



EMPOWERMENT BUILDS CAPACITY FOR STRONGER, HEALTHIER COMMUNITIES

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

**Integrated Health
Project Plus**

in the Democratic Republic
of Congo



USAID
FROM THE AMERICAN PEOPLE



Published: July 31, 2018

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

Cooperative Agreement Number: AID-OAA-A-1100024 **Subagreement Number:** OAA-A-11-00024-01-MSH

For more information:

MSH Communications, 200 Rivers Edge Drive Medford, MA 02155

www.msh.org • communications@msh.org

This product describes the work of the Integrated Health Project Plus, which was made possible by the generous support of the United States Agency for International Development (USAID), the United States President's Malaria Initiative (PMI), and the United States President's Emergency Program for AIDS Relief under Subagreement Number OAA-A-11-00024-01-MSH under USAID Cooperative Agreement Number AID-OAA-A-11-00024. The contents are the responsibility of the Democratic Republic of Congo Integrated Health Project Plus and do not necessarily reflect the views of USAID or the United States Government.

EMPOWERMENT BUILDS CAPACITY FOR STRONGER, HEALTHIER COMMUNITIES

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

**Integrated Health
Project Plus**

in the Democratic Republic
of Congo






USAID
FROM THE AMERICAN PEOPLE





CONTENTS

EXECUTIVE SUMMARY	1
Country context	1
Project performance	2
Key achievements	4
PROJECT BACKGROUND	7
 INTERMEDIATE RESULT 1. Access to and availability of minimum package of activities (MPA) and complementary package of activities (CPA) services and products increased.	10
1.1 Facility-based health care services and products in target health zones increased	12
Utilization of health care services	12
Availability of health services	13
Number of health centers implementing minimum package of activities	15
Availability of medicines, commodities, and equipment	15
1.2 Community-based health care services and products in target health zones increased	23
Integrated management of newborn and childhood illness	23
i-CCM sites	24
Evidence-based WASH activities.	27
1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery	32
Leadership Development Program	32
 INTERMEDIATE RESULT 2. Quality of key family health care services increased	36
2.1 Clinical and managerial capacity of health care providers increased	38
Maternal, neonatal, and child health	38
Expanded Program on Immunization	45
Family planning.	49
Nutrition	52
Malaria	59
HIV.	63
Tuberculosis	72
Sexual and gender-based violence.	81
Fistula.	84
2.2 Minimum quality standards for health facilities and services developed and adopted	87
Results-based financing	87
2.3 Primary health care referral system for prevention, care, and treatment improved	91
 INTERMEDIATE RESULT 3. Knowledge, attitudes, and practices to support health-seeking behaviors increased.	92
3.1 Health sector community outreach linkages	94
Community mobilization campaigns	94
3.2 Health advocacy/Community mobilization organizations.	97
Champion Communities	97
3.3 Social and behavior change campaigns	100

INTERMEDIATE RESULT 4. Health sector leadership and governance improved	104
4.1 Health sector policy alignment	106
4.2 Evidence-based strategic planning and decision-making	106
Improved data for decision making.	106
4.3 Community involvement in health policy and service delivery	111
PROJECT MANAGEMENT	112
Project implementation	114
Success stories	115
Cost share	115
Environmental Mitigation and Monitoring Plan	115
Lessons learned	116
Conclusion	119

Appendices are supplied as a separate document.

Figures

Fig 1. Project performance summary	3
Fig 2. Map of IHPplus activity areas	6
Fig 3. Curative services utilization by coordination office	12
Fig 4. Number of GRHs implementing CPA by coordination office	13
Fig 5. Number of health centers implementing MPA by coordination office	14
Fig 6. Number of health zones with an AOP	14
Fig 7. Stock-outs by essential medicine and project year.	19
Fig 8. Number of cases of childhood pneumonia treated with antibiotics (percentage at i-CCM sites)	25
Fig 9. Number of cases of childhood diarrhea treated (percentage at i-CCM sites)	26
Fig 10. Number of cases of children under five years with malaria treated (percentage at i-CCM sites)	26
Fig 11. WASH indicator results	30
Fig 12. Proportion of senior LDP teams that achieved at least 80% of their desired performance	32
Fig 13. Number and percentage of pregnant women attending ANC1	38
Fig 14. Number and percentage of pregnant women attending ANC4	40
Fig 15. Number and percentage of deliveries with an SBA in USG-supported facilities.	41
Fig 16. Number of women giving birth who received a uterotonic.	42
Fig 17. Number and percentage of newborns receiving essential neonatal care.	42
Fig 18. Number of newborns receiving antibiotic treatment for infection	44
Fig 19. Number of newborns with asphyxia resuscitated in USG-supported programs.	44
Fig 20. Couple years protection (CYP)	50
Fig 21. Number of FP counseling visits during IHPplus	52
Fig 22. Pregnant women who received iron folate tablets to prevent anemia	55
Fig 23. Number of mothers with children two years or less who received counseling on nutrition.	56
Fig 24. Number of expectant mothers who received at least two doses of SP during ANC.	61
Fig 25. Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV-positive pregnant women	65
Fig 26. Number of pregnant women with known HIV status	65
Fig 27. Number of HIV-positive pregnant women who received ARVs to reduce risk of MTCT.	65
Fig 28. Number of individuals who received HTC and received test results	65
Fig 29. Percentage of people testing positive for HIV who knew their HIV status, before and after RBF	68

Fig 30. Number of PLHIV receiving a viral load test, before and after RBF	68
Fig 31. Number of PLHIV receiving a viral load test who received their test results	69
Fig 32. Quality of health services in health centers implementing the HIV-focused RBF program	71
Fig 33. Quality of health services in hospitals implementing the HIV-focused RBF program)	71
Fig 34. Percentage of registered TB cases supported by community health agents	74
Fig 35. Percentage of registered TB cases among children aged 0–14 years	74
Fig 36. Notification rate for new cases of smear-positive pulmonary TB	75
Fig 37. Number of multi-drug resistant TB (MDR-TB) cases detected	74
Fig 38. Therapeutic success rate (for new smear positive TB patients)	77
Fig 39. Percentage of newly enrolled HIV-positive patients screened for TB	77
Fig 40. Percentage of HIV-positive patients without TB receiving INH prophylaxis	77
Fig 41. Care of SGBV survivors	83
Fig 42. Percentage of discrepancies between reported and validated RBF data	89
Fig 43. Evolution of utilization rate of curative services and average FOSACOF scores	89
Fig 44. Number of patients referred to health centers by a CHW	91
Fig 45. Number of patients referred to GRHs by a CHW or other health provider	91
Fig 47. Number and percent of CODESAs that were revitalized and functional	94
Fig 46. Number of mini-campaigns conducted	94
Fig 48. Overall summary of the percent of Champion Communities with statistically improved indicator rates	96
Fig 49. Number of SMS messages, by health topic	101

Tables

Table 1. IHPplus results framework	9
Table 2. IHPplus funding for storage and delivery of medicines to health facilities	16
Table 3. Status of emergency order for eight EGMs	16
Table 4. Health zone savings per province (from use of their EGM credit lines during IHP and IHPplus)	17
Table 5. Utilization rates for i-CCM interventions	24
Table 6. LDP projects per technical area	35
Table 7. Vaccination coverage per antigen and per coordination office, PY1–PY3	47
Table 8. Number of people trained in child health and nutrition	56
Table 9. Individuals receiving HTC services disaggregated by sex, age, and HIV status	67
Table 10. Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load	67
Table 11. Number of adults and children receiving ART	67
Table 12. Percentage of registered TB cases that are HIV-positive who are on ART	67
Table 13. Percentage of laboratories and HTC testing sites that participate in and successfully pass an analyte-specific proficiency testing program	67
Table 14. Number of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary FP services	67
Table 15. MDR/RR-TB therapeutic success rate	76
Table 16. Number of people reached by USG-funded SGBV services, disaggregated by sex	82
Table 17. Fistula repair at Kaziba GRH, Bukavu	84
Table 18. Number of CODESAs with communication action plans	95
Table 19. Champion Communities, both initiated by IHPplus and autonomously, which gained NGO status	96
Table 20. Number of Champion Men trained, IHPplus vs. Other	97
Table 21. Number of youth organizations conducting awareness-raising activities	98
Table 22. Number of SMS messages by coordination office	100

ACRONYMS

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

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



EXECUTIVE SUMMARY

Country context

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

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

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

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

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

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

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

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

Project performance

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

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

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

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

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

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

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

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

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

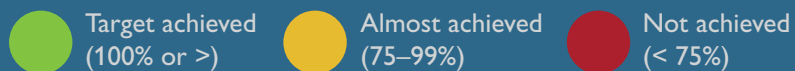
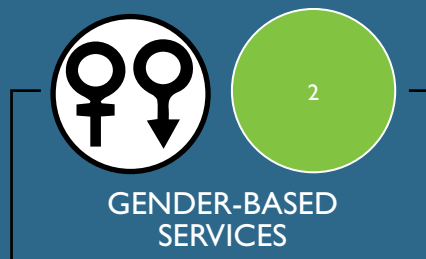
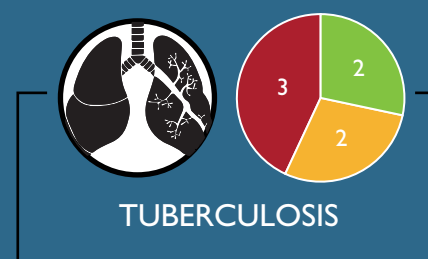
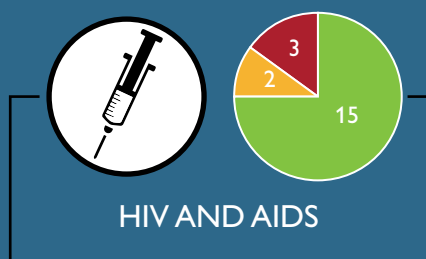
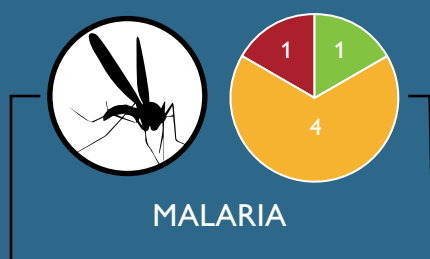
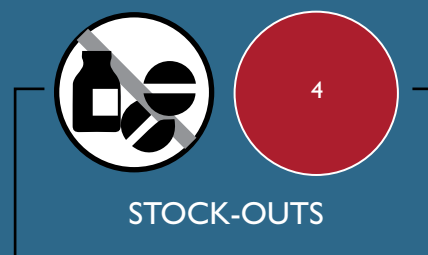
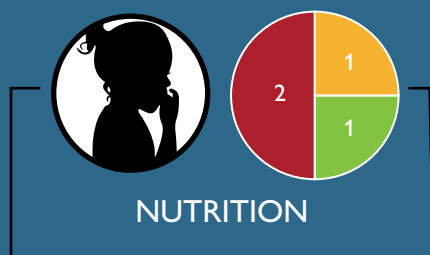
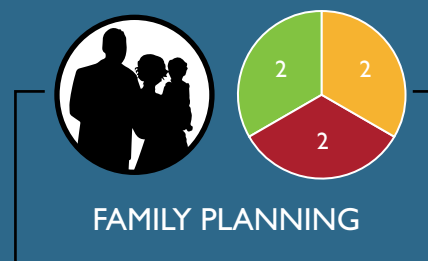
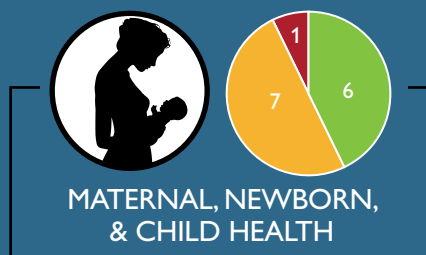


Fig 1. Project performance summary by number of indicators achieved
 Figures represent results from the period of October 1, 2015, to March 31, 2018, only.
 (see Appendix 1 for detail)



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

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

Key achievements

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

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

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

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

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

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

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

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





PROJECT BACKGROUND

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

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

The original, five-year DRC-IHP worked

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

Fig 2. Map of IHPplus activity areas

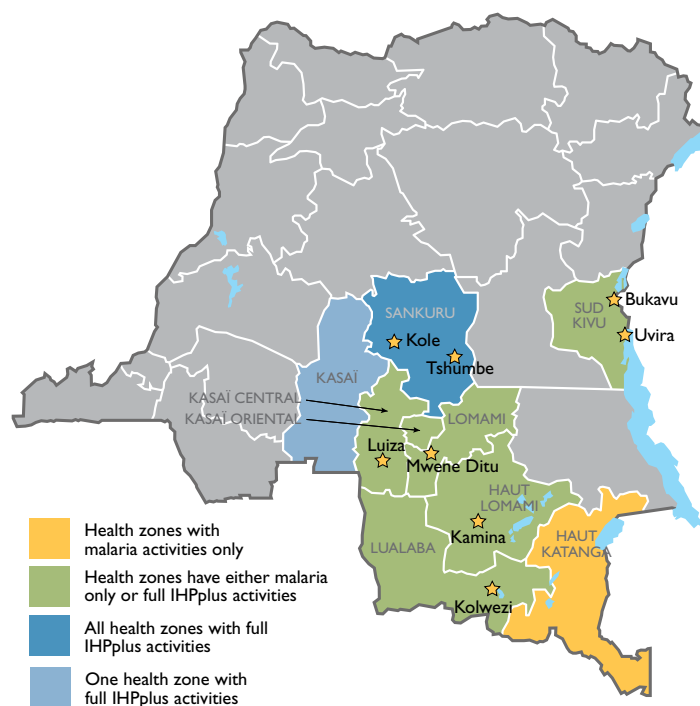


Table 1. IHPplus results framework

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

IR1

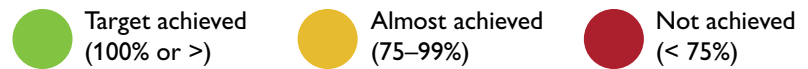
INTERMEDIATE RESULT 1

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

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







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

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

Utilization of health care services

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

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

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

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

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

Fig 3. Curative services utilization by coordination office

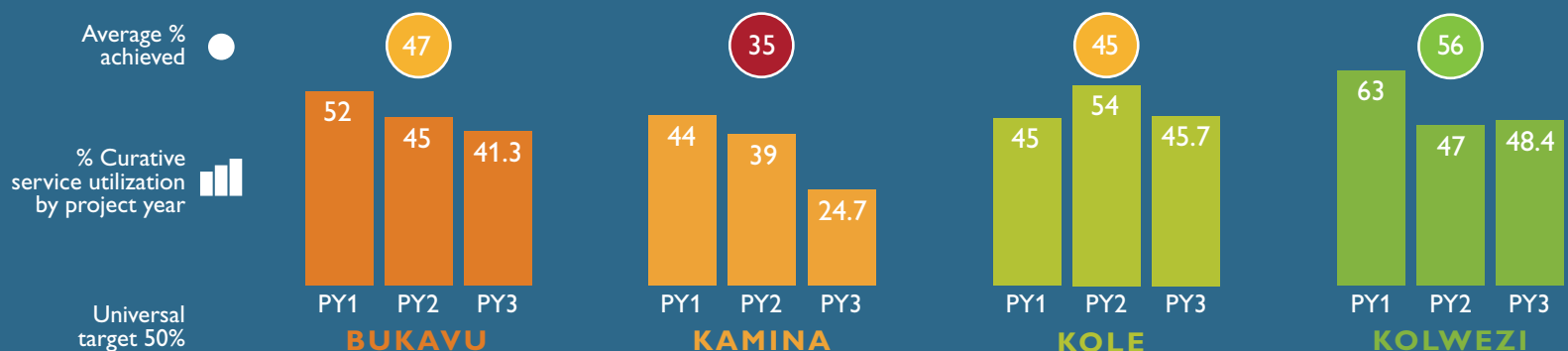
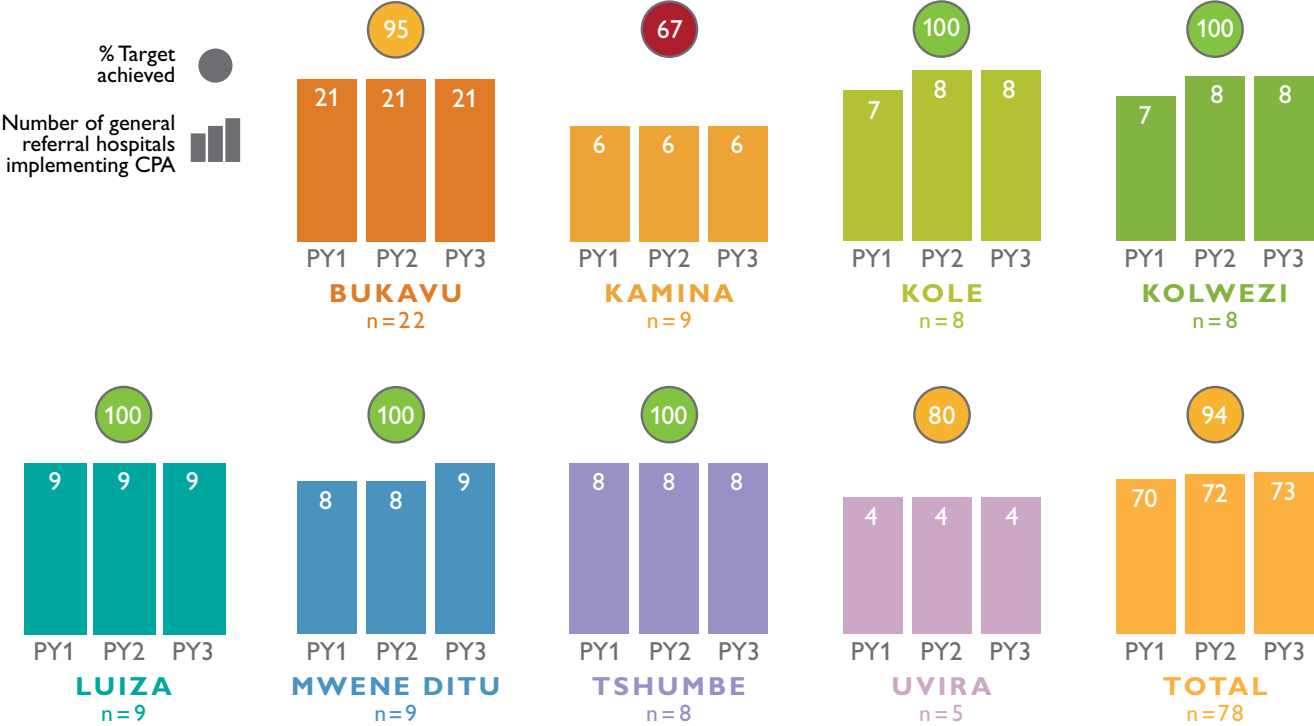


Fig 4. Number of GRHs implementing CPA by coordination office



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

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

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

PY2 thanks to the support of IHPplus and the health zone management teams. With support of the health zone management teams (HZMTs), IHPplus supplied the equipment and material—including delivery tables for birth and desks for consultations—to all GRHs located in health zones supported by the project.

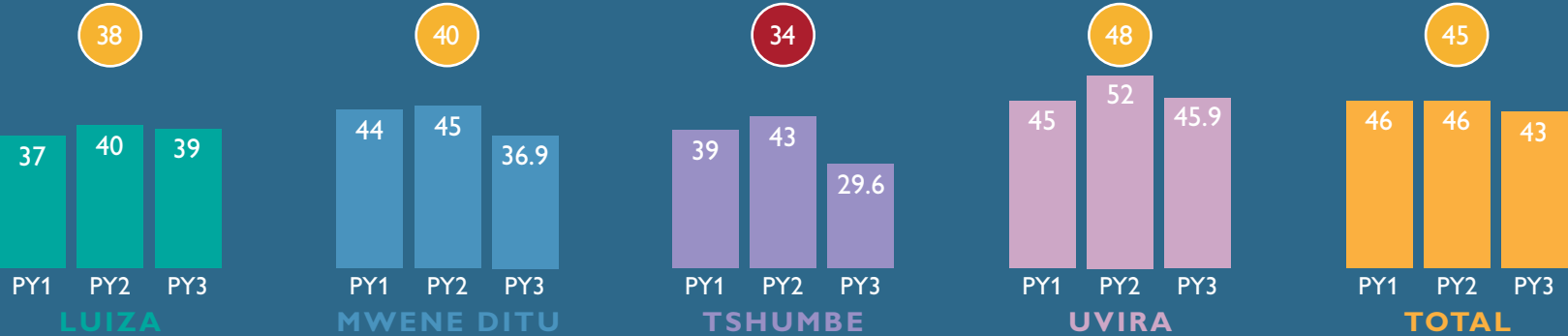


Fig 5. Number of health centers implementing MPA by coordination office

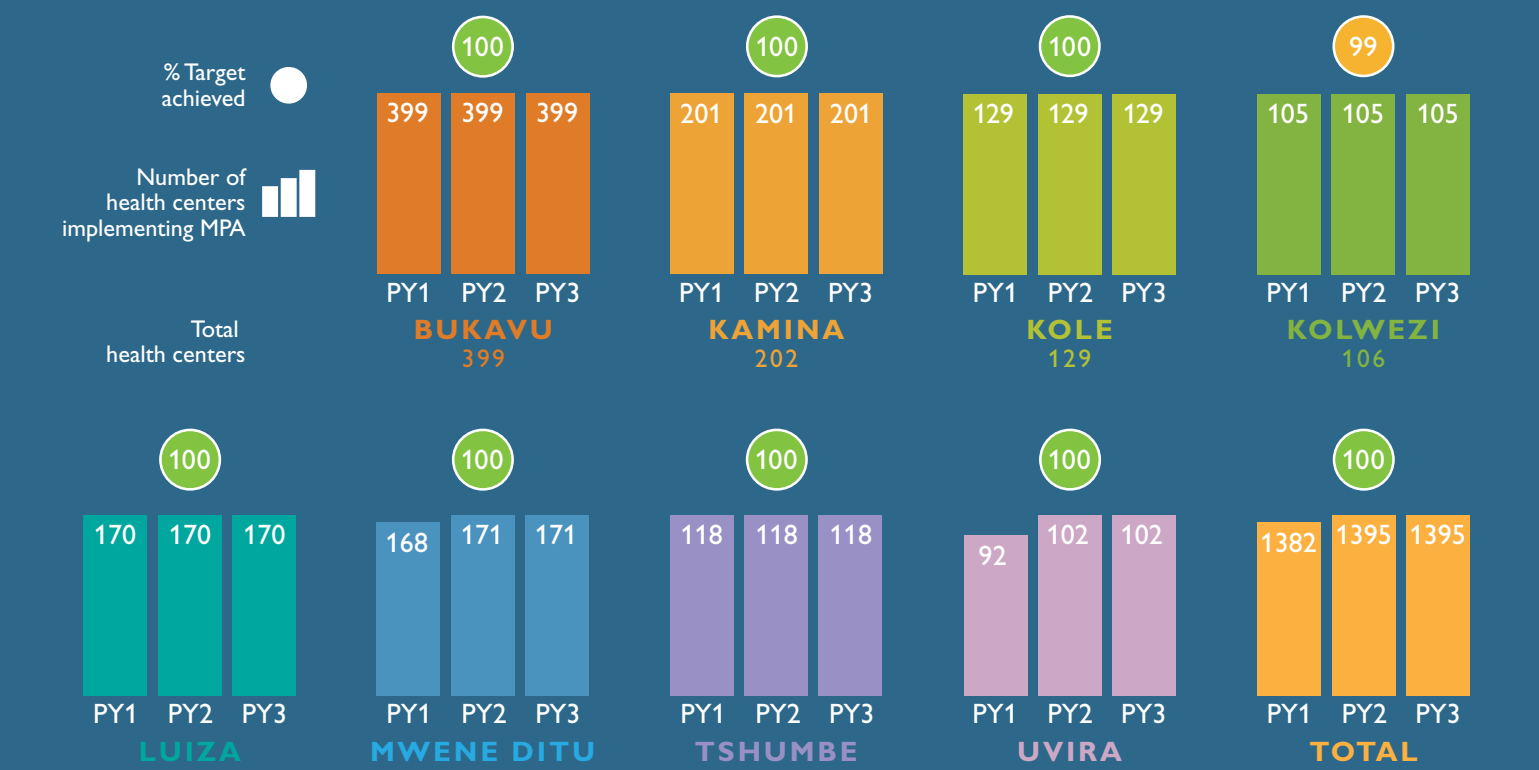
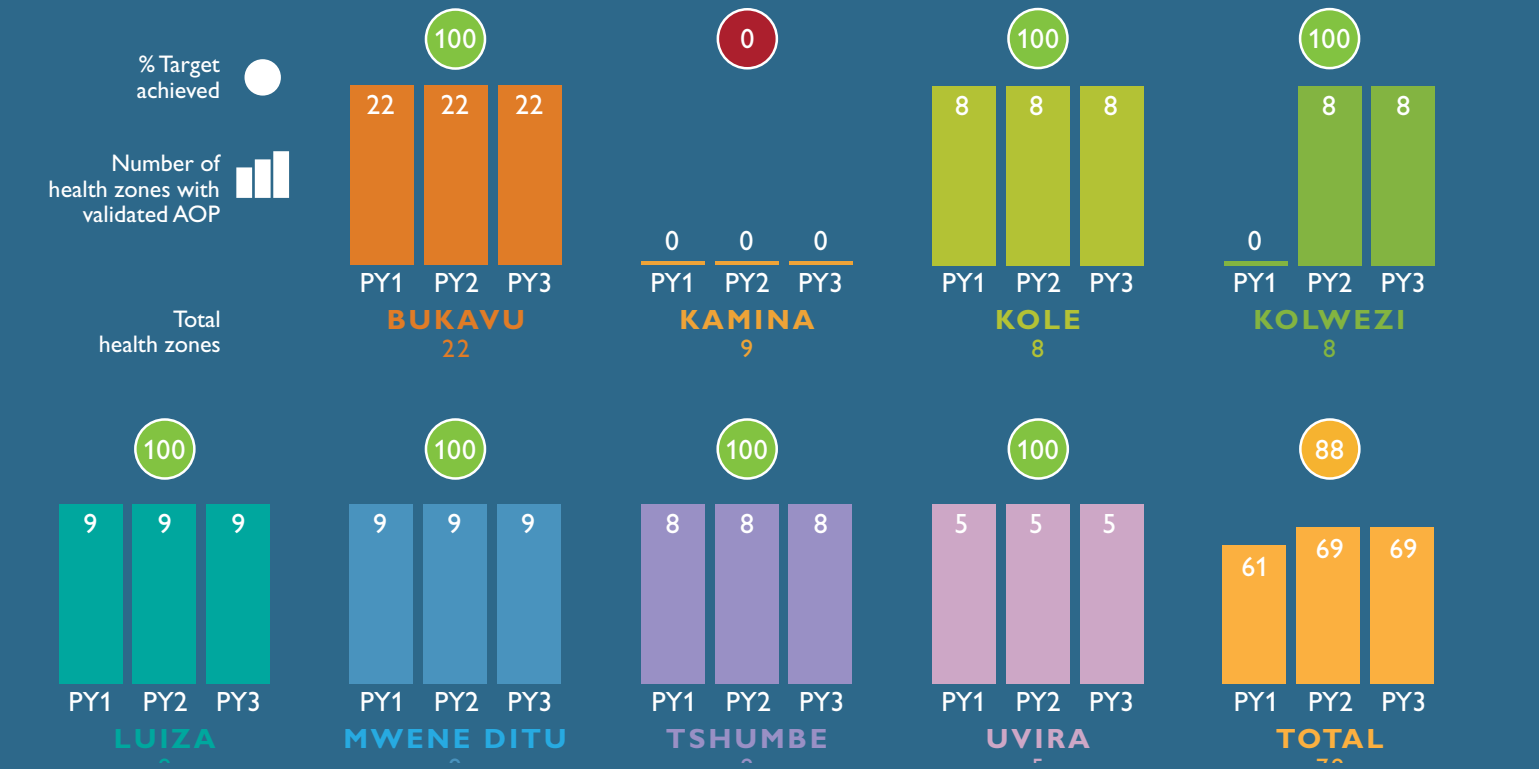


Fig 6. Number of health zones with an AOP



Number of health centers implementing minimum package of activities

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

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

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

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

Availability of medicines, commodities, and equipment

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

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

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

ENSURE THE AVAILABILITY OF MEDICATIONS IN IHPplus-SUPPORTED HEALTH FACILITIES

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

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

IHP PY5 emergency orders 1 and 2:

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

IHPplus orders (1–2):

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

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

IHPplus order 3:

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

Emergency order for eight EGMs:

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

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

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

Table 3. Status of emergency order for eight EGMs

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

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

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

STRENGTHEN THE MANAGEMENT OF ESSENTIAL MEDICINES AND MEDICAL CONSUMABLES

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

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

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

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

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

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

Management of ongoing stock-outs:

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

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

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

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

Warehouse management:

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

Technical assistance to CDRs:

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

Supervision of medicines management:

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

reported and physical stocks.

MINIMIZE STOCK-OUTS OF TRACER MEDICINES

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

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

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

Stock-outs of Depo-Provera:

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

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

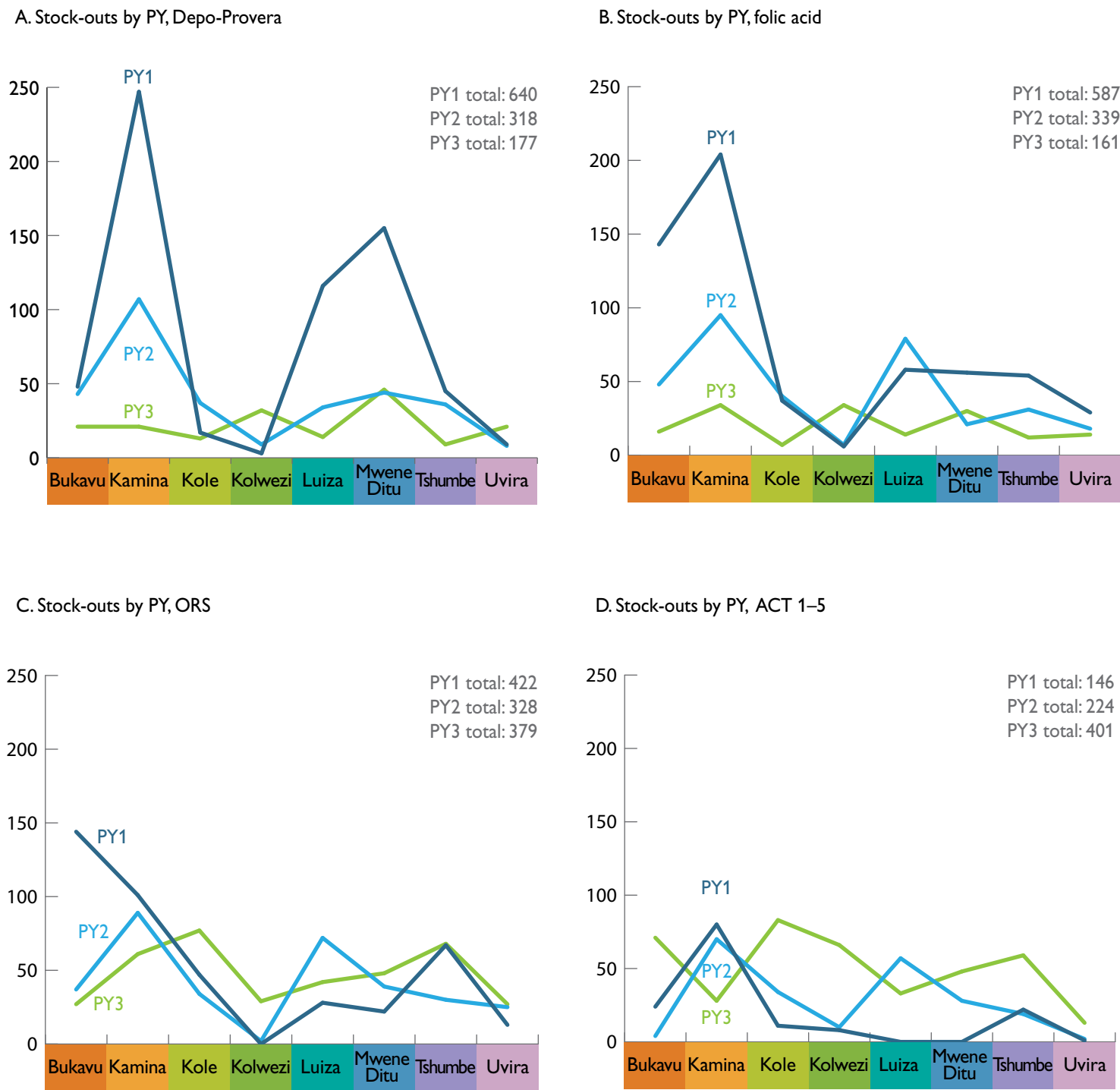
Some of the stock-outs reported are “false” stock-outs; at times, these products are available at CDRs or health zone central office warehouses. Other factors contributing to poor performance include insufficient estimation of needed quantities in health areas, logistical challenges particularly in the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

Stock-outs of folic acid:

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

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

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



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

Stock-outs of ORS:

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

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

Stock-outs of ACT:

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

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

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

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

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

RECOMMENDATIONS

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



Mugeri health center pharmacy. Photo by Rebecca Weaver.



VOICES OF IMPACT

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

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

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

EXCERPTS FROM AN INTERVIEW WITH
DR. GISELLE FATUMA on IHPplus SUPPORT
Director, Ciriri Hospital, outside Bukavu

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

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



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

Integrated management of newborn and childhood illness

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

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

- Supporting 1,221 integrated community case management (i-CCM) sites, including the establishment of 132 new ones and 378 previously supported by the PMI Expansion and the Global Fund. The project supplied all of these sites with medicines and basic equipment (timers, medicine boxes, flashlights, etc.).
- Revitalizing 139 of the sites inherited from PMI and the Global Fund that only supported malaria to integrate management of simple cases of diarrhea, malaria,

and pneumonia, and detection and referral of cases of malnutrition;

- Building the capacity of 197 providers at the health center level in IMNCI, to ensure quality care compatible with the MPA;
- Building the capacity of 60 providers and health care personnel at the hospital level for Triage, Evaluation, and Emergency Treatment (TETU in French) in five hospitals in the Mwene Ditu coordination in order to complete the IMNCI package at all levels of the health system (community, health center, and GRH);
- Providing medicines, tools, supplies, and equipment to ensure quality care compatible with the delivery of MPA at the health center level and CPA at the hospital level;
- Organizing mini-campaigns for IMNCI detection and treatment clinics and open house days at the i-CCM sites, during which community members received explanations of services offered and sick children received care;
- Supplying i-CCM sites and health facilities with medicines, management tools, and basic health care supplies;

- Subsidizing i-CCM site supervision visits, including for community health workers (CHWs) upon submitting their monthly reports and for the head nurses conducting the supervisions.

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

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

i-CCM sites

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

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

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

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

Table 5. Utilization rates for i-CCM interventions

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

RESULTS

Pneumonia:

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

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

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

Diarrhea:

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



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

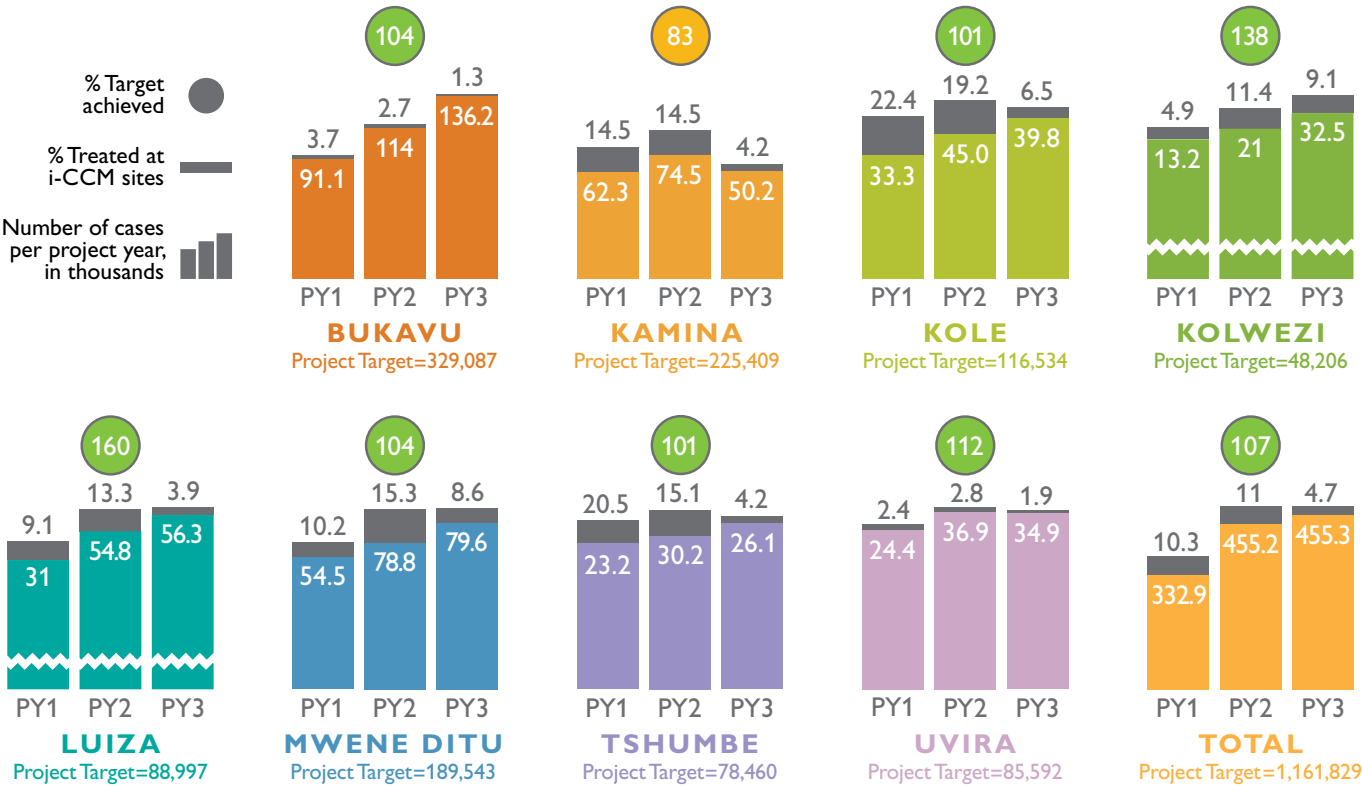


Fig 9. Number of cases of childhood diarrhea treated in USG-supported health facilities (percentage at i-CCM sites)
For the total project, 10.1% of cases were treated at i-CCM sites for a total achievement of 99%.

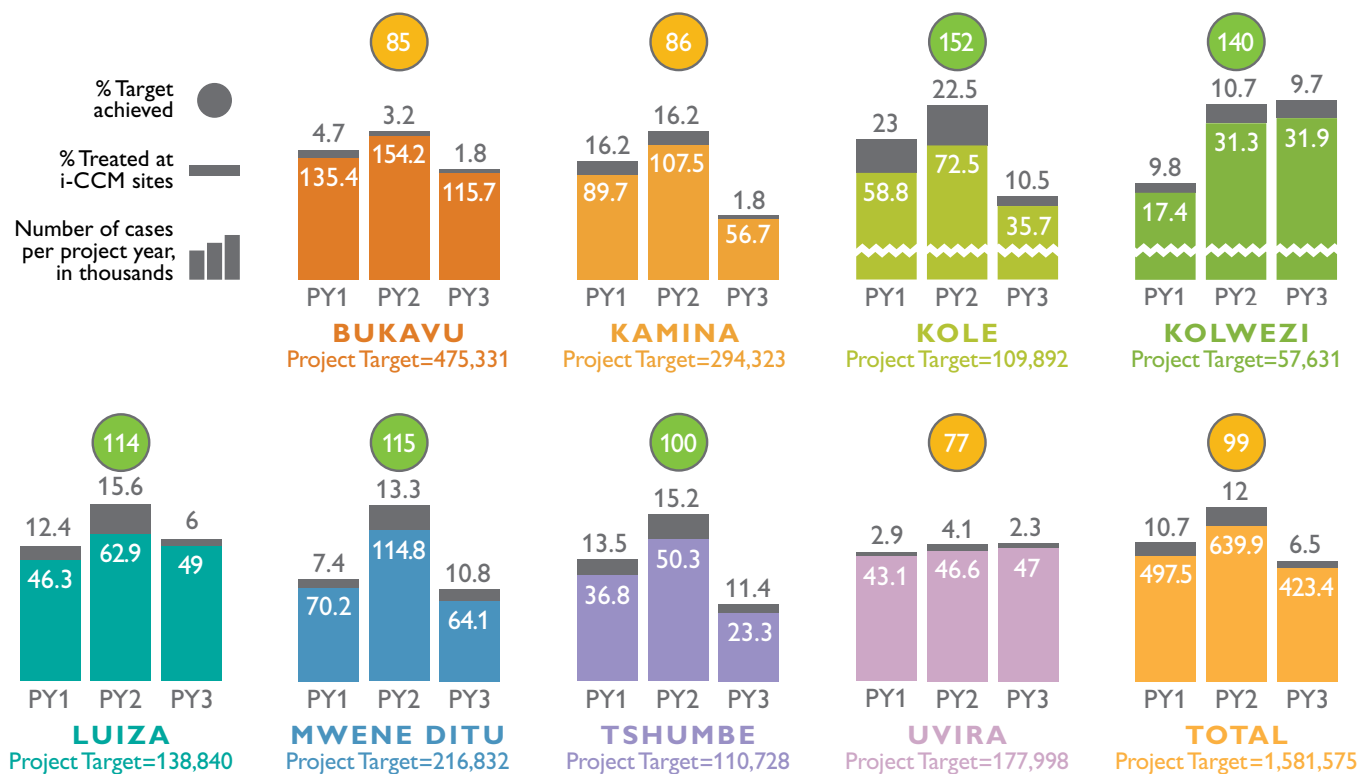
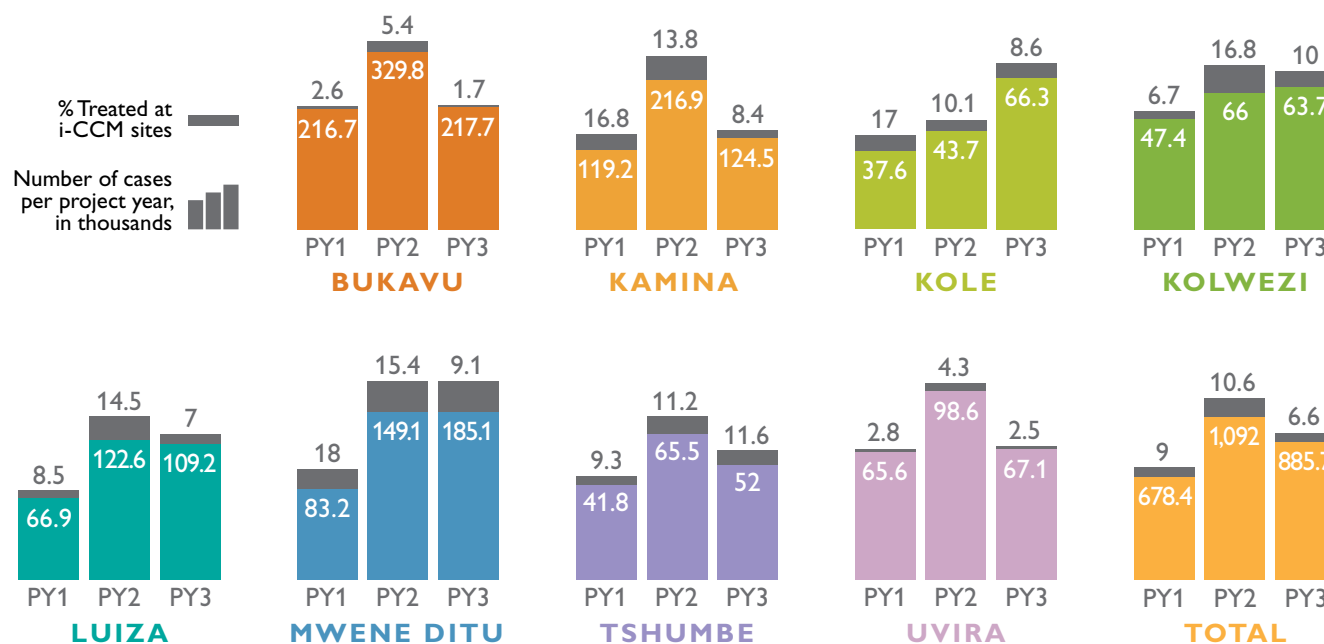


Fig 10. Number of cases of children under five years with malaria treated in USG-supported health facilities (percentage at i-CCM sites)
For the total project, 8.9% of cases were treated at i-CCM sites.



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

Malaria:

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

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

LESSONS

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

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

RECOMMENDATIONS

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

Evidence-based WASH activities

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

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

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

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

TECHNICAL APPROACH AND ACTIVITIES

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

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

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

RESULTS

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

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

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

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

CHALLENGES

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



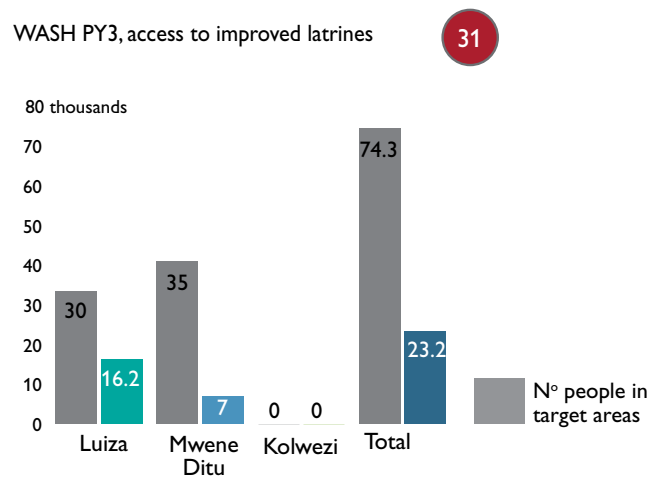
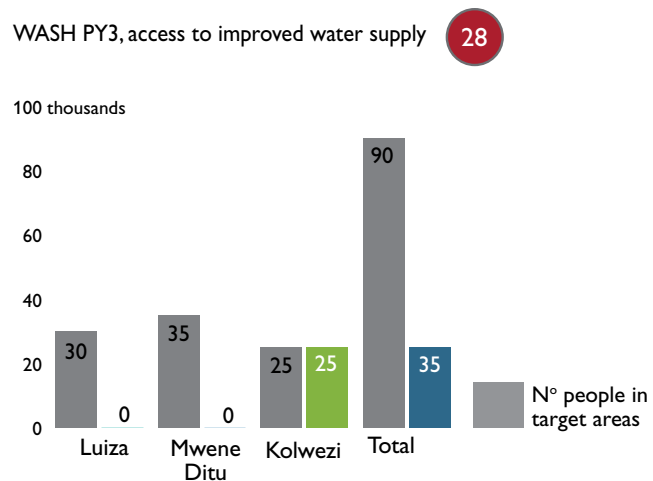
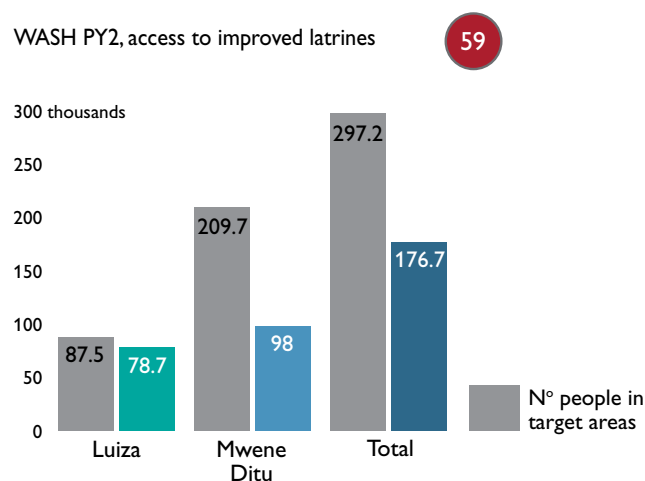
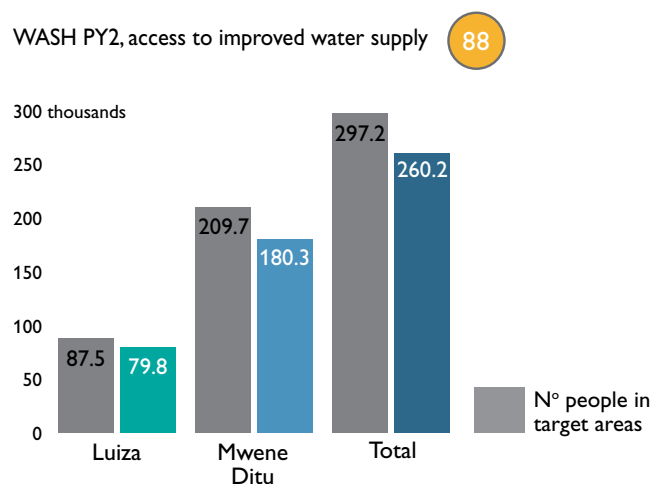
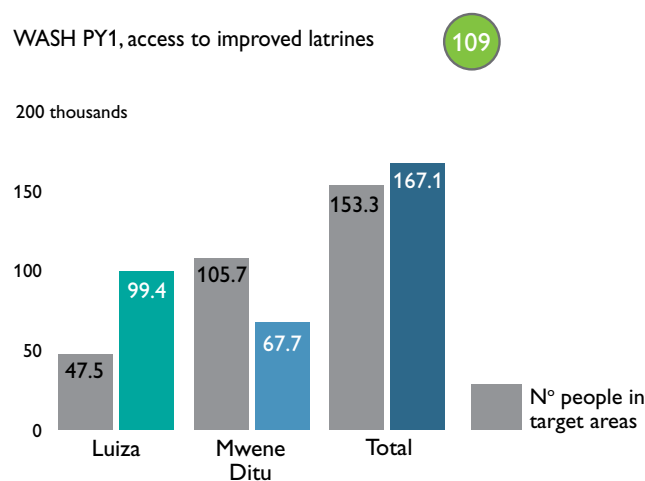
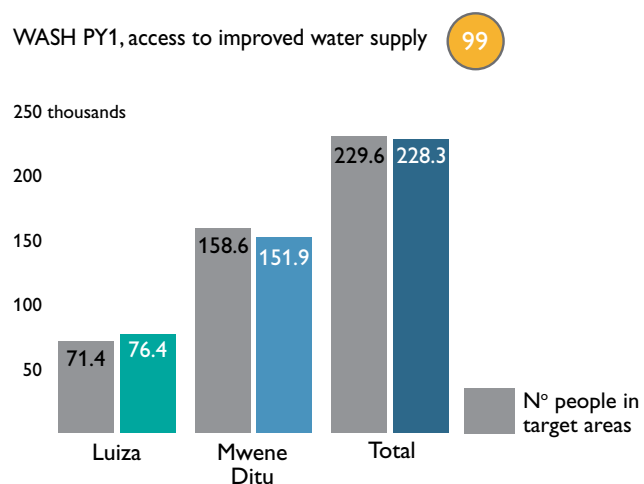
VOICES OF IMPACT

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

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

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

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



RECOMMENDATIONS

- Water source improvement is the first step to implement a WASH program, and then to improve hygiene and sanitation, including appropriate household waste disposal and the use of improved latrines. However, this process should be accompanied by the CLTS approach in order to foster sustainable behavioral changes. Setting up water point committees including health staff and local territorial entities, and motivating civil society organizations (CSOs) helps ensure water quality and sustainability. The introduction of a cost-benefit approach to strengthen collaboration with building material suppliers and users of new technologies, such as for well drilling, could improve hygiene and sanitation practices at the community level.
- Adopt a context-driven approach to determining the types of improved water source technology to implement, and do not focus solely on small sources, which typically have a low water flow rate and are generally located far from villages or at the bottom of valleys, where the terrain is hilly and access is difficult. Alternative technologies could improve geographical accessibility by providing improved water sources closer to larger populations, such as boreholes, manual wells, and collected rainwater, while prioritizing efficiency.
- Quality latrine building materials are lacking in rural areas and the introduction of a sanitation marketing strategy could be very useful in bringing together suppliers, the health sector, and community members through a formative research process.



PHOTO: Sarah Ranney, MSH

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

Leadership Development Program

TECHNICAL APPROACH AND ACTIVITIES

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

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

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

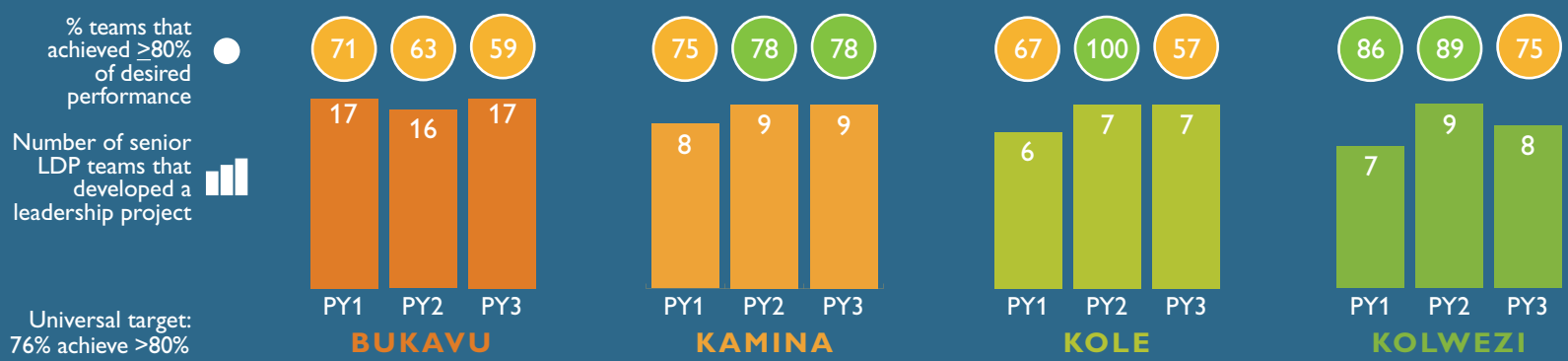
IHPplus provided quarterly support to LDP teams to:

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

RESULTS

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

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



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

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

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



PHOTO: Eleonora Kinnicutt, MSH





VOICES OF IMPACT

“ At the provincial level, **IHPplus BROUGHT US SOMETHING NEW TO IMPROVE GOVERNANCE AND LEADERSHIP,**

and in particular, to strengthen our capacity to conduct supportive supervision visits, through joint supervision visits and coaching from IHPplus staff.

“ONE OF THE MOST INNOVATIVE AND EFFECTIVE TRAINING TOOLS, IN MY OPINION, HAS BEEN THE LDP,

which has helped us to discover new ways to work as a team and to achieve a common goal. Our team in Kanzenze, for example, decided to construct a new health center in the village of Disombo. They developed a plan that they presented to their community, and with their support, were able to achieve this goal.

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

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

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

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

CHALLENGES

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

RECOMMENDATIONS

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

Table 6. LDP projects per technical area

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

IR2

INTERMEDIATE RESULT 2

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

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

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

Photo by Rebecca Weaver



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

IR 2.1 CLINICAL AND MANAGERIAL CAPACITY OF HEALTH CARE PROVIDERS INCREASED

Maternal, neonatal, and child health

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

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

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

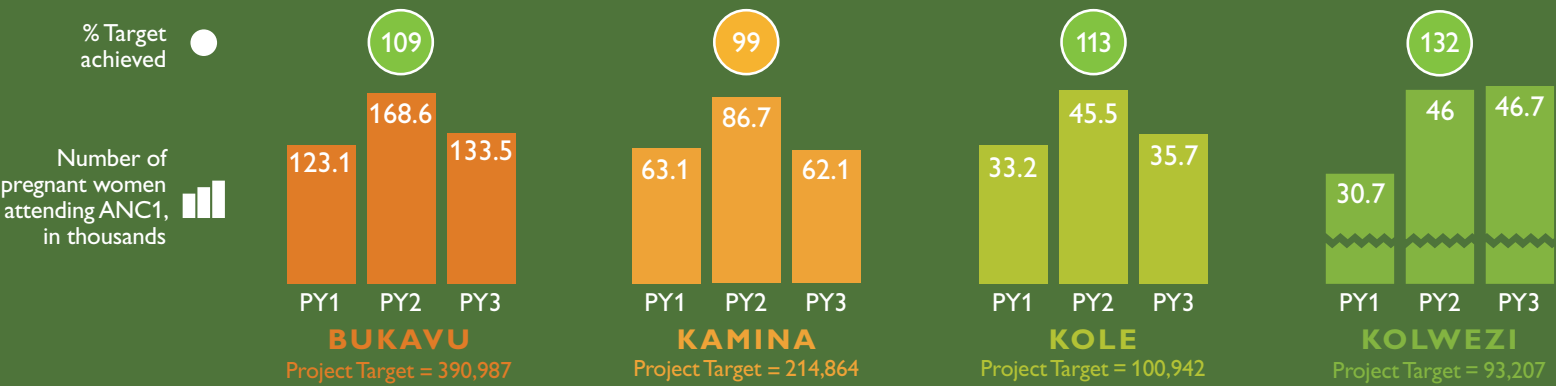
- Insufficient number of trained health personnel;

- Limited emergency obstetric care (less than half, or 47% of all hospitals) and basic obstetric care (less than 15% of health centers and referral facilities);
- Inadequate supplies and medicines for maternal and neonatal care; less than 20% of health facilities have the essential medicines necessary (SARA, 2014).

To achieve its objectives, IHPplus assisted the MOH in the implementation of selected priority activities, including:

- Capacity building of providers in Emergency Obstetric and Newborn Care (EmONC) by focusing on good delivery

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



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

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

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

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

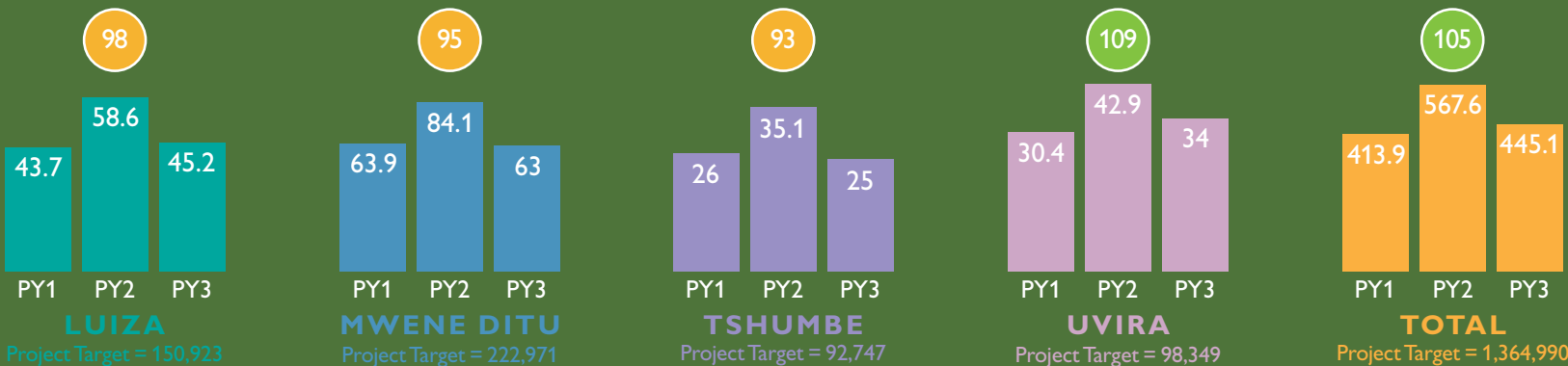
French) carried out on-site provider follow-up and supervision in MNCH through briefings based on real cases and practical training on mannequins.

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

RESULTS

Percentage of pregnant women attending ANC1 visit:

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



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

Percentage of pregnant women attending at least four ANC visits:

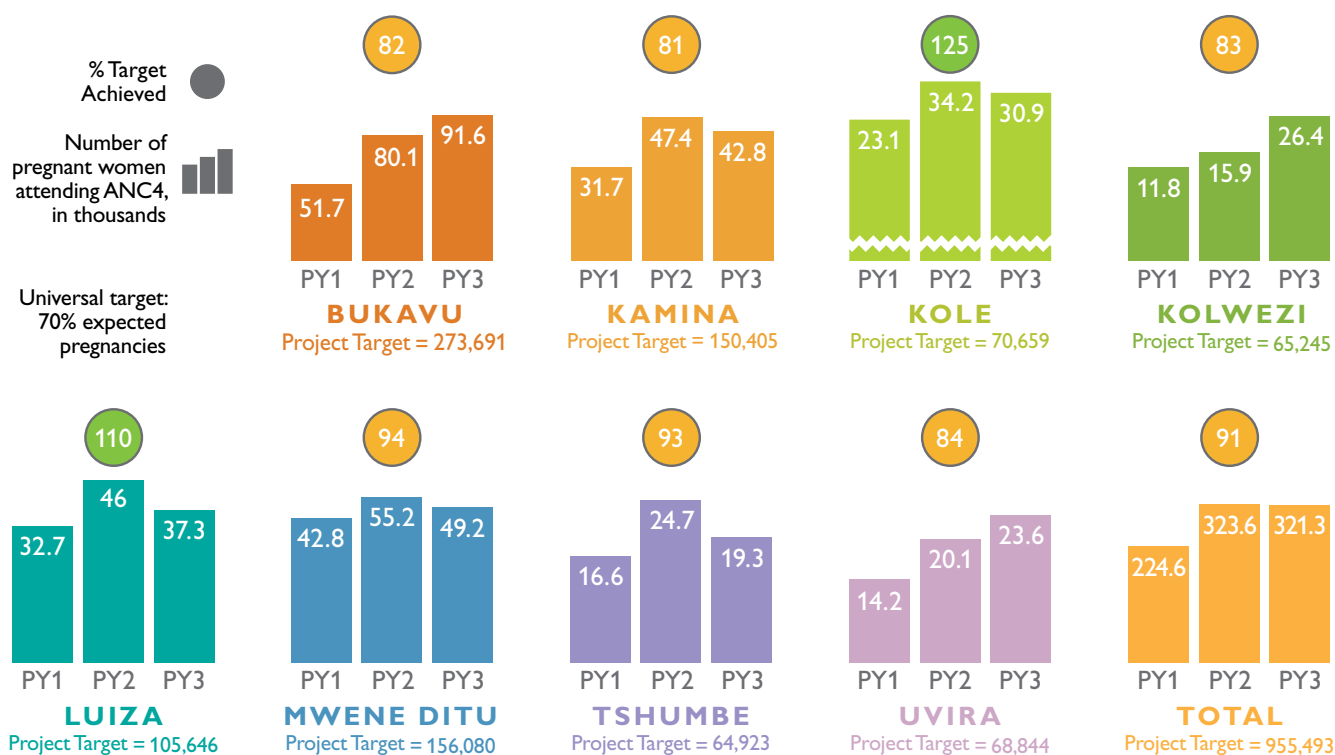
During IHPplus a total of 869,486 women attended at least four ANC visits (ANC4), representing an achievement rate of 91% (Figure 14). Two coordinations (Kole and Luiza) surpassed the target, and the remaining coordinations achieved at least 80% of the target. The number of ANC4 visits increased progressively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

Many pregnant women start their ANC late and therefore cannot achieve the recommended four visits, sometimes due to cost, personal habits or customs, or the long distance to get to a health facility. Some women start their ANC visits on schedule, but do not meet the deadlines to complete all four. While the project did not achieve the highly over-estimated PND5 target of 90% for ANC4 visits, it did surpass it for ANC1. In addition to the strategies mentioned for increasing ANC1 visits, the increase in ANC4 visits may also be linked to the use of mobile phone messaging for awareness raising (Luiza and Tshumbe) and the adoption of this indicator as an LDP goal in certain health zones in Luiza.

Deliveries by a skilled birth attendant:

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

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



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

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

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

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

Newborns receiving essential neonatal care:

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

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

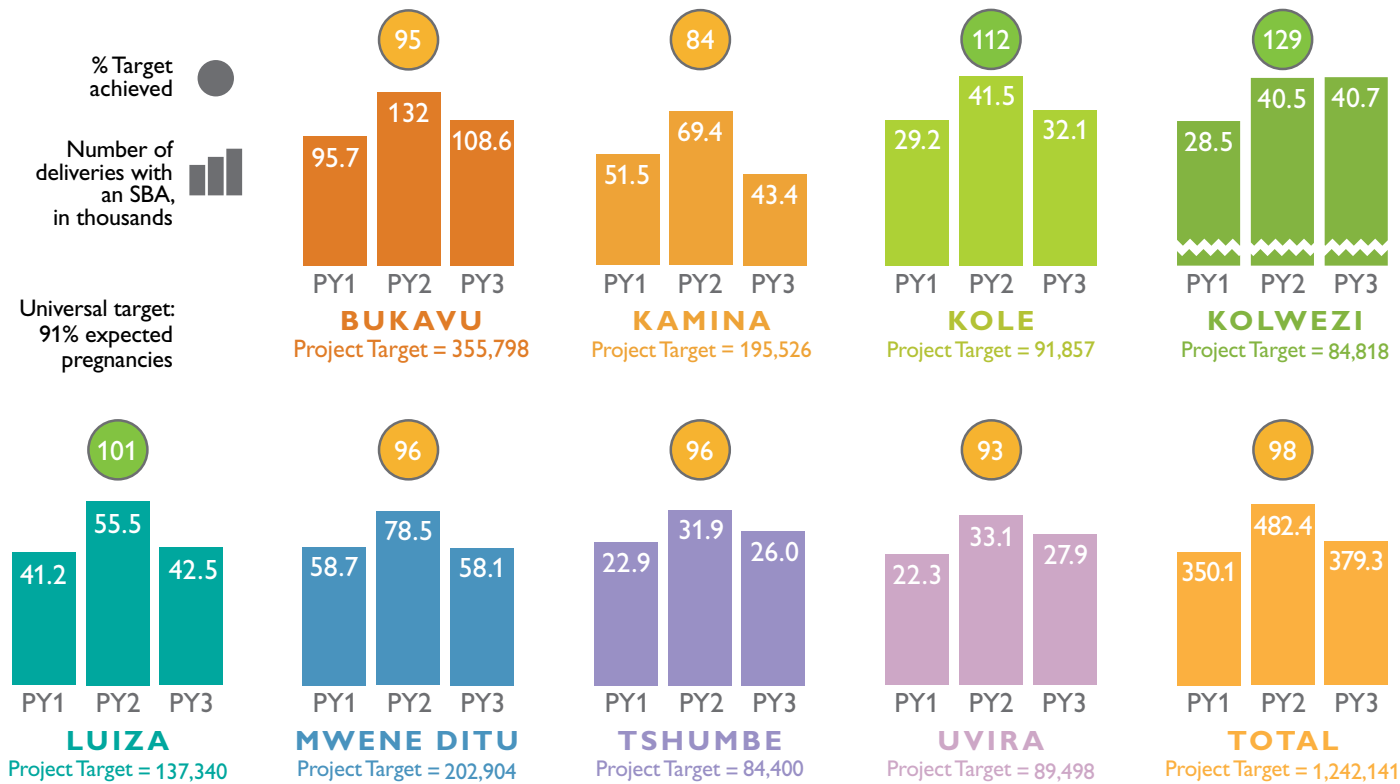
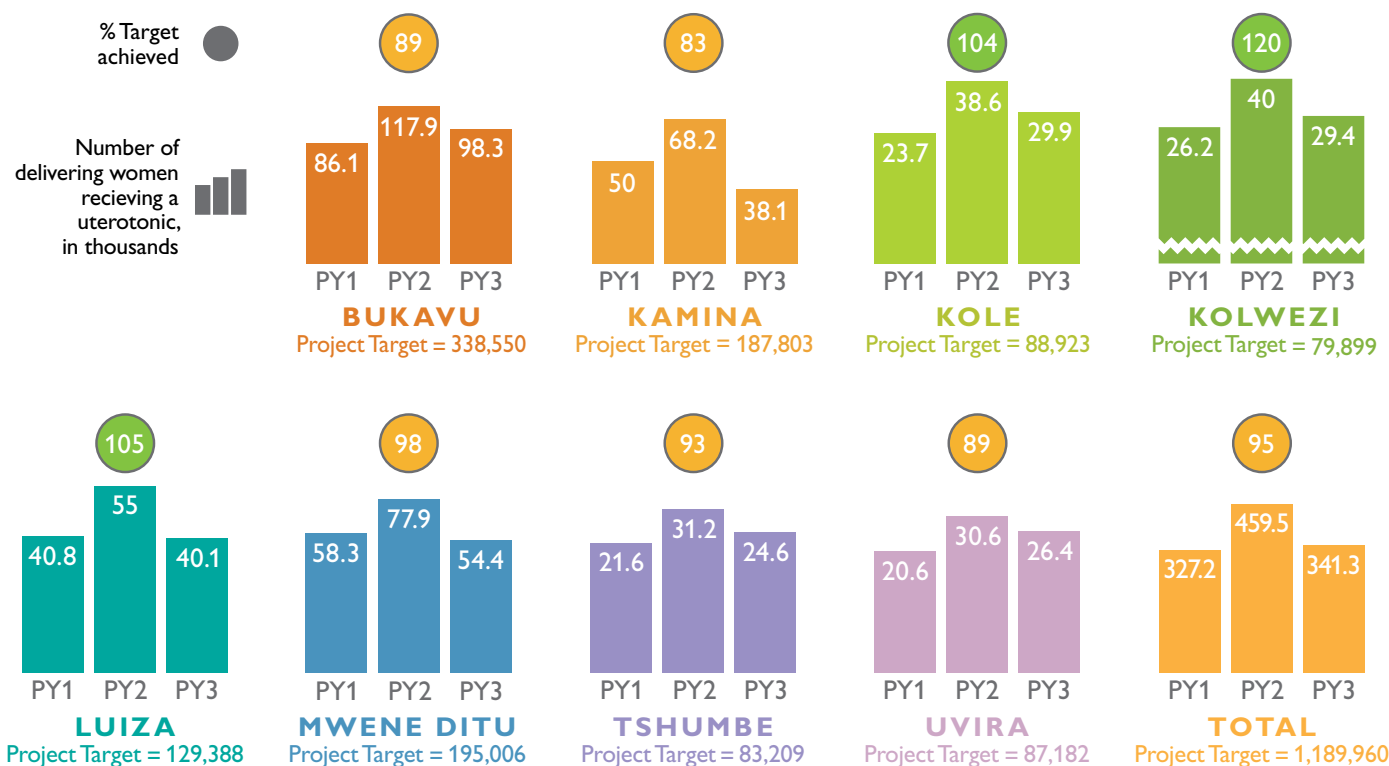
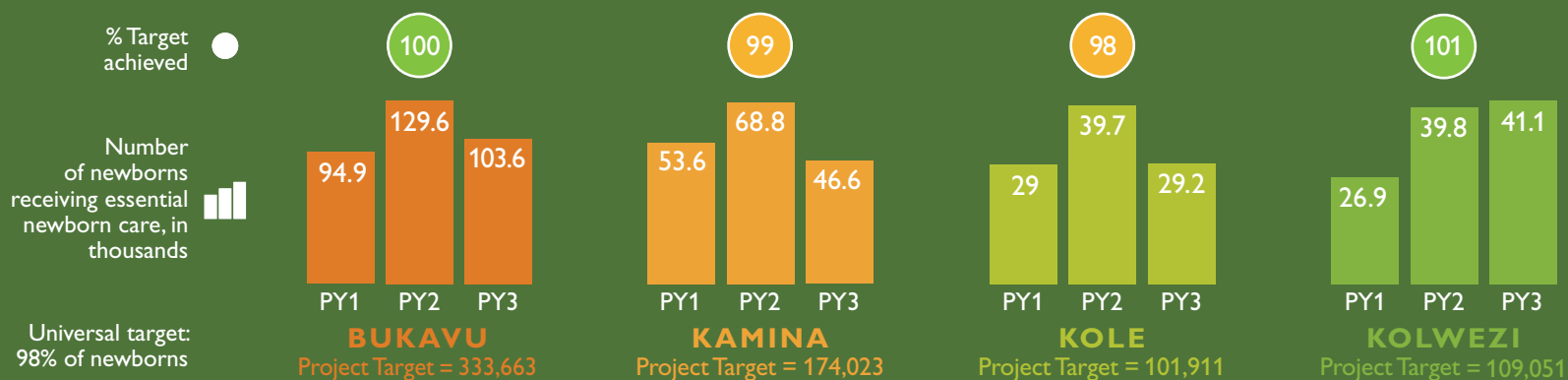


Fig 16. Number of women giving birth who received a uterotonic in the third stage of labor (or immediately after birth) through USG-supported programs



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

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



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

Newborns receiving antibiotic treatment for infection from appropriate health workers:

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

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

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

Helping Babies Breathe:

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

CHALLENGES

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

of ANC visits and costs associated with prenatal care;

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

RECOMMENDATIONS

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

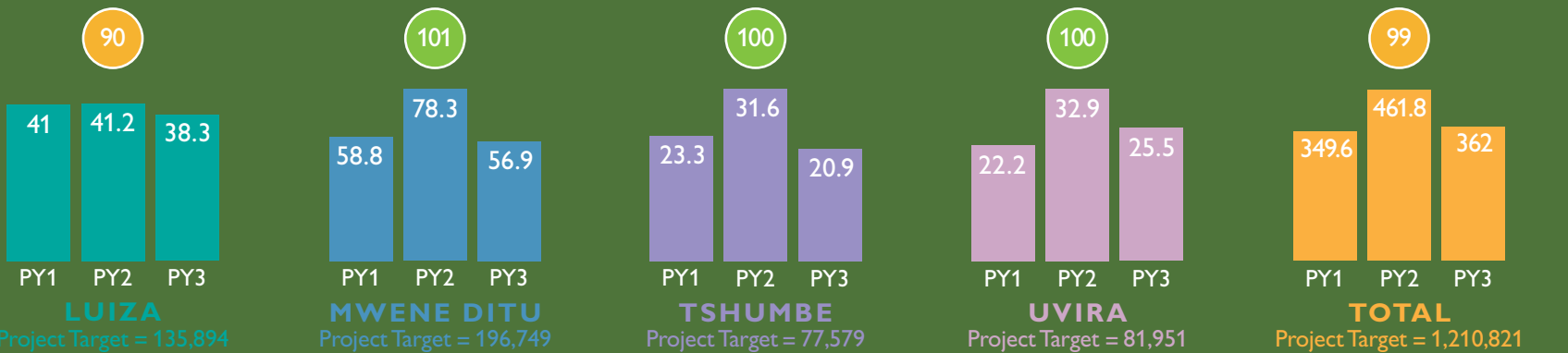


Fig 18. Number of newborns receiving antibiotic treatment for infection from health workers through USG-supported programs

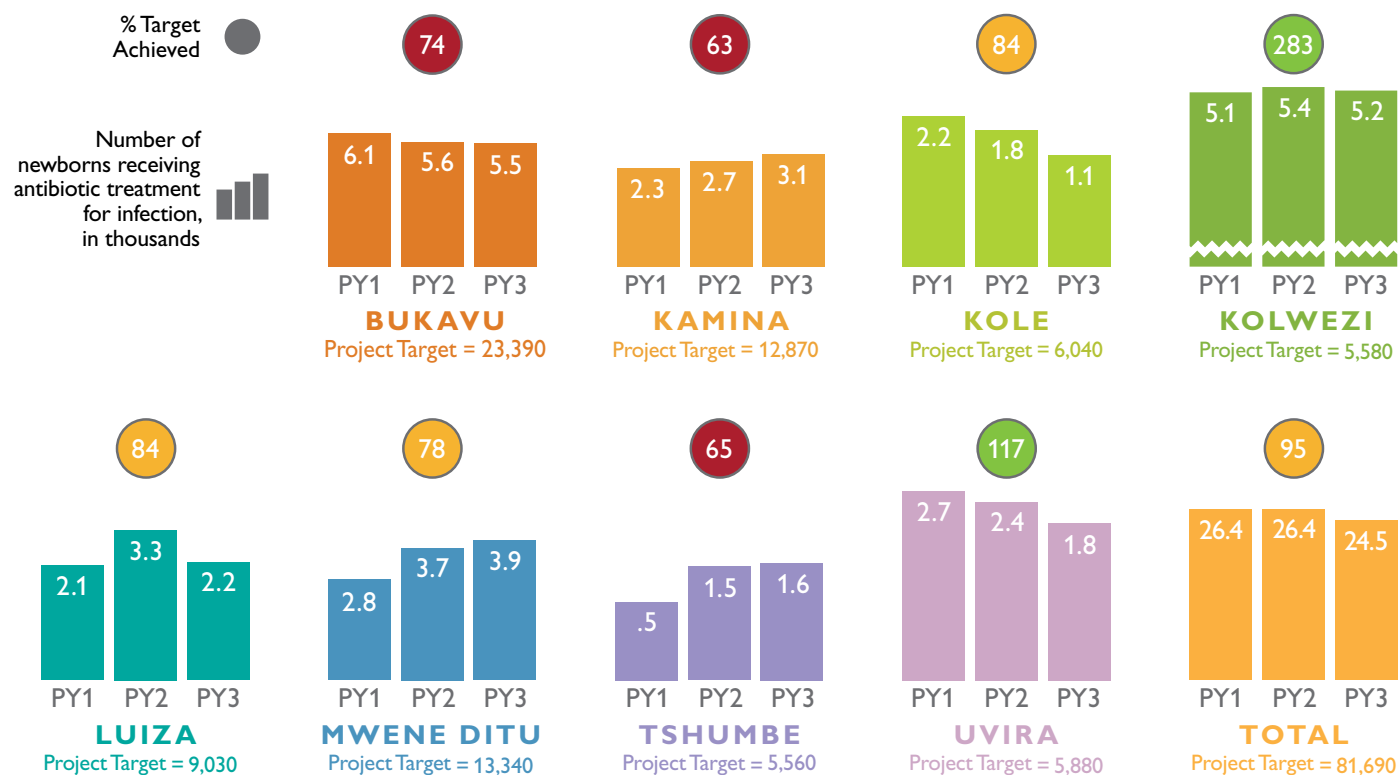
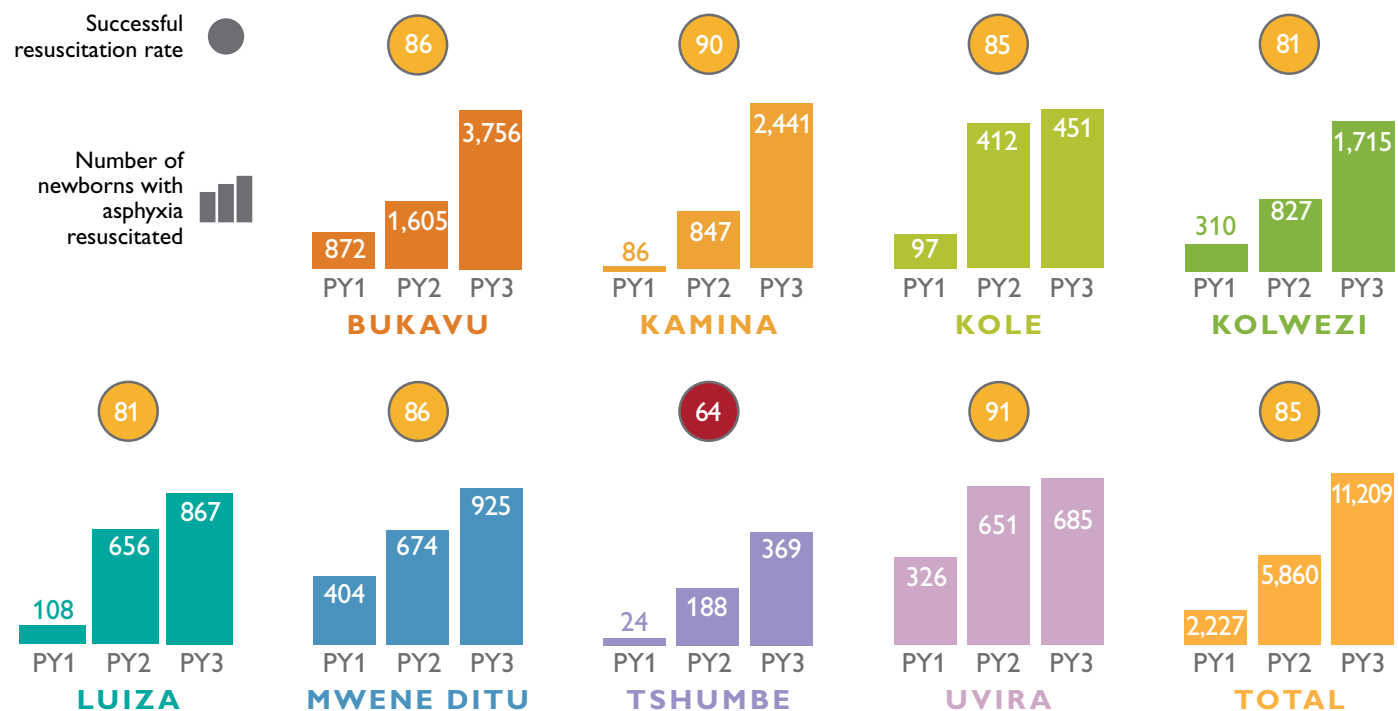


Fig 19. Number of newborns with asphyxia resuscitated in USG-supported programs





“

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

—Julienne Kandanda, Mulamba Health Center

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

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

LESSON LEARNED

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

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

Expanded Program on Immunization

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

The DRC faces major logistical challenges to providing sustainable immunization

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

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

IHPplus strengthened vaccination services by focusing on local capacity building



VOICES OF IMPACT

“

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

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

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

EXCERPTS FROM AN INTERVIEW WITH

NEEMA KITIMA on **HELPING BABIES BREATHE**
Head midwife, Bahira GRH, Bukavu health zone

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHALLENGES

The major challenge to improving vaccination coverage remains poor availability of

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

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

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

RECOMMENDATIONS

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



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

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

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

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

Family planning

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

methods to at least 2.1 million additional women.

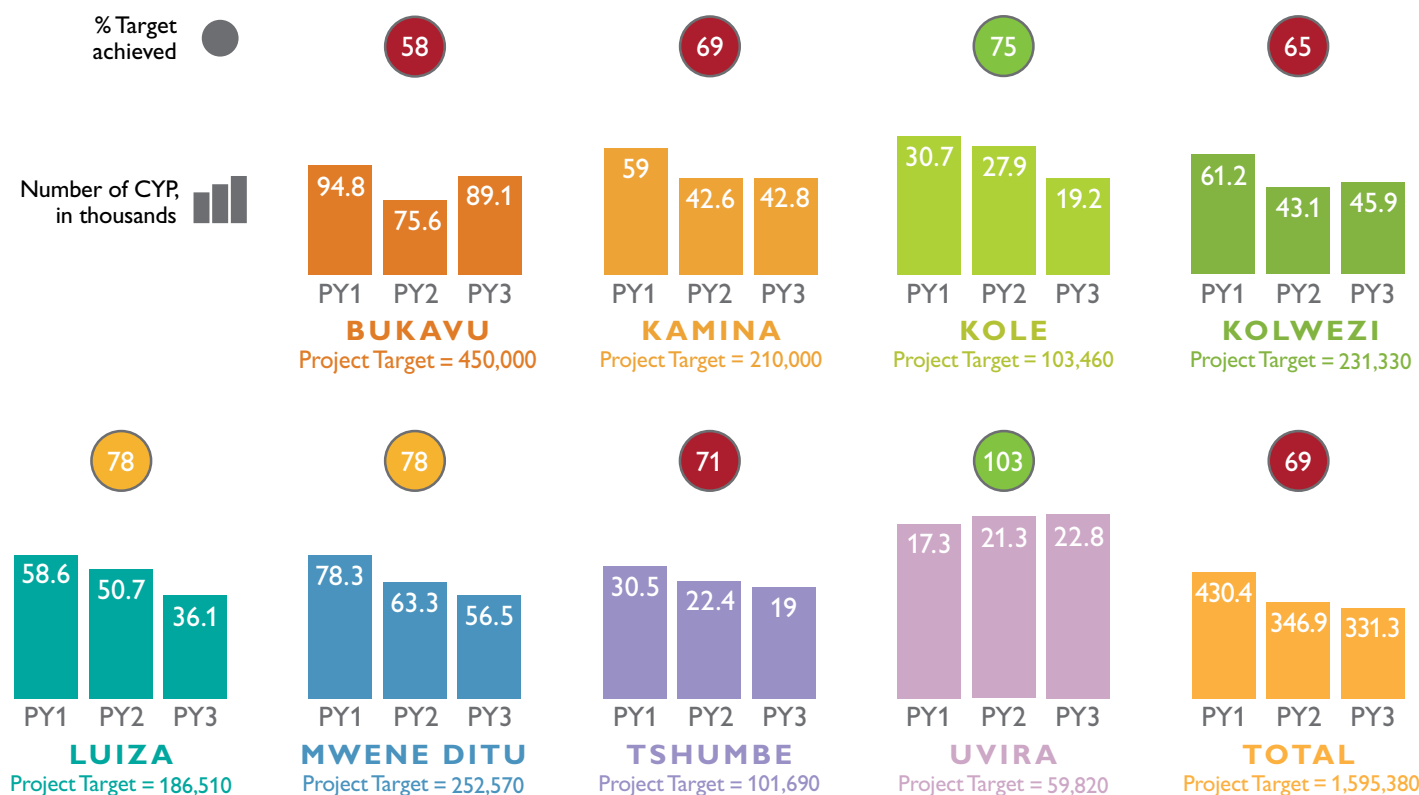
Continuing the work of IHP, IHPplus supported the extension of FP service coverage to 160 new health areas; support to community-based distributors (CBDs) in 82 new health areas; the integration of new contraceptive

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



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

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



To achieve these results, IHPplus:

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

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

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

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

RESULTS

CYP in USG-supported programs:

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

quarters of the project year.

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

FP counseling visits:

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

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

LESSON LEARNED

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

Nutrition

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

RECOMMENDATIONS

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

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

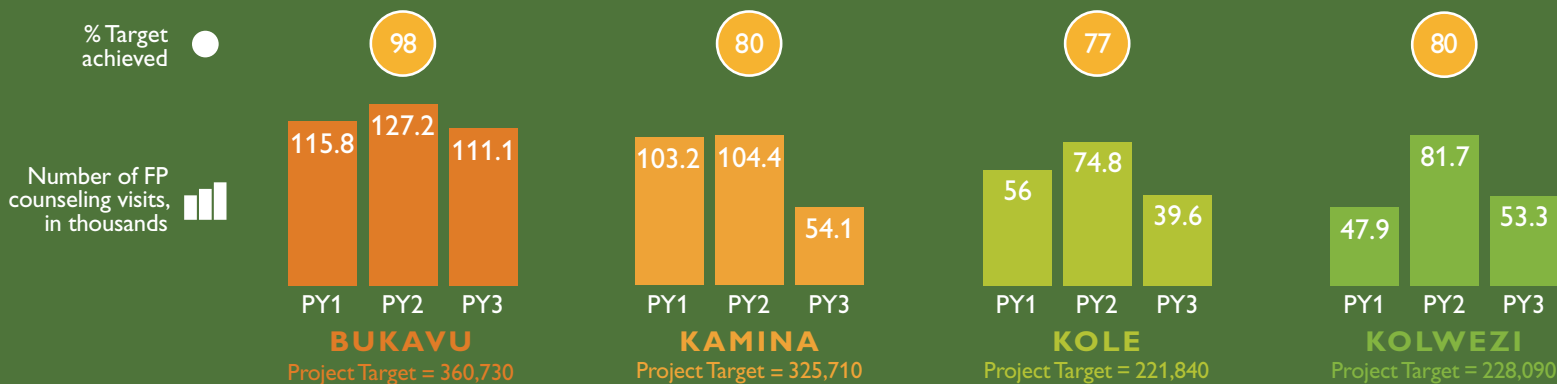
TECHNICAL APPROACH AND ACTIVITIES

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

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

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

Fig 21. Number of FP counseling visits during IHPplus



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

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

RESULTS

Stock-outs of folic acid:

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

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

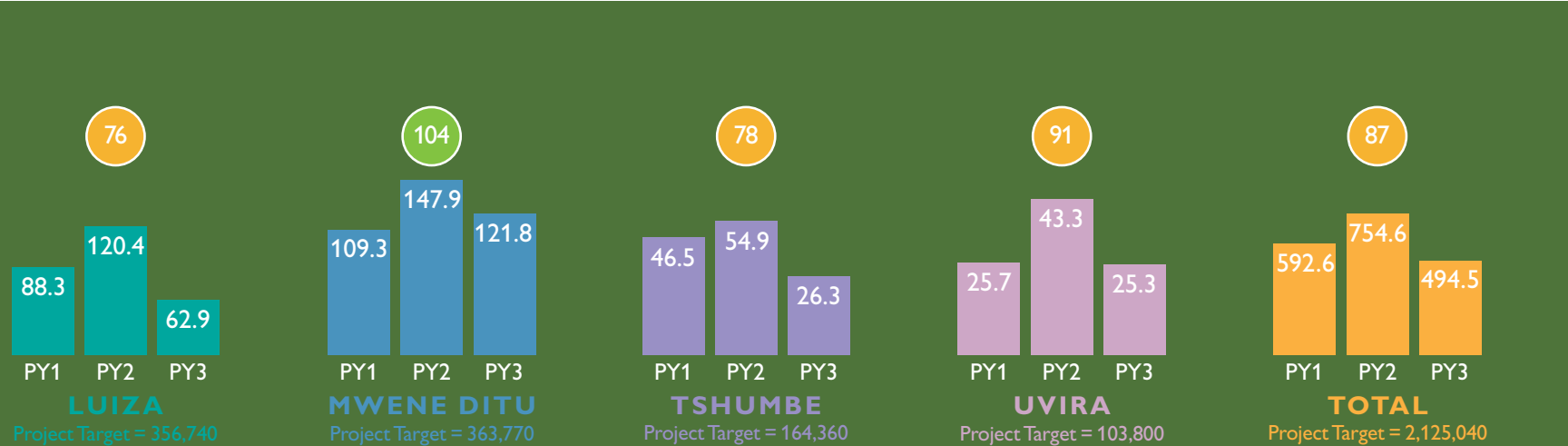
Proportion of pregnant women who received iron folate tablets to prevent anemia during the last five months of pregnancy:

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

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

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

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





VOICES OF IMPACT

“

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

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

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

EXCERPTS FROM AN INTERVIEW WITH

SCHOLASTIQUE MUKENYI on ICYF

33 years old, married with five children, Dibindi health zone

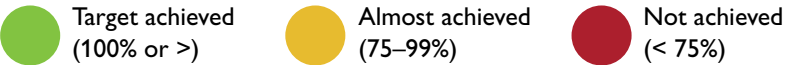
performing coordinations include Bukavu (7%), Kole (0%), Tshumbe (0%), and Uvira (36.6%). The poor performance is due to a lack of funding available to carry out nutrition-related trainings as planned.

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

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

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

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



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

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

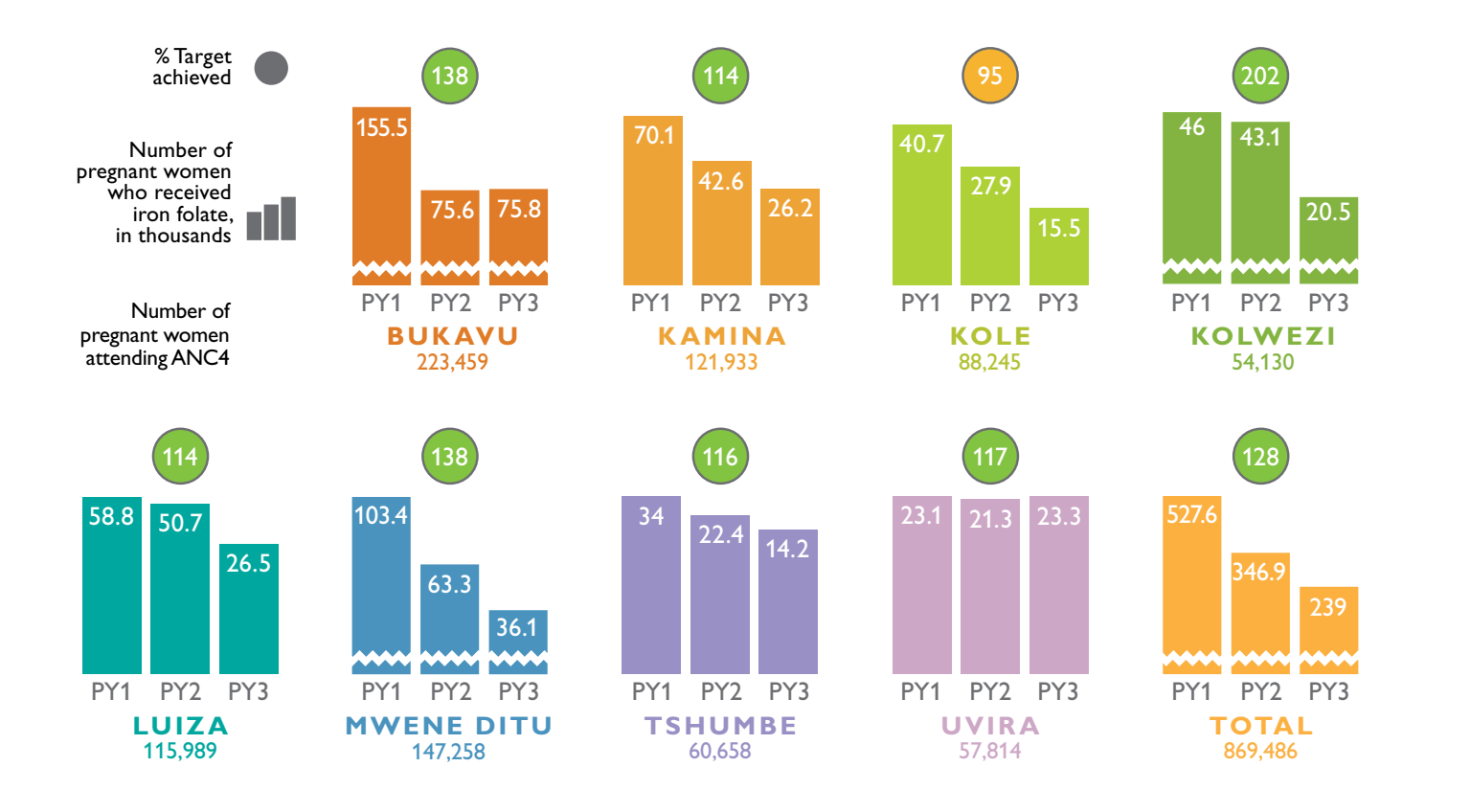


Table 8. Number of people trained in child health and nutrition

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

CHALLENGES

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

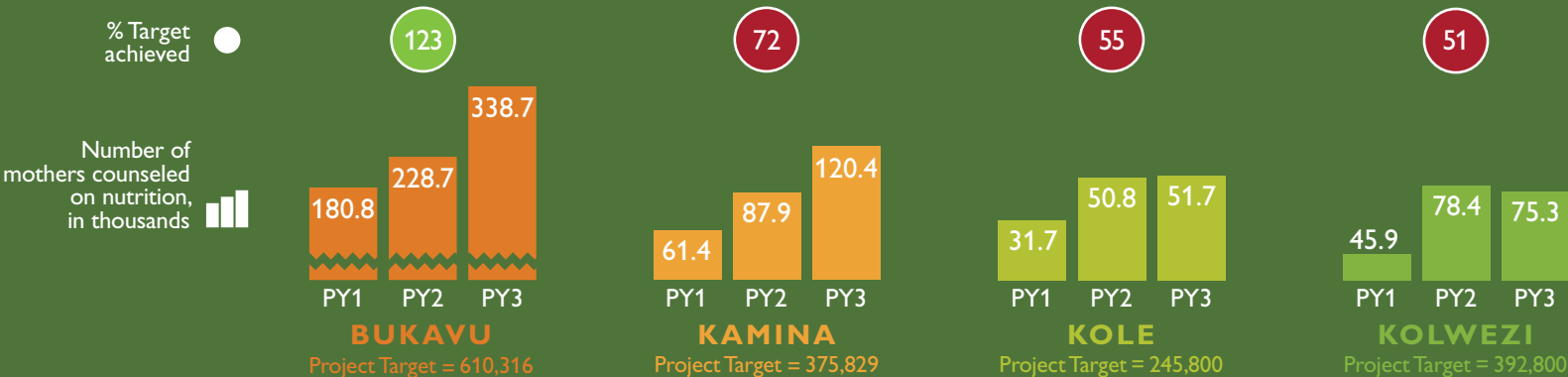
LESSONS LEARNED

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

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

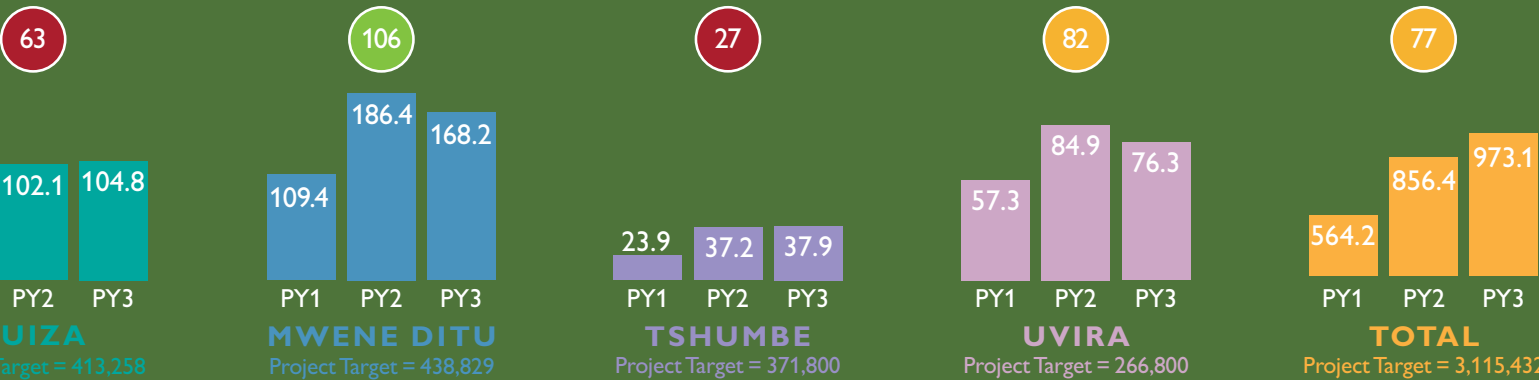
■ It is also important to continue to train providers on supply chain management and proper monitoring of commodities to avoid stock-outs and guarantee a regular and sufficient supply of iron folate and other commodities across health facilities.

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





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



A young girl with dark skin and short hair is standing in a field of tall, green grass. She is wearing a patterned dress with orange, blue, and yellow designs. She is looking directly at the camera with a serious expression. The background is a blurred field of green grass and trees.

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

— Focas Bihigi, member of CODESA in Miti Murhesa

Malaria

TECHNICAL APPROACH AND ACTIVITIES

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

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

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

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

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

- Procurement of antimalarial commodities, tools, and equipment: IHPplus provided financial support throughout the life of the project to transport and distribute commodities, including ITNs, SPs, RDTs, and malaria treatment kits, to all project-supported health zones; stock health facilities and i-CCM sites with data collection and management tools; and equip i-CCM sites with essential tools needed to function, including medicine cases, scales, decanters, water cans, plastic chairs, timers, and plastic baskets with lids.
- Capacity strengthening efforts in malaria case management, supervision, and data quality: IHPplus provided technical and financial support throughout the project to train doctors, nurses, and CHWs on prevention, diagnosis, and treatment of malaria in adherence to national guidelines; conducted joint supervision visits with the PNLP and DPS to health zone central offices and health facilities in the 168 project-supported health zones; and led monitoring and supportive supervision visits to i-CCM sites with the support of PMI, as well as data validation visits at the DPS and health zone central offices in the project-supported health zones.

- SBCC: IHPplus provided technical, logistical, and financial support to carry out malaria mini-campaigns in two health zones within each project-supported coordination, as well as a four-month malaria campaign in the health zones of Idjwi and Miti Murhesa in Sud Kivu to raise awareness of the importance of early ANC for pregnant women and IPT administration; and provided financial and technical support to carry out activities for World Malaria Day annually at both at the national and DPS level.
- Research and innovation: IHPplus provided financial support to carry out research on malaria interventions, including a study on the utilization of rectal artesunate at i-CCM sites for severe malaria cases, as well as an evaluation of the impact of malaria campaigns on IPT of malaria for pregnant women in Sud Kivu (Miti Murhesa and Idjwi health zones); participated in two international conferences, including the Roll Back Malaria SBCC Conference in 2016 during which IHPplus project staff presented the abstract “The Contribution of the Champion Communities Approach to Healthy Behaviors and Utilization of Health Services in Democratic Republic of Congo,” and the 2016 American Public Health Association (APHA) conference where IHPplus staff presented an abstract entitled: “High-impact malaria interventions save children’s lives in the Democratic Republic of Congo.”
- Coordination and partnerships: At the central level, IHPplus has worked closely with the PNLP to organize and lead meetings with its different units, and has provided technical assistance to develop, update, and review national-level normative documents and guidelines related to malaria case management.

RESULTS

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

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

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

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

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

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

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

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

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

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

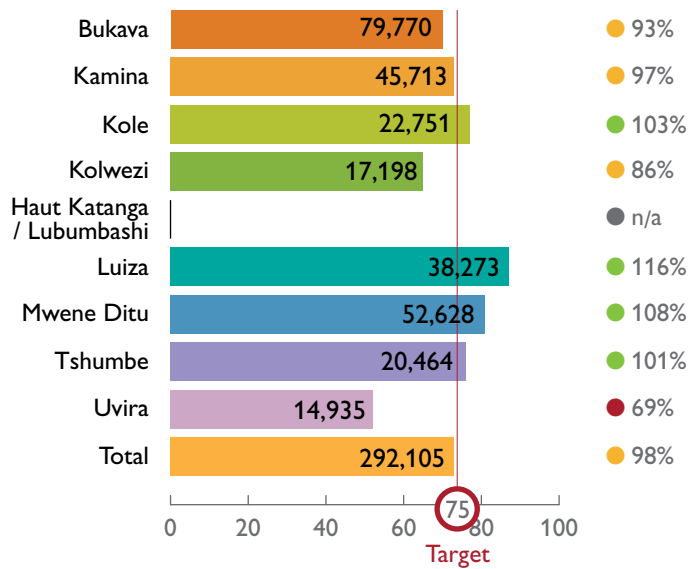
IHPplus also provided support to the PNLP to conduct quarterly supportive supervision visits to health zones as well as monthly joint supervision visits with health zone central offices to health facilities. During the course of these visits some of the key improvements noted include the number of pregnant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

CHALLENGES AND RECOMMENDATIONS

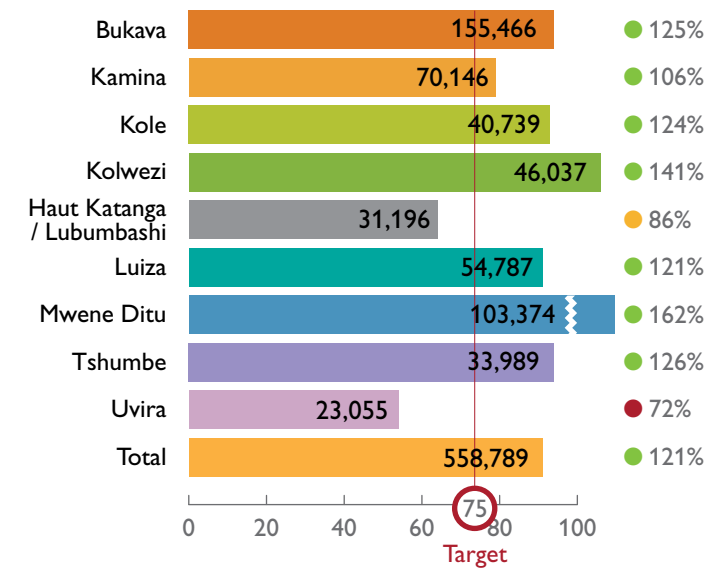
■ The project observed improper use and administration of injectable artesunate, leading to frequent stock-outs. Currently, health facilities are stocked with a limited amount of injectable artesunate intended for children less than five years old who are the most vulnerable and at-risk group for malaria.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

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

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



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



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

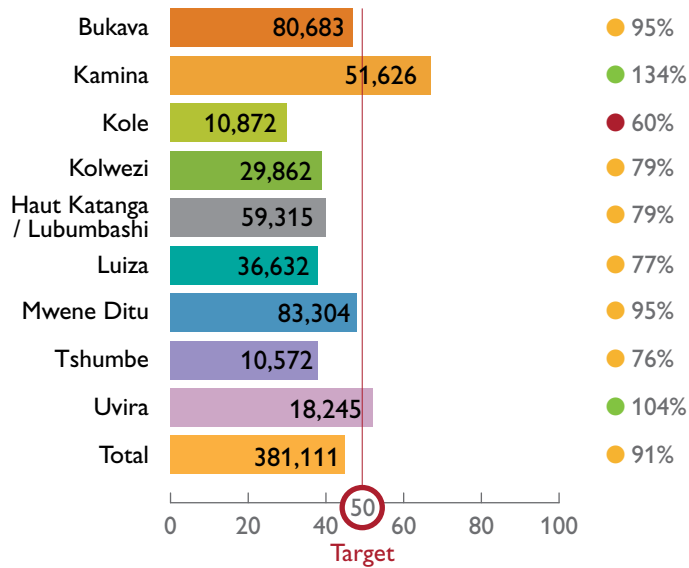


Photo by Warren Zelman



VOICES OF IMPACT

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

“We have been able to rehabilitate this health structure to adequately accommodate our patients. We have completely restructured our patient records and filing systems, and trained staff to properly fill out the forms, which has really helped to improve quality and timeliness of services and tracking of patients. **THESE IMPROVEMENTS MEAN THAT WE NOW NEED TO SPEND LESS TIME ON ADMINISTRATIVE TASKS AND MORE ON OUR PATIENTS.**

I can ask questions and receive one-on-one feedback on my work. This has helped me grow and improve as a provider. Sustaining the gains we have achieved will not be easy; but thanks to our strengthened capacity, skills, and motivation, I am confident we can do it. **I'LL DO MY VERY BEST TO CONTINUE MY LIFE'S WORK: PROVIDING HIGH QUALITY CARE TO TREAT MY BROTHERS AND SISTERS.”**

EXCERPTS FROM AN INTERVIEW WITH

DR. FREDDY MBIYA on **SUPPORT FOR HIV CARE**
HIV focal point, Mwangeji Hospital, Kolwezi

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

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

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

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

HIV

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

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

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

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

TECHNICAL APPROACHES USED AND ACTIVITIES

The project used the following technical approaches:

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

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

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

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

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

RESULTS

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

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

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

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

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

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

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

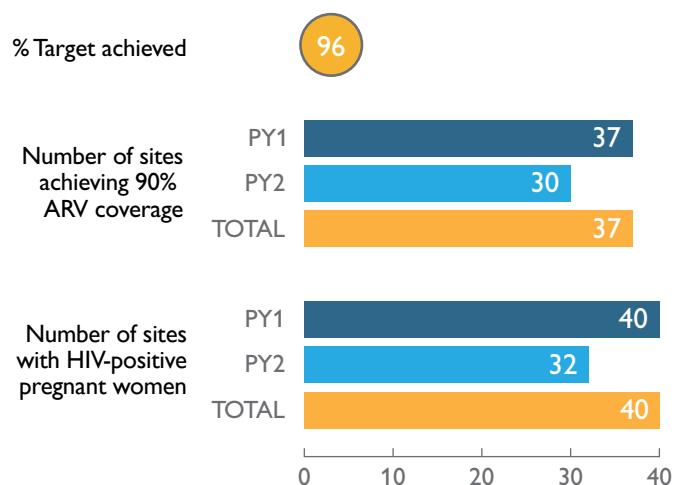
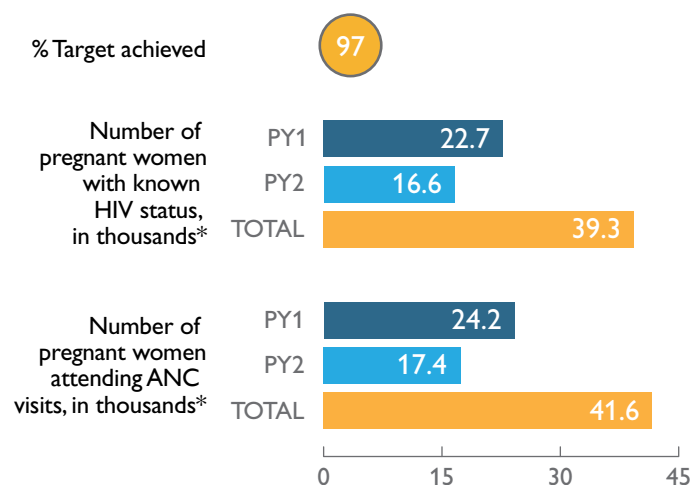


Fig 26. Number of pregnant women with known HIV status (includes women who were tested for HIV and received results)



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

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

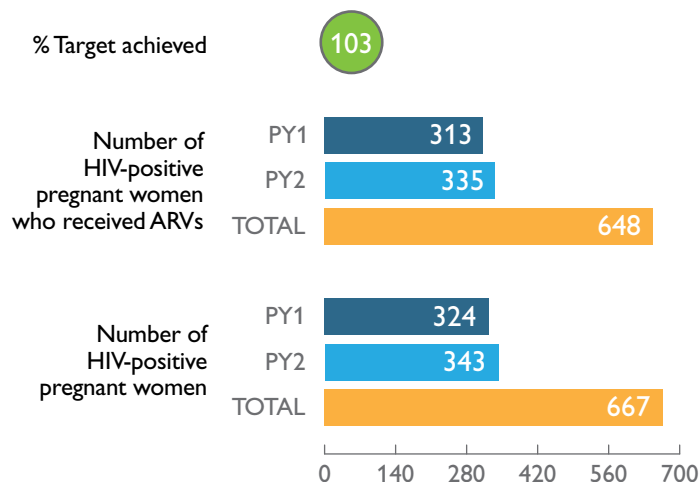
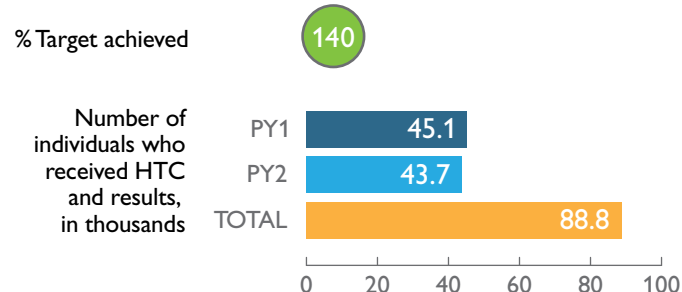


Fig 28. Number of individuals who received HTC and received test results



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

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

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

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

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

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

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

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

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

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

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

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

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

HIV-FOCUSED RBF PROGRAM

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

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

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

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

Table 10. Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) or CD4 count or viral load

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

Table 11. Number of adults and children receiving ART

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

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

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

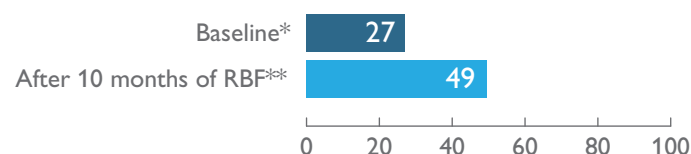
Table 13. Percentage of laboratories and HTC testing sites that participate in and successfully pass an analyte-specific proficiency testing program

PY1	PY2	Total
55	55	55
Target		55
Achievement %		100

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

PY1	PY2	Total
72	44	72
Target		72
Achievement %		100

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



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

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

Implementation process of HIV-focused RBF: Country level

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

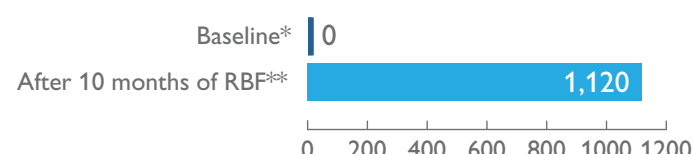
- Program costing: The project budgeted \$193,800 for performance payments, including \$12,000 per GRH, \$2,100 per health center, and \$2,400 per *bureau central de zone de santé*, or health zone central office, as well as \$10,000 per health zone for biological follow-up.
- Quantitative and qualitative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

Provincial level

Preparatory phase

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

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



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

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

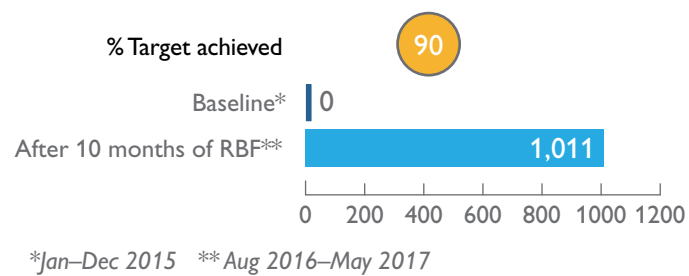
Implementation Phase

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

SELECTED RESULTS

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

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



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

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

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

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

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

CHALLENGES

■ Offering laboratory testing (especially viral load monitoring and EID) to patients in all eight IHPplus-supported health zones was challenging in the absence of an AIDS referral laboratory in Lualaba, and in view of national and international requirements for sampling and analysis of viral load and EID samples. Therefore, the project team worked with the PNLS at the national and provincial levels to institute an effective system of collecting samples for viral load monitoring and EID at HIV treatment sites in Lualaba, transporting the samples to the nearest referral laboratory in Lubumbashi for analysis, and reporting results back to the treatment sites within a two-week

period to ensure correct treatment of HIV-positive patients. However, the system only served the two urban health zones (Dilala and Manika) and the two semi-urban health zones (Fungurume and Lualaba) due to the remoteness of the four rural health zones supported by the project. In collaboration with the Lubumbashi referral laboratory team, IHPplus began to explore other mechanisms to better serve the remaining health zones (including building the capacity of the Lubumbashi laboratory to analyze dried blood spot samples and providing a rechargeable portable mini freezer to store and securely transport blood samples). While IHPplus was not able to implement these strategies, they have been implemented by IHAP and other partners.

■ The configuration of the HIV-RBF complementary module in the RBF web portal was not implemented prior to data verification due to the excessive workload of the RBF technical unit’s IT staff. The project worked around this issue by transmitting the data in Excel tables.

■ It was necessary for fellow PLHIV to conduct community verification and provide psychosocial support due to the sensitive nature of HIV status, but there were few functional local CBOs (with legal

CENTRE DE SANTE KANINA



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

— Raphael Kabangwe, HIV psychosocial assistant and PLHIV

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

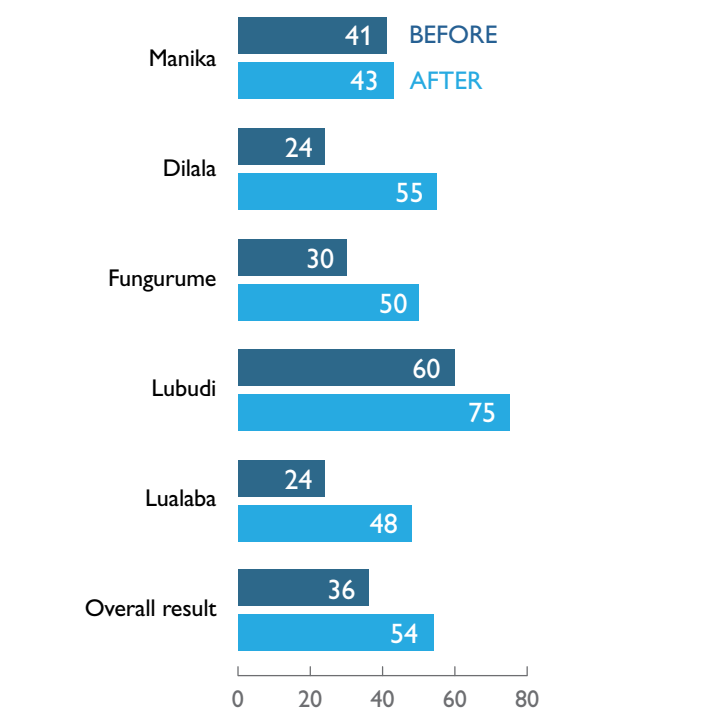
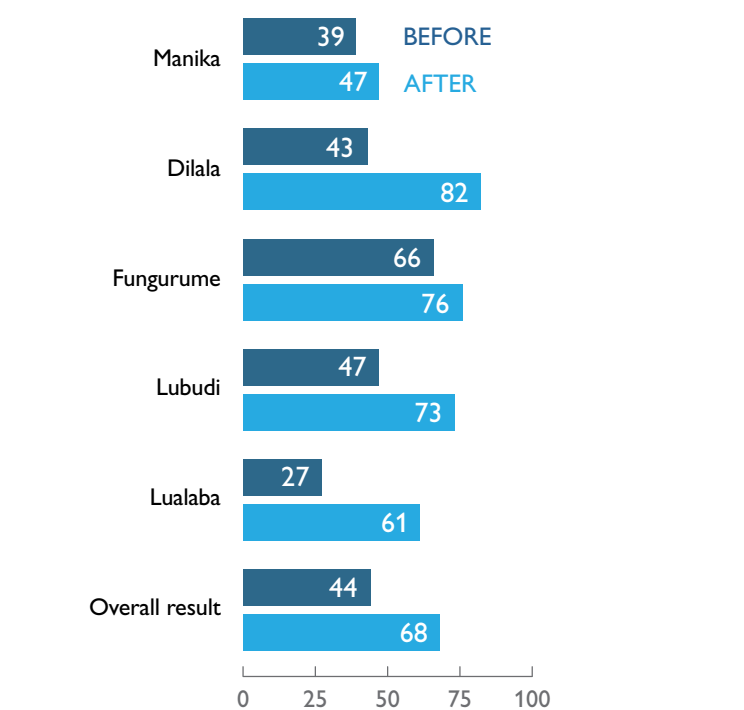


Fig 33. Quality of health services in GRHs implementing the HIV-focused RBF program, as measured by the FOSACOF tool (%)



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

LESSONS LEARNED

■ To be able to provide quality services to PLHIV, the support to HIV programs in resource-constrained countries should prioritize training HIV health care providers, providing adequate stocks of HIV commodities and appropriate equipment, involve the community, and motivate providers (e.g., through RBF programs).

- To retain patients receiving ART in the treatment program, programs should foster a strong connection between treatment facilities and communities to increase community involvement.
- Greater community acceptance of PLHIV leads people to be more open about their HIV status, which fosters increased utilization of services.
- The RBF approach focused on HIV in five health zones in the Lualaba DPS helped achieve the WHO 90-90-90 goal, through case management of PLHIV at points of care, leading to an increase of the number of new patients from 557 to

- 1,574, i.e., a 200% increase, and through follow-up and counseling of PLHIV. Extending this approach to several high-risk zones would further contribute to achieving the program objectives.
- An HIV-focused RBF program can rapidly increase the quantity and quality of indicators of population coverage and patient retention and well-being, as well as other system indicators not related to HIV.

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

Tuberculosis

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

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

TECHNICAL APPROACH

IHPplus used the following main strategies for TB:

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

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

ACTIVITIES

Project activities aimed at:

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

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

RESULTS

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

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

Community participation in active case detection of TB cases:

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



VOICES OF IMPACT

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

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

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

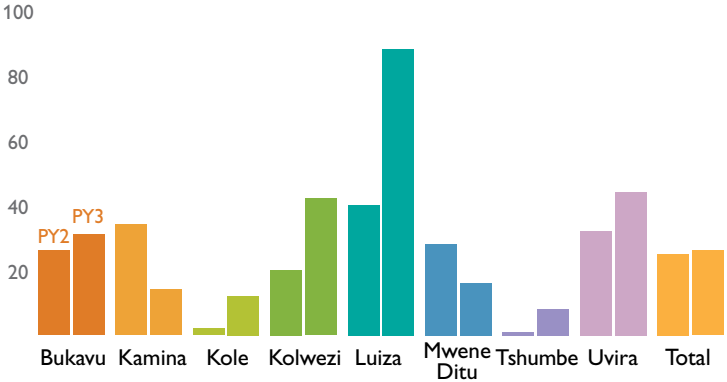
EXCERPTS FROM AN INTERVIEW WITH

YOUSOUF IBRAHIM on TB CARE

Former TB patient,

current member of *Club des Amis Damien*, Lualaba

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



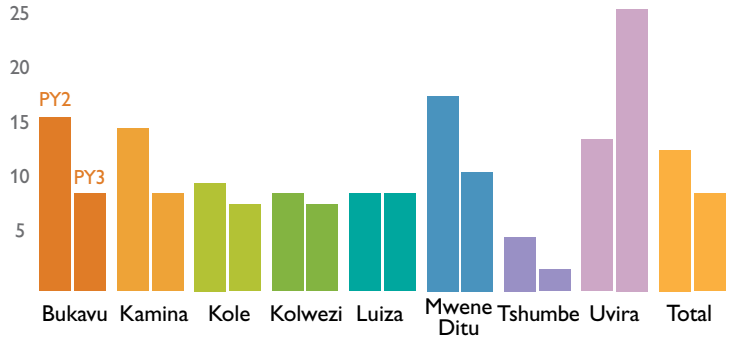
the DOTS, community health agents also provided TB education and awareness-raising to communities and conducted active door-to-door screening of index TB case contacts. During PY3, the strongest performing coordinations with regards to adherence to treatment for the community DOTS were Luiza (88%), Uvira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

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

Screening for pediatric TB:

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

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



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

Fig 37. Number of MDR-TB cases detected

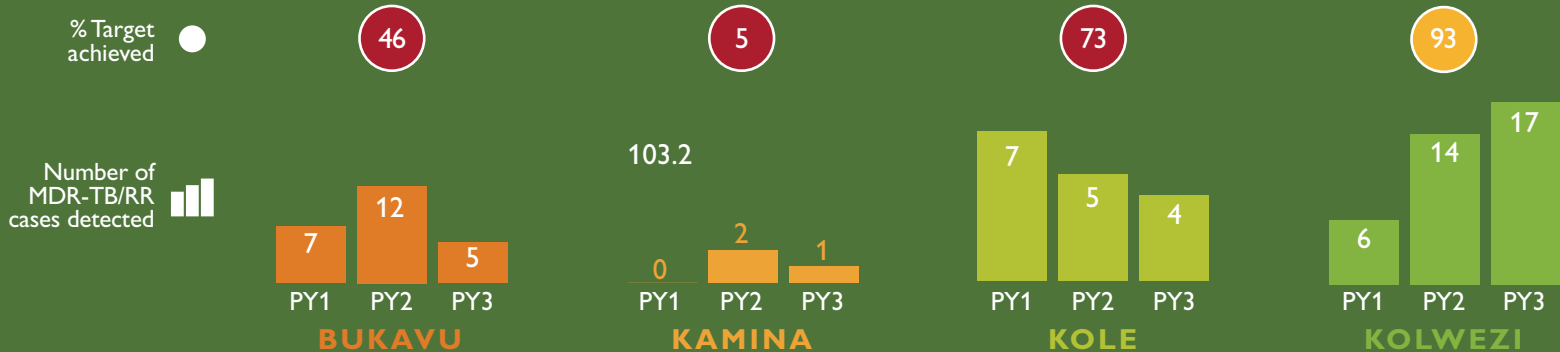


Fig 36. Notification rate for new cases of smear-positive pulmonary TB in USG-supported health zones, by project year

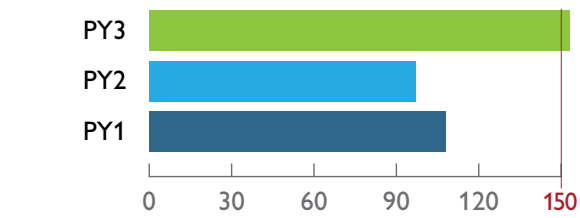


Photo by Warren Zelman

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

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

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

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

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

Number of MDR-TB cases detected:

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

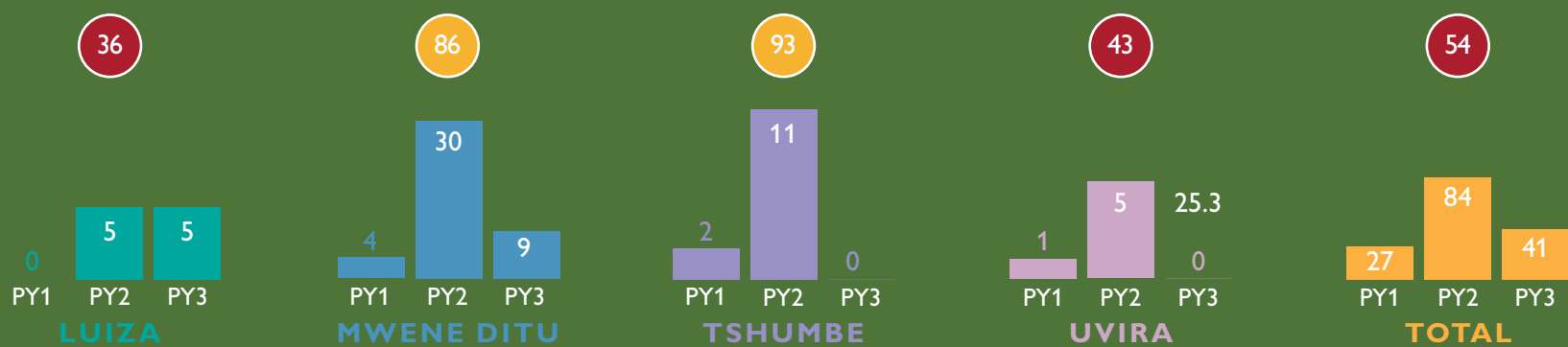


Table 15. MDR/RR-TB therapeutic success rate

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

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

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

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

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

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

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

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

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

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

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

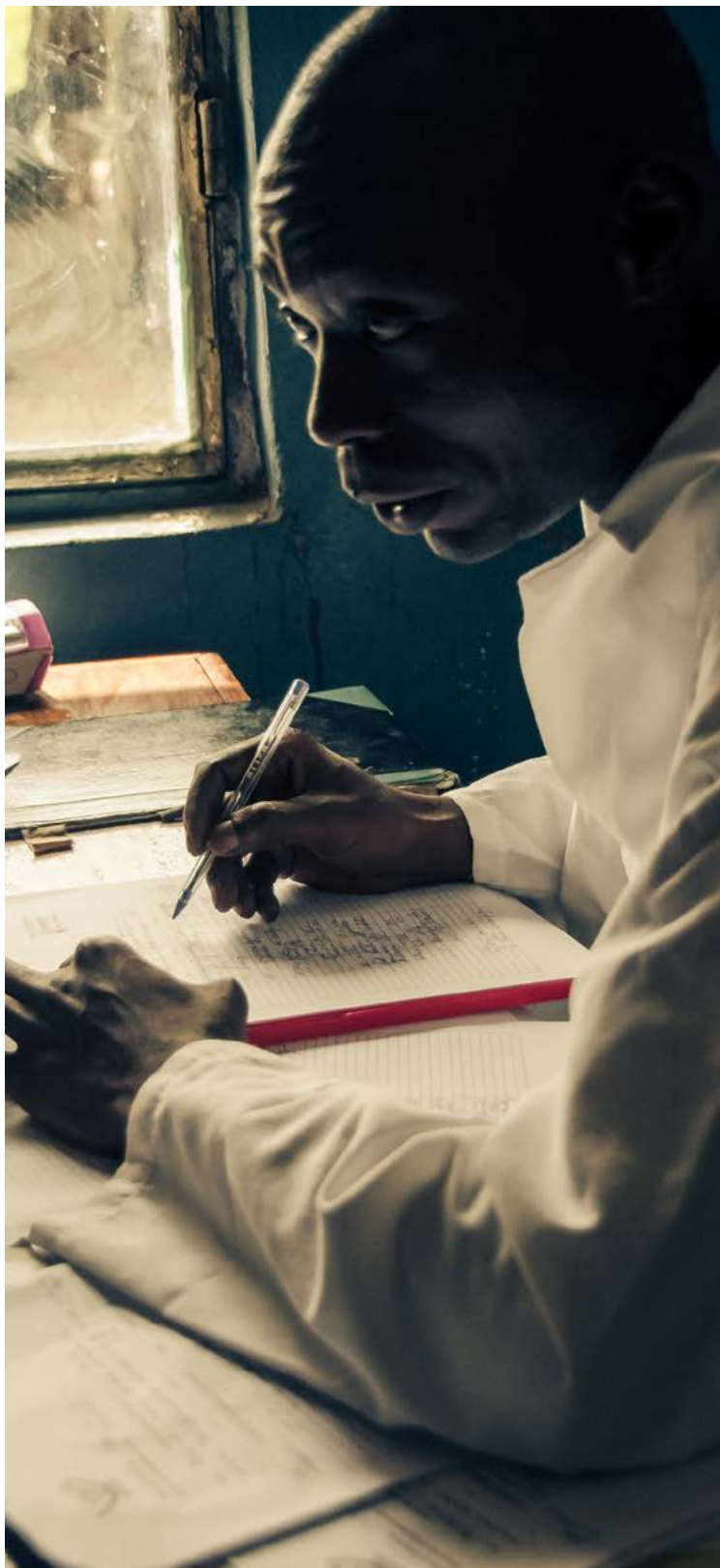
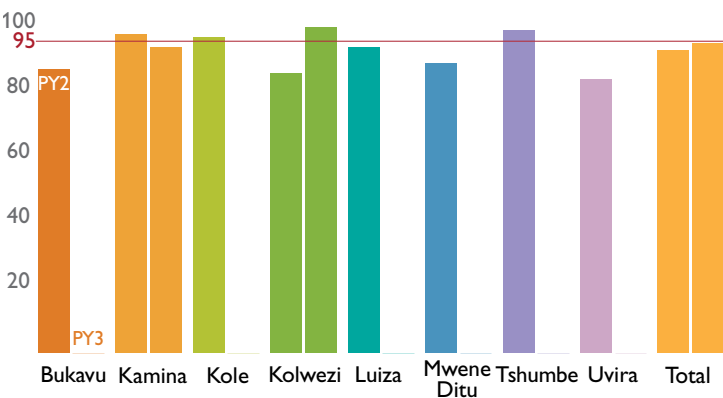


Photo by Warren Zelman

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



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

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

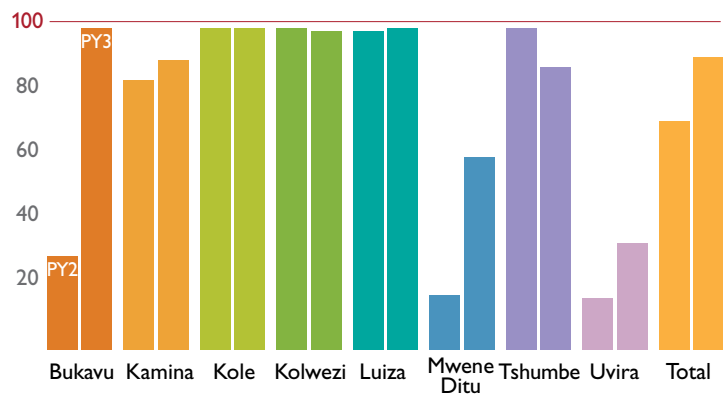
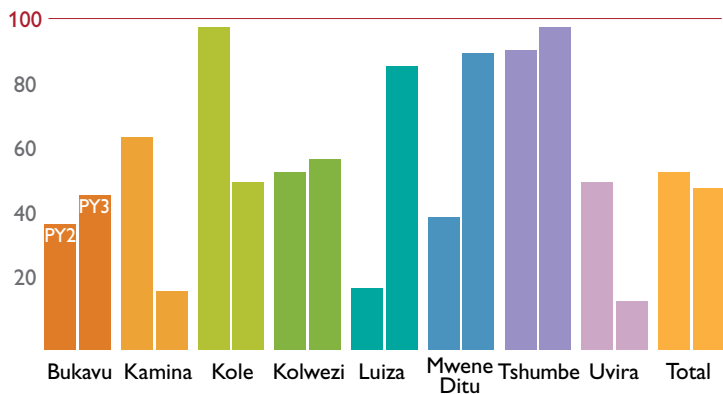


Fig 40. Percentage of HIV-positive patients without TB receiving INH prophylaxis



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

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

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

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

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

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

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

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

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

LESSONS LEARNED

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

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





VOICES OF IMPACT

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

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

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

Sexual and gender-based violence

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

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

ACTIVITIES

At the national level:

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

Children and with support from UN Women;

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

At the provincial level:

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

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

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

RESULTS

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

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

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

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

RECOMMENDATIONS

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

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



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

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

Fig 41. Care of SGBV survivors

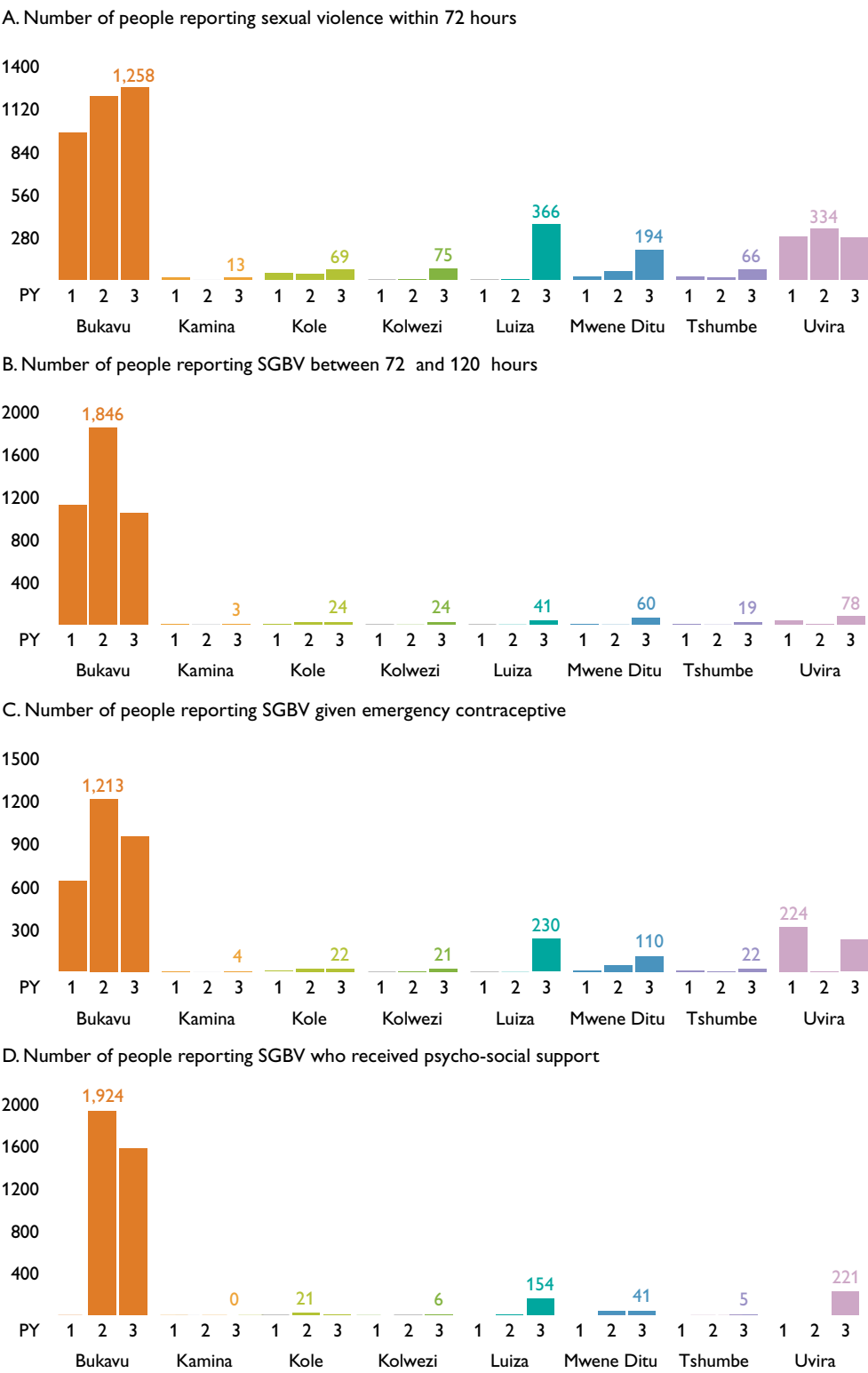


Table 17. Fistula repair at Kaziba GRH, Bukavu

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

*Numbers may not add exactly due to rounding.

Fistula

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

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

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

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

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

LESSONS LEARNED

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

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



VOICES OF IMPACT


“

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

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

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

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



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

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

Results-based financing (integrating the FOSACOF approach)

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

TECHNICAL APPROACH

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

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

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

ACTIVITIES

RBF implementation guides:

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

FOSACOF evaluations:

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

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

Integrated quality approach:

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

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

RESULTS

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

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

CHALLENGES

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

LESSONS LEARNED

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

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

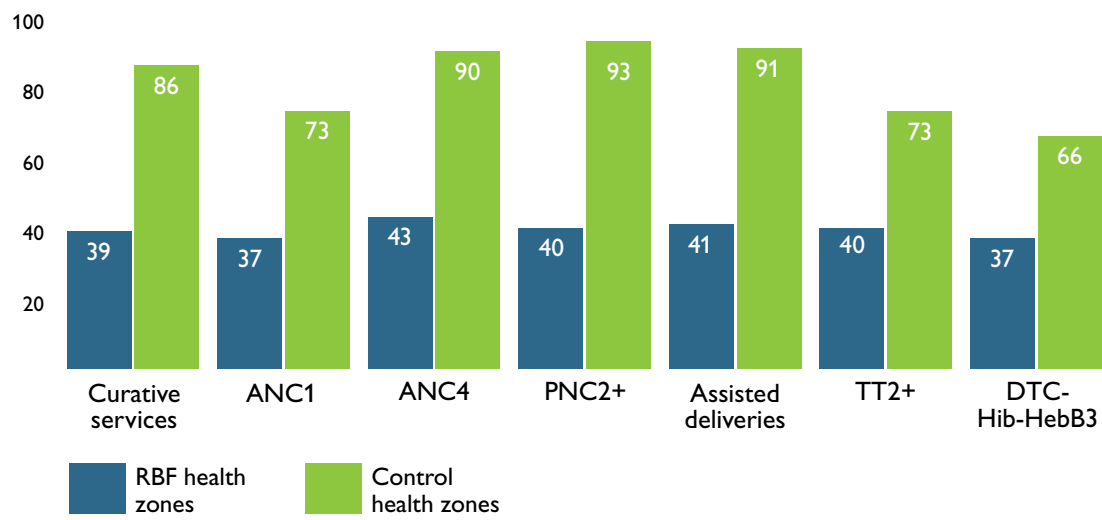
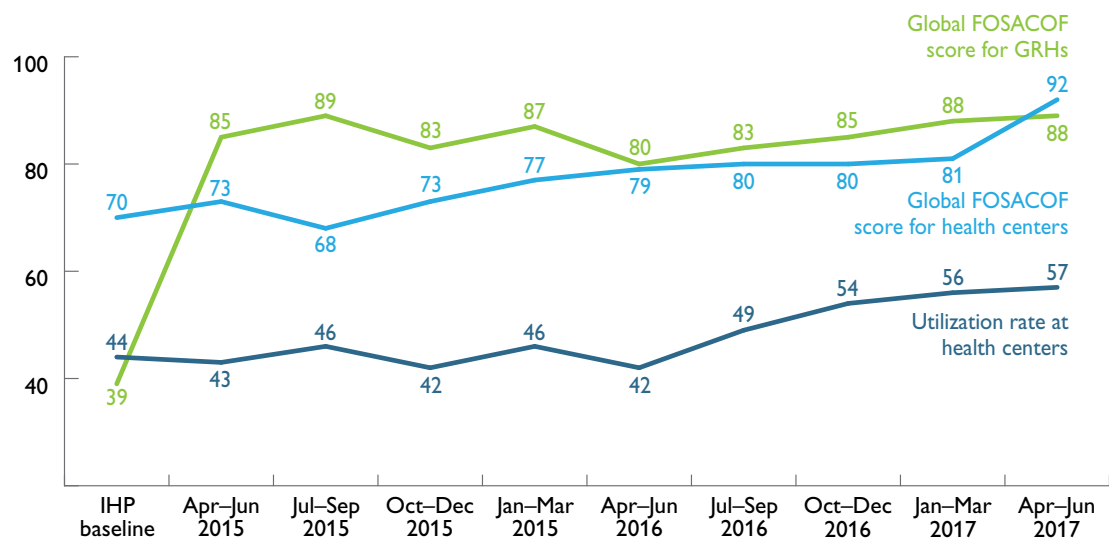


Fig 43. Evolution of utilization rate of curative services and average FOSACOF scores at health centers and GRHs (%)





VOICES OF IMPACT

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

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

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

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

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

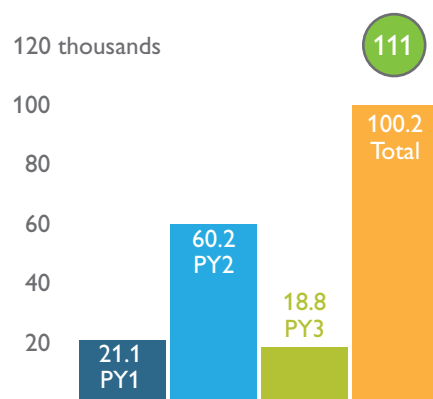
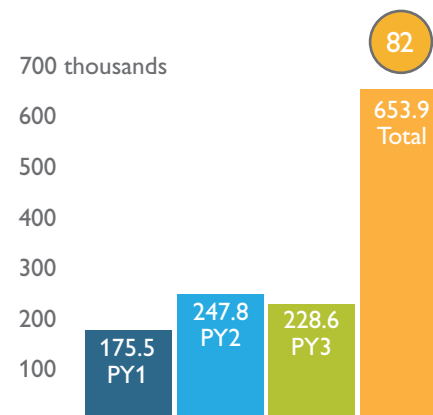


Fig 45. Number of patients referred to GRHs by a CHW or other health provider



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

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

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

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

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

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

IR3

INTERMEDIATE RESULT 3

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

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



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



IR 3.1 HEALTH SECTOR COMMUNITY OUTREACH LINKAGES

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

Community mobilization campaigns

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

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

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

Fig 46. Number of mini-campaigns conducted

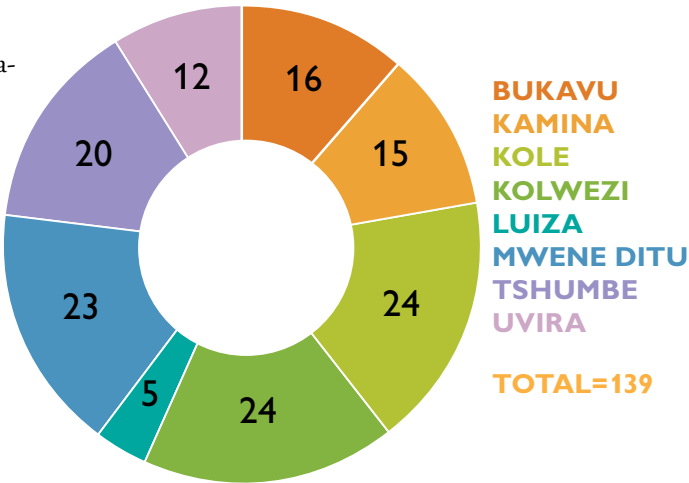


Fig 47. Number and percent of CODESAs that were revitalized and functional

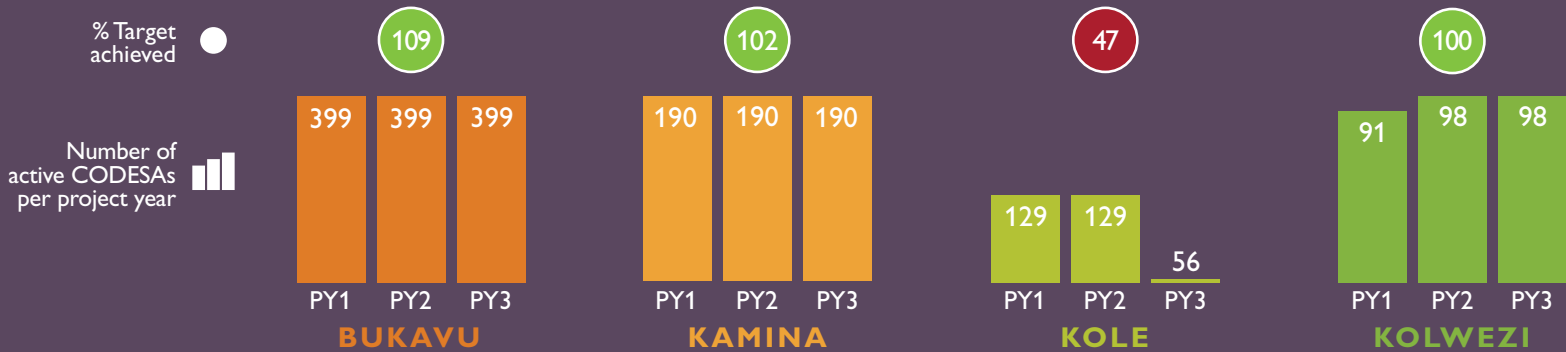


Table 18. Number of CODESAs with communication action plans

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

CODESAs

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

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

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

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

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

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

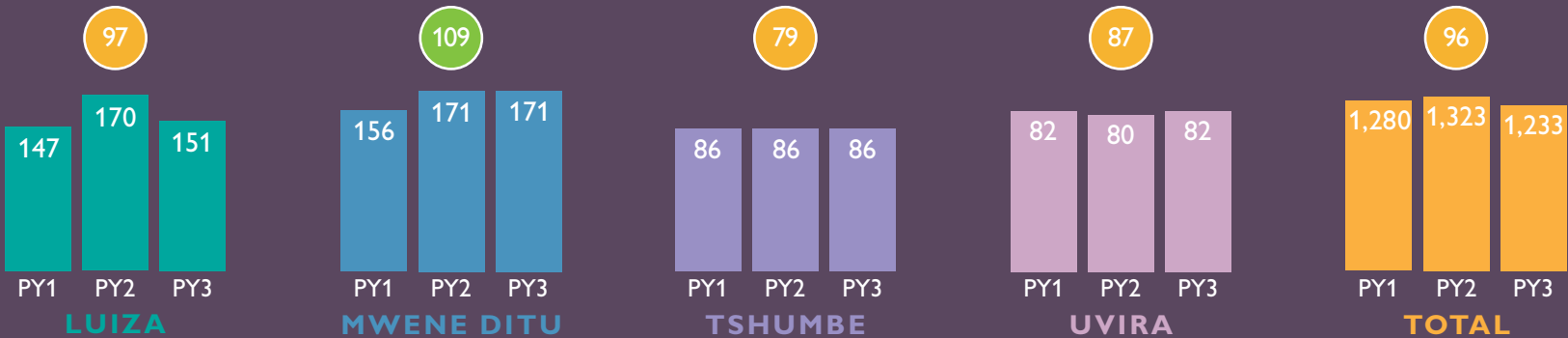


Fig 48. Overall summary of the percent of Champion Communities with statistically improved indicator rates

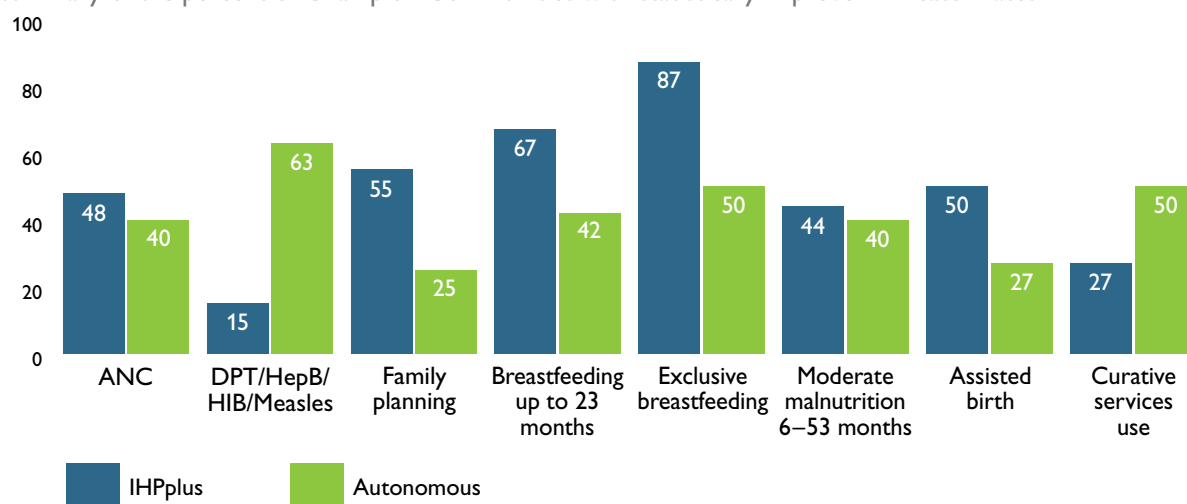


Table 19. Champion Communities, both initiated by IHPplus and autonomously, which gained NGO status

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



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

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

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

IR 3.2 HEALTH ADVOCACY/COMMUNITY MOBILIZATION ORGANIZATIONS

Champion Communities

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

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

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

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

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

CHAMPION MEN

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

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

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

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

CHAMPION MAMAS

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

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

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

YOUTH

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

Champion Youth:

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



VOICES OF IMPACT

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

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

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

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

Table 22. Number of SMS messages by coordination office

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

IR 3.3 SOCIAL AND BEHAVIOR CHANGE CAMPAIGNS

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

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

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

CHALLENGES

Remote communities:

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

Using skills to “fish”:

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

Women’s participation:

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

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

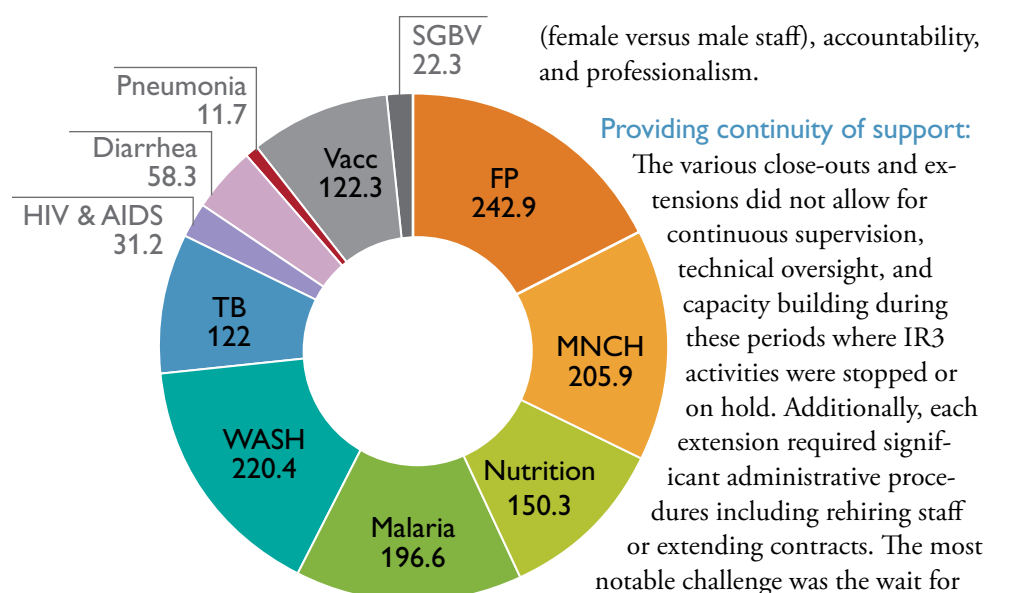
Use of local language:

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

Accounting and transparency:

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

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



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

Data collection:

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

Staff capacity and accountability:

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

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

Providing continuity of support:

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

Youth:

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

CODESAs:

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

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

mHealth:

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

LESSONS LEARNED

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

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

Location:

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

Monitoring, evaluation, learning, and impact:

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

Membership and decision making:

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

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

Making the approach sustainable:

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

Autonomous development of Champion Communities and mentoring:

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

Youth:

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

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

CODESAs:

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

mHealth:

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



VOICES OF IMPACT

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

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

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

IR4

INTERMEDIATE RESULT 4

Health sector leadership and governance in target provinces improved

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



A photograph of a dirt road stretching from the bottom center towards the horizon. The road is flanked by green grass and some trees in the distance. The sky is filled with large, dramatic clouds, with a bright light source (the sun) breaking through near the horizon, creating a golden glow. The overall mood is hopeful and forward-looking.

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

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

IR 4.1 HEALTH SECTOR POLICY ALIGNMENT

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

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

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

IR 4.2 EVIDENCE-BASED STRATEGIC PLANNING AND DECISION-MAKING

Improved data for decision making

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

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

STRENGTHENING THE PROJECT'S M&E SYSTEM

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

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

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

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



VOICES OF IMPACT

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

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

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

EXCERPTS FROM AN INTERVIEW WITH

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



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

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

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

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

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

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

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

CHALLENGES

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

the context of insecurity

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

LESSONS LEARNED

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

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

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



IR 4.3 COMMUNITY INVOLVEMENT IN HEALTH POLICY AND SERVICE DELIVERY

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

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

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

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

LESSONS LEARNED

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

RECOMMENDATIONS

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

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

IHPplus

PROJECT MANAGEMENT

Project implementation

Success stories

Cost share

Status of pharmaceutical procurement

Environmental Mitigation and
Monitoring Plan

Lessons learned

Conclusion





PROJECT IMPLEMENTATION

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

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

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

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

both routine and campaign vaccine strategies.

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

SUCCESS STORIES

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

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

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

COST SHARE

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

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

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

ENVIRONMENTAL MITIGATION AND MONITORING PLAN

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

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

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

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

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

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

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

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

LESSONS LEARNED

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

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

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

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

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

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

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

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



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

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



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

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

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

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

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

members can help provide continued care in these areas.

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

CONCLUSION

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

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

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

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

