported annually.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	PMR		
IR 3.4: Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue												
3.4.1	Percentage of CSO organizations participating in experience-sharing / lessons learned	Output	N/A	100%	100%	27%	26.7%	24	90	PMR	This indicator was not realized during this quarter.	As the VIVA campaign scales-up the number of CSOs participating in
		Kasaï	N/A	100%	100%	25%	25.0%	10	40	PMR		

	Indicator	Region*	Baseline	Annual Target	Target Q2	Achieved in Q2	% Achieved	Percentage Num	Percentage Denom	Sources	Observations	Corrective Actions
	event held at the ZS community participation day or provincial task force communication meetings	Katanga	N/A	100%	100%	20%	20.0%	6	30	PMR		experience sharing will also increase.
		Eastern Congo	N/A	100%	100%	40%	40.0%	8	20	PMR		

* 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.

USAID IHP has resubmitted an updated AMEP with updated Performance Indicator Tracking Table (PITT) and Performance Indicator Reference Sheet (PIRS) in March 2021 to better align the definitions of program indicators to best practices and the observed operationalization of data collection. Please refer to this version of the updated 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.

2, 4, 6, 8, 11, 12, 14, 16: The baselines for these indicators are under review and they have been updated for this report as "UA" or unavailable
1.1, 1.2.1, 1.2.2, 1.4.3: For PICAL indicators, for annual reports we used the average of the first evaluation scores from Y1 and the predecessor, HFG project) for the baselines.
1.1.3 has been removed under the updated AMEP because we are no longer doing this activity and we have never reported any data for this indicator.
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. Quarter data is cumulative unless otherwise defined in the PIRS.
1.5.2 for FY2021 Q2 the targets were corrected from the targets in the updated AMEP and are now a percentage.
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 stockout of any key tracer commodity during the reporting period.
1.7.4: These indicators were collected via the Project Monitoring Report in FY2021 Q2; the process and source for collection is under review to align with the resubmitted AMEP.
2.1.6 for FY2021 Q2 these targets were corrected; the old figures had been used in the AMEP but these targets align with the request to increase targets based on performance at the end of Y2. We will correct the AMEP.
2.1.9: This indicator was collected from DHIS2 this quarter and in previous quarters. USAID IHP is currently reviewing the data collection process and source for this indicator to align with the resubmitted AMEP.
2.1.1: We are currently reviewing the data collection process and source for this indicator and these may be updated as per the revised AMEP.
2.1.12 This indicator was collected from DHIS2 but will be collected in the future from the USAID IHP Project Monitoring Report as described in the resubmitted AMEP.
2.1.20, 2.1.21, 2.1.22: These indicators were collected from DHIS2 during this quarter but USAID IHP is currently reviewing the data collection process and source for this indicator to align with the resubmitted AMEP.
2.1.20 and 2.1.21 targets were corrected. IN Q1 and the PITT the targets were taken from Y2. The CPLT sets the target for 2.1.20 and we can't set a target for 2.1.21 until we know how many MDR cases there are.
2.2.4 for Y3 we have updated these targets from those in the updated PITT using the SPMS data.
2.4.2, 2.4.3: These indicators were collected from the USAID IHP Service Provider Mapping Survey but will be collected in the future from the Project Monitoring Report as per the resubmitted AMEP.
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 Monitoring, Evaluation and Coordination Contract (MECC) as soon as it is made available.
3.3.1: The targets have been changed in Y3 Q2 (increased for internal tracking)

ANNEX B: NOTES ON ANNEX A FY2020 QUARTER 2 REPORT DATA

USAID IHP's AMEP includes 120 indicators, of which 72 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 Performance Indicator Reference Sheets (PIRS). The PIRS and PITT, which were approved by USAID in December 2018, have been superseded by a version aligned to the PWS in contract mod 5 pending approval at the time of submission of this report. These are the primary reference documents for program indicators. The data presented in the MSRT is aligned with the updated 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 Y3 an expanded data tables will be made available on the program platform. Please refer to the PIRS for additional information about any indicator.

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 April 23, 2021; they represent FY2021 Quarter 2 (Jan-Mar 2021). The data was originally downloaded from DHIS2 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 Program, 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 and reported all health zones.

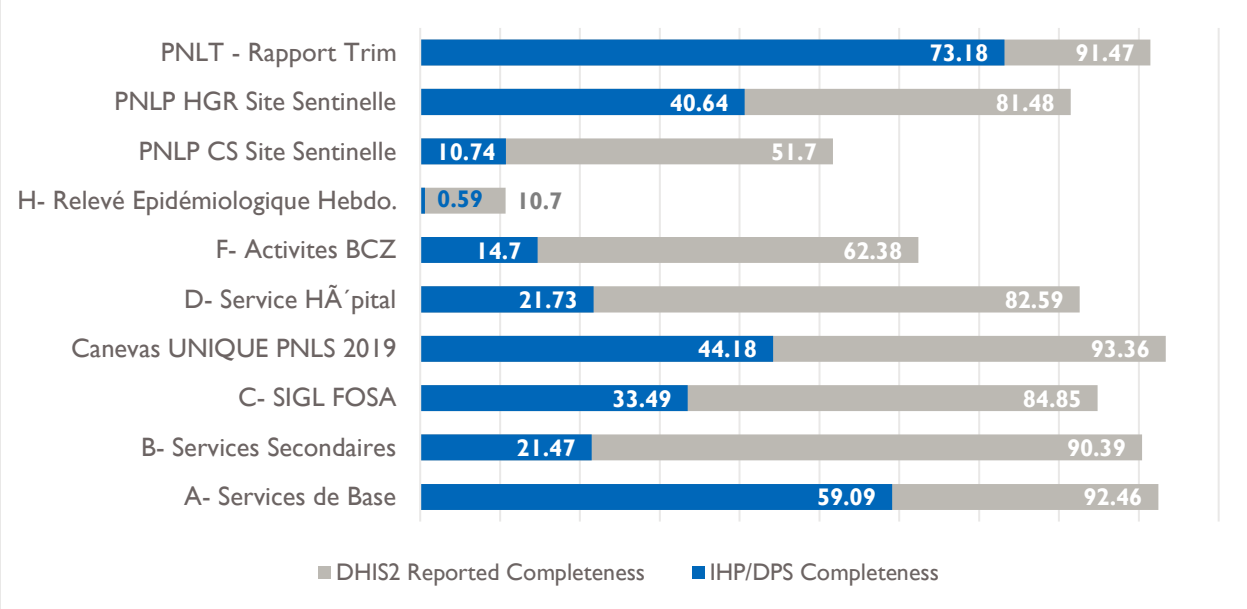
DATA COMPLETENESS: MECC AND MSRT DATA TABLES

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 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 some reports are inflated.

Because of this systemic flaw, USAID IHP has developed as part of the Performance Dashboard and M&E platform a "true" data completeness and timeliness measure, "IHP/DPS Completeness". 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.

Figure 8. Data completeness



Source: DHIS2, accessed Mar 23, 2021, basic services data set. Monthly SNIS *canevas* and the M&E Platform.

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. This quarter, DHIS2 data had a 91.1 percent reporting rate.

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 42. Datasets and sources

Quarter 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 complemenatire*). There is no reliable way to collect this information until the system is operational.

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's next quarterly report.

DETERMINATION OF BASELINE, TARGETS, AND QUARTER 2 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 Q3.
- The USAID IHP household survey (noted in the table as EDM, for *enquête de menages*) 2019
- DHIS2
- The internal USAID IHP Performance Monitoring Report
- 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 reports 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 FY2020 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.

Since the FY2020 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 for indicators 2, 4, 6, 8, 11, 12, 14, 16 originating from the household surveys will be updated when validation is finalized; we have marked these baselines as "UA," or "unavailable at present."

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 FY2019.

Determination of Targets

For the indicators for which we originally used EDS/MICS to determine baselines, we increased the targets from 2 percent 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. For FY2021, we have updated targets in the table to align to the new work plan, PWS and AMEP.

Quarterly targets are noted as NA if an indicator is reported annually, Annual targets are noted as NA as well as for data that is reported only in Years 4, 5 or 7, through service delivery and mapping survey data collection.

Data from the Biweekly Activity Tracker

In this report we reference data from the Biweekly Activity Tracker (BWAT). This tracker is a tool derived from the approved FY2021 work plan to track program implementation. Every month the activity schedule is verified or updated and we track if activities have been initiated, completed, or delayed, cancelled or postponed due to COVID-19.

ANNEX C: SUCCESS STORIES

1. Critical trainings enable interventions to save mothers' lives
2. Vital community distributors boost access to family planning

SUCCESS STORY

Critical trainings enable interventions to save mothers' lives

Since 2019, providers in Luiza General Reference hospital have assisted childbirth for 629 women who developed complications while in labor

Photo: Aime Tshibanda, Pathfinder for USAID IHP

Marie Manga with her newborn after her delivery in Luiza General Reference Hospital in Kasaï-Central province.

"We cannot accept losing another woman to preventable causes, especially when a small intervention can make a difference. These capacity-building exercises taught us simple life-saving techniques."

Dr. Denis Mpika
Medical Director
Luiza General Referral Hospital

In March 2021, Marie Manga, a 26-year-old seamstress and married mother of four, arrived at the maternity ward of Luiza General Reference Hospital, where she had attended her four recommended antenatal care visits. Her delivery proceeded smoothly, but after the birth she suffered an obstetric complication called placental retention, in which the placenta is not delivered within 30 minutes of the baby's birth. In Marie's case, the complication caused postpartum hemorrhage, and she began to show signs of shock. Mwangala, her husband, feared the worst as Marie hemorrhaged for nearly 45 minutes.

Such cases are not uncommon in the Democratic Republic of Congo, where maternal mortality is 846 deaths per 100,000 live births—one of the highest rates of maternal deaths in Sub-Saharan Africa. Kasaï-Central province alone had 95 maternal deaths in 2020. To address this, the USAID Integrated Health Program (IHP) collaborates with the Ministry of Health to technically and financially support training in basic emergency obstetric and newborn care, essential obstetric care, essential newborn care, and maternal and perinatal death surveillance and response.

Between 2019-2021, USAID IHP facilitated trainings for 253 health care providers, including 108 women, across 10 health zones in Kasaï-Central province. In October 2019, Dr. Denis Mpika, Medical Director at Luiza hospital, was among 19 providers who took USAID IHP's obstetric emergency response training in the Luiza health zone. Since the trainings began, Luiza General Reference Hospital has assisted 629 cases of childbirth via instrument delivery with forceps or suction.

When Marie began hemorrhaging, Dr. Mpika swiftly mobilized his team to safely extract the placenta using manual delivery techniques learned during the trainings and administered a transfusion to replace Marie's lost blood. With encouragement from providers at Luiza, Marie and Mwangala even began to consider family planning options before they left the maternity ward to enable recovery and optimal spacing for the next pregnancy, if desired. This comprehensive care follows USAID IHP's integrated model, empowering providers through training and follow-up.

SUCCESS STORY

Vital community distributors boost access to family planning

Thanks in part to Community-Based Distributors, government data shows the number of new family planning acceptors in Tanganyika increased by 46,878 between October 2019 - September 2020

Photo: Landry Malaba, Abt Associates for USAID IHP

Suzanne Mawazao holds up contraceptive pills from her CBD toolkit.

"I started going door-to-door distributing family planning commodities and contraceptives at the community level, and I referred people to the health facility if they had a clinical need."

Suzanne Mawazao
Community-based distributor

Suzanne Mawazao, a farmer in her sixties, lives in Kalemie health zone in Tanganyika province. As a community-based distributor (CBD), she distributes contraceptives in an area without a local health facility, providing family planning information and offering referrals to provider care sites as needed.

Tanganyika is plagued by insecurity and relative inaccessibility to health services. The province has low community awareness and use of voluntary family planning due to false rumors that contraceptive methods cause infertility. In August 2020, the USAID Integrated Health Program organized the province's first CBD training to prepare these crucial health workers to conduct home visits and share information on contraceptive methods.

In two health zones—Kalemie and Nyemba— USAID IHP trained 140 people, including 73 women. The training extended to Tanganyika the Program's approach of empowering CBDs to increase access to family planning methods and products in isolated communities. In each of USAID IHP's nine target provinces, the number of new acceptors of modern methods increased by an average of 46,619 between October 2019-September 2020.

"Many people here gave birth because they didn't use family planning, and there were a lot of teenage pregnancies. After our awareness-raising campaign, people understand the benefits of healthy timing and spacing of pregnancies," explained Suzanne. "The training supplied us with interpersonal communication skills and the knowledge we need to conduct home visits, and we no longer struggle to help people understand the benefits of voluntary family planning."

USAID IHP supplies all 11 health zones in Tanganyika with family planning commodities and provides CBDs with a kit consisting of a backpack, megaphone, boots, umbrella, checklist, technical fact sheet, and service register for recording commodities and acceptants. CBDs usually conduct four to eight home visits each month, in addition to larger informational sessions.

When women have access to voluntary family planning, they better space their pregnancies, reducing risks to maternal and child health. USAID IHP supports the Ministry of Health in integrating family planning into all phases of maternal health care in line with the Ministry's Maternal, Infant, and Child Survival Strategy.

ANNEX D: STAFF HIRED DURING FY2021 QUARTER 2

Position/Title	Employee Name	Gender	Start Date	Contractor
Kinshasa Office				
COP	*Houleymata Diarra*	*F*	*1/4/2021*	*Abt*
Operation Assistant	*Brandy Manzaki*	*M*	*2/11/2021*	*Abt*
Procurement Officer	*Byron Mulonda* (resigned 3/31/2021)*	*M*	*2/1/2021*	*Abt*
Subcontract/Grand Officer	*Geraldin Yussuf*	*M*	*2/8/2021*	*Abt*
Operations Officer	*Lydie Muteka*	*F*	*3/1/2021*	*Abt*
Immunization & EPI Advisor	*Alex Tshimuanga Makenga*	*M*	*1/20/2021*	*IRC*
Kasaï Region				
Kasaï-Central Province Office located in Kananga				
Bookkeeper	*Jimmy Mwanza*	*M*	*3/22/2021*	*Abt*
Kasaï-Oriental Province Office located in Mbuji Mayi				
Bookkeeper	*Evariste Ntumba*	*M*	*3/15/2021*	*Abt*
Lomami Province Office located in Kabinda				
Finance Assistant	*Benoit Lumanu*	*M*	*2/22/2021*	*Abt*
Katanga Region				
Haut-Katanga Province Office located in Lubumbashi				
Project Accountant	*Odette Odia Tshiebue*	*F*	2/1/2021	IRC
Haut-Lomami Province Office located in Kamina				
Admin Assistant	*Ars Mabende*	*M*	1/5/2021	*Abt*
Community Engagement Specialist	*Lisette Mushilange Mbingu*	*F*	2/22/2021	*IRC*
East Congo Region				
Sud-Kivu Province Office located in Bukavu				
Finance & Compliance Lead	*Freddy Akilimali Musenge*	*M*	*2/1/2021*	*IRC*
			TOTAL	**13**

ANNEX E: USAID IHP'S 60 PRIORITY *ZONES DE SANTE*

Region	Province	Final List of USAID IHP *Paquet Supplementaire* Health Zones
Eastern Congo	Sud-Kivu	Mwenga
		Kalehe
		Kitutu
		Kamituga
		Kaziba
		Kadutu
		Miti Murhesa
		Mubumbano
		Kabare
		Walungu
		Katana
	Tanganyika	Kalemie
		Nyemba
		Moba
		Kansimba
Kasaï	Kasaï-Central	Bilomba
		Dibaya
		Kalomba
		Kananga
		Luambo
		Lubondaie
		Luiza
		Ndekesha
		Yangala
	Kasaï-Oriental	Dibindi
		Bibanga
		Mpokolo
		Kabeya Kamwanga
		Bipemba
		Cilundu
	Lomami	Kanda Kanda
		Mwene Ditu
		Luputa
		Kalenda
		Kamiji
	Sankuru	Lomela
		Wembonyama
		Lodja
		Katakokombe
		Dikungu

Region	Province	Final List of USAID IHP *Paquet Supplementaire* Health Zones
Katanga	Lualaba	Dilala
		Manika
		Kanzenze
		Lualaba
		Fungurume
		Bunkeya
	Haut-Katanga	Kenya
		Kapolowe
		Kikula
		Ruashi
		Sakania
		Kipushi
		Lubumbashi
		Kisanga
		Kilwa
	Haut-Lomami	Kamina
		Kabongo
		Kabondo-Dianda
		Kayamba
		Malemba-Nkulu

ANNEX F: 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:	January 31, 2018-May 29, 2025[15]
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/link:	
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:	AFR
Prepared by:	Rio Malemba, USAID IHP WASH Advisor
Date Prepared:	June 2, 2021
Submitted by:	USAID's Integrated Health Program
Date Submitted:	June 4, 2021, Resubmitted July 2, 2021

ENVIRONMENTAL COMPLIANCE REVIEW DATA

Analysis Type:	EMMR
Additional Analyses/Reporting Required:	Water Quality Assurance Plan

PURPOSE

Environmental Mitigation and Monitoring Reports (EMMRs) are required for USAID-funded projects when the 22CFR216 documentation governing the project (e.g., the Initial Environmental Examination (IEE)) impose conditions on at least one project or activity. 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 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

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

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 IHP 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 IHP 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 IHP 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. An 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: _____ _____

Richard Matendo, Activity Manager/A/COR ***[required]*** Date

Clearance:	_____	_____
	Diane Mbanzidi, Mission Environmental Officer ***[as appropriate]***	Date
Clearance:	__NA_____	_____
	[Name, Regional Environmental Advisor ***[as appropriate]***	Date
Concurrence:	__NA_____	_____
	[Name], ____ Bureau Environmental Officer ***[as appropriate]***	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 Government of the DRC (GDRC) strategies and policies.

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

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

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 (FY2021 QUARTER 2)

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 A:			
Education, technical assistance, training to improve service delivery.	• Training/curricula/supervision must address appropriate management practices concerning proper handling of medical waste • Training must address correct water and sanitation practices • Capacity development must address maintenance of health clinic grounds. • Training must address prevention of transmission of HIV/AIDS and other blood-borne pathogens in health-care settings, including availability of post-exposure prophylaxis (PEP) and guidelines. • Training/ supervision must address monitoring, managing and reporting of adverse events related to the training.	USAID IHP continued to build capacity around medical waste management in provinces, ZS, and health facilities in a number of provinces through distribution of guidance posters, distribution of infection prevention control (IPC) materials, trainings, and awareness-raising activities as follows: • The Program began delivering posters that highlight principles of medical-chemical waste management to the provinces. During the Quarter, the Program delivered posters to Kasaï-Central, Lomami, Lualaba, and Kasaï-Oriental DPS and supported Kasaï-Central, Lomami, and Lualaba to distribute the posters to health facilities across 26 ZS and 14 ZS, respectively. In addition, the Program supported the DPS of Kasaï-Central to distribute IPC materials to 21 health facilities across four ZS, including each ZS's general reference hospital. • USAID IHP integrated content on medical waste management into community-based distributor family planning training in Sud-Kivu. • The Program raised awareness of the importance of medical waste management in five general reference hospitals in Sud-Kivu. In addition, USAID IHP supported three ZS in Lualaba to establish hospital hygiene committees which included training on medical waste management practices. Lastly, through the clean clinic approach activities, USAID IHP trained 140 providers in Sud-Kivu in medical waste management.	As USAID IHP implements a large number of activities in health facilities, the Program aims to integrate mitigation measures during each activity to address provider knowledge gaps on required measures and good practices in medical waste management and, ultimately, to reduce potential environmental impacts.

Activity B:			
Strengthening the supply chain from ZS to facility Strengthening storage and management at ZS and facility level.	• Apply guidance from manufacturer's Materials Safety Data Sheet (MSDS) • Apply guidance from WHO Guidelines for the Storage of Essential Medicines and Other Health Commodities. • Apply guidance on siting of storerooms • Apply guidance on inventory control systems • Apply guidance on chain of custody of commodities • Apply guidance on inclusion of sessions on managing medical waste in training programs. • Apply guidance on posting procedures on waste and storage management at health facilities. • Apply guidance on developing plans for managing commodities, waste and obsolete products. • Apply guidance on using standardized operating procedures for disposal of waste of different kinds • Provide guidance manual on incinerator and waste pit operation to hygienists and operators • Apply MOH guidance on remitting expired drugs • Apply guidance on stock management principles, including the first-in, first-out principles • Apply MOH guidance on the use of DHIS2 by health facilities or health zones for estimating needs and placing orders • Apply MOH guidance on disposal of pharmaceutical products, or apply WHO guidelines for Safe Disposal of Unwanted Pharmaceuticals if MOH guidance is unavailable • Apply USAID Sector Environmental Guidelines when supporting MOH in establishing systems for storage, labeling or inventorying waste • Perform due diligence investigation of waste management companies and ensure the use of Letter of Collaboration with parties involved • Apply guidance coming from US and GDRC legal and regulatory frameworks • Apply guidance from USAID Sector Environmental Guidelines to implement best practices.	USAID IHP supported provinces in varying aspects of medication supply chain management including data analyses and validation, distribution, safe disposal, audits, and training in all nine provinces, including: • Supported ongoing routine data analyses and validation in INFOMED to improve forecasting of order quantities. • In collaboration with CDR and the GHSC-TA project, supported health facilities and BCZS in Sankuru, Lualaba, Tanganyika, Haut-Lomami, and Lomami in all aspects of supply chain distribution and management plus basic principles in biomedical waste management. • Ensured proper disposal of expired medications through support to IPS audit missions, BCZS recall missions, and return of expired products to the MOH or manufacturers based on each province's preferred approach to identifying and eliminating medication waste. • Supported training in medication management, medication waste management and proper use of SIGL tools in 26 ZS in Kasaï-Central. • Worked with stakeholders in Sud-Kivu to develop 14 plans for medication distribution, ensuring compliance with supplier conditions for product integrity. • During various supervision visits in Sud-Kivu, integrated awareness-raising on waste management and conducted supervision specifically to observe compliance on the first-in, first-out stock management.	

	• Explore potential for implementation of waste minimization and recycling projects.		
Activity C:			
Funding acquisition of diagnostic and treatment equipment.	• Due diligence on environmental record and practices of each private party acquiring equipment • Training recipients on proper use and proper disposal of equipment • Training recipient on the environmental risk related to the use of the equipment	No mitigation measures required as there were no equipment acquisition activities during Quarter 2.	
Activity D:			
Very small-scale construction or rehabilitation (less than 1000m^2 total disturbed area) with no complicating factors.	• Compliance with USAID Environmental Guidelines for Construction • Proper handling and filing of all kinds of authorizations, permits or contracts • On site availability of drinking water, latrine and handwashing station, to all workers • Setting rules for personal protective equipment, hygiene and first aid • Recruitment or retaining of competent professionals • Sourcing materials from an ecologically safe provider. • Total ban on use of asbestos, lead based paints and other toxic materials • Ensuring that site managers have waste management plans in place • Proper use of hazardous waste tracking slip for hazardous waste • Designation of a waste storage area at the site. • Applying sound principles in waste reduction • Ensure reuse/recycling facilities can accept the waste streams • Ensuring refurbishment waste is processed in a securely controlled landfill. • Ensure leftover materials have been properly disposed of • Construction of drainage canals and infiltration pits within the perimeter of health centers • Complete a site emergency plan. • Conduct post-construction impact assessment • Ensure that construction is managed in such a way that no standing water on the site persists for more than 4 days	No mitigation measures required as there were no very small-scale construction or rehabilitation activities during Quarter 2.	

	• Require construction subcontractors to certify that they do not extract fill, sand or gravel from waterways or ecologically sensitive areas, nor knowingly purchasing these materials from suppliers who do so • Identify and implement any feasible measures to increase the probability that timber is procured comes from legal and well-managed sources • No lead-based paint shall be used, and when lead-free paint is used, it will be stored properly so as to avoid accidental spills or consumption by children. • Empty paint cans will be disposed of in an environmentally safe manner away from areas where contamination of water sources might occur, and the empty cans will be broken or punctured so that they cannot be reused as drinking or food containers • Ensure that the use of burnt brick is limited to when alternatives are not feasible or appropriate • Train health zone management teams (ECZS, Equipe cadre de la zone de santé) and providers in the adoption of good hygiene and sanitation practices as part of the WASH clean clinic approach activities		
Activity E:			
Small-scale construction.	Prior to any construction as per criteria at the right column, an Environmental Review Form (ERF) must be submitted and approved by USAID	No mitigation measures required since as there were no small-scale construction during Quarter 2.	
Activity F:			
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. • Insecticide-Treated Nets must be disposed of according to WHO best available practices[16], but should not be incinerated except under controlled circumstances.	USAID IHP incorporated content on appropriate use and inappropriate use and disposal of long-lasting insecticidal nets (LLINs) during mini-campaigns, trainings, and supervision sessions including: • Malaria and ANC mini campaigns in all nine provinces • Provider trainings on prevention and treatment of malaria in pregnant women in Kasaï-Central, Kasaï-Oriental, Sankuru, Tanganyika, Lualaba, and Lomami. • Clinical and community provider trainings in malaria in Lomami and Lualaba	

[16] WHO recommendations on the sound management of old long-lasting insecticidal nets, 3 March 2014.

Activity G:			
Sub-grant activities.	• Due diligence investigation of sub-grantee to establish environmental competence and commitment • Submitting Environmental Review Form (ERF) for USAID approval prior to any granting activity • Development of mitigation measures appropriate to the nature of the sub-grant.	No mitigation measures are required as there were no sub-grant activities during Quarter 2.	
Activity H:			
Construction and improvement of water and sanitation systems in facilities	• Ensure inclusion of infection prevention and waste management in training activities • Minimize biomedical waste and ensure appropriate use of standard operating procedures for waste disposal • Ensure decontamination and packaging of used instruments in appropriate waste containers • Provide cleaners with protocols for cleaning and disinfection products • Sensitize stakeholders on rational water management • Ensure that dry pit latrines are constructed so that the bottom of the pit is at a level that does not allow contamination of the water table • Ensure the provision of hand washing stations, and the development and implementation of a system for continuous cleaning and maintenance of latrines • Ensure that the use of burnt brick is limited to when alternatives are not feasible or appropriate • Ensure that latrine design plans take into account good ventilation with air pipes • Submit water quality assurance plan (WQAP) to USAID when potable water systems are constructed and prior to water use • Train health zone management teams (ECZS, Equipe cadre de la zone de santé) and providers in the adoption of good hygiene and sanitation practices as part of the WASH clean clinic approach activities • Ensure good-practice design standards are implemented consistent with USAID's Sector Environmental Guidelines for water supply and sanitation	No mitigation measures are required as there were no such construction and improvement activities during Quarter 2.	
Activity I:			
Construction and improvement of water and sanitation systems	• Submit water quality assurance plan (WQAP) to USAID when potable water systems are constructed and prior to water use.	USAID IHP supported training, water quality analyses, and sensitization activities in Sud-Kivu and Kasaï-Oriental focused in ZS where the Program has constructed or	

in communities.	• Water Source Protection and Integrated Watershed Management • Sensitization of the community on hygiene as it relates to water handling and storage. • Use of piping and water collector material of the recommended quality: PE, PVC, HDPE. • Water conservation measures: efficient taps, reduced leakages due to use of high quality high density polyethylene (HDPE) fittings • Develop an efficient monitoring system to detect leakages throughout the system • Safety taps installed at all water supply points: valve chambers built to section off segments of the pipelines in case pipes burst, safety valves at water reservoirs. • Proper maintenance of pipes and storage tanks • Design water points to include drains • Exclusion of livestock from water points • Prevent standing water at water supply points • Water disinfection methods include chlorination, chloramination, ozone, solar, ultraviolet disinfection. • Water testing and treatment done by a competent water specialist using standard methods for nitrate, bacteria, arsenic, and other suspected contaminants • Monitoring of water quality at system start-up, after 1 month, and annually after that • Signage at the water points with messages on sustainable use of water. • Ensure that dry pit latrines are constructed so that the bottom of the pit is at a level that does not allow contamination of the water table. • Ensure that latrine design plans take into account local environmental conditions and good ventilation with air pipes • Ensure the provision of hand washing stations, and the development and implementation of a system for continuous cleaning and maintenance of latrinesEnsure that the use of burnt brick is limited to when alternatives are not feasible or appropriate • Sensitize stakeholders on rational water management • Ensure good-practice design standards are implemented consistent with USAID's Sector Environmental Guidelines for water supply and sanitation use of water.	rehabilitated water supply systems. Specifically, the Program: • Trained 12 plumbers in Sud-Kivu on water access point upkeep and maintenance, including checking the condition of water pipes and detecting and addressing leaks • Supported the conduct of physiochemical and bacteriological water analyses at rehabilitated and expanded water systems in Sud-Kivu in collaboration with the *Centre de Recherche des Sciences Naturelles* of Lwiro and Mercy Corps. • Supported the *Bureau Hygiene et Salubrité Publique* of Kasaï-Oriental to submit water samples for quality analysis • Sensitized RECO, water committee members, and community members in five villages in Sud-Kivu on good practices in water and hygiene including protecting water systems, drinking water consumption, and correct use of rehabilitated family latrines	

Activity J:			
Office management and supply.	• Careful planning and implementation of sustainable practices for resource usage and waste minimization: • Use electricity wisely. • Reduce, reuse, recycle. • Use environmentally friendly office products. • Use non-toxic cleaning products. • Make eco-friendly food choices. • Allow staff to sometimes work from home. • Aim for paperless office. • Buy fair local trade products and organic products.	Across all Program offices, USAID IHP continued to enforce social distancing and barrier measures in accordance with the Government of DRC and Abt guidelines to prevent the spread of COVID-19. In Kinshasa, in particular, the preventative measure of permitting staff to work from home continued to be practiced. These measures reduced paper and electricity usage as well as waste production in Program offices, especially in Kinshasa. In addition, illustrative Program practices that mitigated the environmental impact of office operations include: • Engaged specialized, independent cleaning teams in each office • Regularly serviced and operated the office generator in Sankuru with a one-hour daily break while the office is open • Switched off inside light bulbs afterhours in Lualaba • Replaced incandescent lightbulbs with lower power LED ones in Sud-Kivu • Sensitized office staff on disconnecting electronic devices and inside lights afterhours	
Activity K:			
Transportation of personnel and supplies.	• Adjust mobility of staff concepts, include walking short distances versus being dropped at destination. • Purchase fuel-efficient vehicles, planning to avoid unnecessary trips, management of order quantities.	USAID IHP continued to allow staff to work remotely to prevent COVID-19 transmission, which had the added benefit of reducing vehicle use and related fuel consumption, especially in the Kinshasa office. In provincial offices, vehicle use was primarily restricted to field visits and coordinated local errands. In most provincial offices, the office locations are convenient to staff who may travel to and from the office on foot, which further reduced vehicle use and fuel consumption.	

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

DISTRIBUTION: