Working Together, Saving Lives

Final Report 2010–2015

Integrated Health Project

in the
Democratic Republic of Congo

USAID
FROM THE AMERICAN PEOPLE

RESCUE

OSC

msh
Management Sciences for Health

Project Name: Integrated Health Project in the Democratic Republic of Congo
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ACKNOWLEDGMENTS

To acknowledge the roles of the many people who have contributed to this project, we borrow from African wisdom: *If you want to go quickly, go alone. If you want to go far, go together.* There have been times that we have needed to move quickly, but it never would have been possible without the people who supported the project to go far.

The Integrated Health Project in the Democratic Republic of Congo (DRC-IHP) team would like to thank the Ministry of Health of the DRC which has, at all levels, eloquently demonstrated, over and over, its ownership of this project, from the current Minister of Health, Dr. Félix Kabange Numbi Mukwampa, to the Secretary-General, Dr. Marcel Mukengeshayi, to the health authorities at provincial and health zone level, including the Provincial Medical Officers, Provincial Health Inspection, and Provincial Health Division management teams in Katanga, Kasaï Occidental, Kasaï Oriental, and Sud Kivu. The Chief Medical Officers of the project-supported health zones and the health zone management teams have been intimately involved in all aspects of project implementation, and we could not have achieved project results without their participation and insight. We also wish to recognize the contributions of the Minister of Health and the Secretary-General at the initiation of the project, Dr. Victor Makwenge Kaput and Dr. Pierre Lokadi Otete Opetha, respectively.

DRC-IHP has enjoyed a productive collaboration with the various directorates and programs of the Ministry of Health, including, but not limited to, the Directions of Pharmacy and Medicines, the Fight against Illness, Primary Health Care, Studies and Planning, Health Laboratories, Hygiene, Family Health and Specific Groups; and national programs such as the Expanded Program on Immunization, the National Malaria Control Program, the National Anti-Tuberculosis Program, the National Multisectoral Program for HIV/AIDS Prevention, the National Program for the Fight Against HIV/AIDS, the National Program on Diarrhea Prevention, the National Program on Nutrition, the National Communication Program for Health Promotion, the National Reproductive Health Program, National Program on the Prevention of Acute Respiratory Infections, the National Program on Adolescent Health, the Technical Unit on Results-based Financing, and the National Center for Pharmacovigilance. We have collaborated closely with the Federation of Central Purchasing (FEDECAME) Regional Association for the Supply of Essential Medicines (ASRAMES) to offer high quality pharmaceutical services to the population. DRC-IHP also worked with the Kinshasa School of Public Health on a number of activities, including hosting student interns in the project and working together on studies related to acceptability of rectal artesunate and testing of quality of care indicators for maternal and neonatal health services at the facility level, as well as for approval of study protocols (such as the project's gender analysis).

We gratefully acknowledge the support of the President's Emergency Plan for AIDS Relief (PEPFAR), the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), President's Malaria Initiative (PMI), the Centers for Disease Control (CDC), and the American people for funding this important project, with special recognition to the USAID/DRC Mission for its dedication to strengthening the DRC health system at all levels and improving the health of the people of DRC. We would like to thank Richard Matendo, Lina Piripiri, Izetta Simmons, Nora Madrigal, and the entire health team—all of whom supported the project—whether reviewing a report, discussing strategy, traveling with us to the farthest health zones, or representing us in Washington. Diana Putman, USAID Mission Director, has been a pas-

sionate supporter of strengthening the health system and improving the lives of the population. We would also like to recognize the contributions of previous health team leaders Connie Davis, Joshua Karnes, and Meri Sinnitt, who provided valuable input to the project.

Our collaboration in country has extended to multilateral organizations such as UNICEF, the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNFPA, the World Health Organization (WHO), the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as bilateral organizations such as the Belgian Technical Cooperation, the Canadian Cooperation, United Kingdom Department for International Development (DFID), and the German Corporation for International Cooperation. We have enjoyed both formal and informal collaboration with other implementing organizations such as IMA World Health, Communication for Change/FHI360, USAID|DELIVER/John Snow, Inc. (JSI), the Integrated HIV/AIDS Project in the DRC (ProVIC)/PATH, *Accès aux Soins de Santé (*ASSP/SANRU), ICAP, Support for International Family Planning Organizations/*Association de Santé Familiale*/PSI, Maternal and Child Survival Program JSI/Jhpiego, Elizabeth Glaser Pediatric AIDS Foundation, EngenderHealth FistulaCare, Pathfinder/Evidence to Action, Monitoring and Evaluation to Assess and Use Results (MEASURE Evaluation), Helen Keller International, USAID Applying Science to Strengthen and Improve Systems, and others.

DRC-IHP and MSH would like to recognize the many dedicated staff and consultants who have contributed their time and expertise to the Integrated Health Project, including our partners, Overseas Strategic Consulting (OSC) Ltd. and International Rescue Committee (IRC). Although too numerous to mention, every member of the MSH team in Kinshasa, in the provincial offices, and in the coordination offices—whether working on operations or projects such as SIAPS, Supply Chain Management System (SCMS), IHP, Leadership, Management, and Governance (LMG), TB-CARE, or Challenge TB—has played a key role in the planning and implementation of project activities. In addition, our home office team has been an integrated part of the project every step of the way, providing programmatic, technical, communications, contractual, procurement, human resources, and other support.

We are also grateful to the many organizations that have participated in this project through cost share—UNICEF, Project C.U.R.E. (Commission on Urgent Relief and Equipment), WHO, Latter-Day Saints (LDS) Charities, MAP International, Merck, Brothers' Brother Foundation, community health workers and other individuals, as well as project partners IRC and OSC—many of whom have provided supplies and equipment essential to the implementation of primary health care activities in DRC that would otherwise not have been available.

Finally, it has been our distinct pleasure to work with the people of DRC who, through many of our initiatives, have found new power and voice in working together to achieve their goals—whether through participation in Champion Communities, CODESAs, civil society organizations implementing gender-based violence activities and those verifying results-based financing results, closed user groups spreading the word about family planning, or other initiatives. They have inspired us to implement DRC-IHP for the greater good of the populations we serve.

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ACRONYMS

ACT	Artemisinin-based combination therapy
AMTSL	Active management of third stage of labor
ANC	Antenatal care
AOP	Annual Operational Plan
ART	Antiretroviral therapy
ARV	Antiretroviral
ASRAMES	Regional Association for the Supply of Essential Medicines
BCC	Behavior Change Communication
BCG	Bacillus Calmette-Guerin
CBD	Community-based distribution/distributors
CBO	Community-based organizations
CDC	US Centers for Disease Control
CDR	Regional warehouses
CHW	Community health workers
CLTS	Community-led total sanitation
CODESA	*Comité de Développement Sanitaire*
COMU	Country Operations Management Unit
CPA	Complementary package of activities
CSDT	*Centre de Santé de Diagnostic et Traitement*
CUG	Closed User Group
CYP	Couple years of protection
DFID	United Kingdom Department for International Development
DHS	Demographic and Health Survey
DPS	*Division Provinciale de la Santé*
DQA	Data quality assessment/audit
DRC	Democratic Republic of Congo
DTP	Diptheria, tetanus, pertussis
EGM	Essential generic medicines
EID	Early infant diagnosis
EPI	Expanded Program on Immunization
EPP	Estimation and Projection Package
ETL	Education through Listening
FEDECAME	Federation of Central Purchasing
FOSACOF	Fully functional service delivery point
GBV	Gender-based violence
GRH	General referral hospital
HBB	Helping Babies Breathe
HIV	Human immunodeficiency virus
HPP	Health for Poorest Populations
HSS	Health systems strengthening
IBTCI	International Business and Technical Consultants, Inc.
i-CCM	Integrated community case management
IDA	International Dispensary Association
IHP	Integrated Health Project
IMCI	Integrated management of childhood illness
IPTp	Intermittent preventive treatment (of malaria) in pregnancy
IR	Intermediate result
IRC	International Rescue Committee
IYCF	Infant and young child feeding
KAP	Knowledge, attitudes, and practices
LAM	Lactational Amenorrhea Method
LDP	Leadership Development Program
LDS	Latter-Day Saints
LiST	Lives Saved Tool
LLIN	Long-lasting insecticide-treated bed net
M&E	Monitoring and evaluation
MDR-TB	Multi-drug resistant TB
MEG	Medical Export Group
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MPA	Minimum package of activities
MSH	Management Sciences for Health
MTCT	Maternal to child transmission of HIV
NFP	Natural family planning
NHIS	National health information system
NGO	Non-governmental organization

OR	Odds ratio
ORS	Oral rehydration solution
OSC	Overseas Strategic Consulting, Ltd.
PEP kit	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of mother-to-child transmission
PNDS	National Health Development Plan
PNLP	*Programme National de Lutte contre le Paludisme*
Project C.U.R.E.	Commission on Urgent Relief and Equipment
PRONANUT	National Nutrition Program
PROVIC	Integrated HIV/AIDS Project in the DRC
RBF	Results-based financing
RDQA	Routine data quality assessment
RDT	Rapid diagnostic tests
RH	Rifampicin isoniazid
SBA	Skilled birth attendant
SGBV	Sexual and gender-based violence
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SP	Sulfadoxine-pyrimethamine
SPS	Strengthening Pharmaceutical Systems
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Photo : Warren Zelman

The Integrated Health Project in the Democratic Republic of Congo 2010–2015

KEY ACHIEVEMENTS

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

- Saving the lives of more than 150,000 young children, including 10,900 neonates
- Distributing 2,273,179 long-lasting insecticide-treated bed nets (LLINs) to pregnant women and caregivers of children under one year of age
- Counseling more than 1.7 million mothers of children under two years of age about proper nutrition
- Providing access to assistance from a skilled birth attendant (SBA) for approximatively 2,122,500 women
- Preventing 224,000 unwanted pregnancies, 157,000 unplanned births, subsequently preventing 700 maternal deaths and 28,000 unsafe abortions
- Vaccinating more than 90% of children with two reference antigens (pentavalent and anti-measles)
- Providing antiretroviral therapy to approximately 3,000 HIV-positive adults and children
- Providing access to clean water for more than one million people
- Generating more than 2.7 million new acceptors of modern contraceptive methods
- Providing more than 1.9 million newborns with essential newborn care

Photo : Warren Zelman

EXECUTIVE SUMMARY

The Democratic Republic of Congo (DRC) is a resource-rich country with a landmass nearly two-thirds the size of Europe. Its vast swaths of arable and mineral-rich land provide the potential for DRC to become one of sub-Saharan Africa's wealthiest countries. Decades of conflict, however, have robbed the country of its potential. Weak infrastructure and the displacement of millions of citizens complicate the DRC's path to development. The Congolese Ministry of Health (MOH) struggles to meet the needs of its citizens. Although the country has the resources to support progress toward the achievement of its development outcomes, those resources are not effectively managed or directed toward the public good. With the country struggling to promote effective governance, the challenges to development are immense.[1] The country's maternal, infant, and child mortality rates are some of the highest in the world. To build a bridge to better health, DRC must engage every level of society—individuals, families, communities, and local, provincial, and national government—in creating a system that educates and supports individuals in choosing healthy behaviors and provides quality preventive and curative health services.

According to calculations using the Lives Saved Tool (LiST),[2] between October 2010 and September 2015, the USAID-funded Integrated Health Project (IHP) contributed to saving the lives of nearly 150,000 children, including 10,900 neonates, living in impoverished and remote areas of the DRC.

Implemented by Management Sciences for Health (MSH), the International Rescue Committee (IRC), and Overseas Strategic Consulting, Ltd. (OSC), IHP expanded access to quality health services throughout 78 health zones, using innovative methods to roll out proven practices. IHP developed capacity for quality service provision within health facilities and created demand for quality services in communities, thus laying the foundation for sustained impact.

IHP spent close to $3 million rehabilitating and equipping facilities with the products necessary for quality services—items as basic as scales, laboratory equipment, and medicines. The project invested an additional $4 million to train health sector leaders and facility- and community-based service providers. In addition to routine supportive supervision and informal training sessions, IHP staff conducted 451 formal training sessions for 16,263 participants, including district, provincial, and health zone management teams, service providers, community members, and national and provincial trainers.

At the community level, IHP built the capacity of health development committees, known as CODESAs (for the French acronym for *Comité de Développement Sanitaire*), enabling them to become a core organizing structure of the health system at the local level. These nascent institutions are instruments of social cohesion, which research strongly suggests is a fundamental element of resilience. The organization and management of these committees guide other organizing principles that a village needs to learn if it is to prosper. Good health and prosperity are mutually-reinforcing elements that contribute to a stable and thriving society.

An in-depth assessment of the project's strategies showed that combined approaches to strengthening the health sector—such as the fully-functional service delivery point, supportive training and supervision, leadership development, and results-based financing—contributed to increasing the number of new adopters of modern contraceptives and the number of postpartum/newborn visits within three days of birth.[3] Community-based approaches helped increase the number of counseling visits for family planning, the percentage of women attending at least four antenatal care visits, and the number of cases of diarrhea treated in children. IHP met and in some cases exceeded its targets for these important indicators (see Figure 1 next page), directly contributing to healthier, more resilient, and self-reliant communities, families, and individuals.

1 USAID. *Country Development Cooperation Strategy: Democratic Republic of the Congo 2015–2019*

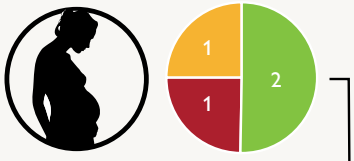
2 LiST, or Lives Saved Tool, is an evidence-based tool for estimating the potential impact of different interventions. As used by IHP, the goal of the LiST was to promote evidence-based decision-making for planning the appropriate expansion of maternal, neonatal, and child health interventions. It was used to estimate the number of lives saved when scaling up key interventions and to provide a user-friendly tool for child survival planning in the DRC. The tool was developed within the Spectrum software package.

3 *Analyse des stratégies du PROSANI et autres déterminants de la performance des zones de santé dans quatre provinces de la République Démocratique du Congo de 2010 à 2015,* Begin Salumu, December 2015. In October 2015, IHP hired a consultant to complete a bivariate and multivariate analysis of all strategic approaches and their corresponding indicators in order to draw evidence-based conclusions on their impact on the project's overall performance between 2010 and 2015.

Figure 1. Project performance overview

The pie charts in Figure 1 present the number of project indicators for which project targets were achieved (green), almost achieved (yellow), or not achieved (red) per health domain. The results presented below the pie charts are illustrative key achievements for each health domain. This list of achievements represents a snapshot of selected data from all indicators represented in the pie charts.

See Appendix 1 for a full list of results from the performance monitoring plan.



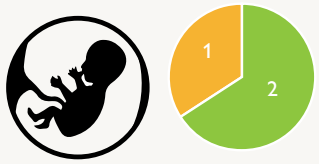
MATERNAL HEALTH

2,536,034 pregnant women
attended at least one ANC visit

768,504 pregnant women
attended at least four ANC visits

2,122,497 deliveries
performed with a skilled birth attendant

1,864,819 women
received Active Management of the Third Stage of Labor

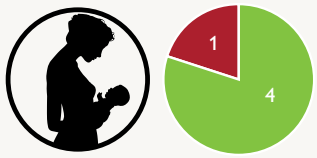


NEONATAL HEALTH

1,982,880 newborns
received essential newborn care

189,787 newborns
received antibiotic treatment for infection

2,002,059 newborn visits
within 3 days of birth (76% target)



CHILD HEALTH

2,308,766 child pneumonia cases
treated with antibiotics

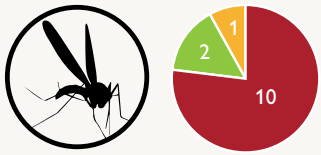
1,914,568 child diarrhea cases
treated with ORS/ORS zinc

2,131,796 children under 12 mos.
received DPT-HepB-Hib3 vaccination

13,927,337 children under 5
received vitamin A supplements

SUCCESS STORIES

136
success stories developed and promoted



MALARIA

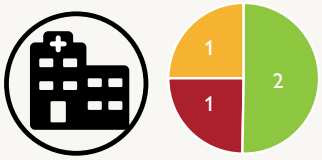
1,513,245 pregnant women
received two doses SP for IPT

872,338 insecticide-treated bed nets
distributed to pregnant women and guardians of children under one year

9,240,067 ACT treatments distributed

3,887,495 rapid diagnostic tests
performed

5,372 health care providers
trained in malaria prevention and case management



AVAILABILITY OF CPA AND MPA

1,365 health centers
offered MPA (target 1,118)

69 general reference hospitals
implemented CPA by PY5 (target 62)

46% curative services utilization
in PY5 over national average of 35%

REFERRAL SYSTEMS

619,137, or 3% of patients
referred to general reference hospitals by CHW or health care provider (193% of target)

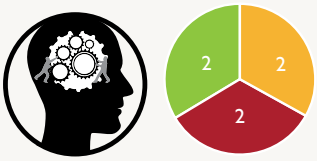
51,194, or 18% of patients
referred to a health center by CHW (353% of target)

WASH

1,059,282 people
had first-time access to improved drinking water (114% coverage)

858,585 people
had first-time access to improved sanitation facilities (92% coverage)

Zonal approach to WASH mobilization
met the needs of 80% of residents in nine health zones



LEADERSHIP, MANAGEMENT, AND GOVERNANCE

390 members of health zone staff
attended 4 LDP workshops

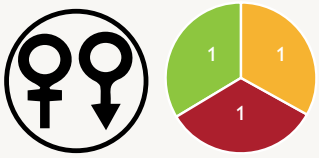
254 leadership projects
were implemented

213 of these projects (84%)
achieved over 80% of measurable result

Target achieved (100% or >)

Almost achieved (75–99%)

Not achieved (< 75%)



GENDER-BASED SERVICES

13,146 people
reached with GBV intervention services during the project

98%
of those reported abused are women

931
health care workers trained in management of sexual violence

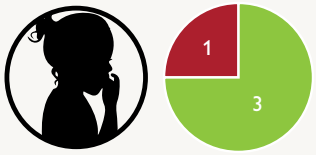
FAMILY PLANNING

2,563,143 individuals
with Couple Years of Protection (CYP)

2,720,700 new acceptors
of any modern contraceptive method

2,833,418 visits
family planning/reproductive health counseling

2,233 service delivery points
provided family planning counseling and/or services



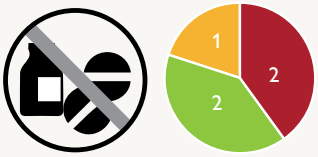
NUTRITION

13,927,337 children under 5 years
received vitamin A

1,742,380 mothers of children 2 years of age or less
received nutritional counseling

551,726 breastfeeding mothers
received vitamin A

1,736,945 pregnant women
received iron folate to prevent anemia

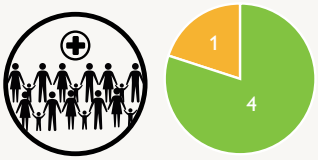


STOCK-OUTS

92% of pharmaceuticals ordered
PY1–4 were delivered to CDRs

40% fewer stock-outs
than target for ACT1–5

32% fewer stock-outs
than target for ORS

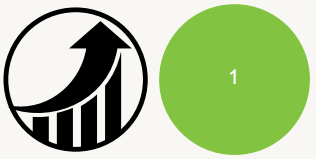


COMMUNITY MOBILIZATION

1,284 CODESA
health development committees revitalized

164 youth groups
participated in youth education outreach

34 people selected
and trained in leading Champion Community groups



HEALTH SERVICES QUALITY

81.2% of staff at FOSACOF facilities
received basic professional training vs. 37.5% at non-FOSACOF facilities

82.5% hospitals
have accurate inventory of essential drugs

737 health centers (50%)
meet all 9 FOSACOF standards

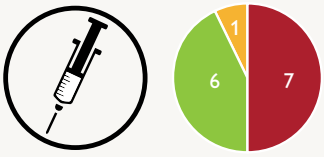
TUBERCULOSIS

28,702 registered TB patients
were tested for HIV

61% TB case detection rate
58,085 detected / 94,615 expected

203 cases
of MDR-TB were detected

5,000 households in 4 days
were visited by CHWs in Sud Kivu to test for TB



HIV AND AIDS

315,317 individuals
received testing & counseling for HIV and received results

1,371 HIV-positive pregnant women
received ARVs for PMTCT

4,438 HIV-positive adults & children
received a minimum of one clinical HIV service

2,983 adults & children
receiving ART (current)

BEHAVIOR CHANGE COMMUNICATION

2,770 SMS distribution campaigns
drove communications in PY4 and PY5

516 mini-campaigns
reached 1.5 million people, leading to:

44 water sources cleared

9,182 latrines built

416 community debates held

Project performance summary

During five years of implementation, IHP made significant improvements in increasing facility-based health care services and products, improving quality health care services, and increasing knowledge, attitudes, and practices to support health-seeking behaviors in targeted health zones.

The project achieved or surpassed targets (achievement rates of 100% or greater) for 51% of the indicators. Sixteen percent (16%) of the indicators were almost achieved (75–99% achievement rate), and the project did not achieve 34% of its indicators (achievement rates less than 75%).

IHP made notable achievements in increasing facility-based health care services and products in target health zones. The project exceeded and almost achieved the targets for the percentage of general referral hospitals (GRHs) implementing the Complementary Package of Activities (CPA) and CPA-plus services, respectively (see Appendix 10). At the health center level, the number of health centers implementing the Minimum Package of Activities (MPA) exceeded the target; however, results related to the implementation of MPA-plus services fell below the target. Reducing stock-outs of tracer medicines remained challenging throughout the project, although IHP's performance in reducing stock-outs of artemisinin-based combination therapy (ACT) and oral rehydration solution (ORS) was strong (with 66% and 146% of the target achieved, respectively). In addition, the project almost achieved its target in reducing stock-outs of Depo-Provera (91%). However, the project did not meet its expected targets for tracer drug stock-outs of rifampicin isoniazid (RH) combination and iron folate. A total of 42 service delivery points experienced stock-outs of RH combination compared to the target of 0 (achievement rate not applicable when the target is 0), and 249 health facilities experienced stock-outs of iron folate compared to the target of 133 (an achievement rate of 53%).

Malaria, diarrhea, and pneumonia are the three main killers of children under five in DRC. IHP's integrated community case management (i-CCM) strategy was largely effective for increasing these community-based health care services. Project-supported providers treated 128,822 children with diarrhea, 112,513 children with pneumonia, and 105,086 children with malaria at i-CCM sites, with the most significant increases occurring in years four and five. Overall, the project exceeded results related to the total number of children treated for pneumonia at all project sites (i-CCM and others); however, it fell below the target number of childhood diarrhea cases treated.

IHP's performance in increasing the number of people with first-time access to improved drinking water supply and sanitation facilities was also strong, as the project exceeded and almost achieved results for the two indicators.

IHP improved the quality of health care services in all health areas. Performance was particularly strong in improving health results in the areas of maternal, newborn and child health, family planning, and nutrition. In the area of maternal, newborn, and child health, IHP almost achieved, achieved, or exceeded performance for all indicators except the percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers and the number of children treated for diarrhea (as mentioned above). IHP exceeded all family planning targets, including 2.7 million new acceptors of any modern contraceptive methods and 2.8 million counseling visits for family planning and reproductive health. IHP exceeded nutrition targets for the number of children who received vitamin A, the proportion of pregnant women who received iron folate to prevent anemia, and the number of mothers who received nutritional counseling for their children. Project results for the number of breastfeeding mothers attending postnatal visits who received vitamin A fell below the target.

IHP achieved or almost achieved 75% if its tuberculosis (TB) indicators and achieved or almost achieved 50% of of its human immunodeficiency virus (HIV) indicators. IHP met or exceeded targets related to the number of adults and children receiving antiretroviral therapy (ART) and HIV clinical services and assessments, as well as testing and counseling for HIV services. The project did not achieve targets related to the percentage of President's Emergency Plan for AIDS Relief (PEPFAR)-supported sites achieving 90% antiretroviral (ARV) or ART coverage for HIV-positive pregnant women, the number and percent of pregnant women with known status, the percentage of HIV-positive pregnant women who received ARVs to reduce maternal to child transmission (MTCT), or the percent of HIV-positive patients who were screened for TB in HIV care or treatment setting. Results were also weak for the number and percentage of HIV sites that meet established standards.

TB results were strong for the number of multi-drug resistant TB (MDR-TB) cases detected, and the project almost achieved targets for the percent of registered TB

During five years of implementation, IHP made significant improvements in increasing facility-based health care services and products, improving quality health care services, and increasing knowledge, attitudes, and practices to support health-seeking behaviors in targeted health zones.

patients tested for HIV and TB case detection rate. Results related to case notification rate of new TB cases fell significantly below the project target.

IHP only achieved or almost achieved 23% of malaria indicators (those related to the number of ACT treatments purchased and distributed). Project results fell below targets for malaria indicators related to the percent of pregnant women receiving at least 2 doses of sulfadoxine-pyrimethamine (SP) for treatment during ANC visits, the number of health workers trained in intermittent preventive treatment (of malaria) in pregnancy (IPTp), case management with ACTs, malaria laboratory diagnostics, and the number of SP tablets, long-lasting insecticide-treated bed nets (LLINs) and rapid diagnostic tests (RDTs) purchased and distributed.

Increasing the number of patient referrals to health facilities is an important aspect of improving the quality of health services provided to the community. IHP exceeded results for the percent of patients referred to health centers and general referral hospitals after being seen by a community health worker (CHW) or health care provider.

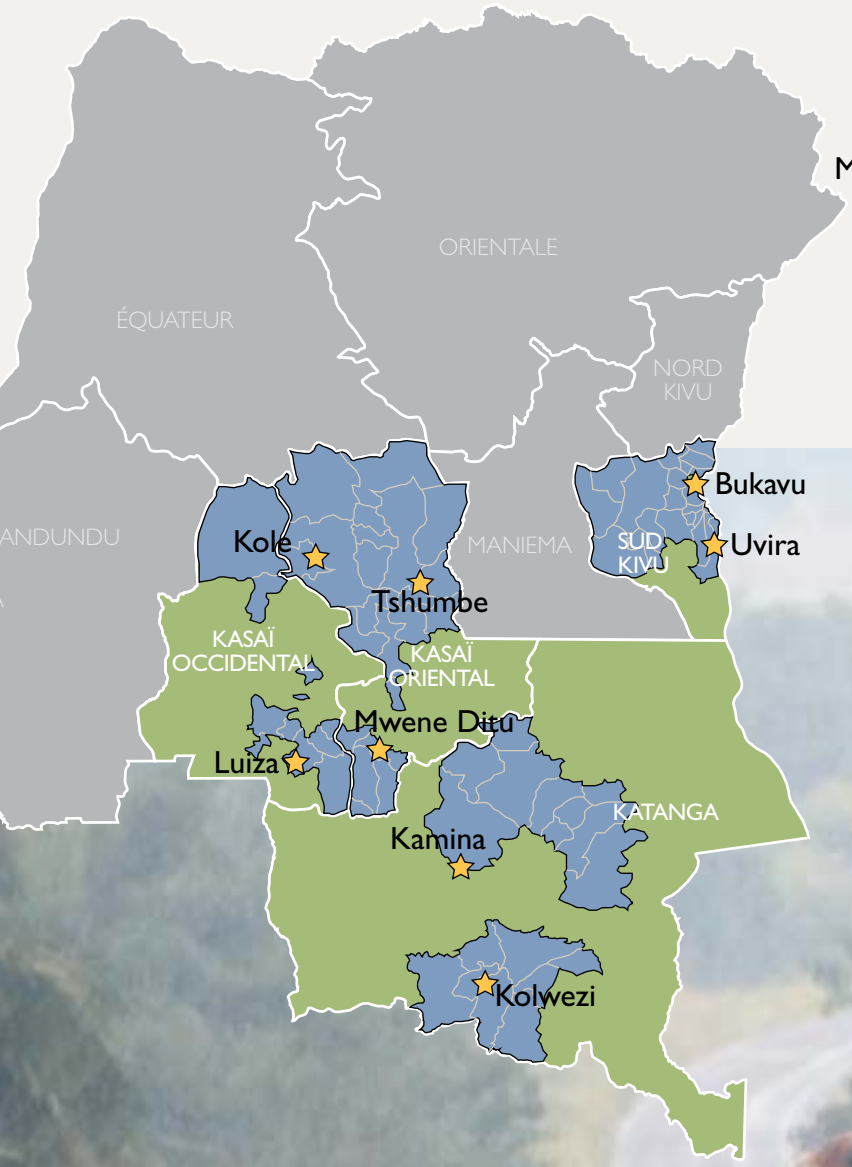
With regard to improving gender-based services, IHP exceeded targets for the number of behavior change communication (BCC) campaigns that delivered key health messages targeting women and girls, and almost met targets related to the number of health workers who are clinically trained in case management of sexual violence. Project results fell below targets for the number of people reached by a USG-supported intervention providing gender-based violence (GBV) services (e.g., health, legal, psycho-social counseling, shelters, hotlines, and other).

IHP implemented the *Formation Sanitaire Complètement Fonctionnelle* (FOSACOF, or fully functional service delivery point in English) and results-based financing (RBF) approaches to promote the adoption of minimum quality standards at health facilities and improve the quality of care. A total of 737 health centers implemented FOSACOF. Project data shows that the FOSACOF approach was significantly associated with improved performance in several health areas. RBF evaluations demonstrated that the RBF approach contributed to significant increases in the utilization rate of curative services and the quality of health center and GRH services.

IHP's performance in increasing knowledge, attitudes, and practices to support health-seeking behaviors was strong. The project almost achieved, achieved, or exceeded targets for the majority of community mobilization and BCC strategies including the percentage of communities with active CODESAs, the number of CODESAs with a communication action plan, the percentage of nongovernmental organizations (NGOs) representing women, youth, and vulnerable groups participating in coordination meetings, the number of Champion Communities selected and trained, the number of community health action plans, and the number of youth organizations participating in youth education outreach. These strategies also proved effective in increasing and improving the quality of health services. IHP did not achieve mHealth results for the number of educational SMS messages sent during campaigns.

IHP contributed to improving health sector leadership and governance throughout the life of the project. The Leadership Development Program (LDP) was a cross-cutting strategy that was implemented to increase and improve the quality of health services in supported in health zones. While the project fell below the target for the number of teams achieving 80% of their desired performance, 84% of the LDP projects achieved their desired results. IHP achieved or exceeded results for the percent of health zones with validated action plans and with annual operational plans based on the National Development Plan. Results related to the percentage of health zone management teams with a performance management system fell below targets.

More detailed discussions related to the project's indicators, including challenges to achieving targets and actions taken to improve performance, are outlined throughout the document.



Bukavu Coordination Office – 22 health zones
Kamina Coordination Office – 9 health zones
Luiza Coordination Office – 9 health zones
Mwene Ditu Coordination Office – 9 health zones
Kole Coordination Office – 8 health zones
Kolwezi Coordination Office – 8 health zones
Tshumbe Coordination Office – 8 health zones
Uvira Coordination Office – 5 health zones

Total Population Served: 13,020,139

IHP's vision was that people in the project health zones—representing about 17 percent of the Congolese population—would participate more fully in determining their health outcomes through greater access to higher-quality comprehensive care; service delivery systems would be accountably and effectively managed in their interests; and family-centered communication would reflect healthy behaviors that people understood and could act on in their daily lives.

Photo : Warren Zelman

PROJECT OVERVIEW

The Integrated Health Project in the Democratic Republic of Congo was a five-year Cooperative Agreement (2010–2015) funded by the US Agency for International Development (USAID)/Democratic Republic of Congo and implemented by Management Sciences for Health (MSH) with partners the International Rescue Committee (IRC), and Overseas Strategic Consulting (OSC), Ltd. The project covered 78 (formerly 80)[4] health zones in four provinces: Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu.

Country context in 2010

Until 1990, the DRC's health system was well known in Africa for its network of clinics, quality of physicians, and primary health care system, but the war and mismanagement led to backsliding in the health sector. Before IHP began in 2010, access to primary health care remained a challenge, and 70% to 80% of the population had little or no access to health care. Access varied widely by province and health zone, with urban areas generally better served than rural.

Health indicators in the DRC were among the worst in the world and reflected the hardships resulting from many years of civil war, continuing conflict in some regions, and the significant deterioration of health services throughout the country. The 2007 Demographic and Health Survey (DHS) estimated that life expectancy was 43 years—the lowest of any country without a high HIV/AIDS prevalence.[5]

According to the DHS 2007, under-five mortality was 148 per 1,000 live births, and infant mortality was 92 per 1,000 live births. An extremely high disease burden—which for a child under five includes 6 to 10 episodes of malaria per year and multiple episodes of diarrhea and acute respiratory infections—contributed to the very high rate of child mortality. The DHS reported that 15% of children under five had symptoms of acute respiratory infection (ARI) in the past two weeks, and 16% had diarrhea during the two weeks preceding the survey. Although immunization rates were increasing in many health zones, measles continued to be a significant cause of death, particularly in the youngest age groups. The National Malaria Control Program reported that malaria accounted for 25% to 30% of under-five mortality contributing to approximately 75,000 to 100,000 deaths a year.

Malnutrition was also a major problem for the under-fives and interacted in a vicious circle with the high disease burden to seriously compromise the health of young children. The DHS 2007 reported that 46% of under-fives were stunted or too short for their age, and therefore suffered from chronic malnutrition. Chronic malnutrition is associated with poor school performance and decreased productivity in later adulthood. Ten percent of under-fives suffered from acute malnutrition and thus were more susceptible to illness and at higher risk of mortality. Approximately 19% of women aged 15 to 45 had a body mass index lower than 18.5, which is considered malnourished. More than 50% of women also suffered from anemia. Malnutrition and anemia both affect birth outcomes and seriously jeopardize the mother and baby's health. A very high fertility rate of 6.3 with short birth intervals also significantly affected both child and maternal mortality rates. The DHS 2007 reported a very high maternal mortality rate of 549 per 100,000 live births. For all deaths of women aged 15 to 49 years, almost one in five were related to pregnancy.

Water, sanitation, and hygiene (WASH) was a critical problem. In 2007, less than half of the Congolese people had access to clean water (79.5% urban; 24.1% rural);

4 Of the initial 80 health zones, IHP dropped the Kalehe health zone (Bukavu) due to insecurity during fiscal year 2012. At USAID's request, the project transferred the Bulape and Tshikaji health zones (Kasaï Occidental) to IMA World Health to be covered under the DFID-funded *Accès au Soins de Santé Primaires* (ASSP) project in May 2014 and split the Dikungu-Tshumbe health zone into 2 separate zones (Dikungu and Tshumbe). This is reflected in modification #12 issued by USAID on January 28, 2015.

5 Democratic Republic of Congo Demographic and Health Survey (DHS), 2007.

83% of households used rudimentary and inappropriate toilets (79% urban, 86% rural), and 12% did not use toilets at all (DHS 2007). According to the MOH, 14% percent of child deaths were attributable to water-borne diseases. The long-term goal of the DRC MOH was to increase and sustain access to safe drinking water and sanitation, and to improve hygiene. The MOH developed a national 5-year program with a specific objective to reach an additional 9 million Congolese people (about 12,000 villages) with clean water throughout the country by 2012.

In 2009, the DRC ranked tenth among the world's 22 high-burden TB countries and fourth among those in Africa. The estimated incidence of TB was 392 cases per 100,000, according to the *WHO Global Tuberculosis Control Report 2009*. TB was one of the leading causes of death in the DRC; each year approximately 51,240 Congolese died from TB infection.[6] In 2009, 307 MDR-TB patients were on treatment.[7] The National TB Program (NTP) reported a national TB case detection rate of 69%, and a cure rate of 83% (2008 figures). HIV prevalence in adult-incident TB patients was 17% in USG-supported clinics in Kinshasa. USAID was a major donor for TB in the DRC and supported programming at the national, provincial, and zonal levels.

The DHS 2007 estimated that 1.3% of the population aged 15-49 years was HIV positive: 1.9% urban and 0.8% rural; 1.6% among women and 0.9% among men. The 2006 surveillance of ANC clinics estimated prevalence at 4.1%. For women, the highest prevalence was between ages 40 to 44 years. For men, the highest prevalence occurred between 35 to 39 years (1.8%). HIV prevalence was highest for both men and women in Kinshasa (2.3% for women and 1.3% for men). The 2008 UNAIDS Estimation and Projection Package (EPP), based on existing surveillance data from the past five years, suggested that 1.2 million Congolese were infected with HIV, that over 42,000 mother-to-child infections would occur in 2008, and that 250,000 Congolese would be eligible for ART by 2010.[8]

Sexual- and gender-based violence (SGBV) was widespread, and the DHS 2007 pointed to alarming data about rape and sexual violence in the DRC. The DHS reported that nearly 75% of women had suffered from spousal or partner abuse, whether physical, emotional, or sexual. Nearly two-thirds of women reported suffering from physical violence since age 15, and nearly half of women suffered violence during the past 12 months, with married women reporting higher levels of violence. Sixteen percent of women had been forced to have intercourse against their will at some point in their lives. The legal system provided little protection to women who experience such violence, and support networks or advocacy organizations to address this fundamental gender inequality were minimal at best. This perceived gender inequity and the related violence against girls and women provided a backdrop for the persistence of different forms of SGBV in the DRC. Until the Congolese public begins to recognize the links between girls' and women's low status, and the resulting vulnerabilities to violence, efforts to address SGBV will be limited in effectiveness.

In 2010, the DRC was ranked in the bottom ten countries in the world on a range of basic social and quality of life indicators, with an estimated 80% of the population living below the poverty line. The country's long decline from relative prosperity and ability to provide for the basic needs of the population shifted to complete free-fall during the decade of conflict that accompanied the collapse of the Zairean state. The socioeconomic context exacerbated the country's health challenges.[9]

The poverty rate remains high in the DRC, despite an impressive economic growth rate and a reduction in the rate from 71% in 2005 to 63% in 2012. DRC is among the poorest countries in the world and was ranked 176 out of 187 countries on the Human Development Index in 2015, and its per capita income—at $380 in 2014—is among the lowest in the world.[10]

In summary, prior to the start of IHP, the DRC faced a very difficult health environment that affected overall development of the country. The very large disease burden—including malaria, TB, and HIV and AIDS—took a high toll on both human and economic resources. One out of 6 children died before their fifth birthday, and chronic malnutrition affected both educational performance and individual productivity. The synergistic effects of malnutrition and disease were a way of life for most young children. The very high fertility rate meant that too many children were born too close together and mothers were

6 National TB Program/APA 5 Workplan.
7 National TB Program/TB CAP 2009 Annual Report.
8 2008 Assessment of HIV/AIDS Program in DRC, Findings and Recommendations for Future USAID Programming, 2008-2012.
9 Excerpt from the Request for Application (RFA) No. RFA-OAA-10-000006, USAID/Democratic Republic of Congo.
10 The World Bank. Country Overview: The Democratic Republic of Congo. Web, http://www.worldbank.org/en/country/drc/overview.

Photo : Warren Zelman

not able to optimally feed and care for their children, while jeopardizing their own health from multiple pregnancies and complications of pregnancy. Lack of adequate water and sanitation led to frequent outbreaks of diarrheal diseases, causing high fatality rates. Many of these diseases were preventable, and most had known and affordable treatments. By increasing the availability and accessibility to quality health services, the DRC could significantly improve the health status of its people.

It was to join the MOH in addressing these and other challenges that IHP began its work in 2010. IHP was considered a follow-on to two USAID health programs, AXxes[11] and the MSH/Leadership, Management and Sustainability (LMS) program, which ended in September 2010 and December 2010, respectively. The two projects together supported service delivery and related supporting services (technical assistance, training, pharmaceutical and other commodities and logistics management, facility renovation and equipment, and information systems/monitoring and evaluation) in 78 target health zones with a population of almost 11 million people in 2010. IHP was expected to provide continued support to service delivery in the targeted health zones in four provinces of Kasaï Oriental, Kasaï Occidental, Katanga, and Sud Kivu.

Project approach

IHP supported the DRC's National Health Development Plan's first two pillars—health system strengthening and support for health zone strengthening—in 6 priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new technologies; and improved health system management. The project worked to:

- increase access to and availability of MPA-plus and CPA-plus services and products in target health zones (later modified to cover MPA and CPA only);
- increase the quality of key family care services (MPA/CPA-plus) in target health zones (later modified to cover MPA and CPA only);
- increase the knowledge, attitudes, and practices that support health-seeking behaviors; and
- improve leadership and governance in the health sector.

IHP's **conceptual approach** was based on people and team-centered health systems strengthening that had at its heart outreach to health service providers, health authorities, community organizations, and families with evidence-based techniques they can use to impact the health system in ways that are meaningful and sustainable. IHP aimed to build human capacity to lead and manage for health results, whether in the public, civil society, or private sector.

IHP's **vision** was that people in the project health zones, representing about 17 percent of the Congolese population, would participate more fully in determining their health outcomes through greater access to higher-quality comprehensive care; service delivery systems would be accountably and effectively managed in the interests of the population they served; and family-centered communication would reflect healthy behaviors that people understood and could act on in their daily lives.

The **overarching objective** of the project was to improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for family planning, maternal, newborn, and child health (MNCH), nutrition, malaria, TB, HIV and AIDS, and WASH in target health zones (see Figure 2).

Through its two components, Health Services and Health Systems Strengthening, IHP

Figure 2. IHP focus areas

11 AXxes was a large USAID-funded health systems strengthening and service delivery program which targeted 8 million people in post-conflict areas of eastern DRC. It was led by IMA World Health and implemented between 2006 and 2011.

Table 1. IHP results framework

USAID DRC Health Assistance Objective: Improve the basic health conditions of the Congolese people			
IHP Project Objective: Improve the enabling environment for, and increase the availability and use of, high-impact health services, products, and practices for family planning, MNCH, nutrition, malaria, TB			
Intermediate Result 1	**Intermediate Result 2**	**Intermediate Result 3**	**Intermediate Result 4**
Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased	Quality of key family health care services (MPA/CPA-plus) in target health zones increased	Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones	Health sector leadership and governance in target provinces improved
Strategies/Activities by Sub-Intermediate Result (IR)			
1.1: Increased facility-based health care services/products ■ Provide materials ■ Provide essential medicines, commodities, and materials	**2.1: Clinical and managerial capacity of health care providers** ■ Training, supportive supervision	**3.1: Health sector community outreach linkages** ■ CODESA ■ Youth outreach groups	**4.1: Provincial and national level health sector policies** ■ Annual operational plans
1.2: Increased community-based health care services/products ■ i-CCM at community treatment sites ■ CODESA, collaborative strategy at community level	**2.2: Minimum quality standards** ■ Fully functional service delivery point (FOSACOF) ■ Results-based financing (RBF)	**3.2: Health advocacy/community mobilization organizations** ■ CODESA ■ Champion Communities	**4.2: Evidence-based tools for strategic planning and management decision-making** ■ Fixed amount awards ■ Data collection and NHIS management ■ Routine data quality assessment
1.3: Effectively engaged provincial management ■ Leadership Development Program	**2.3: PHC referral system for prevention, care, and treatment**	**3.3: Behavior change campaigns** ■ Awareness-raising campaigns ■ mHealth ■ Closed user groups	**4.3: Community involvement in health policy and service delivery institutionalized** ■ Citizen engagement approaches, e.g. CODESA

Photo : Rebecca Weaver

Providing training and support for local village health committees like the Cagombe CODESA (shown here preparing for their monthly meeting with local government health officials) is only one aspect of DRC-IHP's approach to behavior change. In addition to training CODESAs in community mobilization methods like how to approach a woman who is pregnant and provide her information about the importance of four ANC visits, the integrated method includes the Champion Community approach and champion man/woman approach.

supported 1,476 facilities (1,398 health centers and 78 GRHs) in the target zones. Due to poor road conditions and hard-to-reach geographical areas of the majority of the target zones, the need for operational hubs was clear: in addition to establishing a project office in Kinshasa to facilitate communication with the MOH, other host government authorities, and USAID, IHP established 8 provincial-level coordination offices and three provincial representation offices to facilitate implementation of activities at the field level. The project reinforced a people- and team-centered approach to strengthening the DRC's health system, with a focus on four intermediate results detailed in Table 1, page 11.

Integration

Creating sustainable change in a health system requires an integrated approach. Supply, demand, and quality elements need to be integrated at each level of the system (community, health facility, hospital, health zone, provincial, and national), and these levels must also be linked to each other in a holistic manner. IHP endeavored to integrate change mechanisms by focusing on key drivers in the system and working toward creating linkages at all levels.

The project successfully introduced new tools and innovations while working in close collaboration with key actors in the health system. IHP contributed to community empowerment and resilience through bottom-up approaches while simultaneously working with the upper echelons of the MOH to create effective policies, norms, and protocols. Disease-specific programs were integrated through coordinated efforts at several levels of the health system, with a significant focus on the community level.

Theory of change

IHP activities were guided by the principle that *"an essential condition for measurable impact [in improved health outcomes] is empowerment: greater understanding of individual roles and responsibilities throughout the health system leads to changes in attitudes and motivation to make incremental changes that can ignite a chain reaction across the sector. This shift results in improved health services and other health systems, for a greater health impact on clients."* Both the health sector and the community must be empowered to work in collaboration to achieve improved health outcomes.

Providing health sector staff with the knowledge and skills to effectively lead and govern through policy alignment, development, and evidence-based strategic planning and decision-making was a key element of IHP's approach. Effective leadership and governance enables health professionals to promote healthy behaviors, improve access and availability to quality services for the population, and collaborate effectively with community groups. IHP built the capacity of the health system to promote healthy behaviors through the use of technical approaches such as education through listening (ETL) and BCC, using text messaging and social media. In addition, IHP worked with all levels of the health system to improve quality of care using the *Formation Sanitaire Complètement Fonctionnelle* (FOSACOF, or fully-functional service delivery point in English) model in conjunction with supportive training and supervision. IHP provided incentives for improved performance of the health system using RBF as well as providing materials, commodities, and equipment (see Figure 3, page 13).

IHP's integrated approach to achieving positive health outcomes also included increasing the capacity of communities and individuals to access and effectively use health services. IHP mobilized the community using innovative approaches such as Champion Communities and built their capacity to hold the health system accountable for the quality of services provided. This objective was furthered by forming and revitalizing CODESAs, supporting provincial NGOs, and improving CHWs' ability to act as an effective referral network between the community and the health system. Mobilizing and empowering the community leads to more effective health-seeking behaviors and use of the health system. That, in turn, creates more demand for good governance and open communication, better referral networks, and bi-directional flow of information.

Although no perfect mechanism exists to assess the effectiveness of the CODESA, the project has observed the potential of these committees to positively influence health outcomes in the communities they serve. Key issues to consider when working with local health entities are the selection process, the effectiveness of educational techniques, the frequency and quality of monitoring and mentoring, and the ability to maintain motivation—all are tied to a collective empowerment to make meaningful change.

Figure 3. IHP's theory of change

An essential condition for measurable health impact in improved outcomes is empowerment.

Health leadership support

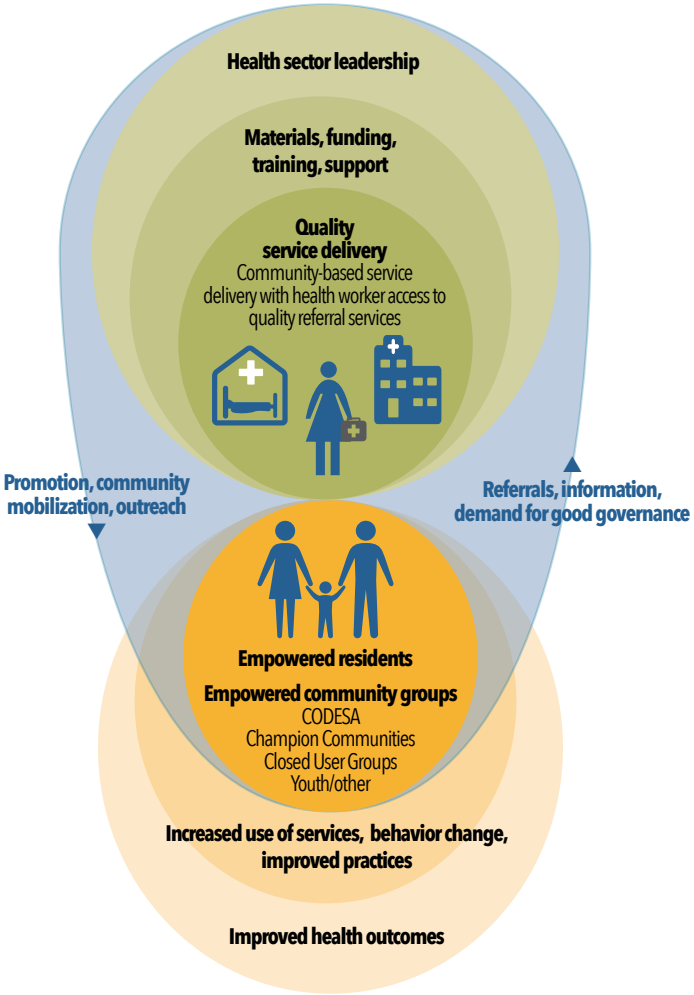
Support the MOH in its leadership and governance roles by providing—

- Leadership, management, and governance support training
- Policy alignment and development
- Evidence-based strategic planning and decision-making

Community health

Increase access to, availability of, and quality of health care by providing systems for—

- Health promotion and enhanced communication (ETL, BCC)
- Essential materials and commodities
- Training and supportive supervision for quality community-based service delivery (i-CCM, CODESA)
- FOSACOF
- RBF
- Medical referrals



Monitoring project performance

Using a systems-strengthening approach to address challenges at all levels of the health system, IHP helped build the institutional capacity of the MOH, while simultaneously strengthening community cohesion. Community leadership initiatives increased awareness of services and created greater demand for them.

IHP tracked 80 indicators in 15 technical areas. Figure 1, on pages 2–3, shows the project's progress as the percent of targets achieved and in absolute numbers. The complete performance monitoring plan (PMP) can be found in Appendix 1. The number of indicators tracked in any specific domain was dependent on multiple variables, including the source of funding, and did not necessarily reflect that domain's relative amount of funding or prioritization. For example, HIV and malaria activities received funding through PEPFAR and the President's Malaria Initiative (PMI) and thus reported according to the requirements of those funding sources, which is reflected in the large number of indicators in these domains.

Assessing Results

To understand the association between project approaches and performance, key IHP strategies such as training of health personnel, equipping and rehabilitating infrastructure, and educating the population about healthy behaviors, IHP selected innovations in family planning, maternal, neonatal, and infant health, and nutrition. Begin Salumu's in-depth assessment of the project's strategies did not include data on TB, HIV, and WASH, so the links between these strategies are not included in this report.[12]

To study the link between these strategies or innovations and performance in the IHP health areas, selected indicators from the PMP for each health area were explored in a multivariate analysis (logistic regression) to highlight the chance that benefiting from a particular strategy or innovation led to higher health zone performance than those that did not benefit from those initiatives. This comparison was done for each selected indicator after statistically grouping (using k-means algorithm) all health zones into two classes (either high performing or low performing), depending on the average result achieved in relation to the relevant indicator.

The multivariate analysis provided an odds ratio (OR) of a particular strategy being associated with higher performance on a specific indicator. In this case, an OR of greater than one indicates that a particular IHP strategy (exposure) was positively associated with higher health zone performance on a specific indicator (outcome). An OR of less than one would suggest that the strategy was associated with poorer performance. The OR should be considered with appropriate caution as it indicates an association, not causation. Results of the analysis are presented throughout the final report.

Using LiST to measure impact and guide implementation

IHP used the Lives Saved Tool (LiST) not just to calculate the project's impact, but also to identify which interventions were successful and thus essential to scale up to save more mothers, babies, and children. The methodology the project used to determine these interventions is based on the 7 steps described in Table 2, opposite, and more fully in Appendix 4.

12 *Analyse des stratégies du PROSANI et autres déterminants de la performance des zones de santé dans quatre provinces de la République Démocratique du Congo de 2010 à 2015,* Begin Salumu, December 2015.

Table 2 LiST methodology

Step 1	
Identify health issues or impact objective by using the tool	The project determined the total number of deceased children and their distribution per cause of death and per supported province.
Step 2	
Identify health challenges, underlying causes/risk factors	Using the project's 2011 baseline study, the project determined the interventions with the lowest coverage and their location.
Step 3	
Identify and choose high-impact interventions	LiST allowed the project to set up and run multiple scenarios to look at the estimated impact of different intervention packages and coverage levels for the supported areas. The project team made coverage estimate targets for 2015 based on the baseline study and was then able to identify high-impact interventions the project should implement (see Appendix 4 for the scenario adopted by the project that informed its decision for specific interventions).
Step 4	
Identify bottlenecks to improve the coverage of the suggested interventions	The project identified the following bottlenecks: *Insufficient offer of services* ■ Limited availability of medical supplies and essential drugs ■ Scarcity of human resources, poorly trained and demotivated staff, low level of supervision ■ Scarcity of health structures, lack of equipment *Insufficient demand of services* ■ Lack of information (few children with diarrhea are taken to health facilities to get treated) ■ Prohibitive costs ■ Lack of trust ■ Disconnect between the health facility and the community it serves
Step 5	
Identify strategies and technical needs	The project focused on reinforcing specific implementation strategies : *Capacity building (support the emergence of well-informed/trained and motivated staff and community actors who benefit from regular supervision)* ■ Health staff ■ CODESA, CHWs, community-based organizations, IYCF support groups, Champion Communities and Men, etc. *Procurement of medical supplies and drugs* ■ Secure essential drugs availability on site ■ Provide basic medical supplies such as beds, scales, chronometers, advice cards, MUAC tapes *Strengthen financing of health facilities* ■ RBF ■ Financial support for specific renovation projects
Step 6	
Select the most appropriate M&E indicators	■ Percent of children of 6 months and under receiving only breastmilk for food ■ Percent of children under 5 years old who sleep under an LLIN ■ Percent of children under five suffering from malaria and who were treated with ACT within 48 hours ■ Percent of children under five suffering from pneumonia and who were treated with antibiotics (cotrimoxazole) ■ Percent of children under five suffering from diarrhea and who were treated with a combination of oral rehydration solution and zinc ■ Percent of children under 12 months who were immunized with DTC-HepB-Hib3
Step 7	
Estimate the number of lives saved	Using the coverage rates of the key interventions selected, the project is able to give an estimate of the total number of lives saved

"On July 29, 2015, I led a large delegation to Dibaya to witness IHP's achievements. This visit enabled me to observe the joy and satisfaction of the population for IHP's support. I admired the strong community dynamic... The testimonies I heard from people led me to believe that the project has changed people's attitudes, behaviors, and awareness to increase favorable health practices."

—Dr. Léandre Kambala,
Provincial Minister of Health, Kasaï Occidental

Photo : Warren Zelman

KEY ACHIEVEMENTS

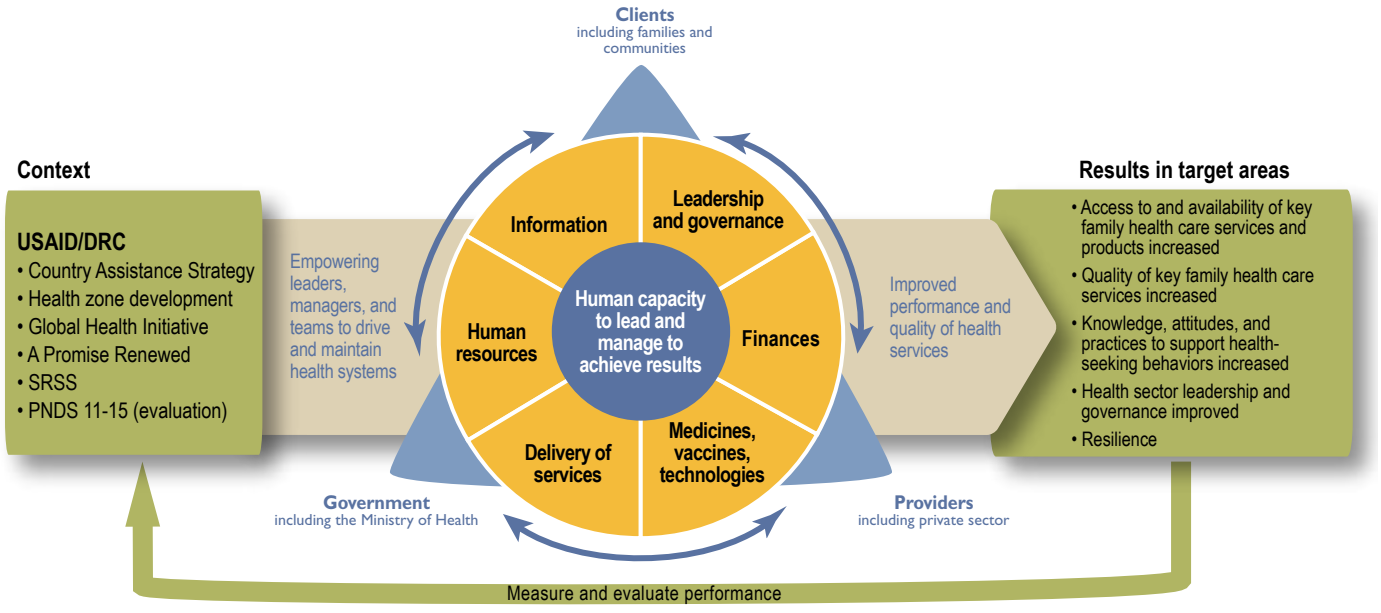
IHP's overarching technical strategy to integrate activities across health system sectors, levels, and geography was people-centered health systems strengthening. Component 1 of the project, its primary focus, concentrated on health services. Three of the project's four intermediate results (IRs) are included in this component, which most immediately impacts the population. IHP addressed service delivery at the community, health center, and referral hospital levels, while working simultaneously to support health-seeking behaviors.

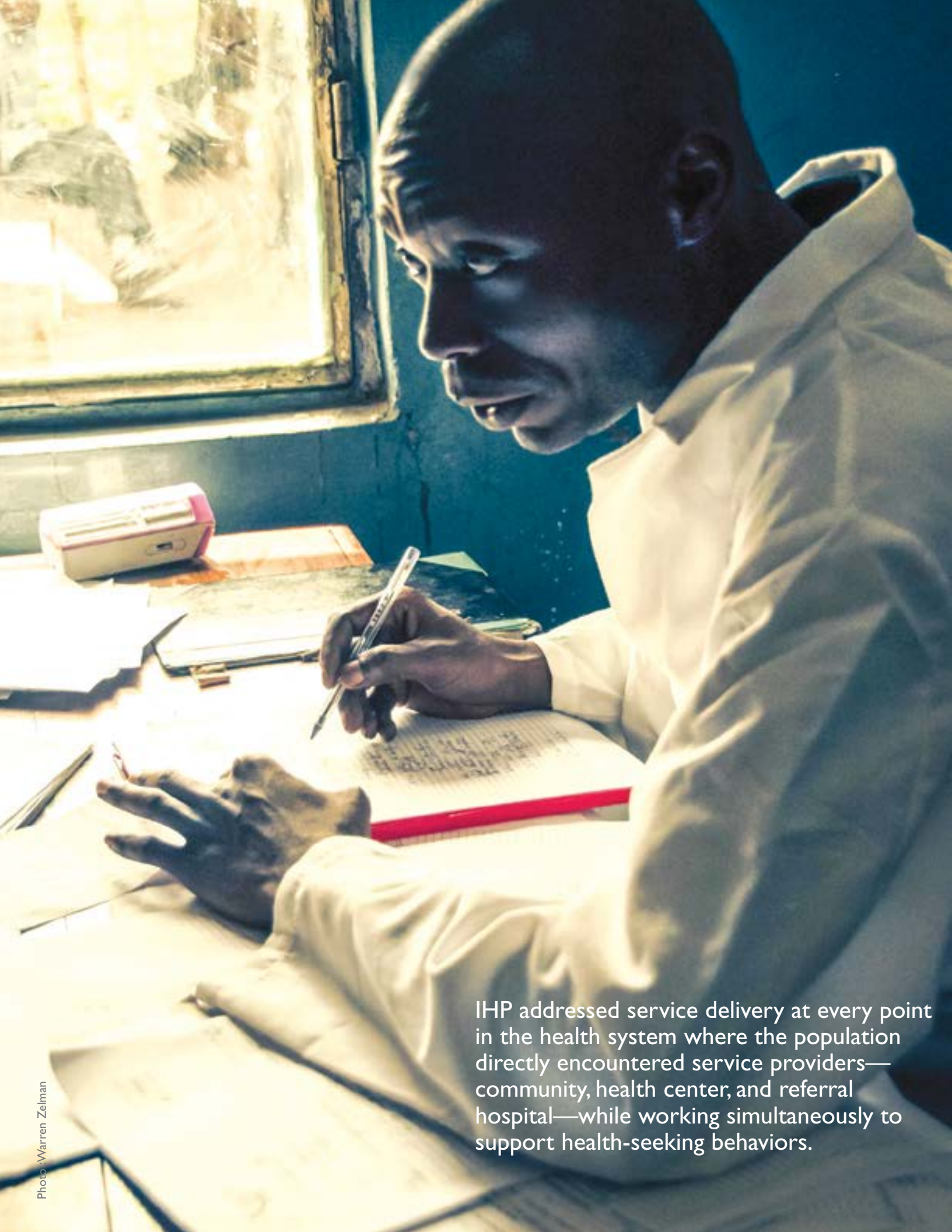
Component 1 strengthened health zones' capacity to deliver services by addressing both supply of and demand for services (see Figure 4 below). IHP focused on activities that increased access to and availability of high-impact, family-centered health services and products (MPA/CPA-plus) through facilities and community-based platforms.

Demand was stimulated by improving the quality of those services and products, as well as by improving the knowledge, attitudes, and practices of households and individuals in support of health-seeking behaviors.

The DRC health sector faces significant challenges, with a high burden of infectious disease, insecurity in many areas, and poor infrastructure. Reducing maternal and infant mortality rates was a project priority, as was addressing the related challenges of high fertility, domestic violence, malnutrition, and poor access to services. IHP worked with multiple partners to increase quality and access to low-cost, high-impact health services and focused its assistance to the service delivery sector on innovative, evidence-based strategies at the primary health care and community levels.

Figure 4. People-centered health systems strengthening

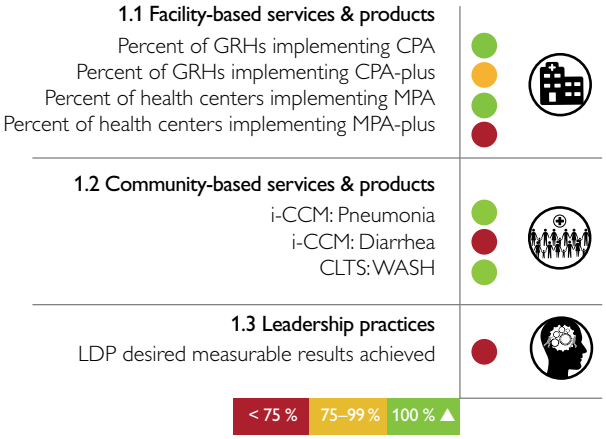




IHP addressed service delivery at every point in the health system where the population directly encountered service providers—community, health center, and referral hospital—while working simultaneously to support health-seeking behaviors.

Photo: Warren Zelman

Figure 5. Summary of IR1 key results by sub-IR



Intermediate Result 1: Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased

To successfully achieve expected results for this IR, IHP worked towards three sub-IRs that addressed access and availability at the hospital, health center, and community levels, while reinforcing institutional capacity at the provincial level to support, supervise, and orient health zones to improve service delivery. Key IHP performance results for IR1 are summarized in Figure 5 above, and are discussed in detail in the following sections.

IR 1.1. Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased

Use of health services

The CPA-plus and MPA-plus services and products include fifty activities that encompass curative, preventive, and promotional services in health centers (MPA-plus) and GRHs (CPA-plus). The original target for IHP was that 80% of project-assisted health centers and GRHs would offer CPA-plus and MPA-plus services by the end of the project. By the third year of the project, however, it was clear that IHP would not be able to attain the set targets for a number of reasons: (1) in the WASH sector, following a field visit to Mwene Ditu, Kasaï Oriental, in July 2012, USAID and IHP decided to shift from a village approach to a zonal coverage approach, to cover at least 80% of the villages in selected zones. As a result, starting in year three, WASH activities concentrated in 9 health zones rather than the original 80 assisted health zones. Therefore, the target for the number of health zones implementing the WASH-related activities included in the MPA-plus or CPA-plus needed to be reduced accordingly; (2) In HIV and AIDS, following the PEPFAR decision to withdraw from non-focus provinces (Sud Kivu, Kasaï Occidental, and Kasaï Occidental) in April 2013, all HIV-related activities stopped in these provinces and continued only in Katanga. Therefore, the target for the number of health facilities implementing the HIV and AIDS activities included in the MPA-plus or CPA-plus again needed to be reduced accordingly; and (3) In FY 2013, USAID and the MOH directed IHP to prioritize MNCH activities aimed at accelerating the reduction of maternal, newborn and child mortality in the assisted health zones. To respond to this global and national priority, in Project Year (PY) 4, USAID increased IHP's MNCH funding substantially. Due to the fact that some MPA-plus and CPA-plus activities and equipment were not considered substantial contributors to the acceleration plan, they were no longer considered among project priorities and therefore were not budgeted.

During the same year (PY3), USAID contracted with International Business and Technical Consultants, Inc. (IBTCI) to conduct an external baseline health facility evaluation that confirmed that the targets set in the IHP cooperative agreement were unrealistic. IBTCI noted that *"It is unrealistic to expect 80% of IHP's health facilities to achieve a full range of MPA-plus services by the end of the project. Both the breadth of the target population (~1,500*

facilities in total) and the depth of the MPA-plus services (some 50 activities) are overly ambitious given the existing status of the health system, logistical constraints, and implementation costs…IHP has not been funded adequately to support the full range of MPA-plus services in the 80 targeted health zones. USAID should convene with IHP and others to revisit project priorities and targets. The depth of the MPA-plus package should be reconsidered."

USAID and IHP teams agreed to keep the 80% target for MPA-plus and CPA-plus and revise the content of packages of services to reflect the reality of services IHP is able to support (see Appendix 10). USAID and IHP teams also refined the calculation of the MPA-plus and CPA-plus achievement according to the redefined package of services. As a result, the number, utilization, and quality of these services all increased dramatically.

Health service utilization increased progressively throughout the project, from 36% in PY1 to 46% in PY5 (see Figure 6). By the end of the project, the health services utilization rate for each of the 8 coordination offices met or surpassed the national average of 35%. Overall, project-supported facilities achieved 114% of the national average.

Figure 6 shows increased utilization by project coordination office. The most impressive increase was in Kolwezi, where the respective averages increased from 44% in PY1 to 68% in PY5. This phenomenon may be explained by the mining boom; the influx of mining companies triggered migration of the population to this area. The vast majority of health facilities received subsidies from the numerous local mining companies that are based in Kolwezi, which contributed to this increase.

Figure 7 shows the increase of service utilization by IHP coordination office and the percentage achieved against the national average. Overall utilization rates increased by four percentage points in the 78 targeted health zones.

Availability of services, MPA and CPA

To more fully serve the Congolese people, IHP prioritized building the capacity of health centers and hospitals to offer MPA and CPA services. During the five years of implementation, the percentage of health facilities and hospitals offering the minimum and complementary package of services substantially increased. By the end of the project, 90% of GRHs (70 out of 78) offered the full suite of CPA services, exceeding the project target of 80% (see Figure 8). This represents an achievement rate of 112%.

The success rate in health centers was similar (Figure 9), with 99% of health centers (1,365 out of 1,382) offering the MPA against a target of 80%, which represents an achievement rate of 124%. These positive results were supported by the project through the rehabilitation of health centers and GRHs (improvements included roof repair, painting, paving of floors and paths, window repair), and provision of materials such as mattresses, delivery boxes, minor surgery supplies, microscopes, and solar panels. In addition, IHP provided technical and supplementary financial support for general operating costs. Project Year performance is summarized in Figure 10.

Availability of services, CPA-plus and MPA-plus

The CPA-plus and MPA-plus services were estimated based on the agreed calculation included in IHP Modification #12. At the end of the project, 57% (794/1,382) of health centers were providing MPA-plus and 66% of GRHs (51/77) were providing CPA-plus (see Figure 11). Against a set target of 80%, the project reported an achievement rate of respectively 72% and 83%, respectively.

Health infrastructure improvements

From October 2010 to December 2015, IHP spent $2,731,331 to support improvements in facility infrastructure.

In partnership with health zone management teams, IHP worked with communities to rehabilitate health facilities. The IHP approach included transparent communication with the communities—who are key stakeholders and are responsible for renovation, oversight, and maintenance—about the project's mandate to support rehabilitation of health facilities. IHP provided technical support from engineers, donated construction materials, and contributed to the workforce payments. The renovations were jointly monitored by representatives of health zones, health areas, communities, and IHP.

Ensuring the availability of medicines, commodities, and equipment

IHP contributed to the accessibility and availability of essential medicines and non-medical supplies through procurement; training and support of community-based distributors of family planning commodities; providing pharmaceutical management and monitoring tools for personnel in regional warehouses; providing logistics support for the distribution of antimalarial commodities from the President's Malaria Initiative; and the transport of vital vaccines.

In order to improve the quantity and quality of medicines, supplies, and equipment, IHP provided supply chain

KEY: PY1 PY2 PY3 PY4 PY5

Figure 6. Health service utilization % change by coordination office, PY1 vs. PY5

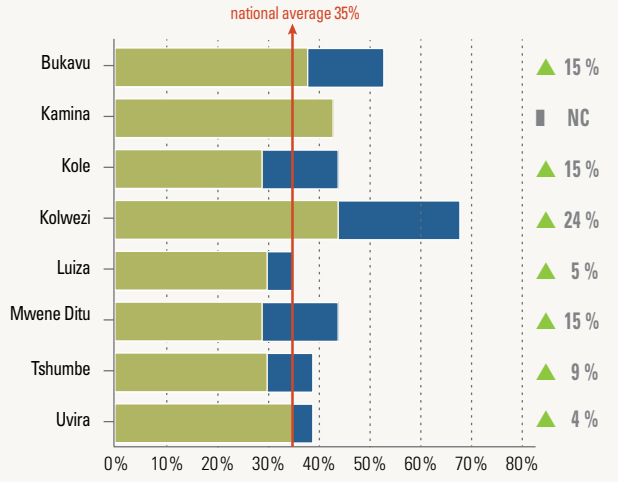


Figure 7. Curative services utilization vs. national average, by coordination office and PY

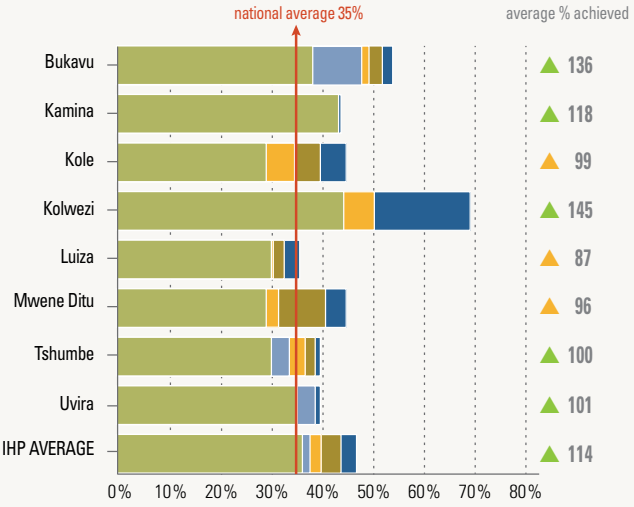


Figure 8. Number of GRHs implementing CPA vs. target, by coordination office and PY

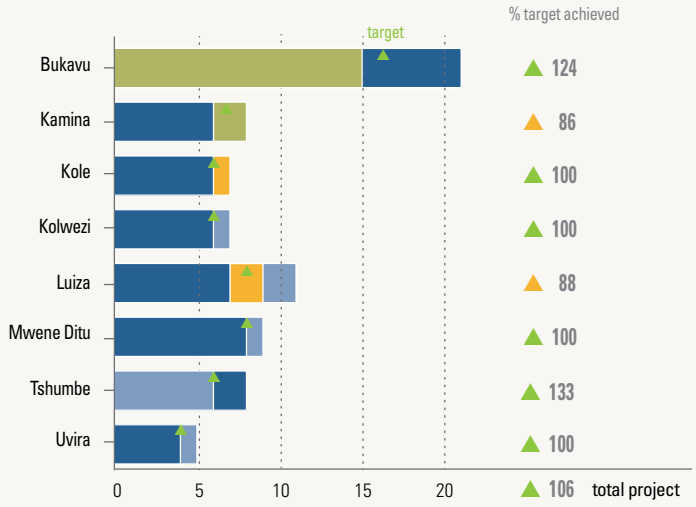


Figure 9. Number of health centers implementing MPA vs. target, by coordination office and PY

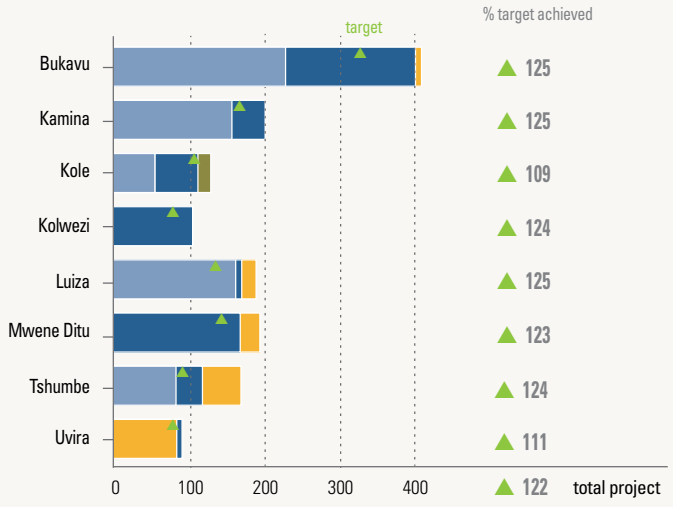


Figure 10. Percent of GRH and health centers implementing respectively CPA and MPA vs target, by PY

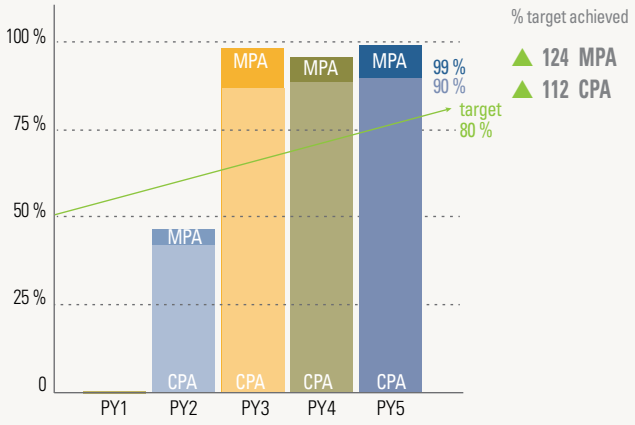


Figure 11. Percent of GRHs and health centers implementing both CPA+ and MPA+ vs. target, by PY

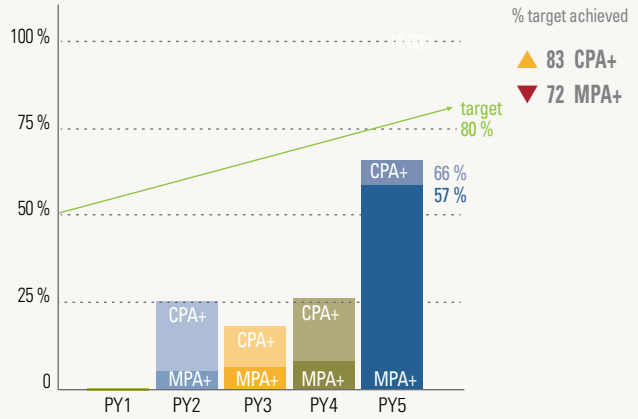


Photo : Rebecca Weaver

Photo : Rebecca Weaver

The Kamoa Health Center before IHP-assisted rehabilitation (above), and after completion (right). The work was performed by community members and supervised by representatives of the health zone, health area, and IHP.

management and technical support from the USAID centrally-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project in DRC. Working in close collaboration with IHP through an MOU, SIAPS increased the availability of essential generic medicines (EGM) at IHP-supported health zones.

Ensure the availability of medications in IHP-supported health facilities

IHP and SIAPS supported the Provincial Health Division (*Division Provinciale de la Santé* or DPS), health districts, and health zones in planning, organizing, and distributing EGM and other supplies. SIAPS was also responsible for obtaining drug importation authorization and narcotics licenses on behalf of IHP.

To ensure the availability of medications in IHP-supported facilities, SIAPS supported the quantification and monitoring of medications and supplies. During PY1, SIAPS' predecessor, the Strengthening Pharmaceutical Systems (SPS) project, filled this role. In PY1, based on an assessment of essential medicine and supply stocks, a technical team finalized the quantification of pharmaceuticals to be procured. The updated national list of essential drugs and supplies was used as reference for this initiative. IHP staff analyzed the bids from the International Dispensary Association (IDA) and MissionPharma A/S and issued awards to the two vendors.

By the third quarter of PY1, IHP had signed contracts with warehouses for the management and distribution of the current stock of essential drugs and medical supplies. The warehouses were managed by their owners under the close supervision of IHP and SPS (which later became SIAPS). Health zones were responsible for requesting medicines using the credit lines provided by IHP.

By the fourth quarter of PY1, IHP completed procurement of essential medicines and medical supplies for PY1, and shipments of drugs began arriving in country in July 2011; IHP delivered these commodities to the 8 regional warehouses (CDRs). Since the procurement of medicines was planned for each year of the project, IHP continuously reviewed the systems in place for procurement, distribution, and tracking of pharmaceutical stocks to increase availability. To this end, IHP worked with SPS support to develop improved pharmaceutical management procedures.

By the end of PY2, SIAPS provincial representatives received 93% of the medicines ordered by IHP, as well as those requested by PMI. In addition to verifying administrative documents, SIAPS conducted a visual inspection of the stock and noted no significant anomalies in the medications. IHP and SIAPS established procedures for medication quality control available for review and use.

Some of the specific pharmaceutical interventions that SIAPS and IHP implemented include:

- Addressing potential stock-outs and delays in delivery of medical supplies by making an urgent request to ASRAMES (a regional association providing EGMs). USAID permitted IHP to procure pharmaceutical products from ASRAMES from April 18, 2012, to April 17, 2014, as long as the organization procured drugs from approved USAID wholesalers and those drugs were received and stored solely at the Goma warehouse. SIAPS monitored the delivery of medicines from ASRAMES.
- During PY3, SIAPS supported the monitoring and delivery of PY2 medicines from the Medical Export Group (MEG), and monitored orders from the health zones, including conducting analysis of requisitions, developing distribution plans, and monitoring commodities, deliveries, and the status of medicines and other commodities.

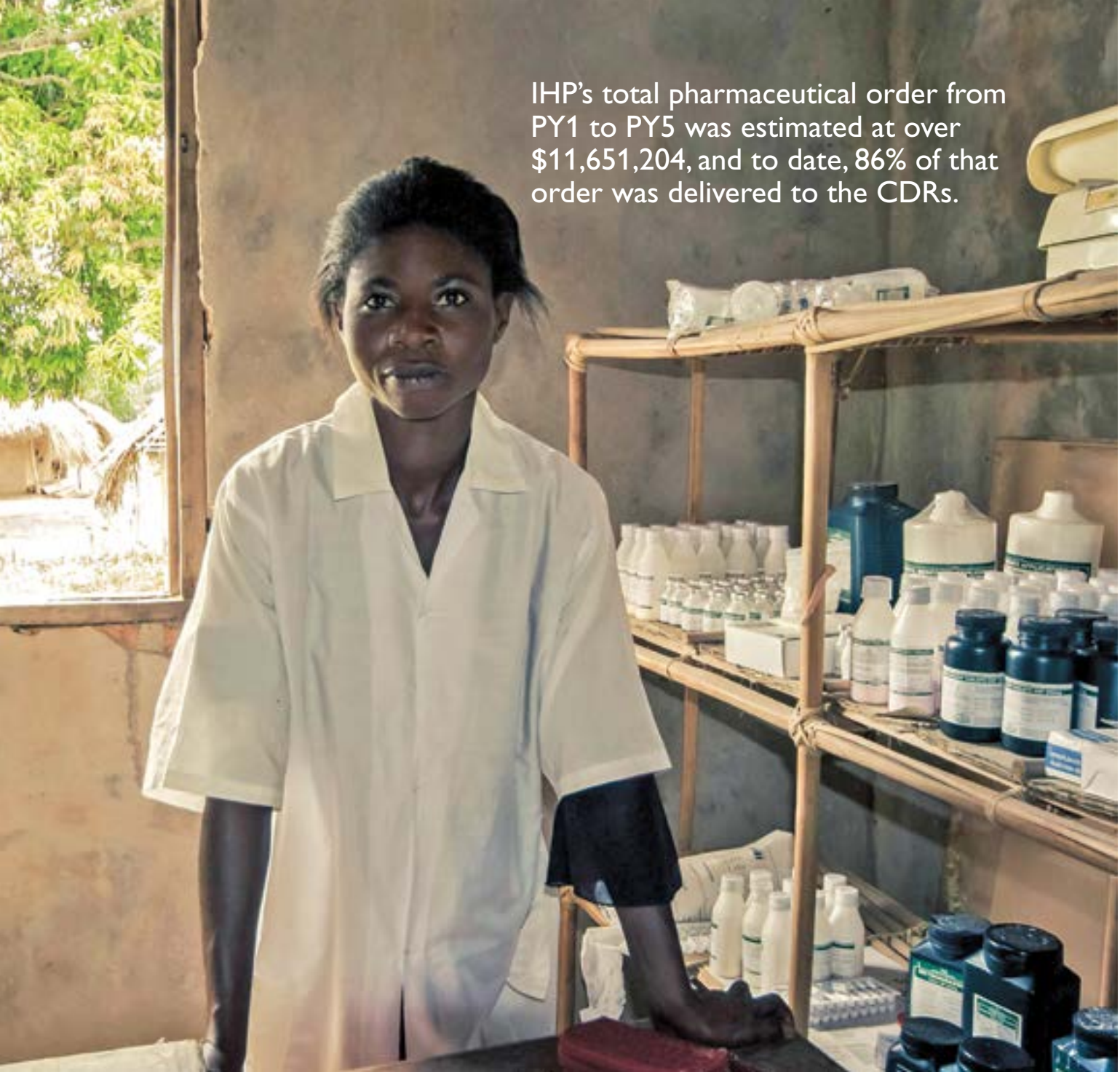


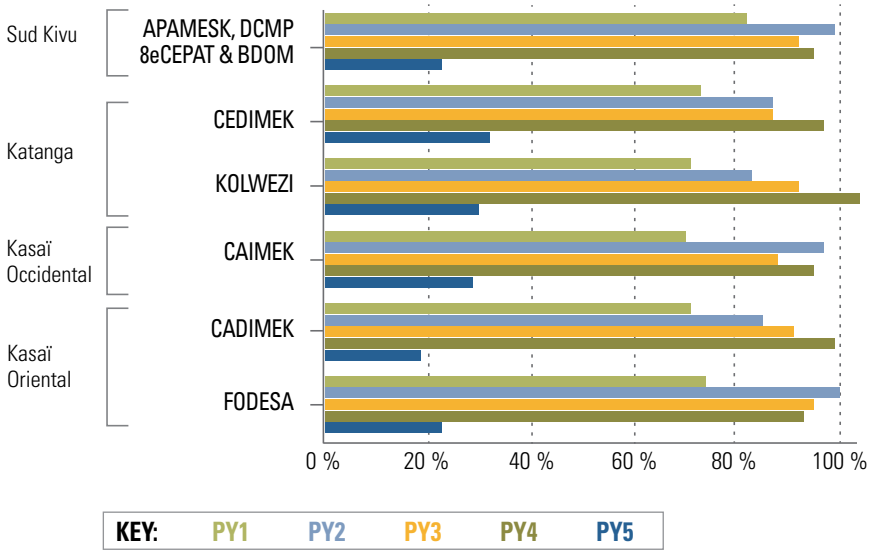
Photo : Warren Zelman

The PY3 pharmaceutical order was placed in September 2013, and pickup from the supplier started on April 2014. The shipment was delivered to the CDRs between June and November 2014. The PY4 pharmaceutical order was placed in August 2014, and pickup from the supplier started in November 2014. The shipment was delivered to the CDRs by October 2015.

During PY5, SIAPS completed a pharmaceutical needs assessment and determined that IHP needed to launch two emergency orders, meant to close the gap between total consumption of PY3 medicines by health zone and the PY4 delivery. The first was placed on April 2015, and pickup from the supplier started in May 2015. The delivery to the CDRs started in February 2016 and was ongoing at this time of this report. The second was combined with the first IHPplus order and was placed in September 2015. Pickup from the supplier started in December 2015; at the time of this report, delivery had not yet begun.

The total value of the IHP pharmaceutical orders from PY1 to PY5 was approximately $11,651,204; to date, 86% of that order has been delivered to the CDRs (see Figure 12, page 23).

Figure 12. Percent (%) of pharmaceutical orders delivered to CDRs (% delivered, by order value to delivery value, in USD, *see also Appendix 5)*[*,**]



** PY5 1st and 2nd orders only.*

*** Drugs that were not delivered were primarily samples that OCC removed for testing at entry points, or were damaged or lost products that the vendor failed to replace. Only quantities that were received by CDRs were valued as deliveries.*

During the last two project years, the Congolese government decided to suspend the emergency removal of EGM and to introduce additional steps for obtaining certification for each shipment from the MOH, resulting in increasing the number of documents necessary to request the *note verbale,* and creating delays in clearing containers through customs.

By the end of IHP, MSH developed an action plan before the start of the pharmaceutical procurement portion of the bridge project (IHPplus) to resolve some of these remaining issues and designated a dedicated staff from SIAPS to work on requesting documents from the MOH, USAID, the US Embassy, the Ministry of Foreign Affairs, and the *Direction Générale des Douanes et Accises* (Directorate of Customs and Excises). In addition, MSH and its freight forwarder requested multiple updates with USAID to follow up on the status of obtaining the *note verbale.* Moreover, MSH organized multiple meetings with vendors, the freight forwarder, its agent in DRC, and the dedicated project staff to ensure that the orders were still on track. Multiple management tools were implemented and shared in order to reach the objective set in the action plan.

Strengthen the management of essential medicines and medical consumables

SIAPS worked continuously on centralizing health zone medication management data. Starting in December 2013, medication consumption data were made available in electronic format in every coordination office and were analyzed and used for quantifications. SIAPS carried out this analysis with the Directorate of Pharmacy and Medicines and IHP. SIAPS also provided ongoing assistance to the CDRs in procurement planning, credit line adjustments, and monitoring of storage conditions.

To improve stock management of essential medicines and medical consumables, IHP provided health zones, health facilities, and CDRs with cold chain equipment, including 1,624 non-digital thermohygrometers to control temperature and humidity. Results are shown in Figures 13 and 14.

The project performance was also measured by the ability of supported health facilities to have accurate and up-to-date inventories of essential drugs and supplies. "Accurate" meant that the records correctly reflected the inventory of essential drugs and supplies that were in stock during the monitoring visit. By the end of PY5, IHP reported that 76% (1,069 out of 1,398) of health centers supported by the project had accurate and up-to-date inventory records. Compared to the PMP target of 100%, this represents an achievement rate of 76%. IHP performed better in the hospitals, with 82% (64 out of 78) of GRH supported by the project having accurate and up-to-date inventory records.

Figure 13. Number of stock-outs of tracer medicines by PY

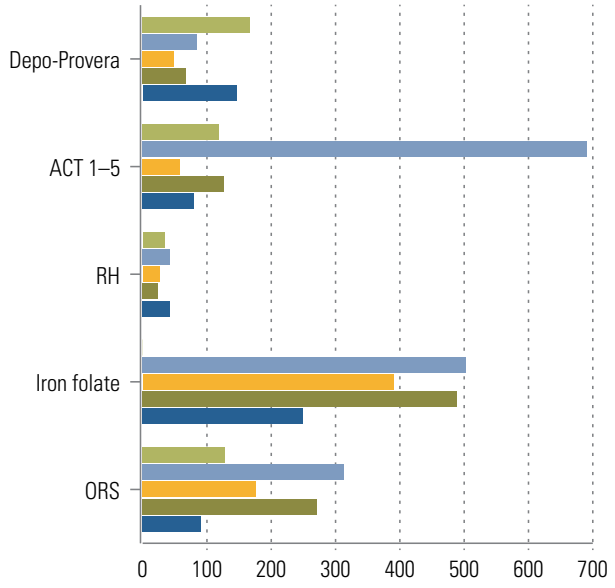
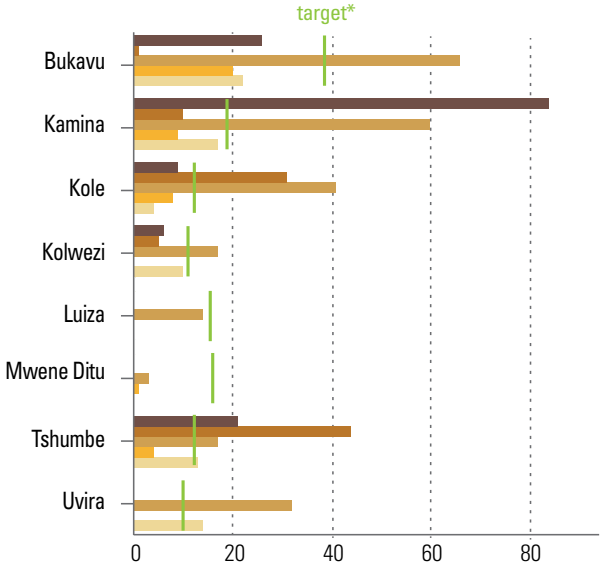


Figure 14. Stock-outs by medicine type and coordination office, at end of project



* RH target was 0 in every region. Others are as indicated by green line.

Depo-Provera ORS Iron folate RH ACT 1-5

Support quarterly supervision of essential medicines management in the health zones, health facilities, and CDRs

SIAPS, in collaboration with IHP and provincial health department staff, conducted monitoring and supervision visits to 288 facilities each project year. Each of the 6 SIAPS units organized a quarterly supervision visit to three health zones. A minimum of three health centers and one GRH were visited in each health zone.

During each visit, the team collected data for drug management indicators, reviewed management reports to reconstruct historical drug consumption, demonstrated the use of management tools, analyzed and consolidated medicine management data, oriented health zone supervisors on the use of thermohygrometers, monitored the recovery of funds generated by medicine sales, and trained providers on the updating of management records and tools.

Minimize tracer medicine stock-outs

Stock-outs decreased during the project; however, there were substantial challenges related to the availability and distribution of medicines and supplies throughout the project, due to longstanding supply chain issues such as insufficient quantities ordered and extended delivery periods (see Figure 12). Coordination offices reported a total number of 80 stock-outs of ACT, exceeding the PMP target of 133 stock-outs and achieving a performance rate of 166%. They also reported 91 stock-outs of ORS against a target of 133, which represents a project achievement rate of 146%. However, Depo-Provera and iron folate stock-out indicators revealed the lowest performance, with 91% (146 stock-outs against a PMP target of 133) and 53% (249 stock-outs against a PMP target of 133), respectively. Finally, the number of RH stock-outs reported by the project by the end of year 5 was 42 against a target of 0.

Health zones in Bukavu, Kamina, Luiza, Mwene Ditu, and Uvira reduced stock-outs of tracer medicines by integrating medicine distribution into regular monitoring meetings and using drug reserve funds from IHP. Stock-outs for some medicines, such as folic acid supplements, ACT, and RH—have been reduced, but did not reach the project's target. The challenge is in their specific procurement and distribution modes: RH for TB treatment is procured by the Global Fund and distributed by the National Tuberculosis Program, and ACTs are purchased by USAID and distributed by IHP. Furthermore, the routine data quality assessment (RDQA) survey conducted in March 2015 revealed that not all health facilities order essential medicines on time, despite their availability. Figure 13 shows the stock-outs for tracer medicines by project year.

COMMUNITY APPROACH

To attain universal coverage (at least 80% of the target) in the management of deadly childhood illness, the following strategies are essential:

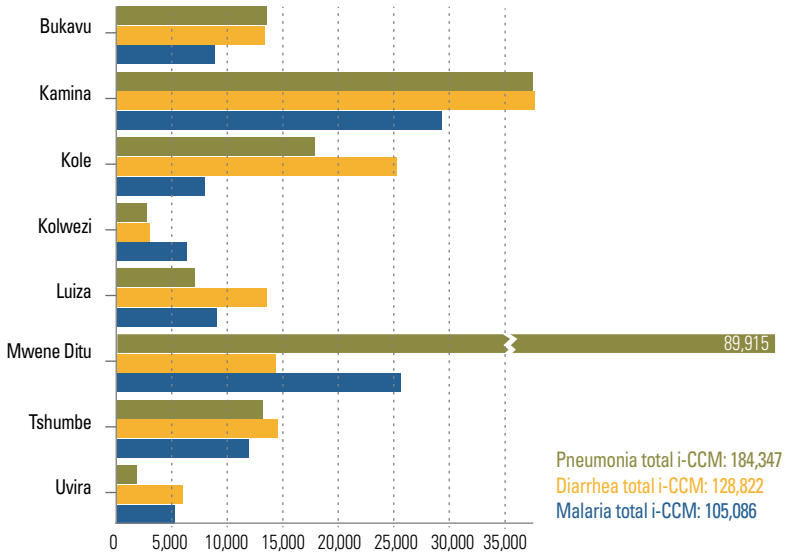
- Establish community care sites in every remote village to improve access
- Reposition the community as a principal agent for health through innovative approaches (improvement collaborative approach, Champion Communities, community involvement)
- Use health communications (mHealth, interpersonal communication)
- Replenish medicines regularly
- Coach, monitor, and evaluate using specialized tools (checklist and SNIS new normative framework)

Since its launch, IHP has contributed to increasing quality health services offered to over 800,000 underserved people living in hard-to-reach villages, among them 160,000 children under five years old (which represents 7% of the total project population served).

Pierre Ngandu, a health worker from a DRC-IHP supported i-CCM site in Tshibue, Kasaï Occidental, DRC, is shown here with his bicycle in front of his house returning from a visit to a family whose children needed treatment.

Photo : Rebecca Weaver

Figure 15. Number of i-CCM cases (only) treated for pneumonia, diarrhea, and malaria, by coordination office



IR 1.2. Community-based health care services and products in target health zones increased

Integrated community case management

Infant and child mortality in the DRC remain among the highest in the world. The child mortality rate is 104 per 1,000 live births, and the infant mortality rate is 58 per 1,000 live births (DHS 2013–2014). According to DRC's LiST assessment in 2011, the main causes were attributed to malaria (19%), diarrhea (17%) and pneumonia (16%). These three causes are responsible for over 50% of child deaths in the DRC. In order to address these high priority diseases, IHP turned to the widely accepted best practice of i-CCM. I-CCM is an equity-based strategy designed to increase access to effective case management for children suffering from malaria, pneumonia, and diarrhea, especially in hard-to-reach areas and in vulnerable populations. IHP partnered with the UNICEF-sponsored Health for the Poorest Populations project to address the egregiously high child mortality rates by expanding i-CCM sites across all 8 IHP coordination areas. By the end of the project, IHP supported 766 i-CCM sites in 59 health zones.

Since its launch in 2010, DRC-IHP contributed to increasing the availability of quality health services to more than 800,000 underserved people living in hard to reach villages, among them 160,000 children under five years old (which represents 7% of the total project population served). Figure 15 shows the evolution of the i-CCM in addressing the three major causes of childhood mortality. By the end of the project, these sites were responsible for treating a total of 418,225 new cases of childhood illness: 128,822 cases of diarrhea, 184,347 cases of pneumonia, and 105,086 cases of malaria.

The strongest performance in i-CCM occurred during PY4 and PY5. IHP accelerated the results from previous years by using innovative community-based strategies by taking the following actions:

- Revitalized 345 community care sites, which were not functioning when the project started
- Developed 421 new community care sites
- Conducted 1,360 short message system (SMS, or text message) distribution campaigns in PY4 and 1,410 in PY5
- Shared SMS on malaria, diarrhea, and pneumonia prevention and treatment in closed user groups (within and between communities) with a focus on Champion Communities and health zones reporting the highest number of these three diseases (Bukavu, Kamina, and Uvira)
- Established a collaborative approach of coaching and training health providers to strengthen relationships between health facilities and the communities they serve
- Introduced the use of a supervision checklist to improve quality of care
- Worked with the MOH to develop household-level data collection tools to integrate data from i-CCM sites with routine health center information

"Before the i-CCM site existed, I lost my first child because his fever kept getting worse. This time his fever dropped, enabling us to reach the health center without a problem. Now he is doing well."

—Bernadette Nene Elotshi, mother of a young patient at Olenga Health Center

SUCCESS STORY

i-CCM—Bringing health care to village children

In rural areas of Kasaï Oriental Province in the Democratic Republic of the Congo, health facilities are few and far between—a major reason for high infant and child mortality rates. In areas where the closest facility is over five kilometers away, the USAID-funded Integrated Health Project partnered with the MOH to establish local i-CCM sites staffed by volunteer CHWs.

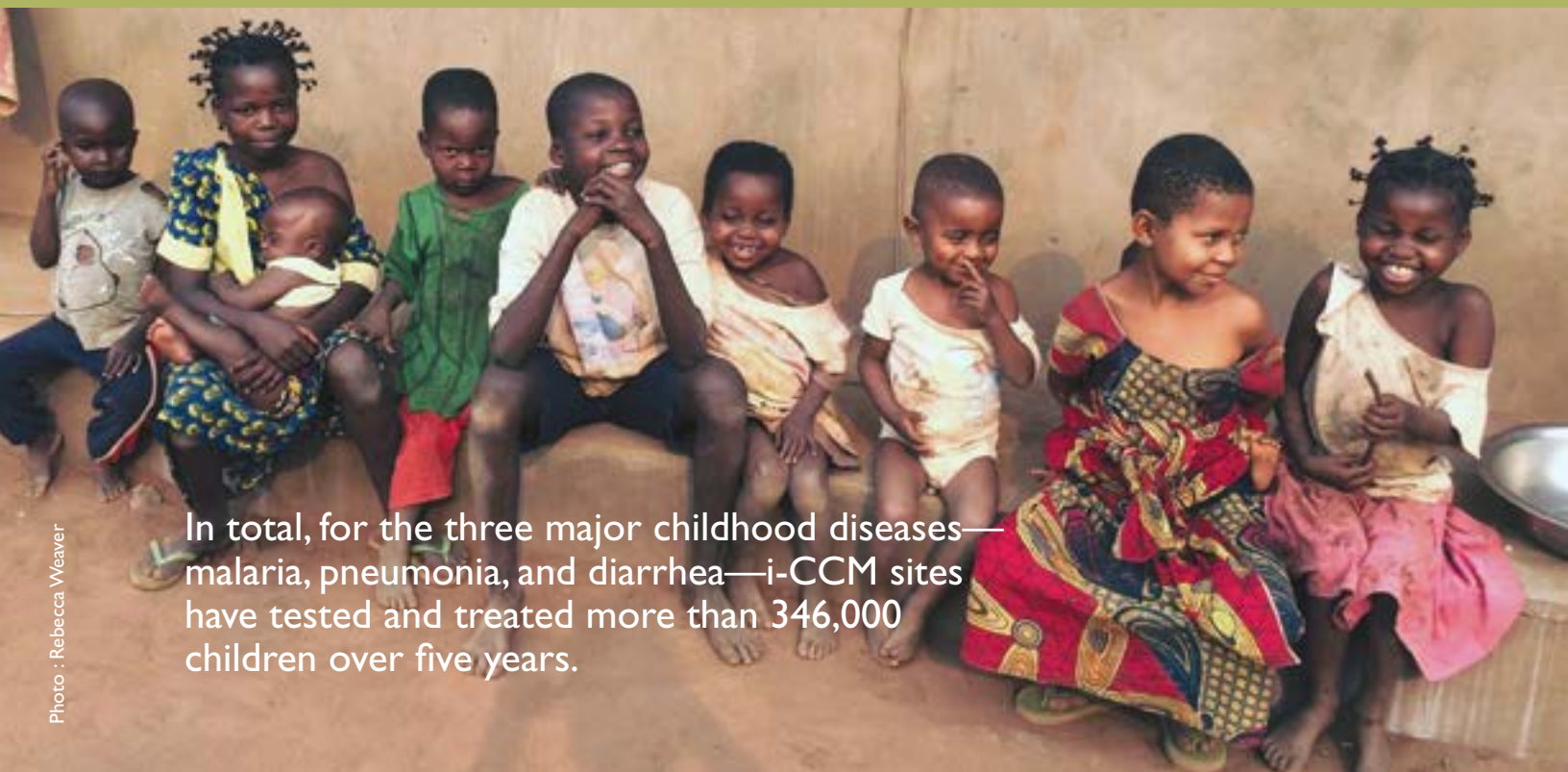
The nearest health center lies nearly 8 kilometers from the village of Iwadji, where Bernadette Nene Elotshi lives with her husband and son, Asele. "One morning," recalls Bernadette, "my husband and I woke up to find that Asele had a fever. It lasted for four days, and I finally made up my mind to take him to the i-CCM site to see Papa Benoit Ikedji, our CHW."

"Papa Ikedji examined Asele and advised me to rush him to Olenga Referral Health Center for a blood transfusion. Thanks to our CHW, Asele's fever dropped, enabling us to reach the health center without a problem. There, a nurse started a blood transfusion and treated Asele for five days, saving his life."

DRC-IHP and the MOH have developed 766 i-CCM sites. It took a while for residents to gain confidence in these convenient care sites—for instance, in the second year of implementation, CHWs at i-CCM sites treated only 924 episodes of malaria. Two years later, they received and treated over 30,000 episodes. In year five, i-CCM sites treated over 60,000 children for malaria.

The project reported the highest number of i-CCM cases treated during PY4 and PY5. IHP increased the acceptability of the i-CCM sites by the community and the overall number of functional sites by revitalizing 345 existing community care sites and developing 421 new ones; sending 1,360 SMS through distribution campaigns; and sharing SMS on malaria, diarrhea, and pneumonia prevention and treatment through closed user groups.

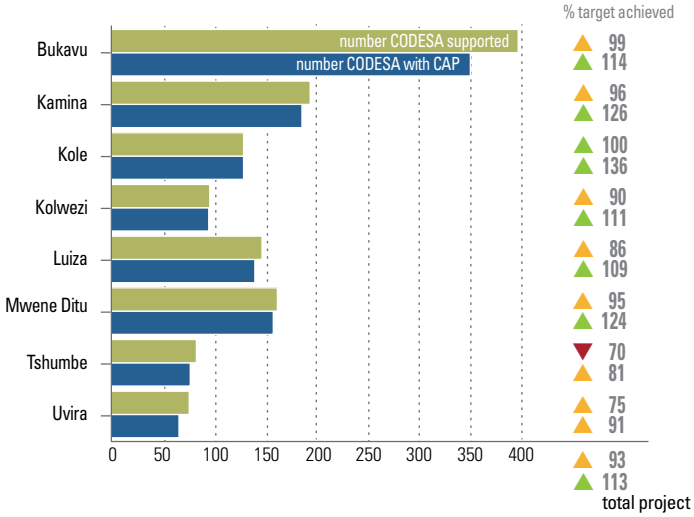
Photo for illustration only, and is not subject of story.



In total, for the three major childhood diseases—malaria, pneumonia, and diarrhea—i-CCM sites have tested and treated more than 346,000 children over five years.

Photo : Rebecca Weaver

Figure 16. Number of revitalized CODESAs with a communications action plan by coordination office at end of project



Although growth was robust, the project fell short of providing a sufficient number of community care sites. Challenges included lack of funding for monthly supervision visits, difficulty reaching landlocked villages, prevailing insecurity, varying levels of motivation among CHWs, and stock-outs of key commodities.

CODESAs

CODESAs represent the subzone level, known locally as the *aires de santé* (health areas) and played a pivotal role in IHP's programming strategy. Although several CODESAs predated IHP, very few were functioning at the project's start. CODESAs are key participants and initiators of several project approaches, particularly under IR 3. CODESAs have become an extension of the formal health system and are now widely believed to be instrumental in creating community resilience.

IHP revitalized 702 CODESAs by the end of the first project year and 1,284 by the end of the project, out of the 1,382 communities located in IHP target area. The project therefore reported 93% of CODESAs actively involved in the management of priority health services against the PMP target of 100%. IHP trained the committees to develop communications action plans and supported their implementation through fixed subsidies and technical assistance. By year five, 1,200 of the 1,284 committees had communications action plans, representing 113% of the project's target for this indicator (see Figure 16). These plans serve as a proxy measure for effectiveness; they provide local solutions to local health problems, such as designing and building latrines, refurbishing health centers, forming WASH committees, and hosting information sessions on disease prevention. The plans encourage communities to take ownership of public health, ensuring the sustainability of these activities following the end of IHP. Sample initiatives in CODESA action plans include partnering with local opinion leaders such as pastors to announce health messages in churches, group discussions on health topics, and announcements of WASH, MNCH, and family planning messages using megaphones in village centers.

IHP supported CODESAs by strengthening their involvement in health system management, supporting their role in two-way community-facility referral networks, and strengthening their role in health advocacy and community mobilization.

In addition, although IHP did not have a contractual relationship with the CODESAs, the health centers located in the 7 RBF pilot health zones took the initiative of incentivizing CODESAs to motivate them to encourage their communities to increase use of health services. An assessment found that after reallocating 10% of incentive payments from selected health centers to CODESAs, use of services improved from 30% to 45%. Attendance at the fourth ANC visit increased from 21% at baseline to 55% by the end of the second year of RBF, and assisted delivery rates rose from 63% to 76%. These results were verified by the RBF unit of the MOH and an external evaluation team.

Childhood pneumonia

IHP achieved 107% of its target for cases of pneumonia treated, reaching 2,308,766 patients with life-saving

antibiotics. As shown in Figure 17 on page 31, the overall trend of pneumonia cases treated increased steadily from PY1 (412,004) to PY4 (495,392). Further analysis indicates that there is an association between health zones with the largest increases in pneumonia cases treated and health zones that benefited either from BCC text messaging (OR 1.61, 95% CI .50–6.23) or inclusion in the Health for Poorest Populations (HPP) project (OR 1.46, 95% CI .50–4.13). The confidence interval (CI) is large and includes 1, which indicates that the association could be due to chance alone.

In addition to an increase in cases treated, fewer children contracted pneumonia over the course of the project. The decrease in total cases in PY5 corresponds to a pneumococcal immunization campaign that has accelerated since its inception in 2011, reaching 94% coverage by PY5. The correlation between the introduction of the vaccine and the reduced rate requires further research to confirm a causal relationship. In PY5, IHP drafted a study protocol for further investigation.

The i-CCM sites treated approximately 5% of the total cases, indicating continued progress at that level. More than 112,513 children were treated at these community sites, providing quicker treatment and avoiding costs related to travel to the nearest health facility. Only Uvira (65%) and Kole (73%) failed to attain at least 80% of their designated targets. Four of the remaining 6 sites exceeded their targets, led by Kamina with 147% achievement (see Figure 17).

Diarrhea

Despite diarrhea being one of the leading causes of death for children under five years old in DRC, this disease remains largely overlooked by parents, guardians, and health providers. For this reason, IHP supported health facilities and community care sites in treating nearly two million cases of diarrhea (1,914,568), 53% of the set target of 3,628,891 (see Figure 18).

Although disease-specific targets for the treatment of infectious diseases is problematic, especially in areas with poor historical data, definite progress was noted in the total number of cases treated. The number of children treated with ORS increased by 250% from 256,000 cases in PY1 to nearly 620,000 cases in PY5. Over 128,000 children were treated at i-CCM sites, a trend that increased during the final years of the project.

Analysis of project data shows larger increases in the number of diarrhea cases treated in health zones that participated in the Champion Community approach (OR 1.26, 95% CI .43–3.54) as well as training and supervision (OR 1.22, 95% CI .42–3.86). The confidence interval (CI) is large and includes 1, which indicates that the association could be due to chance alone.

IHP accomplished these improvements in the treatment of diarrhea and pneumonia by building the capacity of health service providers and providing them with the materials, tools, and supervision required in order to create sustainable change. Key achievements included:

- Trained 1,035 male and 155 female health providers and members of the health zone management teams in facility-based integrated management of childhood illness (IMCI);
- Revitalized or established 766 community care sites;
- Supported HPP's distribution of 156,355 IMCI kits across ten health zones;
- Procured and distributed pneumonia and diarrhea drugs (ORS+Zinc, 480 mg cotrimoxazole, and amoxicillin dispersible);
- Conducted quarterly joint supervision visits with the MOH;
- Increased use of management care flow charts;
- Improved data definition, collection, and management beginning in PY3 during monitoring visits to underperforming health zones; and
- Implemented RBF in underperforming health facilities.

Despite these efforts, some health zones continued to perform poorly throughout the project. Bukavu, Kamina, and Mwene Ditu community care sites reported the highest performance. Kolwezi reported the lowest, reaching only 32% of its collective target. Many health workers resigned from their activities to work as miners in a highly productive local industry, which resulted in a decreased health workforce. Other obstacles included difficulty in conducting monthly supervision visits due to insufficient funds, ongoing security issues, and difficulty reaching remote villages. In addition, i-CCM implementation suffered from an insufficient number of community care sites to reach national health coverage, lack of motivation among CHWs, and stock-outs of key commodities.

Photo : Warren Zelman

Figure 17. Number of cases of childhood pneumonia treated with antibiotics in IHP-supported facilities and i-CCM sites vs. target, by coordination office and PY

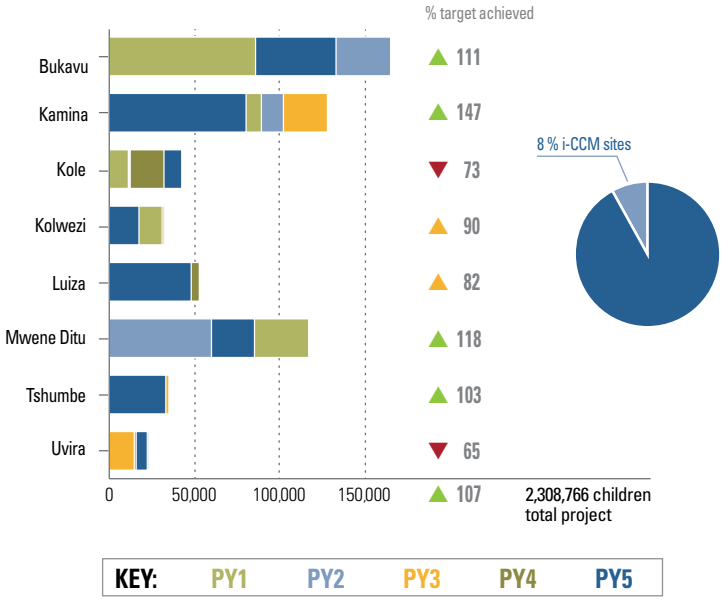


Figure 18. Number of children under 5 with diarrhea treated by ORS or ORS plus zinc in IHP-supported facilities and i-CCM sites vs. target, by coordination office and PY

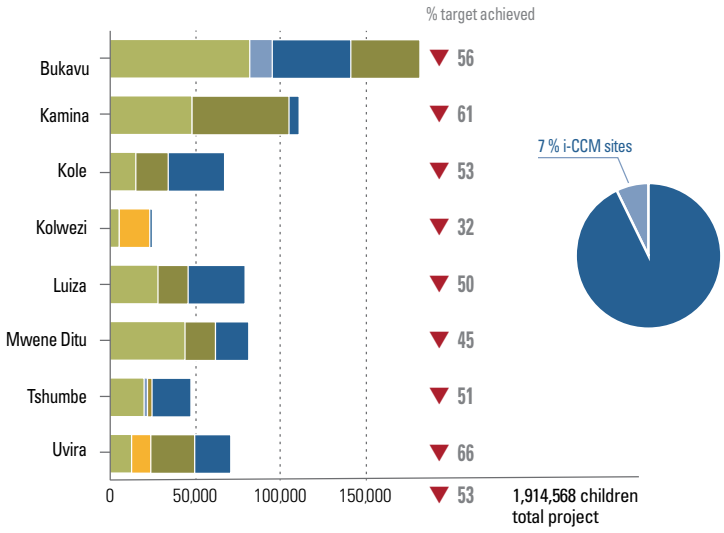


Figure 19. Number of assisted health facilities with stock-outs of ORS vs. target, by coordination office and PY

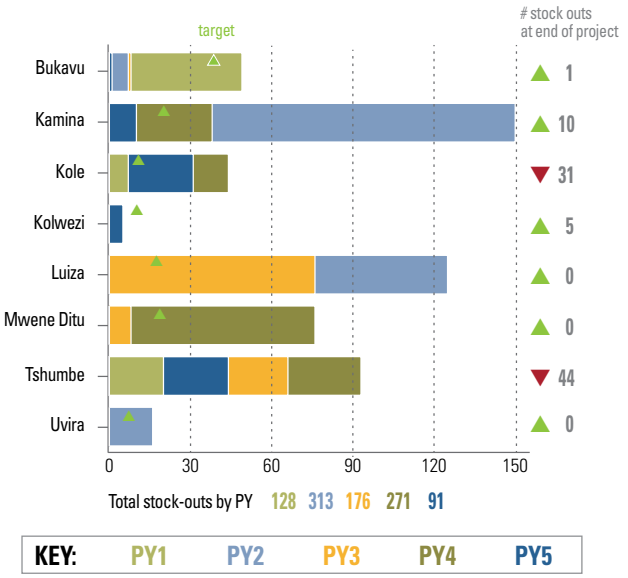
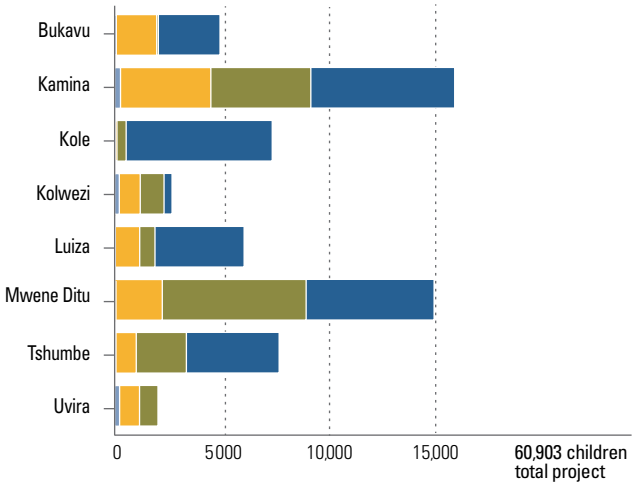


Figure 20. Number of children under 5 with malaria treated in supported i-CCM sites (only), by coordination office and PY



Number of USG-assisted health facilities experiencing stock-outs of ORS

As shown in Figure 19, the number of health centers—including community care sites—experiencing stock-outs of ORS slowly decreased from 128 in PY1 to 91 in PY5. However, the coordination offices in Kamina, Kole, and Tshumbe recorded a large number of facilities with stock-outs of ORS.

The delayed restocking of certain sites by the health zone central health zone offices, arising from the failure of some facilities to pay for medicines and limited accessibility to other facilities, created bottlenecks that limited the availability of ORS.

To resolve this problem, IHP partnered with SIAPS to support the establishment of provincial drug committees to coordinate various partners' interventions. In addition, IHP financed the monthly shipment of medications from the central health zone offices to the health centers and addressed medication management data analysis at both the health center level and the central office level.

Malaria

DRC has one of the highest malaria prevalence rates in the world. The 2013 DHS reported that 23% of children between 6 and 59 months of age tested positive for malarial parasites using microscopy. IHP integrated malaria treatment into the i-CCM protocol according to the MOH's guidance and international norms. This section addresses the results of that initiative, while interventions related to LLIN, BCC, and malaria interventions for maternal health will be addressed elsewhere in the report.

The total number of reported malaria cases treated at the community level has improved over the course of the project (from 924 in PY2 to 60,903 in PY5). At the project's onset, treated cases of malaria were completely unreported; beginning in PY2, the reported number of appropriately-treated malaria cases increased rapidly. This dramatic change can largely be attributed to implementing and revitalizing i-CCM sites and strengthening leadership of the *Programme National de Lutte contre le Paludisme* (PNLP, French for the National Malaria Control Program) staff at the health zone level.

Figure 20 presents the increased use of malaria services at i-CCM sites. Communities now trust i-CCM sites to properly diagnose and treat their children, thanks to more visible supervision of doctors, central health zone office leaders, and nurses at the community level. Revitalizing communities' understanding of community care and their role in sustaining the availability of health care commodities and medications and increasing the community's confidence in the quality and consistency of care has helped to increase the total number of sites.

A LIFE-SAVING INNOVATION

Although most are easily treated, approximately 6% of malaria cases are severe and require hospitalization. Most of these occur in children under five, who might not survive the long trip from a rural home to the hospital. Today those with severe malaria can be treated locally with a new form of treatment—a suppository called rectal artesunate—to make it to the hospital.

In 2012, DRC's national malaria program adopted pre-referral rectal artesunate treatment for severe malaria as part of its malaria strategy, for use in both health centers and integrated community-based care sites.

DRC-IHP organized an assessment to determine how well the new treatment would be accepted by health workers and parents. Implemented in 51 community care sites in 2014, the assessment showed encouraging preliminary results. DRC-IHP became the first project to introduce rectal artesunate in both health centers and community-based health sites in DRC, and the project has trained more than 50 nurses and 70 community health workers in the new treatment.

Photo : Rebecca Weaver

"We used to spend our energy and money to treat diarrhea. But now we invest in raising community awareness on how to prevent it—advising people to adopt healthy behaviors and maintaining our new WASH facilities."

—a member of the WASH committee in Lubemba village

SUCCESS STORY

Cleaning up: a community-led total sanitation effort in Bilomba

In the pilot health zone of Bilomba, in Kasaï Occidental, DRC-IHP introduced a "community-led total sanitation—water, sanitation, and hygiene" (WASH) project. The project trained a local WASH committee, which then developed an action plan for improving and maintaining water and sanitation points. As a result of the committee's efforts in this health zone, cases of water-borne disease decreased from 2,060 in 2010 to 225 in 2015.

Prior to the WASH intervention, most rural households in DRC lacked a clean source of water for drinking or washing, according to the 2013 Demographic and Health Survey, and few rural residents had access to sanitation facilities. Without the necessities of basic hygiene, water-borne diseases ("diseases of dirty hands") are a constant companion in families and claim the lives of thousands of young children.

Thanks to the USAID-funded Integrated Health Project, in collaboration with the MOH, 80 percent of the Biloma's population now has access to clean water and sanitation.

Encouraged by the positive outcomes, Bilomba WASH committees have set up a fund to maintain WASH facilities and have organized weekly visits to clean and weed around the wells.

A woman washes her hands at a water source at Walungu General Referral Hospital in Bukavu that was built with the support of DRC-IHP.

Photo : MSH staff

A PROMISE RENEWED

To contribute to accelerating reductions in maternal, newborn, and child mortality in the DRC, IHP and HPP identified 52 priority health zones (25 health zones solely supported by USAID and 27 health zones jointly supported by USAID and UNICEF) to implement high-impact interventions following 6 strategic approaches adopted by the MOH.

Strategy 1: Universal health coverage for vulnerable populations (pregnant women and children under five) family kit/voucher approach: To ensure universal health coverage in priority health zones, IHP and HPP established 644 community care sites in 46 health zones. HPP distributed 156,355 IMCI kits, 7,908 ANC kits, and 14,365 delivery kits to 79,958 households in ten rural health zones. 1,080 IYCF support groups were established in 45 health zones; the project specifically provided the 13 life-saving commodities for women and children in all health facilities.

Strategy 2: Support health services at the peripheral level including reference facilities: IHP provided health centers with supplies and equipment to offer quality care. These materials included sterilizers, gloves, baby scales, stethoscopes, thermometers, fetoscopes, emesis basins, and neonatal resuscitation equipment.

At least one post-training follow-up and supervision visit is guaranteed for community health workers and service providers (nurses, midwives, and doctors).

Strategy 3: Improve health zone governance and management: A study carried out by the National Center for Pharmacovigilance at the University of Kinshasa on the acceptance and use of family kits showed that the distribution of household kits for children under 5 has increased uptake of services among this target population. The utilization rate for malaria treatment, for example, increased by 26%. The study found that 696 out of 742 households, or 93.5%, can correctly describe the medicines and other supplies that are included in the family kits, and that ORS is the most commonly known medicine in the kit (known by 90.9% of respondents). Zinc sulfate was the least known of the kit contents, known by 16% of respondents. A high number, 613 out of 724, or 82.6%, of respondents also reported that they know how to and can administer the medicines in the kits, while 82.7% reported knowing the correct dosage of ORS, 91.3% reported knowing how to dose paracetamol, and 47.1% reported knowing the correct dosage for zinc sulfate. The study also found that households had a specific place for storing the kits.

- Possession of IMCI kits (ORS plus zinc): 97% of households have a kit; knowledge of medication usage: 91% knew that ORS treats diarrhea, whereas only 16% knew that zinc treats diarrhea.
- Knowledge of dosage: 83% of households knew the dosage for ORS whereas 47% knew the dosage for zinc; storage: there is no specific place for storing kits, but a box is the most popular place (26%); deterioration was found in 5% of kits (dissolution and color change).

IHP also led a feasibility and acceptability study on using artesunate suppositories as a preliminary treatment for children under five with severe malaria in community care sites in the DRC. The preliminary results indicate that the training IHP provided to community health workers enabled them to use rectal artesunate as an initial treatment for children with severe malaria prior to referring them to a health center.

Strategy 4: Provide quality training to motivate facility providers and strengthen human resources: IHP contributed to building the capacity of 697 providers (doctors, nurses, and midwives) at various levels: health center, general referral hospital, central health zone offices, and partners, in 20 health zones, with a focus on maternal, neonatal, and child health.

Strategy 5: Communication for development: With the goal of improving behavior change communication, the project developed 516 mini awareness-raising campaigns, which were implemented in various health zones. Principal themes included exclusive breastfeeding, immunization, and hand washing.

Strategy 6: Community mobilization: Community-based organizations (CBOs) in 145 health areas were re-energized to support and monitor the distribution of family kits.

Photo : Warren Zelman

Evidence-based WASH activities

Only one in three Congolese households has convenient access to potable water, and fewer than one in four has adequate sanitation (DHS 2013). Safe water sources and usable toilets are vital for public health, and their absence leads to high prevalence of diarrheal and water-borne diseases which, as already noted, are among the major causes of infant and child mortality in DRC.

During PY1 and PY2, the IHP WASH strategy focused on the following activities:

- Identify and prioritize communities that are the most in need (two villages per health zone);
- Identify or rehabilitate potable water sources in the community;
- Roll out community-led total sanitation (CLTS) standards to eliminate open defecation through BCC and construction of household latrines; and
- Subsidize water source renovation and household latrine construction, including the provision of two latrine sand plots per family.

IHP's performance in WASH activities was below the expected target in PY2, only achieving 38% of the target for people gaining first-time access to safe drinking water and 18% of the target for people gaining first-time access to hygienic latrines.

In July 2012, USAID and IHP conducted a joint field visit in Luputa health zone in Mwene Ditu to assess effectiveness of the IHP WASH strategy.

The main findings were as follows:

- The implementation of WASH activities was too slow to expect results.
- WASH activities implemented in two villages per health zone did not show any health impact.
- The latrine hardware used (the "VIP latrine") was expensive and not sustainable.
- Even though IHP assessed communities' needs and worked to gain their engagement, the project was not able to secure the communities' contributions (e.g., cement and latrine sand plots and sheet metal) as promised in a timely manner.
- Village awareness activities were not strong enough to maintain and further community engagement.
- The MOH's WASH Bureau Chief of the DPS was not involved in IHP-supported WASH activities.

In response, as recommended by USAID, IHP revised its WASH strategy to address obstacles encountered in PYI and PY2. The revised strategy focused on the following:

- Mobilize community members to meet the needs of at least 80% of residents in each of 9 target health zones, including access to potable water and sanitary latrines.
- Provide technical support to awareness and sensitization activities with messages emphasizing that "the community can take charge of its own health and can improve and maintain their sanitation on its own."

- Focus the project's financial contribution on subsidizing the renovation of water sources and training local masons to maintain and repair water sources and build ventilated latrine, using locally available construction materials.
- Provide financial support for joint field visits with the DPS Chief of the WASH Bureau to monitor progress of IHP-supported WASH activities.

Through the CLTS approach—a globally-recognized system of scaling up water and sanitation facilities—IHP facilitated the following activities:

- Raised awareness about good hygiene practices and links between health and hygiene
- Mobilized communities to participate in the construction of household sanitary latrines and water points and to contribute local materials (e.g., gravel, sand, water to mix cement, and timber)
- Provided construction materials (e.g., iron, cement, pipe, fittings) that are not sourced locally
- Strengthened masons' capacity to construct and repair durable sanitation facilities
- Built and strengthened community capacity to maintain water and sanitation facilities (WASH committees)
- Provided financial support for external expertise to develop local skills
- Strengthened monitoring, evaluation, and reporting

To mobilize communities to change unhealthy and unsanitary habits, awareness-raising activities included: using the water glass test, during which a facilitator presents a glass of water with fecal contamination and asks the audience who would be willing to drink it; community mapping of the village; community assessment of defecation areas; and calculating money spent unnecessarily treating diseases that could be prevented by good hygiene and sanitation.

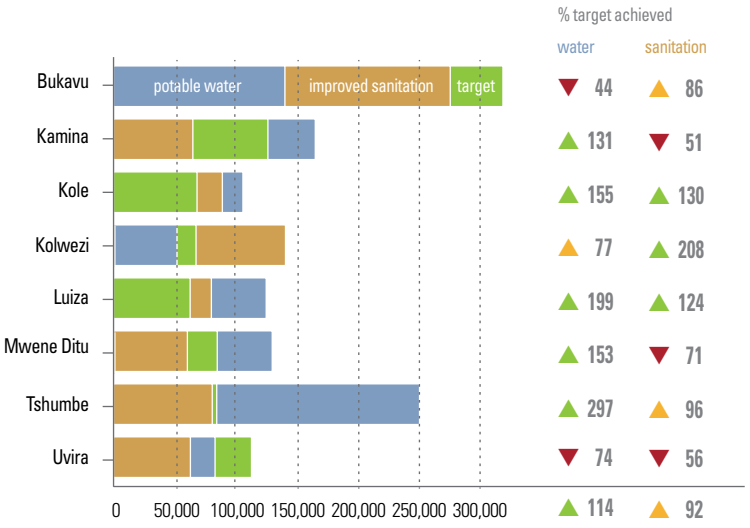
More than one million people (1,059,282) accessed clean water sources for the first time, and 858,585 accessed improved sanitation facilities for the first time as a result of IHP's CLTS activities. While performance on the first indicator is impressive (114%), the number of residents who accessed improved sanitation facilities for the first time did not fully meet its PMP target, with a 92% achievement rate. Nonetheless, the general improvement may be attributed to project initiatives, including the procurement of construction materials, the sensitization of religious and community leaders and their subsequent mobilization, and an increase in routine supervision from the health zone management teams.

For example, the Bilomba health zone demonstrated vast improvements as a result of awareness-raising activities. Between 2010 and 2015, the percentage of residents in Bilomba with access to clean water jumped from virtually none to 81% (72,000 people). Some 108 water points were constructed and maintained. The number of residents using a latrine built from local materials rose from virtually none to 67% (close to 60,000 people).

Table 3. Nine target health zones and their population targets for zonal WASH strategy

No.	Province	IHP coordination office	Select health zones	Target population (80% inhabitants)
1	Kasaï Occidental	Luiza	Bilomba	63,155
2	Kasaï Oriental	Mwene Ditu	Wikong	85,503
3		Kole	Kole	68,846
4		Tshumbe	Dikungu	85,079
5	Katanga	Kamina	Songa	127,275
6		Kolwezi	Kanzenze	68,014
7	Sud Kivu	Bukavu	Katana	142,438
8			Walungu	178,616
9		Uvira	Ruzizi	113,750
	4	**8**	**9**	**932,676**

Figure 21. WASH: Number of people in target areas with improved drinking water and sanitation facilities vs. target



The results in Bilomba are an indication that the revised approach was successful. That said, these approaches will take some time to achieve broader success.

In addition to community interventions, IHP also implemented evidence-based WASH activities within health facilities, with a focus on improving waste management (e.g., building placenta pits, providing incinerators), ensuring the existence of enclosed latrines, and building hand washing posts.

IHP implemented the CLTS approach in 9 pilot health zones, with a target of reaching 80% of the population within those zones. Discussions with USAID have highlighted that this target was unrealistically ambitious, considering the geographic, logistical, and cultural challenges. The project recommended reducing this target to 40%. However, the results presented in Figure 21 on page 37 are provided in the context of a coverage target of 80%, since the target was never officially reduced.

Community-based nutrition activities

Widespread malnutrition has a dramatic impact on the health of Congolese children. Nationwide, 43% are stunted, 23% are underweight, and 8% die in childhood (DHS 2013). These figures are slightly higher for rural areas.

IHP's greatest success in community nutrition was the integration of infant and young child feeding (IYCF) promotion into communities through the creation and support of IYCF groups. These groups share positive breastfeeding experiences and benefits, supervise and coach mothers, conduct cooking demonstrations with local foods, provide nutrition education to women and their families, and host meetings in easily-accessible locations. IHP established 1,080 IYCF support groups, reaching women and their families in 45 health zones in all four provinces, and built the capacity of 160 members of the health zone management teams as trainers. These management team members then trained an additional 261 providers and 1,044 CHWs in IYCF support. IHP provided vitamin A, mebendazole, iron, and folic acid, as well as logistical and technical support to vitamin A and deworming campaigns run by the IYCF groups.

Working through the CODESAs, the project actively pursued a BCC strategy that targeted proven high-impact approaches such as appropriate breastfeeding and feeding practices during episodes of illness. IHP provided nutrition counseling cards and T-shirts promoting breastfeeding and complementary feeding. The project also worked with communities and health centers to ensure appropriate treatment of severe and acute malnutrition, sponsored revision of protocols, supported data systems and vitamin A supplementation for children, and developed curricula for nutrition education at all levels. These interventions are discussed later in the report.

The project found that IYCF trainings and support groups increased rates of early breastfeeding; improved nutrition for mothers, babies, children, and families; reduced malnutrition; reduced cases of childhood diarrhea and fever; reinforced community bonds through sharing food and experiences; and strengthened the health system at the most basic level.

During the four years following the introduction of IYCF activities, IHP-supported providers counseled more than 1.7 million mothers of children under two years of age. **The project achieved 155% of its target of 1.1 million for this indicator.** All coordination offices showed a steady increase in mothers counseled, and all surpassed their individual targets (see Figure 22). Health zones with active IYCF groups showed larger increases in the number of mothers receiving nutritional counseling (OR 1.38, 95% CI .49–4.01). The confidence interval (CI) is large and includes 1, which indicates that the association could be due to chance alone. This accomplishment was made possible by the health care providers who conducted consultations with the mothers (such as preschool consultations, ANC visits, postnatal consultations, and therapeutic consultations) and by the CHWs who organized IYCF support groups. IHP supplied the health zones with management and data collection tools. The project's supportive supervision and leadership development approaches were also associated with higher performance on this indicator (OR 1.4, 95% CI .46–4.83, and OR 1.73, 95% CI .42–6.35, respectively).

To treat severe and acute malnutrition, the project collaborated with the national nutrition program (PRONANUT) to distribute therapeutic foods including Plumpy'Nut and fortified milk. With PRONANUT, the project trained and provided supportive supervision to health providers on the recognition of severe acute malnutrition, growth monitoring and promotion, and community mobilization via CODESAs.

Yvonne Nzeba, a young mother and member of the Mfwamba village IYCF community support group in Kasaï Occidental, talks to a member of the Sanga-Bantu Champion Community about the importance of exclusively breastfeeding her baby.

Figure 22. Number of mothers of children 2 years of age or less who have received nutritional counseling for their children, by coordination office and PY

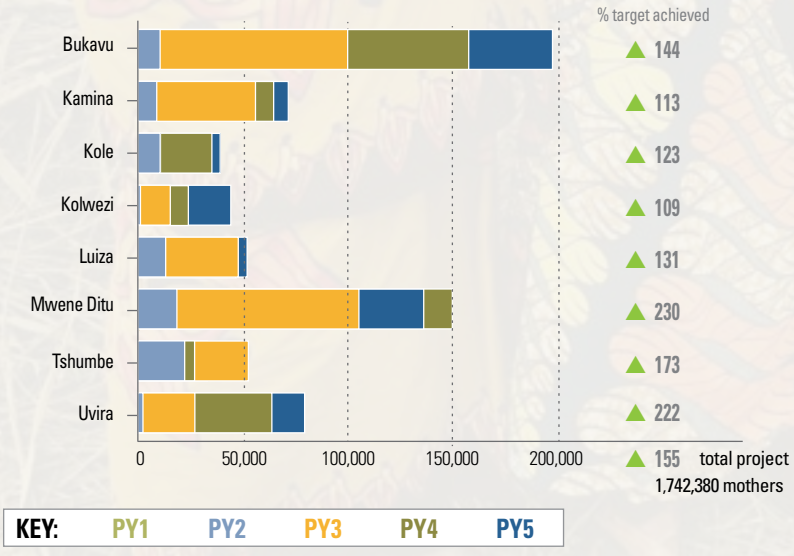


Photo : Rebecca Weaver

"Witnessing this wave of support from Kalomba's inhabitants was priceless. Here is living proof that we can overcome our challenges on our own. But we would not have been able to realize that without LDP training."

—Dr. Nico Kamayi, Kalomba Chief Doctor and health zone management team member

SUCCESS STORY

A space to call their own

In the Democratic Republic of Congo, health staff must often do too much with too little. But what do you do in the absence of the most basic resources, such as work space to perform routine duties?

The Kalomba health zone management team is responsible for making sure that over 150,000 people have essential health services. Until recently, the team found this major task even more difficult due to poor working conditions. Cramped desk space in a hot, unventilated room often led to friction rather than teamwork among colleagues.

Funded by USAID, the DRC Integrated Health Project is assisting the MOH to build leadership and management capability. Since 2011, the project has trained 9 health zone management teams, among them Kalomba, through the Leadership Development Program (LDP). LDP stresses teamwork to set and reach significant goals through a structured methodology. Following the LDP, the team realized that if they wanted more office space, they would have to come up with their own solution.

Taking leadership lessons to heart, the team reached out to the local community for help, and community members answered the call. *They crafted bricks and wood planks, carried materials, and performed masonry work. The health zone management team paid for the cement and metal roofing, and in June 2014, after two years of work, the new administrative building—including offices, a meeting room, electricity, and running water—was ready. This collaborative approach has enabled the Kalomba health zone management team to become one of the most competitive in the province, both in terms of the team's management and the quality of services it provides.*

Photo : : MSH staff

IR 1.3. Provincial management more effectively engaged with health zones and facilities to improve service delivery

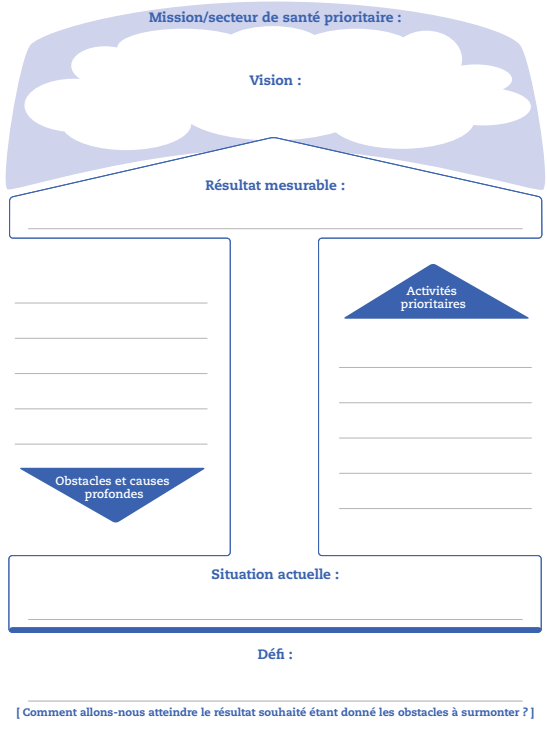
The expansion of services discussed under 1.1 and 1.2 required vigilant leadership and management at all levels. To address this challenge and reinforce capacity to sustain progress, IHP integrated the Leadership Development Program (LDP) into the project's activities. The LDP was designed specifically for health sector personnel, NGOs, community groups, and other stakeholders. This program helps health workers identify and address challenges in their work environment, create an environment that motivates staff, and promote teamwork, transparency, and accountability. LDP teams select leadership projects to implement over 6 to 8 months, which are implemented in collaboration with stakeholders at all levels to address real challenges to improve services and the work environment by using the Challenge Model (see Figure 23).

From October 2010 to September 2015:

- 80 health zone management teams (5 members per zone) engaged in the LDP;
- 400 members of health zone management teams attended four three-day workshops;
- health zone management teams implemented 254 leadership projects; and
- leadership teams achieved 84% of targeted results.

After their training, these health zone management teams launched 254 6- to 8-month LDP projects. Within 6 months of completing their LDP, 59% (46 out of 78) of these health zone management teams reached at least 80% of their targets for 213 projects (see Table 4, page 43). Compared to the PMP target of 100%, this represents

Figure 23. The Challenge Model and LDP



an achievement rate of 59%. These are impressive results, given the novelty of the LDP program in DRC—especially considering that the teams were constrained at times by limited funding for their activities. Further analysis of project data shows that the LDP approach significantly contributed to an increase in new adopters of modern contraceptive methods (OR 2.5) and number of family planning and reproductive health counseling visits (OR 3.37), postpartum visits within three days of birth (OR 1.6), pregnant women receiving at least two doses of SP for IPT of malaria (OR 1.26), number of mothers receiving nutritional counseling (OR 1.96), and the number of breastfeeding mothers receiving vitamin A supplementation (OR 2.63).

The LDP is a practical tool that reinforces learning by doing. Health zone management teams select realistic challenges that are within their sphere of influence to address. By focusing on achieving results in technical areas supported by IHP, the LDP-initiated projects helped to improve service delivery and quality indicators across the spectrum of technical areas supported by the project. The LDP helps develop skills in problem solving, prioritization, planning, and team building that reinforce institutional capacity within the MOH system. Table 4 below shows the challenges addressed by the teams according to technical area and the rate of success for each. The majority of projects (199/254) targeted issues directly pertaining to MNCH interventions.

LEADERSHIP DEVELOPMENT PROGRAM

Many traditional leadership development programs focus on top leaders and their individual development of leadership skills. These programs often reinforce the notion that some people are "born leaders" and just need to add a few skills to their natural abilities. These programs are often conducted in a single off-site workshop. In contrast, the LDP invites managers and teams at all levels of an organization to participate. It demystifies leadership by encouraging participants to apply leading and managing practices to the actual challenges they face in their unit or organization. Its comprehensive approach helps managers work toward improved services, while enhancing the work climate in their group, their management systems, and their ability to adapt to change, all of which can sustain improvements.

Table 4. LDP projects by technical area from PY1 to PY5

Focus area	LDP indicators	# projects implemented	# projects achieving expected result	Performance rate (%)
MNCH	Immunization/ VAT2+	23	19	83
	Immunization/ DTC-HepB-Hib3	21	17	81
	Malaria/IPT 2+	40	35	88
	ANC 4	24	20	83
	ANC 2+	20	17	85
	More than 2 preschool consultations	17	14	82
	IMCI	17	14	82
	Assisted deliveries	19	16	84
	i-CCM (diarrhea and pneumonia)	18	15	83
FP	Contraceptive prevalence	8	7	88
	Awareness sessions organized	5	4	80
L+M+G	Utilization of curative health services	11	9	82
	Referral rate	6	5	83
Nutrition	Awareness sessions organized	10	8	80
TB	TB detection rate	14	12	86
HIV	TB patients tested for HIV	1	1	100
		254	**213**	**84**

"The Champion Community model truly creates community ownership and sustainable action. It is a case for community empowerment."

—Provincial Minister, Sud Kivu

SUCCESS STORY

Champion Communities in Bukavu improve local health—and finances

To improve health literacy and encourage the use of health services, the USAID-funded Integrated Health Project turned to the Champion Community approach—an innovation pioneered in Madagascar in the 1990s.

Guided by IHP staff, Champion Communities mobilize local citizens to plan, carry out, and evaluate health initiatives according to their own priorities.

Like others, the four Champion Communities in Bukavu provide health education to local residents. They perform monthly household surveys on health indicators, and chart trends for planners at the health centers. They also formed Champion Men groups to foster male support for family planning and reproductive health.

These methods have significantly increased the use of health services in Bukavu. For instance, the number of women living in Champion Community health zones who attended four prenatal visits jumped from 9,267 in 2012 (when the program began) to 21,741 in 2015.

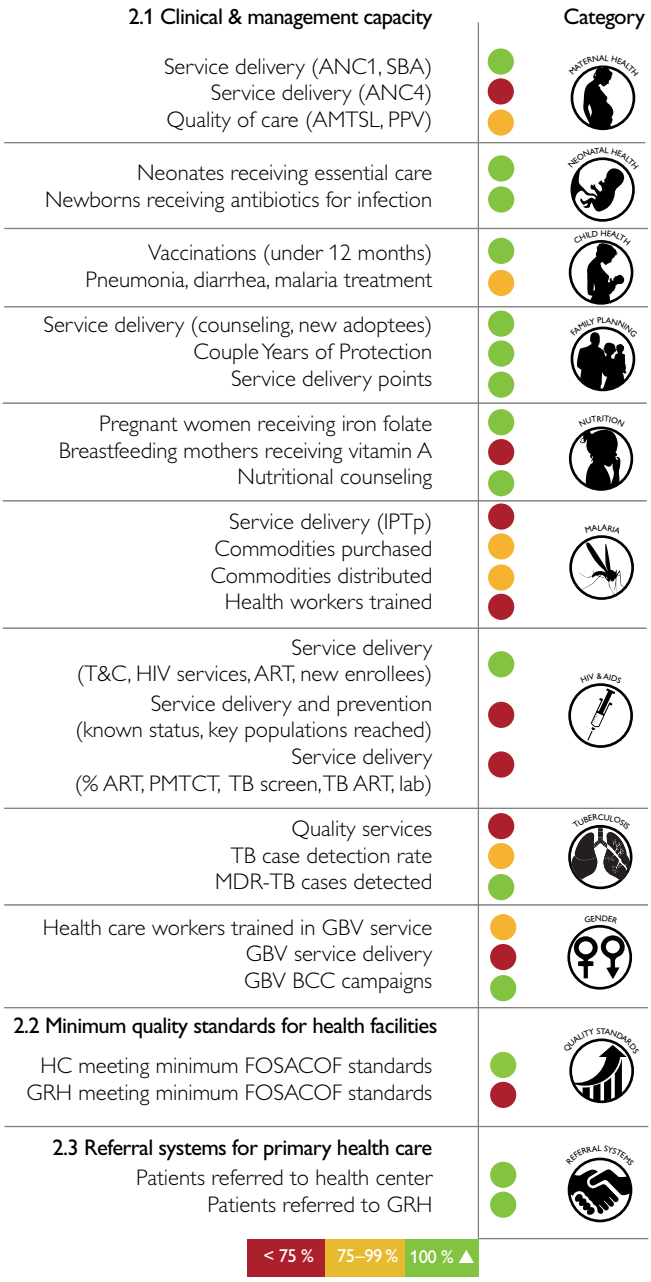
Beyond promoting healthy behaviors, Bukavu Champion Communities pooled profits to create a village savings and loan association. After an earthquake destroyed a health center in August 2015, the Champion Community used funds from its account to buy land for a new, centrally-located clinic. The Champion Community also purchased three computers and invited local children to its office to use them for schoolwork.

In the past, neither Marthe Tumba nor her husband, Yobo Tshiela, took their children to the health center for treatment. During an illness, a local member of the Champion Community persuaded Marthe to visit her local health center. Marthe was impressed by the treatment she received and has continued to go to the health center when she needs care. Today, they are both proud members of the DRC-IHP supported Tuibake Champion Community. Yobo is also a member of a "Champion Men" group.

Photo : Rebecca Weaver

Photo : Warren Zelman

Figure 24. Summary of IR2 key results by sub-IR



Intermediate Result 2: Quality of key family health care services in target health zones increased

Increasing access to quality health services was a key objective of the project. As shown under IR 1.2, the project made substantial progress in ensuring that hospitals and health centers offer MPA-plus and CPA-plus services. The quality of these services must be sustained and improved continually to foster the awareness and community trust required to increase demand for quality services.

Over the course of the project, access to and quality of several important services such as family planning, MNCH, nutrition, referrals, and gender-based care have increased tremendously. Progress against project targets for key indicators is presented in Figure 24 and examined in the following sections.

IR 2.1. Clinical and managerial capacity of health care providers increased

The complex array of health issues that can threaten the health of a mother and her child require expertise across several technical areas, and must be prioritized through an integrated approach to implementing high-impact practices that target the greatest risks. This section describes IHP's successes and challenges in addressing these key priorities. This initiative focused capacity building in key areas: MNCH, expanded program on immunization, family planning, malaria, HIV and AIDS, TB, nutrition, and GBV.

Maternal, newborn, and child health

Maternal mortality in DRC remains among the highest in the world, at 846 deaths per 100,000 live births. Under-five mortality, while decreasing in recent years, is also high, at 104 per 1,000 live births.[13] To help address this grim scenario, IHP worked closely with the Congolese MOH to design and implement an intensive three-week integrated skills-based training package for health providers at all levels. The training instructs providers on the use of the most effective life-saving strategies for mothers and their babies, taking into consideration the local economic, social, cultural, and geographic context. Supplemented with extensive follow-up

13 Democratic Republic of Congo Demographic and Health Survey (DHS), 2013–14.

Figure 25. Number of pregnant women attending at least 1 ANC visit and those attending 4 ANC visits by coordination office at end of project

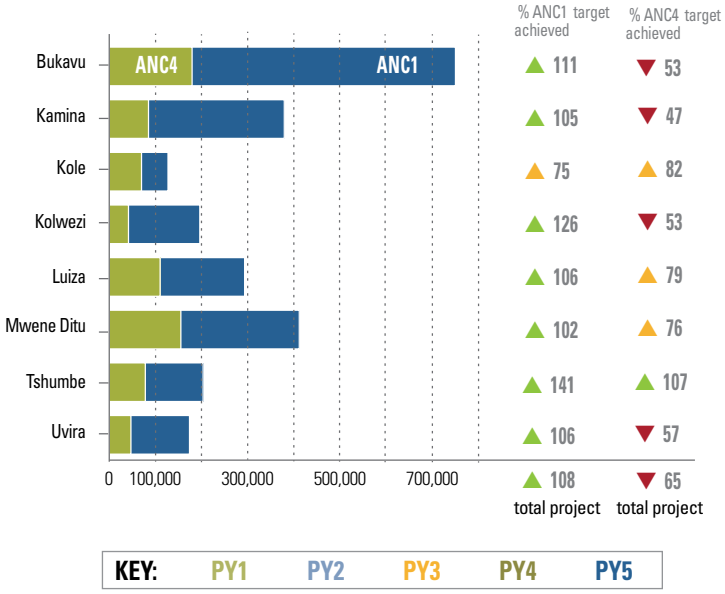
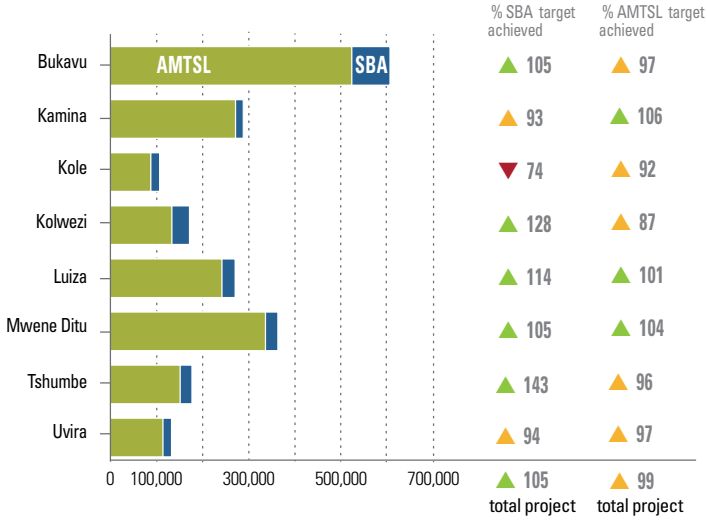


Figure 26. Number of deliveries with a SBA receiving AMTSL, by coordination office at end of project



and carried out across the 78 health zones, the MNCH training package strengthened participants' skills, as follows:

- **Managing difficult births and obstetric emergencies,** including all the signal functions for basic and comprehensive emergency obstetric care[14] with emphasis on appropriately administering antibiotics and other drugs such as oxytocin, manual removal of the placenta, basic neonatal resuscitation care, performing Caesarean sections, safe blood transfusion, as well as newborn care, such as properly caring for sick and low-birth weight newborns, and routine delivery practices, including active management of the third stage of labor (AMTSL) to prevent postpartum hemorrhage.
- **Increasing use of family planning** by training providers to facilitate family planning discussions during awareness sessions and demonstrate proper use of condoms. Providers were also trained to provide individual or couple family planning counseling, facilitate patient consultations, administer oral and injectable contraceptives, and properly insert/remove contraceptive implants and IUDs.
- **Preventing malaria** through the provision of SP for pregnant women, who are particularly susceptible to malaria.
- **Resuscitating newborns using Helping Babies Breathe (HBB),** a simple but powerful technique to start breathing in struggling newborns during their first minute of life, a critical period known as The Golden Minute. Taught using inflatable dolls and performed with a hand air pump, the resuscitation method can be used by anyone who helps with deliveries, including doctors, nurses, midwives, and traditional birth attendants.
- **Supporting mothers to provide Kangaroo Mother Care,** a technique in which mothers and fathers wrap their infant next to their body for constant contact, helping to keep the infant's body temperature stable and promoting bonding and breastfeeding, all of which are essential for the health of premature and other low birth weight babies.

Supportive training and supervision was associated with higher performance in the number of new adopters of modern contraceptive methods (OR 1.4), increasing postpartum/newborn visits (OR 2.29), improving coverage of DPT-HepB-Hib3 in children less than 12 months (OR 4.53), and increasing nutrition counseling for mothers with children less than two years of age (OR 1.07).

By the end of the fifth year of IHP, the number of pregnant women attending at least one antenatal care visit had reached 108% of the project's target (Figure 25). However, only about one-third of the women managed to attend at least four antenatal care visits (65% of the project target). Analysis of project data shows that implementing

14 The signal functions mentioned here are those described in the MOH norms and procedures, which follow the UN recommendations for basic and comprehensive emergency obstetric care and which are continuously updated.

Figure 27. Number of postpartum/newborn visits within 3 days of birth, by coordination office and PY

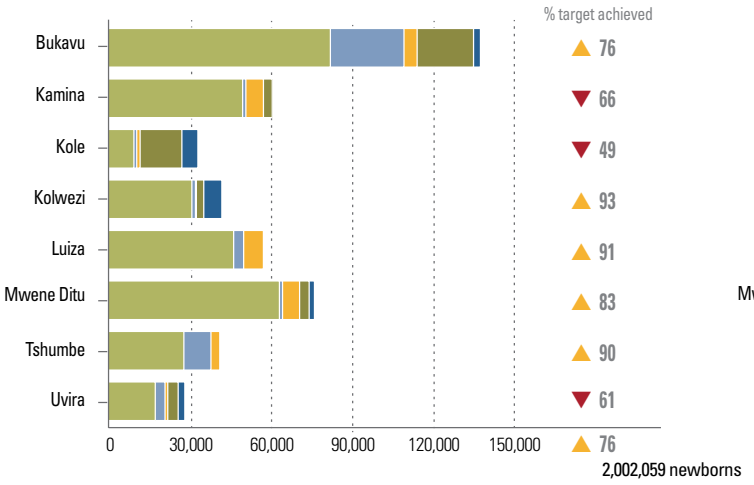
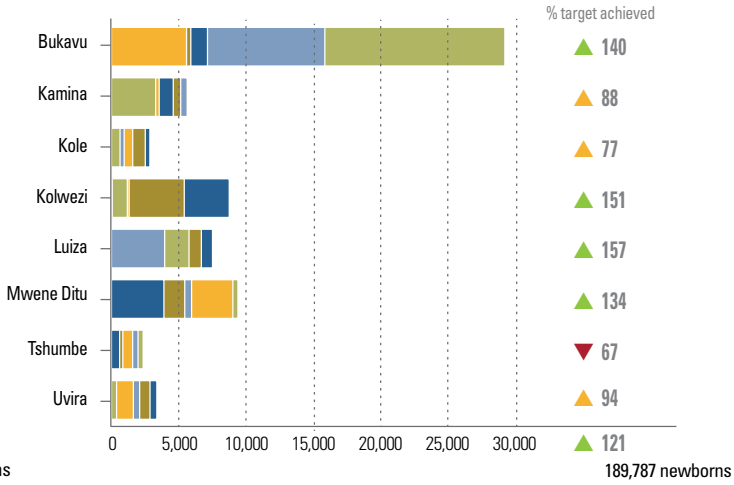


Figure 28. Number of newborns receiving antibiotic treatment for infection, by coordination office and PY



the FOSACOF approach for 19 or more months resulted in higher performance on this indicator (OR 5.46). The RBF approach also contributed to higher performance (OR 1.21), as did the Champion Community approach (OR 2.65) and BCC text messaging (OR 1.23). Health zones that were included in the AXxes project (OR 14.09) or HPP (OR 1.19) also performed better on this indicator compared to health zones that did not participate in those projects.

Pregnant mothers' use of ANC, an integral aspect of the project since PY2, increased steadily through the project. The percent of mothers attending one or more ANC visit increased from 93% in PY1 to 105% in PY5, and those who attended four or more consultations increased from 9% in PY2 to 53% in PY5. In the Congolese culture, women hide their pregnancy as long as they can, which explains why they only attend their first ANC visit during the second trimester of their pregnancy. This cultural factor is one of the main reasons why the gap between the percentage of women attending one ANC visit and the one for women attending four and more is so important. The largest growth in numbers occurred in PY3 through PY5. This increase parallels a change in the project's approach to ANC interventions in PY2, which included: changing the definition of the indicator to better fit the health zones affected by IHP; improving the method of collecting, monitoring, and analyzing project results; improving training of nurses and hospital workers; providing workshops geared toward improving health worker competence; and supporting follow-up visits by health zone management teams. Despite these changes, multiple coordination areas failed to reach their intended goals. For example, project activities reached only 75% of the population of Kole district, where ongoing civil and military unrest contributed to this poor result. Tshumbe's performance far exceeded the other coordination areas. The strong performance can be attributed to:

- active engagement by political and administrative leaders in the Katakokombe health area, who issued a circular to village chiefs recommending ANC visits and deliveries at health facilities for pregnant women;
- involvement of midwives who acted as community health workers and referred pregnant women to health facilities; and
- the availability of free ANC care and commodities (LLINs and iron and folic acid supplements, among others)

Figure 26 shows the number of women who benefited from skilled birth attendant (SBA) assistance during their delivery as well as AMTSL to prevent postpartum hemorrhage. From PY1 to PY5, the percent of pregnant woman who gave birth with an SBA increased from 76% to 91%. By the end of the project, 2,122,497 women had given birth with an SBA, which represented 84% of expected deliveries in USG-supported health facilities. As the set target was 80%, this performance represents an achievement rate of 105%.

"My son was born not breathing or moving. Mama Efuto performed some techniques—and four minutes later my child came back to life! I thank Mama Efuto for reviving my boy whom I love so much. We are now both in good health."

—Agnes, one of Mama Efuto's patients

SUCCESS STORY

Training health workers saves new lives in Dikungu

The maternity ward in Dikungu health zone in the Democratic Republic of Congo used to be a dangerous place to be born. During the first quarter of 2014, 6 of 72 newborns died (8.33 percent).

At the request of the MOH, the USAID-funded DRC-IHP organized two weeks of on-site trainings for midwives and taught the Dikungu service providers how to provide high-quality prenatal care. Midwives learned how to resuscitate newborns using the "Helping Babies Breathe" technique—and supervisors learned useful coaching for midwives.

The intensive skills-building succeeded: the following quarter, from April to June, not a single baby was lost out of 68 births.

"After DRC-IHP staff gave a briefing on resuscitation of newborns, we implemented active monitoring of births and newborns," said Mama Efuto, a midwife at Dikungu General Referral Hospital. "Thanks to the training, we reduced the number of deaths in a quarter from 6 to zero."

Across 78 health zones, DRC-IHP has prioritized a set of low-cost, high-impact interventions that 1) make birth significantly safer for mother and newborn, and 2) dramatically reduce childhood illness and mortality. Innovations include "Helping Babies Breathe," which saved the life of Agnes' baby. Together, these efforts have saved the lives of an estimated 10,900 newborns since 2010.

Photo for illustration only, and is not subject of story.

Photo : Warren Zelman

The percent of women giving birth that benefited from AMTSL increased from 73% to 94% from PY1 to PY5. By the end of the project, 1,864,819 women giving birth had received AMTSL through USG-supported programs in the IHP target area, which represented 88% of all deliveries with an SBA in USG-supported facilities. As the set target was 89%, the project fell short of meeting its target by just one percentage point.

It should be noted that all caesarean-section births were recorded by service providers as benefiting from AMTSL, which included an oxytocin injection. The absence of partograms in many facilities remains a major issue in implementing AMTSL.

Under the indicator of postpartum visits, as shown in Figure 27 on page 47, the project attained a total of 2,002,059 visits against a target of 2,624,837. This represents an achievement rate of 76%. The achievement rate was affected by poor performance in Kamina (66%), Kole (49%), and Uvira (61%), where limited access to clean water and poor road conditions limit the provision of care and women's access to facilities. Due to these factors, multiple mothers remarked that they could not stay in the city for the four to six days required for the consultation. At the level of the health facility, a lack of organization in the postnatal consultation, lack of clarity among birth attendants regarding materials distributed by the project, and lack of a uniform tool to collect information slowed achievement of this indicator's target.

The project observed a continuing increase in the number of newborn infants who received essential newborn care from trained facility, outreach, or CHWs through USG-supported programs/IHP target areas, from 322,736 in PY1 to 457,860 in PY5. Meanwhile, the number of newborns delivered in the IHP target areas also increased, which explains the decrease in the percentage of newborns receiving essential newborn care through USG-supported programs from PY2 to PY5 (from 103% to 97%). By the end of the project, IHP met this target at 100% and reported a performance of 100% on this indicator.

The project experienced an increase in the number of sick newborns receiving correct antibiotic treatment, with 189,787 newborns benefiting from IHP activities (121% of target) (Figure 28, page 47). All health zones achieved 77% or more of their target for this indicator except Tshumbe, which treated 7,356 newborns, or 67% of its target. This indicator proved especially difficult for birth attendants to implement, due to confusion between antimicrobial eye drops and injectable antibiotics. The former are administered as soon as possible after birth to protect the newborn from serious eye infection (which can result in blindness or even death), while the latter are given to newborns with clinically suspected serious bacterial infections, such as pneumonia and sepsis. To combat these issues, IHP provided technical support to revise the MNCH care reference forms, facilitated health worker training, provided needles adapted for newborns, and reinforced the capacity of health zone management teams to assist with questions.

The project supported health facilities in integrating HBB activities into their package of services. By the end of the project, a total of 43 GRHs and 30 health centers across 43 health zones and 8 coordination offices were using the HBB approach. Project wide, HBB activities resulted in a success rate of 88% of babies successfully resuscitated among those that had difficulty breathing after delivery. The coordination zone of Luiza represents the largest share (32%) of facilities that integrated HBB into their activities (the Luiza coordination office organized the highest number of HBB trainings among all IHP offices). A comparison of data shows a higher rate of success (91%) resuscitating babies in GRHs compared to health centers (85%). There is no evidence of correlation between the structure of a health facility and resuscitation success rates.

Family planning

IHP had an impressive impact on maternal and child health through its family planning interventions. Using the IMPACT 2 modeling tool developed by Marie Stopes International, the project estimates that its interventions averted approximately 224,000 unwanted pregnancies and 157,000 unplanned births, subsequently preventing 700 maternal deaths and 28,000 unsafe abortions. These figures indicate that IHP's high-impact practices averted the loss of 40,000 maternal disability-adjusted life years.

DRC has one of the lowest rates of modern contraceptive use in the world; only 5% of rural women of reproductive age use a modern method, and only 15% of this population uses any contraception. Overall fertility, which—counter to international trends in recent years—has risen slightly in DRC, is 6.6 children per women nationally and 7.3 children per woman in rural areas, according to the 2013 DHS. IHP trained health workers at all levels in family planning counseling and contraceptive technology, including the use of long-lasting, reversible contraception such as implants.

IHP trained community-based distributors (CBDs) to conduct door-to-door outreach to inform couples about their contraceptive options. In addition to supplying CBDs with family planning commodities, the project also provided bicycles and job aids to facilitate the outreach.

By the end of the project, each health area had at least three CBDs for a total of 1,548 women and 2,452 men.

A total of 2,233 project-supported delivery points provided family planning counseling or services: 1,551 health facilities and 682 community-based sites. The project exceeded its PMP target of 2,000 and reported an achievement rate of 112%. At the end of project, voluntary family planning services were offered in 100% (68 out of 68) of the HIV service delivery points supported by both IHP and PEPFAR. Compared to the PMP target of 80%, this represents an achievement rate of 125%. Health zones with less than 25 service delivery points were associated with fewer new family planning adopters (OR .43) and counseling visits (OR .54). More than 420 providers were trained in long-term methods, and 54 were provided with training materials on insertion and removal of IUDs and implants. Health zones receiving this training were more likely to have more new family planning accepters (OR 1.4) than those that did not. The health zone management teams' LDP projects discussed above included eleven successful projects that increased demand for family planning services, improved service delivery quality, and contributed to increases in new acceptors (OR 2.5) and family planning and reproductive health counseling visits (OR 3.37).

IMPACT: IHP CONTRIBUTION TO FAMILY PLANNING VARIABLES*

224,000
Unintended pregnancies averted

157,000
Live births averted

28,000
Abortions averted

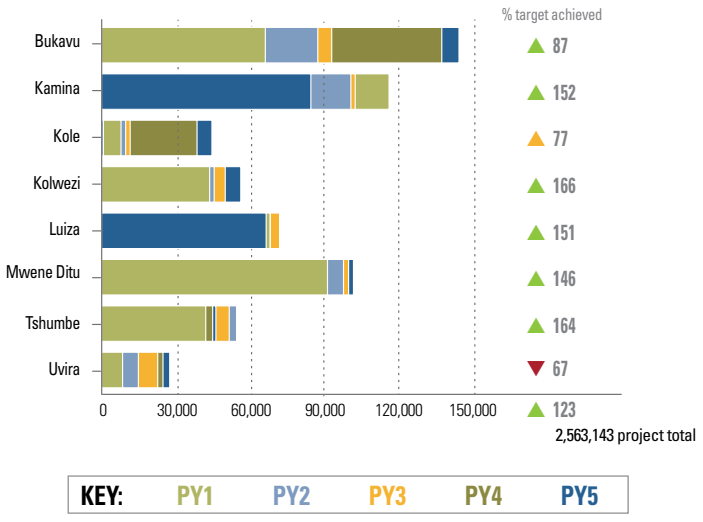
700
Maternal deaths averted

28,000
Unsafe abortions averted

40,000
Maternal DALYs averted

**Using the IMPACT 2 modeling tool. Marie Stopes International, v.3, November 2015.*

Figure 29. Couple years of protection in supported programs, by coordination office and PY
(See also Appendix 11)



The project educated target communities about the benefits of contraception and created demand for services through community radio and SMS messages. The project reported 2,833,418 family planning and/or reproductive health counseling visits at USG-supported service delivery points, which is well above the PMP target of 1,809,908. This represents an achievement rate of 157%. Through the grassroots Champion Community approach, IHP trained community leaders in management and leadership skills, such as developing an action plan, defining targets, and incorporating sustainability strategies to boost the use of modern family planning through interpersonal communication and community messaging. The project also worked with men to educate their peers through the "Champion Men" approach, where men who are supportive of family planning are recruited and trained to address the subject at public meetings, events, churches, and regular hangouts such as bars. By the end of the project, over 900 Champion Men were educating other men about family planning in five health zones. As a result of these approaches, the number of new acceptors of family planning increased (OR 2.67), as did the number of family planning and reproductive health counseling visits (OR 2.43).

Couple Years of Protection (CYP): Figure 29 shows a steady annual increase in CYP, from 443,897 in PY1 to 571,340 in PY5. By the end of the project, IHP had achieved 123% of its target in this area, with its interventions having led to 2.5 million CYP. Another indicator that the project has to report on is the CYP after exclusion of the Lactational Amenorrhea Method (LAM) and natural family planning (NFP) in USG-supported programs. By the end of PY5,

"I gave birth almost every year. My children grew poorly and were always sick, and it was difficult to care for them all. LAM has enabled us to space our children's births. Now they are strong and healthy, and I have more time to take care of them."

—Céline, family planning adopter and CBD in Katana

SUCCESS STORY

Making family planning services available in Katana health zone

Although nearly half of married women in the Democratic Republic of Congo say they would like to space their families, few use any type of family planning method. Barriers include lack of awareness of and access to family planning services—and misconceptions about contraceptives.

The USAID-funded Integrated Health Project has been assisting the MOH to change that. Efforts include providing training and supplies for family planning counseling and services. IHP has facilitated several province-wide trainings on long-term family planning methods with 94 service providers and community-based distributors (CBDs).

In 2012, CBDs from Katanga Province came to Céline's village and visited couples in their homes to discuss how contraceptives can be used for optimal birth spacing—thus helping to ensure that children grow up healthy. After meeting with the CBDs, Céline and her husband adopted the Lactational Amenorrhea Method (LAM) of contraception, in which exclusive breastfeeding and amenorrhea protect against a next pregnancy up to 6 months after birth. When any one of the three parameters change, which in Celine's case was reaching 6 months postpartum, they began using another family planning method, Depo-Provera, to further space out Céline's pregnancies.

Céline explains, "We have had one more child after three years. Now our children are strong and healthy, and I have more time to take care of them. Our success has encouraged us to become CBDs ourselves, and we conduct home visits to couples once per week."

DRC-IHP has enabled over 2,000 health facilities to stock essential family planning products. New adopters of family planning methods have more than tripled between 2010 and 2015—from 6,800 to over 23,000 in Katana health zone alone.

Photo for illustration only, and is not subject of story.

Paulina Kasungu, a member of the Tudisange Champion Community, counsels a young couple in family planning methods in Luiza, Kasaï Occidental. As a member of the Tudisange Champion Community, Paulina provides counseling in family planning not only at the health center but also visits members of the Luiza community in their homes.

Photo : Rebecca Weaver

The Kaziba General Referral Hospital in Sud Kivu serves around 200,000 people. In this photo, mothers bring their babies to the hospital on the weekly "vaccination day."

Photo : Rebecca Weaver

Figure 30. Number of new acceptors of any modern contraception method, by coordination office and PY

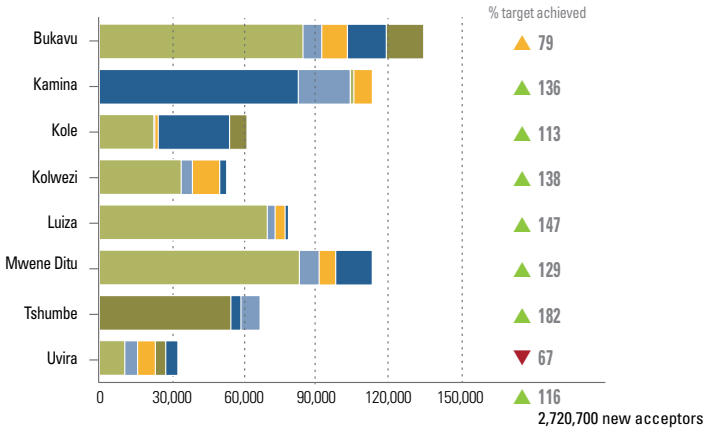
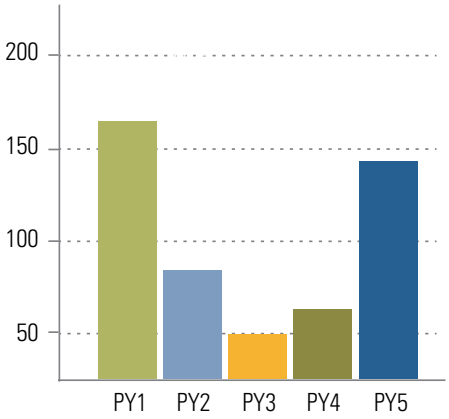


Figure 31. Number of stock-outs of Depo-Provera



the project reported an overall realization of 1,004,203 CYP, which is well above the PMP target of 645,000, for an achievement rate of 156%.

Modern methods of contraception: Figure 30 shows the number of new acceptors of modern methods of contraception according to project year and IHP coordination office. The project achieved 116% of its target, with more than 2.7 million new acceptors during the life of the project.

The favorable rate of adoption of contraception throughout PY5 is linked to the availability of contraceptives, the quality of care offered by qualified health providers, and advocacy of political and administrative leaders. The main challenge in the implementation of family planning activities was maintaining a consistent supply of contraceptives at the service delivery level. In order to monitor progress in this area, IHP monitored stock of Depo-Provera, a widely preferred contraceptive method in the DRC, as a tracer drug. The project and USAID/DRC agreed on an acceptable end-of-project target of no more than 133 facilities experiencing stock-outs of Depo-Provera. Figure 31 above shows that the project fell short of this goal, with a total of 146 USG-assisted health facilities experiencing stock-outs of Depo-Provera. Stock-outs decreased from PY1 to PY3 (from 167 to 49), followed by an increase during the last two project years (67 to 146). This is attributable to challenges faced by three coordination offices: Bukavu, Kamina, and Tshumbe. In Kamina, 84 health facilities reported Depo-Provera stock-outs due to geographical inaccessibility (the two bridges which connected Kamina to four health zones had collapsed in early PY5). The Depo-Provera supply was then shipped by boat, and by the time the health facilities received the order (after September 2015), they were all out of stock. Further analysis of project data shows that health zones with greater than 11 stock-outs of Depo-Provera were more likely to perform poorly in the number of new acceptors (OR .69) and number of family planning/reproductive health counseling visits (OR .91) than those that had few stock-outs. The primary challenge in maintaining stock was not the delivery of this product to the health zone level, but rather the weak performance of health zone teams in ordering new stocks upon depletion of the old. With historically low utilization rates, health center staff had difficulty accurately estimating the demand for modern contraception. Nonetheless, the final year total of 146 stock-outs was a slight improvement over the 167 recorded in PY1.

Expanded program on immunization

Confronted with enormous logistical constraints and poor national coverage, IHP managed to reach its target of vaccinating at least 90% of children with two reference antigens (pentavalent and measles) in the targeted health zones by PY2 and continued to surpass that target throughout the remainder of the project. Routine vaccinations included Bacillus Calmette-Guerin (BCG), diphtheria, tetanus, pertussis (DTP), polio, measles, Hib and HepB. IHP emphasized the development of local capacity to manage an effective and sustainable routine immunization program. The project was active in all key interventions in this area, including the polio eradication effort, the introduction of new vaccines, and measles elimination efforts. All of these interventions were conducted in close collaboration with MOH officials following DRC/MOH protocols.

The foundational principles for strengthening routine immunization were based on the "Reach Every District" approach, which focuses on universal coverage in every

health zone in the country. IHP supported the technical and financial planning of immunization activities, routine supportive supervision of health zone management teams, monthly monitoring meetings, and community monitoring for identifying unvaccinated and inadequately vaccinated children. IHP provided technical and financial support in the production of vaccine management tools to improve data quality and assisted with data validation, especially in health areas implementing RBF. Analysis of project data shows that supportive training and supervision was associated with higher performance on the number of children under 12 months receiving DPT-HepB-Hib3 vaccines (OR 4.53). Health zones participating in RBF also did better on this indicator (OR 2.11) than those who did not.

IHP strengthened supply, demand, and quality aspects throughout the system. The project built local capacity by training 1,027 EPI technical management providers and 113 health zone management team members. IHP technical officers provided joint routine supportive supervision with MOH officials every quarter to each of the 78 zones. These capacity-building efforts were strengthened by logistical support to ensure that vaccines and the materials necessary to maintain a sufficient cold chain were consistently available. IHP created demand for vaccination services through multiple channels, including the following:

- 350 Champion Communities integrated vaccination-related activities into their action plans.
- 104,496 people responded positively to BCC vaccination messages sent by SMS by stating that they had taken their children to vaccination services or planned to do so.
- 36 health zone management teams implemented LDP projects related to improving vaccination coverage.

Health zones that received BCC text messages on vaccinations had higher vaccination coverage for DPT-HepB-Hib3 for children under 12 (OR 3.1) than those that did not. To ensure a consistent supply of vaccines and materials, the project routinely provided vaccination supplies when interruptions in the routine MOH system occurred. Overall, the project provided 245,600 0.05 ml syringes, 1,903,200 0.5 ml syringes, 18,000 dilution syringes, and 1,005 cartons of injection safety boxes (25 boxes/carton). IHP also procured vaccines and distributed 650 kerosene refrigerators to 78 health zones and 12 EPI branches as well as kerosene and diesel fuel for cold rooms. The project procured 30 solar refrigerators for health zones with low storage capacity. These initiatives decentralized the cold chain and improved geographic equity for vaccination coverage, especially in Luiza, Malemba Nkulu, Mwene Ditu, Sankuru, and Uvira.

The percentage of children completely vaccinated before their first birthday is the most important single indicator of the effectiveness of a routine immunization program. The results for this indicator can be seen in pentavalent vaccine (DPT-HepB-Hib3) coverage (Figure 32), which improved continuously over the five years of implementation. Project data show that 2,131,796 children received their final dose of this essential vaccine, representing 97% of children under 12 months of age in the supported health zones, or 111% of the project's target. Vaccination rates reported by Kolwezi were high compared to other coordination offices. These higher rates could be due in part to population movement following the mining boom, resulting in nonresident clients being vaccinated, but the results were far too high to be explained solely by this factor. The provincial health division management staff was unable to research the factors influencing these data, as the management staff had not yet been trained on RDQA by the project staff, due to competing priorities. This gap was planned to be filled by IHPplus.

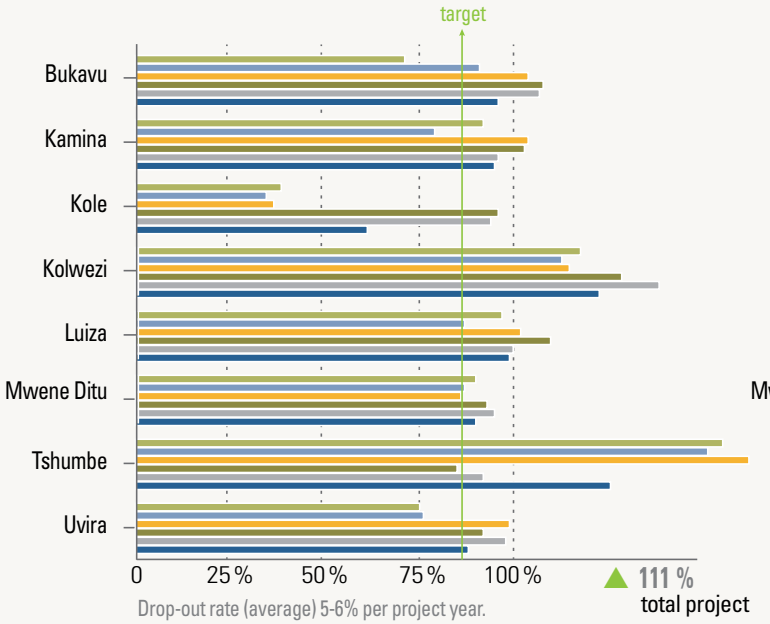
Efforts to improve the coverage of anti-measles vaccinations benefited from the same system-strengthening efforts described above and recorded similar results as those of the DPT-HepB-Hib3. By the end of the project, 90% of children under 12 months of age received the measles vaccine, representing 102% of the project's target. As shown in Figure 33, measles vaccine coverage in IHP zones rose from 85% at the end of PY2 to 93% by the end of the project. The project encountered challenges with stock-outs of measles vaccines and syringes in the first two years of the project (which explains why no data was reported for PY1) and responded by procuring supplies in sufficient quantity to achieve nearly universal coverage.

Political instability and insecurity did threaten success of this intervention in some areas such as Malembe Nkulu. Despite these obstacles, health facilities in the health zone showed continued improvement in reducing the number of reported measles cases.

In a trend consistent with other antigens, the percentage of children receiving at least two doses of the tetanus toxoid vaccination increased from 81% in the first year of the project to 93% by the final year. Only two health zones—Kayamba (IHP Kamina) and Kitutu (IHP Bukavu)—remained at risk, with rates of 3 cases per 4,059 live births and 6 cases per 5,614 live births respectively. The project contributed to the reduction in the number of health

KEY: PY1 PY2 PY3 PY4 PY5

Figure 32. Percent of children under 12 months who received DPT-HepB-Hib3 from supported programs, by coordination office and PY



Drop-out rate (average) 5-6% per project year.

Figure 33. Percent of children under 12 months who received measles vaccine from supported programs, by coordination office and PY

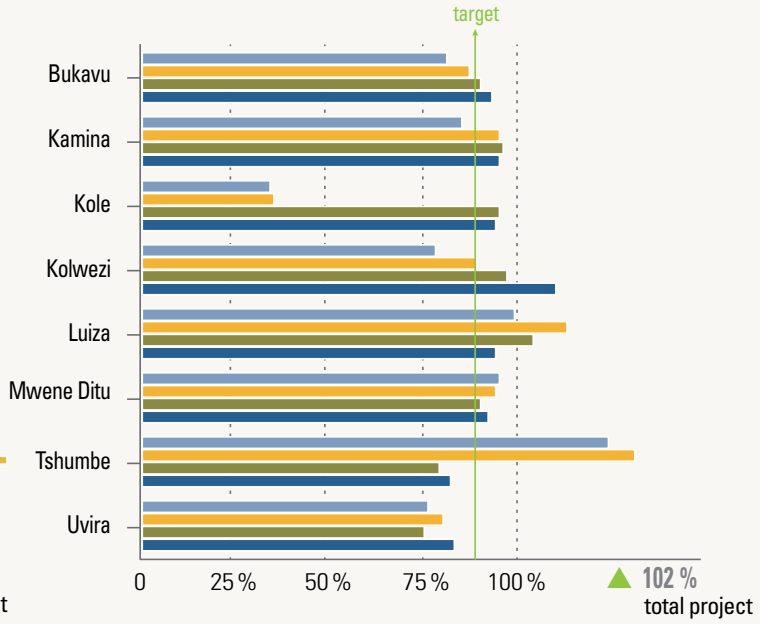


Figure 34. Percent of pregnant women who received TT vaccine from supported programs, by coordination office and PY

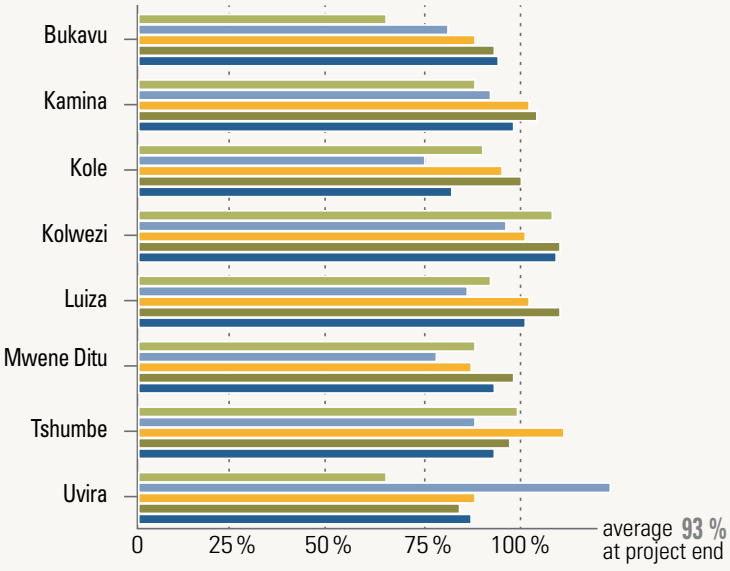
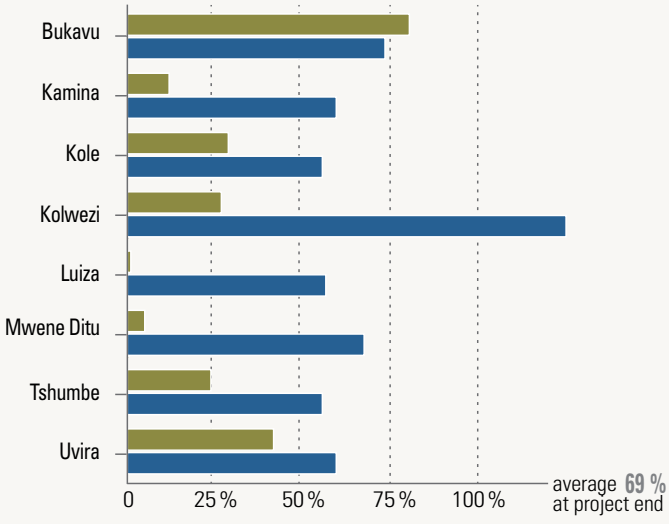


Figure 35. Percent of children less than 12 months who received PCV13-3 vaccine from supported programs, by coordination office, PYs 4 and 5 only



zones at high risk for tetanus. In 2010, DRC reported 150 high risk health zones; 21 of them were supported by IHP. Between 2014 and 2015, the national number dropped to 11, and just three zones supported by IHP remained high risk. IHP also introduced chlorhexidine digluconate 7.1 for umbilical care (to provide a replacement for other risky cord care practices), which is a key strategy for eliminating maternal and neonatal tetanus (Figure 34, page 55).

Throughout the five years of the project, 5 to 6% of children received one but not all of their DPT-HepB-Hib3 vaccinations. This is well within the WHO standard of 0% to 10%. In PY5 the project reported a drop-out rate of 5% against a national average of 7% (*Annual Report EPI DRC*, February 26, 2015, page 11). Kolwezi reported negative drop-out rates in PY1 and PY2, which can be explained by the fact that people who did not get vaccinated for the first dose of the vaccine came to the health facilities and were mistakenly vaccinated for the third dose for that vaccine. This may be caused by movement of people from and between other health areas and provinces of the country. Given the migratory nature of some of the populations in the mining areas and the difficulty of tracking children reliably, this is still a notable accomplishment.

In addition to the above efforts to reinforce the routine immunization program, the project was actively involved in the following initiatives:

- Introduction of PCV-13 to protect against pneumonia
- Polio eradication initiatives, including vaccination campaigns, monitoring acute flaccid paralysis, and the introduction of inactivated polio vaccine (IPV)
- Elimination of measles
- Elimination of maternal and neonatal tetanus
- Elimination of haemophilus influenza or pneumococcus meningitis (the project was supporting EPI activities in health zones that have been designated as meningitis sentinel sites by the MOH)

IHP's technical and financial support for the integration and deployment of IPV in its target health zones helped improve coverage of this vaccine. The project's integrated approach included using health posts to increase outreach into the communities. The project's introduction of PCV-13 vaccine in Sud Kivu province in 2014 was particularly successful; by the end of the project, 69% of children under 12 months had received the vaccine across all project zones, despite problems with stock-outs (see Figure 35, page 55). This signals the existence of a reasonably sound routine system that has the capacity to introduce and integrate new vaccines at an accelerated pace. As noted earlier in this report, the scale-up of this vaccine correlates strongly with a sharp decline in the number of reported pneumonia cases.

DRC has had a successful history with mass immunization campaigns, beginning with the national immunization days against polio in the late 1990s. Different versions of these campaigns over the past two decades have addressed varying health threats, including measles, meningitis, and tetanus. IHP was involved in vaccination efforts at every level of the health system, providing technical and financial support for the national level EPI as well as more direct support to train vaccinators. The project also provided logistical support and cold chain supplies for the EPI branches and health zones. Technical support included briefing providers, assisting with planning and coordination, and organizing independent monitoring surveys during supplementary immunization activities, which identified problems and poor practices and provided corrective measures in real time.

In support of the larger polio eradication effort, IHP integrated the monitoring of acute flaccid paralysis into the project in PY2. The 78 project health zones identified 160 cases of acute flaccid paralysis, 90% of the expected result, which indicates that the system used to identify and report cases through the formal health system was effective. This outcome can be attributed in part to community-based strategies such as Champion Communities; transmitting targeted SMS; active case identification in priority sites; capacity building through field visits; and monthly monitoring of priority site visits by health zone management teams and IHP field teams.

IHP addressed quality improvement issues through routine supportive supervisory visits and special interventions designed to increase empowerment, inclusiveness, and capacity building. The introduction of RBF in 7 zones has had a positive effect as well, which is discussed later in the report.

Malaria

The target populations for malaria prevention and treatment were the most vulnerable groups—pregnant women and children under five. According to calculations using the LiST tool, IHP estimates that just over 44,000 lives were saved in these two groups through an integrated approach addressing supply, demand, and quality issues. The primary interventions for women included routine prophylaxis during pregnancy and increased use

"I'm 16 weeks pregnant and I've come to the hospital to take SP. I know its good medicine that will protect me from malaria and the pregnancy complications that come with it—and it's free. I'm very thankful for this program."

—Ms. Ngoya, an expectant mother and patient at Kikondja Hospital

SUCCESS STORY

Protecting pregnant women and newborns from malaria

The Democratic Republic of Congo has one of the highest rates of malaria-related deaths in the world, with babies and pregnant women especially vulnerable. Malaria can prevent normal weight gain and lead to anemia, premature delivery, low birth weight, and a high risk of infant mortality. The National Program to Fight Malaria recommends that pregnant women take at least three doses of intermittent preventive treatment (IPT) in their 16th, 24th, and 32nd weeks of pregnancy.

Since 2010, the USAID-funded DRC-IHP (with support from the President's Malaria Initiative) has assisted the Congolese MOH by providing high-quality drugs to prevent and treat malaria across dozens of health zones. One of these health zones, Kikondja, has received and distributed 564,000 doses of the antimalarial SP since 2010. In 2013, the project funded training for 26 providers in Kikondja on preventing and treating malaria through antenatal consultations (ANCs). In Kikondja, 837 pregnant women are expected to attend an ANC visit in a given year, 344 of them at the local hospital.

"I am 34 years old and I've had 11 pregnancies," said Ms. Ngoya, one of the women who says she will be attending ANC visits. "Only four of my children are living, the others having died of complications, including from malaria. After my seventh child was born at Kikondja Hospital, I received counseling on the importance of ANC visits and the dangers of getting malaria during the first stages of pregnancy. After that I decided that I would attend the first ANC visit during my next pregnancy."

Photo for illustration only, and is not subject of story.

Photo: Todd Shapera

KEY: PY1 PY2 PY3 PY4 PY5

Figure 36. Percent of pregnant women who received at least two doses of SP during ANC visits

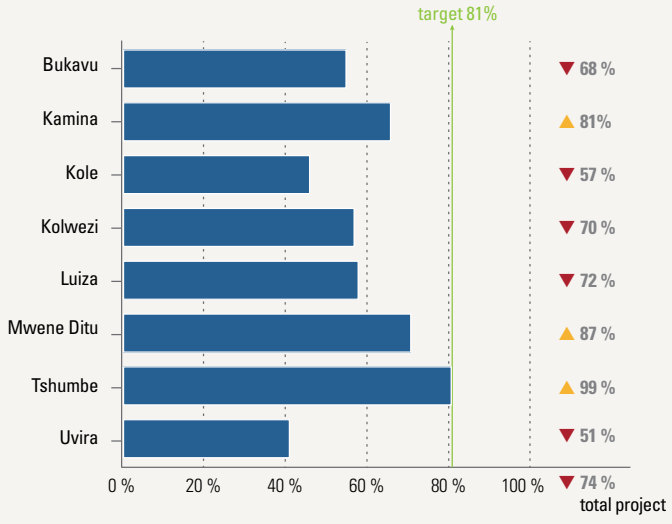


Figure 37. Number of RDTs purchased with USG funds that were distributed to health facilities

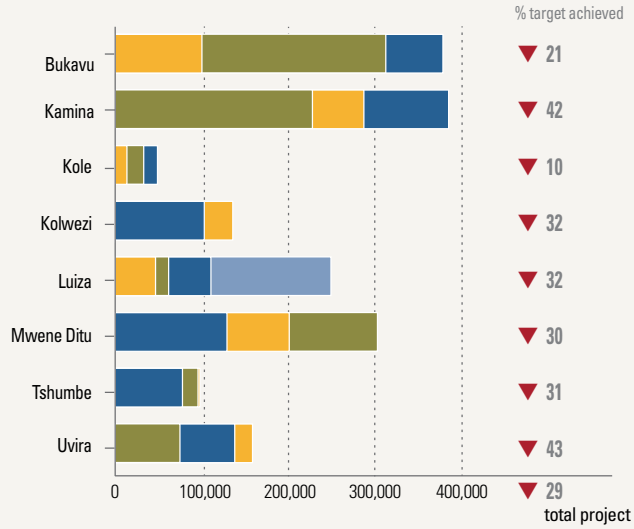


Figure 38. Number of ACT treatments purchased with USG funds that were distributed

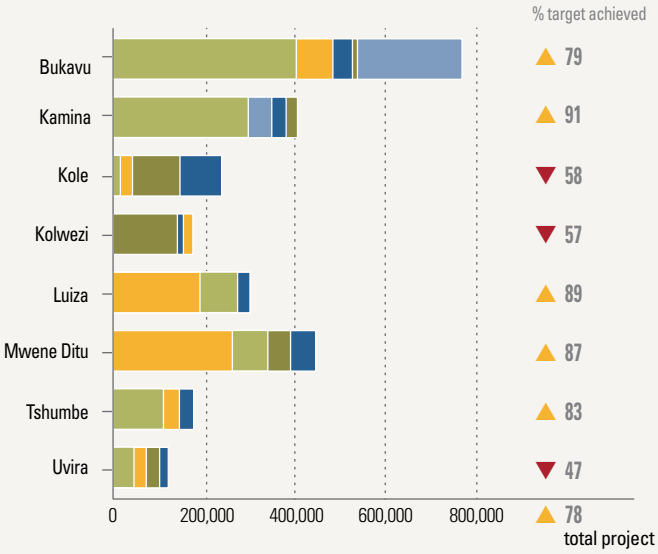


Figure 39. Number of LLINs, SP, ACT, and RDT purchased with USG funds

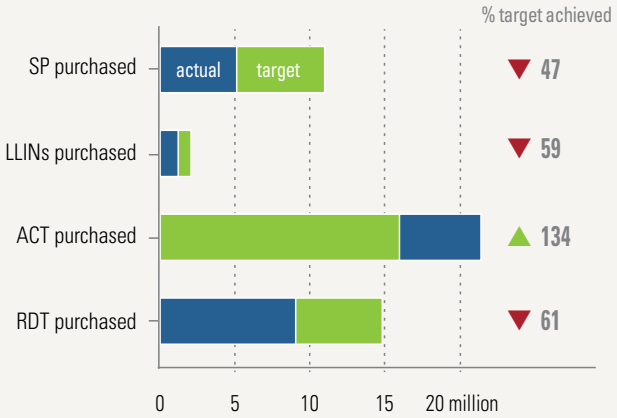


Figure 40. Number of supported delivery sites experiencing stock-outs of ACT (detail)

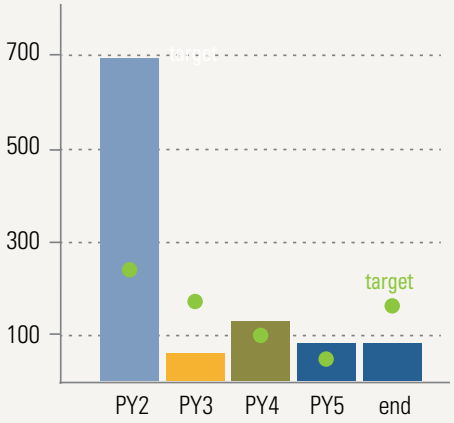
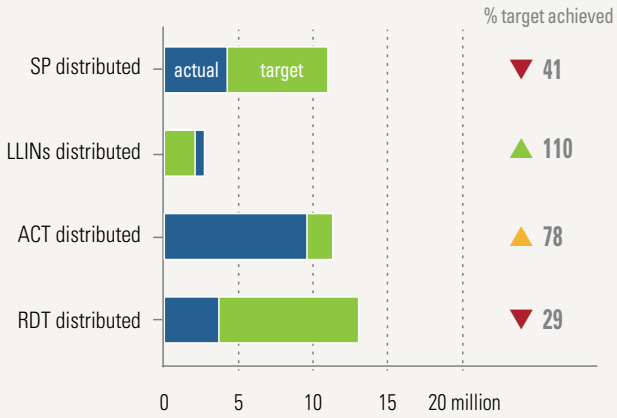


Figure 41. Number of LLINs, SP, ACT, and RDT distributed



of LLINs (these nets were distributed to pregnant woman when they came for their first ANC visit, generally during the second trimester of their pregnancy). While the latter intervention also proved effective in reducing child mortality, the primary intervention for children was the availability and appropriate use of ACTs.

IHP implemented malaria activities in 68 of the 78 IHP health zones to avoid overlap with Global Fund projects working in the other 10 zones. IHP worked closely with the national malaria program, providing SP, LLINs, ACTs, severe malaria kits, and training for providers and laboratory technicians in the prevention, diagnosis, and management of malaria. In addition, joint supervision of facilities with the MOH focused on management of malaria commodities and compliance with management protocols, sensitization campaigns, and joint data quality assessments in the field.

Prevention: Overall, the project purchased 5,121,000 SP tablets which, against a target of 11 million, represents an achievement rate of 47% (see Figure 39). Of the over 5 million tablets bought, 4,546,917 were distributed which against a PMP target of 11 million, represents a 41% achievement rate (see Figure 41).

During the project, 1,513,245 pregnant women received two doses of SP for IPTp (see Figure 36). This represents 74% of the target for this indicator and approximately 60% of the estimated number of pregnant women in the supported area. The national average is just 14% (DHS 2013). This result was achieved by providing SP to the health facilities, training 5,372 health workers on malaria case management with ACT and 4,893 on IPTp. This initiative also included joint supervision visits with the national malaria program, campaigns to raise awareness, and purchase of SP by the health facilities during stock-outs using the revolving medication fund. Further analysis of project data shows that the LDP approach and facilities' inclusion in the RBF program was associated with an increase in the percent of pregnant women attending the facility receiving at least two doses of SP (OR 1.26 and OR 4.5 respectively).

Despite overall increases from PY1 (52%) to PY5 (66%), performance in the Kole and Uvira coordination offices was consistently low, mostly due to regular shortages of SP. The high drop-out rate from the first ANC visit (ANC1) to the fourth (ANC4), which persists at roughly 66% as per the previous section on MNCH, presented another challenge. Although exact figures do not exist for the second ANC visit, this dropout rate, which is partially attributed to the late attendance at ANC1, impacts malaria prophylaxis for pregnant women. Nationally, only 17% of women attended their first antenatal clinic before their fourth month of pregnancy (DHS 2013). Overall the project purchased 1,211,600 LLINs which, against a target of 2,070,000, represents an achievement rate of 59%. However, the project was able to distribute a total of 2,273,179 LLINs through health facilities during ANC visits and preschool consultations thanks to the additional quantities provided by PMI directly to the providers. Against a target of 2,070,000, this represents an achievement rate of 110%.

In PY2, the province of Katanga organized a mass distribution of LLINs. PMI contributed 2.5 million LLINs, and 17 IHP-supported health zones received 1,400,841 LLINs purchased with USG funds. After the LLIN distribution campaign, IHP initiated an 18-month behavior change awareness-raising campaign. From 2012 to 2014, in 20 health areas in 10 health zones in the provinces of Katanga and Sud Kivu, the initiative covered a population of 355,230. The key message was "Sleep under an LLIN every night, and have your family do the same." As a result, the LLIN utilization rate in the target population increased from 60% to 76%.

The distribution of LLINs increased in PY5 thanks to their availability in all health zones, due to the simultaneous delivery of delayed LLIN shipments from PY1, PY2, and PY3.

IMPACT: IHP CONTRIBUTION TO MALARIA INDICATORS

5,632
service providers were trained to manage malaria, including CHWs at community care sites

766
care sites were established

105,086
doses of ACT were provided to children under 5 after CHWs were trained to administer RDTs

35% to 77%
increase in confirmed malaria cases

18% to 14%
proportion of severe malaria cases to total cases

During the course of the project, 315,317 clients were counseled and tested for HIV and received their results, an achievement of 483% of the target.

Photo : Warren Zelman

Treatment: Overall, the project exceeded its PMP target of ACT treatments purchased, with over 21,450,159, compared to a target of 16 million, which represents a 134% achievement rate. IHP reported a total number of ACT treatments of 9,240,067, which against a target of 11,800,000 represents an achievement rate of 78%. IHP also distributed 422,575 ACT treatments purchased by other partners. Regarding RDTs, the project reported 9,063,518 units purchased against a PMP target of 14,580,000, which represents an achievement rate of 61%. IHP reported a total number of RDTs distributed of 3,887,495, which, against a PMP target of 13,350,000, represents an achievement rate of 29%.

The national malaria program recommends that all suspected cases of malaria receive laboratory confirmation, even in remote community care sites, before administering ACTs. The MOH's target is that 80% or more of suspected cases receive a biological diagnosis, and 100% of malaria cases are treated according to protocols with ACTs. This is a change in protocol from a practice that is deeply ingrained in DRC's health care providers, which was to treat all cases of fever presumptively as malaria. Starting after PY2, IHP responded to this challenge by procuring RDTs and training service providers at all levels in their use. As illustrated in Figure 41 on page 58, 3,887,495 RDTs were distributed, representing 42% of the number of ACTs distributed. Ideally, there should be more RDTs used than doses of ACTs administered. That said, there has been a significant increase in the use of RDTs as the quantity that was purchased and distributed to health facilities was multiplied by almost five between PY2 and PY5.

As explained earlier, IHP achieved 78% of its target on number of doses of ACT purchased with USG funds and distributed to health facilities and community care sites (Figure 41, page 58). The low reporting of health zones in the coordination offices of Kole, Kolwezi, and Tshumbe during the first two years pulled the overall project average down. As a result of organized trainings, improved procurement, and supervision missions that focused on compliance with the national protocol, performance in malaria indicators has improved.

Despite average figures in the above indicator, the number of facilities with stock-outs of ACT declined from 691 in PY2 to 80 in PY5, exceeding the target of 133 stock-outs for a performance rate of 166%. Decreased stock-outs can be attributed both to improved ACT availability at the national level, as well as efforts to improve stock management and monitoring (see Figure 40, page 58).

Project performance regarding training providers and laboratory technicians in the prevention, diagnosis, and management of malaria is based on three indicators. The first, number of health workers (doctor, nurse, nurse assistants, clinical officers) trained in IPTp with USG funds disaggregated by gender (male/female), reported by IHP at the close of the project was 4,893 against a target of 7,730, which represents a 63% achievement rate. Men represented 83% of the staff trained and women 17%. The project also reported that by the end of PY5, 5,372 health workers were trained in malaria case management with ACTs, representing an achievement rate of 52%. Finally, the project reported the same achievement rate for the number of health workers trained in malaria laboratory diagnostics (RDTs and microscopy), with 5,632 staff trained against a PMP target of 10,800. After analysis, this target was too ambitious, given the project context (budgetary restrictions during PY4 and USAID's request for IHP to shift its priorities from training to other type of interventions during PY5).

HIV and AIDS

The HIV program has undergone two implementation phases under IHP. The first took place from October 2010 through September 2012 and was implemented in all four provinces (Sud Kivu, Kasaï Oriental, Kasaï Occidental, and Katanga). The second phase began on October 1, 2013, and continued until the end of the project. During this phase, the implementation area was reduced to include only the province of Katanga under the PEPFAR strategic pivot, which focused resources in provinces with high HIV prevalence. Three provinces were prioritized in DRC: Kinshasa, Katanga, and Oriental. The year between these phases corresponded to PY3 (October 2012 to September 2013) and served as a transition period.

During the first phase, the IHP HIV program focused primarily on prevention of mother-to-child transmission (PMTCT) and secondarily on blood safety in 212 HIV care sites across the four provinces and all 8 IHP coordination offices. However, in year one of this phase, the project's HIV activities were severely disrupted by the late delivery of testing supplies and markers of blood safety. The project used this time to train 134 care providers and 79 peer recruiters on blood donation, led an evaluation of existing PMTCT sites, and supplied 30,000 bags of blood to sites covered by the Bukavu and Uvira coordination offices. The approach for this early phase was to build the capacity of service providers through training courses led by central trainers from the PNLS and support for supervision.

This shift in project focus renders data a bit more complex to analyze as targets and program priorities shifted

mid-project. Results for PMTCT show a precipitous decline in PMTCT care sites from 212 in PY2 to 52 in PY3. This eventually increased to 68 in PY5 as more sites were added in the focus areas of Kamina and Kolwezi, with 40 and 28 sites respectively. During the second phase of the project, the number of indicators was raised to 14, thus there are no data for certain indicators for the first three years of the project.

All 68 HIV care sites supported by IHP provided the following package of services: HIV counseling and testing using provider-initiated counseling and testing; PMTCT; care and support at the health center level; ART; prophylaxis with nevirapine to HIV-exposed children and cotrimoxazole for children and adults living with HIV; identification and treatment of TB and HIV coinfection; prevention interventions for key populations; family planning; and equipping Kamina and Kolwezi laboratories with PIMA (CD4 assay) machines. Dried blood spot testing was available in sites for early infant diagnosis (EID).

Option B+: The PNLS adopted Option B+ for the treatment of HIV-infected pregnant women in 2013 and introduced it to HIV care sites supported by the project in Lualaba and Haut Lomani in the second half of 2014. The integration process was completed in Q3 of PY5. IHP made PIMA machines available to all of the health zones where it was supporting HIV care.

At the end of the project, 51% (222,026 out of 439,367) of the pregnant women who attended ANC, labor, or delivery in IHP-supported facilities were tested and were aware of their HIV status. Against the PMP target of 91%, this represents an achievement rate of 55%. The overall project result of 51% was negatively influenced by low testing rates during phase 1. During phase 2, project results were closer to 80% (see Figure 42). This positive outcome resulted from project efforts to ensure the availability of HIV tests and other supplies, training of HIV care providers, and compliance testing.

By the end of PY5, 15 out of 69 (22%) PEPFAR-supported sites providing PMTCT services (HIV testing and counseling and ARV or ART services) achieved 90% ARV or ART coverage for HIV+ pregnant women. The PMP target was 100%. This performance can be explained by the fact that the project only started reporting on this indicator in the last year of the project.

IHP reached 212 sex workers, either individually or in small groups, with prevention interventions in Kamina and Kolwezi, which represents 43% of the target. The activities were conducted in synergy with FHI 360 in Kolwezi and with a local NGO (Batwa Bemba) in Kamina. This indicator was not included in phase 1.

Testing and Counseling: During the course of the project, 315,317 clients were counseled and tested for HIV and received their results, an achievement of 483% of the PMP target of 65,330 (see Figure 44). This is due to awareness-raising activities in communities led by Champion Communities, availability of rapid screening tests, and technical oversight by health zone management teams, as well as joint supportive supervision visits by MOH and IHP.

As shown in Figure 45, by the end of the project 4,438 HIV-infected adults and children (73 in Kamina and 4,365 in Kolwezi) received clinical services at the 68 HIV care sites. IHP collaborated with the Global Fund in Kolwezi to ensure availability of treatment for opportunistic infections in areas covered by the Kamina and Kolwezi coordination offices. The project achieved 294% of the target due to three major factors: 1) underestimating the target population; 2) the significant number of patients receiving ART inherited from other projects in Fungurume health zone beginning in October 2014; and 3) the mining boom.

By the end of the project, 2,983 HIV-positive adults and children had received ART, which represents 353% of the target. The reasons for this achievement are similar to the reasons discussed in the paragraph above. Moreover, the project reported that 1,591 HIV-positive adults and children had received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (DSD). Against the target of 1,511, this represents an achievement rate of 105%. Another project indicator tracks the number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and who received at least one of the following at enrollment: clinical assessment (WHO staging) or CD4 count or viral load. For this indicator, the project reported a total of 1,608 clients against a target of 500, which represents an achievement rate of 322% (Figure 45).

Fifteen percent of HIV-positive patients were screened for TB, well short of the project's target of 90%. Providers in Kamina, where HIV-prevalence is low, systematically screened HIV-positive patients for TB, but providers in Kolwezi, who must handle a large volume of HIV-positive patients, were not as successful. To address this issue, IHP hired two HIV specialists for Kamina and Kolwezi, who joined the health zone management team during monthly supervision of providers. This intervention improved the results for this indicator between the first and last quarters

All 68 HIV care sites supported by IHP provided: HIV counseling and testing; PMTCT; care and support at the health center level; ART; prophylaxis with nevirapine to HIV-exposed children and cotrimoxazole for people living with HIV; identification and treatment of TB and HIV coinfection; prevention interventions for key populations; and family planning.

Figure 42. Number of pregnant women with known HIV status, by PY

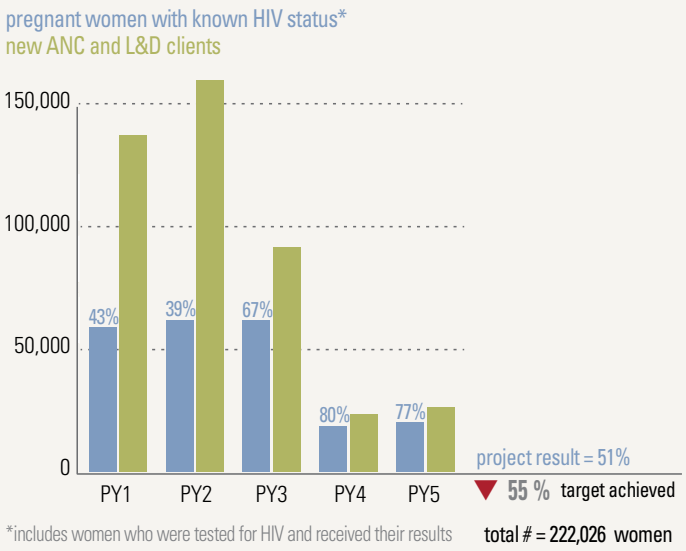


Figure 43. Number of HIV-positive pregnant women who received ARVs for PMTCT, by PY

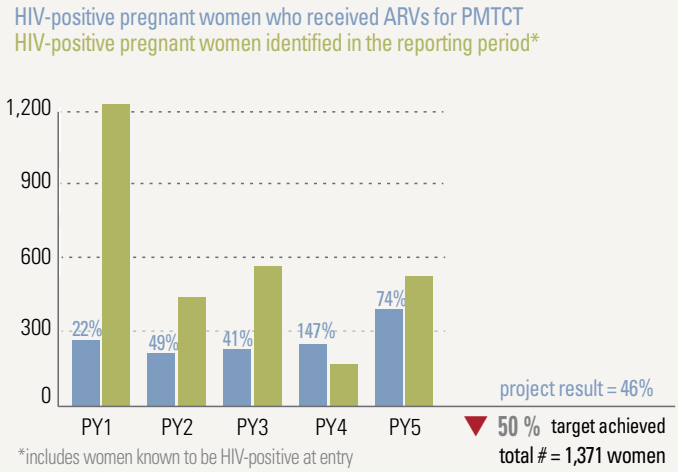


Figure 44. Number of people who received T&C services for HIV and received results

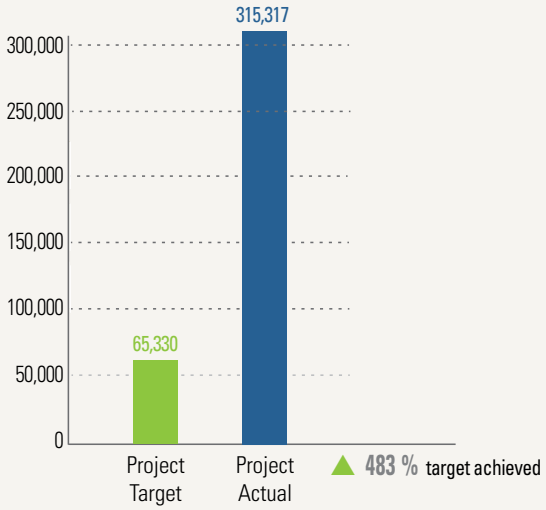
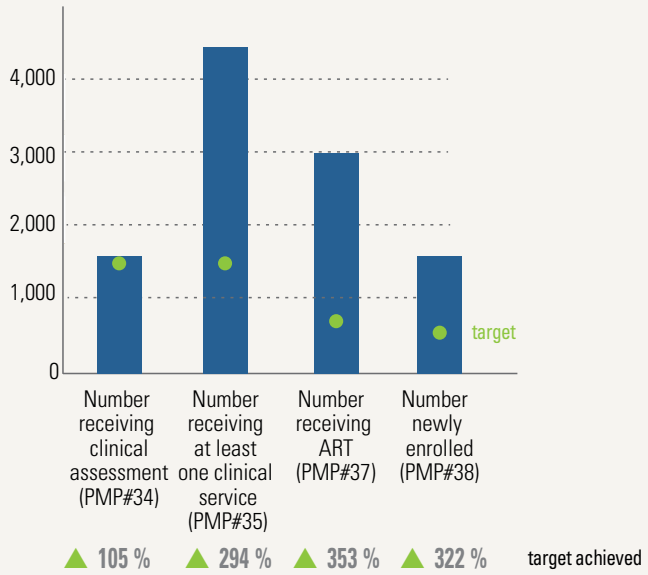


Figure 45. HIV-positive adults and children treated for HIV, *see also Appendix 1*



"Staying with my wife despite her HIV test result showed her how committed I was to our marriage and family. Praise to God, the hospital staff, and DRC-IHP. My wife is doing so much better now, and we are focused on raising our four children together."

—Jacques Mwema, husband of an HIV-infected patient

SUCCESS STORY

Counseling a discordant couple in Kolwezi

Many in the DRC believe that testing positive for HIV is a death sentence. The MOH and international partners have been working to change attitudes by raising awareness on HIV prevention, testing, and treatment. Still, the majority of people are afraid to utter the word "AIDS"—calling it instead "that disease," as if to put as much distance as possible between them and a pathology they presume affects only drug addicts and sex workers.

This stigma is the reason why Yolande Mwema, a married mother of 2 expecting a third child, was in shock when she found out during a prenatal consultation at Kolwezi General Hospital that she was HIV-infected. Nurse Néné Paluku suggested that Jacques get tested as well. His result came back negative, much to his relief. But Yolande worried that he might throw her out of the home because of her status, as has happened to many other Congolese women.

Fortunately, Nurse Paluku had been trained by the USAID-funded DRC-IHP in HIV care, including prevention of mother-to-infant transmission and counseling of serodiscordant couples (in which one partner is infected while the other is not).

First she explained to Jacques that his wife's HIV status is not proof of unfaithfulness. She told him how important it would be for him to stay with her, to increase her chances of staying healthy and delivering an HIV-free baby. She also insisted on reducing his risk by using condoms. Then the nurse brought the couple together to encourage mutual support and continuous ART to avoid mother-to-infant transmission.

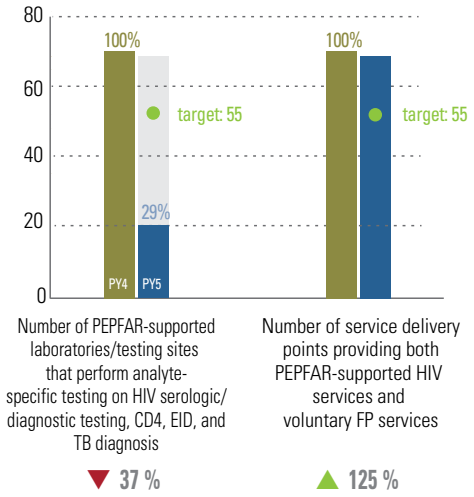
Yolande and Jacques' baby is now 18 months old—and HIV-negative. Thanks to her husband's support and continuous treatment, Yolande's immune system has become more robust.

Photo for illustration only, and is not subject of story.

Photo :Warren Zelman

Photo :Warren Zelman

Figure 46. Point of care and point of service: PEPFAR-supported HIV laboratory and service delivery points



of PY5. Finally, IHP reported that 67% of registered TB cases that were HIV-positive were also on ART. Against the PMP target of 87%, this represents an achievement rate of 77%.

In PY4, the project reported a 100% performance on this indicator, meaning that it had supported 69 health facilities in meeting the criteria to be counted as PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing (HIV serologic/diagnostic testing, CD4, EID and TB diagnostics). However, after conversations with USAID to clarify the criteria on which the indicator was based, the project and MOH were able to more accurately measure the project's performance in PY5 (Figure 46). During the last year of the project, 20 IHP-supported laboratories and testing sites met the donor's criteria for this indicator. Also, in July 2015, IHP/HPP ceded one health facility to ICAP (from Columbia University's Mailman School of Public Health), bringing the denominator to 68. Therefore, at the end of the project, 29% of facilities met the criteria, representing 37% of the project's goal of 80%.

Finally, the project reported that one of the two PEPFAR-supported testing facilities (laboratories) that are located in IHP-supported health zones was recognized by national, regional, or international standards for accreditation or had achieved a minimal acceptable level towards attainment of such accreditation. Against the PMP target of two, this represents an achievement rate of 50%.

Family planning and HIV integration: As also shown in Figure 46, all IHP-supported HIV care sites provided family planning and maternity services during PY4 and PY5 (69 in PY4 and 68 in PY5, or 125% of the project's target). IHP trained providers to offer counseling and modern family planning methods, and supported health zone management teams to provide supervision visits. IHP regularly supplied the 68 sites with contraceptives, reporting support, and family planning education.

Tuberculosis

TB is a leading cause of disability and death in DRC. Half of all cases are undetected and therefore untreated (DHS 2013). Stigma and misunderstanding of the disease cause delays in seeking treatment. IHP worked closely with the national TB program (*Programme National de Lutte Contre la Tuberculose* or PNLT) to execute the core activities for TB control and improve the management of TB services, including MDR-TB and TB-HIV co-infection. The project educated communities and families about TB, including the need for testing, counseling, and referrals for treatment to eliminate TB cases.

Other key TB activities included support to the provincial coordination unit for leprosy and TB in scaling up PNLT initiatives. Methods include integrating TB treatment and diagnosis in health centers; ensuring regular supplies of

Figure 47. Total number TB cases detected, total project by coordination office

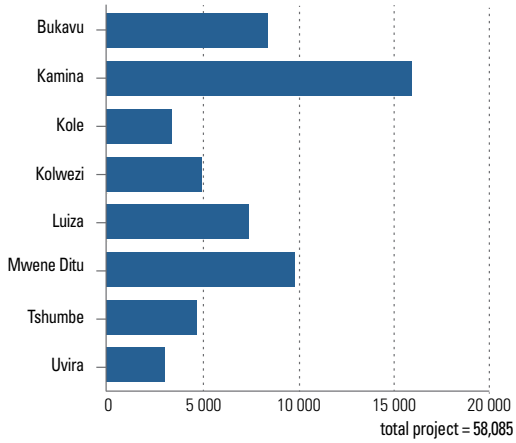
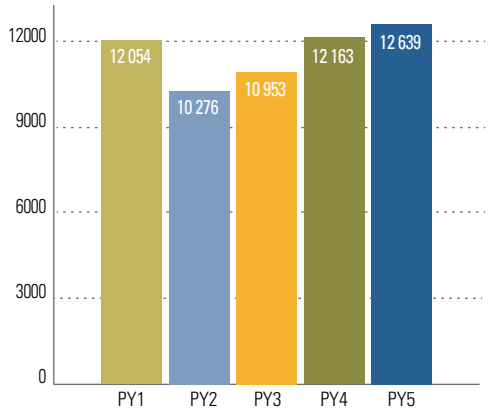


Figure 48. Number TB cases notified, by PY



rapid TB and HIV tests at the treatment and diagnosis centers; and collecting and shipping suspected MDR-TB sputum samples to laboratories equipped with GeneXpert machines for diagnosis. In addition, IHP established a reliable supply chain for TB medications and laboratory supplies.

Key strategies employed by the project included:

- Supported community involvement in the active search for TB cases through local community partners
- Strengthened capacity of service providers to improve the quality of services
- Introduced a new diagnostic tool for MDR-TB (GeneXpert)
- Involved community health agents in the collection and safe transportation of samples from suspected tuberculosis patients' sputum
- Supported joint supervision with the PNLT and the National AIDS Control Program (NACP) under the management of integrated activities of TB-HIV co-infection
- Transported available stocks of anti-TB drugs to supply health and laboratory facilities that were running low

IHP identified 58,085 cases of bacteriologically confirmed pulmonary TB out of 94,615 expected cases, which represents a case detection rate of 61% (Figure 47). Compared to the PMP target of 70%, this represents an achievement rate of 88%. The lowest annual number of new sputum smear positive pulmonary TB cases reported (10,276) was recorded during PY2, a reflection of slower implementation of project activities that year. The Kamina coordination office registered the highest number of TB cases (16,001). The Malemba Nkulu health zone, located in Kamina, is considered the most TB-endemic health zone in DRC. The Bukavu coordination office recorded 1,959 cases in PY4 and 1,886 cases of TB in PY5, a marked increase over PY3 when 1,354 cases were reported. This performance was due to the organization of four mini-campaigns in 11 low-detection rate health zones.

Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas reached 97 (12,639 out of 13,020,139) by the end of PY5 (see Figure 48). Compared to the PMP target of 214, this represents an achievement rate of 45%.[15] During the final year of the project, the case notification rate varied widely by coordination. Kamina, Kolwezi, and Kole recorded the highest rates with 171,141, and 170 per 100,000 people respectively. The coordinations of Luiza, Bukavu, Uvira, and Tshumbe performed poorly at 51, 66, and 73 cases respectively. This is largely attributable to frequent disruptions of laboratory inputs in diagnostic and treatment centers; difficulty in accessing health zones (mainly those on the west axis coordination of Bukavu: Kalole, Kitutu, Lulingu Kamituga, Mwenga, and Shabunda); and decreased activity of community workers in public awareness activities.

Despite this variability in TB case notification, the general trend remained positive throughout the project, increasing from 82 in PY2 to 97 in PY5. This growing trend is due to the support provided by the project to health zones through the payment of transportation costs for anti-TB

15 Knowing that the national objective was 150/100,000, and following discussions with the USAID/DRC TB Advisor, IHPplus revised the target to 120.

In Tshimayi, Kasaï Occidental, Ambroise Ndaye and Crispin Kayembe, members of the local Club des Amis Damien (CAD), men who have been cured of TB, reach out with this simple message. They are also members of the IHP-supported Tuibake Champion Community, trained in community mobilization. This kind of help is very important in a country like the DRC, where it can take up to a day to travel between a village and a hospital that provides testing and TB treatment.

Photo : Rebecca Weaver

KEY: PY1 PY2 PY3 PY4 PY5

Figure 49. Summary, case notification rate per 100,000 population in supported areas, total project

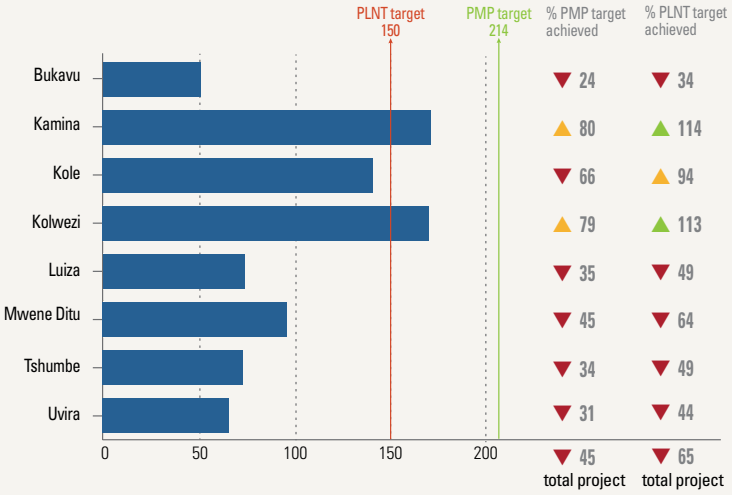


Figure 50. Case notification rate per 100,000 population areas vs. PMP and PLNT targets, by PY

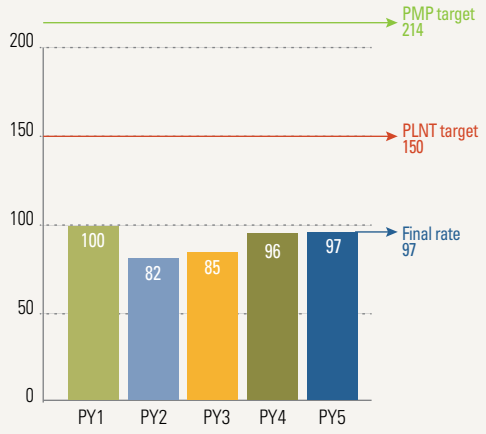


Figure 51. TB/HIV coinfection indicators by coordination office, total project

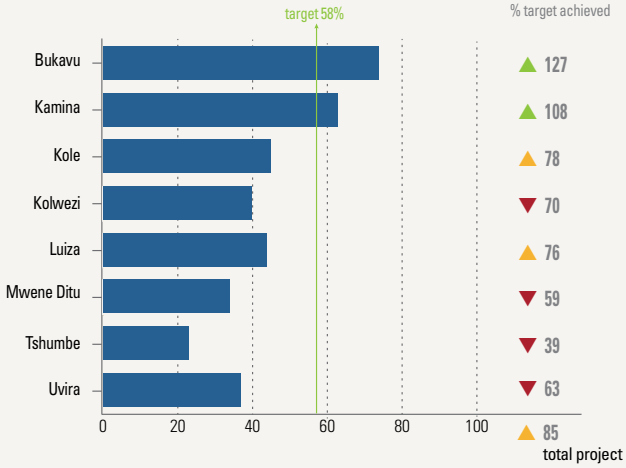


Figure 52. TB case detection rate by coordination office, total project

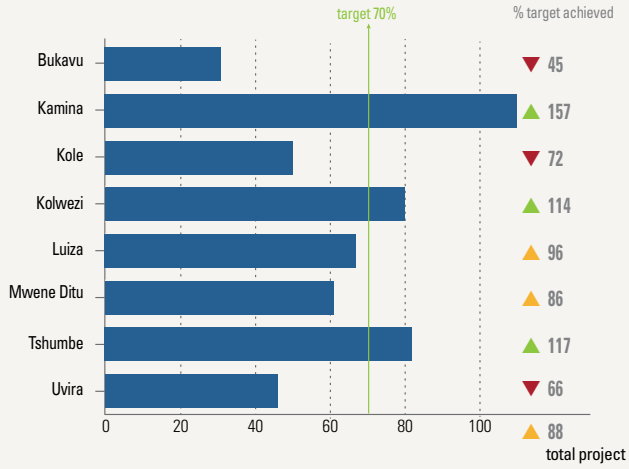


Figure 53. Percentage of registered TB patients who are tested for HIV, by PY

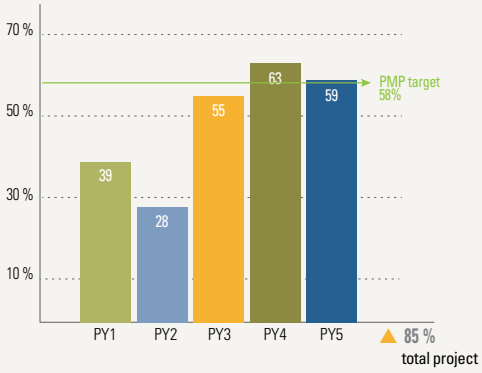
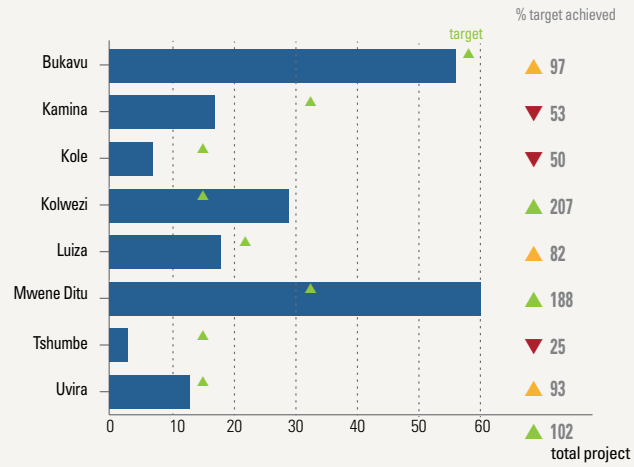


Figure 54. Number of MDR-TB cases detected



In February 2015, IHP assisted the MOH to conduct a "mini-campaign." During four days, volunteer community health workers visited more than 5,000 households in the Kamituga health zone of Sud Kivu. They tested 321 people and found 30 who tested positive for TB (compared with an expected 24 for the month). These people were counseled and referred to a general hospital. At the same time, TB messages through radio broadcasts and church announcements reached more than 45,000 people.

drugs and other lab commodities to the health facilities, support for the installation of 10 branches, transportation of sputum samples to laboratories for diagnosis and treatment, and the training of 335 care providers and 318 CHWs in the treatment of TB.

Case notification in the project's supported area (Figures 48–50) did not reach the target of 214 cases per 100,000 people due to an insufficient quantity of health personnel adequately trained in the management of TB; the insufficient coverage of community activities; and an over-ambitious target established in the PMP. The PNLT has established a national target of 150 cases identified per 100,000 people; if this rate were applied to the project,[16] three of the 8 coordination offices would have reached at least 75% of the target, and two would have exceeded the target (see Figure 49).

Over the course of the project, 49% of TB patients (28,702) seen in IHP-supported facilities were tested for HIV (see Figure 53), which is slightly less than the PMP target of 58%. The highest-performing coordination offices were Bukavu (128%) and Kamina (109%). Tshumbe tested only 40% of patients. However, project performance exceeded the target rate during the final two years of the project.

Despite the loss of resources from the closing of the TB2015 project, IHP maintained good performance in the affected areas: by strengthening providers' capacity, transporting rapid tests for HIV to health facilities, and conducting joint supervision visits with DPS/NTP, the facilities supported by the project have successfully integrated TB and HIV activities. PEPFAR support for maintaining regular supplies of HIV tests and ARVs is an important factor in improving this indicator in the Kolwezi and Kamina coordination offices.

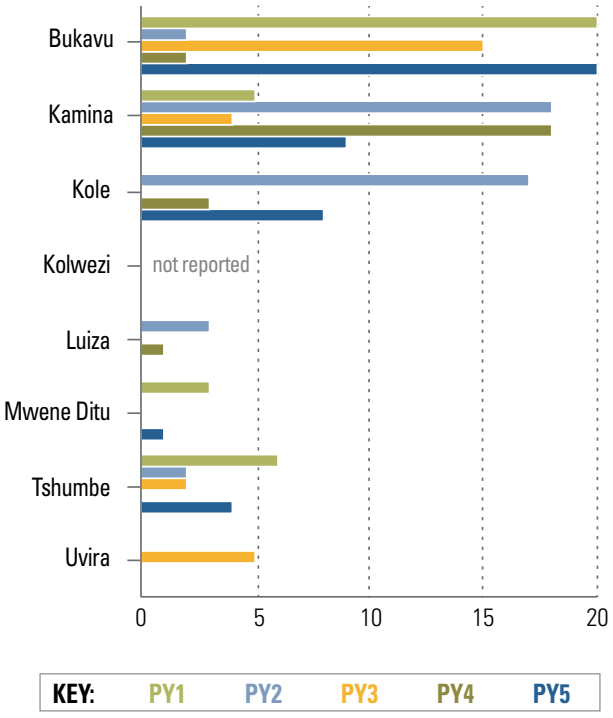
Like the management of TB cases, management of TB-HIV co-infection faced several challenges pertaining to the low quality of services. To meet these challenges and further improve the quality of TB-HIV co-infection services, IHP used many strategies, including integrating TB and HIV activities in voluntary counseling and testing services, training of care providers in the management of TB-HIV co-infection in all health facilities, maintaining a steady supply of RDTs and other laboratory commodities for HIV, and conducting joint supervisory visits with the PNLT and the NACP. By the end of the project, 49% (28,702 out of 58,085) of registered TB patients were also tested for HIV through USG-supported programs which, against a PMP target of 58%, represents an achievement rate of 85%.

MDR-TB: Although identification of MDR-TB cases did not begin until the second year of the project, IHP surpassed its target with a total of 203 cases of MDR-TB detected, representing 102% achievement of the target (see Figure 54).

Mwene Ditu and Bukavu identified the greatest number of MDR-TB cases, with 60 and 56, respectively. However, in terms of percentages based on population figures, Kolwezi and Mwene Ditu achieved the strongest results, reaching 207% and 188% of their targets, respectively. This success is linked to: maintaining availability of GeneXpert machines; improved oversight of MDR-TB activities; developing a plan for the secure transportation of samples between the *Centre de Santé de Diagnostic et Traitement* (CSDT), the health zones, and provincial laboratories; involvement of the provincial coordination unit for leprosy and TB (*Coordinations provinciales lèpre et tuberculose,* or CPLT); and the involvement of CHWs in the transport of sputum samples.

16 DRC-IHP and the USAID/DRC TB Advisor discussed the fact that the target was too ambitious during the closeout period, and IHPplus adjusted the target accordingly.

Figure 55. Number of assisted service delivery points experiencing stock-outs of RH



Kamina, Kole, and Tshumbe's underperformance was in part due to difficulties in accessing some health zones due to poor condition of roads, the low involvement of CHWs, and inoperability of the system for collection and transport of sputum samples. Frequent stock-outs of second-line treatment also discouraged providers to search for new MDR-TB patients.

Number of USG-assisted service delivery points experiencing stock-outs of RH combination: As shown in Figure 55, after experiencing a decrease from PY2 to PY4 (from 42 to 24), the number of facilities that experienced stock-outs of RH increased to 42 in PY5 (against a PMP target of 0).

The Kolwezi coordination office was the only one that did not record any stock-outs of RH, likely due to its ease of access and the support of other partners, including the Damien Foundation.

The Bukavu, Kamina, and Kole coordination offices recorded frequent stock-outs of RH in many health facilities. Poor access to facilities and inadequate coordination in the drug distribution channels are the main reasons for these difficulties. TB drugs in the CPLT and health zones are under the direct responsibility of the PNLT; shortages in health zones are usually due to delayed procurement for the CPLT by the central level of the PNLT. The long procedures implemented by the Global Fund for the disbursement of medical transportation funds and challenges on the part of the PNLT in coordinating the supply circuit for the CPLT, largely explained this situation. To help resolve the issue, IHP financed the transportation of TB drugs from the health zone management offices to the CSDT.

Nutrition

The four nutrition indicators reported and analyzed by the project for this report were:

- Number of children under five years who received vitamin A supplements
- Number of pregnant women who received iron and folic acid supplements
- Number of breastfeeding women who received vitamin A supplements
- Number of mothers of children two years or less receiving nutritional counseling for their children

The first, second, and fourth indicators above exceeded their targets (at 118%, 103%, and 155% respectively). Despite not achieving the target for the number of breastfeeding mothers receiving vitamin A, the project made significant progress during the course of the project, increasing the number of doses provided from 62,909 doses in PY2 to 201,897 in PY5.

Number of children under five years of age who received vitamin A: The project exceeded its target (11,851,287) by supplementing 14 million (13,927,337) children under 5 years of age with vitamin A, which represents an achievement rate of 118% (Figure 56). The project provided technical, logistical, and financial support to the MOH and other partners to conduct mass supplementation campaigns for vitamin A coupled with deworming with mebendazole. Performance was consistently high across all coordination offices, with the exception of Mwene Ditu, which did not participate during the first year of the project.

Photo : Warren Zelman

When DRC-IHP began providing support to organize IYCF groups, 887 women per month received nutritional counseling. This grew to 59,000+ women in March 2015. Today, over 1,000 trained community health workers lead more than 1,080 support groups in 261 health areas in 45 health zones. More than 1.7 million women have received nutritional counseling for their children.

Proportion of pregnant women who received iron folate to prevent anemia: IHP distributed iron folate supplements to 85% (1,736,945 out of 2,042,451) of pregnant women expected in USG-health facilities to prevent anemia. The project performance surpassed the target of 76%, which represents an achievement rate of 113% (see Figure 57). Consistently strong performance was seen across all supported health zones thanks to the availability of commodities, support for supervisory visits to health facilities, and administration of the supplement during ANC visits. IHP coordination offices in Bukavu, Kolwezi, Mwene Ditu, and Tshumbe exceeded their targets, while those in Kamina, Kole, Luiza, and Uvira reached 80%, 81%, 85%, and 90%, respectively. However, some health zones experienced low performance during some quarters due to poor stock management practices.

Number of mothers of children two years of age or less who have received nutritional counseling for their children: From PY1 to PY5, IHP-supported health facilities provided nutritional counseling to 1,742,380 mothers of children two years of age or less (see Figure 58, page 75). The project exceeded its target of 1,124,261, which represents an achievement rate of 155%. This achievement was due to the commitment of providers who advise mothers during consultation visits and community volunteers who organized IYCF support groups meetings during which mothers are counseled. IHP supplied the health zones with management and IYCF data collection tools. Supportive training and supervision as well as the LDP were associated with improved performance on this indicator (OR 1.07 and OR 1.96 respectively).

Working with the MOH, IHP facilitated the development of a national breastfeeding policy directing all health workers in DRC to help mothers breastfeed their newborns within an hour of giving birth. IHP circulated and implemented this policy change in health centers and hospitals in all 78 health zones. With 85 percent of all deliveries in DRC occurring in health facilities, this directive is reaching women and helping them adopt early, optimal breastfeeding practices.

The percent of newborns breastfed within an hour of birth in health centers increased from 2% at the end of PY1 to 96% by the end of September 2014 (according to routine data collected from DRC-IHP health zones).

Figure 56. Number of children under 5 receiving vitamin A supplements

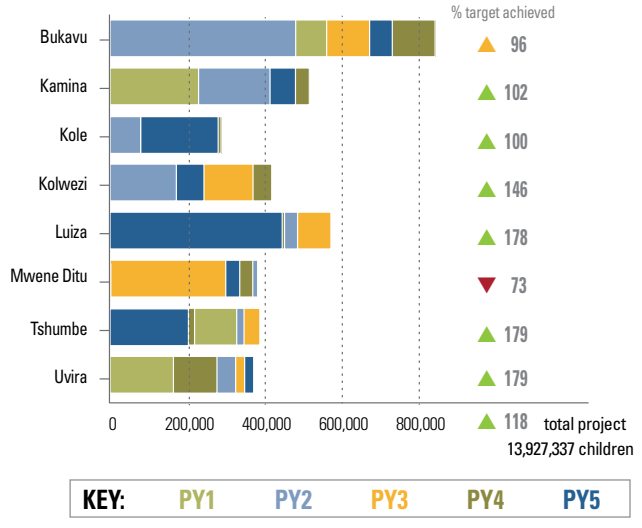
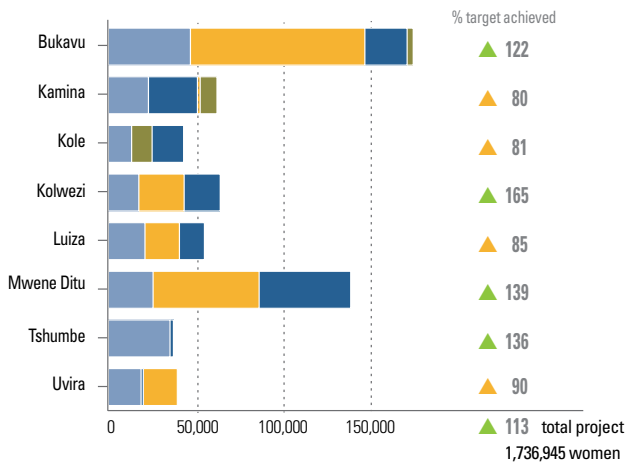


Figure 57. Percent pregnant women receiving iron folate to prevent anemia



"I always had these foods with me, but I didn't know how to combine them to keep my children safe from malnutrition. I thank the community volunteers for their advice, which has allowed me to keep my youngest daughter in good health."

—Monique Mputu, IYCF support group member

SUCCESS STORY

Cooking up good health—making nutrition education memorable through demonstrations

Malnutrition causes severe stunting and other developmental health issues in nearly half of Congolese children under the age of five, according to the DRC Demographic and Health Survey, 2013–14. Not only lack of food, but lack of knowledge about nutrition contributes to this alarming statistic.

The USAID-funded DRC-IHP supports the MOH's efforts to increase nutrition and health literacy. The project promotes breastfeeding and has established Infant and Young Child Feeding (IYCF) support groups for parents to improve child health. In March 2014, DRC-IHP organized an IYCF training which was attended by 30 participants, including two members of the core health zone team, 6 health care providers, and 22 community volunteers.

When DRC-IHP began providing support to organize IYCF groups, 887 women received nutritional counseling in a month. This grew to more than 59,000. Today, over 1,000 trained community health workers lead more than 1,080 support groups in 261 health areas in 45 health zones. Over 1.7 million women have received nutritional counseling for their children.

Salome Nambombo, seen below, was one of the community volunteers who took part in this training; now she organizes weekly cooking demonstrations for community members, highlighting easy-to-make, nutritious meals from local ingredients. Her demonstrations and nutrition education have helped dozens of pregnant women and young children improve their nutrition and therefore their health.

Photo : Rebecca Weaver

Photo : Rebecca Weaver

Figure 58. Number of children under 2 who have received nutritional counseling for their children

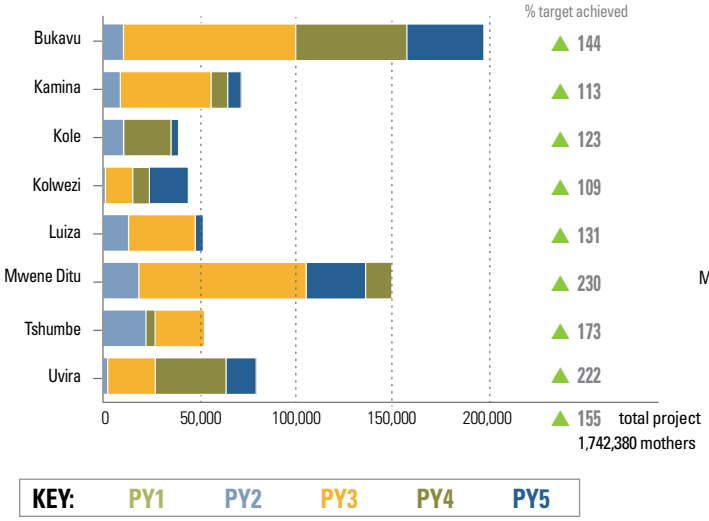
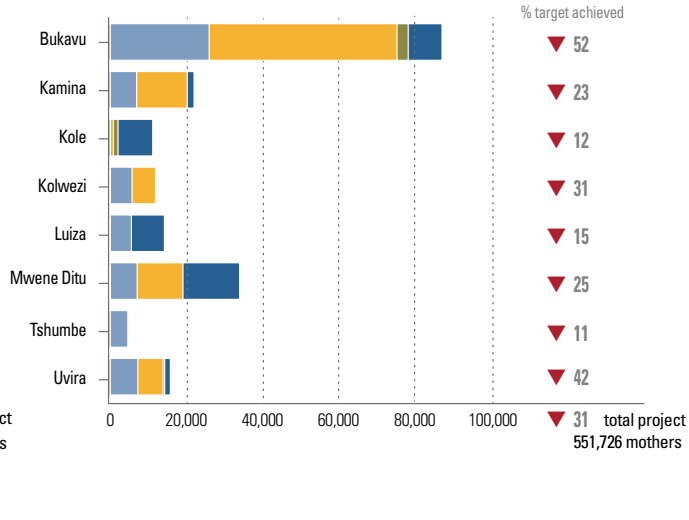


Figure 59. Number of breastfeeding mothers receiving vitamin A supplements



Number of breastfeeding mothers receiving vitamin A: IHP-supported health zones supplemented 551,726 breastfeeding women with vitamin A. This indicator remained consistently low across all coordination offices throughout the project, ultimately meeting only 31% of its target (see Figure 59). Analysis of project data shows that participating in the LDP contributed to improved performance on this indicator (OR 2.63), as did the presence of an IYCF group functioning for more than 27 months (OR 1.94). Difficulties in procurement contributed significantly to this result; it was not until the third year of the project that IHP was authorized to supply the health zones through the CDRs. Prior to this, supplies of vitamin A for breastfeeding women were available only through excess stock from mass pediatric campaigns. The direct procurement by IHP was the beginning of a positive trend from which more than 200,000 women benefited in PY5, a 320% increase from PY2. Despite the initial obstacles, routine supplementation is becoming the norm in health centers.

Sexual and gender-based violence

Women in the DRC suffer disproportionately from poor health outcomes, yet are often voiceless in the development of policies that affect them. Cultural norms that result, for example, in girls' illiteracy constitute major barriers to women's participation in society, and women are notably absent from government, parliament, and other leadership positions. The same is true in the health sector, where it is rare to find a female doctor or chief medical officer. The prevalence of SGBV is alarmingly high: nearly 75% of women report having suffered some form of sexual, mental, or physical abuse (DHS 2007).

Perpetrators of violence against women include intimate partners, relatives, or armed men—militia, rebels, and government soldiers alike—embroiled in the ongoing conflict in the Kivus. Rape often goes unpunished due to the risk of further violence, social stigma, or abandonment. In response, IHP worked with community groups to raise awareness, reduce stigma and victim-blaming, and ensure that victims receive proper medical treatment. The project also worked closely with local MOH officials to ensure that health providers that treat survivors of sexual violence received regular supportive supervision and were equipped with essential tools, guidance, and commodities such as post-exposure prophylaxis (PEP) kits.

In Kamina and Kole, IHP worked with three community-based organizations (CBOs) that received sub-grants from the project (approved in 2013): Synergie in Kole and Batwa Bemba and SOIAF in Kamina. The project strengthened the activities of these CBOs regarding the protection and empowerment of women. The CBOs conducted awareness-raising activities, highlighting the health services available for SGBV survivors, the law regarding violence, and the effects of violence on women's health as well as on the health of the family and society. The CBOs also raised awareness of the importance of men's involvement in family health.

The project also supported other community groups, such as CODESAs and Champion Communities, to wage campaigns against SGBV through radio announcements

Figure 60. Number of people reporting sexual violence in supported health clinics

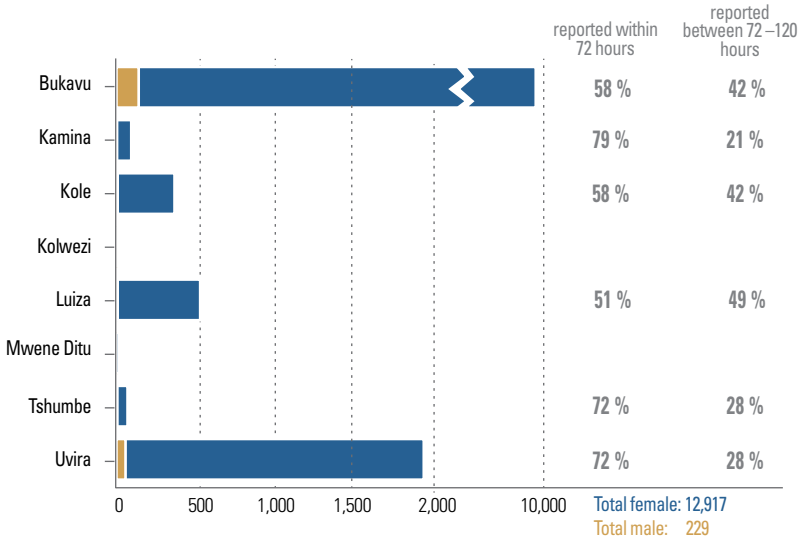
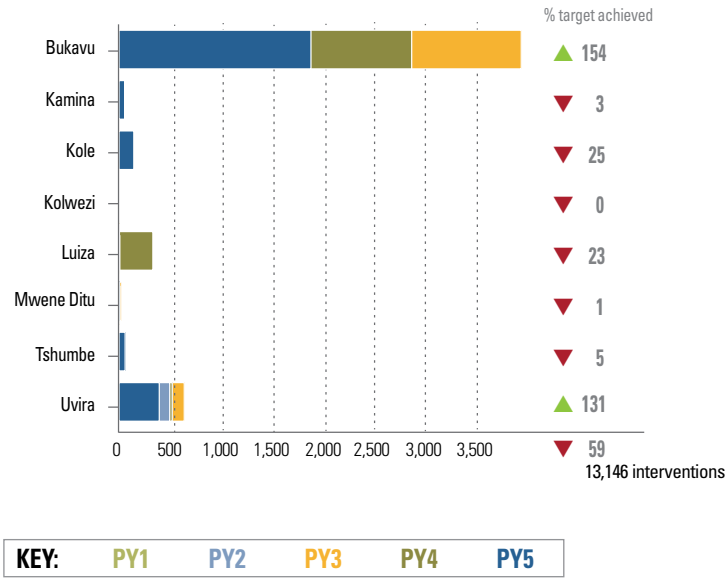


Figure 61. Number of people reached by supported intervention providing GBV services (health, legal, psycho-social, shelter, hotline, other)



and group sessions using the ETL approach, which engages CHWs and leaders in dialogues with community members to promote internally-motivated health behavior change. Under ETL, the paradigm shifts from lecturing to personal and community participation for problem solving.

Since the launch of the project, IHP reached 13,146 SGBV survivors, 98% of whom were women (Figure 60). The project fell short of reaching its target of 22,320 and reported a 59% achievement rate for this indicator. In the project-supported health zones, the prevalence of rape is highest in Sud Kivu due to ongoing conflict and insecurity. Combined, Bukavu and Uvira reported 91% of all cases, including 89% of male survivors. It is important to underline that in Bukavu, the coordination office reporting the highest number of cases of SGBV survivors, 58% (5,723) of victims sought care at a facility within 72 hours after the attack, and 42% (4,217) between 72 and 120 hours after the attack. As a precautionary measure, 55% of patients were given ARVs, and 56% of female survivors were given an emergency contraceptive.

In addition to providing direct clinical services to survivors, in PY2 IHP began providing several interventions to reach people with other SGBV services, including legal assistance, psychosocial counseling, access to shelters, and others. As seen in Figure 61, the total number of people reached almost quadrupled between PY2 and PY3 (from 1,829 to 4,883), before decreasing to 3,891 in PY4 and 2,523 in PY5. Only Bukavu and Uvira exceeded their respective end of project targets.

Finally, the project also provided health workers at health centers and GRHs with clinical training sessions on sexual violence case management. As such, IHP reported a total of 931 staff that successfully completed the training, which against the PMP target of 1,080 represents an 86% achievement rate (Figure 62).

Fistula

Throughout the project, close to 1,560 fistula operations were conducted with partner GRHs, with a successful repair rate of 84%. The project supported the GRHs by providing training for surgeons and anesthesiologists, providing financial assistance to pay for the surgeons' fees, nurses, lab exams, medicines, food and post-surgery hygienic kits, and training CHWs to recognize fistula symptoms so they could refer patients in need of surgery to the GRHs offering fistula care.

An analysis conducted during the project life-span showed that 80% of vesico-vaginal fistulas are caused by prolonged or obstructed labor and are therefore preventable. IHP therefore reinforced and promoted the use of maternal health services and prenatal consultations, with a focus on the ANC4 visit, as well as correct use of the partogram for

Figure 62. Number of health workers clinically trained in case management of sexual violence

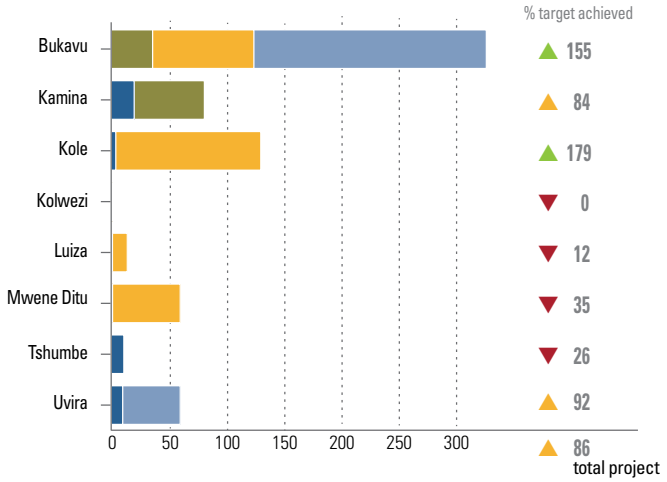
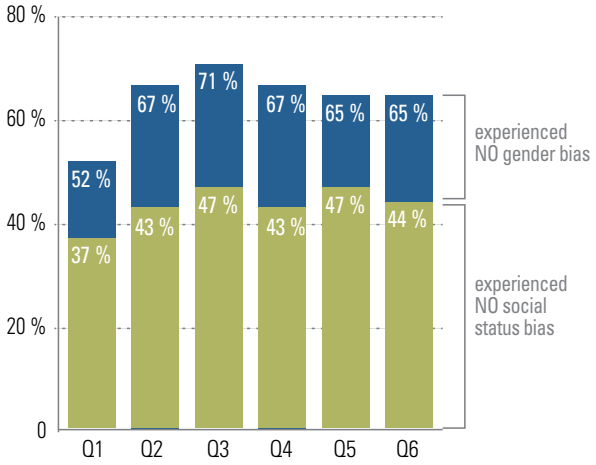


Figure 63. Absence of gender favoritism vs. social status favoritism, November 1, 2013, to September 30, 2015



identification of obstructed labor, and prompt referrals for timely and high quality caesarean sections. When high-risk pregnancies were detected, IHP trained providers to refer women to appropriate facilities in a timely fashion to receive the care they needed. The project addressed contextual factors, such as early marriage, as well.

Gender integration

IHP worked with the MOH to integrate gender into its routine activities. The representation of women is documented in trainings, as well as hospital and community activities. In health zones, gender is represented in 12 client satisfaction RBF indicators, which enabled the project to monitor whether providers showed favoritism in the areas of gender and social status of their clients. IHP evaluated the results for these indicators quarterly. From November 1, 2013, to September 30, 2015, 3,337 patients responded to client satisfaction surveys. A summary of the responses related to favoritism by gender and social status are presented in Figure 63. By the end of the project, 44% of patients said they did not experience any social status bias when visiting IHP-supported health facilities, and 65% of them reported that they did not experience any gender bias. These results showed clear improvement from those collected after the first quarter when only 37% of surveyed patients said they did not experience any social status bias and 52% declared that they did not experience any gender bias.

Results of the survey showed that the majority of clients did not experience discrimination because of their gender; however, the majority reported that they did experience discrimination due to their socioeconomic class. This finding is consistent with the results of the gender situational analysis conducted by IHP in 2012, which also found that socioeconomic discrimination was more common than gender discrimination.

The Wembo Nyama health zone reported the fewest instances of gender and socioeconomic discrimination; Kayamba health zone reported the greatest number, which can be attributed to the fact that traditional community practices and beliefs that discriminate against women are prevalent in this area.

Data were not collected prior to implementation of RBF. It is possible that client satisfaction was even lower before this quality-improvement intervention was initiated. IHPplus will continue work in the area of reducing gender discrimination through the RBF program and will continue to collaborate with the MOH to raise community awareness on the importance of reducing gender discrimination (with intensified focus on Kayamba, where discrimination is reported more frequently).

"One night I awoke to pounding on our front door. I hesitated, but opened the door when I heard my brother's voice. He had been handcuffed by armed bandits, who tied up my parents and robbed us. They took me outside and ordered me to undress at gunpoint. Then they raped me, taking my virginity."

—Olivia,* 13-year-old sexual assault survivor, Kavumu Health Center

SUCCESS STORY

Gender-based violence in Miti Murhesa—Olivia's story

In Sud Kivu Province of the Democratic Republic of Congo, years of warfare and instability have led to rates of sexual and gender-based violence that are among the worst in the world. According to the 2013 Demographic and Health Survey, 35% of women in Sud Kivu had experienced sexual violence, 18% within the past year. *In the face of this epidemic, the USAID-funded Integrated Health Project has supported the MOH to provide physical and emotional support to GBV survivors.*

Olivia's story continues: "My parents brought me to the local health center, where a nurse examined me and referred me to Kavumu Hospital. The medical team treated my injuries and tested me for diseases, including HIV. After a few days, I went back to school.

"But three months later, the bandits returned. They forced me to knock on our neighbors' door so their daughter would come outside, and then they raped both of us. Sometimes in the night, I startle awake because I think they've come back to take me. I constantly feel like I'm being pursued."

To help GBV victims like Olivia, DRC-IHP has supported training for staff on how to treat survivors of sexual violence. Moreover, the health facilities referred these survivors to other NGOs working in the health zone that provided legal and psychological support.

In Miti Murhesa, the project has trained 77 health workers on precautions such as keeping medications regularly stocked and preparing postexposure prophylaxis (PEP) kits. PEP items include short-term antibiotics and antiretroviral treatment to reduce the likelihood of STI and HIV infection after potential exposure.

*Subject's name has been changed for confidentiality.

Photo : Warren Zelman

IR 2.2. Minimum quality standards for health facilities (GRHs and health zone health centers) and services developed and adopted

FOSACOF, the fully functional service delivery model, was a key strategy used to increase the quality of services and care in IHP-supported health zones. It was used to improve quality of the MPA and CPA service packages and improve service delivery in all service delivery points. The FOSACOF uses 9 criteria specifically adapted to reflect the norms and standards outlined in the DRC's National Health Development Plan (see Figure 65). IHP trained health zone management team members, service providers, and community members with this standards-based, whole-systems tool for service quality assurance, improvement, and expansion. The project routinely evaluated and scored facilities according to the 9 FOSACOF criteria for quality compliance (Figure 65, page 80) and rated the facilities as weak, functional, or high-functioning.

After training 611 managers from the province, district, and health zone levels, 1,474 service providers, and 3,685 community leaders between October 2010 and September 2015, 50% of all supported health facilities (737 out of 1,476) have progressively integrated the FOSACOF approach (see Figure 64 below and 65 on page 80), with 708 health centers and 29 GRHs participating. Compared to the target of 50%, the project reached a 100% achievement rate. While the results are impressive, they could have been even better if it were not for IHP's multiple periods of budgetary constraints and a temporary cessation of funding for FOSACOF activities in the second year.

Analysis of project data shows that the FOSACOF approach was significantly associated with improved performance on the following MNCH indicators:

- Percent of pregnant women attending at least four antenatal care visits (OR 5.46)
- Number of child pneumonia cases treated with antibiotics (OR 5.8)
- Number of postpartum/newborn visits within three days of birth (OR 1.41)

Overall, the project performance in integrating the FOSACOF approach within health facilities was better at the health center level than at the GRH level. Bukavu and Mwene Ditu were the highest performing coordination

Figure 64. DRC/FOSACOF strategy

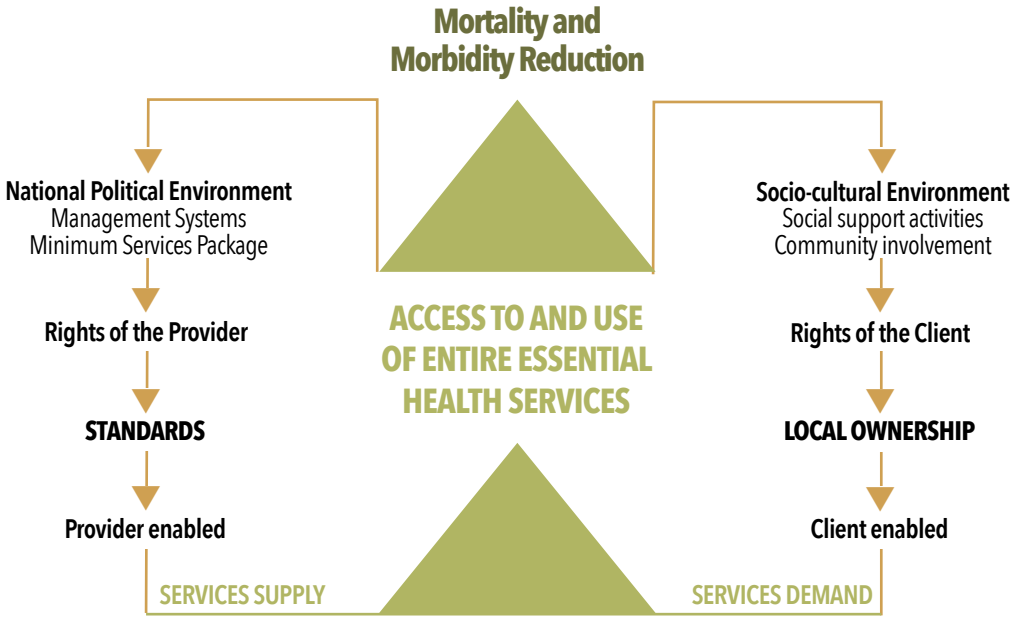
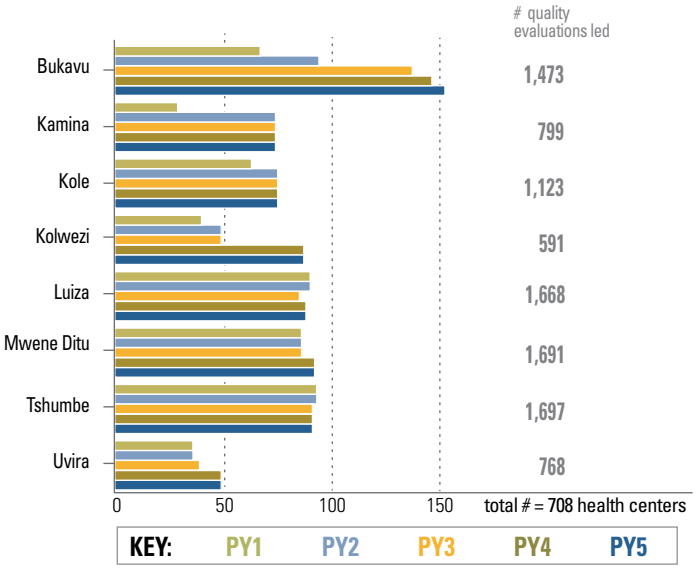


Figure 65. FOSACOF model

Figure 66. Number of health centers using FOSACOF approach and number of evaluations led



offices, with 152 and 92 health centers, respectively, using the FOSACOF approach (see Figure 66,). Uvira implemented the approach in only 49 health centers, because it experienced frequent instability linked to the presence of armed groups. Kamina's low performance (74 centers) was caused by a late start in the integration of FOSACOF.

Bukavu, Luiza, and Mwene Ditu reported the highest performance of GRHs, integrating the approach in 7, five, and five hospitals, respectively (Figure 67, page 81). Kole reported the lowest performance in this aspect, with only one hospital integrating the approach.

The FOSACOF approach was key in promoting hygiene activities in supported health zones. While health zone management team routine supervision visits do not systematically report on hospital hygiene, FOSACOF evaluations do. The project collected data during quarterly FOSACOF visits, which helped the health zone management teams evaluate and promote hygiene activities.

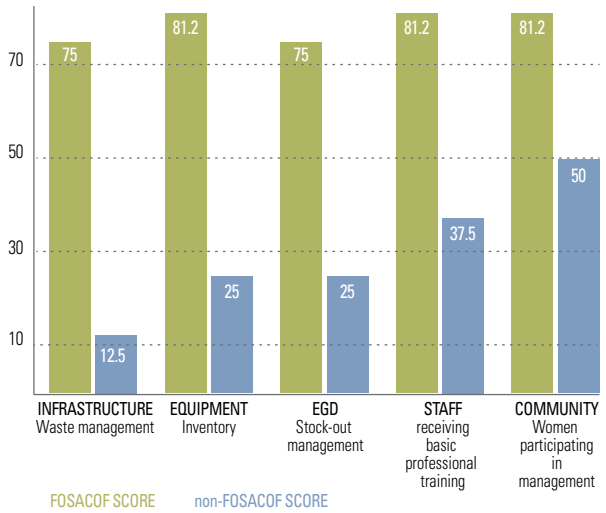
IHP supported 9,810 FOSACOF evaluations on hospital hygiene in health centers and 143 in GRHs. The majority of these evaluations were done in non-RBF health facilities (93% for health centers and 61% for GRHs). The

Table 5. Percentage of health facilities (out of total 737 that integrated FOSACOF) meeting hospital sanitation standards by the end of the project

Indicator	Yes	No
Has an incinerator	28	72
Proper usage of the incinerator by the staff	23	77
Has a garbage pit	89	11
Proper usage of the garbage pit by the staff	73	28
Has a placenta pit	92	8
Proper usage of the placenta pit by the staff	84	16
Has a medical sharp tools box	92	9
Proper usage of medical sharp tools box by the staff	79	21
Has latrines and hand washing station for patients, visitors, and staff	82	18
Proper usage of latrines and hands washing station by the patients, visitors, and staff	71	29

Figure 67. Number of general referral hospitals using FOSACOF approach and number of evaluations led

Figure 68. Comparison between FOSACOF and non-FOSACOF integrated facilities



number of RBF evaluations indicates the late launch of the program in 2013. The low number of GRHs that received FOSACOF evaluations reflects the fact that they were only performed in health centers until PY3. Table 5 shows the results reported in monitoring a sampling of hospital sanitation indicators at the end of PY5.

Most of the facilities had basic sanitation and hygiene equipment and measures appropriate for their facility; 92% have a medical sharp tools box, and in 79% of the facilities the staff knew how to properly use them. In addition, 82% of facilities have latrines and hand washing stations. The low rate of health facilities with incinerators (28%) reflects the inability of health centers to purchase them. However, 89% of all facilities do have a garbage pit, which is the secondary option for waste disposal. Facilities in Sud Kivu were the best equipped.

In March 2013, an independent evaluator assessed the ability of these facilities to meet the optimal conditions for sustainability and ownership of this approach in four health zones in Kasaï Oriental and Kasaï Occidental provinces. Figure 68 shows the results of the evaluation.

IHP organized a workshop to evaluate ownership and capitalization of the FOSACOF approach in March 2014 in the coordination of Bukavu. At the end of this workshop, 6 health facilities in the Ibanda health zone signed a commitment to continue implementation of the approach beyond the end of IHP.

The FOSACOF approach has contributed to improvement in facilities' environments, enabling them to provide quality services, improvement in service organization and the quality of services offered to the population, and strengthened community participation in health development activities.

"…Despite the fact that these facilities have not reached the optimal rating level to be considered completely functional, their performance is at least twice better than the non-FOSACOF integrated ones. What made a difference with this quality improvement approach were the project's continuous monitoring and supervision visits to the supported health facilities…"

—Evaluator's key conclusion

Prior to RBF, the Luiza GRH was very low functioning with a score below 25%. Following the implementation of RBF, Luiza GRH improved its overall score to 68%. The increase is attributed to strengthened management capacity, better community involvement, and increased consideration of the comments of the population recorded during counter-verification satisfaction surveys.

Photo : Warren Zelman

Photo : Rebecca Weaver

Results-based financing

RBF is a financing approach based on results achieved (services produced) that incentivizes providers to improve their performance. The terms of the approach are embodied in a contract between the various actors in the system. RBF improves the quantity and quality of health services and the motivation of health personnel through financial incentives based on performance, allocating health resources more efficiently and improving governance, improved accountability, strengthened data quality (via technical and community verification), the use of data by health facilities and decision-making structures, and establishing links between health facilities and the community.

The IHP RBF program is a cross-cutting program that helps improve the quality, access, and availability of MPA and CPA services, as well as performance in the areas of leadership, resource management, and community participation in the targeted health zones. The program's objectives are aligned with the National Health Development Plan (PNDS), the national strategy called the "Framework for Accelerated Reduction of Maternal and Child Mortality," and USAID health goals.

IHP implemented RBF under the leadership of the MOH's RBF Technical Unit. IHP supported the MOH to implement RBF in 7 health zones, namely Bibanga, Kanzenze Kayamba, Lomela, Luiza, Nundu, and Wembo Nyama, representing 118 health centers, 7 GRHs, and 7 health zone management teams, and covering an estimated population of 987,000. Funding for the program is included in the overall financing of IHP and is estimated at $2.67 per person.

In total, IHP established RBF contracts with 132 health facilities (MPA in 118 health centers, CPA in 7 GRHs, and supervision and resource management in 7 health zone management teams).

IHP implemented RBF in two phases: a preparatory, pre-contract phase and an implementation phase that started once the RBF contracts were authorized and signed.

A. Preparatory phase

The preparatory phase began at the start of the project, with designing the RBF model, developing an RBF manual, and implementing RBF management tools. The project designed the RBF model in line with the national model, while integrating IHP innovations such as the FOSACOF approach, LDP tools, accountability, and legislative and policy requirements governing US assistance for family planning activities.

After the RBF model was designed, IHP worked with the MOH to implement the following main activities of the preparatory phase:

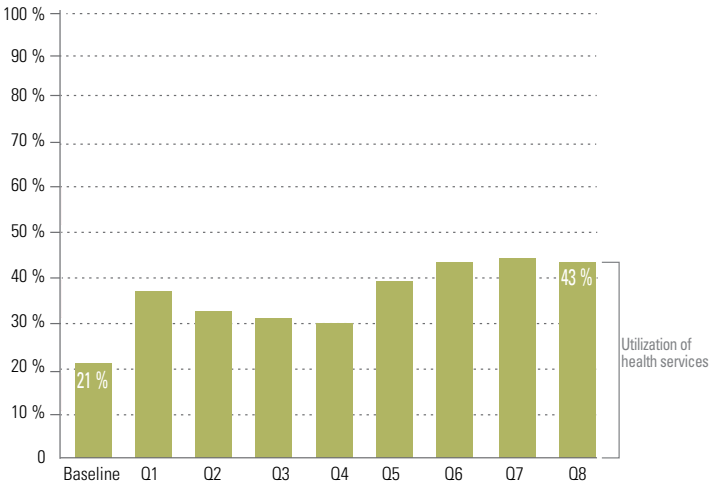
- Supported the MOH RBF Unit to strengthen the regulation and coordination of RBF in DRC. This unit contributed to developing the National RBF Guidance Document, finalizing the DRC RBF Operationalization Guide, developing RBF training manuals for the DPS, central health zone offices, health centers, and CBOs, and to developing RBF management tools in 2011 and 2012. The IHP's RBF implementation process, the expertise of its staff, and its management tools have

been used by the MOH RBF Unit to support other projects like the H4 +[17] (WHO) and Integrated HIV/AIDS Project in the DRC (ProVIC)/USAID.

- Conducted advocacy and awareness-raising activities aimed at health, political, and administrative authorities at the central level in the former provinces of Katanga, Kasaï Oriental, Kasaï Occidental, and Sud Kivu. These activities engaged 78 people at central level, 124 people at the provincial level, and over 300 people at the operational level from 2011 to 2013. In addition to encouraging authorities to embrace innovation, awareness-raising activities also focused on the ethics of RBF and explaining the USG legislative and policy requirements for family planning activities.
- Trained RBF agents in 2011 and 2012, following the training modules of the MOH. IHP trained senior nursing staff at health centers, GRHs, health zone management teams, former health districts, former provincial health districts, as well as IHP staff. In total, 290 people (including 71% of nurses from health centers, health zone management teams, and GRHs and 15% of doctors from health zone management teams, former DS, former DPS, and IHP) were trained. Since the health center is the most numerous RBF structure, health center nursing staff are the category of people who benefited most from training in health facilities (58% of the total).
- Carried out an internal IHP baseline assessment from December 2012 to March 2013 for verification and quality assessment using the FOSACOF tool. The assessment involved 34 health zones, including 27 RBF pilot health zones and 7 control health zones. At the end of this baseline evaluation, there was no significant difference for most indicators between RBF pilot health zones and control health zones.
- Recruited and trained ten members of 14 CBOs to ensure community verification of results, totaling 140 people, of whom 39% were women. In the second year, IHP replaced four CBOs and trained 10 people from each CBO, for a total of 180 trained CBO members.
- Negotiated and signed contracts with 7 RBF pilot health zones in October 2013. The process of negotiating targets was based on previous results (baseline data), MOH standards, and specific constraints between each structure contracting with the performance purchasing agencies in the presence of the regulator.

17 Joint Partnership of UN Agencies Working Together to Improve Women's and Children's Health

Figure 69. RBF and the progression of health services utilization



The prolonged duration of this preparatory phase was due to delays in obtaining approval for the performance contracts and finalizing the external baseline assessment, which was not completed until September 2013.

B. Implementation phase

Primary achievements during the implementation phase

The main activities conducted during this phase included planning, service delivery, data reporting, auditing, verification and counter-verification, payment, supervision, and monitoring and evaluation. These steps are presented in detail in Appendix 6.

Principal results obtained

The results achieved through the RBF program were very strong, and it is clear that RBF had a positive impact on improving the quantity and quality of health services. Results presented in this section reflect RBF data verified using tools during counter-verification. The main results from the health centers are presented in the graphs that follow.

Figure 69 demonstrates the progressive increase in the use of curative services in health services with RBF, improving from 21% to 43% just two years after the introduction

"Before, I dreaded walking the 15 kilometers to reach our hospital—afraid I'd give birth in the middle of the road! Being able to give birth so close to home is such a relief. We are grateful to everyone for our new and improved health center."

—Julienne Mbuyi, new mother and patient at the Kakala maternity ward

SUCCESS STORY

Results-based financing boosts assisted deliveries and saves lives

If you lived in the village of Kakala in Luiza health zone in the DRC and wanted health care, you would have to walk 10 km to the nearest health center—or 15 km to the closest hospital. *Once you reached the health center, you might see the one registered nurse with basic training for common illnesses, but she could not help you with maternal health services. Women therefore mostly gave birth at home, with dire, often fatal, results for mother and child.*

To improve under-performing health centers, the USAID-funded DRC-IHP began an innovative results-based financing (RBF) program in 2013 in 7 health zones. IHP's RBF program provides financial incentives for improvements in health services, resource management, and community engagement, based on meeting agreed-on targets for particular areas.

After implementing RBF, the Kakala health center quickly improved the quality of consultations, ANC, immunizations, and other maternal and child health services. Then came the new maternity ward! The health zone management team, local health committee, and DRC-IHP collaborated with the health center staff to plan the ward. The staff managed the construction, which was funded by RBF incentives.

In response to the renovation, Luiza's head physician assigned more providers to the Kakala facility, including a qualified midwife trained in assisting difficult births and providing care for babies born in respiratory distress. As a result of this initiative, the percentage of assisted deliveries in the Kakala health center soared from 18% in 2012 to 90% in 2015.

Photo : Rebecca Weaver

Figure 70. RBF and the progression of ANC1 and ANC4

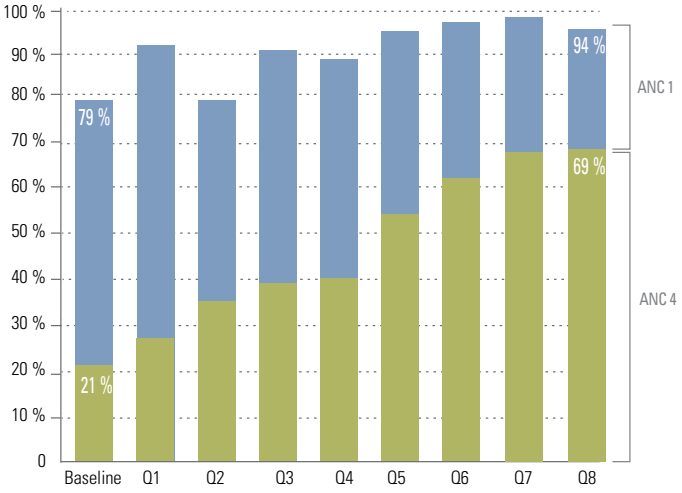
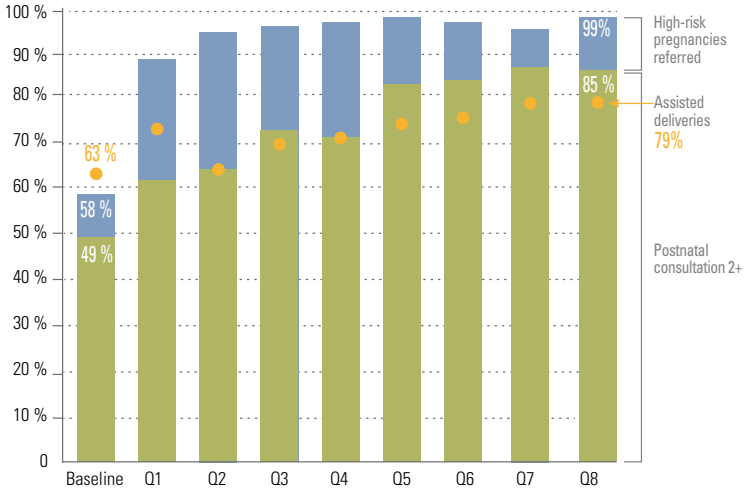


Figure 71. RBF and the progression of maternity and postnatal services



of the RBF program. Health centers implementing RBF improved the utilization of health services at a higher rate than the national progression rate of service utilization under the National Health Development Plan for Health Zones Strategic Plan, which saw an annual increase of only 25% during the five years of this plan (2010–2015). After a sharp increase in the first quarter to 37%, there was a downward trend in the use of curative services to around 30% before a strong increase in the second year. This sharp increase corresponds to the period when the health center CODESAs received 10% performance payments. Strengthening the performance of CODESAs contributed to improving health results in health centers.

The health zones in Luiza, Kayamba, and Wembo Nyama showed the most progress in this area. They implemented successful strategies such as reducing fees for care (Luiza) and improving the overall quality of care to attract patients. Nundu and Bibanga health zones experienced the least progress. In Bibanga, many health centers had data that was invalidated because the management tools were not satisfactorily completed. In Nundu, health facilities faced strong competition from Doctors without Borders related to free health care in the health zone bordering Baraka.

The main factors contributing to the significant increase in the use of curative services under RBF are:

- Negotiation of pricing
- Increase in staff attendance
- Improvements in reception and care of clients
- Increased availability of essential generic medicines
- Increased availability of consultation forms and patients records
- Improved ability to correctly complete forms and records
- Better support of health providers by the health zone management teams

As shown in Figure 70, ANC 1 services increased from a baseline of 79% to 94% in Q8, short of reaching the national target of 95% by one percentage point. The ANC 4 services drastically increased from a baseline of 21% to 69%, exceeding the target of 65% in two years (target agreed upon with the MOH RBF unit). The health zones with the greatest increase in ANC4 services were Luiza and Kayamba; their results can be attributed to awareness-raising sessions with pregnant women in health centers and the support of the CODESAs to facilities in increasing their performance, which led them to earn more RBF subsidies. In fact, CODESAs organized more awareness campaigns and conducted more home visits targeting pregnant woman to encourage them to attend their ANC visits at the health center.

Figure 71 shows that the rate of referrals for high-risk pregnancies almost doubled from a baseline of 58% to over 99% in the contracted zones. This rate is consistent with MOH and WHO norms, and can be attributed to the overall improvement of the referral and counter-referral system through the RBF program. The percentage of assisted deliveries increased from a baseline of 63% to

Figure 72. RBF and the progression of global quality scores at health centers and referral hospitals

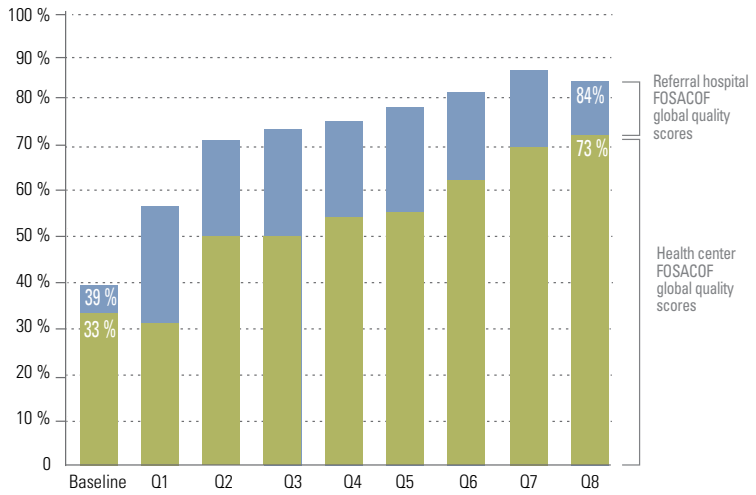


Photo : Rebecca Weaver

79% after two years of RBF implementation. This result is lower than the 2011–2015 National Health Development Program target of 85% and WHO target of 100% of assisted deliveries. It is important to note that the actual results are possibly even higher, since many assisted deliveries were discounted during the verification process as data were not correctly completed. The two main obstacles to increasing the percentage of assisted deliveries was the lack of health providers trained in MNCH, including correct filling of partographs, coupled with an overall shortage of those charts.

The Nundu health zone was one of the areas where the number of assisted deliveries was the lowest. These results are likely due to its proximity to the Baraka hospital, where Doctors without Borders Holland offers free care with complete delivery kits. Thus, pregnant women go for to their first prenatal visit in their local health center area, since this service is provided to them free of charge. Then, since their local health center charge fees for the rest of the ANC visits as well as delivery, they prefer to go to Baraka to finish ANC visits, where they enjoy these services free of charge.

The percentage of woman attending their second or more postnatal consultation (PNC 2+) increased from a baseline of 49% to 85%, meeting the set target. This activity is among those that were not properly followed in health centers before participating in the RBF program. The most successful health zones were Bibanga and Kayamba, while Nundu and Luiza were the lowest performers. The challenges reported by the project in improving this indicator included the lack of health providers properly trained in MNCH, including correct filling of consultation records, and health facilities' limited accommodation capacity, which reduced the patients' postpartum stay.

RBF did not have a significant impact on the DTC-HepB-Hib3 indicator since its coverage rate was already relatively high in the supported health zones. However, the RBF program helped capitalize on its achievements and improved the quality of the data reported.

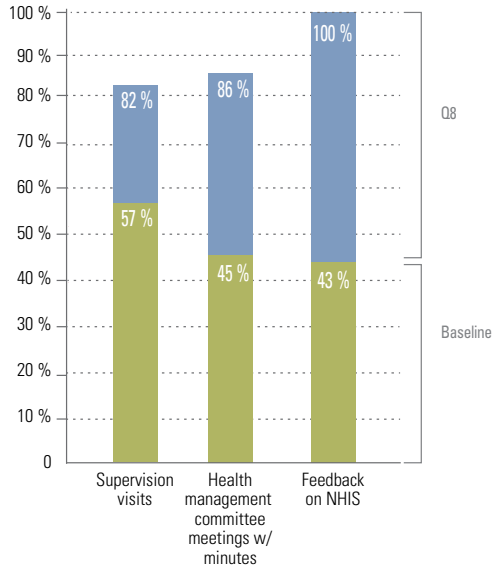
After the first-year evaluation of the RBF program, the MOH and IHP noted that only a few health centers carried out HIV and AIDS and TB activities, and most of them were located in Katanga, where IHP's support became more limited. Therefore, since HIV and AIDS and TB activities were not integrated in every health center, monitoring of indicators was not done systematically. The MOH and IHP decided that the performance of HIV and AIDS and TB indicators would only be monitored in structures where these types of services were integrated.

Figure 72 shows that before RBF implementation, GRHs and health centers had overall quality scores that were under 50%, a sign of low functioning health facilities. RBF implementation resulted in consistently higher quality scores. Health centers became moderately functional exceeding 50% and GRHs were considered fully functional, with a score exceeding 80%. These results are beyond the 30%-point increase expected as result 1 of the PNDS 2011–2015.

The rate of referrals for high-risk pregnancies almost doubled, from a baseline of 58% to over 99% in the contracted zones. The percentage of women attending their second or more postnatal consultation (PNC 2+) increased from a baseline of 49% to 85%.

Photo : Warren Zelman

Figure 73. RBF impact on health zone management team operations



The most significant increases were noted during the first quarters of RBF implementation, followed by a phase of slow progress or stagnation. This is largely explained by the fact that the majority of remaining insufficiencies required large investments of financial resources and therefore were not realistically attainable for health facilities.

The increase in FOSACOF scores is attributed to strengthened management capacity, better community involvement, and increased consideration of the comments of the population recorded during counter-verification satisfaction surveys.

Overall, the strong results from the RBF program can be attributed to the following factors:

- Health zone management teams provided better support to health providers.
- Health facilities performed more self-evaluations to identify weakness and challenges they needed to overcome to improve their overall FOSACOF scores.
- Health facilities developed and implemented corrective action plans.
- Key stakeholders helped identify challenges based on their spheres of influence.
- Health facilities were aligned with the approach.

Figure 73 shows significant progress in improving the operations of health zone management teams. Supervision visits increased from 59% to 82%. RBF contributed to the increase in supervision visits by providing fuel for health zone management team vehicles to conduct the visits and awarding supervision subsidies to teams. Prior to RBF, only 45% of health management committee meetings were held with minutes signed by all participants. Under RBF, this indicator reached 86% in just two years. Since RBF, the feedback from the national health information system (NHIS) has more than doubled to reach 100% by the end of the project. However, efforts are still needed to improve the quality of the NHIS data because significant differences remain between the data reported, verified, and validated.

By the end of the project, Wembo Nyama health zone was the highest-performing health zone, reaching 84% of its RBF subsidies. Lomela was the least performing and only received 76%.

Challenges

Although RBF program implementation has proven to be very successful, there are still critical issues that need to be addressed, including:

- Provide a continuous supply of high-quality drugs to facilities participating in RBF.
- Improve the accuracy of NHIS data (reported and validated).
- Increase performance for indicators that reach a plateau.
- Grant health centers and GRHs competitive premiums compared to other RBF projects (their subsidies may represent twice the amount of IHP's subsidies).
- Promote fairness by giving health facilities performance bonuses while taking into account socio-economic differences, geographical accessibility, and the presence of physicians in health facilities.
- Systematically send proof of fund receipt to IHP's Kinshasa office.
- Explore options to pay RBF subsidies directly to individuals.
- Issue payments for subsidies in a timely manner in areas where bank systems are not reliable.
- Retain new, well-trained staff in a context where the private health facilities in the 7 RBF health zones offer higher salaries.

Figure 74. Referrals to general referral hospitals from health centers

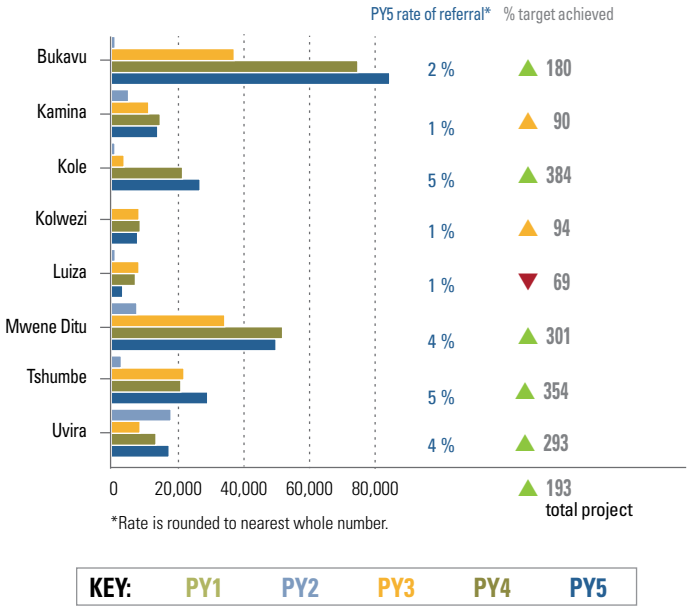
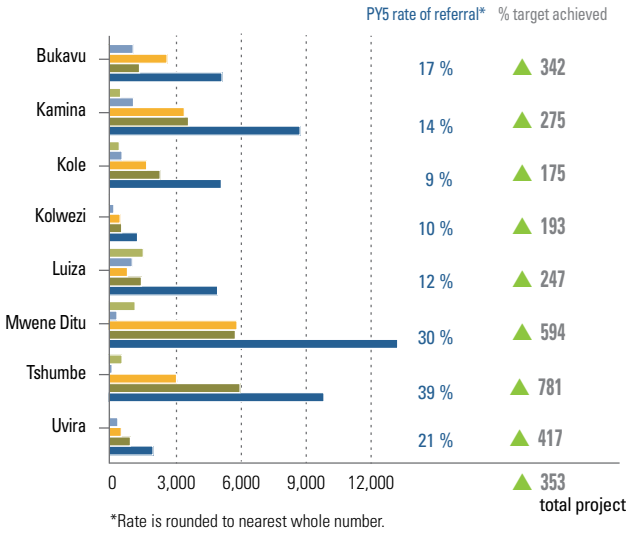


Figure 75. Referrals to health centers from CHWs



KEY: PY1 PY2 PY3 PY4 PY5

IR 2.3. Referral system for primary health care prevention, care, and treatment between community and health facilities (health zone and provincial levels) institutionalized

A well-functioning counter-referral system is key for the continuum of care. IHP performed well in two indicators of referral system functioning. By the end of the project, 18% of patients (adults and children) who needed care were referred to a health center by a CHW, and 2% of patients were referred from health centers to hospitals, exceeding the respective targets of 5% and 1%, which represents an achievement rate of 353% and 193%.

Luiza, Kolwezi, and Kamina were the only coordination offices that did not reach their targeted number of patients referred to health centers, likely due to: under-reporting of data because of a lack of monitoring tools; difficult access to GRHs in relation to respective health centers and between some care sites and health centers: the presence of private facilities that are preferred by the population; higher costs in certain treatment sites; and, occasionally, poor hygienic conditions in a certain GRH. These are demotivating factors that drive clients to other facilities.

All coordination offices exceeded their targets for the number of clients referred to health centers (see Figures 74 and 75, above). The number of patients visited by a CHW and the number of patients referred both increased significantly over the years of the project. These outstanding results over the life of the project can be attributed to the i-CCM approach, the organization of supervision and joint monitoring visits at community care sites, the provision of release forms and referral notes, and the continuous training of CHWs. In addition, the revitalization/rehabilitation of community care sites and health centers in supported health zones, coupled with the measures listed above, have improved the reputation of health centers in their communities.

"I am very grateful to the hospital staff that took care of us."
—Julienne, new mother of twins and patient at the Munya Health Center

SUCCESS STORY

Training pays off for mothers and babies

Fifteen-year-old Julienne arrived at the Munya Health Center, in Sud Kivu Province, in advanced labor with twins. At risk due to her age and stage of labor, she was admitted for urgent delivery.

Fortunately, a nurse and midwife at the health center had been trained and coached in emergency obstetrical and newborn care by the USAID-fumded DRC-IHP. The project had also equipped the health center with basic obstetric supplies and drugs.

The staff immediately put to use their best-practice skills and helped deliver a girl and a boy. They actively managed the last stage of labor to prevent hemorrhage using an oxytocin injection and safe placenta removal, put drops in the babies' eyes to avoid conjunctivitis, and helped Julienne to initiate breastfeeding.

Julienne was lucky. Just five years ago, not a single health provider in the area had been trained in essential and emergency maternal and neonatal care. Now, IHP had trained local service providers in a package of essential and emergency services through a three-week intensive workshop plus follow-up coaching and supportive supervision.

A top health goal in the DRC is to continue to reduce maternal and neonatal mortality. It remains challenging in large part because most Congolese live in the countryside, where health providers, facilities—and even roads— are few and far between.

We met Julienne that afternoon. While a bit overwhelmed with the arrival of 2 more babies—she already had one at home—Julienne said she was happy with the care that she and the twins had received.

Photo for illustration only, and is not subject of story.

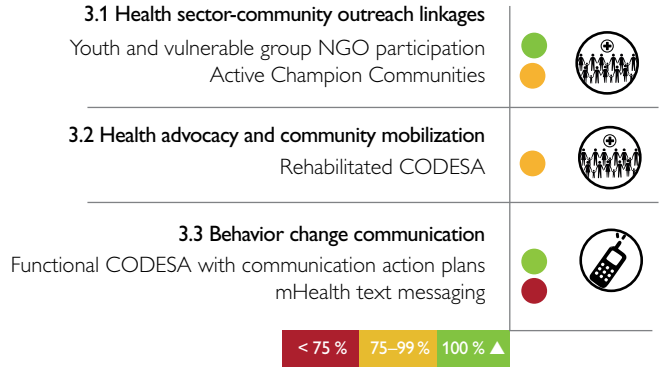
Photo : Warren Zelman

"I visited a community care site and admired how well it was organized (especially the file cabinet filled with neatly-arranged documents and medications). The site agent impressed me with his mastery of which cases to treat and which to refer, of proper medical procedures, and of the usage of various tools."

—Dr. Léandre Kambala,
Provincial Minister of Health, Kasaï Occidental

Photo : Warren Zelman

Figure 76. Summary of IR3 by sub-IR



Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones

Individual responsibility for health care, hygiene, and sanitation begins with education and community awareness about appropriate health seeking behaviors. IHP addressed the community level of the health system through the i-CCM approach (discussed in detail earlier in this report), community organization, mobilization, and behavior change communication. The measures addressed in this section played a crucial role in IHP's integrated response by increasing demand for quality health services and improving behavioral norms. These community initiatives also contribute to cohesion and resilience, since effective change requires a holistic community response.

Figure 76 above shows that the project has generally performed well, according to indicators designed to monitor this IR. Approaches included Champion Communities, ETL, and mobile-based health messaging (mHealth) to encourage exchange of health knowledge, change harmful attitudes and practices, and help communities support healthy behaviors and use of services. IHP helped maximize links between the health sector and community, fostered health advocacy and community mobilization, and facilitated BCC.

IR 3.1. Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations—established

Youth associations

Project experience clearly demonstrated the effectiveness of youth engagement efforts in socioeconomic development, health promotion, and other key practices. Congolese youth were eager to engage in health development when given the opportunity and structure to do so. IHP worked to help young leaders who had created CBOs/NGOs and other youth build decision-making skills and engage their communities, and trained 164 youth groups (see Figures 77 and 78, next page) to implement health-related activities ranging from sensitization campaigns for healthy behaviors to income-generation projects. For this indicator, IHP exceeded its target of 120, for an achievement rate of 137%. The project encourages health zone management teams to collaborate with youth CBOs by developing integrated communication plans that engage youth leaders in awareness-raising activities on issues such as environmental sanitation and building

Figure 77. Youth organizations participating in youth education strategy, by PY

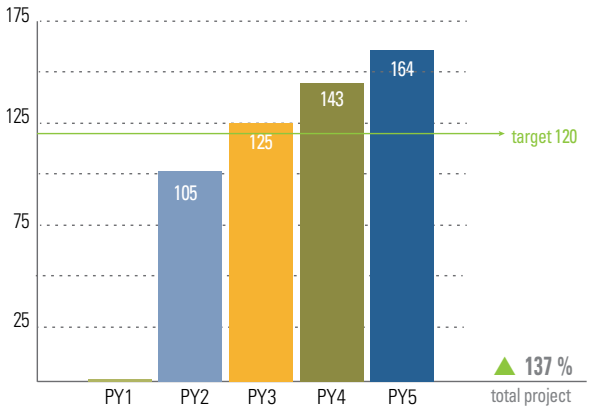
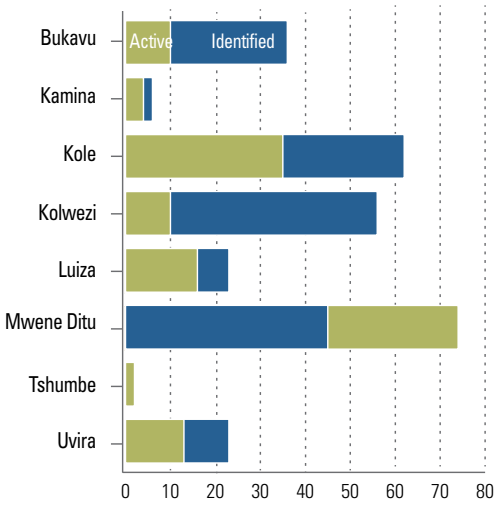


Figure 78. Youth organizations identified and active by coordination office, PY5



latrines with local materials. Health zone staff addressed youth association members about sexual and reproductive health, encouraging them to practice safe sex and emphasizing the importance of education for healthy behaviors and future economic opportunities.

CHWs also worked with youth associations, participating in group meetings, providing guidance on awareness-raising activities based on their own experiences in community mobilization, and coaching youth and adolescents at summer camps, scouting events, sport activities, and churches. Health centers also partnered with youth groups in health zones to complete local development initiatives outside of community health, such as agricultural activities.

In Kolwezi, the Kanina health center and the local Champion Community supported the Tudienge youth association in their income-generating farming activities by providing the group with seeds and small arable plots for a vegetable garden and a 12-acre cornfield.

IR 3.2. Health advocacy and community mobilization organizations strengthened

CODESAs

CODESAs are in many respects the "workhorse" of IHP's citizen engagement initiatives, as exemplified by their inclusion in several of the project's sub-IRs and activities. Many of these groups' core activities were described in section 1.2. Each CODESA consists of about 20 CHWs working in the sub-zone, who are elected or designated by fellow community members.

CODESAs' activities, such as leading awareness-raising and community mobilization activities and providing referrals to local health centers, are an important contribution to increasing the use of community health care services. IHP provided regular financial support to all CODESAs in its target regions in the form of fixed subsidies of $15 per month per CODESA, as well as managerial support to assist CODESAs in monitoring their activities and conducting monthly meetings. Although this support was essential to CODESA functionality, IHP staff encouraged the implementation of income-generating activities to provide financial support for transportation fees and other expenses related to implementing their action plans. These income-generating activities provided for small development projects such as minor improvements to the health centers, e.g., building fences and structural repairs.

IHP assisted CODESAs in developing and implementing self-designed solutions to community health problems. CODESA-proposed solutions to local health problems were codified into action plans, which IHP tracked. Sample initiatives in CODESA action plans included partnering with local opinion leaders, such as pastors, to announce health messages in churches, group discussions on health topics, and public announcements of WASH, MNCH, and family planning messages with megaphones in village centers.

"Maternal deaths surged in an unexplained way. We are grateful for DRC-IHP for its technical and logistical support to remedy this tragic problem."

—Dr. Ernest Ombha Lushima, Tshumbe Hospital

SUCCESS STORY

Achieving zero maternal deaths in Tshumbe

Things were not going well in early 2014 in the maternity ward of Tshumbe health zone's general referral hospital in the Democratic Republic of Congo. During the first quarter of 2014, nearly 5 percent of the 86 births there ended in the mother's death.

Due to the assistance of the USAID-funded Integrated Health Project, this situation quickly turned around: during the second quarter of 2014, the hospital recorded zero deaths per 120 assisted births.

The project supports the MOH to reduce the mortality rate of mothers and children under the age of five by improving maternal, neonatal, and child health services. In April 2014, DRC-IHP brought an intensive training to the hospital's health care providers, upgrading their skills in emergency obstetric care, identifying risk factors in pregnant women, and actively managing the third stage of labor. DRC-IHP also provided oxytocin and partograms to the health centers and hospitals for monitoring women in labor.

The hospital established a sentinel team to monitor and assist deliveries, and prepared an emergency kit for high-risk pregnancies. Finally, the project trained the medical staff in the resuscitation of newborns and women in critical condition.

"We held an emergency meeting with all stakeholders, most importantly DRC-IHP and service providers at the health centers and the hospital," reported Dr. Ernest Ombha Lushima, "We created a technical team to monitor women in labor and developed an emergency kit to address at-risk pregnancies. We are grateful for DRC-IHP for its support and we ask for continuity in order to prevent another like-threatening crisis."

Photo for illustration only, and is not subject of story.

Photo : Rebecca Weaver

CODESA activities, such as leading awareness-raising and community mobilization activities and providing referrals to local health centers, are an important contribution to increasing the use of community health care services.

With regard to the degree of citizen engagement in the role of CODESAs, as defined in the literature, their "participation in health system management" was included among the areas of IHP's focus. However, the emphasis, at least initially, was on using the CODESAs as extensions of the health system—to mobilize community campaigns and resources and to spread health messages, including organizing community distributors of family planning commodities.

Nevertheless, based on discussions with CODESA members, this role appeared to shift toward the end of the project to one that is genuinely more consultative and participatory in some instances. Specifically, CODESA members consistently self-reported as being representatives of the community, rather than as spokespersons for the health system. They see their role as a bridge between the two, carrying information in both directions.

A number of CODESAs have communal fields for crops or small livestock to raise funds. Such group financial ventures require trust and progress at different rates according to the nature and fragility of the community. At least one member expressed uncertainty as to how the funds deposited into their savings account would be used. Positive examples of CODESAs' roles include helping to negotiate the reduction in health center user fees, organizing deferred payment or even dropping fees for health services on behalf of those unable to pay, or bringing patients who are unwilling or unable to come to the health center to the attention of facility staff. Although some of these activities may characterize those of a committed CHW, without the need for a collective organization such as CODESA, it was reported that the more dynamic CODESA members appear to have had a galvanizing effect on the less motivated members, thereby validating the beneficial effect of the committee. These anecdotal benefits are supported by data presented previously across several program areas, such as reduced mortality and an increase in services rendered closer to the population.

In addition, RBF and other innovative approaches adopted by IHP to bring medicines and other commodities to the health centers have motivated both health center staff and CODESAs. Most notably, through RBF, user fees have been decreased significantly, which has created the single most important stimulus for citizens to visit health centers, according to CODESA members, and further motivates CODESAs to encourage community members to take advantage of the health center.

Through the provision of drugs and equipment and through cash incentives provided by RBF, IHP has stimulated a more proactive role for CODESAs in which they have become instruments for social accountability to a degree that was not clearly anticipated in the original project design. Specifically, under the terms of RBF, the CODESA president is present to verify quantities when drug stocks arrive at the health zone headquarters and at the health center. A number of CODESA leaders also expressed awareness of the amount of the RBF performance grant to the health center when it meets its targets, and were aware of how it is spent. By playing this oversight role for health centers, CODESA members expressed a sense of partnership with the health center and motivation to carry forward their work in the community. Finally, IHP has further stimulated the management functions of CODESAs by ensuring that one of the CODESA presidents, selected by all CODESA presidents in the health zone, attends quarterly health zone management meetings to review performance indicators and future plans of action. Some have participated in the LDP as well.

These "champion women" are members of the Tuibake Champion Community. They have been trained in community mobilization by DRC-IHP. Their specialty is providing information about family planning at their local health center and in the communities surrounding Tshimayi, Kasaï Occidental.

Photo : Rebecca Weaver

Over the course of the project, the number of functional CODESAs supported by IHP that have a communications action plan drastically increased from 80 in PY2 to 1,200 in PY5, an achievement of 113% of the project's target.

Education Through Listening

ETL is an innovative, non-didactic, interpersonal communication approach that engages community leaders in dialogue with community members on health issues. Reflecting research showing the limitations of behavior change through passing information in a top-down approach, ETL was developed to enhance the abilities of health professionals and lay people to communicate and engage with people to encourage the adoption of healthy behaviors. Grounded in behavioral theory principles, ETL is an effective behavior change approach supported by the CDC. ETL was used to train Champion Communities.

Champion Communities

Champion Communities were adapted from a successful mid-1990s program in Madagascar which was based on the idea that families and villages have a critical role to play in solving pressing health problems. The Champion Community approach recognizes that a local community knows best how to meet its own challenges. Members of a Champion Community are local leaders as well as teachers, clerics, grandparents, parents, farmers, traders—all of whom recognize the importance of belonging to a Champion Community. Each Champion Community covers a specific geographic area, and with health zone officials and DRC-IHP support, selects health priorities to address and commits to a plan of action in their village or area. Health zone and project staff jointly monitor the plans and activities. They also train Champion Community members in health issues and community mobilization, and provide funding and operational and technical guidance.

Champion Communities were first introduced into the DRC by the USAID-funded Leadership, Management and Sustainability (LMS) program as a means to support health advocacy and community mobilization organizations for purposes of BCC. The concept took hold by the second year of IHP and has seen significant growth, with 34 Champion Communities in 27 health zones supported by the end of the project. **The project surpassed its target of 26, which represents an achievement rate of 131%.** There were a total of 946 persons trained in this approach, including 193 women.

Champion Community members successfully mobilized their communities to achieve healthier behaviors by working with health officials and providers to disseminate health messages and raise awareness on multiple health topics. The project accompanied Champion Community members on advocacy visits to local political and administrative authorities to request necessary documentation to receive NGO status in order for them to be recognized by the state and enable them to sign contracts with other local associations and health zone offices. Under the guidance of the project, 23 of the 34 assisted Champion Communities have received NGO status from the government, which will allow them to solicit funds from other sources; the remainders are in the process of finalizing their applications. Four Champion Communities have formed a consortium to generate funds and leverage their ability to seek funding.

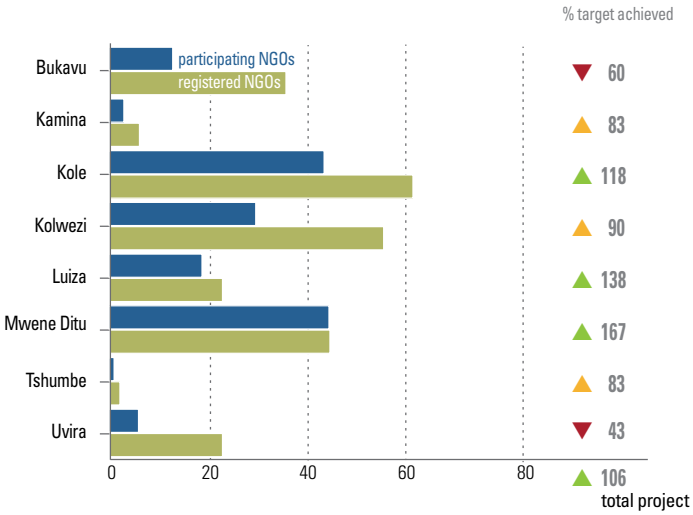
Workplans are essential to the existence and functioning of Champion Communities. From 2012, the implementation of the Champion Community approach has led to 34 groups developing workplans.

Champion Communities' workplans cover a 6-month period. Monitoring takes place jointly by the project and health zone management teams during the implementation of the workplan. This allows for adjustments to be made to planned activities and to ensure the fulfillment of objectives. At the end of the 6 months, the results are evaluated by health zone management teams, and new bi-annual plans are developed. OSC led an impact evaluation of the effectiveness and sustainability of the Champion Community approach and of CUGs and SMS campaigns in the IHP-supported communities in May, September, and October 2015. The evaluation findings showed that Champion Communities were instrumental in diffusing health messages, especially SMS messages, to target communities. For example, in the Kanda Kanda community of Kasaï Oriental, diarrhea cases reported in the health center dropped after the interventions of the Kanda Kanda Champion Community (25% of all visits as reported in August 2014 to 8% in May 2015). The percentage of women attending four antenatal care visits increased to 96% (May 2015) from 67% (August 2014), and the rate of use of LLINs increased to 75% of households in May 2015, from 20% in August 2014. In May 2015, 68% of households had latrines, compared to 24% in August of the previous year.

Further analysis of project data shows that health zones with Champion Communities were more than two times as likely to have high performance on the number of new acceptors of modern contraceptive methods (OR 2.67), the number

Photo : Rebecca Weaver

Figure 79. Percentage of NGOs registered in DRC-IHP supported health zones representing women, youth, and vulnerable groups participating in coordination meetings



of family planning/reproductive health counseling visits (OR 2.43), and the percentage of pregnant women attending at least four ANC visits (OR 2.65) than health zones not implementing the approach. The Champion Communities approach was also positively associated with improved performance in the number of cases of child diarrhea treated (OR 1.56).

A recommendation for the next integrated project would be to create a framework that would support opportunities to establish active partnerships that respect the principles of equality between the community and health facilities. This would also facilitate exchange of experiences between the Champion Communities and other partners in the areas of health and development. Furthermore, if fewer Champion Communities need to be established due to less funding available, the established Champion Communities, as part of their action plans, could develop other communities using their own income-generating projects.

Champion Men

Founded on the concept of positive deviation, the Champion Men initiative is part of the Champion Community approach. Individuals displaying exemplary attitudes and behavior were selected to influence positive changes in other men in their community on issues related to gender, violence against women, and the link between gender roles and health. This initiative has proved successful, with over 1,000 Champion Men speaking out in churches and other public venues to educate peers on health issues.

NGO representation in coordination meetings

A key take-away of the project's community work was the creation of local groups and networks of exchange, both of which served as conduits for receiving and disseminating quality health information. IHP partnered with 161 NGOs working with women, adolescents, and vulnerable populations to facilitate the exchange of health information, encourage their participation in innovations in community mobilization, and engage them in planning. The project reported that these specific NGOs represented 64% of all NGOs registered in DRC-IHP supported health zones. Compared to the PMP target of 60%, this represents an achievement rate of 106%. The highest performing coordination offices were Kole, Luiza, and Mwene Ditu (with 118%, 138%, and 167% achievement of their targets, respectively, see Figure 79). The project's interest in empowering NGOs inspired local authorities to do the same, such as the mayor of Mwene Ditu, who started working with youth organizations to build their leadership skills.

Figure 80. Number of BCC campaigns conducted, total project

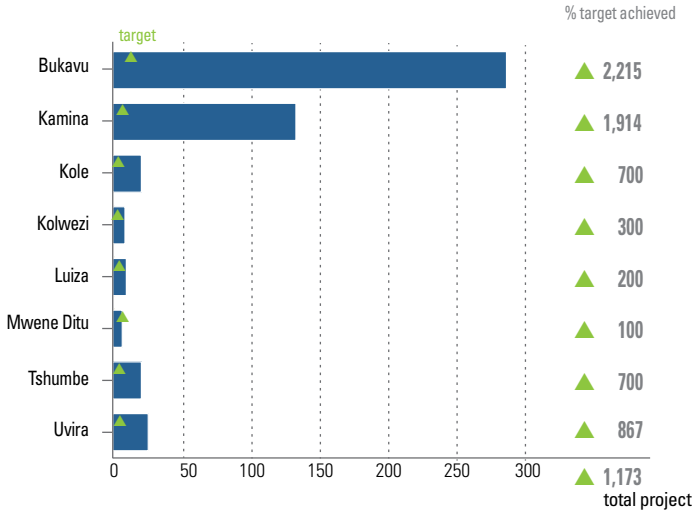
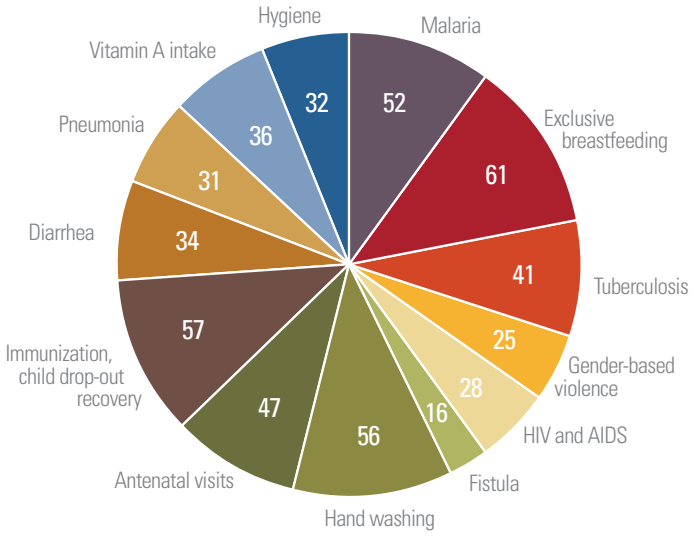


Figure 81. Number of BCC campaigns by theme, total project



IR 3.3. Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched

Awareness-raising campaigns

IHP employed highly targeted mini-campaigns to address specific issues related to priority topics such as malaria, family planning, WASH, MNCH, TB, and exclusive breastfeeding. These mini-campaigns took advantage of the structures that had been established to serve, among other things, as communication outlets. CODESAs, Champion Communities, CHWs, health officials, and other active community members all played a role. Strategic initiatives to impart healthy initiatives by communities included: composing songs in local languages; involving religious representatives and other opinion leaders to spread healthy behavior messages (including encouragement to report cases of sexual violence); conducting household visits to discuss the use and repair of mosquito nets, launching hand washing and sanitation demonstrations in churches, schools, and sporting events; and advocating for political authorities to participate in awareness-raising activities. They also created demand for services by raising awareness of the need to attend antenatal clinics and to have their children vaccinated.

IHP conducted 516 mini-campaigns, outpacing its target more than tenfold (see Figure 80). The project reached more than 1.5 million individuals during these sensitization campaigns, approximately 40% of whom were women. Mini-campaigns were important as they required the collaboration of the community structures already established, including CODESAs, Champion Communities, CHWs, health officials, and other active community members to determine health and campaign priorities to increase access to high-impact services. The campaigns were community-owned and generated. A breakdown of the BCC campaigns per theme is shown in Figure 81.

As a result of the mini-campaigns, the following activities took place:

- 416 community debates were held in churches, schools, and associations
- 44 water sources were improved, allowing 41,455 individuals to have access to potable water
- 9,182 latrines and 9,404 hand washing stations were built using local materials
- 61,756 SMS messages were referenced in client feedback to head nurses

Figure 82. Number of educational SMS messages during BCC campaigns, by PY and coordination office

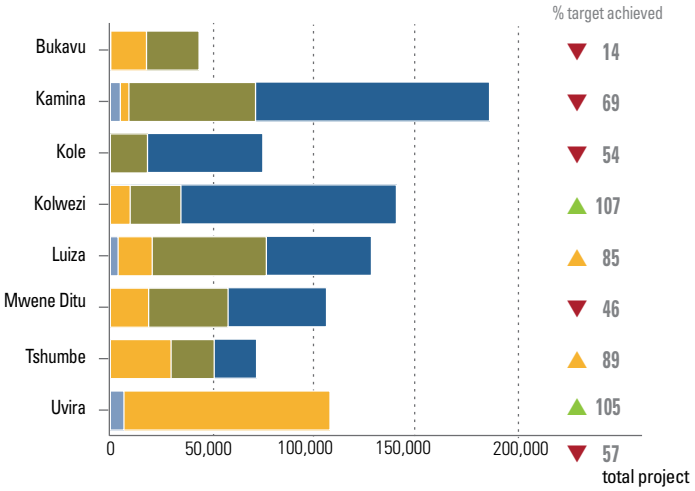


Photo : mHBB

mHealth

According to OSC's impact evaluation findings, the project's targeted SMS campaigns were often very effective in reaching target populations as messages were frequently shared by those who received them with others at home and in schools and churches. Conducting BCC campaigns using mobile phones (mHealth) allows for wide distribution of SMS messages to target communities, especially households with children under the age of five and pregnant women. IHP sent 1,407,211 MOH-approved SMS messages. Compared to the PMP target of 2,480,000, this represents an achievement rate of 57% (Figure 82). Only half of the coordination offices (Kolwezi, Luiza, Tshumbe, and Uvira) reported achievement rates of 85% or more of their target. Some health zones still struggle with poor network coverage and lack of electricity, which slowed progress on this indicator. Some health zones neglected to procure the FrontlineSMS software, and some health zones sent no messages in PY1 and PY2 due the lack of funding for phone credits.

Analysis of project data shows that this approach was associated with improved performance on a wide variety of family planning, MNCH, nutrition, and malaria indicators as shown below:

- Number of family planning and reproductive health counseling visits (OR 1.64)
- Percent of pregnant women attending at least four ANC visits (OR 1.23)
- Number of postpartum/newborn visits within three days of birth (OR 1.99)
- Number of child pneumonia cases treated with antibiotics by trained facility or CHWs (OR 2.75)
- Number of cases of child diarrhea treated (OR 1.37)
- Percent of children less than 12 months of age receiving DPT-HepB-Hib3 (OR 3.1)
- Number of mothers of children 2 years of age or less who received nutritional counseling for their children (OR 2.72)
- Number of breastfeeding mothers receiving vitamin A (OR 2.12)
- Percent of pregnant women receiving at least two doses of SP for IPT during ANC visits (OR 2.16)

Exposure to BCC text messages increased performance on these indicators by a factor of 1.23 to 3.1 compared to health zones that did not implement this approach.

To further assess the reach and effectiveness of this approach, IHP followed up with women in the Lodja health zone after a three-month mini-campaign aimed at increasing the adoption of modern contraceptive methods. During the campaign, 2,042 SMS messages were sent to approximately 2,000 men and women. Following this

Community members overwhelmingly asked for more messages to be sent, with a suggested frequency of two to three times per week and including information on SGBV, HIV and AIDS, alcohol abuse, child nutrition, and topics specific to young men and women.

campaign, 386 women who visited health facilities were asked whether they had seen or shared the SMS messages.

They reported the following results:

- 219 stated that they had received at least one SMS on family planning.
- 167 thought that SMS messages were an effective means of transmitting health information.
- 108 shared the messages with other women.
- 43 shared the information with their husbands.
- 74 received the information from their husbands.

Social network analysis of SMS sharing will be essential for better understanding of cost/benefits, number of phones needed, and the distribution of messages in a community.

The impact evaluation reported that community members overwhelmingly asked for more messages to be sent, with a suggested frequency of two to three times per week and including information on SGBV, HIV and AIDS, alcohol abuse, child nutrition, and topics specific to young men and women (HIV and AIDS, sexually transmitted infections (STIs), staying in school, deferring marriage, prostitution, respecting women, and child care). Champion Communities collected mobile numbers in their communities; therefore, it is possible to group the numbers by age and sex to send targeted messages, which could be more effective. For instance, elderly community members would benefit more from messages regarding non-communicable diseases (diabetes, hypertension, kidney disease) rather than STIs or child care.

The next project should support the installation of Frontline software on field office and central office computers and laptops, as well as on the computers and laptops of local partners at the health zone level, to mitigate problems associated with network coverage.

Closed user groups

Closed user groups (CUG) were introduced by IHP in mid-July 2012 in five health zones to increase the reach and frequency of BCC messaging and to support dialogue among community members about health concerns and behaviors. Because of the anonymity of CUGs, they proved particularly helpful to women seeking sensitive information. Cell phones were distributed to about a dozen health service personnel and community members in each location. Community members with a health question or who wanted more information about an "mHealth" SMS message could ask a group member to contact health personnel at the local health center. The program focused largely on downward transmission of information to citizens, with the emphasis on opportunities for the latter to request clarification or further information, rather than for two-way exchange or consultation (although the latter was not excluded).

CUG evaluations undertaken in 2013 and 2015 revealed positive responses in some communities; however, challenges arose in a number of areas, some of which are characteristic of those affecting SMS-based information sharing in general. In particular, messages focused on women's health issues, but men tended to be the holders of cell phones, which, along with a higher rate of illiteracy among women, limited women's ability to access text messages. The project suspended CUG activity in January 2015 due to an increase in mobile phone rates.

Photo : Linda Suttenfield, Pathfinder

"IHP has developed many innovative approaches, and I do not want these experiences to go unnoticed. I would like the provincial government to take ownership and bring in other partners to implement them in our health zones. To this end, I strongly support organizing a workshop in our province to discuss the lessons learned from each of these pioneering approaches."

—Dr. Léandre Kambala,
Provincial Minister of Health, Kasaï Occidental

José Tchofa, Malaria Technical Advisor with USAID during the project, at a professional meeting

Photo : Warren Zelman

Intermediate Result 4. Health sector leadership and governance in target provinces improved

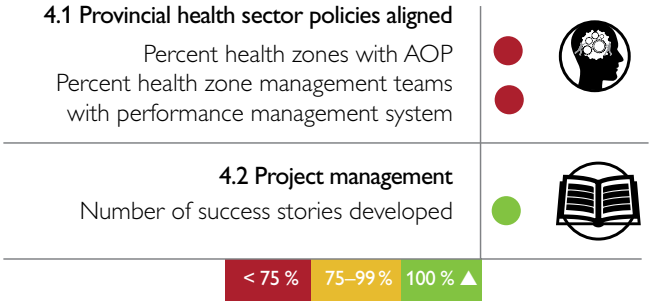
IR 4.1. Provincial and national level health sector policies aligned

Annual operational plans (AOP)

The annual operational plans are an important tool for programming and monitoring the implementation of activities in a health zone. IHP supported health zone management teams to develop their respective AOPs through funding for meetings and development, validation, and consolidation of AOPs at both the health zone and the DPS levels.

By the end of PY5, the project reached its target, with 100% of health zones that had developed their AOPs, including all the health zones implementing RBF. Supervision visits revealed that teams from the 7 RBF health zones developed more realistic AOPs, which were used to negotiate annual performance targets for RBF indicators and develop quarterly workplans. Among the AOPs that were submitted, 100% were validated by the advisory board, compared to a target of 100%. Between PY1 and PY3, performance increased impressively (from 6% to 98%) due to the project financial and technical support to health zones during the process of AOP development and validation. IHP reported a slight decrease during PY4 (74%), before reaching 100% by the end of the project. Differences in the pace of development of the AOPs are mainly related to conflicting calendars: health zones attempted to juggle this work between mass immunization campaigns, reorganizing geographic districts and health zones, and MOH annual reviews of the health system. In addition, the MOH is responsible, at the national and provincial levels, for providing technical and financial support to health zones in the implementation of consolidation workshops. This support was not provided consistently, which negatively affected some health zones.

Figure 83. Summary of IR4 by sub-IR



Another leadership- and governance-related indicator the project reported on was the percentage of health zone management teams with a performance management system that includes essential components: up-to-date job descriptions and organigrams; workplans (including supervision plans and guides); and performance review reports. By the end of PY5, the project reported that 55% (43 out of 78) of the health zone management teams met the criteria listed above, which against the PMP target of 100% represents a 55% achievement rate. With the exception of the 7 RBF health zones, the project had no means to encourage the health zone management teams to improve their performance management system.[18]

IR 4.2. Evidence-based tools for strategic planning and management decision-making adopted

Throughout the life of the project, IHP provided fixed amount awards at the provincial and health zone levels to support meetings with the advisory boards, monitoring meetings, supervision missions, health zone level operations, engine maintenance, donations of gasoline, and other supplies related to the cold chain for vaccine storage. IHP also provided: technical support at the national, provincial, health zone, and community levels, including supervision visits to health zone management teams; assistance with monitoring review and technical meetings; and assistance with the management of medicines, family planning commodities, and LLINs provided by IHP. During PY2, IHP was actively involved in the Annual National Health Review in Lubumbashi, participating in the Service Commission which identified challenges and bottlenecks in the implementation of health activities, and providing financial

18 For future programming, it would be interesting to fill this programmatic gap by finding innovative ways to promote performance management system improvement by health zone management teams.

support for the attendance of provincial ministers and a representative of the FEDECAME at the review.

Support to monitoring and evaluation systems and the national health information system (NHIS)

Throughout the life of the project, IHP regularly supplied data collection tools and NHIS management tools (such as records and inventory forms) to all health zones, furnished technical assistance for data compilation and analysis, provided feedback and recommendations on data quality and performance of health areas, and organized NHIS trainings for health zone management team members and service providers. The project also purchased risograph copiers for all provincial coordination offices, which facilitated local printing of management forms and NHIS data collection tools.

Moreover, during PY4, DRC-IHP provided financial and technical support to DSNIS to train the management teams of 8 health zones and DPS from Kasaï Central in DHIS2. The project also equipped them with desktops and USB modems for internet access and conducted post-training follow-up visits with the MOH.

Routine Data Quality Assessment

During the life of the project, two RDQAs took place, both in PY5. First, a joint IHP-MOH team led RDQAs in three coordinations (Kamina, Kolwezi, and Luiza) to verify the data authenticity of four indicators related to maternal health, family planning, and service delivery. In addition, the project audited WASH data in 19 health areas across the health zones of Mwene Ditu and Wikong.

IHP provided technical and financial support for MOH-led trainings on RDQA for the provincial health division management team in Mwene Ditu. As of the final year of the project, no gaps in the NHIS framework were reported from any IHP supported-health facility (health center, GRH, or health zone central office).

IR 4.3. Community involvement in health policy and service delivery institutionalized

IHP financed interventions to strengthen access, availability, and quality of health services in 78 health zones in DRC during the period 2010–2015, while concurrently engaging citizens through a variety of groups to improve their health practices and behaviors. The theory of change embodied in the project's conceptual framework is that, to be effective, enhanced supply and quality of health services must be accompanied by motivating citizens to become empowered to use health services and to improve their own health practices, both of which can lead to improved health outcomes.

Most significant of these IHP interventions were support to CODESAs, which created a two-way communication and consultation network between citizens and health service providers, and development of community action organizations (Champion Communities and Champion Men), which spearheaded community health action plans and campaigns while developing a sustainable framework (NGO status) to carry forward their work. The project also piloted a client satisfaction survey to provide structured feedback that has the potential to strengthen management of health centers. Project efforts to strengthen citizen involvement in health policy and planning at the provincial level were not successful due to the overall weak governance that characterizes the sector.

As a result of IHP's continuous efforts, by the end of PY5, 164 active youth organizations participated in youth education outreach strategies, 1,200 functional CODESAs had "communications action plans" developed, 64 Champion Communities completed a capacity building program led by IHP community mobilizers, and 1,000 Champion Men were trained on educating peers on health issues.

Two factors in particular contributed to positive results in implementing citizen engagement approaches. The first was a project design that made "people-centered" approaches integral to many of the project's components, with an emphasis on dialogue and personal empowerment to promote internally-motivated behavior changes. The second was the inclusion of measures to strengthen both the supply (quantity and quality) of health services and the demand (citizen interface groups as well as accountability measures) for health services. RBF further incentivized both health service staff and citizen groups to improve services.

Photo :Warren Zelman

Champion Men helped to spearhead communication and cooperation to educate communities about family planning and disease prevention.

Table 6. Financial summary, project expenses by year

Line Item		Total Budget	Year 1 (Oct 10–Sept 11)	Year 2 (Oct 11–Sept 12)	Year 3 (Oct 12–Sept 13)	Year 4 (Oct 13–Sept 14)	Year 5 (Oct 14–Sept 15)	Year 6 (Oct 15–Jan 16)	Accruals / Projection Feb-Jun 16	TOTAL	Difference
1	Salaries and wages		3,111,050	4,886,253	5,464,156	5,533,660	5,090,257	561,384	88,503	24,735,262.64	
2	Consultants		46,277	46,302	69,026	95,114	100,714	25,592	0	383,023.96	
3	Overhead		1,509,372	1,861,215	2,084,895	2,183,282	1,973,459	240,628	31,222	9,884,073.51	
4	Travel & transportation		1,070,848	1,261,490	1,909,193	1,092,210	1,226,494	218,528	74,366	6,853,128.66	
5	Allowances		455,329	490,835	383,514	379,939	298,223	32,163	1.118	2,041,121.72	
6	Contracted services		2,618,348	5,601,966	14,099,928	9,324,280	9,279,615	1,365,437	262,426	42,551,999.81	
7	Training		757,350	1,297,123	2,107,554	760,550	494,841	24,838	133,709	5,575,963.94	
8	Equipment		0	1,084,482	130,470	11,522	3,108	0	0	1,229,581.89	
9	Other direct costs		3,268,701	8,811,466	11,533,274	7,199,109	9,556,486	1,289,032	4,854,904	46,512,972.87	
SUBTOTAL		139,767,129	12,837,274	25,341,131	37,782,011	26,579,666	28,023,198	3,757,602	5,446,248	139,767,129	
Cost Share Distribution		4,193,014	0	1,901,713	442,212	1,131,255	1,036,072	0	0	4,511,252	(318,238)
TOTAL		143,960,143	12,837,274	27,242,844	38,224,224	27,710,921	29,059,269	3,757,602	5,446,248	144,278,381	

Table 7. Financial summary, project expenses by province

Line Item		Kasaï Occidental	Kasaï Oriental	Katanga	Sud Kivu	Kinshasa	TOTAL
1	Salaries and wages	5,563,609.96	5,545,368.61	5,727,782.06	5,709,540.71	2,188,961.30	24,735,262.64
2	Consultants	86,152.14	85,869.68	88,694.34	88,411.87	33,895.93	383,023.96
3	Overhead	2,223,187.63	2,215,898.49	2,288,789.88	2,281,500.74	874,696.77	9,884,073.51
4	Travel & transportation	1,541,448.56	1,536,394.63	1,586,933.92	1,581,879.99	606,471.56	6,853,128.66
5	Allowances	459,101.86	457,596.61	472,649.13	471,143.88	180,630.24	2,041,121.72
6	Contracted services	9,571,061.90	9,539,681.37	9,853,486.68	9,822,106.15	3,765,663.70	42,551,999.81
7	Training	1,254,180.68	1,250,068.61	1,291,189.29	1,287,077.22	493,448.14	5,575,963.94
8	Equipment	276,565.25	275,658.48	284,726.19	283,819.42	108,812.56	1,229,581.89
9	Other direct costs	10,461,988.74	10,427,687.13	10,770,703.16	10,736,401.56	4,116,192.29	46,512,972.87
SUBTOTAL		$31,437,296.71	$31,334,223.61	$32,364,954.65	$32,261,881.55	$12,368,772.48	$139,767,129.00
Cost Share Distribution		1,014,698.98	1,011,372.10	1,044,640.92	1,041,314.03	399,225.83	4,511,252
TOTAL		$32,451,995.69	$32,345,595.71	$33,409,595.57	$33,303,195.58	$12,767,998.31	$144,278,380.85

Table 8. Financial summary, project expenses by program element

Line Item		HIV & AIDS	TB	Malaria	MCH	FP	WASH	Nutrition	TOTAL
1	Salaries and wages	1,625,179.78	2,505,770.71	3,352,076.96	10,620,282.26	3,167,374.12	2,332,314.65	1,132,264.16	24,735,262.64
2	Consultants	25,165.80	38,801.70	51,906.70	164,454.39	49,046.59	36,115.74	17,533.04	383,023.96
3	Overhead	649,412.81	1,001,292.05	1,339,471.33	4,243,805.78	1,265,665.10	931,979.98	452,446.47	9,884,073.51
4	Travel & transportation	450,270.78	694,246.48	928,723.30	2,942,445.44	877,549.70	646,188.91	313,704.05	6,853,128.66
5	Allowances	134,107.72	206,772.94	276,609.03	876,371.89	261,367.60	192,459.57	93,432.97	2,041,121.72
6	Contracted services	2,795,792.01	4,310,670.00	5,766,568.16	18,270,040.44	5,448,824.41	4,012,274.06	1,947,830.72	42,551,999.81
7	Training	366,357.29	564,865.12	755,644.30	2,394,084.58	714,007.53	525,763.67	255,241.44	5,575,963.94
8	Equipment	80,787.16	124,561.05	166,630.66	527,930.79	157,449.14	115,938.61	56,284.48	1,229,581.89
9	Other direct costs	3,056,039.63	4,711,930.76	6,303,351.89	19,970,715.81	5,956,030.81	4,385,758.49	2,129,145.47	46,512,972.87
SUBTOTAL		$9,183,113.00	$14,158,910.82	$18,940,982.33	$60,010,131.38	$17,897,315.00	$13,178,793.67	$6,397,882.80	$139,767,129.00
Cost Share Distribution		296,402.56	457,005.97	611,356.49	1,936,941.96	577,670.13	425,370.81	206,503.92	4,511,251.85
TOTAL		$9,479,515.56	$14,615,916.79	$19,552,338.82	$61,947,073.34	$18,474,985.13	$13,604,164.48	$6,604,386.72	$144,278,380.85

PROJECT MANAGEMENT

Financial Management

Table 6 summarizes the life-of-project expenditures per year through January 2016, as well as accruals and forecasted expenses for the period February through June 2016. The project received $139,767,129 in total obligations and anticipates spending the entire obligated amount by project closure on June 30, 2016. However, the figures in this report are provisional estimates based on the most current financial data available at the time of submission and are subject to change.

USAID required a cost share contribution of 3% of the obligation to the project, or $4,193,014 over the life of the project. The project documented a total cost share of $4,511,252, exceeding the target amount by $318,238. Over the life of the project, IHP had an average annual burn rate of $26,025,611, peaking during PY3 with $37,782,011 in total expenditures (see Figure 84).

Figure 84. IHP expenditures by project year

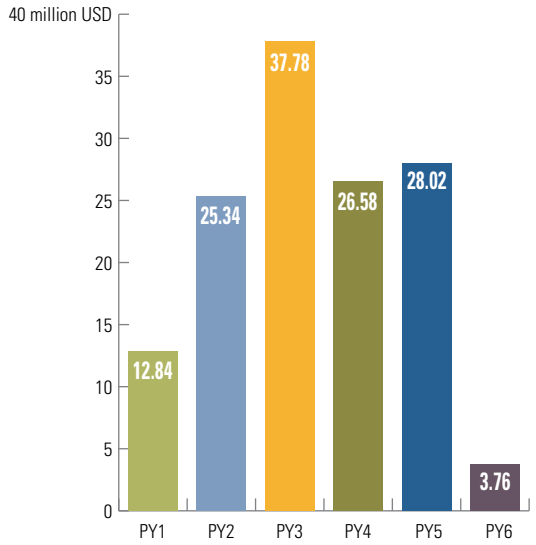


Table 7 outlines the life-of-project expenditures by province. Just over 91% of the expenses were focused on implementation outside of Kinshasa. The largest portion of expenses ($46,512,972.87) was dedicated to operational costs and the procurement and distribution of pharmaceutical goods. The second largest expense ($42,551,999.81) was allocated for contracted services with partner organizations in the form of subcontracts and grants awarded to local health zones.

Table 8 describes the life-of-project expenditures by program element. Expenditures were greatest in MCH, which represents approximately 43% of total project expenses.

Cost share:

Project Year One: Towards the end of PY1, the WHO mission in the DRC donated an interagency emergency health kit valued at $23,012.88 to DRC-IHP to respond to the measles epidemic that broke out in 6 DRC-IHP-targeted health zones. DRC-IHP contributed transportation costs for a total of $6,903.86 as cost share. In total, the project booked $29,917 as cost share in PY1.

Project Year Two: Early in PY2, DRC-IHP developed a partnership with Project C.U.R.E., an in-kind donation agency based in the US that provides donated medical supplies and equipment to developing countries around the world. Through USAID matching funds, for each container of medical equipment that IHP paid for, C.U.R.E. donated another container of equipment. Project C.U.R.E conducted a needs assessment in October 2011 to determine the specific equipment needs in health facilities and donated in-kind materials worth a total value of $925,566, including consumables such as gloves and syringes, as well as health facility furniture such as beds and wheelchairs. As a partner, in addition to covering shipping costs, DRC-IHP also managed customs clearance and arranged all in-country delivery logistics.

Table 9. Cost share value booked for IHP

Type/Source of cost share	Booked value (USD)
Project C.U.R.E	2,333,698
MAP International	405,162
IRC	703,558
WHO AFRO donation of *"Kit d'urgence sanitaire"*	29,917
Latter-Day Saints (LDS) Charities	300,869
UNICEF's HPP	620,612
UNICEF Nutrition	56,195
Brother's Brother Foundation	8,542
Dr. Robert Metcalf	9,000
Hubert Zirimwabagabo Internship	8,060
Merck	19,267
OSC	16,372
Total	4,511,252

Also during PY2, DRC-IHP partnered with MAP International to secure a donation of medical supplies for health facilities, such as surgery instruments, syringes, and other consumables, based on a needs assessment conducted by field staff. The fair market value of donated goods, $110,755, was booked as cost share contribution. MAP International was responsible for the loading and shipping of these supplies from their US warehouse to Kinshasa, and DRC-IHP cleared the shipment out of customs and managed the distribution of goods to final recipients.

Also during the second year, LDS Charities contributed expenses for a "Helping Babies Breathe" training-of-trainers program. LDS Charities donated in-kind goods for the training, including lodging and transportation of trainers, fair market value of donated medical supplies, shipping fees, trainer fees, and the venue rental fee. In total, DRC-IHP booked $143,370 of cost share from LDS Charities.

DRC-IHP's project implementing partner IRC also documented financial and commodity support to the Mutoto and Kalehe health zones (e.g., operating costs, drugs, and equipment) from the United Kingdom Department for International Development (DFID) as cost share for the project, for a total of $692,105.

Project Year Three: DRC-IHP booked $9,000 as cost share for the time and services of volunteer WASH consultant Dr. Robert Metcalf. Dr. Metcalf provided technical assistance in Tshumbe and Kole, where he conducted a training-of-trainers program for 22 local MOH and IHP personnel on water analysis techniques using microbiology and chemical test kits (Colilert, Petrifilm, and arsenic testing kits). The consultant also led a mass awareness-raising event for about 500 people on the detection of contaminated water in the community of Kole.

Also during the third year, LDS Charities contributed expenses for another HBB training-of-trainers program. LDS Charities donated in-kind goods for the training, including lodging and transportation of trainers, fair market value of donated medical supplies, shipping fees, trainer fees, and the venue rental fee. In total, DRC-IHP booked $138,806 of cost share from LDS Charities.

Also during the year, the project booked cost share for the second MAP International shipment, consisting of medical equipment valued at $294,406. Project C.U.R.E. also sent two more containers of medical equipment worth $563,616 and $844,515, respectively, which were booked as cost share.

Project Year Four: During the fourth year of the project, the global pharmaceutical company Merck donated training materials for a series of training courses for service providers that the company conducted. The training materials included 30 Implanon training kits, 220 Implanon placebos from the *Projet d'Appui au Secteur de la Santé* (in English, the Support Project for the Health Sector, PARSS in its French acronym), 200 classic placebos, and 300 NXT placebos from CARE-Goma, and 200 classic placebos and 300 NXT placebos from IMA World Health and *Santé Rurale* (SANRU). The fair market value of the training materials was $19,267.

Also during this year, the project documented $56,195 of cost share from UNICEF's donation of Plumpy'Nut nutritional supplements, solar refrigerators, and transportation costs related to nutrition programming.

Additionally, the project booked $8,060 of cost share for volunteer time from Dr. Hubert Zirimwabagabo, who worked with DRC-IHP staff to develop a prototype of a redesigned health record that the project entered in the Records for Life Contest by the Bill and Melinda Gates Foundation.

During the same period, both implementing partners contributed to the project cost share. OSC booked $16,372 in cost share for staff time that was used to develop the CUG focus group discussion analysis and mHealth evaluation report. Meanwhile, IRC booked an additional $11,453 in cost share as part of the United Kingdom Department

of International Development financial and commodity support to the Mutoto and Kalehe health zones.

The UNICEF-funded HPP project also contributed $194,659 of cost share to the project in year four. HPP focused on community-based delivery of an integrated package of evidence-based child health interventions. As the HPP project operated in 27 of the 78 health zones supported by IHP and contributed directly to IHP's indicators and goals, all of HPP's costs—costs of expatriate and national staff salaries and benefits, office rental maintenance, and utilities, transport, storage, and distribution, office equipment, other supplies, communications materials, workshops, training, and travel—were booked as cost share.

Project Year Five: During the project's final year, DRC-IHP identified a new partner, the US-based Brothers' Brother Foundation (BBF), which shipped a 20-foot container of donated beds, mattresses, bicycles, and other medical equipment with a market value of $8,542. BBF, a Pittsburgh-based international charity, has provided over $4 billion worth of medical supplies, pharmaceuticals, and other humanitarian supplies across the world.

The project also received a second shipment of neonatal resuscitation supplies worth $18,693 from LDS Charities, which was booked as cost share. The project also booked $425,953 of cost share from the HPP project for technical support in 27 health zones.

Success Stories

The project produced 136 success stories highlighting key project achievements and testimonials from project beneficiaries. This result exceeds the end-of-project target of 120 stories, for a 113% achievement rate. MNCH is the most represented health area (24%), followed by BCC (15%) and WASH (13%). A summary table of all the success stories can be found in Appendix 8.

To build the field team capacity in identifying and writing compelling success stories through the project, the home office provided short-term technical assistance visits during PY1, PY4, and PY5. The assistance included training project staff on how to identify and write success stories, map out story ideas across the project, development of templates and examples, and providing guidelines for photography.

Participation in conferences

Sharing project results and experiences within the international and Congolese community was a key priority for the project. IHP staff produced 9 abstracts that were accepted to conferences (complete list of accepted abstracts is available in Appendix 9). Family planning and BCC abstracts represented more than 50% of the successful abstracts. MSH staff provided capacity building support to project staff, particularly the senior technical advisors, to improve their skills in writing winning abstracts and developing oral presentations, through a workshop and coaching sessions.

End-of-project conferences

IHP, in partnership with the MOH, organized five closeout conferences during the last four months of the project to present the project's key achievements to stakeholders. The project held four events in the supported provinces: Mbuji Mayi on June 24–25, 2015; Lubumbashi on July 15, 2015; Kananga on July 29–30, 2015, and Bukavu on August 11–12, 2015. The final and largest event took place in Kinshasa on December 10, 2015. During these two-day events, IHP and the MOH presented an overview of the activities and technical strategies implemented, their impact on the population served—with a focus on the number of lives saved—lessons learned, and the way forward.

Over 1,300 attendees participated in the conferences. The MOH took ownership of these gatherings as several high-ranking officials were part of both the speaker's panels and the participants. Representatives from the DRC government included the Vice-Governors of the Kasaï Oriental, Kasaï Occidental, and Sud Kivu provinces, as well as Provincial Ministers, Advisors to the Province Governors, Provincial Medical Inspectors, Territory Administrators, mayors, customs officials, and Heads of Medicine for the IHP-supported health zones. IHP's Chief of Party, Ousmane Faye, along with several project staff, were among the speakers during these five conferences. Moreover, representatives from the USAID/DRC mission were accompanied by the USAID health team, led by Richard Matendo and Lina Piripiri. The USAID/DRC Front Office was represented at all of these closeout events:

Karen Koprince (Health Officer) attended the Mbuji Mayi event; Richard Kimball (Deputy Director of the USAID/DRC Democracy, Human Rights and Governance Office) was present at the Lubumbashi event; Timothy Stein (Supervisory Program Officer) attended the Bukavu event; and Diana Putman (Mission Director) attended the Kinshasa event. MSH Chief Operating Officer, Paul Auxila, and MSH/DRC Country Representative, Philippe Tshiteta, were among the participants at the events in Lubumbashi and Kinshasa.

Other participants included university professors specializing in health sciences, public health researchers and professionals, employees from the MOH, public health NGOs, and local media and journalists.

In addition to the conferences, IHP also organized on-site visits to supported health zones (Bibanga, Dibaya, Kanzenze, Katana, and Mwene Ditu) during which government officials, donor representatives, and journalists witnessed first-hand the project's health achievements and impact on Congolese lives.

The media coverage at these five end-of-project events was unprecedented. A total of 68 journalists reported on the provincial and national conferences. Their attendance resulted in four articles being published on national newspapers and one online, in addition to ten TV and radio broadcasts at the regional/provincial level and 6 TV and one radio broadcast at the national level.

Family planning and HIV and AIDS statutory requirements

During the lifespan of the project, IHP actively monitored adherence to the USG family planning and HIV and AIDS statutory regulations during supervision visits and implemented activities to support health providers, MOH staff at various levels of the health pyramid, and project staff in respecting these regulations.

Family planning

IHP's activities were guided by the principle that family planning services should be voluntary and based on an informed choice. The project conducted the following activities to promote adherence to the USG regulations:

- Procured various contraceptives (Depo-Provera, IUD, diaphragm, pills, etc.) through USAID and delivered them to GRHs, health centers, community care sites, and community-based distributors. The provision of contraceptive supplies enabled clients to make an educated selection from a range of methods. Moreover, to support health facilities in avoiding stock-outs, IHP worked in close collaboration with SIAPS, USAID|DELIVER Project, and SCMS to build capacity throughout the supply chain levels, including CDRs, the Provincial Health Divisions, and health zone management team members in charge of commodity management. During meetings, staff were briefed on quantification methods for actual needs, how to ensure an appropriate order, how to make timely deliveries to different health facilities, and how to rigorously monitor the stock situation.
- Provided USG family planning statutory regulations training and refresher trainings on a regular basis to health providers, MOH staff, and project staff.
  - » Every year, project technical staff were required to take family planning courses from the USAID Global Health eLearning center, and receive a certificate upon completion. In total, 314 project staff were trained and certified on the USG family planning regulations.
  - » MSH also developed its own online course on family planning statutory requirements, which 80 project staff completed.
  - » IHP trained MOH staff from the *Programme National de Santé de la Reproduction* (PNSR or National Reproductive Health Program) at the central level and PNSR coordination areas in the provincial offices in Sud Kivu, Katanga, Kasaï Oriental, and Kasaï Occidental. More than 3,000 staff members were trained on family planning, including USG statutory requirements, in these areas.
- Distributed 3,280 Tiahrt amendment posters on informed consent to every IHP-supported health facility and verified during supervision visits that they were well displayed.
- Monitored Tiahrt amendment vulnerabilities and violations during post-training supervision and RBF verification visits. In 2013, Uvira coordination project staff were alerted to a possible violation at the Uvira GRH and Kiliba health center. After completing its investigation, the team found that two care providers were illegally charging patients for IUDs and other types of implants

Photo : Warren Zelman

"A heartfelt and warm congratulations for the PROSANI team—Congolese and expatriates—for an incredibly successful project. You have given hope to the people of Congo and have helped the health care providers improve the quality of services. *Félicitations*, congratulations!"

— Diana Putman, USAID DRC Mission Director

donated by PSI. Consulting with former patients also revealed that they did not receive appropriate family planning counseling. In response to these violations, the PNSR in Uvira organized a refresher training for all staff at the hospital and health center. In addition, the Uvira health zone chief of health sent a letter to every health facility under his supervision reminding health care providers about the MOH and Tiahrt amendment compliance requirements.

- Ensured that the RBF program was compliant with the Tiahrt amendment by restricting family planning targets from performance criteria. Providers are not provided any incentives to or compensation for achieving family planning targets.

HIV and AIDS

IHP required all project staff and health care providers from 68 supported health facilities in 15 health zones involved in HIV programming and implementation to complete an HIV training package as recommended by the *Programme National de Lutte contre le SIDA* (PNLS, or National AIDS Control Program) and PEPFAR. After the PNLS adopted Option B+ for the treatment of HIV-infected pregnant women in 2013, IHP trained these staff on the implementation of this approach during its introduction to HIV care sites in Lualaba and Haut Lomani in the second half of 2014.

Regarding HIV care and treatment, IHP ensured that PLHIV received psychosocial counseling and routine consultations, and that ART was available for patients adhering to treatment.

Health care providers at HIV sites supported by the project monitored compliance with the HIV and AIDS statutory requirements, including individual habits (washing hands, wearing masks and gloves), administrative procedures (good ventilation of work spaces and spacing TB and PLHIV consultations), or environmental measures (appropriate bio-medical waste management and recycling and incinerator usage). In addition, IHP also trained health zone management team members, service providers, and community members in the FOSACOF model. As described previously, the project routinely evaluated and scored facilities according to the 9 FOSACOF criteria (equipment, infrastructure, essential medicines and supplies, personnel, in-service training, community approach, community support, clinical quality, and management) for quality compliance, which were often overlapping with HIV and AIDS statutory requirements.

IHP continuously procured HIV and AIDS testing kits to health facilities in the 78 supported health zones to ensure safe blood transfusion.

Finally, IHP integrated family planning services in all of the PMTCT care sites supported by the project and guaranteed the availability of contraceptives at sites. Health providers were also trained to offer counseling and modern family planning methods, and health zone management teams provided supervision.

Photo : Warren Zelman

Environmental Monitoring and Mitigation Plan

The project monitored environmental compliance and provided technical and financial support to health zones, health facilities, and communities to improve medical waste management and WASH, according to the IHP Environmental Monitoring and Mitigation Plan that was approved by USAID in July 2011. The IHP staff members were not able to make joint visits with the MOH to all of the supported health facilities (1,398 health centers and 78 GRHs). But they were able to visit all the health facilities in the 7 RBF health zones during the verification of reported RBF results. In addition, IHP provided technical support and funding—through subgrants—to the health zone, DPS, and health district management teams to conduct monthly field visits and integrated supportive supervision to health facilities.

IHP provided technical and financial support for WASH mini-campaigns to raise awareness on recommended hygiene and sanitation practices in the community and for establishment of WASH committees, resulting in the renovation of 515 water sources and construction of 53,877 household ventilated improved pit (VIP) latrines with locally made and adapted hand washing stations. IHP also provided technical and financial support for 675 hand washing stations, alongside newly-built household latrines, 69 incinerators renovated for health centers, 64 placenta pits, 186 garbage holes, and 91,030 internal and external bins.

Reinforcing the capacity of stakeholders is a critical intervention to ensure that the EMMP-recommended practices can be adopted by the beneficiaries of the project (including health care providers, health zone management teams, health development committee members, community leaders, Champion Communities, WASH committees, and families). IHP provided technical and financial support for refresher trainings on hospital hygiene (including infection prevention, good hygiene practices, and use and maintenance of waste management devices in health facilities) and on renovation, use, and monitoring of WASH facilities in the community (including testing quality of the drinking water from the improved sources and their maintenance by WASH committees). IHP developed a standard and integrated PowerPoint presentation, which takes into account the Congolese legislation in regard to the environment and specific waste management. This presentation was regularly delivered during all clinical training sessions (maternal health, malaria, tuberculosis, HIV, family planning, IMCI, etc.), to reinforce the importance of the EMMP.

Please refer to table 5, page 80, for a summary of the end-of-project situation of select factors that are critical to EMMP compliance in health facilities.

Photo : Warren Zelman

CHALLENGES ENCOUNTERED

Data quality

IHP faced challenges with data quality and timely reporting at the health zone level from PY1. Data collection tools are lacking and health facility staff are poorly trained, which leads to weak data interpretation and analysis that is often done hastily without attention to detail in the different health intervention areas. Weak data collection at the local level made it challenging for the project and health authorities to assess the population's health needs and identify strategies to address public health system problems. The project tackled this challenge early on by regularly providing data collection and NHIS management tools such as records and inventory forms to all health facilities. In PY3, IHP started providing technical support to improve data quality during monitoring and evaluation meetings organized at the DPS, health zone management offices, and coordination level. During PY4, project staff also conducted Routine Data Quality Assessment (RDQA) exercises in several field offices and supported health zones and DPS to develop action plans to address them. Some of the weaknesses identified include:

- Data inconsistency between the basic collection tools (records) and reporting tools (NHIS framework);
- Data on health zone population varied according to the source of information (EPI, NHIS, etc.) used;
- Faulty archiving of basic data collection tools (records) and reporting tools (NHIS framework);
- Lack of monitoring at the health area level; and
- Absence or low quality of feedback.

In addition, the RBF program launched by the project in PY4Q3 in 7 health zones motivated health providers to improve their data reporting and analysis skills. Ensuring accurate data collection on RBF-bound performance indicators increased the chances of health facilities having their achievement confirmed during the CBO counter-verification process, therefore improving their chance to receive their payment. For example, some head nurses decided, with project support, to facilitate monthly meetings on data analysis with all health-area nurses, leading to a clear improvement of data accuracy.

During the second half of PY5, IHP provided technical and financial support to the department in charge of NHIS to train the DPS of Lomami and Kasaï Oriental in conducting RDQA exercises on a regular basis. In order to guarantee that the DPS will conduct RDQA exercises on a routine basis, IHP also included RDQA reports among the expected deliverables of the fixed amount awards or grants that IHP extended to cover in PY5Q4. Moreover, IHPplus will continue providing this technical support to the remaining 6 DPS.

Pharmaceutical procurement

Overall, the first two years of the project were the most challenging in terms of pharmaceutical procurement. Delays in pharmaceutical procurements during PY1 were attributed to the following:

1. Unanticipated UNICEF distributions of several pharmaceutical products (e.g., ORS and zinc), requiring an adjustment in the IHP order to suppliers to avoid oversupply of those products
2. Longer than expected identification of appropriate CDRs followed by prolonged contract negotiation with selected CDRs, leading to delays in notifying suppliers of final shipping points
3. Corrections to the consignee and CDR addresses became necessary. While on the surface, this appears to be a relatively simple task, it was complicated by the following factors:
   - Ten shipping points with both air and sea shipment; and
   - Two suppliers required more than one shipment due to manufacturers only being able to provide partial quantities—each time a change was made, considerable time and effort was needed to enter information into computers and reprint proforma invoices.
4. Due to multiple shipping points, air and sea shipments, etc., more than 40 separate shipments were required, and each had to be cleared and forwarded.
5. Customs clearing was challenging with some of the freight forwarders. One supplier (IDA) used multiple freight forwarders who in turn used subcontractors. Some of the forwarders used improper clearing procedures, resulting in delays in clearing and distributing goods.

MSH adopted the following corrective measures to strengthen a number of procurement processes:

- Hold a meeting with each supplier shortly after the order is placed to review the order requirements and establish a plan of communication, schedule for shipments, etc.
- Require suppliers to provide more frequent updates from the beginning of the orders through final deliveries to all destinations (on daily, weekly, or bi-weekly basis depending on the situation).
- Make every effort to split orders of each drug between suppliers to help ensure that a quantity of each drug arrives in country even if one shipment encounters delays.
- Reduce or eliminate changes to the orders to avoid delays, including more up-front discussions and co-ordination with other donors to avoid duplication of procurement.
- Ensure that each supplier designates a single clearing agent.
- Better define roles and responsibilities for MSH, supplier, and freight forwarder staff.

During PY2, the project experienced a stock-out of essential generic drugs and specific commodities. To address the shortage, IHP, with approval from USAID, quickly procured a 6-month order through ASRAMES to shorten the delivery delay.

During the last two project years, it took 14 and 12 months, respectively, for the orders to reach the CDRs. Compared to the project estimated timeline of 6 to 9 months, PY4 and PY5 orders were considered as "delayed." The main challenges included, but were not limited to, unclear communication, lack of clarity in the responsibilities from the pharmaceutical vendors, the shipping services outside and inside DRC to the CDRs, and the extensive administrative procedures for customs clearance, which IHP continued to address with the appropriate authorities within the Congolese government.

Prior to the start of IHPplus, MSH developed an action plan to overcome many of the pharmaceutical procurement challenges faced during IHP. The project designated a dedicated staff from SIAPS to work on requesting documents from the MOH, USAID, US Embassy, Ministry of Foreign Affairs and the *Direction Générale des Douanes et Accises*. Also, MSH and its freight forwarder increased communication with USAID to follow up on the status of obtaining *note verbales*. Moreover, MSH organized multiple meetings with vendors, the freight forwarder, its agent in DRC, and the dedicated project staff to ensure that all orders were still on track. The team developed and used multiple management tools to reach the objectives established in the action plan.

Supply chain management

Health commodity stock-outs are related to several factors, including: the type of goods (vaccines, tests, LLINs, medicines, vitamins, etc.), the entity responsible for their procurement/distribution, and the ability of health facilities and CDRs to accurately calculate monthly consumption and forecast quantification needs.

Vaccine stock-outs, for example, are mainly due to delays in co-funding from the Congolese government to purchase the vaccines. IHP requested USAID's support to identify and implement short- (immediate), medium-, and long-term solutions to the chronic vaccine shortages.

While some health facility stock-outs were due to the project delays in clearing pharmaceutical orders from customs or delivering them to the CDR, the majority of the stock-outs reported were "false stock-outs," caused by the health facilities' inability to carefully manage their average monthly use of essential drugs. As a result, they did not properly quantify their needs and ordered commodities once they were already out of them. The inadequate quantification of needs was a major challenge as the project was unable to evaluate if the health zones' needs were fully met. It also made it challenging to determine if stock-outs were due to the unavailability of drugs at CDR, delivery delays, or delays of health facilities in ordering commodities. Poor supply chain management at health facilities also had a negative impact on the project's overall performance, as stock-outs usually led to other activities being delayed or canceled.

One of IHP's sub-objectives under IR1 is to minimize tracer medicine stock-outs (ACT, RDT, Depo-Provera, ORS, iron, and rifampicin isoniazid). As explained earlier in the report, the project's performance related to reducing stock-outs improved during the project. To support health facilities in avoiding stock-outs, IHP worked in close collaboration with SIAPS, USAID|DELIVER, and SCMS to build capacity throughout the supply chain levels, including CDRs, the Provincial Health Divisions, and health zone management team members in charge of commodity management. During these meetings, health care workers were briefed on quantification methods for actual needs, how to place an appropriate order, how to make timely deliveries to different health facilities, and how to rigorously monitor the stock situation.

Another factor contributing to stock-outs for some tracer drugs is that many are procured and distributed by different entities. For example, rifampicin isoniazid for TB treatment is procured by the Global Fund and distributed by the National Tuberculosis Program, and ACTs are purchased by PMI/USAID and distributed by IHP. IHP initiated coordination meetings and joint monitoring visits with USAID supply chain implementing partners to improve collaboration and achieve greater impact in the reduction of stock-outs and expirations.

Additionally, the stock-outs of essential medicines such as SP and iron folate remain challenging for IHP, largely due to some systemic factors. USAID|DELIVER is responsible for ordering and delivering SP. In addition to the delivery delay, the quantities IHP has received to date have not been sufficient to cover IHP needs. While IHP continued to coordinate with USAID|DELIVER, the project also promoted using the health zone funds to obtain SP for the stock of the CDRs. Unfortunately, most of the health facilities prefer to purchase the SP from the private local market because it is less expensive. Nevertheless, IHP continued to advocate for purchase from the CDRs as a better value for the health zones in terms of quality.

During PY3, IHP also worked with other USAID mechanisms and partners to conduct other activities to improve supply chain systems for health commodities. For example, to reduce stock-outs of SP, ACT, and RDT, IHP participated with SIAPS in a PMI-organized training-of-trainers in Kinshasa in October 2013, on the correct quantification of commodity needs. PMI also organized on-the-job training on quantification and the verification of average monthly consumption during supervisory visits that were carried out by SIAPS in the health zones. During PY1 and PY2, the project did not routinely provide a sufficient quantity of vitamin A and folic acid to pregnant women, and used leftover commodities from vitamin A campaigns. In order to ensure regular and consistent access, IHP added these two medicines to the list of products that the project ordered from suppliers. The project also supported the management of the transport of medicines from the health zones to the health centers, and provided funding for the monitoring and production of monthly reports reporting on medicine management.

During PY1 and PY2, DRC-IHP experienced several challenges with the procurement of essential generic medicines, including receiving packages that had been tampered with, theft of large quantities of Determine HIV tests, and delivery of nearly expired essential generic medicines. Essential generic medicines were sometimes stored for three to four months in the customs warehouse in Kinshasa pending clearance due to the DRC government's decision to cancel the emergency removal of thermolabile drugs. To address this situation, DRC-IHP changed the incoterms of the commodity orders, which allowed the project to store all essential generic medicines abroad pending completion of the customs clearance process.

When the project discovered a case of fraud related to pharmaceutical products in its warehouse in 2013, IHP took swift action to involve the SIAPS project in the management and supervision of the warehouse. To prevent theft and prevent further fraud, SIAPS and IHP took the following steps: (1) developed a procedure manual for warehouse employees, highlighting the segregation of duties between the staff to increase effectiveness and accountability; (2) increased the frequency of inventories to quarterly and reinforced the team responsible for conducting inventories by hiring more staff and building their supply management skills through training; (3) strengthened the monitoring and verification of proofs of delivery to document that commodities reached their intended destinations; and (4) created an electronic file to increase the traceability of the commodities from the moment they leave the warehouse to their arrival at the CDR.

Security

Insecurity in the provinces remained a challenge throughout the life of the project, particularly in some areas of the Sud Kivu province, due to the presence of armed groups. The health zones falling under the Bukavu and Uvira coordinations frequently reported lower performance due to insecurity. During PY1, IHP staff members were the target of attacks while traveling between Bunyakiri and Kalonge. Shots were fired at the vehicle, and when the vehicle stopped, the passengers were robbed of their belongings. Fortunately, no one was injured. The incident was closely followed up by IHP security focal points and reported to USAID. Measures were immediately applied across Sud Kivu to minimize these risks, including removal of identifying characteristics on vehicles and organizing travel in convoy.

Overall, recurring insecurity led to a migration of the population, mostly women and children, and has had a negative impact on project activities (e.g., stopping activities, inaccessibility of health facilities, late reporting, and inability to carry out planned supervision visits). Despite these challenges, IHP worked closely with the health zones and health authorities in the affected health zones to make sure that the basic technical and financial support needed to health facilities (e.g., essential medicines, commodities for cold chain for vaccines) was consistently available. It was only during the closeout process in PY5Q3 that IHP offices managed by IRC downsized field activities to a minimum, particularly for insecure areas.

Budgetary Restrictions

The project was required to operate on an interim spending plan in the first quarter of PY4 due to a delay in obligating project funding. The delay had negative consequences for the implementation of the IHP PY4 workplan, as the project was only able to focus on four principal activities: the supply of medicines and medical commodities; technical and financial support to health zones; provision of medical equipment in rehabilitated facilities; and staffing activities related to RBF. After funding was received, it took longer than anticipated for the project to reestablish full operational capacity.

Recurring insecurity led to a migration of the population, mostly women and children, and has had a negative impact on project activities. Despite these challenges, IHP worked closely with the health authorities in the affected health zones to ensure that basic support was available.

Photo : Warren Zelman

Photo : Warren Zelman

"Sincere congratulations for the impact that DRC-IHP has had on the lives of thousands of underserved women and children in rural areas of the DRC, and for bringing them high quality care under difficult conditions. Please keep it up!"

—Richard Matendo, USAID Agreement Officer's Representative for DRC-IHP

LESSONS LEARNED

Increasing access to and availability of key family health services

- **Project innovations, including LDP, FOSACOF, Champion Communities, Education through Listening, and RBF demonstrably contributed to the improved use of health services.**
- **Cooperation between health centers and i-CCM sites and lowering fees greatly increased both quality of care and demand for services.** Friendly competition among health workers significantly boosts health indicators. When local leadership was involved in setting up the community care sites, the community took greater ownership—increasing the likelihood of services being sustained over time.
- **The RBF pilot demonstrated the effectiveness of this approach for increasing the rate of utilization of health services and increasing referral.** The 7 supported health zones demonstrated an increased rate of health services utilization (from 21% to 43%), increased referral rate of high risk pregnancies (from 58% to 98%), an increased rate of single ANC visits (from 79% to 91%), an increased percentage of women attending four ANC visits (from 22% to 63%), and an increased rate of deliveries with skilled birth attendants (from 63% to 69%). These results were linked with a considerable increase in the overall quality of services delivered in health centers and general hospitals. Linking incentives with improved results from health facility employees and management teams showed promise for expansion beyond the pilot zones.
- **The CLTS initiative was a powerful approach for promoting community empowerment and ownership of good sanitation and hygiene practices (WASH).** This approach contributed to the rapid scale-up of improved household sanitation facilities.

Increasing the quality of key family health care services

- **Community engagement in health prevention and promotion activities was a key element** in strengthening the quality and sustainability of health services.
- **The HBB approach proved to be an effective technique for reducing newborn mortality.** IHP provided technical and financial support to the MOH to implement an innovative HBB training methodology, which featured hands-on application and immediate feedback, and was tailored to all levels of health providers and administrators. The training methodology proved effective in developing the skills and confidence of health care workers and promoting the scale-up of this technique. Continued investment in the equipment, such as the inflatable dolls for training and resuscitation equipment, also contributed to the success of this approach.

- **Educating community members on nutrition—especially mothers—dramatically improved infant, child, and maternal health outcomes** using low-cost local resources. Emphasizing simple and achievable actions led to measurable change. IYCF group leaders knew who to call for more information, as the project created strong links between central, regional, and community levels through cascading training and continuing supervision. Cooking demonstrations were a popular way to gather a broad cross-section of the community to learn something new. Success required an adequate budget and synergy with other sectors, particularly education and agriculture. Nonetheless, in some communities, the availability of food—not just feeding practices—is a barrier to adequate nutrition.
- **RBF dramatically improved the overall quality of health services and information** (by verifying and counter-verifying data), strengthened community participation in primary health care, contributed to the management capabilities, accountability, and motivation of health zone staff, and enhanced project ownership at all levels of the health systems. Champion Communities identified a pool of community-based organizations, which the project could then contract to successfully perform RBF counter-verification activities.
- **FOSACOF, continuous monitoring, and supportive supervision** visits were important factors in successfully implementing this quality improvement approach.

Increasing knowledge, attitudes, and practices to support health-seeking behaviors

- **Community mobilization and engagement approaches work.** CODESAs, collaborative approaches, IYCF efforts, the involvement of political and administrative authorities, and community leaders all contributed to the improved demand and use of health services.
- **Youth organizations play an important role in implementing health zone action plans** due to their proximity to the key target populations.
- **Leaders of Champion Communities may determine success.** The most successful leaders were vibrant, imaginative, well-liked, committed, and self-motivated. In addition, support from community leaders was a must; this also includes support from traditional and religious leaders. All decisions made by the Champion Communities need to be approved by the community, and any problems in implementation are best discussed with the community as a whole.

  Champion Communities were most effective when paired with mHealth to reinforce health messages transmitted in home visits and community mobilization. Strong collaboration between health centers and Champion Communities was necessary to sustain motivation and correct messaging. Unlike previous Champion Community approaches in the DRC, which did not continue after the end of the funding, the IHP model has proven to be successful and sustainable, as many Champion Communities have transitioned to functioning autonomously. The Champion Communities that gained the status of NGOs became important implementing partners to health zones, capable of contributing to the improvement of the population's well-being. They are now able to sign contracts with other local associations as state-recognized organizations. Other communities have begun to realize the benefits and are starting their own autonomous Champion Communities, using IHP Champion Communities to mentor them in the process.
- **The Champion Men themselves play a large role in the success of the initiative.** Communities were more receptive to the messaging when Champion Men explained the nature of their involvement as volunteers and their personal commitment to the initiative. Multiple follow-up visits by Champion Men also promoted greater acceptance of messaging within households.

  For future programming, the Champion Men facilitator's guide should be updated to include data related to the health consequences of the behaviors that the initiative addresses.
- **mHealth messages are well received and demonstrate health impact at the individual, provider, and community levels** (pending a larger, population-based quantitative and qualitative study to confirm this impact). Uniformly, communities asked for mHealth messages on topics of GBV, HIV and AIDS, alcohol abuse, child nutrition, and breastfeeding, confirming that sensitive topics—such as those specific for young men (HIV and AIDS, sexually transmitted infections or STIs, staying

in school, deferring marriage, prostitution, respecting women) and young women (HIV and AIDS, STIs, staying in school, deferring marriage, avoiding prostitution, and child care topics)—can be sent by mHealth SMS.

Topics sent in mHealth should be age and gender appropriate. Champion Communities were able to subgroup mobile numbers by age and gender to send targeted messages. In addition, mHealth messages need to be coordinated with local/provincial health authorities, NGOs, and others involved in health promotion to ensure, for example, LLINs are available after LLIN messages are sent via SMS.

The elderly are an underrepresented group in mHealth. Given that USAID has a priority for non-communicable diseases (diabetes, hypertension, kidney disease), which are predominant in the elderly, the program should be expanded to include elderly community members. In mHealth Champion Communities, there should be a push for the communities who have NGO status and/or programs that bring money into the community to start buying credit for SMS messaging. The cost of SMS can hinder wider scale-up of mHealth if the CUG system is not operational.

Improving health sector leadership and governance in target provinces

- **Conducting CODESA activities in close succession facilitates group cohesion and member participation.** When the health zones provided support to CODESAs by distributing reporting tools (frameworks, checklists) and performing monitoring visits, they increased CODESA engagement, effectiveness, community impact, and overall reporting on the implemented activities. The participation of CODESAs in monitoring meetings at the health zone level allowed for the exchange of information within a framework adapted to the locality. Civil engagement within the CODESAs has driven work that benefits the community (e.g., health facility renovations, the development of roads, and potable water sources).
- **Donor financing of citizen engagement in the health sector was likely to be most effective when it included the following:**
  - Citizen engagement measures that fostered both consultation and participation to stimulate positive health practices, as well as (social) accountability to improve governance;
  - Financing interventions to strengthen concurrently both citizen groups and health service infrastructure and capacity, including the use of RBF to incentivize both groups;
  - A project design with built-in instruments for monitoring and evaluation of citizen engagement measures; and
  - Consistent and ongoing dialogue with the government in order to strengthen the governance framework for provision of health services.

  These findings are summarized from the Leadership, Management and Governance project case study on DRC-IHP's citizen engagement interventions and how they may have influenced overall project implementation and outcomes.[19]

19 Leadership, Management and Governance Project. "Integrated Health Project in Democratic Republic of Congo: A Case Study on Citizen Engagement and its Influence on Health Program Outcomes," December 2015.

Photo : Warren Zelman

List of Appendices

Appendix 1a. IHP Performance Monitoring Plan: Indicator detail

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

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
USAID/DRC/IHP Objective: Increase use of high-impact health services, products, and practices for family planning, MNCH, nutrition, malaria, neglected tropical diseases,** TB, HIV&AIDS, and WASH in target health zones									Realisation	Target	Achieve-ment Rate (%)
1	FP: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	432,325	443,897	482,331	502,592	562,982	571,340	2,563,143	2,088,854	123
1.1	FP: Couple years of protection (CYP) after exclusion of LAM and self-observation methods (NFP) for FP in USG-supported programs		n/a	158,037	192,133	195,912	225,530	232,590	1,004,203	645,000	156
2	FP: Number of new acceptors for any modern contraceptive method in USG-supported family planning (FP) service delivery points	Number of new FP acceptors of a modern method will be calculated based upon records from USG-supported FP clinics in the IHP target areas	364,152	460,695	505,206	556,320	606,320	592,158	2,720,700	2,336,555	116
3	FP: Number of counseling visits for FP/RH as result of USG support	Number of FP/RH counseling visits at USG-supported service delivery points	n/a	344,993	384,349	534,847	747,573	821,657	2,833,418	1,809,908	157
4	FP: Number of USG-supported delivery points providing family planning (FP) counseling or services	Number of USG-supported service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service	n/a	1,277	1,499	1,950	2,025	2,233	2,233	2,000	112
	Disaggregated by type of service delivery:	(a) Health facility based	n/a	1,269	1,430	1,586	1,542	1,551	1,551	1,600	97
		(b) Community-level based	n/a	8	69	364	483	682	682	400	171
5	FP: Number of USG-assisted health facilities experiencing stock-outs of Depo-Provera	Maximum number of USG-supported health facilities experiencing stock-outs of Depo-Provera	n/a	167	84	49	67	146	146	133	91
6	MNCH: Percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	433,226	448,873	484,770	508,331	546,162	547,898	2,536,034	2,443,849	
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	480,000	480,615	500,497	515,512	505,636	520,806	2,523,066	2,624,837	
		Numerator/Denominator (in percentage)	90%	93%	97%	99%	108%	105%	101%	93%	108

*Achievement rate is not applicable when target is 0.

** IHP never received funding for this health area and therefore asked for it to be removed in Modification #12 of the Award AID-OAA-A-10-00054 approved on January 28, 2015.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
7	MNCH: Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	n/a	0	44,550	200,309	246,154	277,491	768,504	1,236,856	
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	480,000	480,615	500,497	515,512	505,636	520,806	2,523,066	2,624,837	
		Numerator/Denominator (in percentage)	n/a	0.0%	8.9%	38.9%	48.7%	53%	30%	47%	65
8	MNCH: Percent of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Numerator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	351,073	364,416	398,673	425,322	460,227	473,859	2,122,497	2,099,024	
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	480,000	480,615	500,497	515,512	505,636	520,806	2,523,066	2,624,837	
		Numerator/Denominator (in percentage)	73%	76%	80%	83%	91%	91%	84%	80%	105
9**	MNCH: Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	Numerator: Number of women giving birth who received AMSTL through USG-supported programs in IHP target area	n/a	264,772	334,105	395,628	424,835	445,479	1,864,819	1,867,402	
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	n/a	364,416	398,673	425,322	460,227	473,859	2,122,497	2,099,024	
		Numerator/Denominator (in percentage)	n/a	73%	84%	93%	92%	94%	88%	89%	99
10	MNCH: Number of postpartum/newborn visits within 3 days of birth in USG-supported programs	Number of postpartum/newborn visits within 3 days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery) (4% Tot Pop)	480,000	328,579	372,299	403,174	440,147	457,860	2,002,059	2,624,837	76
11	MNCH: Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area	323,516	322,736	364,897	398,162	439,793	457,292	1,982,880	1,987,791	
		Denominator: # of newborns delivered in the IHP target areas (4% of total population)	480,000	336,457	354,996	395,346	430,006	470,986	1,987,791	1,987,791	
		Numerator/Denominator (in percentage)	67%	96%	103%	101%	102%	97%	100%	100%	100
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

**See page A1-14 for a different comparison of this indicator.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
12	MNCH: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/IHP target area (4% of Total Population *6% Infection rate-MICS 2010)	28,800	52,275	36,430	27,511	34,820	38,751	189,787	157,490	121
13	MNCH: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	Number of children under five years old with pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs/ IHP target area (20% Tot Pop*6% infection rate-MICS 2010)	144,000	412,004	453,541	484,407	495,392	463,422	2,308,766	2,165,287	107
14	MNCH: Number of cases of child diarrhea treated in USG-supported programs	Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) or ORT plus zinc supplements in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	432,000	256,856	252,480	263,191	522,511	619,530	1,914,568	3,628,891	53
15	MNCH: Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	324,772	366,525	387,315	453,004	457,056	467,896	2,131,796	1,997,469	
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	418,800	419,336	436,684	449,784	441,168	454,403	2,201,375	2,290,170	
		Numerator/Denominator (in percentage)	78%	87%	89%	101%	104%	103%	97%	87%	111
16	MNCH: Drop-out rate in DPT-HepB-Hib3 among children less than 12 months of age	Numerator: Number of children less than 12 months who did not complete the full regimen of DPT-HepB-Hib1-3 vaccination	19,486	17,556	24,402	22,872	24,473	23,687	112,990	99,873	
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	324,772	384,081	411,717	475,876	481,529	491,583	2,244,786	1,997,469	
		Numerator/Denominator (in percentage)	6%	5%	6%	6%	6%	5%	5%	5%	101
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
17	MNCH: Percent of children less than 12 months of age who received measles vaccine from USG-supported programs	Numerator: Number of children less than 12 months of age who received measles vaccine from USG-supported programs/IHP target area	308,533		378,753	418,585	431,855	451,480	1,680,673	1,653,211	
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	418,800		444,305	457,634	471,363	485,504	1,858,806	1,858,806	
		Numerator/Denominator (in percentage)	74%		85%	91%	92%	93%	90%	89%	102
18	MNCH: Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	n/a	128	313	176	271	91	91	133	146
19	NUTRITION: Number of children under 5 years of age who received vitamin A	Number of children under 5 years of age who received vitamin A from USG-supported programs/IHP target area	2,239,288	1,763,378	2,683,504	3,014,114	3,378,133	3,088,208	13,927,337	11,851,287	118
20	NUTRITION: Proportion of pregnant women who received iron folate to prevent anemia	Numerator: Number of pregnant women who have received iron folate tablets to prevent anemia during the last five months of pregnancy	n/a	0	201,635	450,213	504,282	580,815	1,736,945	1,608,544	
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	n/a		500,497	515,512	505,636	520,806	2,042,451	2,130,437	
		Numerator/Denominator (in percentage)	n/a	0	40%	87%	100%	112%	85%	76%	113
21	NUTRITION: Number of mothers of children 2 years of age or less who have received nutritional counseling for their children	Number of mothers of children 2 years of age or less who have received nutritional education within group support (8% of Total Population X 15% Malnutrition Prevalence Rate)	n/a	0	88,939	419,122	574,577	659,742	1,742,380	1,124,261	155
22	NUTRITION: Number of breastfeeding mothers receiving vitamin A	Number of breastfeeding mothers attending post natal visits during the 8 weeks following delivery who received vitamin A	n/a	0	62,909	148,917	138,003	201,897	551,726	1,766,675	31
23	NUTRITION: Number of USG-supported health facilities experiencing stock-outs of iron folate	Number of USG-supported health facilities that experienced stock-outs of iron folate tablets	n/a	0	503	390	489	249	249	133	53
24	TB: Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year (150 cases for 100,000 people)	18,000	12,054	10,276	10,953	12,163	12,639	12,639	28,903	
		Denominator: Total population in the specified geographical area	12,000,000	12,015,371	12,512,423	12,887,796	12,640,912	13,020,139	13,020,139	14,328,628	
		Numerator/Denominator (per 100,000 population)	150	100	82	85	96	97	97	214	45
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
25	TB: Percent of all registered TB patients who are tested for HIV through USG-supported programs	Numerator: Number of TB patients who are tested for HIV	4,500	4,705	2,901	6,026	7,610	7,460	28,702	73,554	
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	18,000	12,054	10,276	10,953	12,163	12,639	58,085	127,457	
		Numerator/Denominator (in percentage)	25%	39%	28%	55%	63%	59%	49%	58%	85
26	TB: Case detection rate	Numerator: Number of new smear positive TB cases detected	n/a	12,054	10,276	10,953	12,163	12,639	58,085	55,923	
		Denominator: Estimated number of TB cases expected	n/a	18,023	18,769	19,332	18,961	19,530	94,615	79,891	
		Numerator/Denominator (in percentage)	n/a	67%	55%	57%	64%	65%	61%	70%	88
27	TB: Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	n/a	0	18	25	39	121	203	200	102
28	TB: Number of USG-assisted service delivery points experiencing stock-outs of RH (rifampicin isoniziad) combination	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of TB drugs at any time during the defined reporting period	n/a	34	42	26	24	42	42	0	n/a*
29	HIV: Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	Numerator: Number of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	n/a	0	0	0	0	15	15	69	
		Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	n/a	0	0	0	0	69	69	69	
		Percent =(Num/Den)x100	n/a					22%	22%	100%	22
30	HIV: Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results) (DSD)	Numerator: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	59,041	62,130	61,836	18,778	20,241	222,026	21,894	
		Denominator: Number of new ANC and L&D clients	n/a	137,666	160,013	91,858	23,525	26,305	439,367	24,007	
		Percent =(Num/Den)x100	n/a	43%	39%	67%	80%	77%	51%	91%	55
31	HIV: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	n/a	272	216	233	254	396	1,371	194	
		Denominator: Number of HIV- positive pregnant women identified in the reporting period (including known HIV-positive at entry)	n/a	1,232	444	572	173	533	2,954	208	
		Percent =(Num/Den)x100	n/a	22%	49%	41%	147%	74%	46%	93%	50
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
32	HIV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (DSD)	Number of female sex workers (FSW) reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	0	0	0	0	212	212	490	43
33	HIV: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (DSD)	Number of individuals who received T&C services for HIV and received their test results during the reporting period	n/a	68,735	73,321	87,833	39,211	46,217	315,317	65,330	483
34	HIV: Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (DSD)	Number of HIV positive adults and children (aggregated by age/sex : female, male , <15 and >15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) or CD4 count or viral load (DSD)	n/a	0	0	0	0	1,591	1,591	1,511	105
35	HIV: Number of HIV-positive adults and children receiving a minimum of one clinical service (DSD)	Number of HIV-positive adults and children –aggregated by age/sex , female, male , <15 and > 15) in the reporting period receiving a minimum of one clinical service (DSD)	n/a	0	0	0	0	4,438	4,438	1,511	294
36	TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	n/a	0	0	0	0	1,933	1,933	1,359	
		Denominator: Number of patient HIV-positive	n/a	0	0	0	0	12,487	12,487	1,511	
		Percent =(Num/Den)x100	n/a					15%	15%	90%	17
37	HIV: Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD)	Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD) (aggregated by age/sex , female, male , <15 and >15) in the reporting period	n/a	0	0	0	0	2,983	2,983	846	353
38	HIV: Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV-infected adults and children newly enrolled in clinical care (aggregated by age/sex , female, male , <15 and >15) during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	n/a	0	0	0	0	1,608	1,608	500	322
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
39	TB/HIV: Proportion of registered TB cases who are HIV-positive who are on ART	Numerator: The number of registered TB cases with documented HIV-positive status who start or continue ART during the reporting period	n/a	0	0	0	0	1,433	1,433	520	
		Denominator: The number of registered TB cases with documented HIV-positive status during the reporting period	n/a	0	0	0	0	2,136	2,136	600	
		Percent =(Num/Den)x100	n/a					67%	67%	87%	77
40	HIV: Percentage of laboratories and POC testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program	Number of PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing on HIV serologic/diagnostic testing , CD4, EID and TB diagnostic	n/a	0	0	0	69	20	20	55	
		Denominator: Total number of laboratories and testing sites	n/a	0	0	0	69	68	68	69	
		Percent =(Num/Den)x100	n/a				100%	29%	29%	80%	37
41	HIV: Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation	Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation aggregated by site support type (DSD and TA)	n/a	0	0	0	0	1	1	2	50
42	HIV: Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	Numerator: Number of service delivery points supported by PEPFAR for HIV services that are directly providing integrated voluntary family planning services	n/a	0	0	0	69	68	68	55	
		Denominator: Total number of PEPFAR-supported HIV service delivery points	n/a	0	0	0	69	68	68	69	
		Percent =(Num/Den)x100	n/a					100%	100%	80%	125
IR 1 : Access to and availability of MPA-plus and CPA-plus services and products in target health zones increased (Component 1)											
IR 1.1: Facility-based health care services and products (provincial hospitals and district health centers) in target health zones increased											
43	L+M+G: % of general referral hospitals GRHs implementing complementary package of activities CPA	Numerator: # of GRHs implementing CPA	n/a	0	34	69	70	70	70	62	
		Denominator: Total # of GRHs	80	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	n/a	0%	43%	86%	88%	90%	90%	80%	113
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
44	L+M+G: % of GRHs implementing CPA-plus	Numerator: # of GRHs implementing CPA-plus/	n/a	0	20	13	21	51	51	31	
		Denominator: Total # of GRHs	80	80	80	80	80	77	77	78	
		Numerator/Denominator (in percentage)	n/a	0%	25%	16%	26%	66%	66%	80%	83
45	L+M+G: % of health centers implementing minimum package of activities MPA	Numerator: # of health centers implementing MPA	n/a	0	685	1,399	1,382	1,365	1,365	1,118	
		Denominator: Total # of health centers	1,509	1,419	1,419	1,419	1,419	1,382	1,382	1,398	
		Numerator/Denominator (in percentage)	n/a	0%	48%	99%	97%	99%	99%	80%	124
46	L+M+G: % of health centers implementing MPA-plus	Numerator: # of health centers implementing MPA-plus	n/a	0	61	93	120	794	794	559	
		Denominator: Total # of health centers	1,509	1,419	1,419	1,419	1,419	1,382	1,382	1,398	
		Numerator/Denominator (in percentage)	n/a	0.0%	4.3%	6.6%	8.5%	57%	57%	80%	72
47	MALARIA: Percent of pregnant women who received at least two doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Number of pregnant women who received at least two doses of SP for IPT during ANC visits/	n/a	248,185	293,717	310,539	317,588	343,216	1,513,245	1,733,723	
		Denominator: Total number of pregnant women attending ANC visits in the reporting period (12 months)	480,000	480,615	500,497	515,512	505,636	520,806	2,523,066	2,130,437	
		Numerator/Denominator (in percentage)	n/a	52%	59%	60%	63%	66%	60%	81%	74
48	MALARIA: Number of USG-supported service delivery points experiencing stock-outs of ACT for 1-5 year olds	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of ACT for 1 – 5 years at any time during the defined reporting period	n/a	n/a	691	58	127	80	80	133	166
49	MALARIA: Number of ITNs purchased with USG funds	Number of ITNs purchased with USG funds	n/a	490,000	0	0	12,500	709,100	1,211,600	2,070,000	59
50	MALARIA: Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	n/a	277,717	1,613,124	142,306	26,158	213,874	2,273,179	2,070,000	110
50.1		(a) through campaigns	0	0	1,400,841	0	0	0	1,400,841	0	
50.2		(b) through health facilities	0	277,717	212,283	142,306	26,158	213,874	872,338	2,070,000	42
50.3		(c) through the private/commercial sector	0	0	0	0	0	0	0	0	
50.4		(d) through other distribution channels	0	0	0	0	0	0	0	0	
50.5		(e) through voucher schemes	0	0	0	0	0	0	0	0	
51	MALARIA: Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female)	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	n/a	1,500	1,297	1,220	876	0	4,893	7,730	63
		Male	n/a	1,200	1,053	1,044	758	0	4,055	5,153	79
		Female	n/a	300	244	176	118	0	838	2,577	33
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
52	MALARIA: Number of SP tablets purchased with USG funds	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	n/a	713,000	265,000	573,000	0	3,570,000	5,121,000	11,000,000	47
53	MALARIA: Number of ACT treatments purchased by other partners that were distributed with USG funds	Total number of ACT treatments available for distribution using USG funds	n/a	0	0	0	162,593	259,982	422,575	0	n/a*
54	MALARIA: Number of SP tablets purchased with USG funds that were distributed to health facilities	Number of SP tablets purchased with USG funds that were distributed to health facilities (hospitals, health centers, health posts/stations, clinics)	n/a	746,761	1,122,583	839,920	676,557	1,161,096	4,546,917	11,000,000	41
55	MALARIA: Number of health workers trained in case management with ACTs with USG funds	Number of health workers (doctor, nurse, nurse's assistant, clinical officer or community/village health worker) trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	n/a	1,500	1,525	1,331	1,016	0	5,372	10,430	52
56	MALARIA: Number of ACT treatments purchased with USG funds	Number of ACT treatments purchased with USG funds	n/a	0	2,297,680	4,313,722	5,387,813	9,450,944	21,450,159	16,000,000	134
57	MALARIA: Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	n/a	1,487,452	1,585,947	1,654,729	2,166,145	2,345,794	9,240,067	11,800,000	78
		(a) to health facilities	n/a	1,487,452	1,585,023	1,641,499	2,136,117	2,284,890	9,134,981	11,572,777	79
		(b) to community health workers (HBMF, CCM)	n/a	0	924	14,279	30,028	60,903	106,134	227,223	47
		(c) to the private/commercial sector	n/a	0	0	0	448	0	448	0	
58	MALARIA: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds Disaggregate in 3 sub-categories:	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	n/a	1,500	1,693	1,345	1,094	0	5,632	10,800	52
	(a) Number of health facility workers trained (male/female)	Male	n/a	1,128	1,200	1,032	805	0	4,165	5,153	81
		Female	n/a	292	97	188	128	0	705	2,577	27
	(b) Number of community health workers trained (male/female)	Male	n/a	0	217	102	124	0	443	1,800	25
		Female	n/a	0	11	9	33	0	53	900	6
	(c) Number of laboratory technicians trained (male/female)	Male	n/a	72	158	14	4	0	248	273	91
		Female	n/a	8	10	0	0	0	18	97	19
59	MALARIA: Number of RDTs purchased with USG funds	Number of RDTs purchased with USG funds	n/a	0	274,900	2,812,000	100,700	5,875,918	9,063,518	14,850,000	61
60	MALARIA: Number of RDTs purchased with USG funds that were distributed to health facilities	Number of RDTs purchased with USG funds that were distributed to health facilities	n/a	0	301,213	1,044,750	1,165,561	1,375,971	3,887,495	13,350,000	29
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
IR 1.2: Community-based health care services and products in target health zones increased											
61	L+M+G: % of communities with CODESAs actively involved in management of priority health services	Numerator: # of communities with CODESAs with active involvement in management of priority health services for their communities/	n/a	702	1,052	1,179	1,292	1,284	1,284	1,398	
		Denominator: Total # of communities in IHP target area	n/a	1,419	1,419	1,419	1,419	1,398	1,382	1,398	
		Numerator/Denominator (in percentage)	50%	49.5%	74.1%	83.1%	91.1%	91.8%	92.9%	100%	93
62	WASH: Number of people in target areas with first-time access to improved drinking water supply as a result of USG support	# of people in target areas with first-time access to improved drinking water supply (Improved drinking water technologies are those more likely to provide safe drinking water)	233,580	0	138,137	435,972	232,631	252,542	1,059,282	932,676	114
63	WASH: Number of people in target areas with first-time access to improved sanitation facilities as a result of USG support	# of people in target areas with first-time access to improved sanitation facilities. (Improved sanitation facilities include those more likely to ensure privacy and hygienic use, e.g., connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine)	123,284	0	43,980	309,907	234,236	270,462	858,585	932,676	92
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased											
64	L+M+G: % of senior LDP teams that have achieved their desired performance according to indicators in their action plans within 6 months of completing the LDP	Leadership Development Program (LDP) team made up of senior health managers working towards improving organizational performance and service delivery of health zones and facilities in their respective health zones/areas. Numerator: Number of health zone with leadership that has undergone LDP training	n/a	1	8	5	23	46	46	78	
		Denominator: Total number of IHP health zones	n/a	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	29%	1%	10%	6%	29%	59%	59%	100%	59
IR 2: Quality of key family health care services in target health zones increased (Component 1)											
IR 2.1: Clinical and management capacity of health care providers increased											
65	L+M+G: Percent of health zones (health zones) with validated action plans	Numerator: # health zone with validated actions plans	n/a	5	40	78	59	78	78	78	
		Denominator: Total # health zones in IHP target area	n/a	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	15%	6%	50%	98%	74%	100%	100%	100%	100
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
65.1	L+M+G: Percent of health centers with accurate and up-to-date inventory records	Numerator: Number of health centers with up-to-date and accurate record of inventory of essential drugs and supplies ("accurate" means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	n/a	0		594	954	1,069	1,069	1,398	
		Denominator: Total number of health centers in IHP areas	1,438	1,419	1,419	1,419	1,419	1,398	1,398	1,398	
		Numerator/Denominator (in percentage)	n/a	0.0%	0.0%	41.8%	67.3%	76.5%	76.5%	100%	76
65.2	L+M+G: Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies (Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	n/a	0	9	47	64	64	64	78	
		Denominator: Total number of hospitals in IHP areas	80	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	n/a	0.0%	10.8%	58.5%	80.1%	82.5%	82.5%	100%	82
66	GENDER: # of health workers clinically trained in case management of sexual violence	# of health workers at health centers and GRHs who successfully completed clinical training sessions on sexual violence case management in IHP target health zones	n/a	0	430	328	128	45	931	1,080	86
67	GENDER: Number of people reached by a USG-supported intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Number of people reached by a USG-supported intervention providing GBV health services	n/a	0	1,829	4,883	3,891	2,543	13,146	22,320	59
68	GENDER: # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	n/a	0	28	218	221	49	516	44	1,173
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted											
69	L+M+G: % of health centers meeting all 9 FOSACOF minimum standards, disaggregated by type of health facility (Please create another row for hospitals with same indicator)	Numerator: # of health centers meeting all 9 FOSACOF minimum standards	115	0	10	13	67	737	737	700	
		Denominator: Total # of facilities	1,438	1,499	1,499	1,499	1,499	1,476	1,476	1,398	
		Numerator/Denominator (in percentage)	8%	0%	1%	1%	4%	50%	50%	50%	100%
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized											
70	% of patients referred to ealth centers, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to health centers by a CHW	n/a	0	4,588	5,053	19,008	22,545	51,194	154,216	
		Denominator: Total # of patients seen by a CHW	n/a	0	8,646	54,520	72,502	154,604	290,272	3,084,320	
		Numerator/Denominator (in percentage)	n/a		53.07%	9.27%	26.22%	15%	18%	5%	353
71	% of patients referred to GRHs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to GRHs by a CHW or health care provider	n/a	0	37,466	134,376	213,788	233,507	619,137	168,330	
		Denominator: Total number of patients seen by a CHW or health care provider	n/a	4,247,604	4,541,783	4,910,656	5,457,998	5,981,828	25,139,869	13,202,846	
		Numerator/Denominator (in percentage)	n/a	0%	1%	3%	4%	4%	2%	1%	193
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased (Component 1)											
IR 3.1: Evidence-based health sector-community outreach linkages – especially for women, youth and vulnerable populations– established											
72	L+M+G: % of NGOs representing women, youth and vulnerable groups participating in coordination meetings	Numerator: # of NGOs representing women, youth, and vulnerable groups attending NGO coordination meetings	n/a	0	78	61	217	161	161	60	
		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	n/a	0	269	196	309	253	253	100	
		Numerator/Denominator (in percentage)	n/a		29%	31%	70%	64%	63.6%	60%	106
73	L+M+G: # community champions selected and trained	# community champions completing capacity building program led by IHP community mobilizers	n/a	0	67	1	6	34	34	26	131
74	L+M+G: # community health action plans created	# community health action plans developed by community members and reviewed by IHP staff	n/a	0	11	1	3	34	34	26	131
75	L+M+G: # youth organizations participating in youth education outreach strategy	# youth organizations conducting member outreach and health education as part of IHP youth health education strategy	n/a	0	105	125	143	164	164	120	137
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched											
76	BCC: # of CODESAs supported by IHP and which have a "Communications action plan"	# of CODESAs supported by IHP within the IHP target area and which have a "Communications action plan" developed	0	0	80	889	1,075	1,200	1,200	1,060	113
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Indicator		Definition	Baseline	PY1	PY2	PY3	PY4	PY5	END OF PROJECT		
77	BCC: # of educational SMS messages during BCC campaigns or mini campaigns on malaria, nutrition and/or family planning	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	n/a	0	15,663	217,129	371,431	802,988	1,407,211	2,480,000	57
IR 4: Health sector leadership and governance in target provinces improved (Component 2)											
IR 4.1: Provincial health sector policies and national level policies aligned											
78	L+M+G: % of health zones with an annual operational plan based on National Development Plan ("PNDS")	Numerator: # of health zones with an annual operational plan based on National Development Plan ("PNDS")	n/a	5	33	69	62	78	78	78	
		Denominator: Total # of health zones	n/a	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	n/a	6%	41%	86%	78%	100%	100%	100%	100
79	L+M+G: % of health zone management teams with a performance management system that includes essential components	Numerator: # of health zone management teams with a performance management system that includes any of the three essential components: 1) up-to-date job descriptions and organigrams, 2) workplans (including supervision plan and guide), and 3) performance review reports	n/a	1	16	60	48	43	43	78	
		Denominator: Total # of health zones	n/a	80	80	80	80	78	78	78	
		Numerator/Denominator (in percentage)	10%	1%	20%	75%	60%	55%	55%	100%	55
Project Management											
80	PM: Number of success stories developed	Number of success stories developed disaggregated by technical components and sub-components where applicable (HIV/AIDS, TB, Malaria, NTD, MNCH, FP/RH, Nutrition, WASH, GBV, Gender, HSS, BCC, Commodities, Coordination, M&E, etc.)	n/a	8	15	37	35	41	136	120	113
									Realisation	Target	Achievement Rate (%)

*Achievement rate is not applicable when target is 0.

Appendix 1b. Comparison between IHP service utilization rate and service coverage rate for selected PMP indicators

Indicator		PMP Result		Coverage of the intervention in the USG-supported program		Comments
1	MNCH: Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	Numerator: Number of women giving birth who received AMTSL through USG-supported programs in IHP target area	1,864,819	Numerator: Number of women giving birth who received AMTSL through USG-supported programs in IHP target area	1,864,819	
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	2,122,497	Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	2,523,066	
		Numerator/Denominator (in percentage)	88%	Numerator/ Denominator (in percentage)	74%	
2	MNCH: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/IHP target area (4% of Total Population *6% Infection rate-MICS 2010)	189,787	Numerator: Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs	189,787	
				Denominator: # of infection case expected (4% of Total Population *6% Infection rate-MICS 2010)	212,050	
				Numerator/ Denominator (in percentage)	90%	
3	MNCH: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	Number of children under five years old with pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	2,308,766	Numerator: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	2,308,766	
				Denominator: # of infection case expected (20% Tot Pop*31% infection rate-MICS 2010)	5,477,946	
				Numerator/ Denominator (in percentage)	42%	
4	MNCH: Number of cases of child diarrhea treated in USG-supported programs	Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) or ORT plus zinc supplements in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	1,914,568	Numerator: Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	1,914,568	
				Denominator: # of infection case expected (20% Tot Pop*34.7% infection rate-MICS 2010)	6,131,765	
				Numerator/ Denominator (in percentage)	31%	
5	HIV: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	1,371	Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	1,371	
		Denominator: Number of HIV- positive pregnant women identified in the reporting period (including known HIV-positive at entry)	2,954	Denominator: # of HIV-positive pregnant women expected (# of expected pregnancy * HIV prevalence rate within pregnant women (1.2%)	10,072	
		Numerator/Denominator (in percentage)	46%	Numerator/Denominator (in percentage)	14%	

Indicator		PMP Result		Coverage of the intervention in the USG-supported program		Comments
6	TB: Percent of all registered TB patients who are tested for HIV through USG- supported programs	Numerator: Number of TB patients who are tested for HIV	28,702	Numerator: Number of TB patients who are tested for HIV	28,702	
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	58,085	Denominator: Estimated number of TB cases expected	94,615	
		Numerator/Denominator (in percentage)	49%	Numerator/Denominator (in percentage)	30%	
7	TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	1,933	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	1,933	Only PY5
		Denominator: Number of patient HIV-positive	12,487	Denominator: # of patient HIV-positive expected (1.7% as prevalence rate)	47,948	
		Numerator/Denominator (in percentage)	15%	Numerator/Denominator (in percentage)	4%	
8	HIV: Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	Number of HIV positive adults and children (aggregated by age/ sex : female, male , <15 and <15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	1,591	Numerator: Number of HIV positive adults and children (aggregated by age/sex : female, male , <15 and >15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	1,591	Only PY5
				Denominator: # of patient HIV-positive expected (1.7% as prevalence rate)	47,948	
				Numerator/Denominator (in percentage)	3%	
9	HIV: Number of HIV infected adults and children receiving antiretroviral therapy during the reporting period (current) DSD	Number of HIV infected adults and children receiving antiretroviral therapy during the reporting period (current) DSD	2,983	Numerator: Number of HIV infected adults and children receiving antiretroviral therapy during the reporting period (current) DSD	2,983	Only PY5
				Denominator: # of patient HIV-positive expected (1.7% as prevalence rate)	47,948	
				Numerator/Denominator (in percentage)	6%	

Appendix 2. STTA Integrated Health Project PY1-PY5

Strong technical and managerial assistance from consortium member home offices and active participation in international conferences and workshops contributed to successful project implementation.

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
STTA/Project Managment and Monitoring: International Travel PY1						
1	Recruitment	Tori Caldwell	MSH	11 Nov-3 Dec 10	Complete local staff recruitment for IHP, including training a new Human Resources Manager	Boston/Kinshasa
2	COMU	Kate Onyejekwe	MSH	17 Nov-4 Dec 10	Orient the Finance and Administration Specialist, and set up the Kinshasa office	Boston/Kinshasa
3	Project Management	Kristin Cooney	MSH	17 Nov-10 Dec 10	Start up IHP and assist the project transition from the Axxes Project and Leadership, Management, and Sustainability program to the Integrated Health Project, including meetings with USAID and project partners and stakeholders.	Boston/Kinshasa
4	Workplanning	Jean Kagubare	MSH	29 Nov-5 Dec 10	Support the start-up phase and development of the workplan for IHP	Boston/Kinshasa
5	Workplanning and Communication Plan	Ryan Crow	OSC	29 Nov-7 Dec 10	Contribute to the development of the workplan and the strategic communications plan, and work with the Senior Staffing Specialist to recruit local communication staff	DC/Kinshasa
6	Operations Start-up	Christele Joseph-Pressat	MSH	30 Nov-10 Dec 10	Start up IHP and assist in development of the workplan.	Boston/Kinshasa
7	Operations/ Finance	Steve Morgan	MSH	9-23 Dec 10	Provide coverage for the Director of Finance and Operations	Boston/Kinshasa
8	Recruitment	Felix Austine	MSH	4 Jan-2 Feb 11	Continue the recruitment of new staff	Nigeria/Kinshasa
9	Program Management	Gordana Ivkovic-Grujic	IRC	13 Jan-2 Apr 11	Support operational start-up of IHP	Serbia/Kinshasa
10	Team Orientation Workshop	John Pollock	MSH	18-30 Jan 11	Conduct team orientation and Role & Clarification workshop	Boston/Kinshasa
11	M&E	Juan-Carlos Alegre	MSH	2-11 Feb 11	Provide M&E assistance	Boston/Kinshasa
12	Security	John McKenney	MSH	5-19 Feb 11	Strengthen security systems and processes in Kinshasa and provinces, and advise on travel security	Boston/Kinshasa
13	BCC Assessment	Andrei Sinioukov	OSC	14 Feb-4 Mar 11	Conduct baseline KAP assessments for IHP target zones	Tanzania/ Kinshasa
14	BCC Assessment and Technical Assistance	Waverly Rennie	OSC	14 Feb-4 Mar 11	Conduct baseline KAP assessments for IHP target zones	Tanzania/ Kinshasa
15	Program Management	Suleiman Abdiel	IRC	15 Feb-15 May 11	Support operational start-up of IHP at field level	
16	Recruitment	Tori Caldwell	MSH	21 Feb-4 Mar 11	Finalize local staff recruitment for IHP and offer additional orientation for the new Human Resources Manager	Boston/Kinshasa
17	Program Management	Kristin Cooney	MSH	6-19 Mar 11	Provide technical support and guidance/reporting assistance	Boston/Kinshasa
18	WASH	Hassan Coulibaly	IRC	21 Mar-5 Apr 11	Support development of IHP WASH strategy	Nairobi/Kinshasa
19	BCC Assessment and Technical Assistance	Waverly Rennie	OSC	28 Mar-1 Apr 11	Provide support to communications and KAP assessments for IHP target zones	Tanzania/ Kinshasa
20	SNIS	Nkossi Dambita	MSH	2-20 Apr 11	Support IHP to strengthen MOH Système National d'Information Sanitaire (SNIS)	Maryland/ Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
21	RBF	Jean Kagubare	MSH	3-13 Apr 11	Support an internal RBF workshop (with USAID and other implementing agencies funded by USAID) and design the IHP RBF approach	Boston/Kinshasa
22	Contract and Grant Management	Peter Mahoney	MSH	4-15 Apr 11	Provide assistance on Contracts and Grants Management, RBF contracting system, and contractor/grantee monitoring system	Boston/Kinshasa
23	WASH	Hassan Coulibaly	IRC	13-20 Apr 11	Support development of IHP WASH strategy	Nairobi/Kinshasa
24	Program Management	Gordana Ivkovic-Grujic	IRC	14 Apr-27 May 11	Support operational start- up of IHP	Serbia/Kinshasa
25	Finance	Donna Coulibaly	MSH	18-28 Apr 11	Review Navigator and Quickbooks, review and strengthen financial systems, and support payroll outsourcing	Nigeria/Kinshasa
26	M&E	Juan-Carlos Alegre	MSH	15-20 May 11	Provide assistance on documenting and analyzing data from the IHP baseline study	Arlington/ Kinshasa
27	MNCH	Ciro Franco	MSH	18 May-17 Jun 11	Train MNCH advisor, strengthen planning on maternal health interventions, and strengthen community care sites	Arlington/ Kinshasa
28	Communications	Elizabeth Walsh	MSH	22 May-9 Jun 11	Implement IHP communications plan, including building staff capacity to develop success stories	Boston/Kinshasa
29	BCC	Amelie Sow-Dia	OSC	17 Jun-11 Aug 11	Review existing data, begin comprehensive baseline KAP assessment to guide BCC and other strategic communication components, work with Senior BCC Expert to develop BCC campaign materials, assist in launch of BCC activities, and initiate BCC training of local professional staff working in field offices	Baltimore/ Kinshasa
30	Newborn Health	Indira Narayanan	MSH	30 Jun-27 Jul 11	Train MNH advisor and strengthen planning on newborn health interventions	Arlington/ Kinshasa
31	RBF	Jean Kagubare	MSH	1-14 Jul 11	Provide technical support to develop the RBF operational manual and conduct a training of trainers	Cambridge/ Kinshasa
32	BCC	Karin Veltman	OSC	7-22 Jul 11	Work with BCC staff on new approaches in utilizing ICT, orient new local professional staff, meet with partners on the strategic communications plan, and harmonize administrative procedures	Philadelphia/ Kinshasa
33	WASH	Jean-Claude Somda	IRC	7 Jul-1 Sep 11	Assist with production of BCC training manual and training of trainers	Ouagadougou/ Kinshasa
34	Project Management and Technical Assistance	Kristin Cooney	MSH	9-23 Jul 11	Provide technical support and guidance/ reporting	Boston/Kinshasa
35	BCC	Paul Neely	OSC	4 Aug-10 Sep 11	Develop, implement and monitor an SMS pilot in 16 IHP-targeted health zones (two health zone in each of the 8 coordination office areas) to support community-based BCC campaigns on family planning	Montreal/ Kinshasa
36	WASH	Munoz-Pierre Kenmeni	IRC	6 Aug-10 Sep 11 18 Oct- 6 Nov 11	Conduct three trainings of trainers for building WASH structures (pit latrines, hand washing stations, rehabilitation of WASH structures, and bio-sand filters), and produce training manual that includes plans and detailed instructions for the construction of the above	Cameroon/ Kinshasa
37	Operations, Workplanning, and Technical Assistance	Joan Marshall-Missiye	MSH	5 Sep-8 Oct 11	Provide technical support during workplanning workshop, and visit project sites	Boston/Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
38	Workplanning and Technical Assistance	Jean Kagubare	MSH	7 Sep-6 Oct 11	Provide technical support during workplanning workshop, and visit project sites related to RBF	Boston/Kinshasa
39	Commodity Security Technical Assistance	Ned Heltzer	MSH	11-24 Sep 11	Provide technical assistance on quality assurance for essential medicines, procurement, and distribution	Arlington/ Kinshasa
40	Commodity Security Technical Assistance	Tom Layloff	MSH	12-24 Sep 11	Provide technical assistance on quality assurance for essential medicines	Arlington/ Kinshasa
41	Workplanning	Karin Veltman	OSC	20 Sep-7 Oct 11	Provide technical support during workplanning workshop	Philadelphia/ Kinshasa
42	Project Management, Technical Assistance, and Workplanning	Kristin Cooney	MSH	21 Sep-7 Oct 11	Provide technical support during workplanning workshop, and visit project sites	Boston/Kinshasa
43	Operations and Workplanning	Christele Joseph-Pressat	MSH	24 Sep-9 Oct 11	Work with finance/admin team on budgeting workplan produced during workplanning workshop	Boston/Kinshasa
44	Workplanning and M&E	Juan-Carlos Alegre	MSH	25 Sep-6 Oct 11	Provide technical support during workplanning workshop, train M&E staff, and visit project sites related to M&E system	Arlington/ Kinshasa
45	Workplanning and Technical Assistance	Lara Ho	IRC	25 Sep-3 Nov 11	Provide technical support to IHP activities, including workplan workshop	Geneva/Kinshasa
46	BCC	Remi Vallet	OSC	29 Sep-2 Nov 11	Organize health sensitization workshops for journalists, host journalist site visits, work with the MOH to ensure regular health outreach events for the press, develop an earned media plan in each of the four provinces, and set up procedures and systems for media monitoring	Paris/Kinshasa
International Travel: IHP Local Staff and Partners PY1						
1	WHO Training	Narcisse Naia Embeke	MSH	28 Feb-4 Mar 11	Attend Immunization Program Manager's meeting for Central Africa	Kinshasa/Gabon
2	Regional Workshop on Pneumonia and Diarrhea	Gilbert Andrianandrasana	MSH	21-29 May 11	Attend WHO/UNICEF Regional Workshop on Pneumonia and Diarrhea	Kinshasa/ Ouagadougou
3	Family Planning	Pauline Kasungi	MSH	25-29 Jul 11	Attend USAID/East Africa FP meeting and serve as ongoing contact for action plans developed at meeting	Nairobi/Kinshasa
4	Family Planning	Severin Bushiri	MSH	25-29 Jul 11	Attend USAID/East Africa FP meeting and serve as ongoing contact for action plans developed at meeting	Kinshasa/Nairobi
5	Partnership Compliance Coordinator	Jenny Mundela Mbiya	IRC	3-8 Oct 11	Undergo official USAID training on rules and regulations	Kinshasa/Nairobi

STTA/Project Managment and Monitoring: International Travel PY2						
1	M&E	Nkossi Dambita	MSH	1-24 Oct 11	Receive orientation and provide support for development of annual report	Baltimore/ Kinshasa
2	BCC	Amelie Sow-Dia	OSC	1-28 Oct 11	Review existing data, begin comprehensive baseline KAP assessment to guide BCC and other strategic communication components, work with Senior BCC Expert to develop BCC campaign materials, assist in launch of BCC activities, and initiate BCC training of local professional staff working in field offices	Baltimore/ Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
3	Nutrition	Chouahibou Nchamoun	MSH	5-27 Oct 11	Train nutrition advisor and strengthen planning on nutrition interventions	Bamako/Kinshasa
4	Information Systems	Rabin Khadgi	MSH	10-27 Oct 11	Review IT systems and options for optimal IT Support to Kinshasa and other regions and orient the IT Manager	Boston/Kinshasa
5	MNCH and Workplanning	Ciro Franco	MSH	12-29 Oct 11	Work with IHP and MOH on maternal health interventions, strengthen community care sites, and provide input into annual workplanning	Arlington/ Kinshasa
6	BCC/Champion Community	Vololoniaina Razaka	OSC	15 Oct-3 Nov 11	Research and develop the Champion Community approach, develop user manual, train field staff in field staff	Cambridge/ Kinshasa
7	Technical Assistance	Lara Ho	IRC	22 Jan-3 Apr 12	Provide technical support to IHP activities (IHP covered 4 days of LOE and 3 days of per diem)	Geneva/Kinshasa
8	BCC/Mobile Technology Expert	Paul Neely	OSC	6 Mar-7 Apr 12	Provide technical assistance and training to BCC team in design, implementation and testing of SMS and PBx pilots to support community-based behavior change interventions in the context of the Community Champion approach.	Los Angeles/ Kinshasa
9	BCC/Community Champion Consultant	Vololoniaina Razaka	OSC	10 Mar-6 Apr 12	Research and develop community champion (CC) approach, develop CC user manual, training module, M&E tool and IEC materials; train field staff in CC approach and use of the manual and tools and assist in implementation of CC pilot in target health zones.	Antananarivo/ Kinshasa
10	Program Management	Kristin Cooney	MSH	17-31 Mar 12	Provide technical and management support and visit project sites.	Boston/Kinshasa
11	Gender/GBV	Theoneste Benson Ganza	IRC	5 May-1 Jun 11	Conduct qualitative research - gender analysis	Entebbe/ Kinshasa/
12	Gender/GBV	Fodié Maguiraga	IRC	5 May-14 Jun 12	Conduct qualitative research - gender analysis	Atlanta/Kinshasa
13	Gender/GBV	Isabelle Turcotte	IRC	5 May-23 Jun 12	Conduct qualitative research - gender analysis	New York/ Kinshasa
14	Gender/GBV	Luisa Ryan	IRC	15 May-6 Jul 12	Conduct qualitative research - gender analysis	Brisbane/ Kinshasa
15	Communication	Elizabeth Walsh	MSH	9-23 Jun 12	Train new Communication Advisor and work on the Communication Strategy Document	Boston/Kinshasa
16	BCC	Paul Neely	OSC	25 Jun-7 Aug 12	Monitor and evaluate SMS and CUG pilots in the 8 IHP target health zones (resp. 2 health zone for SMS and 1 health zone for CUG in each of the 8 coordination offices) to support community-based BCC interventions under the Champion Community approach	Los Angeles/ Kinshasa
17	M&E	Lara Ho	IRC	28 Jun-3 Jul 12	Assess advancement and quality of project activities in the field against the logframe in preparation for the annual review and Year 3 workplan process.	Geneva/Kinshasa
18	Program Management	Kristin Cooney	MSH	7-20 -Jul 12	Provide technical and management support and visit project sites	Boston/Kinshasa
19	MNCH	Ciro Franco	MSH	9-27 Jul 12	Provide technical assistance in maternal care and child health, focusing on community case management and IMCI, maternal health, and quality assurance	DC/Kinshasa
20	Operations	Christèle Joseph-Pressat	MSH	29 Jul-19 Aug 12	Fill the Finance and Administrative Specialist and Country Operations Management Unit (COMU) Director's role for an interim period during annual leave of Lila Rabibisoa	Boston/Kinshasa
21	Workplanning	Marlie Sarr	MSH	6-22 Sep 12	Provide administrative and management support during workplanning workshop	Boston/Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
22	Workplanning	Andrea Spakauskas	OSC	11-29 Sep 12	Provide technical and management support during workplanning for PY3, and work with the IHP team to develop an IHP strategic communications plan	Philadelphia/ Kinshasa
23	RBF/ Workplanning	Jean Kagubare	MSH	15-25 Sep 12	Provide technical and management support during workplanning workshop and conduct an RBF refresher training course	Boston/Kinshasa
24	Workplanning	Kristin Cooney	MSH	15-22 Sep 12	Provide technical and management support during workplanning workshop	Boston/Kinshasa
25	Workplanning	Aboubakar Mama Sambo	MSH	15 Sep-4 Oct 12	Provide budgeting and financial management support during workplanning workshop	Boston/Kinshasa
26	Workplanning	Lara Ho	IRC	16-23 Sep 12	Participate in the PY3 workplanning process by meeting with IHP coordinators and IHP senior management in Kinshasa to follow up on previous trip recommendations and contributing to development of the year 3 workplan and PMP	Geneva/Kinshasa
27	Workplanning	Joan Marshall-Missiye	MSH	17 Sep-14 Oct 12	Provide technical and management support during workplanning workshop	Boston/Kinshasa
International Travel: IHP Local Staff and Partners PY2						
1	Program Management	Lila Rabibisoa	MSH	1-6 Mar 12	Attend a training on USAID rules and regulations with InsideNGO	Antananarivo/ S. Africa
2	Program Management	Joel Amisi	MSH	1-6 Mar 12	Attend a training on USAID rules and regulations with InsideNGO	Kinshasa/ S. Africa
3	Program Management	Marius Mie	MSH	1-6 Mar 12	Attend a training on USAID rules and regulations with InsideNGO	Kinshasa/ S. Africa
4	WASH	Simeon Kenfack	IRC	3-10 Mar 12	Attend a training on WASH in emergencies	Kinshasa/Nairobi
5	Child Health	Harper McConnell	ECI	13-16 Jun 12	Participate in USAID Child Survival Call to Action Forum in Washington, D.C.	Kinshasa/D.C.
6	Child Health	Jo Lusi	HEAL Africa	13-16 Jun 12	Participate in USAID Child Survival Call to Action Forum in Washington, D.C.	Kinshasa/D.C.
7	Child Health	Denis Mukwege	Panzi Hospital	13-16 Jun 12	Participate in USAID Child Survival Call to Action Forum in Washington, D.C.	Kinshasa/D.C.
8	Child Health	Therese Mambu	University of Kinshasa	13-16 Jun 12	Participate in USAID Child Survival Call to Action Forum in Washington, D.C.	Kinshasa/D.C.
9	Support Services	Emmanuel Drouard	IRC	16-28 Jun 12	Attend IRC Supply Chain Leadership Conference	Kinshasa / Istanbul
10	Health	Crispin Batubenga	IRC	2-7 Sep 12	Attend annual IRC Health Conference	Kigali/Bangkok
11	Health	Janvier Barhobagayana	IRC	2-7 Sep 12	Attend annual IRC Health Conference	Kigali/Bangkok
12	Health	Britou Ndela	IRC	2-7 Sep 12	Attend annual IRC Health Conference	Kinshasa/ Bangkok
13	Gender/GBV	Bridget Lombardo	IRC	23-27 Sep 12	Attend annual IRC GBV Conference	Kinshasa/Entebbe

STTA/Project Managment and Monitoring: International Travel PY3						
1	M&E	Elena Chopyak	MSH	24 Oct-18 Nov 12	Provide technical and management support in the drafting of the Quarterly Report	Boston/Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
2	BCC	Vololoniaina Razaka	OSC	25 Oct-13 Nov 12	Evaluate the implementation of the Community Champion approach in Uvira and finalize the M&E tools and the drafts of the IEC materials for community festivals that will commemorate the 6-month anniversary of the pilot's initiation	Antananarivo/ Kinshasa/Uvira/ Nundu/Bukavu
3	Program Management	Kristin Cooney	MSH	31 Oct-18 Nov 12	Provide technical and management support and visit project sites	Boston/Kinshasa
4	BCC	Amelie Sow-Dia	OSC	20 Nov-2 Dec 12	Finalize the Tuendi-Kampala communication strategy, focusing on amplifying the strategy to integrate the communications strategies piloted during PY1 and PY2	Dakar/Kinshasa
5	WASH	Robert Metcalf	IRC	24 Nov-7 Dec 12	Conduct TOT on water analysis techniques using microbiology and chemical test kits (Colilert, Petrifilm, and arsenic testing kits)	Sacramento/ Kinshasa
6	RBF	Alfred Antoine Uzabakiliho	MSH	19-28 Jan 13	Provide short-term technical assistance for the RBF database	Kigali/Kinshasa
7	M&E	Elena Chopyak	MSH	19 Jan-16 Feb 13	Provide technical and management support in the drafting of the Quarterly Report.	Boston/Kinshasa
8	M&E	Sarah Castle	MSH	25 Jan-10 Feb 13	Provide M&E support	London/Kinshasa
9	Program Management	Kristin Cooney	MSH	3-17 Feb 13	Provide technical and management support and visit project sites	Boston/Kinshasa
10	BCC	Paul Neely	OSC	11 Feb-3 Mar 13	Evaluate the implementation of the CUG systems, continue to evaluate the mini SMS campaigns and produce at least 2 success stories as result of the Technical support to IHP	Los Angeles/ Kinshasa
11	HIV	Erik Schouten	MSH	10-23 Mar 13	Provide technical and management support to IHP HIV Advisor and visit project supported PMTCT sites	Lilongwe/ Kinshasa
12	M&E	Elena Chopyak	MSH	4-18 May 13	Provide technical and management support in the drafting of the Quarterly Report	Boston/Kinshasa
13	FISC	Christelle Celestin	MSH	4-18 May 13	Provide financial support in the reviewing of financial documents during Year 3	Boston/Kinshasa
14	M&E	Sarah Castle	MSH	5-19 May 13	Provide M&E support	London/Kinshasa
15	BCC	Vololoniaina Razaka	OSC	6-19 May 13	Evaluate new Community Champion pilots, in particular those that were set up during the previous trip 6 months prior	Antananarivo/
16	Program Management	Kristin Cooney	MSH	13-24 May 13	Provide technical and management support and participate in the semi-annual workplan review meeting with USAID	Boston/Kinshasa
17	MNCH	Ciro Franco	MSH	15-26 Jul 13	Provide technical support to IHP MNCH projects	Boston/Kinshasa
18	Operations	Christele Joseph-Pressat	MSH	28 Jul-19 Aug 13	Provide financial management support and coverage for Lila Rabibisoa's R&R	Boston/Kinshasa
19	M&E	Elena Chopyak	MSH	1-16 Aug 13	Provide technical and management support in the drafting of the Quarterly Report	Boston/Kinshasa
20	Workplanning	Elena Chopyak	MSH	11 Sep-11 Oct 13	Provide technical and management support during workplanning workshop	Boston/Kinshasa
21	Workplanning	Andrea Spakauskas	OSC	12-27 Sep 13	Provide technical and management support during workplanning workshop	Philadelphia/ Kinshasa
22	Workplanning	Kristin Cooney	MSH	14-27 Sep 13	Provide technical and management support during workplanning workshop	Boston/Kinshasa
23	RBF/ Workplanning	Jean Kagubare	MSH	15-26 Sep 13	Conduct an annual visit of internal evaluation of the program at the central level/provide technical and management support during workplanning workshop	Boston/Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
24	RBF	Alfred Antoine Uzabakiliho	MSH	15-30 Sep 13	Provide technical support and training for RBF database set-up	Kigali/Kinshasa
25	Workplanning	Aboubakar Mama Sambo	MSH	15 Sep-10 Oct 13	Provide technical and management support during workplanning workshop	Boston/Kinshasa
26	Health	Lara Ho	IRC	18-23 Sep 13	Provide technical and management support during workplanning workshop	Geneva/Kinshasa
International Travel: IHP Local Staff and Partners PY3						
1	FP/RH	Jean-Baptiste Mputu	OSC	12-16 Nov 12	Participate in an international conference on Mobile Technology for family Planning/ Reproductive Health	Kinshasa/Dar es Salaam
2	TB	Jean-Pierre Kabuayi Nyengele	MOH	13-17 Nov 12	Participate in the 43rd TB international conference in Malaysia	Kinshasa/Kuala Lumpur
3	MNCH	Joseph Kongolo	MSH	25-27 Feb 13	Attend 2013 WHO African Region EPI Managers' Meetings	Kinshasa/Douala
4	MNCH	Lucie Zikudieka	MSH	25 May-2 Jun 13	Attend the Women Deliver conference and present in the panel on MNCH in Crisis Settings	Kinshasa/Kuala Lumpur
5	GBV	Yisa Zagabe	IRC	22-30 Jun 13	Attend the IRC's Women's Protection and Empowerment Conference on Adolescent Girls	Bukavu/Bangkok
6	Health	Landry-Serges Malaba	MSH	19 Jul-22 Aug 13	Participation in the In-Design Training Workshop.	Kinshasa/Tunis
7	Program Management	Tchim Tabaro	IRC	27 Jul-3 Aug 13	Receive Strategic Orientation at MSH home offices and present brownbag on IHP accomplishments to date and way forward	Kinshasa/New York/Boston
8	BCC	Jean Baptiste Mputu	OSC	15-21 Sep 13	Participate in the PMI workshop on the use of effective BCC in the prevention and treatment of malaria	Kinshasa/Addis Ababa

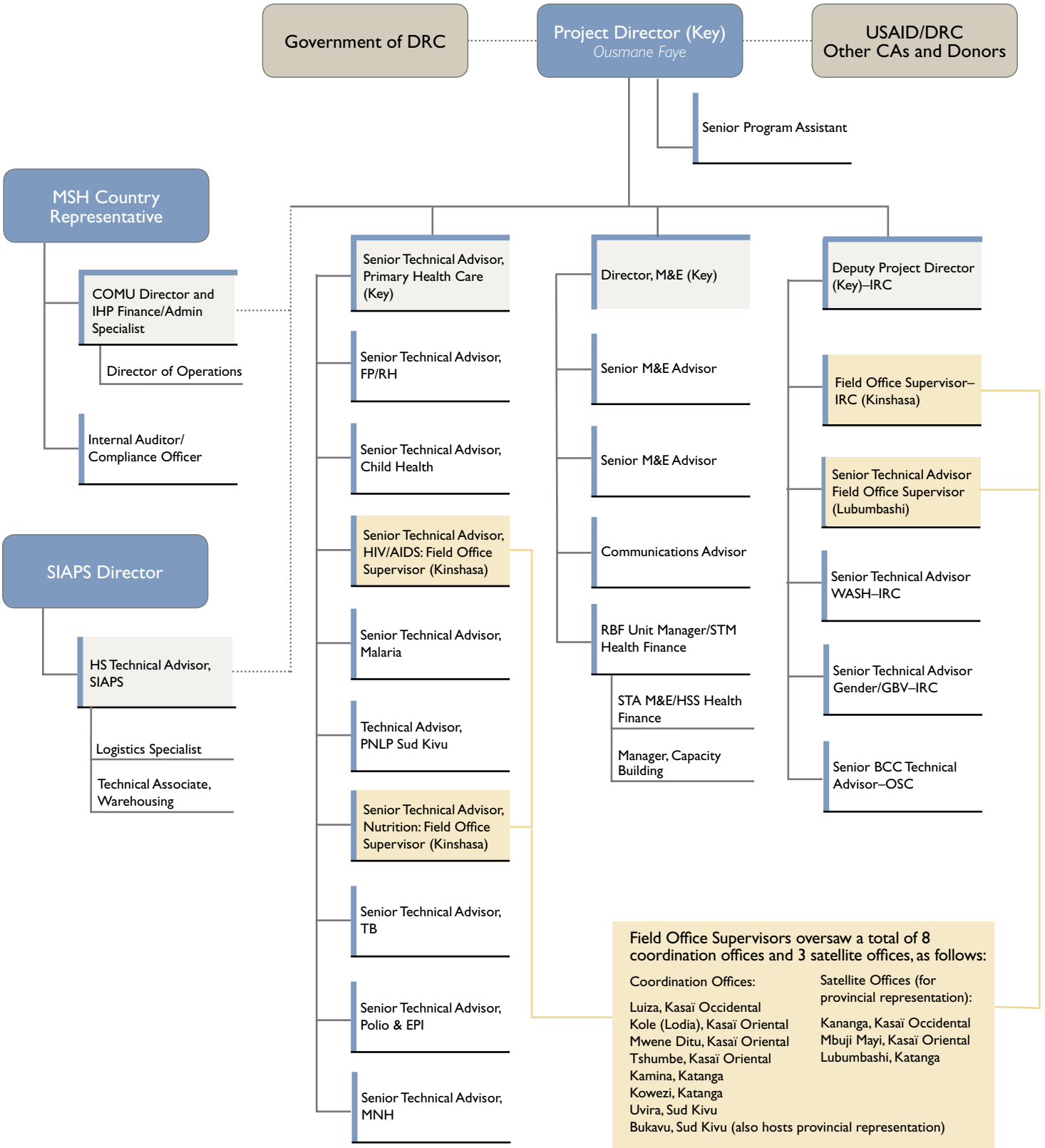
STTA/Project Managment and Monitoring: International Travel PY4						
1	Program Management	Kristin Cooney	MSH	1-14 Feb 14	Provide technical and management support and visit project sites	Boston/Kinshasa
2	Program Management	Steve Morgan	MSH	10 Feb-11 Mar 14	Provide financial and administrative assistance	Kabul/Kinshasa
3	Supply Chain Management	Atanas Stoilov	MSH	25 Mar-27 Apr 14	Provide technical support and capacity building support on supply chain management	Boston/Kinshasa
4	RBF	Alfred Antoine Uzabakiliho	MSH	30 Mar-12 Apr 14	Provide technical support for RBF activities	Kigali/Kinshasa
5	Workplanning	Aboubakar Mama Sambo	MSH	5-25 Apr 14	Provide interim coverage as IHP Finance and Administrative Specialist and COMU Director for MSH DRC	Boston/Kinshasa
6	MNCH	Ciro Franco	MSH	15 Apr-1 May 14	Provide technical support for MNCH components	Boston/Kinshasa
7	Communications	Elizabeth Walsh	MSH	24 May-8 Jun 14	Provide technical and management support to communications team	Boston/Kinshasa
8	BCC	Paul Neely	OSC	14-29 Jun 14	Conduct research and explore options for a low-cost, potentially community-based hotline system that could eventually be established across all of IHP's health zones with CUGs	Montreal/ Kinshasa
9	Workplanning	Kristin Cooney	MSH	5-20 Jul 14	Provide technical and management support during workplanning workshop	Boston/Kinshasa
10	Workplanning	Amy Daffe	OSC	12-24 Jul 14	Provide technical and management support during the PY5 workplanning workshop, and continue assistance with finalizing the workplan post-workshop	Philadelphia/ Kinshasa
11	Workplanning	Joan Marshall-Missiye	MSH	12-26 Jul 14	Provide technical and management support during workplanning workshop	Boston/Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
12	M&E	Nancy Nolan	MSH	18 Jul-11 Aug 14	Provide technical and capacity building support to local M&E staff	Boston/Kinshasa
13	Workplanning	Christelle Celestin	MSH	19 Jul-4 Aug 14	Provide technical and financial support during workplanning workshop	Boston/Kinshasa
14	BCC	Amelie Sow-Dia	OSC	18-24 Aug 14	Evaluate the implementation of the ETL approach, focusing on the RACOJ youth association network in Mwene Ditu; and update the M&E guidelines and tool for subsequent evaluations	Baltimore/ Kinshasa
International Travel: IHP Local Staff and Partners PY4						
1	i-CCM	Narcisse Naia Embeke	MSH	7-11 Oct 13	Participate in and present during Diarrhea and Pneumonia Working group, and present IHP i-CCM work to the MSH home office	Kinshasa/D.C./ Boston
2	Program Management	Ousmane Faye	MSH	6-22 Nov 13	Participate in the 3rd Global Forum on Human Resources for Health, visit US Congress to enhance project visibility, and work on IHP PY4 workplan and budget	Kinshasa/Recife/ D.C./Boston
3	Child Health	Narcisse Naia Embeke	MSH	3-7 Mar 14	Participate in an international symposium on IMCI	Kinshasa/Accra
4	BCC	Jean-Baptiste Mputu	OSC	7-9 Apr 14	Present a poster at the Fourth International Conference on M4D Mobile Communication for Development in Dakar, Senegal	Kinshasa/Dakar

STTA/Project Managment and Monitoring: International Travel PY5						
1	Program Management	Kristin Cooney	MSH	4-17 Oct 14	Provide technical and management support, and visit project sites	Boston/Kinshasa
2	Contracts	Kelley Scarmeas	MSH	18-24 Oct 14	Provide contractual technical and management support	Boston/Kinshasa
3	Communications	Elaisha Stokes	MSH	24 Nov-15 Dec 14	Visit project sites to develop video that documents and promotes project results, specifically focusing on project's strongest contributions to "A Promise Renewed"	Boston/Kinshasa
4	Monitoring and Evaluation	Monita Baba Djara	MSH	10-30 Jan 15	Provide M&E technical support in preparation for project close-out	Boston/Kinshasa
5	RBF	Jean Kagubare	MSH	22 Mar-2 Apr 15	Provide technical support for RBF activities	Boston/Kinshasa
6	Program Management	Kristin Cooney	MSH	4-17 Apr 15	Provide technical and management support	Boston/Kinshasa
7	Operations	Kevin Fitzcharles	MSH	19-30 Apr 15	Provide operational close-out support to Country Operations Management Unit (COMU) and project team	DC/Kinshasa
8	Communications	Carole Douglis	MSH	4-27 May 15	Develop materials that document and promote project results	D.C./Kinshasa
9	Program Management	Kristin Cooney	MSH	11 May-1 Jun 15	Provide COP coverage during Ousmane Faye's leave	Boston/Kinshasa
10	Health Systems and Innovation	Olivier Raynaud	MSH	18-29 May 15	Provide technical assistance to document project innovations	D.C./Kinshasa
11	BCC	Lynn Lawry	OSC	19 May-6 Jun 15	Evaluate implementation of the Champion Communities approach	D.C./Kinshasa
12	Monitoring and Evaluation	Ismail Yusuf Koleleni	MSH	21 Jun-31 Aug 15	Install and adapt the technical architecture for the DHIS 2 to meet project information management needs	Dar Es Salaam/ Kinshasa

N°	Technical Area	Traveler's Name	ORG	Travel Dates	Indicative Scope of Work	Origin/ destination
13	Communications	Rebecca Weaver	MSH	27 Jul-21 Sep 15	Support the project team to carry out an effective communication strategy and lead the development of new project publications and communication materials	Brussels/Kinshasa
14	Operations	Christele Joseph-Pressat	MSH	3-22 Aug 15	Provide operational close-out support to Country Operations Management Unit (COMU) and project team	Boston/Kinshasa
15	Contracts	Kelley Scarmeas	MSH	31 Aug-9 Sep 15	Provide contractual technical and management support	Boston/Kinshasa
16	BCC	Dr Lynn Lawry	OSC	18 Sep-4 Oct 15	Develop an impact evaluation of the effectiveness and sustainability of the Champion Community approach and of Closed User Groups and SMS campaigns	D.C./Kinshasa
17	Program Management	Kristin Cooney	MSH	26 Sep-17 Oct 15	Provide technical and management support during close-out	Boston/Kinshasa
18	Contracts	Ned Heltzer	MSH	October 4-10, 2015	Negotiate a Procurement Services Agreement with ASRAMES (IHP covered airfare only)	Philadelphia/ Kinshasa
International Travel: IHP Local Staff and Partners PY5						
1	Project Management	Rood Merveille	MSH	3-14 Nov 14	Attend home office orientation, briefing, and meetings with key staff	Kinshasa/Boston
2	i-CCM	Narcisse Embeke	MSH	11-21 Nov 14	Present a poster on Collaborative Approach at APHA Conference	Kinshasa/New Orleans
3	i-CCM	Dr. Fidele Ilunga Mubayi	MOH	11-21 Nov 14	Present a poster on Collaborative Approach at APHA Conference	Kinshasa/New Orleans
4	M&E	Sam Mbuyamba	MSH	7-12 Dec 14	Attend PEPFAR DATIM Training of Trainers	Kinshasa/ Johannesburg
5	EPI	Joseph Kongolo	MSH	23-27 Feb 15	Attend WHO Central Africa EPI Manager's Meeting	Kinshasa/Douala
6	Health	Narcisse Embeke	MSH	24 May-3 Jun 15	Participate in UNICEF Pneumonia and Diarrhea workgroup in NYC and visit MSH home office to meet with key staff	Kinshasa/NYC/ Boston
7	M&E	Derek Kahongo	MSH	9-18 Jun 15	Attend DHIS 2 Academy	Kinshasa/ Cotonou
8	Program Management	Dorah Kashosi	MSH	14-20 Jun 15	Attend the Leadership, Management and Governance Coaching Program conference	Kinshasa/ Kampala
9	Nutrition	Matthieu Koy	MSH	13-31 Oct 15	Attend Global Maternal Newborn Health conference to present IHP Nutrition results and share findings with MSH home office	Kinshasa/Boston/ Mexico City
10	RBF	Delmond Kyanza	MSH	13-31 Oct 15	Attend Global Maternal Newborn Health conference to present IHP RBF results and share findings with MSH home office	Kinshasa/Boston/ Mexico City

Appendix 3. Organizational structure of Kinshasa office headquarters, IHP



Appendix 4a. Selected LiST scenario — Coverage rate projections for select indicators run by DRC-IHP in September 2012

Indicator	Coverage Rate by Year					
Nutrition	Baseline	2011	2012	2013	2014	2015
Percent of children receiving only breastmilk for food (plus medication, vaccines, and vitamins).	54.7	55.8	56.8	57.9	58.9	60.0
Percent of mothers intensively counseled on the importance of continued breastfeeding beyond 6 months and appropriate complementary feeding practices. and given appropriate supplements. Standard indicator would be the % of 6-23 month old children receiving all three ICYF practices. The three ICYF practices refer to continued breastfeeding. appropriate quantity and diversity of diet. When this data is not available it is possible to use the percent of children 6-9 months old receiving breastmilk and complementary foods.	23.1	24.5	25.9	27.2	28.6	30.0
Percent of children 6-59 months of age receiving 2 doses of Vitamin A during the last 12 months.	76.0	78.8	81.6	84.4	87.2	90.0

Vaccines	Baseline	2011	2012	2013	2014	2015
Percent of children 12-23 months who have received 3 doses of pentavalent vaccine.	32.0	41.6	51.2	60.8	70.4	80.0
Percent of neonates receiving at least three doses of polio vaccine.	58.0	62.4	66.8	71.2	75.6	80.0
Percent of children 12-23 months who have received 1 dose of measles vaccine.	68.0	71.4	74.8	78.2	81.6	85.0

Children under 5 years of age	Baseline	2011	2012	2013	2014	2015
Percent of children with suspected diarrhea treated with oral rehydration solution. including sachets or pre-mixed solutions. This indicator does not include homemade sugar-salt solution or recommended home fluids due to lack of adequate data. Also. note that this is an indicator of appropriate diarrhea treatment. This does not suggest that increased fluids, continuous feeding, or ORT should not be recommended.	29.3	33.4	37.6	41.7	45.9	50.0
Percent of children 6-59 months of age with suspected diarrhea treated with 20mg of zinc daily.	0.0	10.0	20.0	30.0	40.0	50.0
Percent of children with suspected pneumonia treated with appropriate antibiotics.	62.3	63.8	65.4	66.9	68.5	70.0
Percent of children treated within 48 hours of the onset of fever in malaria endemic areas with an artmesinin containing compound.	33.0	38.3	43.7	49.0	54.3	59.7

Indicator	Coverage Rate by Year

Neonates (under 1 month of age)	Baseline	2011	2012	2013	2014	2015
Percent of premature neonates receiving facility-based Kangaroo Mother Care. Kangaroo Mother Care is defined as continuous skin-to-skin contact between a mother and her newborn as well as frequent and exclusive breastfeeding.	25.0	29.0	33.0	37.0	41.0	45.0
Percent of neonates with suspected sepsis/pneumonia treated with oral antibiotics.	12.5	13.8	15.0	16.3	17.5	18.8
Percent of neonates with suspected sepsis/pneumonia treated with injectable antibiotics.	37.5	41.2	45.0	48.7	52.5	56.2
Percent of neonates who are protected at birth (PAB) from tetanus infection. PAB is defined as the percent of women who received two doses of tetanus toxoid during this pregnancy or ever: Received at least 2 doses. the last within 3 years; Received at least three doses. the last within 5 years; Received at least 4 doses. the last within 10 years. Received at least five doses during lifetime. Also known as TT2+.	46.6	52.3	58.0	63.6	69.3	75.0

Maternal	Baseline	2011	2012	2013	2014	2015
IPT: Percent of pregnant women receiving 2+ doses of Sp/Fansidar during pregnancy or sleeping under an insecticide treated bednet.	26.1	32.9	39.7	46.4	53.2	60.0
Percent of women who go to four or more antenatal care visits during their pregnancy (ANC 4+). (Notes: This has no impact alone. It is used to estimate the coverage of syphilis detection and treatment. calcium supplementation. and case management indicators.)	46.8	49.8	52.9	55.9	59.0	62.0
Percent of women with their third stage of labor managed actively. Active management of the third stage of labor (AMTSL) is defined as controlled cord traction, uterine massage, and appropriate oxytocics.	75.0	77.0	79.0	81.0	83.0	85.0

Preventative (all groups)	Baseline	2011	2012	2013	2014	2015
Improved water source (percent of households having an improved water source within 30 minutes)	41.8	43.2	44.6	46.0	47.4	48.8
Improved sanitation - Utilization of latrines or toilets (percent of households using and improved sanitation facility)	6.3	7.6	9.0	10.3	11.7	13.0
Percent of households owning at least 1 insecticide treated bed net or protected by indoor residual spraying.	46.6	53.3	60.0	66.6	73.3	80.0

Baseline study conducted at the start of the project. 2011

Appendix 4b. LiST Lives Saved 2012 (projected), vs. 2015 (measured)

Number of lives saved for children aged 1-59 months by intervention relative to impact year Integrated Health Project, Democratic Republic of Congo			
Pregnancy	Baseline	Total predicted in 2012	Total calculated PY2–PY5
IPTp: Pregnant women protected via intermittent preventive treatment of malaria during pregnancy or by sleeping under an LLIN	0	45	120
Micronutrient supplementation (multiple micronutrients + iron folate)	0	*	56
Preventive			
Appropriate complementary feeding	0	397	*
Vitamin A supplementation	0	2,465	4,452
Improved water source	0	816	1,438
Improved sanitation: Utilization of latrines or toilets	0	1,665	7,448
LLIN/IRS Ownership of insecticide treated nets (LLIN/LLIN) or household protected with indoor residual spraying	0	14,363	3,143
Vaccines			
DPT	0	3,767	4,668
Pneumococcal	0	*	1,635
Measles	0	*	895
Hib	0	5,591	10,841
Curative after birth			
ORS (oral rehydration solution)	0	13,345	34,289
Zinc - for treatment of diarrhea	0	6,104	5,794
Oral antibiotics: case management of pneumonia in children	0	4,833	21,357
Antimalarials (Artemesinin compounds for malaria)	0	14,706	43,107
Antibiotics for the treatment of dysentery	0	*	686
Total		68,097	139,929

Source: Integrated Health Project. Health Systems Analysis and LiST Projections. 2012, 2015.

** indicates no data for indicator.*

Number of lives saved for children aged 0-1 months by intervention relative to impact year Integrated Health Project, Democratic Republic of Congo			
Pregnancy	Baseline	Total predicted in 2012	Total calculated PY2–PY5
TT - Tetanus toxoid vaccination	0	275	994
IPTp - Pregnant women protected via intermittent preventive treatment of malaria during pregnancy or by sleeping under an LLIN	0	129	883
Micronutrient supplementation (multiple micronutrients + iron folate)	0	*	436
Syphilis detection and treatment	0	37	*
Promotion of breastfeeding	0	2,144	*
Curative after birth			
KMC - Kangaroo mother care	0	3,560	*
Injectible/oral antibiotics	0	*	4,627
Case management of severe neonatal infection	0	5,707	2,304
ORS (oral rehydration solution)	0	628	1,792
Total		12,480	11,036

Source: Integrated Health Project. Health Systems Analysis and LiST Projections. 2012, 2015.
** indicates no data for indicator*

Appendix 5a. Essential generic medicines ordered and delivered during IHP (PY1–PY5*) in USD

Province	Warehouse or CDR	PY	Order Value (USD)	Delivery Value (USD)	% Delivered
Sud Kivu	APAMESK, DCMP 8eCEPAC and BDOM	PY1	$473,383	$388,174	82.0%
		PY2	$730,697	$720,167	98.6%
		PY3	$882,084	$810,626	91.9%
		PY4	$1,243,630	$1,183,198	95.1%
		PY5*	$268,752	$61,405	22.8%
		TOTAL	$3,598,547	$3,163,570	87.9%
Katanga	CEDIMEK	PY1	$158,029	$115,614	73.2%
		PY2	$364,513	$317,326	87.1%
		PY3	$585,498	$510,757	87.2%
		PY4	$599,135	$583,729	97.4%
		PY5*	$135,293	$43,929	32.5%
		TOTAL	$1,842,469	$1,571,355	85.3%
Katanga	KOLWEZI	PY1	$158,050	$112,295	71.1%
		PY2	$229,767	$190,048	82.7%
		PY3	$370,231	$339,793	91.8%
		PY4	$261,713	$271,563	103.8%
		PY5*	$122,281	$37,992	31.1%
		TOTAL	$1,142,043	$951,690	83.3%
Kasaï Occidental	CADIMEK	PY1	$158,144	$110,717	70.0%
		PY2	$378,325	$366,023	96.7%
		PY3	$558,845	$489,323	87.6%
		PY4	$430,625	$409,492	95.1%
		PY5*	$147,658	$42,133	28.5%
		TOTAL	$1,673,597	$1,417,688	84.7%
Kasaï Oriental	CADMEKO	PY1	$157,759	$112,056	71.0%
		PY2	$219,714	$186,630	84.9%
		PY3	$485,314	$442,566	91.2%
		PY4	$719,109	$711,440	98.9%
		PY5*	$177,240	$33,136	18.7%
			$1,759,135	$1,485,829	84.5%
Kasaï Oriental	FODESA	PY1	$157,773	$116,916	74.1%
		PY2	$268,523	$267,333	99.6%
		PY3	$453,546	$429,173	94.6%
		PY4	$581,820	$542,621	93.3%
		PY5*	$173,751	$39,357	22.7%
			$1,635,414	$1,395,401	85.3%
TOTAL VALUE Ordered/Delivered			$11,651,204	$9,985,533	85.7%

**PY5 1st and 2nd orders only. Figures may not add up exactly due to rounding.*

N.B.: During PY5, SIAPS launched 2 emergency orders. The first order 's delivery is ongoing, and the second one has not started yet. PY5 total value is estimated at $1,024,975, with the first order being valued at $322,333 and the second one at $702,642.

Appendix 5b. Medicine value and logistical costs summary

	Delivery value from PY1 to PY5 (USD)	Logistical cost to CDRs (USD)	Logistical costs from CDRs to facilities	Management cost at CDRs (8% value)	Total Cost
Essential generic medicines purchased by IHP	$9,985,533	$5,053,921	$1,350,680	$798,843	
PMI comodities (ACT, RDT, LLIN, etc.) purchased by UNILEVER	$16,981,974	$5,094,592		$1,358,558	
HIV products purchased by SCMS	$761,466	$228,440		$60,917	
Family planning commodities purchased by USAID and managed by MSH	$1,695,707	$508,712		$135,657	
TOTALS	$29,424,679.72	$10,885,665.39	$1,350,680.40	$2,353,974.10	$44, 014,999.61

N.B.:This table presents the total value of commodities purchased by using both IHP and other types of funds, for which storage and distribution costs were paid by IHP.

Appendix 6. Activities carried out during 2 years of RBF implementation

N°	Activities	Planned	Implemented	%	Comments
1	Development and approval of quarterly workplans	792	792	100	In 42 health zone management teams, 42 GRHs, and 708 health centers
2	Technical verification (within RBF program structure)	790	792	99.7	Elingopango health center suffered a fire in Year 1 Quarter 3
3	Community verification of results	722	722	100	Data from 792 contracting structures. The GRH data concerns Year 1 Semester 1
4	Payments received by the structures (DPS, health zone management team, GRH, HC)	792	792	100	Payment of performance bonuses to 792 contracting structures
5	Payments received by the CBOs	84	84	100	Payment of bonuses to 84 contracting CBOs
6	Supervisory/coaching visits	27	25	92.6	
7	Supervisory/coaching visits (national, DPS, health zone management team)	810	641	79.1	
8	Review of RBF activities	3	2	67	1 annual review and 1 6-month review conducted during Year 1 of RBF
9	Set-up and usage of the DRC RBF Web portal	1	1	100	
10	Interns from the School of Public Health coached in the RBF program	8	8	100	
11	RBF studies funded by IHP	2	2	100	To obtain a Masters in Health Economics from the School of Public Health
12	Abstracts on RBF accepted at the international level	1	2	200	Presented at conferences in Mexico City and Washington, D.C.
13	Monitoring hygiene in health centers	942	944	99.8	Elingopango health center suffered a fire in Year 1 Quarter 3
14	Monitoring hygiene in general referral hospitals	56	56	100	

Appendix 7. Documents and/or tools developed by the MOH with support from DRC-IHP

N°	Document Description	Justification	Usage		Contribution Type			Status
			Internal	External	Technical	In-kind	Financial	
Child Health								
1	Health facility care services flowchart			✔	✔	✔	✔	Distributed to health facilities
2	Health facility care services flowchart training guide			✔	✔	✔		Distributed to health facilities
3	Child care form for community care sites			✔	✔			Distributed to health facilities
4	Community care site supervision checklist		✔	✔	✔	✔		Distributed to health facilities
5	Community health workers manual (revised version)			✔	✔		✔	Distributed to health facilities
6	Integrated management of childhood illness (IMCI) booklet (revised version)			✔	✔	✔		
Malaria								
7	Artemisinin-based Combination Therapy (ACT) poster	Facilitate ACT correct dosage per age group	✔		✔	✔		Distributed to health facilities
8	Standart Diagnostics Bioline Rapid Diagnostic Test (RDT) job aid	Facilitate Standart Diagnostics Bioline RDT correct usage	✔	✔	✔	✔	✔	Distributed to health facilities
9	Injectable artesunate job aid	Facilitate treatement of severe malaria	✔		✔	✔	✔	Distributed to health facilities
10	Artesunate suppository job aid	Facilitate pre-referral treatment of severe malaria	✔		✔	✔	✔	Distributed to health facilities
11	Malaria guidance card	Raise community awareness on malaria preventive measures and early diagnostic and treatment through recognizing warning signs	✔		✔	✔	✔	Distributed to health facilities
12	Insecticide-treated mosquito net (LLIN) poster	Raise community awareness on LLIN usage during Tuendeni-Kumpala campaign			✔	✔	✔	Distributed to health facilities
13	LLIN themed tee shirts, hats and calendars	Raise community awareness on LLIN usage during Tuendeni-Kumpala campaign	✔		✔	✔	✔	Distributed to health facilities
14	2012 National Malaria Control Program performance review		✔	✔	✔		✔	The National Malaria Steering Committee is conducting the final review before dissemination

N°	Document Description	Justification	Usage		Contribution Type			Status
			Internal	External	Technical	In-kind	Financial	
15	National Malaria Control Program Strategic Plans for 2013-2015 and 2016-2020		✔	✔	✔			The National Malaria Steering Committee is conducting the final review before dissemination
16	Technical guides for malaria care at general referral hospitals and health centers (revised version)		✔	✔	✔			Distributed to health facilities
17	Feasibility study on the use of artesunate suppository in pre-referral treatment of severe malaria with children under five treated in community care sites		✔		✔	✔	✔	Ongoing
18	Tuendeni Kumpala LLIN behavioral change/ awareness campaign materials	Raise community awareness on LLIN usage in 20 health areas and 10 health zones	✔		✔	✔	✔	Distributed to health zone management offices
MNCH								
19	MNCH norms and guidelines kits			✔	✔	✔		Distributed to health facilities
20	Registry kit (19 registries for health centers and GRH) and guide on how to fill a registry			✔	✔	✔		Distributed to health facilities
21	Addendum to MNCH norms and guidelines			✔	✔	✔		Distributed to health facilities
22	Community care sites register kit (3 per community)			✔	✔	✔		Distributed to health facilities
23	Register for community care sites			✔	✔	✔		Distributed to health facilities
24	Partograph			✔	✔	✔		Distributed to health facilities
25	Antenatal consultation form			✔	✔	✔		Distributed to health facilities
26	Postnatal consultation form			✔	✔	✔		Distributed to health facilities
27	Family planning consultation form			✔	✔	✔		Distributed to health facilities
28	IMCI form for newborns between 0-2 months			✔	✔	✔		Distributed to health facilities
29	IMCI form for newborn between 2-59 months			✔	✔	✔		Distributed to health facilities

N°	Document Description	Justification	Usage		Contribution Type			Status
			Internal	External	Technical	In-kind	Financial	
30	Tracking sheet for newborns who benefit/ benefited from the kangaroo mother care technique			✔	✔	✔		Distributed to health facilities
31	Pre-school consultation form			✔	✔	✔		Distributed to health facilities
32	Active management of the third stage of labor poster			✔	✔	✔		Distributed to health facilities
33	Helping babies breathe poster			✔	✔	✔		Distributed to health facilities
34	Eclampsia poster			✔	✔	✔		Distributed to health facilities
35	Norms and guidelines popularisation guide			✔	✔	✔		Distributed to health facilities
36	Dexamethasone poster			✔	✔	✔		Distributed to health facilities
37	Post exposure prophylaxis treatment kit			✔	✔	✔		Distributed to health facilities
38	Magnesium sulfate protocol for health center			✔	✔	✔		Distributed to health facilities
39	Magnesium sulfate protocol for general referral hospitals			✔	✔	✔		Distributed to health facilities
40	Antenatal consultation services poster			✔	✔	✔		Distributed to health facilities
41	Helping mothers survive poster			✔	✔	✔		Distributed to health facilities

Publications			
Publication site	Location	Link or Source	Authors
American Society of Tropical Medicine and Hygiene (ASTMH)	Washington	http://www.astmh.org/Abstracts_and_Education1.htm	J. Otshudiema, N. Embeke;
American Public Health Association	New Orleans	https://apha.confex.com/apha/142am/webprogram/Paper311578.html	N. Embeke, C. Franco, Ilunga
CCMCentral	NewYork	http://ccmcentral.com/wp-content/uploads/2014/07/2013.09.25-MDG4-Special-donor-session-on-financing-DP-treatment-gaps-NYC-Concept-Notes_UNICEF_2013.pdf	C. Franco; N. Embeke
Frontline Health Workers Coalition Blog & MSH Global Health Impact Blog	Washington & Medford	bit.ly/1GIVUEM & http://ow.ly/TX7cU	N. Embeke
MSH Global Health Impact Blog	Medford	Helping Children Survive in Democratic Republic of the Congo: A Family Tradition | Management Sciences for Health	E. Judem

Appendix 8. List of success stories PY1–PY5

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
6 May 11	Kasaï Oriental	Dikungu-Tshumbe	Leadership Development Program		Leadership Skills Increase Patient Visits	PY1Q2
4 Aug 11	Kasaï Oriental	Kole	Family Planning		Promoting the Benefits of Family Planning in Kole	PY1Q3
4 Aug 11	Kasaï Oriental	Kamiji	Immunization		Immunizing Children against Polio to Ensure a Healthy Future	PY1Q3
4 Aug 11	Sud Kivu	not specified	Water, Sanitation, Hygiene		Community Participation for Better Water, Sanitation, and Hygiene	PY1Q3
31 Oct 11	Sud Kivu	Mulamba	Water, Sanitation, Hygiene		Clean water, better health in Mulambi	PY1Q4 (quarterly and annual for PY1)
31 Oct 11	Kasaï Oriental	Tshumbe	Malaria		Strengthening Malaria Treatment Services in Tshumbe	PY1Q4 (quarterly and annual for PY1)
31 Oct 11	Sud Kivu	Katana	Maternal, Newborn and Child Health	Malaria	Protecting Mothers and Babies from Malaria in Katana	PY1Q4 (quarterly and annual for PY1)
31 Oct 11	Kasaï Oriental	Kalenda	Tuberculosis		Improving Treatment of Tuberculosis in Kalenda	PY1Q4 (quarterly and annual for PY1)
15 Feb 12	Kasaï Occidental	Ndekesha	Family Planning		Bicycle Donations Increase Family Planning Outreach	PY2Q1
15 Feb 12	Kasaï Oriental	Kole	Water, Sanitation, Hygiene		Community Mobilizes to Improve Hygiene Conditions	PY2Q1
15 Feb 12	Sud Kivu	Bukavu	Water, Sanitation, Hygiene		Clean Hands for Healthier Living in the DRC	PY2Q1
15 May 12	Katanga	Dilala	Behavorial Change Communication		Mobilizing Blood Donors in Dilala	PY2Q2
15 May 12	Katanga	Fungurume	Maternal, Newborn and Child Health	Kangaroo Mother Care	Kangaroo Mother Care Saves Lives of Littlest Babies	PY2Q2
21 Aug 12	Sud Kivu	Katana	Maternal, Newborn and Child Health	Malaria	Protecting pregnant women against malaria	PY2Q3
21 Aug 12	Kasaï Oriental	Mwene Ditu	Behavorial Change Communication/ Education Through Listening	Human Immuno-deficiency Virus	Empowering Youth to Fight Human Immunodeficiency Virus/AIDS in Mwene Ditu	PY2Q3

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
21 Aug 12	Katanga	Kolwezi	Behavorial Change Communication	Human Immuno-deficiency Virus	Friendly Competition Educates Youth about Human Immunodeficiency Virus Prevention	PY2Q3
21 Aug 12	Sud Kivu	Kaziba	Maternal, Newborn and Child Health	Fistula (obstetric)	Recovering proudly from obstetric fistula	PY2Q3
21 Aug 12	Sud Kivu	Mulungu	Medecines delivery		Delivering Medicines in the Face of Insecurity	PY2Q3
15 Nov 12	Kasaï Occidental	Luiza	Maternal, Newborn and Child Health	Fistula (obstetric)	A Husband and Wife Reunited in Luiza, thanks to Fistula Repair	PY2Q4 (quarterly and annual for PY2)
15 Nov 12	Sud Kivu	Idjwi	Maternal, Newborn and Child Health	Helping Babies Breathe	Supporting Safer Deliveries through "Helping Babies Breathe"	PY2Q4 (quarterly and annual for PY2)
15 Nov 12	Sud Kivu	Lemera	Leadership Development Program	Maternal, Newborn and Child Health	Improving Prenatal Care through Leadership Development	PY2Q4 (quarterly and annual for PY2)
15 Nov 12	Kasaï Oriental	Mwene Ditu	Behavorial Change Commun-ication/Closed User Groups	Access to care	Increasing Health Center Referrals in Mwene Ditu with Mobile Phones	PY2Q4 (quarterly and annual for PY2)
15 Nov 12	Sud Kivu	Uvira	Leadership Development Program	Human Immuno-deficiency Virus	Leadership Development Facilitates Human Immunodeficiency Virus Testing of Women in Uvira	PY2Q4 (quarterly and annual for PY2)
15 Feb 13	Kasaï Occidental	Dekese	Medecines delivery	Maternal, Newborn and Child Health	Delivering Medicines to Improve Maternal & Child Health in Dekese	PY3Q1
15 Feb 13	Kasaï Oriental	Lodja	Nutrition	Exclusive Breastfeeding	Reducing Malnutrition through Exclusive Breastfeeding	PY3Q1
15 Feb 13	Kasaï Occidental	Dekese	Family Planning		Increasing Family Planning Rates in Dekese	PY3Q1
15 Feb 13	Sud Kivu	Kadutu	Water, Sanitation, Hygiene		Celebrating Global Hand Washing Day in the Kadutu Health Zone	PY3Q1
15 Feb 13	Kasaï Occidental	Bilomba	Water, Sanitation, Hygiene		Improving Water, Hygiene, and Sanitation in the Village of Lubemba	PY3Q1
15 Feb 13	Katanga	Kanzenze	Water, Sanitation, Hygiene		Collaborating for Safe Drinking Water in Nkomesha Village	PY3Q1
15 Feb 13	Katanga	Kanzenze	Leadership Development Program	Access to care	Community Efforts Lead to New Health Center in Disombo	PY3Q1

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 Feb 13	Kasaï Oriental	Mwene Ditu	Maternal, Newborn and Child Health		Reducing Post-Cesarean Infection Rates in Mwene Ditu	PY3Q1
15 Feb 13	Sud Kivu	Uvira	Behavorial Change Communication/ Education Through Listening	Malaria	Catching Mosquitos, not Fish: Using Bed Nets Properly in Sud Kivu	PY3Q1
15 Feb 13	Sud Kivu	Uvira	Maternal, Newborn and Child Health		Blood Donations Saving Mothers' and Babies' Lives in Uvira	PY3Q1
15 May 13	Kasaï Occidental	Demba	Access to Care	Community Health Worker	From Seamstress to Community Health Worker: Justine's Story	PY3Q2
15 May 13	Kasaï Oriental	Kole	Nutrition	Exclusive Breastfeeding	Fostering Child Health through Exclusive Breastfeeding	PY3Q2
15 May 13	Katanga	Fungurume	Maternal, Newborn and Child Health	Helping Babies Breathe	Helping Babies Breathe: Three Minutes Saves a Baby's Life	PY3Q2
15 May 13	Sud Kivu	Walungu	Maternal, Newborn and Child Health	Malaria	Protecting Children with Bed Nets in Sud Kivu	PY3Q2
15 May 13	Kasaï Oriental	Lusambo	Maternal, Newborn and Child Health	Malaria	Protecting Expectant Mothers from Malaria	PY3Q2
15 May 13	Kasaï Oriental	Mpokolo	Malaria		Improving Malaria Testing and Treatment in Mpokolo	PY3Q2
15 May 13	Katanga	Mukanga	Quality of care		Improving the Quality of Care at Mukanga General Referral Hospital	PY3Q2
15 May 13	Kasaï Oriental	Kole	Water, Sanitation, Hygiene		New Water Sources Reduce Diarrheal Illnesses in Kole	PY3Q2
15 May 13	Kasaï Oriental	Mwene Ditu	Behavorial Change Communication	Education Through Listening	Youth-led Community Outreach Increases Health Center Referrals	PY3Q2
15 Aug 13	Kasaï Oriental	Lomela	Maternal, Newborn and Child Health	Helping Babies Breathe	Increasing Child Survival with the "Helping Babies Breathe" Technique	PY3Q3
15 Aug 13	Kasaï Occidental	Lubondaie	Maternal, Newborn and Child Health	Integrated Community Case Management	i-CCM: Providing Better Care for Children through "Community Care Sites"	PY3Q3
15 Aug 13	Kasaï Occidental	Luiza	Maternal, Newborn and Child Health	Helping Babies Breathe	Helping Babies Breathe at the Luiza General Referral Hospital	PY3Q3
15 Aug 13	Kasaï Oriental	Kole	Water, Sanitation, Hygiene		Improving Sanitation and Hygiene in the village of Mongosenge	PY3Q3

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 Aug 13	Kasaï Oriental	Mwene Ditu	Water, Sanitation, Hygiene	Quality of care	New Latrines Improve Hospital Hygiene in Tshamala	PY3Q3
15 Aug 13	Kasaï Occidental	Luiza	Behavorial Change Communication/ Education Through Listening		Community Mobilizes to Fund Health Services Projects in Luiza	PY3Q3
15 Aug 13	Sud Kivu	Katana	Maternal, Newborn and Child Health	Nutrition	Reducing the Number of Low Birth Weight Babies in Ihimbi	PY3Q3
15 Nov 13	Kasaï Oriental	Kole	Nutrition	Exclusive Breastfeeding	Encouraging Mothers to Practice Exclusive Breastfeeding in Kole	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Kasaï Oriental	Dikungu-Tshumbe	Maternal, Newborn and Child Health	Fistula (obstetric)	A Return to Dignity after Fistula Repair	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Katanga	Kolwezi	Maternal, Newborn and Child Health	Fistula (obstetric)	Recovering Smiles in Kolwezi after Fistula Repair Campaign	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Kasaï Oriental	Sankuru	Immunization	Maternal, Newborn and Child Health	Cold Chain Guaranteed Children's Vaccines in Sankuru	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Sud Kivu	Uvira	Immunization		Immunizing Children in Challenging Circumstances in Haut Plateaux	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Sud Kivu	Uvira	Leadership Development Program	Immunization	Improving Immunization Coverage through Leadership Development	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Katanga	Manika	Human Immuno-deficiency Virus	Maternal, Newborn and Child Health	Improving Treatment for Pregnant Women Infected with Human Immunodeficiency Virus in Manika	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Kasaï Oriental	Mwene Ditu	Behavorial Change Communication	Tuberculosis	Increasing Tuberculosis Detection via Community Outreach and Mobilization	PY3Q4 Report (quarterly and annual for PY3)

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 Nov 13	Katanga	Kanzenze	Access to Care		Increasing Access to Health Services in Kaponda	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Sud Kivu	Bukavu	Behavorial Change Communication/ Champion Community		Developing a Champion Community in Walungu, Sud Kivu Province	PY3Q4 Report (quarterly and annual for PY3)
15 Nov 13	Sud Kivu	Minova	Family Planning		Meeting Family Planning Needs in DRC	PY3Q4 Report (quarterly and annual for PY3)
13 Feb 14	Kasaï Oriental	Bibanga	Maternal, Newborn and Child Health		Keeping "A Promise Renewed" in Bibanga	PY4Q1
13 Feb 14	Kasaï Occidental	Yangala	Leadership Development Program	Maternal, Newborn and Child Health	Leadership Program Contributes to Improved Maternal Health Care	PY4Q1
13 Feb 14	Kasaï Oriental	Mwene Ditu	Maternal, Newborn and Child Health	Fistula (obstetric)	Reducing Stigma and Promoting Fistula Treatment in Mwene Ditu	PY4Q1
13 Feb 14	Katanga	Kanzenze	Maternal, Newborn and Child Health	Human Immuno-deficiency Virus	Involving Men in Prevention of Mother-to-Child Transmission of Human Immunodeficiency Virus	PY4Q1
13 Feb 14	Kasaï Oriental	Kanda Kanda	Malaria	Integrated Community Case Management	Community Care Sites Improve Malaria Case Management for Children	PY4Q1
13 Feb 14	Kasaï Oriental	Wikong	Water, Sanitation, Hygiene	Water, Sanitation, Hygiene Committee	Wikong Health Zone Builds 68 Water Sources in One Year	PY4Q1
13 Feb 14	Katanga	Songa	Behavorial Change Communication/ Education Through Listening	Water, Sanitation, Hygiene	Encouraging Household Latrine Construction and Use in Songa	PY4Q1
13 Feb 14	Sud Kivu	Katana	Water, Sanitation, Hygiene		Delivering Drinking Water to Lubona and Mbarhi at Long Last	PY4Q1
13 Feb 14	Kasaï Occidental	Bilomba	Water, Sanitation, Hygiene		Rehabilitated Water Sources Broker Peace in Bilomba	PY4Q1
15 May 14	Kasaï Occidental	Dibaya	Behavorial Change Communication/ Champion Man	Closed User Groups	Promoting Male Engagement in Household Health in Dibaya	PY4Q2

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 May 14	Katanga	Songa	Maternal, Newborn and Child Health	Community Health Worker	A Collaborative Approach to Malaria and Pneumonia Improves Care	PY4Q2
15 May 14	Kasaï Occidental	Luiza	Maternal, Newborn and Child Health	Fistula (obstetric)	Maternal, Newborn and Child Health : Fistula Surgery Restores Woman's Health and Her Joy in Life	PY4Q2
15 May 14	Kasaï Occidental	Luiza	Immunization	Maternal, Newborn and Child Health	Safeguarding Vaccines for Children under Age 5 in Haut Lomami	PY4Q2
15 May 14	Katanga	Kanzenze	Leadership Development Program	Quality of care	Community Effort Gives Mulomba Residents a Renovated Health Center	PY4Q2
15 May 14	Kasaï Occidental	Luiza	Human Immuno-deficiency Virus/ Tuberculosis	Quality of care	Expanding Human Immunodeficiency Virus-Tuberculosis Co-infection Services in Kasaï Oriental Province	PY4Q2
15 May 14	Sud Kivu	Uvira	Tuberculosis	Community Health Worker	Marking World Tuberculosis Day in Uvira	PY4Q2
15 May 14	Kasaï Oriental	Wikong	Water, Sanitation, Hygiene	Water, Sanitation, Hygiene Committee	Strengthening Community Health Committees in Wikong	PY4Q2
15 Aug 14	Kasaï Occidental	Bilomba	Behavorial Change Communication	Malaria	Preventing Malaria Among Women and Children, One Community at a Time	PY4Q3
15 Aug 14	Kasaï Oriental	Kamiji	Behavorial Change Communication/ mHealth	Tuberculosis	A Community Comes Together to Create Awareness of Tuberculosis	PY4Q3
15 Aug 14	Kasaï Oriental	Luilu	Maternal, Newborn and Child Health	Human Immuno-deficiency Virus	Preventing Mother-to-Child Transmission of Human Immunodeficiency Virus in Luilu Health Center	PY4Q3
15 Aug 14	Kasaï Occidental	Luiza	Family Planning	Community Based Distributor	The Mother of Birth Spacing in Luiza: Charlotte's Story	PY4Q3
15 Aug 14	Kasaï Occidental	Luiza	Nutrition		Introducing Supplementary Feeding to Improve Baby's Health	PY4Q3
15 Aug 14	Katanga	Kayamba	Results-based Financing	Quality of care	Results-based Financing Strengthens Services at Kibila Health Center	PY4Q3
15 Aug 14	Kasaï Occidental	Luiza	Results-based Financing	Access to care	Increasing Access to Services Through Results-based Financing	PY4Q3
15 Nov 14	Katanga	Kolwezi	Nutrition	Exclusive Breastfeeding	Fighting Malnutrition in Kolwezi by Promoting Exclusive Breastfeeding	PY4Q4/ Annual Report

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 Nov 14	Kasaï Occidental	Luiza	Behavorial Change Communication/ Education Through Listening	Water, Sanitation, Hygiene	Community Leaders Work to Combat Diarrhea OuTuberculosisreak in Luiza	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Wembo Nyama	Results-based Financing	Quality of care	Results-based Financing Improves Service Utilization in Osomba Health Center	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Lodja	Family Planning		Spacing Births to Reduce Health Risks for Families in Lodja	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Kole	Gender-based Violence	Fistula (traumatic)	Improving Care of Sexual Violence Victims in Kole: Alice's Story	PY4Q4/ Annual Report
15 Nov 14	Kasaï Occidental	Luiza	Maternal, Newborn and Child Health	Helping Babies Breathe	The Golden Minute: Saving Newborns' Lives in the DRC through the "Helping Babies Breathe" Method	PY4Q4/ Annual Report
15 Nov 14	Sud Kivu	Uvira	Maternal, Newborn and Child Health		Reducing Maternal and Neonatal Mortality through Reliable Blood Banks	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Tshumbe	Malaria		Rapid and Accurate: Improving Malaria Case Management for Children in Tshumbe using Rapid Diagnostic Tests	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Dikungu-Tshumbe	Water, Sanitation, Hygiene	Water, Sanitation, Hygiene Committee	Fighting Diarrhea by Improving Water, Hygiene, and Sanitation Conditions in Kasaï Oriental	PY4Q4/ Annual Report
15 Nov 14	Kasaï Oriental	Tshumbe	Family Planning		Happier and Healthier: A Family in Tshumbe Enjoy the Benefits of Family Planning	PY4Q4/ Annual Report
15 Nov 14	Katanga	Kayamba	Results-based Financing	Quality of care	Improving Health Services in a Remote Congolese Village through Results-based Financing	PY4Q4/ Annual Report
23 Feb 15	Katanga	Kanzenze	Results-based Financing	Quality of care	Results-based Financing Improves Health Services through Incentives and Better Management	PY5Q1
23 Feb 15	Kasaï Oriental	Kole	Behavorial Change Communication/ Champion Community	Family Planning	"Champion Community" Champions Family Planning to Reduce Maternal and Child Mortality	PY5Q1
23 Feb 15	Sud Kivu	Miti Murhesa	Behavorial Change Communication	Tuberculosis	Community Members Use Trust, Persuasion to Screen Tuberculosis Sufferers at Home, and Lead Them to Treatment	PY5Q1

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
23 Feb 15	Kasaï Occidental	Luiza	Nutrition	Infant and Young Child Feeding (Infant and Young Child Feeding), Community Health Worker	Feeding Baby Ali: Better Nutrition with Local Foods Gives Children a Healthier Start	PY5Q1
23 Feb 15	Katanga	Kanzenze	Quality of care		"Fix it and They Will Come: Serving More Patients by Renovating Health Centers"	PY5Q1
23 Feb 15	Katanga	Mwambayi	Immunization	Maternal, Newborn and Child Health	Refrigerators Powered by Sunshine Help More Children Get Vaccines	PY5Q1
23 Feb 15	Kasaï Oriental	Bibanga	Results-based Financing	Tuberculosis	Results-based Financing Dramatically Boosts Tuberculosis Detection and Treatment	PY5Q1
23 Feb 15	Kasaï Oriental	Wembo Nyama	Results-based Financing	Quality of care	Revitalizing Health Services through Performance Contracts and Results-based Financing	PY5Q1
23 Feb 15	Kasaï Oriental	Dibindi	Leadership Development Program	Tuberculosis	Setting–and Meeting–Targets for Better Tuberculosis Detection and Care	PY5Q1
15 May 15	Kasaï Oriental	Wembo Nyama	Results-based Financing	Community Based Organisation	Results-based financing inspires a youth group to rebuild a clinic in the Congo	PY5Q2
15 May 15	Sud Kivu	Kamituga	Tuberculosis	Community Health Worker	House to house: Searching for and treating Tuberculosis cases in the Democratic Republic of Congo	PY5Q2
15 May 15	Sud Kivu	Ruzizi	Water, Sanitation, Hygiene	Water, Sanitation, Hygiene Committee	Water at last: Access to drinking water is changing lives in a Congolese village	PY5Q2
15 May 15	Kasaï Occidental	Ndekesha	Maternal, Newborn and Child Health	Kangaroo Mother Care	A life saved at the 11th hour: Training and doing in Ndekesha, DRC	PY5Q2
15 May 15	Sud Kivu	Uvira	Behavorial Change Communication	Human Immunodeficiency Virus, Gender-based Violence, Family Planning	Love in the time of AIDS: Promoting safer sex and family planning on Valentine's Day	PY5Q2
15 May 15	Kasaï Oriental	Mwene Ditu	Community Mobilization	Health Commitee	Going to the People with Sustainable Community Health Committees in Mwene Ditu	PY5Q2

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
15 May 15	Sud Kivu	Miti Murhesa	Gender-based Violence	Fistula (traumatic)	Overcoming the trauma of rape in the DRC: Valence's story	PY5Q2
15 May 15	Kasaï Oriental	Lomela	Results-based Financing	Quality of care	A neglected health center springs to life through results-based financing in the Congo	PY5Q2
14 Aug 15	Kasaï Oriental	Bibanga	Maternal, Newborn and Child Health		Yes, it's possible: No maternal deaths for 6 months in a well trained and equipped health zone in DRC	PY5Q3
14 Aug 15	Sud Kivu	Lemera	Maternal, Newborn and Child Health	Helping Babies Breathe	The Golden Minute: Saving newborns in the DRC	PY5Q3
14 Aug 15	Kasaï Occidental	Luiza	Leadership Development Program	Maternal, Newborn and Child Health	A precious gift: Providing doctors with leadership and management skills in the DRC	PY5Q3
14 Aug 15	Sud Kivu	Bukavu	Behavorial Change Communication/ Champion Community	Family Planning	Championing Modern Family Planning in Bukavu	PY5Q3
14 Aug 15	Kasaï Oriental	Bibanga	Maternal, Newborn and Child Health		Better care for healthier deliveries: increasing the number of antenatal care visits in Kasaï Oriental	PY5Q3
14 Aug 15	Sud Kivu	Miti Murhesa	Malaria	Rapid Diagnostic Tests	Not every fever is malaria: Rapid diagnostic tests provide precision in treating fevers	PY5Q3
14 Aug 15	Kasaï Occidental	Ndekesha	Behavorial Change Communication/ Champion Community	Maternal, Newborn and Child Health	"Champion Communities" visibly boost maternal and child health	PY5Q3
14 Aug 15	Katanga	Kabongo	Maternal, Newborn and Child Health	Helping Babies Breathe	No PowerPoint needed: Teaching birth attendants to save lives with simple methods	PY5Q3
14 Aug 15	Kasaï Occidental	Luiza	Gender-based Violence	Fistula (traumatic)	Restoring dignity to women with fistula: Clémentine's Story	PY5Q3
14 Aug 15	Kasaï Oriental	Kole	Water, Sanitation, Hygiene	Water, Sanitation, Hygiene Committee	Cleaning up a village for health's sake in DRC	PY5Q3
14 Aug 15	Kasaï Oriental	Kanda Kanda	Malaria	Integrated Community Case Management	Saving lives of children with severe malaria: Artesunate suppositories buy time to get to treatment	PY5Q3

Date Published	Province	Health Zone/ Coordination Office/ Commune	Topic	Subtopic or Innovation	Title	Publication
11 Feb 16	Kasaï Occidental	Kakala	Results-based Financing	Maternal, Newborn and Child Health	The 15-km walk to give birth is a thing of the past: Results-based financing inspires a local maternity ward	PY5Q4/Final report
11 Feb 16	Kasaï Occidental	Kalomba	Leadership Development Program		A space to call their own: Leadership Development Program inspires health managers to build their own workplace	PY5Q4/Final report
11 Feb 16	Kasaï Oriental	Tshumbe	Maternal, Newborn and Child Health		Nobody should die from giving birth: Achieving Zero Maternal Deaths in Tshumbe	PY5Q4/Final report
11 Feb 16	Kasaï Oriental	Iwadji	Integrated Community Case Management	Maternal, Newborn and Child Health	Bringing health care right to the village, for healthier children	PY5Q4/Final report
11 Feb 16	Kasaï Occidental	Bilomba	Water, Sanitation, Hygiene	Community Led Total Sanitation	Cleaning up: A Community-Led Total Sanitation Effort in Bilomba, DRC	PY5Q4/Final report
11 Feb 16	Kasaï Oriental	Dikungu	Maternal, Newborn and Child Health	Helping Babies Breathe	"My child came back to life:" training health workers saves new lives in Dikungu, DRC	PY5Q4/Final report
11 Feb 16	Sud Kivu	Mithi Murhesa	Gender-based Violence	Fistula (traumatic)	Gender-based Violence in Mithi Murhesa : Olivia's Story	PY5Q4/Final report
11 Feb 16	Sud Kivu	Katana	Family Planning	Community Based Distributor	Planned families are healthier families: Making family planning services available in Katana Health Zone	PY5Q4/Final report
11 Feb 16	Katanga	Kikondja	Malaria	Maternal, Newborn and Child Health	Saving Lives by Protecting Pregnant Women and Newborns from Malaria	PY5Q4/Final report
11 Feb 16	Katanga	Dilala	Human Immuno-deficiency Virus		One positive, one negative: Counseling a discordant couple in Kolwezi	PY5Q4/Final report
11 Feb 16	Katanga	Dilala	Human Immuno-deficiency Virus	Maternal, Newborn and Child Health	New life for a mother living with Human Immunodeficiency Virus—and hope for others	PY5Q4/Final report
11 Feb 16	Kasaï Occidental	Luiza	Nutrition	Infant and Young Child Feeding	Cooking up health: Demonstrating better nutrition in the Democratic Republic of Congo	PY5Q4/Final report
11 Feb 16	Sud Kivu	Bukavu	Behavorial Change Communication/ Champion Community		"Champion Communities" in Bukavu improve local health – and finances	PY5Q4/Final report
11 Feb 16	Sud Kivu	Bukavu	Maternal, Newborn and Child Health		Training pays off: Saving mothers and new lives in the DRC	PY5Q4/Final report

Appendix 9. Publications and presentations PY1–PY5

Date	Title or Topic	Event (where applicable)	Type	Location (where applicable)
2011				
			Fact Sheet French/ English	
8 Jun	"Vaccinating Children Against Polio in the DRC"		MSH Impact Blog	
30 Jul– 29 Aug		Foire Internationale de Kinshasa (FIKIN)	Photo Powerpoint Poster Handout	Kinshasa, DRC
19 Sep	"Involving Men Along with Women in Family Planning in the DRC"		MSH Stories	
2012				
12–16 Nov	"Mobile Phone Technology to Improve FP"	mHealth Conference	Poster	Dar es Salaam, Tanzania
2013				
3 Jan	"Saving Newborns in DRC - Supporting Safer Deliveries Through Helping Babies Breathe"		MSH Impact Blog	
6 May	"Catching Mosquitoes, Not Fish: Returning Bed Nets to their Proper Use in the DRC"		USAID Impact Blog	
28 May	"From Seamstress to Community Health Worker : Justine's Story"		MSH Stories	
28–30 May	"Against All Odds: Improving Women and Children's Health in the DRC"	Women Deliver	Abstract & Presentation	Kuala Lumpur, Malaysia
31 May	"DRC Making Great Strides in Child Survival"		USAID Impact Blog	
27 Jun	"Powering Quality Hospital Care with Solar Energy"		MSH Stories	
20 Aug	"Increasing TB Detection and Treatment in DRC"		MSH Impact Blog	
25 Nov	"Improving Child Nutrition Through Mothers' Support Groups in DRC"		MSH Stories	
16–20 Sep	"mHealth to promote malaria services and products"	Social and Behavior Change Communication Partner's Meeting	Poster	Addis Ababa, Ethiopia
7–8 Oct	"DRC Update on Diarrhea & Pneumonia Situation"	Diarrhea and Pneumonia Working Group	Presentation	Washington, DC
12–15 Nov		2013 International Family Planning Conference	Abstract	Addis Ababa, Ethiopia
2014				
	IHP		Fact Sheet/French	
	Leadership Development Program		Fact Sheet/French	
	Malaria		Fact Sheet/French	

Date	Title or Topic	Event (where applicable)	Type	Location (where applicable)
2014, *continued*				
	Nutrition		Fact Sheet/French	
	Tuberculosis		Fact Sheet/French	
	Water, Sanitation, Hygiene		Fact Sheet/French	
2-5 Dec	"Implication des hommes dans l'augmentation du nombre de visites de conseil et des nouvelles acceptantes de méthodes modernes en PF"	CNRPF	Abstract Presentation	
15-19 Nov	"Collaborative Quality Improvement as an Approach to Strengthen Links Between CHWs and Health Centers in the DRC"	American Public Health Association Annual Meeting	Abstract Poster	
8-9 Apr	"Closed User Groups for Health: Integrating Mobile Technology to Promote Healthy Behaviors and Health Services in the DRC" (English)	Mobile Communication for Development Conference (M4D)	Abstract Poster	Dakar, Senegal
8-9 Apr	"Closed User Groups pour santé: intégrant la technologie mobile pour promovoir les comportements sains et les services sanitaires en RDC" (French)	M4D	Poster	Dakar, Senegal
	Open House		Poster	
12 Nov	"Simple Measures Save Children's Lives: Creating Universal Access to Pneumonia Care and Treatment in DRC"		MSH Impact Blog	
28 Mar	"Enhancing HIV Testing Through HIV-TB Co-infection Integration"		MSH Stories	
24 Nov	"Community-based Initiatives Improving Maternal and Child Health in DRC"		MSH Stories	
2015				
	Results-based Financing		Fact Sheet French/ English	
	Nutrition		Fact Sheet French/ English	
	Maternal, Neonatal, Child Health		Fact Sheet French/ English	
	Tuberculosis		Fact Sheet French/ English	
	Malaria		Fact Sheet French/ English	
	FOSACOF		Fact Sheet French/ English	
	Overview of IHP		Fact Sheet French/ English	
	Water, Sanitation, Hygiene		Fact Sheet French/ English	
	Family Planning		Fact Sheet French/ English	
	Leadership Development Program		Fact Sheet French/ English	
	IYCF		Innovation Brief French/English	

Date	Title or Topic	Event (where applicable)	Type	Location (where applicable)
	Helping Babies Breathe		Innovation Brief French/English	
	Champion Communities		Innovation Brief French/English	
	i-CCM		Innovation Brief French/English	
	Kangaroo Mother Care		Video on USAID's website	https://www.usaid.gov/news-information/videos/node/164116
	Helping Babies Breathe		Video	
	Beatrice's Story		Video	
	Communauté Championne		Video	TUWE MFANO
	Financement Basé sur les Résultats		Video	
	Sites de soins Communautaires		Video	
	Leadership Development Program		Video	
	"Skilled Attendants Use 'Helping Babies Breathe' Method to Save Newborns in the DRC"		MSH Success Story Compendium 2015	
12 Jun	"CHWs Champion Family Planning to Reduce Maternal and Child Mortality"		MSH Stories	
12 Jun	"Reducing Maternal and Neonatal Mortality in DRC: Reliable Blood Bank"		MSH Stories	
5 Aug	"Early to Breast, Early to Thrive - Let's Make It Work for Women in Developing Countries"		MSH Impact Blog	
Oct	"IHP Support for Nutrition in the DRC"	InterAction	Presentation	
Oct	"RBF Support to the MOH in DRC"	USAID	Presentation	
3 Oct	"Saving Lives of Children with Severe Malaria in DRC: Can Artesunate Suppositories Buy Time to Get to Treatment?"		MSH Stories	
5 Oct	"Helping Children Survive in DRC: A Family Tradition"		MSH Stories	
5 Oct	"Teaching Birth Attendants to Save Newborn Lives: No Powerpoint Needed"		MSH Stories	
18-21 Oct	"Do results-based financing approaches improve maternal and child health? The case of DRC"	Global Maternal Newborn Health Conference (GMNHC)	Abstract Poster	Mexico City, Mexico
18-21 Oct	"Early to breast, early to thrive: Promoting breastfeeding in DRC"	GMNHC	Abstract Presentation	Mexico City, Mexico
29 Oct	"Community-based Case Management: A Life-Saving Strategy for Rural Children"		MSH Impact Blog	
4 Nov	"The Keys to Improving Infant Nutrition in the DRC"		MSH Impact Blog	
9 Nov	"CBDs of Family Planning: Mother Who Takes Care of Birth Spacing"		MSH Stories	

Date	Title or Topic	Event (where applicable)	Type	Location (where applicable)
2015, *continued*				
13 Nov	"Pneumonia Day 2015 in DRC: Make Every Breath Count"		MSH Impact Blog	
Dec	Radio broadcast on Closeout Ceremony			*Topcongo.be*
Dec	TV broadcast on Closeout Ceremony			*B-One TV*
3 Dec	"House to House: Seeking and Treating TB Cases in DRC"		MSH Stories	
14-15 Dec	"Motivating village health development committees with incentives based on performance to improve serviceutilization rates in DRC"	Science of Dissemination and Implementation Conference	Abstract Poster (poster created under IHPplus)	Washington, DC USA
2016				
8-10 Feb	"The Contribution of the Champion Communities Approach to Healthy Behaviors and the Utilization of Health Services in the DRC"	International SBCC Conference	Abstract Poster (poster created under IHPplus)	Addis Ababa, Ethiopia
16-17 Apr	"Saving Lives and Improving Health in the Democratic Republic of Congo: A Health Systems Approach to Saving Mothers and Newborns"	Global Health and Innovation Conference (GHIC)	Abstract Presentation (presentation created under IHPplus)	New Haven, CT USA
16-17 Apr	"Breathing easier in Democratic Republic of Congo: Simple technology saves new lives"	GHIC	Abstract Presentation (presentation created under IHPplus)	New Haven, CT USA

List of abstracts accepted to conferences PY1–PY5

Conference Name	Location	Health Topic	Abstract Title	Oral or Poster	Authors
Using Mobile Technology to Improve Family Planning and Health Programs	Dar es Salaam, Tanzania	Behavorial Change Communication	"DRC-IHP: Mobile Phone Technology to Improve Family Planning"	Poster	Jean Baptiste Mputu
Women Deliver	Kuala Lampur, Malaysia	Maternal, Newborn and Child Health	"Against All Odds: Improving Women & Children's Health in the Democratic Republic of Congo"	Oral	Kristin Cooney (Country Portfolio Director) and Lucie Zikudieka (Senior Technical Advisor MNCH)
US President's Malaria Initiative (PMI)	Addis Ababa, Ethiopia	Behavorial Change Communication	"DRC-Integrated Health Project: mHealth to promote malaria services and products"	Poster	Jean Baptiste Mputu
2013 International Family Planning Conference Addis Ababa	Addis Ababa, Ethiopia	Family Planning	"Service porte à porte: la planification familiale dans la République Démocratique du Congo (Community-based Distributors: Expanding Family Planning access in DRC)"	Oral*	Colette Losso (Senior Technical Advisor FP and Reproductive Health)
2014 Mobile Communication for Development (M4D) Conference	Dakar, Senegal	Behavorial Change Communication	"Closed User Groups (CUG): Integrating Mobile Technology to Promote Health Services in the DRC"	Poster	Jean Baptiste Mputu (Senior Technical Advisor BCC)
3ème Conférence Nationale pour le Repositionnement de la Planification Familiale en RD Congo (3rd National Conference on Family Planning Repositioningin DRC)	Kinshasa, DRC	Family Planning	"Implication des hommes dans l'augmentation du nombre de visites de conseil et des nouvelles acceptantes de méthodes modernes en PF" (Involving men to increase modern method of contraception usage)	Oral	Gilbert Andrianandras (Senior Technical Advisor, Primary Health Care (Key))
American Public Health Association Annual Meeting and Expo	New Orleans, USA	Integrated Community Case Management	"Collaborative quality improvement as an approach to strengthen the link between CHWs and health centers in DRC"	Poster	Ciro Franco, Narcisse Naia Embeke (Senior Technical Advisor Child Health), Jean Fidèle Ilunga (DRC MOH), Gilbert Andrianandras (Senior Technical Advisor, Primary Health Care), Ousmane Faye (Chief of Party)

**due to project-wide budgetary restrictions, no one from IHP attended the conference to make the oral presentation*

Conference Name	Location	Health Topic	Abstract Title	Oral or Poster	Authors
Global Maternal, Newborn and Child Health Conference	Mexico City, Mexico	Results-based Financing	"Do results-based financing approaches improve maternal and child health?"	Poster	Delmond Kyanza (Senior Technical Advisor RBF), Kristin Cooney (Country Portfolio Director), Jean Kagubare (Health Financing Global Technical Lead), Raphael Tshinzela (Senior Tech. Advisor/ IH Field Director), Matthieu Lutondo (Technical Advisor, IH Field Director), Didace Demba (Senior Technical Advisor/ Provincial Representative), Alexis Ndumbi (M&E specialist), Freddy Tshamala (Manager Capacity Building), Francine Ngalula and Ousmane Faye (Chief of Party)
		Nutrition	"Early to breast, early to thrive: Promoting breastfeeding in Democratic Republic of Congo"	Oral	Matthieu Koy (Senior Technical Advisor Nutrition), Raphael Tshinzela (Senior Technical Advisor/ IH Field Director), Freddy Mbuse (Technical Advisor), Jean Kayembe (Senior Technical Coordinator), Joseph Ekandji (Technical Advisor), Emmanuel Mulunda (Technical Advisor), Jean Mpiana (IHP Coordinator), Dieudonné Cigajirajira (BCC Specialist), Adamo Fumie (IHP Coordinator), Sylvain Kasonga (Senior Technical Advisor/ IH Field Director), Ousmane Faye (Chief of Party), Joan Marshall-Missiye (Senior Project Officer) and Kristin Cooney (Country Portfolio Director)

Appendix 10. MPA/CPA-plus services (as defined 2014) and RBF delivery indicators

MPA and CPA services (revised 2014) for IHP implementation	
MPA-plus services at health centers	
Preventive activities	■ Monitoring growth and development of children under 5 ■ Antenatal consultations (ANC) ■ PMTCT, including counseling, HIV testing, antiretroviral prophylaxis, FP counseling, and Cotrimoxazole, nutrition counseling, and referrals for treatment, if indicated ■ Cotrimoxazole for exposed infants ■ Family planning consultations ■ Postnatal consultations ■ Extended vaccination program ■ Universal precautions for infection prevention and blood safety ■ Distribution of IPTp and LLINs ■ HIV information ■ Vitamin A or other micronutrient supplementation
Curative services	■ Clinic-based IMCI including treatment of malaria, ARI, diarrhea ■ Screening and treatment of chronic illnesses (TB, leprosy, diabetes, HIV and AIDS, etc.) ■ Diagnosis and treatement (referrals as indicated) for other NTDs ■ Other curative care not elsewhere cited ■ Nutritional rehabilitation ■ Small medical and surgery interventions (minor surgeries) ■ Natural deliveries including practice of AMTSL ■ IPTp for pregnant women and children under 5 years ■ STI syndromic treatment and referrals ■ Post-exposure prophylaxis and appropriate counseling for victims of SGBV
Health promotion services	Activities for the promotion of healthy behaviors: ■ Use of condoms for dual protection ■ Sanitation ■ Exclusive breastfeeding ■ Healthy eating, nutritional, and cooking habits ■ Use of iodized salt ■ Fistula awareness and prevention ■ Hygienic latrines ■ Oral rehydration therapy, etc.
Management and other activities	■ Increase availability of essential services ■ Resource management (human, material, financial) ■ Continuing education/training of personnel ■ Linkages and referrals to private health providers ■ Supervision of health workers (meetings, field visits) ■ Management of health information ■ Management of pharmaceutical information

MPA and CPA services (revised 2014) for IHP implementation	
Community activities	■ Community-based IMCI ■ Measures for food safety and handling ■ Capture and management of springs, wells, supply of drinking water, community water treatment ■ Disease surveillance: TB, NTDs, etc. ■ Disease control ■ Information/education on FP commodities ■ Gardening, fish farming, livestock breeding
CPA-plus services at general referral hospitals	
CPA includes preventative, curative, and promotional activities that are organized within the framework of internal medical services, surgery, gynecology, obstetrics, and pediatrics. CPA also includes management-related activities (management of hospital health information; human, material, and financial resources; action research; and supervision of health zone personnel). In addition, it includes: ■ On-site inspections of reference laboratories ■ Medical imaging ■ Equipment sterilization ■ Rehabilitation activities	
Specialized services	■ Long-acting and permanent methods of contraception (implants, tubal ligation, vasectomy) ■ Fistula repair ■ Post-abortion care (PAC) ■ Blood screening, storage & collection at selected hospitals, and maintenance of a "living blood bank" at others ■ Multi-drug resistance (MDR) TB sputum collection and forwarding to Kinshasa or Lubumbashi labs; treatment and follow-up ■ PMTCT-plus, to include provision and monitoring of ARV prophylaxis to HIV-infected women and exposed infants ■ TB-HIV co-infection screening and treatment (entry point is PMTCT)
Laboratory testing and analyses	■ Parasites (including Rapid Diagnostic Tests and microscopy for malaria) ■ HIV (with PMTCT as point of entry) ■ TB microscopy ■ Blood (hematology) ■ Bacterial ■ Biochemical
Medical imaging	■ Radiography ■ Echography
Equipment sterilization	■ Cleansing followed by disinfection, sterilization with autoclave or hot water
Rehabilitation	■ Physiotherapy

Appendix 11. Selected figure detail

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

Figure 7 (detail). Curative services utilization, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	Project Average	National Average	Achievement %
Bukavu	38	47	47	51	53	47	35	136
Kamina	43	40	41	40	43	41	35	118
Kole	29	27	33	39	44	35	35	99
Kolwezi	44	43	48	49	68	51	35	145
Luiza	30	27	29	32	35	31	35	87
Mwene Ditu	29	25	30	40	44	34	35	96
Tshumbe	30	33	35	38	39	35	35	100
Uvira	35	38	33	33	39	35	35	101
Total	36	37	38	43	46	40	35	**114 %**

Figure 8 (detail). Number of general referral hospitals implementing CPA, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achievement %
Bukavu		15	21	21	21	21	17	124
Kamina		8	6	6	6	6	7	86
Kole		4	4	7	6	6	6	100
Kolwezi		0	7	6	6	6	6	100
Luiza		3	11	9	7	7	8	88
Mwene Ditu		0	9	8	8	8	8	100
Tshumbe		4	6	8	8	8	6	133
Uvira		0	5	5	4	4	4	100
Total		34	69	70	66	66	62	**106 %**

Figure 9 (detail). Number of health centers implementing MPA, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu		228	408	399	400	400	319	125
Kamina		157	200	201	201	201	161	125
Kole		55	55	129	112	112	103	109
Kolwezi		0	100	105	105	105	85	124
Luiza		162	189	170	170	171	136	125
Mwene Ditu		0	194	168	168	168	137	123
Tshumbe		83	169	118	118	118	95	124
Uvira		0	84	92	91	91	82	111
Total		685	1,399	1,382	1,365	1,365	1,118	122 %

Figure 14 (detail). Stock-outs of tracer medicines by coordination office, end of project

	Depo-Provera		ORS		Iron folate		RH		ACT for children under 5 years	
	Actual Project	Target Project	Actual Project	Target Project	Actual Project	Target Project	Actual Project	Target Project	Actual Project	Target Project
Bukavu	26	39	1	39	66	39	20	0	22	39
Kamina	84	19	10	19	60	19	9	0	17	19
Kole	9	12	31	12	41	12	8	0	4	12
Kolwezi	6	11	5	11	17	11	0	0	10	11
Luiza	0	15	0	15	14	15	0	0	0	15
Mwene Ditu	0	16	0	16	2	16	1	0	0	16
Tshumbe	21	12	44	12	17	12	4	0	13	12
Uvira	0	9	0	9	32	9	0	0	14	9
Total	146	133	91	133	249	133	42	0	80	133

Figure 17 (detail). Number of cases of childhood pneumonia treated with antibiotics in USG-supported facilities and i-CCM sites, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	Total health facilities	Total i-CCM sites	Total Project, Actual	Total Project, Target	Achieve-ment %
Bukavu	86,073	165,539	160,547	149,095	133,430	681,073	13,611	694,684	627,933	111
Kamina	89,534	102,479	128,370	107,116	80,512	470,049	37,962	508,011	346,446	147
Kole	11,252	11,706	12,346	32,197	42,648	92,110	18,039	110,149	151,570	73
Kolwezi	31,112	32,136	32,365	23,274	17,497	133,653	2,731	136,384	151,570	90
Luiza	23,365	27,925	43,804	53,013	48,226	189,301	7,032	196,333	238,182	82
Mwene Ditu	117,338	60,147	57,143	87,629	85,448	317,790	89,915	407,705	346,446	118
Tshumbe	30,854	30,331	35,116	27,225	33,282	143,544	13,264	156,808	151,570	103
Uvira	22,476	23,278	14,716	15,843	22,379	96,899	1,793	98,692	151,570	65
Total	412,004	453,541	484,407	495,392	463,422	2,124,418	184,347	2,308,766	2,165,287	**107 %**

Figure 18 (detail). Number of children under 5 with diarrhea treated by ORS or ORS plus zinc in health zones supported by IHP, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	Total health facilities	Total i-CCM sites	Total Project, Actual	Total Project, Target	Achieve-ment %
Bukavu	82,093	94,692	91,435	181,169	140,690	576,590	13,489	590,079	1,052,378	56
Kamina	48,205	47,508	40,931	104,492	110,438	313,485	38,089	351,574	580,623	61
Kole	15,360	13,000	6,954	33,760	66,770	110,305	25,539	135,844	254,022	53
Kolwezi	5,593	4,916	22,952	22,732	24,484	77,741	2,936	80,677	254,022	32
Luiza	28,338	23,921	24,730	45,414	78,782	187,520	13,665	201,185	399,178	50
Mwene Ditu	44,170	34,744	37,135	61,425	80,918	243,946	14,446	258,392	580,623	45
Tshumbe	20,211	21,612	15,510	24,266	47,065	114,005	14,659	128,664	254,022	51
Uvira	12,886	12,087	23,544	49,253	70,383	162,154	5,999	168,153	254,022	66
Total	256,856	252,480	263,191	522,511	619,530	1,785,746	128,822	1,914,568	3,628,891	**53 %**

Figure 19 (detail). Number of USG-assisted health facilities experiencing stock-outs of ORS

Coordination office	PY1	PY2	PY3	PY4	PY5	Total End Project	Total Target
Bukavu	49	7	8	4	1	1	39
Kamina	37	150	2	38	10	10	19
Kole	7	2	9	44	31	31	12
Kolwezi	0	0	0	0	5	5	11
Luiza	0	125	76	13	0	0	15
Mwene Ditu	0	0	8	76	0	0	16
Tshumbe	20	13	66	93	44	44	12
Uvira	15	16	7	3	0	0	9
Total	128	313	176	271	91	91	133

Figure 20 (detail). Number of children under 5 with malaria treated in i-CCM sites, PY1 to PY5

Coordination office	PY1	PY2	PY3	PY4	PY5	Total
Bukavu	0	77	1,950	2,025	4,886	8,938
Kamina	0	272	4,460	9,095	15,765	29,592
Kole	0	33	107	534	7,306	7,980
Kolwezi	0	217	1,187	2,290	2,662	6,356
Luiza	0	33	1,162	1,870	6,003	9,068
Mwene Ditu	0	0	2,209	8,878	14,810	25,897
Tshumbe	0	62	1,002	3,326	7,627	12,017
Uvira	0	230	1,154	2,010	1,844	5,238
Total	0	924	13,231	30,028	60,903	105,086

Figure 22 (detail). Number of mothers of children 2 years of age or less who have received nutritional counseling for their children

Coordination office	Population (2015)	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	3,728,540	10,721	100,897	159,106	199,410	470,134	326,036	144
Kamina	2,052,277	9,091	56,572	65,307	72,355	203,325	179,882	113
Kole	962,652	10,733	10,887	35,611	39,592	96,823	78,698	123
Kolwezi	888,812	1,255	15,597	24,295	44,699	85,846	78,698	109
Luiza	1,439,232	13,380	48,288	47,293	52,554	161,515	123,669	131
Mwene Ditu	2,126,267	18,782	106,308	151,223	137,476	413,789	179,882	230
Tshumbe	884,460	22,514	53,159	27,296	33,448	136,417	78,698	173
Uvira	937,899	2,463	27,414	64,446	80,208	174,531	78,698	222
Total	13,020,139	88,939	419,122	574,577	659,742	1,742,380	1,124,261	155 %

Figure 25 (detail). Number of pregnant women attending at least one antenatal (ANC1) and four antenatal care visits (ANC4) by skilled providers at supported facilities, by coordination office

Coordination office	ANC 1 Results			ANC 1 Target			ANC1	ANC 4 Results			ANC 4 Target			ANC4
	Num	Den	%	Num	Den	%	% Achieve-ment	Num	Den	%	Num	Den	%	% Achieve-ment
Bukavu	749,983	722,619	104	708,716	761,203	93	111	179,680	722,619	25	358,688	761,203	47	53
Kamina	379,293	387,232	98	391,016	419,974	93	105	85,281	387,232	22	197,897	419,974	47	47
Kole	127,524	181,637	70	171,069	183,739	93	75	70,169	181,637	39	86,580	183,739	47	82
Kolwezi	196,349	167,705	117	171,069	183,739	93	126	41,936	167,705	25	86,580	183,739	47	53
Luiza	293,467	296,723	99	268,824	288,732	93	106	110,462	296,723	37	136,054	288,732	47	79
Mwene Ditu	411,757	434,656	95	391,017	419,974	93	102	155,360	434,656	36	197,897	419,974	47	76
Tshumbe	203,570	155,528	131	171,069	183,738	93	141	78,386	155,528	50	86,580	183,738	47	107
Uvira	174,091	176,966	98	171,069	183,738	93	106	47,230	176,966	27	86,580	183,738	47	57
Total	2,536,034	2,523,066	101	2,443,849	2,624,837	93	108 %	768,504	2,523,066	30	1,236,856	2,624,837	47	65 %

Figure 26 (detail). Number of deliveries with a skilled birth attendant (SBA) in supported facilities receiving Active Management of the Third Stage of Labor (AMTSL), by coordination office

Coordination office	SBA Results			SBA Target			SBA	AMTSL Results			AMTSL Target			AMTSL
	Num	Den	%	Num	Den	%	% Achievement	Num	Den	%	Num	Den	%	% Achievement
Bukavu	607,830	722,619	84	608,717	761,203	80	105	524,748	607,830	86	541,547	608,717	89	97
Kamina	289,000	387,232	75	335,844	419,974	80	93	272,130	289,000	94	298,784	335,844	89	106
Kole	107,298	181,637	59	146,932	183,739	80	74	88,062	107,298	82	130,718	146,932	89	92
Kolwezi	172,172	167,705	103	146,932	183,739	80	128	133,823	172,172	78	130,718	146,932	89	87
Luiza	271,354	296,723	91	230,892	288,732	80	114	242,623	271,354	89	205,415	230,892	89	101
Mwene Ditu	364,181	434,656	84	335,843	419,974	80	105	337,172	364,181	93	298,784	335,843	89	104
Tshumbe	177,516	155,528	114	146,932	183,738	80	143	151,840	177,516	86	130,718	146,932	89	96
Uvira	133,147	176,966	75	146,932	183,738	80	94	114,421	133,147	86	130,718	146,932	89	97
Total	2,122,497	2,523,066	84	2,099,024	2,624,837	80	**105 %**	1,864,819	2,122,497	88	1,867,402	2,099,024	89	**99 %**

Figure 27 (detail). Number of postpartum/newborn visits within 3 days of birth in supported programs, by coordination office

Coordination office	Population (2015)	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achievement %
Bukavu	82,348	108,895	113,762	134,643	137,204	576,852	761,203	76
Kamina	49,860	50,361	56,874	60,127	59,580	276,802	419,974	66
Kole	9,620	9,966	11,217	26,677	32,609	90,089	183,739	49
Kolwezi	31,073	31,711	32,048	34,784	41,477	171,093	183,739	93
Luiza	46,545	49,546	56,862	56,852	52,878	262,683	288,731	91
Mwene Ditu	63,489	63,938	70,252	73,794	75,763	347,236	419,973	83
Tshumbe	28,115	37,441	40,704	27,960	30,575	164,795	183,739	90
Uvira	17,529	20,441	21,455	25,310	27,774	112,509	183,739	61
Total	328,579	372,299	403,174	440,147	457,860	2,002,059	2,624,837	**76 %**

Figure 28 (detail). Number of newborns receiving antibiotic treatment for infection from appropriate health workers in supported programs, by coordination office

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	29,260	15,870	5,584	5,901	7,142	63,757	45,672	140
Kamina	3,287	5,630	3,549	5,149	4,594	22,209	25,198	88
Kole	637	943	1,579	2,513	2,856	8,528	11,024	77
Kolwezi	1,178	0	1,314	5,413	8,760	16,665	11,024	151
Luiza	5,769	3,956	3,254	6,686	7,516	27,181	17,325	157
Mwene Ditu	9,409	5,959	9,028	5,451	3,901	33,748	25,199	134
Tshumbe	2,357	1,976	1,574	842	607	7,356	11,024	67
Uvira	378	2,096	1,629	2,865	3,375	10,343	11,024	94
Total	52,275	36,430	27,511	34,820	38,751	189,787	157,490	121 %

Figure 29 (detail). Couple years of protection in USG-supported programs, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	66	87,283	92,908	137,337	144,288	527,927	605,768	87
Kamina	116,054	101,723	102,387	101,984	84,496	506,646	334,217	152
Kole	7,141	11,322	11,554	38,548	44,558	113,123	146,220	77
Kolwezi	44,837	45,449	49,935	46,874	56,199	243,294	146,220	166
Luiza	67,997	68,115	71,857	72,185	66,449	346,603	229,773	151
Mwene Ditu	91,203	99,057	99,724	96,391	101,690	488,065	334,216	146
Tshumbe	42,059	54,512	51,551	44,857	46,150	239,130	146,220	164
Uvira	8,495	14,868	22,676	24,805	27,511	98,355	146,220	67
Total	443,897	482,331	502,592	562,982	571,340	2,563,143	2,088,854	123 %

Figure 30 (detail). Number of new acceptors of any modern contraceptive method, by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	84,595	92,379	103,042	134,745	119,206	533,967	677,601	79
Kamina	105 721	104,212	113,436	103,865	82,642	509,876	373,849	136
Kole	22,624	23,012	24,460	61,327	54,078	185,501	163,559	113
Kolwezi	33,983	38,650	49,960	49,905	52,870	225,368	163,559	138
Luiza	69,760	73,004	77,162	78,339	78,566	376,831	257,020	147
Mwene Ditu	83,100	91,304	98,186	95,957	113,386	481,933	373,849	129
Tshumbe	50,366	66,782	66,827	54,625	58,808	297,408	163,559	182
Uvira	10,546	15,863	23,247	27,557	32,602	109,815	163,559	67
Total	460,695	505,206	556,320	606,320	592,158	2,720,700	2,336,555	**116 %**

Figure 32 (detail). Percent of children less than 12 months of age who received DPT-HepB-Hib3 by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Average	End Project, Target	Achieve-ment %
Bukavu	72	92	105	109	108	97	87	112
Kamina	93	80	105	104	97	96	87	110
Kole	39	35	37	97	95	62	87	71
Kolwezi	119	114	116	130	140	124	87	143
Luiza	98	88	103	111	101	100	87	115
Mwene Ditu	91	88	87	94	96	91	87	105
Tshumbe	157	153	164	86	93	127	87	146
Uvira	76	77	100	93	99	89	87	103
Total	87	89	101	104	103	97	87	**111%**

Figure 33 (detail). Percent of children less than 12 months of age who received measles vaccine by coordination office and PY

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Average	End Project, Target	Achieve-ment %
Bukavu	0	81	87	90	93	88	89	99
Kamina	0	85	95	96	95	93	89	104
Kole	0	34	35	95	94	65	89	74
Kolwezi	0	78	89	97	110	94	89	106
Luiza	0	99	113	104	94	102	89	115
Mwene Ditu	0	95	94	90	92	93	89	104
Tshumbe	0	124	131	79	82	103	89	116
Uvira	0	76	80	75	83	78	89	88
Total	0	85	91	92	93	90	89	**102%**

Figure 36 (detail). Number and percentage of pregnant women who received at least 2 doses of SP during ANC visits at supported facilities, by coordination office

Coordination office	Project Actual			Project target			SP
	Num	Den	%	Num	Den	%	Achievement %
Bukavu	398,063	722,619	55	502,780	617,827	81	68
Kamina	254,344	387,232	66	277,396	340,870	81	81
Kole	83,556	181,637	46	121,361	149,131	81	57
Kolwezi	96,195	167,705	57	121,361	149,131	81	70
Luiza	172,737	296,723	58	190,709	234,348	81	72
Mwene Ditu	309,294	434,656	71	277,396	340,870	81	87
Tshumbe	125,788	155,528	81	121,360	149,130	81	99
Uvira	73,268	176,966	41	121,360	149,130	81	51
Total	1,513,245	2,523,066	60	1,733,723	2,130,437	81	**74 %**

Figure 37 (detail). Number of RDTs purchased with USG funds that were distributed to health facilities

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	0	4,245	100,561	313,687	379,914	798,407	3,871,500	21
Kamina	0	100	288,297	228,653	386,525	903,575	2,136,000	42
Kole	0	0	13,629	33,086	49,043	95,758	934,500	10
Kolwezi	0	3,993	136,310	53,037	103,295	296,635	934,500	32
Luiza	0	250,125	46,788	61,966	110,987	469,866	1,468,500	32
Mwene Ditu	0	0	201,761	304,028	129,615	635,404	2,136,000	30
Tshumbe	0	15,750	98,207	96,015	78,000	287,972	934,500	31
Uvira	0	27,000	159,197	75,089	138,592	399,878	934,500	43
Total	0	301,213	1,044,750	1,165,561	1,375,971	3,887,495	13,350,000	**29 %**

Figure 38 (detail). Number of ACT treatments purchased with USG funds that were distributed in health facilities and community

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	402,884	767,275	483,344	537,411	526,384	2,717,298	3,422,000	79
Kamina	297,313	348,985	280,563	405,529	380,606	1,712,996	1,888,000	91
Kole	16,145	33,430	42,757	147,149	238,789	478,270	826,000	58
Kolwezi	0	217	175,521	141,480	154,717	471,935	826,000	57
Luiza	273,826	86,814	191,114	300,900	301,069	1,153,723	1,298,000	89
Mwene Ditu	340,334	198,804	262,373	390,311	445,572	1,637,394	1,888,000	87
Tshumbe	110,853	108,137	145,940	140,970	177,206	683,107	826,000	83
Uvira	46,097	42,285	73,117	102,395	121,450	385,344	826,000	47
Total	1,487,452	1,585,947	1,654,729	2,166,145	2,345,794	9,240,067	11,800,000	**78 %**

Figure 47, 49, 50, 51, 52, 54 (detail). IHP achievement on key TB indicators

Coordination office	TB cases detected (PY 1-5)	TB case notification rate (see also Table 44 detail)					TB/HIV coinfection			TB case detection rate			TB-MDR		
		Rate	Target PMP	% PMP Achieve-ment	Target PNLT	% PNLT Achieve-ment	Rate	Target PMP	% PMP Achieve-ment	Rate	Target PMP	% PMP Achieve-ment	Rate	Target PMP	% PMP Achieve-ment
Bukavu	8,443	51	214	24	150	34	74	58	127	31	70	45	56	58	97
Kamina	16,001	171	214	80	150	114	63	58	108	110	70	157	17	32	53
Kole	3,430	141	214	66	150	94	45	58	78	50	70	72	7	14	50
Kolwezi	5,020	170	214	79	150	113	40	58	70	80	70	114	29	14	207
Luiza	7,482	74	214	35	150	49	44	58	76	67	70	96	18	22	82
Mwene Ditu	9,863	96	214	45	150	64	34	58	59	61	70	86	60	32	188
Tshumbe	4,764	73	214	34	150	49	23	58	39	82	70	117	3	14	25
Uvira	3,082	66	214	31	150	44	37	58	63	46	70	66	13	14	93
Total	58,085	97	214	**45 %**	150	**65 %**	49	58	**85 %**	61	70	**88 %**	203	200	**102 %**

Figure 56. (detail). Number of children under 5 years of age who received vitamin A

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	560,381	480,291	671,551	840,983	730,307	3,283,513	3,436,873	96
Kamina	228,979	413,937	287,061	515,596	479,768	1,925,341	1,896,206	102
Kole	104,814	79,172	78,956	287,260	279,753	829,955	829,590	100
Kolwezi	10,354	171,495	369,963	418,301	243,003	1,213,116	829,590	146
Luiza	367,174	485,156	571,482	451,440	445,447	2,320,699	1,303,642	178
Mwene Ditu	0	381,861	299,330	369,243	335,549	1,385,983	1,896,206	73
Tshumbe	327,725	346,616	387,527	218,685	202,785	1,483,338	829,590	179
Uvira	163,951	324,976	348,244	276,625	371,596	1,485,392	829,590	179
Total	1,763,378	2,683,504	3,014,114	3,378,133	3,088,208	13,927,337	11,851,287	**118 %**

Figure 57 (detail). Number of pregnant women receiving iron folate to prevent anemia

Coordination office	End Project, Actual			End Project, Target			% Achieve-ment
	Num	Den	%	Num	Den	%	
Bukavu	539,888	583,928	92	466,478	617,827	76	122
Kamina	188,945	314,295	60	257,367	340,870	76	80
Kole	90,499	147,425	61	112,598	149,131	76	81
Kolwezi	169,359	136,117	124	112,598	149,131	76	165
Luiza	154,352	241,021	64	176,940	234,348	76	85
Mwene Ditu	365,507	348,263	105	257,367	340,870	76	139
Tshumbe	131,310	127,769	103	112,598	149,131	76	136
Uvira	97,086	143,634	68	112,598	149,131	76	90
Total	1,736,945	2,042,451	85	1,608,544	2,130,437	76	**113 %**

Figure 58 (detail). Number of mothers of children 2 years of age or less who have received nutritional counseling for their children

Coordination office	Population (2015)	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu	3,728,540	10,721	100,897	159,106	199,410	470,134	326,036	144
Kamina	2,052,277	9,091	56,572	65,307	72,355	203,325	179,882	113
Kole	962,652	10,733	10,887	35,611	39,592	96,823	78,698	123
Kolwezi	888,812	1,255	15,597	24,295	44,699	85,846	78,698	109
Luiza	1,439,232	13,380	48,288	47,293	52,554	161,515	123,669	131
Mwene Ditu	2,126,267	18,782	106,308	151,223	137,476	413,789	179,882	230
Tshumbe	884,460	22,514	53,159	27,296	33,448	136,417	78,698	173
Uvira	937,899	2,463	27,414	64,446	80,208	174,531	78,698	222
Total	13,020,139	88,939	419,122	574,577	659,742	1,742,380	1,124,261	**155 %**

Figure 59 (detail). Number of breastfeeding mothers receiving vitamin A

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu		25,944	75,271	78,213	87,566	266,994	512,336	52
Kamina		6,905	20,189	16,862	22,460	66,416	282,668	23
Kole		0	811	2,021	11,601	14,433	123,667	12
Kolwezi		5,693	11,866	8,935	11,718	38,212	123,667	31
Luiza		5,523	4,556	5,030	14,675	29,784	194,334	15
Mwene Ditu		7,034	19,078	9,724	34,429	70,265	282,669	25
Tshumbe		4,593	3,302	2,944	3,210	14,049	123,667	11
Uvira		7,217	13,844	14,274	16,238	51,573	123,667	42
Total	N/A	62,909	148,917	138,003	201,897	551,726	1,766,675	**31 %**

Figure 61 (detail). Number of people reached by a USG-supported intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hot lines, other)

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual	End Project, Target	Achieve-ment %
Bukavu		1242	3946	2871	1883	9,942	6,473	154
Kamina		0	2	47	55	104	3,571	3
Kole		86	53	104	145	388	1,562	25
Kolwezi		0	1	0	1	2	1,562	0
Luiza		1	217	332	4	554	2,456	23
Mwene Ditu		0	22	0	0	22	3,572	1
Tshumbe		5	2	15	60	82	1,562	5
Uvira		495	640	522	395	2,052	1,562	131
Total	N/A	1,829	4,883	3,891	2,543	13,146	22,320	**59 %**

Figure 66 (detail). Number of health centers using the FOSACOF approach

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual
Bukavu	67	94	137	146	152	152
Kamina	29	74	74	74	74	74
Kole	63	75	75	75	75	75
Kolwezi	40	49	49	87	87	87
Luiza	90	90	85	88	88	88
Mwene Ditu	86	86	86	92	92	92
Tshumbe	93	93	91	91	91	91
Uvira	36	36	39	49	49	49
Total	504	597	636	702	708	708

Figure 67 (detail). Number of GRHs using the FOSACOF approach

Coordination office	PY1	PY2	PY3	PY4	PY5	End Project, Actual
Bukavu	0	0	1	7	7	7
Kamina	0	3	3	3	3	3
Kole	0	0	1	1	1	1
Kolwezi	0	0	3	3	3	3
Luiza	0	0	0	5	5	5
Mwene Ditu	0	3	3	5	5	5
Tshumbe	0	2	2	2	2	2
Uvira	0	0	0	3	3	3
Total	0	8	13	29	29	29

Figure 74 (detail). Number of patients seen by a CHW or health care provider and number of patients referred to GRH, percentage, vs. target

	PY1		PY2		PY3		PY4		PY5		End Project, Actual			Project Target	
	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Rate (%) Actual	Rate (%), Target	Achieve-ment %
Bukavu	0	1,331,586	1,133	1,678,387	37,277	1,726,908	74,780	1,926,915	84,442	1,987,119	197,632	8,650,915	2	1.27	180
Kamina	0	786,737	5,215	753,971	11,332	780,484	14,825	788,383	14,061	850,363	45,433	3,959,938	1	1.27	90
Kole	0	98,819	1,091	94,271	3,863	117,834	21,593	363,446	26,912	423,027	53,459	1,097,397	5	1.27	384
Kolwezi	0	347,269	0	350,933	8,395	401,926	8,753	421,553	7,964	584,929	25,112	2,106,610	1	1.27	94
Luiza	0	419,071	1,155	388,724	8,379	461,421	7,288	525,318	3,433	525,660	20,255	2,320,194	1	1.27	69
Mwene Ditu	0	665,382	7,735	594,103	34,400	741,896	51,943	854,132	49,949	918,034	144,027	3,773,547	4	1.27	301
Tshumbe	0	310,277	3,024	356,411	22,024	392,158	21,072	284,344	29,218	333,247	75,338	1,676,437	5	1.27	354
Uvira	0	288,463	18,113	324,983	8,706	288,029	13,534	293,907	17,528	359,449	57,881	1,554,831	4	1.27	293
Total	0	4,247,604	37,466	4,541,783	134,376	4,910,656	213,788	5,457,998	233,507	5,981,828	619,137	25,139,869	2	1.27	193 %

Figure 75 (detail). Number of patients seen by a CHW and number of patients referred to health center percentage, vs. target

	PY2		PY3		PY4		PY5		End Project, Actual			Project Target	
	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Patients referred	Patients seen	Rate (%) Actual	Rate (%), Target	Achieve-ment %
Bukavu	16	614	1,118	5,325	2,702	9,757	1,419	15,048	5,255	30,744	17.09	5	342
Kamina	551	1,634	1,134	18,312	3,502	19,189	3,695	25,528	8,882	64,663	13.74	5	275
Kole	492	1,514	601	4,495	1,753	9,055	2,377	44,606	5,223	59,670	8.75	5	175
Kolwezi	0	0	219	4,676	522	3,967	589	5,148	1,330	13,791	9.64	5	193
Luiza	1,606	903	1,074	4,594	862	9,051	1,507	26,297	5,049	40,845	12.36	5	247
Mwene Ditu	1,228	2,170	364	9,494	5,951	12,804	5,872	20,687	13,415	45,155	29.71	5	594
Tshumbe	621	844	138	4,927	3,141	6,062	6,090	13,741	9,990	25,574	39.06	5	781
Uvira	74	967	405	2,697	575	2,617	996	3,549	2,050	9,830	20.85	5	417
Total	4,588	8,646	5,053	54,520	19,008	72,502	22,545	154,604	51,194	290,272	17.64	5	353 %