USAID'S INTEGRATED HEALTH PROGRAM

Fiscal Year (FY) 2020 Annual Report

Submitted December 7, 2020

Resubmitted January 25, 2021

Recommended Citation: USAID Integrated Health Program, "Fiscal Year (FY) 2020 Annual Report." Prepared for USAID IHP by Abt Associates, Rockville, Maryland, submitted December 7, 2020.

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Cover Photo: A man organizes portable handwashing stations to distribute to 22 general referral hospitals in Kasai-Oriental province. Credit: Rose Kiabu, Abt Associates for USAID IHP *Where possible, the project has included photos where subjects are wearing masks and/or social distancing. However, some photos have been included that were taken pre-COVID and therefore there is no mask wearing or social distancing.*

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(October, 2019 – September, 2020)

Contract No.: 72066018C00001

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based combination therapy
ANC	Antenatal care
ARI	Acute respiratory infection
ASSR	*Appui au système de santé en RDC* (Support to the health system in the DRC) (Project)
BCZS	*Bureau central de la zone de santé* (Central office of the health zone)
BEmONC	Basic emergency obstetric and newborn care
BMGF	Bill and Melinda Gates Foundation
CAC	*Cellules d'animation communautaire* (community action groups)
CBD	Community-based distributor (of contraceptives)
CDCS	Country Development Cooperation Strategy
CODESA	*Comités de Développement de l'Aire de Santé* (Health Area Development Committees)
COGE	*Comité de Gestion* (Management Committee)
COP	Chief of Party
COR	USAID Contracting Officer's Representative
CPLT	*Coordinations Provinciales Lèpre et Tuberculose* (Provincial Committees for Leprosy and Tuberculosis Control)
CPSr	*Consultations préscholaire* (Preschool consultations)
CSDT	*Centres de santé de diagnostic et traitement* (Diagnosis and treatment health centers)
CSO	Civil society organization
CTMP-PF	*Comité Technique Multisectoriel Permanent de Planification Familiale* (Multisectoral Technical Committee for Family Planning)
CYP	Couple years of protection
D&F	Determination and Findings
DEP	*Direction d'Etudes et Planification* (Planning Directorate)
DGOGSS	*Direction Générale de l'Organisation et de Gestion des Services et des Soins de Santé* (Directorate-General for the Organization and Management of Health Care Services)
DHIS2	District Health Information System 2
DMPA-SC	Dihydroxy Methyl Progestatif A – Subcutaneous (Subcutaneous Medroxyprogesterone acetate)
DOO	Director of Operations
DOT	Directly observed therapy
DPS	*Divisions Provinciales de Santé* (Provincial Health Districts)
DQI	*Demarche de Qualite Integre* (Data quality improvement)
DQST	Data Quality Supervision Tool
DQS	Data quality self-assessment
DRC	Democratic Republic of the Congo (*République démocratique du Congo*)
E2A	Evidence to Action
ECDPS	*Equipe Cadre de DPS* (Executive Team of the Provincial Health District)
ECZS	*Equipe Cadre de la Zone de Sante* (Health Zone Mangement Team)

EEAQ	Evaluation and quality improvement teams
EGM	Essential generic medicines
EMMP	Environmental Mitigation and Monitoring Plan
EMMR	Environmental Mitigation and Monitoring Report
EmONC	Emergency obstetric care
EOC	Essential obstetric care
ETD	*Entités Territoriales Décentralisées* (Decentralized Territorial Entities)
EVD	Ebola Virus Disease
FFP	USAID's Food For Peace project (*Bureau de l'alimentation pour la paix)*
FP	Family planning
FY	Fiscal Year
GDRC	Government of the Democratic Republic of the Congo
GHSC-TA	Global Health Supply Chain-Technical Assistance
GIZ	*Deutsche Gesellschaft fur Internationale Zusammenarbeit* (German Corporation for International Cooperation)
GTM	*Groupe de Travail Médicament* (Essential Drugs Working Group)
HGR	*Hôpital Général de Référence* (General Reference Hospital)
HMIS	Health Management Information System
iCCM	Integrated community case management
IMNCI	Integrated management of newborn and childhood illness
INH	Isoniazid
IPC	Iinfection prevention and control
IPS	*Inspection Provinciale de la Santé* (Provincial Health Inspectorate)
IPTp	Intermittent preventive treatment in pregnancy
IRC	International Rescue Committee
ITN	Insecticide-treated net
IVR	Interactive voice response
IYCF	Infant and young child feeding
LAM	Lactational amenorrhea method
LMIS	Logistics Management Information System
LLIN	Long-lasting insecticidal nets
MCZS	*Médecins chefs de zone de santé* (Health zone chief medical officers)
MDR-TB	Multi-drug resistant TB
MDR-TB/RR-TB	Multi drug-resistant/rifampicin-resistant TB
MDSR	Maternal death and surveillance response
M&E	Monitoring and Evaluation
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
NGO	Non-governmental organization
OCC	*Office* Congolais de *Contrôle* (Congolese Office of Control)
ORS + zinc	Oral rehydration salt + zinc sulfate
OTSS	Outreach Training and Support Supervision
PAO	*Plan d'Action Opérationnel* (Annual Operation Plan)
PDSS	*Projet de Développement de Système de Santé* (Health Care System Development Project)
PEV	*Programme Elargi de Vaccination* (Expanded Program on Vaccination or EPI)

PICAL	Participatory Institutional Capacity Assessment and Learning (Tool)
PIRS	Performance indicator reference sheets
PLHIV	People living with HIV
PMI	U.S. President's Malaria Initiative
PMR	Project Monitoring Report
PNAM	*Programme Nationale d'Approvisionnement en Medicaments* (National Drug Supply Program)
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLP	*Programme National de Lutte contre le Paludisme* (National Malaria Control Program)
PNLS	*Programme National de Lutte contre la SIDA* (National AIDS Control Program)
PNLT	*Programme National de la Lutte Contre la Tuberculose* (National Program to Combat Tuberculosis)
PNSA	*Programme National de Santé des Adolescents (*National Adolescent Health Program)
PNSR	*Programme National de Santé de la Reproduction* (National Program for Reproductive Health)
PPFP	Post-partum family planning
PRODS	*Programme de Renforcement de l'Offre et Développement de l'Accès aux Soins de Santé* (Program for Strengthening of Supply and Development of Access to Health Care)
PRONANUT	*Programme National de Nutrition* (National Nutrition Program)
PwC	PricewaterhouseCoopers
RDQA	Routine data quality assessment
RDT	Rapid diagnostic test
REC	Reaching Every Child
RECO	*Relais communitaires* (Community health workers)
RH	Reproductive Health
RM&E	Research, Monitoring, and Evaluation
RSO	Regional security officer
SANRU	*Santé Rurale* (Project)
SBC	Social and behavior change
SGBV	Sexual- and gender-based violence
S/P	Sulfadozine-pyrimethamine
TB	Tuberculosis
TP+	Bacteriologically confirmed pulmonary TB
TRG	Training Resources Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID IHP	USAID's Integrated Health Program
VSAT	Very-small-aperture terminal
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
XDR-TB	Extensively drug-resistant TB
ZS	*Zone de santé* (Health zone)

EXECUTIVE SUMMARY

Fiscal FY2020 (FY20) was a transformative one for USAID's Integrated Health Program (USAID IHP) in the Democratic Republic of the Congo (DRC), which encountered and overcame numerous challenges—including the global pandemic—to tangibly advance the capacity of Congolese institutions and communities to deliver quality integrated health services that sustainably improve the health of men, women, and children in target provinces.

USAID IHP Objectives

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

Increase access to quality integrated health services in target health zones

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

Working in 179 *zones de santé* (ZS, health zones) across nine provinces within three regions—Eastern Congo, Kasaï, and Katanga—USAID IHP continued expanding previous Agency health investments in the DRC, USAID's Country Development Cooperation Strategy, and related Government of the DRC (GDRC) strategies and policies—particularly the *Plan National de Développement Sanitaire* (PNDS, National Health Development Plan) 2019–2022. The Program deepened its engagement with major partners, which demonstrated increased investment in and ownership of health outcomes at various levels, including the national Ministry of Health (MOH) level, the *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) and ZS within provinces, and communities and *Comités de Développement de l'Aire de Santé* (CODESA, Health Committees).

USAID IHP encompasses USAID programming in six health areas: malaria; maternal, newborn, and child health (MNCH); nutrition; reproductive health and family planning; tuberculosis (TB); and water, sanitation, and hygiene (WASH). In FY20, Program activities generated results across these domains—as well as in health systems strengthening, gender integration, conflict sensitivity, and environmental monitoring and mitigation. The COVID-19 pandemic widely affected activities; USAID IHP redirected FY20 workplan funds and activities in support of the GDRC COVID-19 Response Plan, and creatively adjusted modes of intervention to execute many activities remotely and ensure that providers, *relais communautaire* (RECO, community health workers), and government counterparts could safely and continuously deliver health care to local populations. Highlights by program area follow.

Malaria. In FY20, USAID IHP supported the MOH's *Programme National de Lutte contre le Paludisme* (PNLP, National Malaria Control Program) to prevent and treat malaria, including in pregnant women and young children. Interventions included training health care providers in case management and rapid diagnostic tests (RDTs); improving uptake of sulfadoxine/pyrimethamine (S/P); organizing social behavior change (SBC) campaigns, and distributing insecticide-treated nets (ITNs). In most provinces, these efforts led to improved results over FY19 results, including:

- Distribution of nearly 1.2 million ITNs during antenatal and child immunization visits
- Training of more than 3,000 providers in malaria prevention, testing and treatment
- Treating nearly 3.6 million children under 5 years of age for confirmed malaria

MNCH. Despite significant obstacles—including roads damaged by torrential rains, political instability, and COVID-19 travel restrictions—USAID IHP continued to address the major killers of mothers and

children. USAID IHP supported the promotion of increased use of ANC services through joint ANC/FP mini campaigns; the provision of ANC medicines and other commodities; increased awareness-raising activities and information-sharing focused on the importance of ANC attendance; and support for functional community champions and health workers to raise awareness and counsel women on the use ANC. For For immunizations, the main activities included: support to RECOs for the recovery of unvaccinated children; support for the vaccine outreach program (advanced strategy); maintenance of cold chain equipment and vaccine support; training and formative supervision for providers; and support for data quality audits. Standout results included:

- 959,566 pregnant women attended at least four ANC visits with a skilled provider from USG-supported health facilities (116.2% achievement rate).
- 1,329,873 children were vaccinated with pentavalent 3 and 1,314,978 children with the measles vaccines in FY2020, exceeding both targets
- More than 3.1 million children under 5 treated for an acute respiratory infection, 1.1 million treated for diarrhea, and more than 3.1 million vaccinated against measles

Nutrition. USAID IHP partners with MOH's *Programme National de Nutrition* (PRONANUT, National Nutrition Program) to fight malnutrition in children under 5, pregnant and breastfeeding women, and women of childbearing age. In FY20, the Program targeted providers, *relais communautaires* (RECO), and community members with interventions including support and training for *consultation pré-scolaires rédynamisé* (CPSr, revitalized preschool consultations); infant and young child feeding (IYCF) community groups; promotion of exclusive breastfeeding; and vitamin supplementation.

- More than 3,000 providers, ECZS, and RECO were trained in essential family nutrition practices for children and pregnant and breastfeeding women
- More than 2.7 million children under 5 received nutritional assistance (this refers to USAID IHP nutrition-related technical assistance)

Reproductive health and family planning. USAID IHP supports GDRC and USAID commitments to the Family Planning 2020 global partnership through training for health care providers, community-based distributors, and youth peer educators; assistance to the *Comité Technique Multisectoriel Permanent de Planification Familiale* (CTMP-PF), Permanent Multisectoral Technical Committee for Family Planning); and promotion of SBC campaigns. In FY20, the Program established a pool of trainers, supported CTMP-PF meetings, and trained community-based distributors (CBDs). Key results included:

- Achieved 1,351,422 couple years of protection (CYP) in Fy2020 (achievement rate of 127.3%)
- More than 1.3 million new users adopted modern contraceptive methods

Tuberculosis. USAID IHP supports the GDRC's *National Tuberculosis Control Program* (PNLT) to implement the World Health Organization's End TB Strategy Program and encourage local participation in TB control. FY20 activities prioritized universal access to TB diagnosis and treatment; better management of TB/HIV co-infection and drug-resistant TB; data-driven decision-making at the provincial level; and improved ability to diagnose and treat TB in children under 14**.** Notable results included:

- Out of nearly 35 million people, providers confirmed 49,279 cases of pulmonary TB (TP+), an improved detection rate over FY19
- More than 40,000 cases were successfully treated, an achievement rate of 92.5 percent

- Collaborative activities led to a high percentage of persons living with HIV who received prophylaxis, especially in Lomami, Lualaba and Kasaï-Central

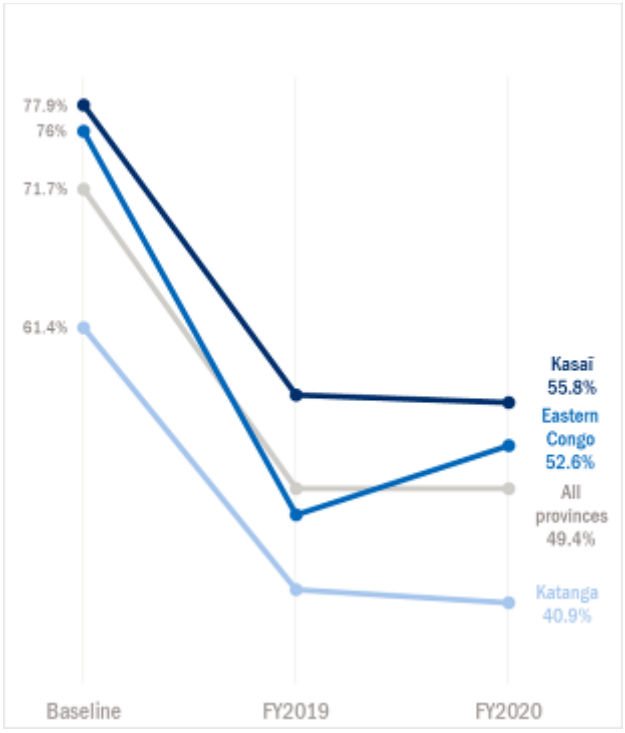
WASH. During FY20, USAID IHP implemented two main WASH strategies in Eastern Congo and Kasaï: community-based and health facility-focused. Halfway through the year, USAID IHP began transitioning to a USAID-recommended strategy, phasing out community-based WASH and focusing attention on the clean clinic approach, training health care providers and *équipes cadre de la zone de santé* (ECZS, health zone management teams) in WASH for health centers. In parallel, the Program continued to complete in-progress community WASH activities.

Key achievements included:

- 5,358 Congolese gained access to potable drinking water, and 125 local leaders received training in upkeep, maintenance, and governance of rehabilitated water supply systems
- 87 health facilities in Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central have identified priority WASH improvement needs and are ready for implementation

Health system strengthening. USAID IHP initiatives to strengthen the DRC health system at all levels bore fruit in FY20. Working with partner I+Solutions, in ***last-mile supply chain delivery*** to rural health centers, an analysis of the nine target provinces showed vital medicines and health products are more consistently available now than two years ago. As shown in Figure 1, across USAID IHP's three target regions, facility stockouts of one or more tracer commodities fell from a baseline of 71.7 percent to 46.3 percent in FY20. COVID-19 restrictions limited progress in Q3, but most provinces rebounded after July.

Figure 1. Facility stockouts by region (Indicator #1.7.1)



Source: DHIS2

With partner the Training Resources Group (TRG), all nine DPS and 26 ZS completed their Program-guided institutional analyses under the ***Participatory Institutional Capacity Assessment and Learning (PICAL)*** tool, which are informing institutional capacity-building plans. USAID IHP continued to support all nine DPS and 179 ZS to develop their ***Plan d'Action Opérationnel (PAO, Annual Operation Plan)*** and align them with national and provincial budgets and PICAL assessment findings, supporting the development of a funding coordination mechanism known as *"contrat unique."* In Lualaba province, the PAO has spurred significant domestic resource mobilization for local health priorities, and the Program is organizing a FY21 event for Lualaba to share its experience as a model for other provinces. Following efforts to ***improve health data inputs***, all nine provinces exceeded the MOH's standard of 80 percent for data completeness in the District Health Information System 2 (DHIS2), with all but two provinces achieving greater than 90 percent.

Gender. Notable achievements for gender in FY20 included support for the creation and operationalization of the newly established Gender Unit at the MOH to develop their national gender integration action plan. USAID IHP also established gender champions networks in five provinces consisting of men and women committed to promoting gender equality. Technical and financial assistance was provided for the revitalization of *Cellules d'animation communautaire* (CACs, community action groups) in four ZS in Kasaï-Oriental, and the number of women occupying leadership positions in CACs increased from 115 to 251. Finally, the Program integrated modules on gender and women's rights and supported the DPS in Lomami and Sankuru provinces to orient their senior staff on gender integration in their human resource deployment plans.

Conflict Sensitivity. USAID IHP operationalized the Program's conflict sensitivity and do-no-harm implementation strategy in FY20, ensuring that staff and partners understood key components well and were ready to integrate tenets into Program activities and communications. The Program conducted the second conflict sensitivity analysis, collecting data from 362 participants using key informant interviews, focus group discussions, and a perception survey. As a result, the Program is better equipped to implement activities that reflect regional and provincial conflicts and contextual factors.

Environmental Monitoring and Mitigation. In FY20, USAID IHP ensured integration of best practices in environmental compliance and mitigation in various integrated health activities, especially Program trainings and those related to implementation of the clean clinic approach in facilities. Particular topics included: water and sanitation, medical waste management, public health commodity management, health facility maintenance, ITN distribution, office management and supply, transportation, equipment management, and infection prevention and control.

Research, Monitoring and Evaluation. In close collaboration with partner BlueSquare, the Program made improvements to streamline generation of the Annex A MSRT table and improve the data entry interface for Project Monitoring Report (PMR) indicator data. The team also developed generic dashboards for PMR, service provider mapping survey data and household survey data; and for setting automated complex computations that are not possible using the MOH's instance of DHIS2. Surveys conducted by partners 1) explored perceptions of provincial health workers on transparency and accountability in performance management, policies and procedures (Mobile Accord/Geopoll), and 2) assessed health worker knowledge and understanding of key health program areas, such as infection prevention and control and malaria (Viamo). Survey results were shared with the program team and are informing ongoing program implementation.

Looking forward. In FY21, USAID IHP will continue shrinking supply chain gaps on multiple fronts, including improving data collection and visualization through a new automated platform; training hundreds of data managers, stock managers, and executives to enter and interpret data correctly; and assembling a transport network for last-mile delivery to remote clinics, including a mobile money initiative now in the pilot stage. The Program will host events with health system stakeholders to disseminate the results of its groundbreaking baseline service delivery mapping and household surveys to guide responsive, locally grounded activity implementation. Finally, the Program will continue to collaborate closely with implementing partners to leverage activities and ensure synergies, including Breakthrough Action for VIVA campaign messages across health areas, Evidence to Action (E2A) for FP/RH demand creation and provision of FP commodities, UNICEF for immunization, and Food for Peace for improved coordination of nutrition, FP and WASH activities. More on our collaboration across partners can be found in Chapter 2 and lessons learned overall in FY20 can be found in Chapter 9 of this report.

1. INTRODUCTION

This report describes implementation of USAID's Integrated Health Program (USAID IHP) during USAID's fiscal year (FY) 2020 (October 1, 2019 – September 30, 2020). The goal of the Program is to strengthen the capacity of Congolese institutions and communities to deliver quality integrated health services that sustainably improve the health status of Congolese men, women, and children. To meet this goal, USAID IHP has three objectives:

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

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

PROGRAMMATIC AND GEOGRAPHIC SCOPE

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

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

Table 1. Where USAID IHP works

Region	Province	# Zones de santé	# Aires de santé*	# General referral hospitals†	# Health centers†	# iCCM sites†	Population covered
Eastern Congo	Sud-Kivu	34	641	38	622	157	7,703,971
	Tanganyika	11	267	7	243	867	3,246,186
Kasaï	Kasaï-Central	26	451	22	403	252	5,099,281
	Kasaï-Oriental	19	314	16	319	250	5,361,397
	Lomami	16	316	17	304	213	4,183,357
	Sankuru	16	248	16	229	163	2,531,768
Katanga	Haut-Katanga	27	388	24	708	147	6,250,148
	Haut-Lomami	16	329	15	301	89	4,125,593
	Lualaba	14	232	13	297	135	2,873,532
TOTAL		**179**	**3,186**	**168**	**3,426**	**2,273**	**41,375,233**

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

PARTNERSHIPS

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

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

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

2. PROGRAM MANAGEMENT

STRATEGIES

USAID IHP works with the Government of the Democratic Republic of the Congo (GDRC) MOH and other stakeholders to strengthen the capacity of Congolese institutions and communities to deliver sustainable, quality, integrated health services that improve the health status of Congolese men and women. This mission derives from the multi-sectoral framework of USAID's CDCS 2015–2021, whose goal is to support a long-term transition to more effective and empowering development in the DRC. This aligns with GDRC's *Stratégie de Renforcement du Système de Santé* (SRSS, Health System Strengthening Strategy) and the PNDS 2019–2022. The 2006 SRSS and the revised version in 2010 focus on the development of integrated primary health care services in ZS, the most decentralized level of the system.

The fundamental principles behind the organization of public health in the DRC were signed into law in December 2018.[2] The health system's goals include the three dimensions of universal health coverage: population coverage, service coverage, and financial risk protection. USAID IHP interventions align with these commitments. The DGOGSS is the link that connects the Program to the MOH and serves as a channel for all other MOH contacts. USAID IHP works closely with USAID and MOH counterparts to identify actions or activities that support MOH program areas laid out in the PNDS 2019–2022 that reflect Program objectives. The PNDS 2019–2022 focuses on drastic improvements in MNCH indicators, and therefore on feasible, achievable, interventions of proven value in achieving health outcomes.

The Program prioritizes strategies that strengthen Congolese health institutions and community structures with the goal of improving indicators for maternal mortality rates, and neonatal, infant and under-5 mortality rates. USAID IHP's theory of change is based on the idea that the Program's successful implementation of institutional strengthening and support to DRC health systems will result in more effective stewardship of financial, human, and programmatic resources in the health sector and in significantly improved health outcomes for the population. The theory of change emphasizes harmonization between the overarching change theories of the MOH (through the SRSS) and USAID IHP's logical framework (captured in the results framework). It also underscores that the Program's complex health systems approach attaches great importance to consensus and to the convergence of stakeholders' views as an overall strategy for simplifying and reducing the challenges of managing large-scale health systems.

Based on Participatory Institutional Capacity Assessment and Learning (PICAL) assessments conducted in Year 1, the Program provided support to the *Divisions Provinciales de Santé* (DPS, Provincial Health Districts) to develop capacity-building plans. The Program also expanded PICAL and capacity-building support to the ZS-level of the health system, supporting 26 ZS to conduct PICAL assessments in FY20. USAID IHP additionally provides technical and financial support to a number capacity-building strategies across all nine provinces.

For the GDRC's current planning period of 2019–2022, the MOH's overarching policy objective is universal health coverage. The Ministry seeks international donor support for reforms and health finance reform, the provincial-level *contrat unique*, and increased utilization and quality of maternal and child

[2] Law n° 18/035 of 13 December 2018 establishing the fundamental principles relating to the organization of public health

health services. The MOH expects partners to buy into the *contrat unique* for each province and align themselves with this approach in order to foster decentralization and help provinces improve the quality of services. Throughout FY20, the Program supported the *contrat unique* process across all nine provinces.

IMPLEMENTATION

When COVID-19 first appeared in the DRC in Quarter 2, it did not at first significantly impact Program activities. In response to a direct request from USAID and the MOH, USAID IHP submitted a proposal to redirect certain Quarter 3 (and subsequently Quarter 4) activities and funds in the FY20 workplan to support GDRC's COVID-19 response plan at the provincial level. Activities focused on three objectives: (1) strengthen capacities for surveillance and investigation of cases, (2) improve infection prevention and control (IPC) and WASH in all health facilities and the community, and (3) strengthen risk communication and community engagement.

In Quarter 3, pandemic travel restrictions brought several field interventions to a standstill. For example, national-level trainers could not be deployed to conduct trainings in the provinces due to COVID-19-related travel restrictions. In total, 117 activities were impacted (delayed or cancelled) due to COVID-19; of these, 34 were rescheduled before the end of FY2020 and 83 were postponed to FY2021. *For more information on the impact of COVID-19 on programmatic activities, please see Annex F.*

In Q3, following the April 20 approval for redirection of Program funds, USAID IHP provincial offices engaged with DPS counterparts to coordinate COVID-19 preparedness and response and to procure protective equipment. Such activities necessarily displaced a few routine activities. The Program also redesigned and standardized protocols for modified conduct of meetings, dissemination events, trainings, and even coaching and supervision. In Q4, USAID IHP was awarded a "Prix d' Excellence" by Haut-Katanga's provincial government during Q4 for exemplary work to prevent the spread of COVID-19. *Please refer to Annex C for a success story on USAID IHP's COVID-19 activities.*

Working from home became the norm for staff in the USAID IHP Kinshasa office from end of March through early September, when a progressive office reopening with strict preventive measures was rolled out. Partial office closures / remote working arrangements were also instituted for limited periods in the Bukavu and the Lubumbashi offices. *For more on the impact of COVID-19 on our operations and offices, please see the Security section later in this chapter.*

Workplanning and Activity Implementation

At the start of the fiscal year, USAID granted permission to extend the validity of the July-September 2019 workplan for one additional month while the FY2020 annual workplan was being finalized. The FY2020 workplan was approved on October 31, 2019.

USAID IHP made concerted efforts during Quarter 4 to improve the overall workplanning process to engage key partners. The Program held planning sessions with the DPS and other USAID implementing partners early in the process and incorporated feedback and comments from the Secretary General into the workplan following a presentation and technical discussion. The resulting workplan better reflects the needs of the DPS and is more integrated with their annual planning. *For a complete list of deliverables submitted in accordance with the FY20 workplan, please see Annex E.*

Relationship with USAID

In April 2020, because there were fewer occasions for interaction with USAID due to COVID-19, the USAID Contracting Officer's Representative (COR) suggested regular USAID-USAID IHP meetings for each technical program area to maintain effective levels of consultation. The Program put into place routine collaboration between USAID health specialists and USAID IHP technical teams, to ensure better information-sharing and coordination on strategies. *More information on the joint coordination meetings between USAID and USAID IHP can be found in Chapter 5, IR 2.7.*

Relationship with the MOH and the DPS

In Q1, Abt Associates revised its per diem policy and shared it with USAID. The redesigned policy aligned with the *Groupe international de bailleurs en santé* (GIBS, International Health Donors Group) policy, to which MOH staff were already accustomed, which offered members of the MOH traveling for Program-related activities the option of a flat rate for their accommodation and other expenses. The impact of this change was dramatic and restored confidence between MOH staff and the Program.

USAID IHP supported the replication of institutional analysis and implementation of institutional strengthening plans in each province based on PICAL analysis conducted in FY19. During FY20, the Program focused on reinforcing the capacity of the DPS teams to conduct institutional analyses with minimal technical support and eventually transfer these competencies to the DPS. The Program built the DPS's capacity to coach, lead and support ZS through capacity-building workshops with DGOGSS executives. In Q2, the Director General of the DGOGSS participated in the field workshop in Haut-Katanga in order to become an official trainer.

In Q2, USAID IHP held its first programmatic review meeting with the MOH to share FY19 results and lessons learned. The meeting created opportunities for direct, valuable feedback from the MOH on a number of challenges and opportunities and discussion of otherwise sensitive subjects, such as the relationship between the ZS and the central ministry. The Program received kudos not only from the MOH leadership but from the USAID Health Office Director, who said the meeting served as a solid foundation for future information-sharing and dialogue. Following this meeting, the Program took the Secretaire General's recommendations into account in planning for priority FY21 activities.

Determination and Findings

In Q1, in collaboration with the MOH, USAID IHP released a competitive solicitation intended to identify a subcontractor to conduct a comprehensive assessment of the nine DPS, an essential first step that will provide USAID with critical information about each entity to inform their Determination and Findings (D&F) process. A D&F clearance is required before Abt can move forward with awarding subcontracts that will provide financial resources to the DPS.

In Q2, USAID IHP finalized the selection of PricewaterhouseCoopers (PwC) as a subcontractor to perform the assessments of the nine DPS. IHP, PwC and the MOH held a preliminary meeting on February 11 to ensure proper alignment and understanding between all parties, and Abt and PwC fully executed the subcontract on March 3. PwC submitted its first workplan deliverable on March 30; the proposed timeline included a few weeks of initial preparation, followed by field visits to each of the three provinces. Unfortunately, the onset of the COVID-19 pandemic immediately led to travel restrictions within DRC, so the field visits were postponed.

In Q3 and Q4, USAID IHP facilitated buy-in from the MOH on the assessment elements, helping to organize meetings and obtain inputs for PwC at the provincial level. In addition, the Program provided technical support to establish and organize the *Commission Mixte*, which resulted in the merging of two different Directorates in the MOH (Planning Directorate and DGOGSS) as part of the *Commission* (whose members also include IHP and PwC leadership*)*. In mid-September, following the lifting of travel restrictions from Kinshasa to the provinces, PwC rescheduled travel to Bukavu, Kananga and Kamina to conduct the three DPS assessments in Haut-Lomami, Kasaï-Central and Sud-Kivu provinces. PwC competed evaluations soon after the close of FY20, and the Program shared its high-level findings with USAID and the MOH.

Communication

Person-to-person contact remains important, but amid the limited resources available to ZS, DPS, and *Inspection Provinciale de la Santé* (IPS, Provincial Health Inspectorate), and the logistical challenges created by the pandemic, technology offers opportunities to remotely conduct meetings, trainings, planning sessions, dissemination, and even supervision and coaching. In FY20, USAID IHP embraced the "affordable, allocable, and reasonable" approach to such activities, and aggressively designed alternative, cost-effective strategies. For example, the Program found opportunities to adjust the costs of central-level facilitator support by providing internet connection credit rather than paying for transport, food, and per diem to continue training at a distance, safely.

For the Program to share data with the DPS, both parties must have reliable internet connectivity. Because many DPS are in remote areas, the Program determined that a very small aperture terminal (VSAT)—a two-way ground station that transmits and receives data from satellites—was the most appropriate mechanism to provide reliable internet connection. Since installation of these VSATs, the Program has noted an increase in the rate of completeness and promptness of data shared by the DPS.

Data

USAID IHP uses surveys and routine project monitoring to inform decision making. In FY20, USAID IHP leveraged the baseline service delivery mapping survey along with the following criteria by data sources, including presence in economic corridor (CDCS) and high maternal and infant mortality (District Health Information System 2 (DHIS2)) to determine and implement the essential packet (*paquet essential)* of services that will be provided across all 179 ZS and the *paquet supplémentaire* (supplementary packet of services) which will be provided to the 60 focus ZS. The *paquet essential* includes social and behavior change communication; management support tools (e.g., registers, reference sheets), vaccine transportation assistance; antenatal and postnatal health care support; training on key service delivery interventions; and annual operational planning at the ZS level to improve RH/FP; MNCH; nutrition; malaria; and TB. The *paquet supplémentaire* includes all *paquet essentiel* activities plus additional, specialized service delivery trainings, materials, and equipment, WASH and renovation support, supervision support, and technical assistance to enhance the capacities of community health workers and champions and increase the availability of youth-friendly services. In FY21, USAID IHP will follow up with more robust analysis and dialogue with provincial stakeholders to program activities based on the results of the baseline service delivery mapping survey.

PROGRAM STAFFING

During the first quarter, 20 finance and accounting staff in all nine project offices received hands-on, practical training on QuickBooks and USAID IHP financial procedures and processes. During this period, the team captured a total of 5,352 transactions in the system, completed more than 150 bank reconciliations, and achieved 75 petty cash reconciliations.

In Q2, the Program revised its organogram which was then codified in the budget realignment which USAID approved in the third quarter. The realigned budget included a total of 53 new positions, of which 21 are in Kinshasa and 32 are in the nine provinces. Adding these staff will significantly improve the efficiency and quality of support to the Program team as USAID IHP ramps up the pace and volume of activities and implementation.

During Q4, following the resignations of the Director of Operations (DOO) and the Senior Procurement Manager, and the retirement of the Chief of Party (COP), the project hired eight new staff. These included a new DOO, and a new Director of Administration and Finance (DAF) for a total staff count of 237 (150 Abt and 87 subcontractors). An acting COP also temporarily joined the Program to fill the gap until a new COP could be hired and onboarded (projected for end of FY20). *For details on program staffing in FY20, please see Annex D.*

OPERATIONS

USAID IHP incorporated lessons learned from the first year of project implementation into a revised program staffing and structure that was a part of the revisions in the approved budget realignment. Towards the end of Q2, USAID granted permission to start recruitment of these additional staff In November 2019 prior to final approval of the budget realignment.

The budget realignment approved in Q3 confirmed a transition from a regionally focused to a provincially focused Program structure. The revised structure aims to provide stronger technical oversight with a greater focus on delivering program results at the provincial level, coordinating technical and programmatic implementation efforts across offices, and fostering cost and operational efficiencies. The expanded finance and operations teams in Kinshasa are structured to deliver strong financial, operational, and human resources support to the provinces.

During Q1, the Program began internal reorganization of its finance and operations departments. In Q2, USAID IHP made notable improvements to the process of cash transfers to the field, building on more streamlined financial and administrative processes put in place in previous quarters.

During Q3 and Q4, the Program focused on establishing strategies to improve the efficiency of program implementation. An example of this is the roll-out of mobile money as a financial mechanism to pay for program activities such as last-mile drug delivery, enabling payments to be processed and reconciled more efficiently and accurately. This process will launch early in FY21.

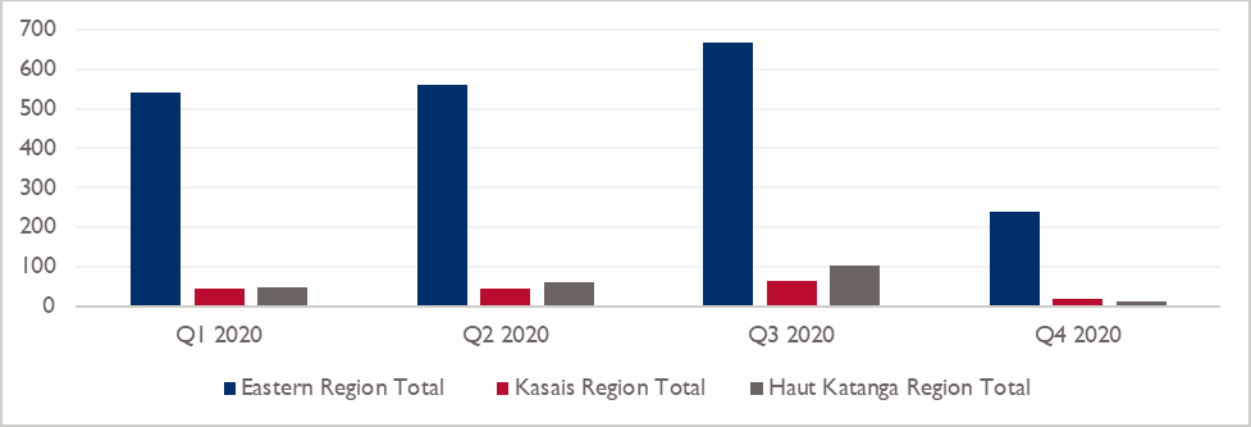
SECURITY

Overall Security Trends

Total reported external security incidents in the DRC in 2020 showed upticks in September and May, coinciding with the start and end of the rainy season. Most incidents were reported in the eastern provinces of Ituri, Nord Kivu, Sud-Kivu and Tanganyika and tended to be related to armed conflict.

USAID IHP has a central office in Kinshasa and 10 provincial offices in its three target regions—Eastern, Haut-Katanga and Kasaï. Figure 2 shows the total reported external incidents in provinces per quarter in 2020 where USAID IHP have project offices, showing a high number of incidents reported in the Eastern Region.

Figure 2. Quarterly reported external incidents USAID IHP per region 2020 YTD



Politics. In FY20, the political situation calmed somewhat, with fewer politically motivated demonstrations recorded in the first three quarters.

Disease. The tenth and eleventh epidemics of Ebola Virus Disease (EVD), had no direct impact on the project. During COVID-19 lockdowns, the Kinshasa office was closed but has since reopened on a 50 percent occupancy basis. Given national trends in the reduction in the number of confirmed cases and low fatality rates, the leadership team plans to incrementally scale up the number of staff in the Kinshasa office to allow for full technical and operational support capability to the provinces.

Table 2. Office status during COVID-19 restrictions

Office location	Province impacted	Office directly impacted	Staff directly impacted	Dates	Current impact
Kinshasa	Yes	Yes (GDRC restrictions now expired)	No	Ongoing	75% occupancy in the Kinshasa office to maintain social distancing
Kananga	No	No	No	N/A	100% operational
Mbuji Mayi	No	No	No	N/A	100% operational
Lodja	No	No	No	N/A	100% operational
Kabinda	No	No	No	N/A	100% operational
Lubumbashi	Yes	Yes (GDRC restrictions now expired)	No	Temporary restrictions all expired	100% operational
Kamina	No	No	No	N/A	100% operational
Kolwezi	No	No	No	N/A	100% operational
Bukavu	Yes	Yes (GDRC restrictions now expired)	No	Temporary restrictions all expired	100% operational
Uvira	Yes	No	No	N/A	100% operational
Kalemie	No	No	No	N/A	100% operational

Source: USAID IHP Security Office metrics

Project-related Incidents

Table 3 shows 15 project-related incidents reported in 2020, including an increase in road traffic collisions during the rainy season and four incidents of theft.

Table 3. Project related incidents 2020

Date	Category	Region	Province	Office	Details
01/22/2020	Accident	Kasaï	Kasaï Central	Mbuji Mayi	Minor head wound
02/09/2020	Theft	Eastern	Tanganyika	Kalemie	Theft of batteries
04/06/2020	Prevention	Eastern	Tanganyika	Kalemie	CIT
04/28/2020	Theft	Kinshasa	Kinshasa	Kinshasa	Computer
05/09/2020	Theft	Katanga	Haut-Lomami	Kamina	Computer
05/29/2020	Theft	Kasaï	Kasaï-Central	Mbuji Mayi	Illegal checkpoint
06/26/2020	Fire	Kasaï	Sankuru	Lodja	Domestic fire loss of service telephone
09/04/2020	Medical	Eastern	Tanganyika	Kalemie	Food poisoning Emeraud
09/04/2020	Armed confrontation	Kasaï	Sankuru	Lodja	Security operation interrupted activity
09/15/2020	RTC	Eastern	Sud-Kivu	Bukavu	RTC vehicle rolled no injuries
09/25/2020	RTC	Kasaï	Sankuru	Lodja	RTC driver error no injuries
10/07/2020	Medical	Katanga	Lualaba	Kolwezi	Suspected AVC
10/13/2020	Shooting	Kinshasa	Kinshasa	Kinshasa	Shooting at Jeffrey Travels
10/22/2020	Accident	Eastern	Tanganyika	Kalemie	Slip and broke ankle
10/27/2020	RTC	Kasaï	Sankuru	Lodja	RTC

Source: USAID IHP Security Office metrics

- **Incident reports.** USAID IHP staff submitted 15 security incident reports to the home office during the last year for internal and external events that directly impacted the project**.**
- **Alerts.** The office issues security alerts in advance of publicized or known rallies or incidents likely to impact normal operations. This proactive measure usually warns of areas to avoid and gives alternative routes. The office sent 50 security alerts to staff due to events with a direct impact on operations. Each region also operates WhatsApp groups for unexpected events, which give advice to staff on immediate actions.
- **Reports.** The security office produces
  - Real-time WhatsApp and SMS alerts for incidents
  - Daily Security Report for every office
  - Weekly security report for each region
  - Bi-monthly incident security report nationwide
  - Monthly incident trends report home office and project leadership
- **Security meetings.** Each security officer and the Director attend regular security meetings to reinforce the civil security sector. In FY2020, the security director attended:
  - Regional security officer (RSO) U.S. Embassy – 10 meetings
  - RSO's other embassies (UK, German) – eight meetings
  - International development security group – six meetings

In addition, each security officer attends weekly civil sector security engagement meetings in their own region.

Outlook

Overall the security picture improved in FY2020 with greater access for development workers who have a positive impact on the overall security situation. As the project seeks to ramp up activities, project-related incidents will likely increase during more missions to the field. Given the pattern analysis, the area of most impact is likely to be the Eastern Region. USAID IHP continues to train and equip Program teams with sufficient and appropriate knowledge to mitigate the majority of risks.

3. PROGRAM AREAS

Knowledge-sharing event at community school. (*Credit:* Abt Associates for USAID IHP.) *Photo taken before COVID.*

- **1,194,790 ITNs** distributed during ANC and immunization visits
- **959,566 pregnant women** attended at least four ANC visits with a skilled provider from USG-supported health facilities
- **1,329,873 children** vaccinated with pentavalent 3 and **1,314,978 children** with the measles vaccine
- **5,358 Congolese** gained access to potable drinking water and **2,764,804 children under 5** received nutritional assistance
- **1,320,634 new users** of modern contraception reached
- **77,890 reported TB cases** under treatment and **40,662 TB cases** successfully treated, for a therapeutic success rate of 92.5 percent

- **1,194,790 insecticide treated nets** distributed during antenatal and child immunization visits
- **1,677 providers** trained in prevention and case management of malaria in pregnant women.
- **1,351 providers** trained in case management of malaria with artemisinin combination therapies (ACTs) and Rapid Diagnostic Tests (RDTs).
- **3,591,320 children** under 5 with confirmed malaria received treatment

MALARIA

According to the World Health Organization (WHO) 2019 World Malaria Report, the DRC has the world's second-highest number of cases and deaths due to malaria. As one of the DRC's key partners in the implementation of its 2020–2023 National Strategic Plan, USAID—through USAID IHP—is implementing the U.S. President's Malaria Initiative (PMI) in nine provinces. During FY20, USAID IHP activities in the provinces to support the National Malaria Control Program have included technical and financial support for (1) refresher training for providers on malaria prevention and case management for pregnant women; (2) training for providers on using rapid diagnostic tests (RDTs) to diagnose suspected malaria cases and on treating confirmed cases of uncomplicated and severe malaria; (3) equipping health facilities with materials to facilitate the observed uptake of sulfadoxine/pyrimethamine (S/P) during well child clinic visits; (4) mobilization and awareness campaigns for communities on the use of health facilities; (5) routine distribution of long-lasting insecticidal nets (LLINs).

Supported Refresher Training for Providers on Prevention and Case Management of Malaria for Pregnant Women

During FY20, USAID IHP supported refresher trainings across all nine provinces on the malaria prevention and case management for pregnant women. The PNLP's module on malaria prevention and treatment among pregnant women served as a key document for the refresher course. Trainings on malaria and the competency-based approach have also enabled the *Equipes cadre de DPS* (ECDPS, executive teams of the DPS) and providers to build their capacity in the following areas: components of antenatal care (ANC), malaria prevention during pregnancy, identifying signs of malaria, key elements of an individual birth preparedness plan, and interpersonal communication for the intermittent preventive treatment in pregnant women (IPTp) through the directly observed therapy strategy with S/P during ANC sessions and reminders about the S/P schedule. Training focused on appropriate use of RDTs, artesunate + amodiaquine (ASAQ) and artemether + lumefantrine (AL) in pregnant women with confirmed, uncomplicated malaria. Total trainees numbered 1,677 providers out of 1,958 planned, an 85.6 percent achievement. While below target, this is a marked improvement from FY19 when only 801 providers were trained, an achievement rate of 41.9 percent.

Support to providers for malaria case management in Lualaba. Credit: Abt Associates for USAID IHP. Photo taken before COVID.

Throughout the year, USAID IHP managed challenges across the regions. In Q1, Haut-Lomami, Sud-Kivu, and Tanganyika did not plan trainings due to competing priorities in their *Plan d'Action Opérationnel* (PAO, Annual Operation Plan) process, and the additional time required to establish per diem rates with the DPS. Haut-Katanga and Tanganyika had difficulties carrying out their trainings in Q3 due to restrictions related to COVID-19 when humanitarian flights were no longer traveling to this area. In Q4 the Kasaï region caught up and exceeded its target for the year (112.5 percent). Katanga at 58.2 percent and Eastern Congo at 65.4 percent did not achieve their targets; however, with travel restrictions lifted the team has developed a recuperation plan for FY21. USAID IHP will pay extra attention in FY21 to ZS with the lowest performing providers to ensure they are prioritized for refresher training.

Table 4. Number of health workers trained in IPTp with USG funds (#2.1.14)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	253	154	0	0	407	409	99.5
	Kasaï-Oriental	84	85	0	37	206	169	121.9
	Lomami	101	54	68	46	269	255	105.5
	Sankuru	70	N/A	25	84	179	110	162.7
Total Kasaï		508	293	93	167	1061	943	112.5
Katanga	Haut-Katanga	54	88	0	0	142	302	47.0
	Haut-Lomami	0	80	55	17	152	180	84.4
	Lualaba	21	30	40	0	91	180	50.6
Total Katanga		75	198	95	17	385	662	58.2
Eastern Congo	Tanganyika	0	N/A	14	0	14	156	9.0
	Sud-Kivu	0	197	0	20	217	197	110.2
Eastern Congo Total		0	197	14	20	231	353	65.4
Total General		**583**	**688**	**202**	**204**	**1,677**	**1,958**	**85.6**

Source: Project Monitoring Report

Percentage of Women Receiving Doses of Sulfadoxine/Pyrimethamine (S/P) for IPT during ANC Visits

IPTp is a key strategy in the prevention of malaria in pregnant women. In FY20, 72.1 percent of pregnant women received doses of S/P during ANC sessions, an achievement rate of 90.1 percent that exceeds the previous year's rate of 83.5 percent. Kasaï Region led with an achievement rate of 73.6 percent followed closely by the Eastern Congo Region with 72.8 percent and Katanga at 69.7 percent. Throughout the year the Kasaï region consistently had the strongest performance with an achievement rates of 92 percent followed by Eastern Congo at 90.1 percent and Katanga at 87.2 percent. Provider knowledge of the ANC/IPTp calendar influences performance for this indicator, and USAID IHP planned refresher trainings throughout the year to support skills such as this. For example, in Q1, Kasaï-Central exceeded its target due to availability of S/P and trainings held for service providers. This indicator is also supported by the Program's awareness-raising activities encouraging pregnant women to use ANC services. Social and behavior change activities supporting community engagement such as community champions also supported positive results. In Q1, community champions in Lualaba organized these activities at health facilities, and Kasaï-Central and Lualaba hosted ANC family planning mini-campaigns. In Q2 in Tanganyika and Sud-Kivu, USAID IHP financially supported the PNLP to work with community champions—particularly *relais communautaires* or RECO—to raise awareness in the community for ANC services. In Q3, DRC celebrated World Malaria Day under the theme "Zero Malaria Starts with Me." The Program technically and financially supported the campaign in five provinces—Haut-Katanga, Haut-Lomami, Kasaï-Central, Lualaba, and Sankuru—which sensitized a a total of 106,826 people. The Program supported the DPS and the ZS to brief RECO and deploy them into communities, where they conducted household visits to pregnant women and referred them to health facilities. Among the women reached, 1,276 attended ANC visits and received S/P.

Table 5. Percent of pregnant women who received doses of sulfadoxine/ pyrimethamine (S/P) for Intermittent Preventive Treatment (IPT) during ANC visits (#2.4)

Region	Province	Q1	Q2	Q3	Q4	Achieved FY2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	82.4	79.7	81.5	77.7	80.3	80.0	100.4
	Kasaï-Oriental	73.2	78.9	80.7	76.7	77.4	80.0	96.7
	Lomami	75.6	75.0	89.6	67.2	76.9	80.0	96.1
	Sankuru	74.4	72.0	58.7	34.8	60.0	80.0	75.0
Total Kasaï		76.4	76.4	77.6	64.1	73.6	80.0	92.0
Katanga	Haut-Katanga	61.6	60.4	63.7	66.3	63.0	80.0	78.7
	Haut-Lomami	76.7	80.7	80.9	80.5	79.7	80.0	99.6
	Lualaba	67.8	65.7	66.1	66.5	66.5	80.0	83.2
Total Katanga		68.7	68.9	70.2	71.1	69.7	80.0	87.2
Eastern Congo	Tanganyika	76.1	75.6	74.0	59.3	71.3	80.0	89.1
	Sud-Kivu	62.5	88.5	75.8	70.5	74.3	80.0	92.9
Eastern Congo Total		69.3	82.0	74.9	64.9	72.8	80.0	91.0
Total General		**71.5**	**75.8**	**74.2**	**66.7**	**72.1**	**80.0**	**90.1**

Source: Routine data from the Health Management Information System (HMIS)

A major barrier to achieving these targets is the availability of S/P. During Q3, cancelled flights due to COVID-19 restrictions disrupted the supply chain. Throughout the year, the Program supported better coordination of the supply chain with GHSC-TA to prevent stock-outs at the regional distribution center level. The Program is preparing a financial model for last-mile drug delivery to improve stock levels of S/P at health facilities.

Provided Supplies for Direct Observation of Adherence to IPT in Pregnancy

During FY21, USAID IHP provided cups and filters to 180 facilities for directly observed therapy of S/P during ANC sessions in Haut-Katanga, Kasaï Central, Sud-Kivu and Tanganyika.

Distributed Insecticide-treated Nets to Prevent Malaria Transmission

In FY21, USAID IHP distributed 1,194,790 insecticide-treated nets (ITNs) to pregnant women during ANC and well child visits, an overall achievement rate of 98.7 percent. Kasaï Region distributed 520,905 ITNs (an achievement rate of 89.7 percent) Eastern Congo Region distributed 375,635 ITNs (an achievement rate of 93.8 percent) and Katanga Region distributed 298,250 ITNs, exceeding its annual target with an annual rate of 130.4 percent. SBC activities also supported ITN distribution through community engagement. For example, in Q2, the Program organized mini-campaigns with distribution of ITNs in Lualaba and Haut-Katanga, and in Q3 the Program technically and financially supported World Malaria Day celebrations that promoted ITNs in five provinces: Haut-Katanga, Haut-Lomami, Kasaï-Central, Lualaba, and Sankuru.

World Malaria Day event, Kasaï-Oriental. Credit: Aime Tshibanda, Pathfinder for USAID IHP. Photo taken before COVID.

In Q1, the *Office Congolais de Control* (OCC, Congolese Control Office) quarantined a large quantity of ITNs due to potential quality assurance issues identified by the manufacturer Dawa at its factory. The OCC then confirmed the adequate quality of the batches, which were distributed in Q3. Delivery of these previously quarantined stocks led to a catch-up period in Q3 where six provinces exceeded their targets (Haut-Katanga, Tanganyika, Kasaï-Oriental, Lomami, Haut-Lomami, and Kasaï-Central).The COVID-19 quarantine created stock-outs in the regional distribution centers across the three regions during Q1 and Q2, though some provinces in Haut-Lomami, Kasaï Central, Sankuru and Tanganyika were able to use existing ITN stocks. USAID IHP is conducting advocacy with GHSC-TA to ensure the supply of ITNs at the ZS level, through consistent stocking at regional distribution centers. In Q3, Sankuru's low achievement rate was due to lack of appropriate transportation for ITNs from the *Bureau central de la zone de santé* (BCZS, Central office of the health zone) to health facilities, and a stock shortage in Lualaba was due to poor road conditions during rainy season. In Sud-Kivu, the Suabunda ZS (which can only be accessed by plane) and Mulungu ZS both faced challenges related to insecurity, yet this province exceeded its target for the year. Despite challenges, the Program nearly reached its overall target for the year.

Table 6. Number of insecticide-treated nets (ITN) distributed during antenatal and/or child immunization visits (#17)

Region	Province	Q1	Q2	Q3	Q4	Achieved FY2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	56,310	54,842	71,361	59,861	242,374	221,665	109.3
	Kasaï-Oriental	3,473	8,271	51,682	32,898	96,324	115,289	83.6
	Lomami	2,128	7,588	52,751	29,282	91,749	128,119	71.6
	Sankuru	23,661	25,024	24,237	17,536	90,458	115,868	78.1
Kasaï Total		85,572	95,725	200,031	139,577	520,905	580,941	89.7
Katanga	Haut-Katanga	5,192	24,298	52,857	33,356	115,703	54,671	211.6
	Haut-Lomami	22,958	14,738	35,935	27,072	100,703	104,179	96.7
	Lualaba	24,508	25,063	12,405	19,868	81,844	69,837	117.2
Total Katanga		52,658	64,099	101,197	80,296	298,250	228,687	130.4
Eastern Congo	Tanganyika	24,833	17,141	29,765	9,755	81,494	59,247	77.0
	Sud-Kivu	47,273	40,624	76,917	77,696	242,510	353,211	193.8
Eastern Congo Total		86,109	106,466	113,830	69,230	375,635	400,445	93.8
Total General		**224,339**	**266,290**	**415,058**	**289,103**	**1,194,790**	**1,210,073**	**98.7**

Source: Routine data from HMIS

Provided Provider Training on Malaria Diagnosis, Based on RDTs, and on Treatment of Confirmed Cases of Simple and Severe Malaria

Throughout FY21, USAID IHP provided financial and technical support for training 1,351 providers in case management of malaria with ACTs and RDTs. This achievement rate of 74.6 percent is a significant increase from FY19, when only 536 providers were trained, an achievement rate of 21.5 percent. The Kasaï region performed most trainings with 925 providers (94.4 percent achievement rate). Katanga trained 292 providers (57.8 percent achievement rate). Eastern Congo trained 134 providers (41.1 percent achievement rate). In Q4, the DPS from Kasaï-Oriental and Sankuru trained providers in case management. During the same period, USAID IHP provided financial and technical support to the PNLP to revise their guidelines for malaria case management, to be finalized in the first quarter of FY21.

The team encountered various challenges and successes when conducting these trainings. In Q1, Lualaba completed only a portion of planned trainings, because the designated trainer was often unavailable due to competing priorities for the development of the PAO. In Q2 the team launched the Malaria Reduction Process in Katanga and Kasaï regions. A priority goal of the PNLP's 2020-2023 National Strategic Plan is to reduce malaria morbidity and mortality by 50 percent by 2023, and the Malaria Reduction Process shows providers how to calculate annual targets for in their individual *aires de santé* (health areas). This process helps providers track their progress and link their local strategies to an overall reduction in the number of malaria cases and deaths. USAID IHP incorporated this approach into previously scheduled malaria trainings and supervisory visits so it doesn't incur additional costs to the training budget. In Q3, Kasaï Region exceeded its targets, due to the fact that Lomami has a high rate of malaria-related mortality. Poor performance in Lualaba was related to the poor road conditions that prevented the target ZS from implementing this activity. Plans for FY21 will target ZS not reached in FY20 and ZS with low rates of adherence to RDT results.

Table 7. Number of health workers trained in case management with ACTs with USG funds (#2.1.15)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	0	154	41	0	195	236	82.6
	Kasaï-Oriental	120	18	115	37	290	368	78.8
	Lomami	101	54	84	0	239	215	111.2
	Sankuru	83	N/A	39	79	201	161	124.8
Total Kasaï		304	226	279	116	925	980	94.4
Katanga	Haut-Katanga	0	88	0	0	88	212	41.5
	Haut-Lomami	45	68	0	0	113	113	100.0
	Lualaba	21	30	40	0	91	180	50.6
Total Katanga		66	186	40	0	292	505	57.8
Eastern Congo	Tanganyika	0	N/A	32	0	32	128	25.0
	Sud-Kivu	0	102	0	0	102	198	51.5
Eastern Congo Total		0	102	32	0	134	326	41.1
Total General		**370**	**514**	**351**	**116**	**1,351**	**1811**	**74.6**

Source: Routine data from HMIS

Number of Children under 5 with Confirmed Malaria who Received Treatment for Malaria from a Provider in USG-supported Areas

USAID IHP supports treatment for children under 5 with confirmed malaria according to PNLP guidance. In FY20, 3,591,320 children were received treatment, an achievement rate of 118 percent. Kasaï and Katanga regions exceeded their targets with an achievement rate of 119 and 137 percent respectively. Eastern Congo region nearly reached its target with an achievement rate of 99.2 percent.

Complementary activities throughout the year supported high achievement rates for this indicator including training on effective diagnosis and treatment of malaria in children under 5; consistent availability of RDTs and ACT in health facilities; contributions from GHSC-TA to make supplies available in the BCZS; and training and mobilization of community champions in conjunction with malaria awareness mini-campaigns. In Q3, mini- campaigns referred 1,864 children under 5 with fever to the health centers, where 1,452 tested positive for malaria and received treatment.

Table 8. Number of children under 5 years of age with confirmed malaria who received treatment for malaria from an appropriate provider in USG-supported areas (#15)

Region	Province	Q1	Q2	Q3	Q4	Achieved FY2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	155,029	148,304	158,627	163,966	625,926	474,236	132.0
	Kasaï-Oriental	115,299	141,836	134,627	123,165	514,927	407,882	126.2
	Lomami	118,305	111,849	100,107	74,661	404,922	398,381	101.6
	Sankuru	47,841	50,474	59,272	60,092	217,679	201,908	107.8
Total Kasaï		436,474	452,463	452,633	421,884	1,763,454	1,482,407	119.0
Katanga	Haut-Katanga	61,406	105,190	81,178	72,170	319,944	263,264	121.5
	Haut-Lomami	94,067	110,561	108,724	109,938	423,290	297,721	142.2
	Lualaba	58,323	68,504	65,980	60,743	253,550	162,126	156.4
Total Katanga		213,796	284,255	255,882	242,851	996,784	723,111	137.8
Eastern Congo	Tanganyika	58,415	61,955	58,374	59,451	238,195	202,888	117.4
	Sud-Kivu	147,437	153,215	144,377	147,858	592,887	635,174	93.3
Eastern Congo Total		205,852	215,170	202,751	207,309	831,082	838,062	99.2
Total General		**856,122**	**951,888**	**911,266**	**872,044**	**3,591,320**	**3,043,580**	**118.0**

Source: Routine data from HMIS

Organized Monthly Malaria Data Monitoring Meetings

USAID IHP provided technical and financial support to the ZS management teams to organize monthly monitoring meetings, in which all registered nurses from the *aires de santé* participate. In FY20, these monitoring meetings included analyses of malaria data in 82 health zones including the 35 ZS in Katanga region, 31 ZS in Kasaï and 16 ZS in Eastern Congo. Analyses in the provinces of Kasaï-Central and Sud-Kivu show consistency between the rate of treatment and the confirmed cases in 5-year-old children in the ZS. The data show that children with positive RDTs are treated with ACTs according to national policy. Briefing providers, and reinforcing the protocol for management of malaria cases improved likely contributed to improving providers' knowledge and thus their adherence to these national guidelines. The Program leveraged the *Malaria Reduction Process* during Q3 and Q4 to strategically utilize morbidity and mortality data for better monitoring and improved health outcomes. The Program will review this strategy closely in FY21, evaluate its effectiveness and eventually scale it up.

Supported PNLP Quarterly Supervision Visits to the ZS

Thanks to USAID IHP's technical and financial support, 82 ZS have benefited from PNLP supervision visits, including 16 ZS in Katanga, 35 ZS in the Kasaï region and 31 ZS in the Eastern Region. Supervision visits to health facilities ensure providers comply with standards and guidelines for effective malaria treatment and prevention among pregnant women. The supervision built the capacity of ZS managers and providers to produce quality data and manage antimalarial supplies. Supervision by the provincial coordinators contributed to the improvement of the quality of malaria care (diagnosis and treatment), the quality of malaria data (analysis and reporting), the prevention of malaria in pregnant women (through IPT) in health facilities, and the monitoring of the management of PMI inputs in the ZS.

Lessons Learned

- The delayed start of ANC by pregnant women remains a major challenge in malaria prevention. Service provision can be improved through mini-campaigns, home visits conducted by peer educators, and other SBC activities implemented through the champion communities and RECO. To address this, USAID IHP is planning to work with pregnant women to encourage their peers (other pregnant women) to attend ANC visits. In ZS where a high number of clients are already seeking ANC services, the number of ANC sessions offered will be increased. ANC sessions will also be organized in remote communities far from ZS with a health facility.
- Through community awareness-raising, community engagement, and community champions, trained and highly committed RECO have a significant impact on improving the number of women who receive doses of S/P.
- Refresher training for providers on malaria prevention and case management for pregnant women helped improve participants' knowledge of the revised guidelines for case management. The guidelines promote directly observed therapy with S/P in recognition that observation from a provider ensures that pregnant women actually take their dose of S/P.
- USAID IHP's support for "last-mile" delivery of malaria commodities helped ensure the availability of ITNs in the ZS, particularly in health facilities and the community.
- Monitoring meetings made it possible to identify gaps among providers, namely the difficulty in estimating needs, the treatment of uncomplicated malaria cases with quinine, the case management of non-malarial fevers, and identification and disposal of poor quality RDTs.

- **959,566 pregnant women** attended at least four ANC visits with a skilled provider from USG-supported health facilities (116.2% achievement rate).
- Achieved **90.8% of USAID IHP's target** for percentage of deliveries with a skilled birth attendant in USG-supported facilities in target provinces.
- With USAID IHP's support, there are now **45 ZS with MPDSR teams** in seven of the nine provinces and a total of **65 ZS** have BEmONC in place.
- **1,316,048 children under five** received treatment for an acute respiratory infection from an appropriate provider and USAID supported treatment for **1,104,700 cases of child diarrhea**.
- **1,329,873 children** were vaccinated with pentavalent 3 and 1,314,978 children with the measles vaccines in FY2020, exceeding both targets

MATERNAL, NEONATAL, AND CHILD HEALTH

The DRC is one of 24 USAID priority countries for MNCH. During FY20, USAID IHP implemented maternal and child health interventions in support of MOH standards and guidelines in the nine provinces. USAID IHP supports its target provinces' implementation of MNCH interventions such as ANC visits, assisted deliveries and postnatal care visits, essential newborn care, emergency care, integrated management of childhood illness, and immunization according to MOH guidelines and standards.

Q2 brought several implementation challenges, including floods caused by torrential rains in Sud-Kivu and destruction of road infrastructure in Lualaba, Haut-Lomami, Tanganyika, and Lomami. In Q2 and Q3, the COVID-19 pandemic led to restrictions on gatherings of more than 20 people (affecting meetings, trainings, retrainings, and sensitization activities) and on travel from Kinshasa to the provinces and from the provincial capital to the ZS. In addition, political instability in certain provinces (e.g., Sud-Kivu and Tanganyika) slowed down some activities.

In Q4, residual travel restrictions and the cancellation of humanitarian and civilian flights due to COVID-19 slowed the implementation of minimum services at all levels of the health system: hospitals, CS, ZS, DPS, and IPS. The lockdown in Kinshasa, which started on March 24, 2020 and lasted until August 15, where the highest number of COVID-19 cases were detected, had a negative impact on activities because national-level experts could not travel to the provinces; provincial-level experts could not travel to the health facilities.

MATERNAL AND NEWBORN HEALTH

ANC visits with a Skilled Provider

In the DRC, national standards and guidelines recommend at least four ANC consultation visits, including a first visit in the first trimester, the second at 24-28 weeks of amenorrhea, and the last two visits in the last trimester. ANC visits are opportunities for providers to consult with pregnant women to: identify potential risks, provide preventive care, and improve their pregnancy outcomes; discuss the importance of giving birth in health facilities with the assistance of a skilled provider; and review information about the pregnant woman's delivery plan (e.g., identifying a blood donor, saving for unexpected costs during delivery). In addition, they are opportunities to educate women and their families about the danger signs during pregnancy and provide information about family planning, an important factor in improving maternal and newborn health. Despite efforts by the MOH and its partners since the adoption of the Health System Strengthening Strategy in 2006, the health system's performance falls short in the fight against maternal and infant mortality. To improve maternal and child survival rates, the World Bank-funded PDSS project implemented strategic purchasing of services, giving the MOH an instrument for ZS to improve quality of care and encourage preventive and promotional services. PDSS operates in 14 provinces, of which four overlap with USAID IHP (Haut-Katanga, Haut-Lomami, Lualaba, and Sud-Kivu).

As shown in Table 9, USAID IHP had an overall achievement rate of 97 percent for Indicator #2.1.2 (percentage of pregnant women attending at least one ANC visit with a skilled provider from USG-supported health facilities) in FY20. Performance increased steadily from one quarter to the next, and in Q4, the Program reached an achievement rate of 103 percent. Certain provinces, such as Tanganyika (83 percent), underperformed compared to others. Performance was strongest in the Katanga region (99.9 percent) due in part to PDSS purchase of services, which motivated community health workers to recruit pregnant women for the ANC indicator. Performance in the Eastern Congo region (91.9 percent) was linked to the availability of ANC inputs (LLINs, S/P) and community champion activities in the ZS (awareness-raising and referral of pregnant women to ANC services).

As shown in Table 10, in FY20, a total of 959,566 pregnant women attended at least four ANC visits with a skilled provider from USG-supported health facilities (Indicator #13), an achievement rate of 116.2 percent for the year. While performance varied, all provinces met their targets. USAID IHP implemented the following activities to promote early initiation and use of ANC services:

- Improved data completeness due to USAID IHP's support for internet connections in all the ZS.
- Provider training and follow-up (with a focus on provinces that performed poorly in previous quarters), and provider supervision and coaching by the DPS.
- Capacity building of providers in basic emergency obstetric and newborn care (BEmONC) and malaria and antenatal care for pregnant women.
- Monthly monitoring meetings at the BCZS to identify *aires de santé* with problems in all provinces, for the ZS where data are identified as problematic.
- Organization of the joint ANC-FP mini-campaigns in underperforming *aires de santé*.
- Availability of ANC medicines and other inputs (specifically LLINs, IPTp with S/P during ANC visits, iron and folic acid).

- Increased awareness-raising activities and information-sharing focusing on the importance of ANC attendance (with particular emphasis on the DRC national guideline that the first ANC visit should take place before the 12th week of pregnancy), which has helped increase the number of pregnant women who complete four ANC visits.
- Mini ANC awareness-raising and referral of pregnant women to health centers during World Malaria Day activities.
- Support for functional community champions and health workers to raise awareness and counsel women on the use of ANC and malaria services.
- Payment for Indicator #13 results, supported by the PDSS, which encourages the ZS to have women attend four ANC visits. This activity was implemented in Quarters 2 through 4, and served to improve Indicator #13 results in 31 ZS in Katanga Region: 12 ZS in Haut-Lomami, six ZS in Haut-Katanga, and 13 ZS in Lualaba.

Immunization mini-campaign, Lomami. Credit: Jean Michel Motombo, Abt Associates for USAID IHP. Photo taken before COVID

Table 9. Percentage of pregnant women attending at least one ANC visit with a skilled provider from USG-supported health facilities (#2.1.2)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	92.4	98.9	106.9	106.7	101.3	100	101.3
	Kasaï-Oriental	83.4	95.6	98.3	99.7	94.3	100	94.3
	Lomami	92.5	98.7	99.9	97.9	97.2	100	97.2
	Sankuru	89.2	99.2	95.7	104.8	97.3	100	97.3
Total Kasaï		89.4	98.1	100.2	102.2	97.5	100	97.5
Katanga	Haut-Katanga	75.2	99.4	98.4	98.3	93.0	100	93.0
	Haut-Lomami	91.0	98.8	97.6	101.3	97.2	100	97.2
	Lualaba	94.3	104.1	117.2	121.7	109.4	100	109.4
Total Katanga		86.8	100.8	104.4	1.1	1.0	100	99.9
Eastern Congo	Tanganyika	65.4	86.7	88.7	90.7	83.0	100	83.0
	Sud-Kivu	94.0	104.1	98.7	105.7	100.7	100	100.7
Eastern Congo Total		79.7	95.4	93.7	98.2	91.8	100	91.8
Total General		86.4	98.4	100.1	103.0	97.0	100.0	97.0

Source: Routine data from HMIS

Table 10. Number of pregnant women attending at least four ANC visits with a skilled provider from USG-supported health facilities (#13)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	37,116	39,643	44,541	45,144	166,444	151,966	109.5
	Kasaï-Oriental	30,258	35,083	35,776	36,983	138,100	118,801	116.2
	Lomami	26,147	28,302	29,096	29,114	112,659	108,802	103.5
	Sankuru	17,535	19,238	19,098	19,856	75,727	64,376	117.6
Total Kasaï		111,056	122,266	128,511	131,097	492,930	443,945	111.0
Katanga	Haut-Katanga	17,529	22,234	22,445	25,324	87,532	72,353	121.0
	Haut-Lomami	19,860	23,161	24,432	26,757	94,210	71,589	131.6
	Lualaba	12,032	13,510	15,273	16,677	57,492	40,781	141.0
Total Katanga		49,421	58,905	62,150	68,758	239,234	184,723	129.5
Eastern Congo	Tanganyika	9,438	14,322	14,497	15,995	54,252	41,212	131.6
	Sud-Kivu	36,531	43,438	46,125	47,056	173,150	155,951	111.0
Eastern Congo Total		45,969	57,760	60,622	63,051	227,402	197,163	115.3
Total General		**206,446**	**238,931**	**251,283**	**262,906**	**959,566**	**825,831**	**116.2**

Source: Routine data from HMIS

Delivery with a Skilled Birth Attendant and Proper Administration of Uterotonics

Attended childbirth includes all the appropriate care that a woman and her newborn should receive during childbirth and the postnatal period. This requires healthcare workers with childbirth skills, supplied with drugs and other commodities, equipment, and infrastructure to provide the mother and newborn with the appropriate care. Childbirth is sometimes complicated by serious health risks, even for women with no previous health problems. Bleeding after childbirth (postpartum hemorrhage) is an unpredictable and rapid cause of maternal death in the DRC. Uterine atony (lack of normal retraction of the uterus after delivery) is the most common cause of immediate and severe postpartum hemorrhage (occurring within 24 hours of delivery). The WHO and the DRC Ministry of Health recommend active

management of the third stage of labor to reduce the incidence of postpartum hemorrhage. Active management of the third stage of labor is carried out by qualified providers who have received adequate training and are equipped with uterotonics.

As shown in Table 11, the Congolese health system in the nine target provinces achieved 90.8 percent of USAID IHP's overall target for deliveries with a skilled birth attendant in USG-supported facilities (Indicator #2.1.3). Performance showed significant improvement over the course of the year, starting with an overall achievement rate of 66.6 percent in Q1 and ending with an overall achievement rate of 86.7 percent in Q4. These improvements are attributable to the increase in the number of skilled providers, trained in previous quarters in BEmONC); availability of oxytocin; and maternal death surveillance and response (MDSR) with USAID IHP support.

Other activities that contributed to these improvements included the sensitization campaigns for pregnant women, conducted by champion communities, which focused on seeking ANC care and giving birth in health facilities. Coordination and synergies with other partner activities in Program regions also contributed to USAID IHP's performance, including the (1) World Bank-funded PDSS project (overlaps in three provinces in Katanga) for the strategic purchase of services; and (2) USAID-funded ASSP in Kasaï which focuses on training and clinical mentoring on maternal and newborn health.

The Kasaï and Katanga regions performed the best overall, at 94.9 percent and 97.9 percent respectively, while Eastern Congo's achievement rate, at 72.1 percent, was much lower. This underperformance is due to (1) absence of maternity wards in most health facilities; (2) lack of qualified personnel in health facilities; (3) community customs and traditions that discourage use of health services; (4) ongoing insecurity, which limits women's ability to travel to health centers (especially at night) and limits centers' ability to operate; and (5) weather-related challenges that prevent people from seeking care (poor road conditions, for example). In Tanganyika specifically, obstacles include traditional practices and customs that hinder use of maternity services, the influence of traditional churches on health-seeking behavior, lack of maternity services in most health facilities, and scarcity of qualified personnel for assisted childbirth.

Table 11. Percentage of deliveries with a skilled birth attendant in USG-supported facilities (#2.1.3)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	90	85.8	91.2	98.3	93.7	90	104.1
	Kasaï-Oriental	90	71.1	84.6	85.4	81.7	90	90.8
	Lomami	90	76.6	81.3	82.0	80.6	90	89.6
	Sankuru	90	80.2	87.2	88.8	85.6	90	95.1
Total Kasaï		90.0	78.4	86.1	88.6	85.4	90	94.9
Katanga	Haut-Katanga	56.9	90	65.4	86.7	80.3	90	89.3
	Haut-Lomami	32.5	90	76.0	86.7	81.2	90	90.2
	Lualaba	58.4	90	88.6	113.3	102.9	90	114.3
Total Katanga		49.3	90.0	76.7	95.5	88.1	90	97.9
Eastern Congo	Tanganyika	62.8	90	36.6	54.2	47.6	90	52.9
	Sud-Kivu	29.0	90	74.1	85.0	82.2	90	91.3
Eastern Congo Total		45.9	90.0	55.3	69.6	64.9	90	72.1
Total General		**66.6**	**84.8**	**76.1**	**86.7**	**81.7**	**90**	**90.8**

Source: Routine data from HMIS

As shown in Table 12, the Congolese health system in the nine target provinces achieved only 66.1 percent of USAID IHP's overall target for women giving birth who received uterotonics in the third stage of labor or immediately after birth (Indicator #2.1.4). Performance was the highest in Q3 and decreased considerably in Q4. The main reasons for not meeting targets in Kasaï region (in three of the four provinces) are the following: (1) limited availability of medicines; (2) weak provider capacity in emergency obstetric care (EmONC); (3) limited DPS support and supervision of ZS; and (4) weak financial support for ZS supervision of the aires de santé. In Katanga, the main reason for underperformance was the insufficient number of providers trained in EmONC, essential obstetric care (EOC), post-abortion care, and MDSR.

Eastern Congo had the worst performance of the three regions, with an achievement rate of 59.2 percent of the target. The main reason was the low percentage of women who received uterotonics after childbirth in Tanganyika, where challenges included: (1) absence of maternity wards in most health facilities; (2) lack of oxytocin; (3) low level of awareness of skilled birth attendants among women in the communities; and (4) long distances between health facilities (e.g., in the ZS of Kabalo, the farthest *aire de santé* is 310 km from the general referral hospital), which means that most deliveries are at home.

Improved performance in Sud-Kivu between Q3 and Q4 was due to: (1) supply of essential generic medicines to ZS; (2) training of midwives and doctors responsible for maternity hospitals in SOU, SOE, SEN, SONU, and SDMR in the ZS of Mubumbano and Walungu; (3) training of trainers of the Ciriri center of excellence in the Panzi simulation center; and (4) installation of the SDMR committee in five ZS (Walungu, Mubumbano, Mwenga, Kamituga, and Kitutu). In Q4, USAID IHP began addressing issues of insufficient data collection and data management in the health facilities through the following activities: (1) delivery of a complete set of SNIS tools to improve the timeliness and completeness of data at all levels; (2) support for routine data quality assessments with the routine data quality assessment (RDQA) tool; (3) purchase of megabytes of storage space for the ZS to facilitate data entry into DHIS2 on time; and (4) training of DPS and ZS managers on data analysis for decision making. Finally, the GIZ-funded ASSR project in Sud-Kivu—which supports governance, human resources, equipment, service delivery, procurement of essential generic medicines (EGM) and specific inputs in eight ZS—helped contribute to improved performance in this province.

Table 12. Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs (#2.1.4)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	2,538	2,787	3,263	3,368	11,956	12,952	92.3
	Kasaï-Oriental	1,481	1,808	1,850	1,831	6,970	10,353	67.3
	Lomami	855	913	1,093	1,012	3,873	5,798	66.8
	Sankuru	675	741	824	834	3,074	4,218	72.9
Total Kasaï		5,549	6,249	7,030	7,045	25,873	33,321	77.6
Katanga	Haut-Katanga	5,193	6,427	6,008	6,345	23,973	37,158	64.5
	Haut-Lomami	1,584	2,306	2,766	2,966	9,622	8,712	110.4
	Lualaba	3,836	4,163	4,336	4,600	16,935	21,495	78.8
Total Katanga		10,613	12,896	13,110	13,911	50,530	67,366	75.0
Eastern Congo	Tanganyika	939	1,059	1,309	1,414	4,721	7735	61.0
	Sud-Kivu	16,940	19,766	20,742	21,712	79,160	133919	59.1
Eastern Congo Total		17,879	20,825	22,051	23,126	83,881	141654	59.2
Total General		**34,041**	**39,970**	**42,191**	**44,082**	**160,284**	**242341**	**66.1**

Source: Routine data from HMIS

PROMOTING ESSENTIAL NEWBORN CARE

Essential Newborn Care and Post-partum Visits

The MOH recommends for all newborns in the DRC received Essential Newborn Care, characterized by immediate and complete drying of the newborn, skin-to-skin contact of the newborn with its mother, clamping and then cutting of the cord within the first minutes after childbirth, early latching and exclusive breastfeeding, and administration of Vitamin K1.

Performance for Indicator #2.1. 6 improved over the course of the reporting period, and USAID IHP ended the year with an achievement rate of 113.5 percent. Only Kasaï-Central fell slightly short of its target, with an achievement rate of 98 percent. This was due to the performance of a single ZS in Demba, which was primarily supported by the ASSR/SANRU project, and therefore did not benefit from all Program ENC interventions as in the corridor ZS.

USAID IHP's strong performance for Indicator #2.1.6 was a result of the following activities:

SONU training with providers, Kasaï-Central. Credit: Abt Associates. Photo taken before COVID.

- Establishment of MNCH training pools in six provinces, which enabled the multidisciplinary provincial supervisors to support some ZS.
- DPS implementation of guidelines for maternity wards that advise keeping new mothers until their newborns are immunized.
- BEmONC training for providers on monitoring of women giving birth and newborns.
- Community health workers' home visits to women who have given birth.
- Provider training in EmONC, EOC, post-abortion care, MDSR, and comprehensive EmONC for hospitals (specifically, midwives and doctors in charge of maternity wards).
- Provider supervision and support.
- Increase in joint DPS-USAID IHP follow-up visits in certain ZS.
- Supply of nine of the 13 life-saving drugs for mothers, children, and newborns.
- Support of other implementing partners, including UNICEF, the PDSS, GIZ, PRODES, and ASSR.

Table 13. Number of postpartum/newborn visits within three days of birth in USG-supported programs (#2.1.6)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	42,890	45,768	50,936	50,985	190,579	194,383	98.0
	Kasaï-Oriental	37,586	44,256	46,081	45,880	173,803	163,148	106.5
	Lomami	32,108	34,323	35,281	35,285	136,997	128,116	106.9

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
	Sankuru	19,962	21,872	22,021	22,791	86,646	71,377	121.4
Total Kasaï		132,546	146,219	154,319	154,941	588,025	557,024	105.6
Katanga	Haut-Katanga	40,266	53,587	52,784	55,749	202,386	174,876	115.7
	Haut-Lomami	28,028	33,810	35,370	37,421	134,629	94,234	142.9
	Lualaba	25,067	28,666	30,761	32,494	116,988	88,359	132.4
Total Katanga		93,361	116,063	118,915	125,664	454,003	357,469	127.0
Eastern Congo	Tanganyika	12,336	16,719	16,774	18,121	63,950	41,064	155.7
	Sud-Kivu	53,538	61,138	64,109	65,418	244,203	234,457	104.2
Eastern Congo Total		65,874	77,857	80,883	83,539	308,153	275,521	111.8
Total General		**291,781**	**340,139**	**354,117**	**364,144**	**1,350,181**	**1,190,014**	**113.5**

Source: Routine data from HMIS

Performance for Indicator #2.1.7 steadily improved over the course of the year, and USAID IHP ended the year with an overall achievement rate of 100 percent, though some provinces (Sankuru and Tanganyika) fell just short of their targets. Improved indicator performance in Sankuru is linked to provider training in FP (including postpartum FP); in Tanganyika, it is attributed to regular support of providers by the ECZS. Activities that affected this indicator's performance included USAID IHP's support for post-partum visits, provider training in EmONC, and the supply of life-saving drugs for children and newborns. In past quarters, provinces faced challenges in providing essential care for 100 percent of live births because of insufficient provider capacity. In previous quarters, the low utilization of chlorhexidine digluconate and Vitamin K1 limited the number of newborns receiving the comprehensive package of essential care; other provinces experienced fluctuations in performance due to poor road conditions that prevented the transport of essential medicines to health facilities.

Table 14. Percentage of newborns receiving essential newborn care through USG-supported programs (Indicator #2.1.7)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	96.1	97.8	97.3	97.0	97.6	97.2	100.4
	Kasaï-Oriental	95.6	94.8	92.1	91.8	95.3	94.4	101.0
	Lomami	87.1	85.9	88.5	84.3	87.1	87.1	99.9
	Sankuru	96.2	93.4	96.9	92.6	91.9	94.5	97.3
Total Kasaï		93.7	93.0	93.7	91.4	93.0	93.3	99.6
Katanga	Haut-Katanga	94.5	94.2	94.7	93.4	94.7	94.5	100.2
	Haut-Lomami	89.9	89.0	94.8	92.3	94.2	92.1	102.3
	Lualaba	93.8	93.0	94.2	93.9	95.5	94.2	101.4
Total Katanga		92.7	92.1	94.6	93.2	94.8	93.6	101.3
Eastern Congo	Tanganyika	101.4	92.4	90.0	97.4	89.2	92.6	96.4
	Sud-Kivu	95.7	96.8	97.6	91.4	98.1	97.1	101.0
Eastern Congo Total		98.5	94.6	93.8	94.4	93.6	94.8	98.7
Total General		**94.2**	**93.6**	**94.5**	**94.6**	**94.2**	**93.8**	**100.0**

Source: Routine data from HMIS

Number of Newborns Resuscitated

In DRC, neonatal asphyxia is responsible for nearly 20 percent of neonatal deaths. The Helping Babies Breathe (HBB) approach focuses on the initial stages of neonatal resuscitation: immediate drying of the baby, providing warmth and additional stimulation to breathe, followed by Ambu bag and mask ventilation, if necessary, during the first 60 seconds after birth (the "golden minute"). USAID IHP is scaling up this approach in health facilities. To date, 45 ZS have had the BEmONC training and have integrated training in neonatal resuscitation. Sixteen of the 45 ZS were added in Q4.

As shown in Table 15, the overall achievement rate for Indicator #2.1.5 was 89.4 percent. Performance increased somewhat over the course of the year, but USAID IHP was able to meet/exceed the target only in Haut-Lomami province. Poor performance in some of the provinces was due in large part to lack of resuscitation equipment in the ZS. Specific examples of reasons for other provinces' poor performance are as follows:

- *Haut-Katanga:* Lack of capacity among service providers, (resulting in an inadequate number of trained providers); lack of support from other partners (UNICEF, PDSS) in the strategic purchase of health services; and lack of strong technical capacity among health facilities (consisting of availability biomedical equipment and qualified staff for service provision).
- *Sankuru:* Incomplete data in DHIS2 across the province; lack of close monitoring by the multidisciplinary provincial supervisor as well as the PNSR in certain ZS (Pania-Mutombo, Lusambo and Tshudi-Loto) compared to the ZS of the corridor; and lack of resuscitation equipment.
- *Lomami:* Childbirth was led by traditional matrons in most of the health facilities in Q2; providers were not trained in SONU, SOE, SEN, SAA, and SDMR for most ZS in Q1 and Q2; and resuscitation equipment was insufficient in the health facilities in the ZS with BEmONC.

Activities that contributed to performance for this indicator include:

- Increased number of providers (midwives, doctors in maternity wards) trained in EOC, essential newborn care, EmONC, and MDSR.
- Financial support for data analysis meetings in the ZS.
- Retraining of providers.
- Supply of essential generic medicines.
- Supervision support in MNCH and maternal and perinatal death surveillance and response.
- Coordination and synergies with other partner activities: (1) PDSS (which overlaps with USAID IHP in three provinces in the Katanga region) for the strategic purchase of services; (2) ASSP in the Kasaï Region, which focuses on training and clinical mentoring on maternal and newborn health; (3) UNFPA in Tanganyika, Sud-Kivu, and the Katanga Region focusing on emergency obstetric care and newborn care; and (4) UNICEF's support for hospital provider training on essential and emergency newborn care in all the ZS (which impacted Q2 numbers in particular).

Table 15. Number of newborns not breathing at birth who were resuscitated in USG-supported programs (Indicator #2.1.5)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	531	502	633	699	2,365	3,539	66.8
	Kasaï-Oriental	532	678	785	596	2,591	2,940	88.1
	Lomami	501	613	583	589	2,286	2,810	81.4
	Sankuru	163	243	262	256	924	1,127	82.0
Total Kasaï		1,727	2,036	2,263	2,140	8,166	10,416	78.4
Katanga	Haut-Katanga	1,233	1,937	1,600	2,012	6,782	8,126	83.5
	Haut-Lomami	965	1,029	1,181	1,226	4,401	3,668	120.0
	Lualaba	694	722	859	908	3,183	3,536	90.0
Total Katanga		2,892	3,688	3,640	4,146	14,366	15,330	93.7
Eastern Congo	Tanganyika	326	499	466	333	1,624	1,743	93.2
	Sud-Kivu	1,645	1,786	2,069	2,121	7,621	8,061	94.5
Eastern Congo Total		1,971	2,285	2,535	2,454	9,245	9,804	94.3
Total General		**6,590**	**8,009**	**8,438**	**8,740**	**31,777**	**35,550**	**89.4**

Source: Routine data from HMIS

MATERNAL DEATH SURVEILLANCE AND RESPONSE (MDSR)

In DRC, the direct causes of maternal deaths are postpartum hemorrhage, septicemia, eclampsia/pre-eclampsia, uterine rupture, sepsis, dystocia, and complications from caesarean sections. Meanwhile, contributing factors include the lack of a blood bank in the majority of the ZS; the four "toos" (pregnancies that are too early, too many, too close, too late); self-medication; influence of traditional customs and practices, including churches; the three "delays" (delay in decision making, delay in care, delay due to road conditions). Tanganyika remains the province with the highest maternal death rate; this is due to geographic inaccessibility and a poorly organized referral system; the limited presence of matrons in the health facilities; and a lack of equipment and inputs for blood transfusion, as in Lomami.

USAID IHP provides technical and financial support to the nine provinces in order to implement their MDSR activities. Previously, maternal and perinatal death surveillance and response (MPDSR) teams had not been established in all the ZS, so that all cases could not be analyzed and reviewed. In FY20, USAID IHP provided financial support to maternal death review meetings in 281 ZS in the nine provinces. As shown in Table 16, there are now 45 ZS with MPDSR teams in seven of the nine provinces (Haut-Katanga and Lualaba still do not have the MDSR committee in place). A total of 65 ZS have BEmONC in place. The ZS recorded a total of 1,315 maternal deaths (674 at the community level; 509 in health facilities).

Table 16. ZS with BEmONC and MPDSR

Provinces	# ZS	# ZS with BEmONC	# ZS with MPDSR	Comments
Kasaï-Central	25	5	2	Started only in Q4 (2 ZS)
Kasaï-Oriental	19	10	10	There are still nine ZS without MPDSR; follow up with the 10 ZS regarding the orientation.
Sankuru	16	5	5	Continue rollout of the remaining ZS with SONU B.
Lomami	16	10	10	Six ZS still remaining.
Lualaba	14	8	0	Not planned in Y2.
Haut-Lomami	16	5	4	Set up in Q3.

Provinces	# ZS	# ZS with BEmONC	# ZS with MPDSR	Comments
Haut-Katanga	26	8	0	Not planned in Y2.
Sud-Kivu	34	5	5	Began only in Q3.
Tanganyika	11	9	9	2 ZS remaining; maternal deaths are the highest in the country.
Total	**177**	**65**	**45**	**There are 45 ZS with MDSR committees out of 65 that have integrated BEmONC.**

Source: Project Monitoring Report

A total of 522 maternity death cases were reviewed and 41 meetings held in FY2020 with support from USAID IHP. Overall, implementation of the SDMR committee at the ZS level has been weak and USAID IHP needs to improve the analysis of cases and the quality of the response. Out of 1,315 cases, only 40 percent were reviewed.

In FY21, USAID IHP will focus on the following: 1) transition responsibility for maternal death reviews to the ZS for in-depth analysis and effective response actions adapted to the local context; 2) advocate the installation of committees in all ZS with integrated BEmONC; and 3) plan an annual review in the provinces, with the support of the central level and the relevant entity (e.g., SCOGO, SCOSAF) to implement concrete actions.

CHILD HEALTH

Strengthened Integrated Management of Childhood Illnesses

USAID IHP supports the MOH in implementing the strategy for integrated management of newborn and childhood illness (IMNCI). This strategy covers the treatment of children suffering from diseases such as acute respiratory infections (ARIs or pneumonia), diarrhea, and malaria at the community (SSC) and health facility levels. In FY20, USAID IHP set up pools of trainers, delivered provider training on IMNCI and pediatric emergencies for certain DPS, and built provider capacity in IMNCI.

Table 17. Trainees by subject and affiliation

Trainees	Q1		Q2		Q3		Q4		Total
	M	F	M	F	M	F	M	F	
Clinical IMNCI									
ZS level	16	2	0	0	19	5	72	10	124
Health facility providers	197	57	0	0	199	39	0	0	492
DPS level	0	0	0	0	9	1	9	3	22
IMNCI Total	213	59	0	0	227	45	81	13	638
Trainees	**Q1**		**Q2**		**Q3**		**Q4**		**Total**
Emergency triage assessment and treatment									
ZS level	0		0		4		0		4
Health facility providers	0		0		48		40		88
Emergency triage total	0		0		52		40		92
TOTAL	**272**		**0**		**324**		**134**		**730**

Source: Project Monitoring Report

As shown in Table 18, the Program achieved a rate of 108.5 percent for Indicator #5 (number of children under 5 years that received treatment for an acute respiratory infection from an appropriate provider) and rate of 94.9 percent for Indicator #7 (number of cases of child diarrhea treated in USG-

supported programs). The Program showed steady progress in its performance for both indicators over the course of the year. The following activities supported these results:

- Training of 492 health facility providers and 124 ZS leaders and 22 DPS leaders in clinical IMNCI.
- Training of 88 service providers from HGRs and referral health centers and four managers in the ZS on emergency triage assessment and treatment.
- Creation of a pool of trainers in Haut-Lomami, Sankuru, Sud-Kivu, and Kasaï-Oriental.
- Revival of the CACs in Lualaba and Tanganyika.
- Printing of clinical IMNCI flowcharts and booklets for providers.
- ECDPS and ZS supervision and monitoring for ZS and health facilities.
- Support to the ZS for data entry in DHIS2.
- Information sharing and sensitization activities on danger signs and the importance of early access to health care with RECO, community leaders, journalists, and political and administrative authorities. USAID IHP also carried out these activities with households and community members in Haut-Katanga, Tanganyika, Kasaï-Oriental, Kasaï Central, and Haut-Lomami.
- Financial support for 1,239 household visits by RECO, which reached 7,018 people and identified 74 children under 5 with danger signs and referred them to health facilities in Haut-Katanga and Kasaï-Oriental.
- Coordination with other partners: IRC, *Médecins d'Afrique*, UNICEF in Tanganyika, Save the Children, PRODS, UNICEF in Kasaï-Oriental, and PDSS in Haut-Katanga and Haut-Lomami.
- The DPS of Lualaba, Haut-Katanga, Tanganyika, and Kasaï-Central also benefited from the Program's support for the transport of essential generic medicines (EGM) by RECO to the hard-to-reach *aires de santé*.

For Indicator #5, performance varied across the provinces, with Sankuru being the lowest performing (77.8 percent), due to the low availability of dispersible amoxicillin in nine ZS in Sankuru, which brought down the provincial average. Tanganyika over-performed at 169.8 percent overall. This was due to a steady supply of medicines and support for management of pneumonia; in particular, for children living in displaced camps where humanitarian partners IRC, *Medecins d'Afrique,* and UNICEF provide services free of charge. In the other provinces, high performance was due to provider training on IMNCI to evaluate, diagnose, and treat children with possible pneumonia; the supply of dispersible amoxicillin in Q4; and the Program's coordination of activities with other implementing partners. These partners are PDSS in the Katanga region, PRODS and UNICEF in the Kasaï Region, and UNICEF and WHO in Sud-Kivu.

Similarly for Indicator #7, Sankuru was the lowest performing province, with an achievement rate of 44.9 percent for the entire year, followed by Lomami at 78.4 percent, due to a significant shortage of medicines (oral rehydration salt + zinc sulfate (ORS + zinc)) to treat diarrhea. In Q2 through Q4 COVID-19 impacted the global supply chains and therefore availability of medicines via the GHSC-TA project. Fever and cough cases were referred to health facilities in the context of COVID-19, according to MOH guidelines that USAID IHP helped disseminate. By Q4, health facilities were stocked with the necessary medicines for diarrhea and pneumonia. In addition, PNDSS support for procurement of EGM helped health facilities purchase these medicines, especially in the Katanga region. Home-based diarrhea

treatment is no longer recommended by the MOH and therefore was not advised in Q4. Instead, health facilities without ORS provide prescriptions to purchase it from private pharmacies.

Table 18. Number of children under five years of age that received treatment for an acute respiratory infection from an appropriate provider (#5)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	67,414	67,392	66,123	69,905	270,834	238,950	113.3
	Kasaï-Oriental	34,497	40,386	38,632	39,496	153,011	132,581	115.4
	Lomami	35,435	37,227	36,294	39,288	148,244	149,498	99.2
	Sankuru	14,469	17,499	15,069	17,819	64,856	83,360	77.8
Total Kasaï		151,815	162,504	156,118	166,508	636,945	604,389	105.4
Katanga	Haut-Katanga	19,069	30,907	24,719	24,078	98,773	84,071	117.5
	Haut-Lomami	19,872	24,052	23,037	25,316	92,277	86,323	106.9
	Lualaba	21,364	27,892	26,179	25,565	101,000	73,533	137.4
Total Katanga		60,305	82,851	73,935	74,959	292,050	243,927	119.7
Eastern Congo	Tanganyika	18,828	28,773	21,910	24,995	94,506	55,653	169.8
	Sud-Kivu	68,288	87,209	71,580	65,470	292,547	308,803	94.7
Eastern Congo Total		87,116	115,982	93,490	90,465	387,053	364,456	106.2
Total General		**299,236**	**361,337**	**323,543**	**331,932**	**1,316,048**	**1,212,772**	**108.5**

Source: Routine data from HMIS

Table 19. Number of cases of child diarrhea treated in USG-supported programs (#7)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	50,927	41,764	45,435	60,923	199,049	187,784	106.0
	Kasaï-Oriental	23,187	26,234	24,886	26,227	100,534	120,162	83.7
	Lomami	21,975	21,793	22,525	25,133	91,426	116,585	78.4
	Sankuru	4,311	4,054	7,800	20,362	36,527	81,407	44.9
Total Kasaï		100,400	93,845	100,646	132,645	427,536	505,938	84.5
Katanga	Haut-Katanga	20,739	31,129	24,216	25,442	101,526	90,208	112.5
	Haut-Lomami	25,543	27,704	30,917	33,925	118,089	101,943	115.8
	Lualaba	16,297	17,304	21,043	23,637	78,281	62,251	125.8
Total Katanga		62,579	76,137	76,176	83,004	297,896	254,402	117.1
Eastern Congo	Tanganyika	12,360	13,593	11,739	15,939	53,631	53,651	100.0
	Sud-Kivu	58,299	68,978	65,992	75,750	269,019	290,709	92.5
Eastern Congo Total		70,659	82,571	77,731	91,689	322,650	344,360	93.7
Total General		**233,638**	**252,553**	**254,553**	**307,338**	**1,048,082**	**1,104,700**	**94.9**

Source: Routine data from HMIS

Integrated Community Case Management

Pneumonia, diarrhea, and malaria are the three main killers of children in the DRC, accounting for more than 50 percent of deaths among children under 5. These deaths are most prevalent in areas with difficult access to health facilities. Integrated Community Case Management (iCCM) sites facilitate access for children who otherwise have problems accessing health care services. USAID IHP supports this strategy at the community level.

As shown in Table 20, now updated to show iCCM treatment visits disaggregated by province and illness, in FY20 6,296,960 cases of the main childhood killer diseases (ARIs, diarrhea, and malaria) were treated at health facilities and iCCM sites in the nine USAID IHP-supported provinces. This includes 341,510 cases treated at iCCM sites, or 5.4 percent of the total number of cases treated.

Table 20. Management of pneumonia, diarrhea, and malaria at iCCM sites in FY20

	Cases of Acute respiratory infection treated FY 2020			Cases of child diarrhea treated FY 2020			Cases of Malaria treated FY 2020			TOTAL FY2020		
Province	FOSA	SSC	Total	FOSA	SSC	Total	FOSA	SSC	Total	**TOTAL FOSA**	**TOTAL iCCM**	**TOTAL**
Kasaï-Central	270,834	6,308	277,142	199,049	9,609	208,658	625,926	39,860	665,786	1,095,809	55,777	1,151,586
Kasaï-Oriental	153,011	7,890	160,901	100,534	9,589	110,123	514,927	39,745	554,672	768,472	57,224	825,696
Lomami	148,244	5,633	153,877	91,426	4,423	95,849	404,922	34,343	439,265	644,592	44,399	688,991
Sankuru	64,856	1,919	66,775	36,527	1,516	38,043	217,679	20,081	237,760	319,062	23,516	342,578
Total Kasaï	636,945	21,750	658,695	427,536	25,137	452,673	1,763,454	134,029	1,897,483	2,827,935	180,916	3,008,851
Haut-Katanga	98,773	986	99,759	101,526	1,535	103,061	319,944	9,267	329,211	520,243	11,788	532,031
Haut-Lomami	92,277	2,530	94,807	118,089	6,155	124,244	423,290	24,682	447,972	633,656	33,367	667,023
Lualaba	101,000	1,697	102,697	78,281	1,970	80,251	253,550	8,083	261,633	432,831	11,750	444,581
Total Katanga	292,050	5,213	297,263	297,896	9,660	307,556	996,784	42,032	1,038,816	1,586,730	56,905	1,643,635
Tanganyika	94,506	3,823	98,329	53,631	4,630	58,261	238,195	34,279	272,474	386,332	42,732	429,064
Sud Kivu	292,547	9,924	302,471	269,019	10,669	279,688	592,887	40,364	633,251	1,154,453	60,957	1,215,410
Eastern Congo Total	387,053	13,747	400,800	322,650	15,299	337,949	831,082	74,643	905,725	1,540,785	103,689	1,644,474
Total IHP	**1,316,048**	**40,710**	**1,356,758**	**1,048,082**	**50,096**	**1,098,178**	**3,591,320**	**250,704**	**3,842,024**	**5,955,450**	**341,510**	**6,296,960**

Source: Project Monitoring Report

The following activities supported these results:

- Retraining of 794 RECOs at SSCs and 419 registered nurses and 127 managers in the ZS.
- Monthly supervision of 920 iCCM sites in Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, Tanganyika and Sud-Kivu.
- Training of 10 community "animators" from the central level via videoconference with Haut-Katanga, Lualaba, and Tanganyika provinces.

Educational activity with RECO and lactating mothers during World Breastfeeding Week, Kasaï-Central. Credit: Abt Associates for USAID IHP. Photo taken before COVID.

- Provision of 400 iCCM sites with equipment (garbage cans, soap, buckets, trash receptacles, water cans, decanters and cups, flashlights, plastic chairs), management tools, and patient assessment forms and iCCM management guidelines during the COVID-19 pandemic. These guidelines indicate that for all cases of fever, to treat them as suspected malaria cases; and for cases of cough, to refer children with pneumonia to the health facilities for treatment.
- Ensuring the supply of medicines (amoxicillin and ORS + zinc) in Sud-Kivu and Tanganyika.
- Coordinating with partners such as PRODES in Lomami and UNICEF in Kasaï-Central for the supply of medicines (amoxicillin DT 250 mg and ORS + zinc).

Earlier in the year, cases of fever and cough were referred to health facilities before the COVID-19 iCCM guidelines were shared with all provinces. As a result of the increased precautions due to COVID-19 in Q2 and Q3, fewer cases were treated at iCCM sites. In Quarters 3 and 4, the decrease in the number of children treated at iCCM sites was due to the low availability of amoxicillin DT 250 mg and ORS + zinc at the majority of the sites because of stockout issues at the *centrales de distribution régionale* (CDR, regional distribution centers) (IR 1.7). This has been a serious challenge to USAID IHP's performance for child health indicators.

In FY21, USAID IHP will prioritize the following activities for child health:

- Organize supervision and monitoring activities of the ZS by the ECDPS.
- Organize follow-up visits for the management of medicines in the health facilities (to ensure that medicines are being used rationally).
- Collaborate closely with GHSC-TA to ensure that amoxicillin and ORS + zinc are available at CDRs so the Program can ensure a continued supply of these medicines at the ZS level.
- Ensure the supply of iCCM sites with medicines (ORS + zinc, Amoxicillin DT 250 mg).
- Continue to support the supervision of iCCM sites.
- Support follow-up for groups of RECOs at the SSC.

IMMUNIZATION

The DRC's *Programme Elargi de Vaccination* (PEV, Expanded Program on Vaccination) seeks to strengthen the delivery of vaccinations on a routine basis to prevent, eliminate and/or eradicate vaccine-preventable diseases. Immunization is a high-impact intervention that can help achieve the Sustainable Development Goals, including Goal 3, quickly and effectively. The Reaching Every Child (REC) strategy, implemented in the DRC since 2004, has proven central to systems strengthening and to ensuring a sustainable and equitable increase in immunization coverage rates. Since 2018, DRC has implemented the Emergency Plan for the relaunch of systematic vaccination in the DRC (called the "Mashako Plan") with support from a broad range of donors. The first year of the Mashako Plan focuses on the nine provinces most affected by measles and polio epidemics, where half of all children live who are not fully vaccinated or not vaccinated at all (this includes three provinces supported by USAID IHP: Haut-Lomami, Haut-Katanga and Tanganyika).

USAID IHP's goal is to strengthen the routine delivery of vaccinations. USAID IHP has used the REC approach to ensure that children even in remote areas receive vaccinations. In FY20, USAID IHP supported the following activities in the six "non-Mashako" provinces (Kasaï Central, Kasaï-Oriental, Lomami, Lualaba, Sankuru and Sud-Kivu): training and formative supervision for providers; recovery of unvaccinated children through defaultor tracing; and logistical activities (maintenance of cold chain equipment and vaccine transport). In the three provinces that have already integrated the Mashako Plan (Haut-Katanga, Haut-Lomami and Tanganyika), USAID IHP provided technical support for activities and financed the maintenance of cold chain equipment in these three provinces, as they are primarily supported by partners UNICEF, GAVI, Bill and Melinda Gates Foundation (BMGF), PATH, and Village Reach.

Implementation of Service Delivery and Quality Activities for Immunization

For indicator #9—Number of children less than 12 months of age who received three doses of pentavalent vaccine—USAID IHP had an achievement rate of 108.3 percent for the year. Achievement rates were lowest in Eastern Congo, specifically in Tanganyika. Poor performance in Tanganyika was due to issues of coordination and management of immunization activities across the DPS and the ZS, which led to GAVI and BMGF suspending financial support until improved coordination could be ensured; the coordination issues have since improved.

For Indicator #10—Number of children less than 12 months of age who received measles vaccine from USG-supported programs—USAID IHP had an achievement rate of 111.1 percent. Data for both

indicators show that the Program achieved a good level of vaccination coverage for almost all targeted children in all nine provinces. The strong performance for these two indicators (see Table 12) this quarter was due to USAID IHP's technical and financial support for the improved supply of and demand for immunization services. This included support of CACs and community leaders, organization of awareness mini-campaigns to reach unvaccinated children, support for the advanced strategy to reach the target, training supervision, data analysis through the data quality self-assessment (DQS) tool for action in both the Mashako and non-Mashako provinces, and logistical supply chain support for the availability of vaccines in the six non-Mashako provinces (Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Lualaba, Sud-Kivu).

In FY20, USAID IHP supported trainings or formative supervision for 790 people (301 of whom were women), including 116 members of the ECZS, 247 providers, and 428 RECO in 23 ZS in Kasaï-Central, Kasaï-Oriental, Lualaba, and Sud-Kivu. Despite the COVID-19 pandemic, in Quarter 3, USAID IHP supported the organization of formative supervision activities for vaccination in 27 ZS, including nine in Sud-Kivu, 15 ZS in Kasaï-Oriental, and three ZS in Sankuru. These formative supervision activities targeted the new *Médecins chefs de zone de santé* (MCZS, Health zone chief medical officers), the registered nurses, and their assistants. Formative supervision sessions focused on the organization of practical, hands-on immunization sessions, the completion of several PEV technical data sheets and other data reporting tools, the reporting quality and the quality audit of immunization data using the DQS tool. Starting in Quarter 4, USAID IHP supported formative supervision activities were associated with briefings in Kasaï-Oriental and Sud-Kivu. In the Mashako Plan provinces (Tangayika, Haut-Katanga, and Haut-Lomami), these supervision activities were supported by UNICEF, PATH, and Village Reach. Supervision scores as of June 2020 were 100 percent, 94 percent, and 93 percent respectively for Tanganyika, Haut-Lomami (only the Kayamba ZS was not supervised), and Haut-Katanga (Vangu and Kamalondo ZS were not supervised).

USAID IHP also supported CACs and community health workers in the identification of unvaccinated children and children lost to follow-up. During Quarter 2, four ZS in Sankuru and Sud-Kivu were identified as having a high number of unvaccinated children. In Quarter 3, USAID IHP supported the organization of recovery activities for unvaccinated children and/or children who have defaulted on their vaccinations, in these four ZS and in Quarter 4, in 10 ZS in Sud-Kivu. This resulted in the cumulative vaccination of 1,329,873 children with pentavalent 3 and 1,314,978 children with the measles vaccines in FY20; in addition, 436 pregnant women received tetanus vaccines. The RECOS visit the households of the children that missed their vaccinations, discussed the reasons they had missed them, and returned the evening before the next immunization day to encourage families and sometimes to bring the children themselves for vaccinations.

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

- Supplied 11,830 liters of oil for the functioning of refrigerators in Lomami, Sankuru, Kasaï-Oriental, Kasaï-Central, Lualaba, and Sud-Kivu ;
- Supplied 3,348 liters of diesel fuel for cold room generators in Tanganyika, Kasaï-Oriental, Kasaï-Central, and Lualaba.

USAID IHP also supported preventive maintenance for the three cold rooms and repair of the power generator for the cold room of the Mbuji-Mayi branch office.

Table 21. Number of children less than 12 months of age who received three doses of pentavalent vaccine (#9)

Region	Province	Q1	Q2	Q3	Q4	Achieved (#)	Target (%)	Achievement rate (%)
Kasaï	Kasaï-Central	38,843	39,779	44,872	44,803	168,297	156,791	107.3
	Kasaï-Oriental	44,297	41,505	45,899	46,188	177,889	158,124	112.5
	Lomami	34,335	34,217	35,119	35,791	139,462	128,331	108.7
	Sankuru	16,590	19,084	19,989	20,577	76,240	65,983	115.5
Total Kasaï		134,065	134,585	145,879	147,359	561,888	509,229	110.3
Katanga	Haut-Katanga	40,915	52,216	53,296	57,415	203,842	164,151	124.2
	Haut-Lomami	30,652	33,668	34,429	35,691	134,440	125,413	107.2
	Lualaba	19,683	20,581	22,819	22,551	85,634	75,909	112.8
Total Katanga		91,250	106,465	110,544	115,657	423,916	365,473	116.0
Eastern Congo	Tanganyika	17,512	23,550	22,527	25,379	88,968	94,989	93.7
	Sud-Kivu	58,610	67,301	62,555	66,635	255,101	257,799	99.0
Eastern Congo Total		76,122	90,851	85,082	92,014	344,069	352,788	97.5
Total		**301,437**	**331,901**	**341,505**	**355,030**	**1,329,873**	**1,227,490**	**108.3**

Source: Routine data from HMIS

Table 22. Number of children less than 12 months of age who received measles vaccine from USG-supported programs (Indicator #10)

Region	Province	Q1	Q2	Q3	Q4	Achieved	Target (%)	Achievement rate (%)
Kasaï	Kasaï-Central	38,014	40,595	44,143	44,894	167,646	161,086	104.1
	Kasaï-Oriental	38,748	41,207	47,067	46,247	173,269	158,437	109.4
	Lomami	33,704	35,060	35,801	36,073	140,638	123,271	114.1
	Sankuru	16,174	19,415	20,242	20,276	76,107	64,488	118.0
Total Kasaï		126,640	136,277	147,253	147,490	557,660	507,282	109.9
Katanga	Haut-Katanga	43,414	51,987	54,440	57,368	207,209	154,663	134.0
	Haut-Lomami	30,168	33,560	33,896	34,937	132,561	125,633	105.5
	Lualaba	18,483	20,877	23,280	22,041	84,681	70,273	120.5
Total Katanga		92,065	106,424	111,616	114,346	424,451	350,569	121.1
Eastern Congo	Tanganyika	16,353	23,427	22,983	26,172	88,935	87,769	101.3
	Sud-Kivu	56,568	64,856	59,567	62,941	243,932	238,257	102.4
Eastern Congo Total		72,921	88,283	82,550	89,113	332,867	326,026	102.1
Total General		**291,626**	**330,984**	**341,419**	**350,949**	**1,314,978**	**1,183,877**	**111.1**

Source: Routine data from HMIS

Data Quality and Other Support Activities for Vaccination

In Q3, USAID IHP conducted immunization data quality audits in Kasaï-Central and Sankuru. The audit reports reveal that most health facilities have a reporting system for the recovery of children who have defaulted on their vaccinations and that health facilities plot and display monitoring curves for doses of measles and pentavalent 3 administered. Regular monthly monitoring meetings, including PEV activities,

are held with the RECO. During the meetings, the providers bring with them the list of children who not show up to the last vaccination sessions, and provide this list to the RECOs. USAID IHP identified the following challenges: (1) discrepancies in data between data collection tools; (2) absence of sufficient planning at the *aires de santé* level; (3) limited understanding of routes to access hard-to-reach communities; (3) failure to meet standards for surveillance of adverse events following immunization; and (4) low availability of vaccines in *aires de santé*. To address these problems, USAID IHP put in place corrective actions and recommendations, including ensuring: (1) RECO carry out their role for the recovery of children; (2) correct, up-to-date completion of individual vaccine stock management forms; and 3) visual presentations for follow-up of vaccination coverage are correctly drawn and posted on facility walls.

In Q3, USAID IHP supported a series of meetings in Lomami with the DPS, the Provincial Government, and the Provincial Assembly. During the meeting on June 19, 2020, the Governor of the Province declared a tax exemption for boat crossings on the Lomami River for vaccines and re-emphasized the importance of the immunization budget line. In Sankuru, the meeting with the legal representative of the Governor of Sankuru, under the chairmanship of the Administrator of Lodja Territory, served as an opportunity to disseminate the content of the Kinshasa Declaration, and to share immunization results for the province. A follow-up meeting with the Governor was planned for Q4, but was not able to take place due to the non-availability of the provincial authorities.

In FY21, USAID IHP will maintain financial support to the ZS to reinforce routine PEV activities; integrate Lomami province into the Mashako Plan; and extend the quality data audit for vaccination data to other provinces. Immunization targets have already been revisited by the RME and program teams and included in the revised Activity Monitoring and Evaluation Plan (AMEP) now with USAID/DRC for approval.

LESSONS LEARNED

- Provider supervision conducted by the DPS, alongside community awareness-raising on care-seeking behavior and ANC attendance, helped to ensure that: (1) all pregnant women continue with ANC visits where they receive IPTp, tetanus vaccinations, and iron supplementation; and (2) access to skilled birth attendants.
- Delivery at health facilities remains counter-traditional among some segments of the population, which contributes to a reduction in the use of ANC services. Local community awareness-raising about the importance giving birth at a health facility is proving critical to help change these behaviors.
- The lack of involvement of providers and ECZS members in the search for community-based maternal death cases hinders in-depth analysis to find appropriate solutions for maternal-infant mortality reduction.
- Recording and analyzing each case of maternal death immediately following the event is essential to understand real causes of death and to avoid a backlog of cases to review at the end of the month or quarter.
- Establishing provincial trainer pools helps to ensure the continuity of activity implementation at the provincial level, so that activities aren't dependent on the physical presence of executives from the central MOH.

- Provider training in clinical IMNCI at iCCM sites is important for the the integrated management of cases in general and in particular of pneumonia and diarrhea, to ensure treatment is provided in accordance with standards and the rational use of MEGs.
- Community care referrals during COVID-19 made it possible to maintain and continue activities at the iCCM sites.
- Involvement of RECO in community-level EPI activities in the FOSA helped recover unvaccinated children, and ultimately helped to improve vaccination coverage at the ZS level.
- Immunization data quality audits help health facilities to identify specific issues of inconsistency in immunization data and to propose specific corrective actions to address data inconsistencies.

- **3,123 providers**, ECZS, and RECO trained in essential family nutrition practices for children and pregnant and breastfeeding women.
- **2,764,804 children** (124.2 percent of target) under 5 years of age received nutritional assistance
- **803,279 children** (103.5 percent of target) under 2 years of age reached with community-level nutritional assistance

NUTRITION

USAID IHP supports the MOH's National Nutrition Program to fight malnutrition in the DRC through key preventative and promotional interventions targeting providers, RECO, and community members. The Program trains and supervises providers and RECO in *consultation pré-scolaires rédynamisé* (CPSr, revitalized preschool consultations) and infant and young child feeding (IYCF); establishes community support groups and conducts behavior change communications to promote IYCF and good nutritional practices for children and pregnant or breastfeeding women; supports key supplementation, including iron-folic acid and vitamin A; and supplies health facilities with tools for quality nutritional care.

As shown in Table 23, USAID IHP achieved a completion rate of 84.5 percent for the number of individuals receiving nutrition-related professional training through USG supported nutrition programs. The Program exceeded its target for the number of children under 5 reached by USG-supported nutrition programs with a 124.2 percent achievement rate. Finally, the Program achieved a 103.5 percent rate for the number of children under 2 reached with community-level nutrition interventions through USG-supported programs.

Number of Individuals Reached with Nutrition-related Training through USG-supported Programs (#2.1.10)

USAID IHP contributed to improving nutrition services at health facilities and in communities through trainings in essential family nutrition practices for children and for pregnant and breastfeeding women. Table 23 details the 3,123 providers, ECZS, and RECO (including iCCM site RECO) trained[3], with a Q3 peak of 1,597 trained, in CPSr, IYCF, clinical-level IMNCI, and community-level IMNCI.

In FY20, USAID IHP expanded clinical-level and community-level IMNCI trainings to include the following topics by category:

- **Clinical-level IMNCI:** assessment, classification, and management of moderate acute malnutrition, as well as counseling on IYCF.
- **Community-level IMNCI:** detection and referral of cases of malnutrition.

[3] Originally measured as purely nutrition-centered trainings, midway through FY2020, USAID IHP expanded the definition of nutrition trainings to include any training with at least one nutrition module, IMNCI integrated into MNCH training, medical advice on child nutrition, and RECO training on malnutrition.

Kasaï had the highest performance of all three regions, particularly in Sankuru and Lomami, where USAID IHP supported the DPS to prioritize nutritional training activities in the latter quarters of the year given the non- or low activity in the first half of the year. During Q3 and Q4, USAID IHP also worked with several other provinces—including Kasaï-Oriental, Lualaba and Sud-Kivu—to boost the volume of nutritional training in clinical IMNCI, iCCM, CPSr, and IYCF.

Overall, Eastern Congo had the lowest performance of the three regions due to COVID-19. The pandemic state of emergency and related travel and gathering restrictions barred USAID IHP technical team members and national nutrition trainers from facilitating several trainings and also limited implementation of some nutritional training activities planned with implementing partners like

Médecins d'Afrique, UNICEF, and Save the Children. Where USAID IHP had already enabled provincial trainers, conflicting agendas affected training implementation. Despite these challenges, USAID IHP conducted several nutritional trainings in the latter half of FY20 in small groups with social distancing, mask wearing, and frequent handwashing. All regions achieved an average of at least 75 percent of FY20 training targets.

Table 23. Number of individuals receiving nutrition- related professional training through USG supported nutrition programs (#2.1.10)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievements rate (%)
	Kasaï-Central	50	0	143	80	273	604	45.20
	Kasaï-Oriental	69	0	116	228	413	483	85.51
	Lomami	7	199	58	81	345	280	123.21
	Sankuru	0	0	495	45	540	372	145.16
Total Kasaï		126	199	812	434	1,571	1,739	90.34
Katanga	Haut-Katanga	21	0	161	44	226	419	53.94
	Haut-Lomami	0	81	67	19	167	315	53.0
	Lualaba	79	26	379	53	537	401	133.92
Total Katanga		100	107	607	116	930	1,135	81.94
Eastern Congo	Tanganyika	0	30	83	78	191	294	64.97
	Sud-Kivu	0	0	95	336	431	527	81.78
Eastern Congo Total		0	30	178	414	622	821	75.76
Total General		**226**	**336**	**1,597**	**964**	**3123**	**3,695**	**84.52**

Source: Project Monitoring Report

Number of Children under 5 (0-59 months) Reached by USG-Supported Nutrition Programs (#2.1.11)

In Q3 and Q4, USAID IHP provided routine Vitamin A supplementation to children under 5, contributing to reach 2,764,804 children, including 1,453,573 girls, (Table 24). The Program supported health facilities to adhere to Vitamin A administration guidelines, providing it to children under 5 during CPSr based on the child's age and the child's preschool consultation card. USAID IHP also supported RECO training so they could effectively follow-up with children late in supplementation during home visits or in tandem with advanced vaccination campaigns. During COVID-19 restrictions, USAID IHP supported health facilities and RECO to conduct CPSr sessions safely, including social distancing, handwashing at the entrance to facilities, mask wearing, and glove wearing.

The Kasaï and Eastern Congo regions exceeded their targets with 147.1 percent and 122.8 percent, respectively. In fact, almost all USAID IHP-supported provinces exceeded their annual targets, with

Lomami achieving 310.8 percent and Sankuru achieving 239.2 percent. High achievements in Lomami and Sankuru are primarily due to higher presence of providers and RECO who have received nutrition-related training. In these provinces, USAID IHP provides joint nutritional support with other partners, namely World Bank's PDSS Project and UNICEF, which has greatly increased the facility-level availability of Vitamin A and improved organization of CPSr sessions. Beyond these reasons, USAID IHP suspects data quality issues could also be contributing to these very high results.

Tanganyika (84.1 percent) and Haut-Lomami (43.0 percent) reached substantially fewer children than targeted, likely due to underreporting, as five ZS in Haut-Lomami reported subpar data completion in DHIS2. As data quality issues could be contributing to these results as well, the Program will work with teams in FY21 to improve data reporting and quality in DHIS2, including conducting data quality audits. See Objective 1, IR 1.5 for more information on how USAID IHP is supporting DPS, ZS, and health facilities to improve data quality and completeness in DHIS2.

Table 24. Number of children under 5 (0-59 months) reached by USG-supported nutrition programs (#2.1.11)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	NA	NA	NA	NA	380,498	382,827	99.4
	Kasaï-Oriental	NA	NA	NA	NA	451,625	387,666	116.5
	Lomami	NA	NA	NA	NA	442,787	142,455	310.8
	Sankuru	NA	NA	NA	NA	177,412	74,170	239.2
Total Kasaï		0	0	0	0	1,452,322	987,118	147.1
Katanga	Haut-Katanga	NA	NA	NA	NA	273,024	202,736	134.7
	Haut-Lomami	NA	NA	NA	NA	135,588	315,024	43.0
	Lualaba	NA	NA	NA	NA	144,056	103,007	139.9
Total Katanga		0	0	0	0	552,668	620,767	89.0
Eastern Congo	Tanganyika	NA	NA	NA	NA	220,948	262,631	84.1
	Sud-Kivu	NA	NA	NA	NA	538,866	356,220	151.3
Eastern Congo Total		0	0	0	0	759,814	618,851	122.8
Total General		**0**	**0**	**0**	**0**	**2,764,804**	**2,226,736**	**124.2**

Source: Routine data from HMIS

Number of Children under 2 (0-23 months) reached with community-level nutrition interventions through USG-supported programs (#2.1.12)

USAID IHP partnered with DPS, ECZS, and RECO to implement a suite of activities to sensitize mothers to IYCF and deliver IYCF counseling. These efforts led to a total of 803,279 (103.5 percent) of children ages 0-23 months, including 416,980 girls, reached by community-based nutrition interventions (Table 25). These activities included: helping establish and support 277 community IYCF support groups; providing IYCF training to 136 providers and administrators and 773 RECO; supporting RECO to follow-up on IYCF support groups; and providing direct follow-up to IYCF support groups.

Table 25. Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs (Ind 2.1.12)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	NA	NA	NA	NA	126,976	109,633	115.8
	Kasaï-Oriental	NA	NA	NA	NA	140,757	126,496	111.3

	Lomami	NA	NA	NA	NA	98,230	80,183	122.5
	Sankuru	NA	NA	NA	NA	44,679	51,846	86.2
Total Kasaï		0	0	0	0	410,642	368,158	111.5
Katanga	Haut-Katanga	NA	NA	NA	NA	85,175	90,094	94.5
	Haut-Lomami	NA	NA	NA	NA	55,132	51,306	107.5
	Lualaba	NA	NA	NA	NA	37,178	38,299	97.1
Total Katanga		0	0	0	0	177,485	179,699	98.8
Eastern Congo	Sud-Kivu	NA	NA	NA	NA	58,970	64,046	92.1
	Tanganyika	NA	NA	NA	NA	156,182	163,969	95.3
Eastern Congo Total		0	0	0	0	215,152	228,015	94.4
Total General		**0**	**0**	**0**	**0**	**803,279**	**775,872**	**103.5**

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

Overall, USAID IHP provided IYCF training to 909 health professionals in FY20 including 773 RECO, with over 30 percent of training occurring in Q4 in Kasaï-Oriental, Kasaï-Central, Sud-Kivu, and Tanganyika.

Community-level nutrition demonstration, Lualaba. Source: Abt Associates for USAID IHP.

USAID IHP also set up IYCF support groups to promote exclusive breastfeeding, complementary feeding, feeding healthy and sick children, and nutrition for pregnant and breastfeeding women. IYCF support groups demonstrated good breastfeeding practices and healthy cooking using local ingredients. Across FY20, USAID IHP helped establish and support a total of 277 IYCF support groups in Sankuru (85), Haut-Katanga (20), Lomami (9), Kasaï-Central (94), Kasaï-Oriental (39), Haut-Lomami (11), and Tanganyika (19). Over half of these support groups were in Sankuru and Kasaï-Central, where the DPS were highly motivated to partner with USAID IHP and advance IYCF support to communities in the latter half of FY20. USAID IHP further bolstered IYCF support groups in Lomami, Kasaï-Oriental, and, in Q4, in Haut-Lomami where the Program supported monitoring of 35 RECO across five *aires de santé* in Malemba ZS and 36 RECO across four *aires de santé* in Kamina ZS.

Number of Pregnant Women Reached with Nutrition Interventions through USG-Supported Programs (#2.1.13)

USAID IHP provided iron-folic acid supplementation to pregnant and breastfeeding women throughout FY20, contributing to a total of 1,544,543 pregnant women (101.6 percent) receiving the supplement during their ANC1 visit (Indicator 2.1.13).

Table 26. Number of pregnant women reached with nutrition interventions through USG-supported programs (#2.1.13)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	34,653	49,857	54,484	54,983	193,977	201,995	96.0
	Kasaï-Oriental	33,962	50,795	52,774	53,290	190,821	194,987	97.9
	Lomami	28,452	41,188	42,151	41,786	153,577	157,146	97.7
	Sankuru	16,181	24,916	24,334	26,935	92,366	86,553	106.7
Total Kasaï		113,248	166,756	173,743	176,994	630,741	640,681	98.4
Katanga	Haut-Katanga	36,035	61,173	61,464	62,353	221,025	209,857	105.3
	Haut-Lomami	35,768	40,867	41,325	43,242	161,202	143,562	112.3
	Lualaba	19,678	29,637	33,786	35,064	118,165	105,098	112.4
Total Katanga		91,481	131,677	136,575	140,659	500,392	458,517	109.1
Eastern Congo	Tanganyika	10,364	27,925	28,970	29,886	971,45	103,035	94.3
	Sud-Kivu	72,891	80,990	77,950	84,434	316,265	317,278	99.7
Eastern Congo Total		83,255	108,915	106,920	114,320	413,410	420,313	98.4
Total General		**287,984**	**407,348**	**417,238**	**431,973**	**1,544,543**	**1,519,511**	**101.6**

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

USAID IHP achieved or exceeded 94 percent of its targets in all regions, and provinces within them. The Katanga region (109.1 percent) had the highest achievement rates due largely to USAID IHP's joint support with PDSS to make funds locally available for purchase of iron and folic acid—even when complementary supply chain inputs from other partners such as GHSC-TA are unavailable.

Increased Awareness to Improve Nutrition among Pregnant and Breastfeeding Women

USAID IHP implemented a number of awareness-raising activities focused on better nutrition for pregnant and breastfeeding women, including ANC and post-natal care visits, CPSr sessions, ANC mini-campaigns, home visits by RECO and additional activities to give nutritional advice.

USAID IHP amplified the benefits of exclusive breastfeeding through World Exclusive Breastfeeding Week events in Q4. In July and August 2020, USAID IHP facilitated the sensitization of 113,957 people—including 72,672 pregnant women, breastfeeding women, and women who recently delivered in maternity hospitals and 41,285 male partners and community leaders—in Lualaba, Kasaï-Central, Kasaï-Oriental, Lomami, Sud-Kivu, and Tanganyika.

Finally, interventions such as IYCF support groups, awareness-raising on exclusive breastfeeding during World Exclusive Breastfeeding Week celebrations, ANC campaigns, and including IYCF advice in CPS visits made it possible to promote nutrition, hygiene, and rest for pregnant and breastfeeding women and the involvement of men in women's health.

World Breastfeeding Week, Sankuru. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Increased Institutional Capacity to Improve access and Quality of Nutrition Interventions

In addition to the above-listed activities that directly contributed to FY2020 results, USAID IHP conducted a number of activities to build the capacity of health system actors to more effectively and sustainably ensure that nutritional services are accessible and of high-quality. They were:

- Organized supervision of the ZS on nutrition themes by PRONANUT and provincial leadership.
- Organized quarterly nutritional coaching visits by provincial coaches to the ZS
- Supported DPS and ZS teams to conduct quarterly IYCF support group follow-up
- Supported quarterly nutrition partner technical meetings
- Provided in-kind financial support for post-training follow-up of providers trained in CPSr and IYCF
- Reproduced and distributed nutritional management tools to RECO and IYCF support groups
- Organized supervision of health facilities and communities by ECZS.

Lessons Learned

- Strengthening providers and RECO training in CPSr and IYCF improves the use of services
- IYCF support groups provide a space for mothers to learn good nutritional practices for children and pregnant and breastfeeding women during the first 1,000 days of the child's life.
- Practical IYCF support group sessions strengthen RECO attitudes and skills.
- Monitoring IYCF support group activities ensures their functionality and RECO IYCF-related activities.
- Community awareness activities lead by RECOs trained in CPSr and IYCF are key to breaking barriers and taboos around nutrition.
- World Exclusive Breastfeeding Week is an opportunity to sensitize different subpopulations on breastfeeding and the principles of complementary feeding.
- Engaging actors across sectors, including health, gender, civil society, and media, has helped broaden the audience for breastfeeding promotion.

- A total of 1,351,422 **couple years of protection achieved**
- USAID IHP reached **1,320,634 new users of modern contraception**

REPRODUCTIVE HEALTH AND FAMILY PLANNING

According to the PNDS 2019-2022 and the 2013-2014 DHS, maternal mortality is driven by short pregnancy spacing due to low contraceptive use, unmet need for family planning, and inadequate quality of health services. USAID IHP supports the implementation of the DRC's National Multisectoral Strategic Plan for Family Planning 2014-2020, which aims to increase contraceptive prevalence from 8.1 percent to 19 percent by the end of 2020. This translates to enrolling 2.1 million new contraceptive users by 2020 to reduce maternal deaths in the DRC, which is one of the 69 focus countries of the Global Family Planning 2020 Partnership. USAID IHP is investing in family planning to increase access to and use of modern contraceptive methods as a way to prevent unwanted pregnancies, protect couples by spacing births, and reduce maternal deaths. In FY20, USAID IHP reached 1,320,634 new users of modern contraception.

USAID IHP supported integration of FP in health facilities and the *Comité Technique Multisectoriel Permanent de Planification Familiale* (CTMP-PF, Multisectoral Technical Committee for Family Planning). The Program established a pool of trainers, built provider capacity in FP and postpartum family planning (PPFP), set up the CTMP-PF in Tanganyika, and supported CTMP-PF meetings and trained community-based distributors (CBDs). In collaboration with implementing partner Pathfinder through its Evidence to Action (E2A) project in the Kasaï Region, the Program ensured that a full range of contraceptive methods was always available.

Despite COVID-19 restrictions, USAID IHP continued implementing FP/RH activities during the pandemic and was even able to strengthen infection prevention control measures in the health facilities. Activity adaptations included:

- Conducting door-to-door visits and disseminating messages through radio and posters (instead of large gatherings) for awareness-raising and demand creation activities.
- Providing combined ANC/FP services based on client entry at the facility vs. trying to reach established targets.
- Holding monitoring meetings with a restricted number of participants (ITs or registered nurses from the *aires de santé* and ZS management team members), in line with guidelines of limiting in-person meetings to fewer than 20 people.

Peer training for youth on RH/FP, Kasaï-Central. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Increased Protection Provided by Family Planning Methods

As shown in Table 27, as shown in table 27, USAID IHP achieved 1,351,422 couple years of protection, representing an achievement rate of 127.3 percent. There were significant variations among provinces, with two provinces in Kasaï falling short of their targets.

A number of USAID IHP activities contributed to strong performance for this indicator, including:

- Availability of FP inputs (modern contraceptive methods, including injectables, oral contraceptives, implants, and barrier methods, as well as abstinence, cycle beads, and other natural methods).
- Training/retraining of CBDs (CBDs are considered "specialist" RECO in offering FP services).
- Training of 776 service providers on PPFP and supervisory activities (701 clinical providers and 75 HGR providers).
- Demand creation activities such as FP mini-campaigns, FP paired with ANC (for PPFP), community champion activities at local markets, and household visits conducted by CBDs.
- Support for 8,375 visits for FP/RH counseling.
- Redeployment of providers to other health facilities in a ZS or to another ZS in a province.

Table 28 shows that the FY20 achievement rate for couple years of protection (CYP) after exclusion of the lactational amenorrhea method (LAM) and standard days methods for FP is approximately the same

at 126.4 percent. As for Indicator #2.1, there were significant variations among provinces, with two provinces in Kasaï falling short of their target. Lomami, which had an achievement rate of only 62.2 percent, had very low geographic coverage for FP. In contrast, underperformance in Kasaï-Central (89.4 percent) was due to weak CYP coverage as a result of as a result of partner E2A's activities, which focus more on community-based distribution of short-acting methods (pills, condoms) as opposed to long-acting methods (IUDs and implants) over injectables. For indicator #2.2 CYP by all methods except LAM and standard days methods, data is difficult to collect and poorly reported by most providers. Overall, these two methods are underused by clients, hence the data in 2.1 is almost the same as in 2.2. Routine awareness-raising activities will be organized during mini campaigns to encourage the use of exclusive breastfeeding.

For the overstock of certain FP products reported in the Q3 Quarterly Report, USAID IHP is developing a rationalization plan to better manage excess supplies of FP products across the supply chain; and is also working with the CTMP-PF and Groupes de Travail Medicaments (Essential Drugs Working Group) to redeploy any excess commodities. From the demand side, USAID IHP is developing a plan for demand creation for FP products once the supplies have been deployed, which will involve mini-campaigns in the target ZS.

Table 27. Couple years of protection in USG-supported programs (Indicator 2.1)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	33,860	38,229.66	34,172.0	58,323	164,584	184,046	89.4
	Kasaï-Oriental	38,967	22,655.90	40,859.0	33,133	135,615	58,183	233.1
	Lomami	16,327	19,521.58	19,707.0	16,930	72,486	116,542	62.2
	Sankuru	15,310	15,720.21	17,476.0	25,719	74,225	48,377	153.4
Total Kasaï		104,463.6	96,127.35	11,2214	134,105	446,910	407,148	109.8
Katanga	Haut-Katanga	48,653	64,137.85	45,560.0	64,733	223,084	185,065	120.5
	Haut-Lomami	31,409	33,418.30	36,054.0	37,303	138,184	72,444	190.7
	Lualaba	24,076	28,330.44	32,075.0	31,820	116,301	91,656	126.9
Total Katanga		104,138.2	125,886.59	11,3689	133,856	477,570	349,165	136.8
Eastern Congo	Tanganyika	32,001	27,245.50	19,535.0	49,593	128,374	39,915	321.6
	Sud-Kivu	62,635	69,092.20	87,536.0	79,305	298,568	265,106	112.6
Eastern Congo Total		94,635.4	96,337.7	107,071	128,898	426,942	305,021	140.0
Total General		**303,237.2**	**318,351.64**	**332,974**	**396,859**	**1,351,422**	**1,061,334**	**127.3**

Source:: Routine data from HMIS.

Table 28. Couple years of protection after exclusion of LAM and standard days methods for FP in USG-supported programs (Indicator 2.2)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	32,346	36,718.67	31,963.8	56,206	157,234	177,146	88.8
	Kasaï-Oriental	37,043	20,148.28	37,891.4	30,425	125,508	53,040	236.6
	Lomami	15,154	18,127.02	18,175.8	15,341	66,798	111,860	59.7
	Sankuru	13,085	13,097.53	14,910.4	22,924	64,017	40,375	158.6
Total Kasaï		97,628	88,092	10,2941	124,895	413,556	382,421	108.1
Katanga	Haut-Katanga	44,398	59,480.13	39,729.7	59,697	203,305	177,566	114.5
	Haut-Lomami	28,616	30,310.40	32,595.6	33,926	125,448	59,520	210.8
	Lualaba	22,308	26,536.89	29,991.2	29,650	108,487	84,540	128.3
Total Katanga		95,322	116,327	102,317	123,274	437,240	321,626	135.9

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Eastern Congo	Tanganyika	31,663	26,231.70	19,009.2	49,259	126,162	39,091	322.7
	Sud-Kivu	58,520	64,466.33	82,955.4	74,264	280,206	251,705	111.3
Eastern Congo Total		90,182	90,698	101,965	123,523	406,368	290,796	139.7
Total General		**283,132**	**295,117**	**307,223**	**371,692**	**1,257,164**	**994,843**	**126.4**

Source:: Routine data from HMIS.

Gained New Acceptors of Modern Contraceptive Methods

As shown in Table 29, there were a total of 1,320,624 new acceptors of modern contraceptive methods in FY20 (146.7 percent of the target for Indicator #3). Certain provinces (such as Kasaï-Oriental) over-performed significantly, whereas Kasaï-Central and Sankuru achieved their targets, but did not perform as strongly as the other provinces. The reason for over-performance in Kasaï-Oriental is due to training/retraining of providers, the organization of FP mini-campaigns, CTMP-PF meetings with the active participation of all the implementing partners working in FP, and the availability of FP inputs in all the ZS. In Sankuru, however, there was a stockout of FP commodities in all the facilities, as well as underreporting of facility data in the DHIS2 platform. In Kasaï Central, underperformance was linked to the fact that five ZS previously supported by the EU-funded PRODS project no longer receive support for FP activities. Due to supply chain issues with GHSC-TA, the FP supplies and commodities that should have been procured by USAID IHP were not provided in these ZS.

The following USAID IHP-supported activities are linked to this indicator's performance:

- Setup of trainer pools.
- Training for CBDs on conducting FP chats, counseling on FP at the community level, providing FP consultations, and following up with clients on FP methods.
- Post-training follow-up.
- Supervision for quality of care/quality improvement.
- Engagement of community champions to refer women for FP-ANC services.
- ZS provider training in FP and post-partum FP, including the integration of Subcutaneous Medroxyprogesterone acetate (DMPA-SC) by community actors in all facilities that USAID IHP supports. (Community actors are CBDs who distribute non-clinical methods such as pills, cycle beads, and condoms, and now, also administer the DMPA-SC injection).
- Joint FP/ANC mini-campaigns conducted by CBDs, which generated demand for the use of ANC and FP services and CBD of contraceptives.
- Awareness raising and involvement of men in FP services.
- Follow-up home visits, which helped new FP clients adhere to their contraceptive methods. This follow-up was particularly important during the COVID-19 pandemic to ensure contraceptive coverage.
- Synergy between technical and financial partners supporting FP during the CTMP-PF meetings.

These activities helped to promote a rapid, sustained increase in the use of effective modern methods of contraception by Congolese men and women who want to use them. These activities have also allowed for the discussion of strategies for accelerating the increase in modern contraceptive prevalence in line

with the national FP strategic plan. The plan takes into account the realities of implementing FP activities during the COVID-19 pandemic. Four thematic groups (youth, faith-based, health care providers, and opinion leaders), supported by USAID IHP, aim to recruit more FP users through various awareness-raising activities and channels.

Table 29. Number of new acceptors using modern contraceptive methods in USG-supported facilities (Indicator #3)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	35,581	40,665	49,325	72,511	198,082	175,625	112.8
	Kasaï-Oriental	37,029	26,326	30,060	47,094	140,509	54,626	257.2
	Lomami	19,476	20,982	31,957	29,188	101,603	69,643	145.9
	Sankuru	23,454	23,814	24,729	29,414	101,411	90,863	111.6
Total Kasaï		115,540	111,787	136,071	178,207	541,605	390,757	138.6
Katanga	Haut-Katanga	29,307	35,229	40,350	55,395	160,281	114,173	140.4
	Haut-Lomami	33,372	50,020	47,846	52,412	183,650	81,620	225.0
	Lualaba	24,200	30,917	39,610	41,495	136,222	93,755	145.3
Total Katanga		86,879	116,166	127,806	149,302	480,153	289,548	165.8
Eastern Congo	Tanganyika	6,557	13,575	10,227	37,736	68,095	17,639	386.0
	Sud-Kivu	47,875	56,242	63,354	63,310	230,781	202,282	114.1
Eastern Congo Total		54,432	69,817	73,581	101,046	298,876	219,921	135.9
Total General		**256,851**	**297,770**	**337,458**	**428,555**	**1,320,634**	**900,226**	**146.7**

Source:: Routine data from HMIS.

CBD training on cycle beads, Haut-Lomami. Source: Abt Associates for USAID IHP.

Referrals to the health facilities increased this year to more than double that of past years, as evidenced for example in Haut-Lomami, which had an achievement rate of 117 percent for the year. The ZS that contributed the most are Mulongo, Kinkondja, Songa, Kabongo, and Malemba. The activities that contributed the most to this indicator's performance are awareness-raising activities organized in conjunction with the FP mini-campaigns and household visits, which emphasize referring individuals to health facilities with the support of community actors (RECOs and CBDs). The weak performance in Tanganyika has more to do with the targets being set too high; the Program has adjusted targets accordingly in the revised AMEP recently submitted to USAID.

Table 30. Number of individuals referred to supported health facilities by *relais communitaire* and CBDs (#2.3.1)

Region	Province	Q1	Q2	Q3	Q4	Achieved 2020	Target (%) FY 2020	Achievement rate (%)
Kasaï	Kasaï-Central	2,581	2,086	3,203	3,485	11,355	10,113	112.3
	Kasaï-Oriental	1,186	1,193	1,408	1,430	5,217	6,443	81.0
	Lomami	1,722	1,879	2,195	2,349	8,145	9,957	81.8
	Sankuru	2,638	2,926	3,236	3,408	12,208	7,896	154.6
Total Kasaï		8,127	8,084	10,042	10,672	36,925	34,409	107.3
Katanga	Haut-Katanga	330	497	516	676	2,019	2,021	99.9
	Haut-Lomami	1,476	1,606	1,308	1,512	5,902	5,035	117.2
	Lualaba	396	381	412	482	1,671	1,565	106.8
Total Katanga		2,202	2,484	2,236	2,670	9,592	8,621	111.3
Eastern Congo	Tanganyika	923	703	723	696	2,867	11,486	32.5
	Sud-Kivu	1,890	1,926	1,881	2,708	840	8,984	7.5
Eastern Congo Total		2,813	2,629	2,604	3,404	11,450	20,470	18.5
Total General		**13,142**	**13,197**	**14,882**	**16,746**	**57,967**	**63,500**	**91.3**

Source: We used data from the DHIS2 indicator *Refere vers CS* for this indicator and will propose to update the Performance indicator reference sheets (PIRS) in future reports.

In FY21, USAID IHP will focus on (1) reinforcement of provider capacity (training/retraining of CBDs) in order to increase community awareness of FP services and to refer FP users in case of side effects or if they choose a clinical method; and (2) acceptance and use of FP services and products by dispelling rumors and providing clear explanations about the side effects of modern contraceptive methods.

Lessons learned

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

- **49,279 cases** of bacteriologically confirmed pulmonary TB (TP+) reported.
- **77,890 reported TB cases** under treatment
- **40,662 TB cases** successfully treated, representing a therapeutic success rate of 92.5 percent
- Collaborative activities between the PNLT and PNLS programs, within the framework of the "one-stop shop" strategy at the provincial and operational levels leading to a high percentage of PLHIV who received INH prophylaxis especially in Lomami, Lualaba, and Kasaï-Central

TUBERCULOSIS

Tuberculosis remains a major public health problem in the DRC. The DRC is one of the 30 countries most affected by TB; it ranks ninth worldwide and second in Africa in terms of reported incidence of cases. The GDRC's 2018-2020 National Strategic Plan for TB Control emphasizes the reduction of morbidity and mortality due to TB. To help achieve this goal, USAID IHP is supporting the GDRC's National Tuberculosis Control Program in implementing the WHO's End TB Strategy by supporting political commitment and providing funding to combat the disease. USAID IHP supports the PNLT by aiming to improve the quality of TB treatment and services in 179 ZS spread over nine provinces.

USAID IHP supports the implementation of anti-tuberculosis strategies and activities, taking into account USAID and PNLT priorities, by encouraging the participation of local civil society in TB control. These strategies and activities mainly include: (1) providing universal access to TB diagnosis and treatment; (2) improving management of TB/HIV co-infection; (3) improving management of drug-resistant TB, improving clinical and biological monitoring of patients with this form of TB and their nutritional support; (4) strengthening the capacities of provinces in the collection, analysis, and use of data for decision making; (5) improving the ability to diagnose and treat TB in children aged 0-14 years; and (6) improving the prevention and control of tuberculosis infection.

Improved TB Notification Rates

With a population of 34,165,336 inhabitants covered by the directly observed therapy (DOT) program in the nine supported provinces, 49,279 cases of bacteriologically confirmed pulmonary TB (TP+) were reported in FY20. This is a reporting rate of TP+ of 144 per 100,000 inhabitants, representing an achievement rate of 96.2 percent. This rate is slightly lower than the target of 150 per 100,000 inhabitants, but higher than the FY19 rate of 112 per 100,000 inhabitants.

The continuing upward trend in the reporting rate throughout FY20, exceeding the target of 150 per 100,000 inhabitants in Q4 (153 per 100,000 inhabitants), testifies to the effectiveness of active screening for TB. In FY20, five provinces (Haut-Lomami, Lualaba, Tanganyika, Kasaï-Oriental, Haut-Katanga) recorded reporting rates above the target (150 per 100,000 inhabitants). This performance can be

largely explained by the increase in the detection of TB cases thanks to the active research activities that USAID IHP supported throughout FY20 among populations at risk, particularly mine workers, prisoners, contacts of tuberculosis patients, people living with HIV (PLHIV), and vulnerable populations.

In ZS in Lomami Provinces, TB Detection Rates Soar after Training

Betty, aged 19, was losing weight and coughing. A traditional doctor had labeled her a witch because of her poor health. Her family wasn't interested in seeking medical care for her, though her symptoms were classic indicators of tuberculosis.

Betty wasn't alone. In 2019, the nearby Lusuku Tuberculosis Screening and Treatment Center had a shockingly low rate of tuberculosis detection: around 39 percent, far below the national standard of 75 percent. The rest of the Luputa ZS, located in the Lomami province, had similarly low rates.

Supported by USAID IHP, the ZS trained all community health workers to identify potential cases and treatment options. In Lusuku, 41 additional trained volunteers—11 women and 30 men—began to search for potential cases of tuberculosis. Referral rates soared and so did detection of TB, to 95 percent and 92 percent in the first and second quarter of 2020.

Following a discussion with a community health worker, the village chief insisted that Betty be brought to the Lusuku center, which quickly diagnosed and treated her for tuberculosis.

"I was going to die blindly if the village chief hadn't gotten involved," Betty said. "My health has improved so much... I've even gotten married."

One province, Sud-Kivu, showed poor performance, with an achievement rate of only 50.7 percent. This could be explained by various factors; for example, the *centres de santé de diagnostic et traitement* (CSDT, diagnosis and treatment health centers) are located in the armed conflict zones and are rarely supplied with diagnostic laboratory reagents.

In FY21, USAID IHP will intensify support to CPLTs in the implementation of innovative strategies for actively finding missing TB cases. These strategies will include the investigation of any cough occurring in a care structure and active screening in all low-detection ZS supported by the Program. USAID IHP will also collaborate with other stakeholders (Action Damien, Cordaid, and PDSS) and provide support to the CPLTs. USAID IHP will support CPLTs in systematically involving community health workers and the *Club des Amis Damien* (Club for the Friends of Damien, CAD) in referring people with suspected TB and safely transporting sputum samples to the CSDTs.

Table 31. TB notification rates through USG-supported programs (Indicator #2.1.17)									
Region	Province	Reported TP+ cases (#) and reporting rate per 100,000 population				FY2			
		Q1	Q2	Q3	Q4	Total TP+ cases (#)	TB reporting rate	Target (%)	Achievement rate (%)
Kasaï	Kasaï-Central	1,223 (106)	1,161 (101)	1,129 (102)	1,587 (133)	5,100	111	150	74.0
	Kasaï-Oriental	1,964 (182)	2,097 (165)	2,242 (174)	2,514 (199)	8,817	180	150	120.0
	Lomami	877 (108)	1,106 (136)	1,171 (124)	1,200 (127)	4,354	124	150	82.6
	Sankuru	904 (152)	933 (155)	-	872 (156)	2,709	115	150	76.7
Total Kasaï		4,968 (136)	5,297 (138)	4,542 (115)	6,173 (151)	20,980	137	150	91.0
Katanga	Haut-Katanga	1,671 (141)	1,891 (160)	1,889 (159)	1,920 (162)	7,371	156	150	103.8
	Haut-Lomami	1,942 (258)	2,086 (277)	2,115 (293)	1,687 (234)	7,830	266	150	177.1
	Lualaba	917 (183)	993 (194)	1,116 (221)	1,315 (286)	4,341	219	150	146.3
Total Katanga		4,530 (186)	4,970 (203)	5,120 (212)	4,922 (208)	19,542	202	150	134.9
Eastern Congo	Sud-Kivu	1,183 (69)	1,314 (72)	1,414 (81)	1,453 (81)	5,364	76	150	50.7
	Tanganyika	718 (139)	886 (172)	901 (182)	888 (158)	3,393	162	150	108.2
Eastern Congo Total		1,901 (86)	2,200 (94)	2,315 (103)	2,341 (100)	8,757	96	150	63.9
Total General		**11,399 (137)**	**12,467 (145)**	**11,977 (139)**	**13,436 (153)**	**49,279**	**144**	**150**	**96.2**

Source: Routine data from HMIS-PNLT.

Supported First-line Treatment for Patients Diagnosed with TB and Children under 5 Who Received (or are receiving) INH Prophylaxis

Of 82,476 patients enrolled during in FY20 who have the drug-sensitive form of TB, 77,890 patients (94.4 percent) were put on first-line treatment (Table 32). This rate is higher than the rate in Year 1 (80 percent), but below the target of 100 percent, which means that all screened patients should benefit from treatment. Only the province of Lomami treated 100 percent of the patients diagnosed, followed by four provinces (Kasaï Central, Sud-Kivu, Kasaï-Oriental and Haut-Lomami) that provided treatment to 99.8 percent, 98.9 percent, 96.9 percent and 92.9 percent of tuberculosis patients, respectively.

The provinces of Tanganyika (88.3 percent), Haut-Katanga (88.7 percent), Lualaba (90.0 percent), and Sankuru (91.8 percent) performed poorly, in large part due to the mobility of tuberculosis patients detected in mining areas and by stock-outs of first-line anti-tuberculosis drugs in certain remote and difficult-to-access CSDTs, particularly in Tanganyika. Stock-outs are mainly caused by delays in supplying regional distribution centers by the PNLT central unit. The Program worked during FY20 with Cordaid

and GHSC-TA to improve availability of anti-TB drugs through better coordination of the supply chain. USAID IHP, through i+ Solutions, also plans to use community agents in the last-mile drug transport circuit during in FY21 to improve availability of anti-TB drugs in remote and difficult-to-access CSDTs.

Table 32. Number of patients diagnosed with TB that have initiated first-line treatment through USG- supported programs (Indicator 2.1.18)

Region	Province	Reported TB cases that have initiated first-line treatment (#)				FY2		
		Q1	Q2	Q3	Q4	Total reported TB cases under treatment (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	1,639	1,611	1,520	2,023	6,793	6,806	99.8
	Kasaï-Oriental	3,954	4,643	4,811	5,133	18,541	19,139	96.9
	Lomami	1,715	2,138	2,254	2,277	8,384	8,384	100.0
	Sankuru	1,582	1,312	-	1,720	4,614	5,024	91.8
Total Kasaï		8,890	9,704	8,585	11,153	38,332	39,353	97.4
Katanga	Haut-Katanga	2,636	2,877	3,104	3,225	11,842	13,349	88.7
	Haut-Lomami	2,036	2,442	2,723	2,266	9,467	10,187	92.9
	Lualaba	1,244	1,087	1,298	1,517	5,146	5,720	90.0
Total Katanga		5,916	6,406	7,125	7,008	26,455	29,256	90.4
Eastern Congo	Sud-Kivu	1,863	1,908	2,100	2,114	7,985	8,070	98.9
	Tanganyika	1,146	1,363	1,247	1,362	5,118	5,797	88.3
Eastern Congo Total		3,009	3,271	3,347	3,476	13,103	13,867	94.5
Total General		**17,815**	**19,381**	**19,057**	**21,637**	**77,890**	**82,476**	**94.4**

Source: Routine data from HMIS-PNLT.

Helped Ensure Children under 5 Receive Isoniazid Prophylaxis

During FY20, out of 24,327 children under 5 declared eligible for isoniazid (INH) prophylactic treatment after ruling out active TB, 17,541 were put on prophylactic treatment. This number represents an achievement rate of 72.1 percent against the FY20 target of 100 percent (Table 33), due in large part to regular stock-outs of the pediatric form of INH (100 mg) in the CPLTs and poor application of the guidelines on using INH in children. An unusually serious shortage of the pediatric form of INH occurred in 2019 and early 2020 because remaining shelf life of stocks was not taken into consideration when estimating needs.

While USAID IHP's mandate is limited to last-mile distribution, the Program proposes that quantification of TB medicines by the national PNLT and Cordaid should be refined using data from quarterly reviews with the field. USAID IHP also proposes that regional distribution centers actively participate in these reviews to help the provincial PNLT analyze ZS requisitions. The Program is also working on the development of a financial mechanism to address delivery challenges at the last mile. Nevertheless, the provinces of Kasaï-Central (97.6 percent), Sankuru (95.5 percent), Lomami (89.1 percent), and Sud-Kivu (85.2 percent) recorded the best performances for the percentage of children put on INH prophylaxis. To improve this USAID IHP supported Haut-Katanga and Lualaba provinces in Q4 by training provincial trainers in the prevention of latent tuberculosis in children and adolescents. In FY21, the Program will continue this cascade training for provincial leaders and healthcare providers in the nine provinces.

Contact tracing and treatment in Bena Dibele ZS, Sankuru. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Table 33. Percentage of children under 5 who received (or are receiving) INH prophylaxis through USG-supported programs (#2.1.24).

Region	Province	Under five children placed on INH				FY20				
		Q1	Q2	Q3	Q4	Total placed on INH (#)	Total eligible for INH (#)	Placed on INH (%)	Target (%)	Achieve-ment rate (%)
Kasaï	Kasaï-Central	273	318	383	561	1,535	1,572	97.6	100	97.6
	Kasaï-Oriental	400	294	275	384	1,353	2,287	59.2	100	59.2
	Lomami	541	702	846	953	3,042	3,414	89.1	100	89.1
	Sankuru	923	782	-	760	2,465	2,582	95.5	100	95.5
Total Kasaï		2,137	2,096	1,504	2,658	8,395	9,855	85.2	100	85.2
Katanga	Haut-Katanga	147	86	179	267	679	2,920	23.3	100	23.3
	Haut-Lomami	995	814	1,195	791	3,795	4,819	78.8	100	78.8
	Lualaba	292	281	448	565	1,586	2,229	71.2	100	71.2
Total Katanga		1,434	1,181	1,822	1,623	6,060	9,968	60.8	100	60.8
Eastern Congo	Sud-Kivu	321	335	388	594	1,638	1,923	85.2	100	85.2
	Tanganyika	461	330	305	352	1,448	2,581	56.1	100	56.1
Eastern Congo Total		782	665	693	946	3,086	4,504	**68.5**	100	**68.5**
Total General		**4,353**	**3,942**	**4,019**	**5,227**	**17,541**	**24,327**	**72.1**	**100**	**72.1**

Source: Routine data from HMIS-PNLT

Sharpened Detection of Multi-drug Resistant TB Cases

During FY20, the continued upward trend in the number of multi-drug resistant TB (MDR-TB) cases recorded over the four quarters (i.e., 65, 78, 87, and 99) represents the effectiveness of the active case-finding approach in suspected subjects. These include contacts of confirmed MDR-TB cases, relapses, and first-line treatment failures. The provinces of Kasaï-Oriental and Haut-Katanga, recognized as MDR-TB hot-spots, recorded a higher number of cases: 113 and 85, respectively, or 60.1 percent (198 out of 329) of all MDR-TB cases detected during in FY20. This year's underachievement for the number of

multi-drug resistant cases reported can be largely explained by the low coverage of Xpert diagnostic sites, the frequent shortages of Xpert test cartridges, and the dysfunction of the networks for transporting sputum samples from suspected MDR-TB patients to diagnostic sites. The transport networks have been dysfunctional mainly because of the challenges related to reimbursing remote ZS. USAID IHP is working on a financial mechanism for this, which will launch early in FY21. Of the 329 cases of MDR-TB reported this year, 241 cases started second-line treatment, for a performance rate of 73.3 percent. Only the province of Sankuru treated 100 percent of MDR-TB patients detected in FY20.

Table 34. Number of multi-drug resistant TB (MDR-TB) cases detected (Indicator #2.1.20) and number of multi-drug resistant TB cases that have initiated second line treatment (Indicator #2.1.21)

Region	Province	RR/MDR/XDR-TB patients				FY2					
		Q1	Q2	Q3	Q4	Reported cases of RR/MDR/XDR-TB (#)	Target (#)	Achievement rate (%)	Reported and treated cases of RR/MDR/XDR-TB (#)	Target (#)	Achievement rate (%)
Kasaï	Kasaï-Central	2	5	3	6	16	48	33.3	14	16	87.5
	Kasaï-Oriental	26	19	24	44	113	160	70.6	69	113	61.1
	Lomami	3	2	7	4	16	48	33.3	11	16	68.8
	Sankuru	0	17	-	0	17	32	53.1	17	17	100.0
Total Kasaï		31	43	34	54	162	288	56.3	111	162	68.5
Katanga	Haut-Katanga	13	22	20	30	85	244	34.8	70	85	82.4
	Haut-Lomami	3	2	6	0	11	16	68.8	9	11	81.8
	Lualaba	7	3	11	5	26	48	54.2	21	26	80.8
Total Katanga		23	27	37	35	122	308	39.6	100	122	82.0
Eastern Congo	Sud-Kivu	9	8	6	7	30	76	39.5	21	30	70.0
	Tanganyika	2	0	10	3	15	48	31.3	9	15	60.0
Eastern Congo Total		11	8	16	10	45	124	36.3	30	45	66.7
Total General		**65**	**78**	**87**	**99**	**329**	**720**	**45.7**	**241**	**329**	**73.3**

Source: Global TB database.

Boosted Therapeutic Success Rates for TB

Of 43,951 new patients and TP+ relapse cases evaluated in Q4, representing the cohort who started treatment a year earlier (during FY19, Q4), 40,662 patients successfully completed their treatment. This number represents a treatment success rate of 92.5 percent and corresponds to an achievement rate of 97.4 percent compared to the target rate of 95 percent (Table 35). Four provinces—Sankuru (98.8 percent), Haut-Lomami (98 percent), Kasaï-Oriental (97.8 percent), and Lomami (97.5 percent)—had a therapeutic success rate above the target of 95 percent. The availability of first-line anti-tuberculosis drugs and the application of guidelines for monitoring TB patients under treatment largely explain the high performance in these provinces.

Two provinces of the Katanga region (Haut-Katanga at 81 percent and Lualaba at 88 percent) recorded lower treatment success rates, in part because of the mobility of TB patients in these two mining provinces. This mobility caused interruptions in the bacteriological monitoring and treatment of miner patients working in artisanal mining units. To reverse this trend, in FY21 USAID IHP will work with community health workers involved in TB control at the CSDTs and TB treatment centers to recover irregular and lost patients and to strictly enforce the DOT program.

Table 35. TB therapeutic success rate through USG-supported programs (Indicator #2.1.19)										
Region	Province	TP+ cases successfully treated				FY2				
		Q1	Q2	Q3	Q4	Total TP+ cases successfully treated (#)	Total reported cases of TP+ (#)	Therapeutic success rate (%)	Target (%)	Achievement rate (%)
Kasaï	Kasaï-Central	1,293	1,264	1,048	1,113	4,718	5,019	94.0	95	99.0
	Kasaï-Oriental	1,782	1,687	1,768	1,819	7,056	7,218	97.8	95	102.9
	Lomami	923	969	1,060	817	3,769	3,865	97.5	95	102.6
	Sankuru	813	802	-	1,126	2,741	2,775	98.8	95	104.0
Total Kasaï		4,811	4,722	3,876	4,875	18,284	18,877	96.9	95	102.0
Katanga	Haut-Katanga	1,163	1,467	1,433	1,677	5,740	7,083	81.0	95	85.3
	Haut-Lomami	1,047	1,311	1,609	1,688	5,655	5,770	98.0	95	103.2
	Lualaba	676	700	848	801	3,025	3,437	88.0	95	92.6
Total Katanga		2,886	3,478	3,890	4,166	14,420	16,290	88.5	95	93.2
Eastern Congo	Sud-Kivu	1,287	1,358	1,370	1,168	5,183	5,719	90.6	95	95.4
	Tanganyika	574	773	744	684	2,775	3,065	90.5	95	95.3
Eastern Congo Total		1,861	2,131	2,114	1,852	7,958	8,784	90.6	95	95.4
Total General		**9,558**	**10,331**	**9,880**	**10,893**	**40,662**	**43,951**	**92.5**	**95**	**97.4**

Source: Routine data from HMIS-PNLT.

TB supervision activity, Kasaï-Oriental. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Newly Enrolled HIV-positive Patients without TB who Received (or are receiving) INH Prophylaxis

Preventive treatment with isoniazid (INH), 17,820 PLHIV (64.5 percent) were put on INH prophylaxis (Table 36). This result is low compared to the target. The greatest underperformance was recorded in the provinces of Haut-Lomami (47.9 percent) and Haut-Katanga (69.3 percent). The non-application of guidelines related to the prevention of latent TB partly explain this poor performance. Indeed, a significant number of health care providers have not yet benefited from training on the prevention of latent tuberculosis in PLHIV. Nonetheless, three provinces recorded high percentages of PLHIV who received INH prophylaxis; namely, Lomami (97.4 percent), Lualaba (97.6 percent), and Kasaï-Central (89.6 percent). The implementation of collaborative activities between the PNLT and PNLS programs, within the framework of the "one-stop shop" strategy at the provincial and operational levels, largely explains this performance. This is particularly true in the province of Lualaba, which received support from FHI360/CDC (Family Health International), and in Lomami and Kasaï Central, which received support from Cordaid for the HIV component.

USAID IHP supports the monthly meetings of the provincial TB/HIV task force and contributes to strengthening the coordination of collaborative activities between the PNLT and the PNLS. During Q4 the Program also provided support to trainers on the prevention of latent TB, especially among PLHIV.

Table 36. Percentage of newly enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG- supported programs (Indicator #2.1.24)

Region	Province	PLHIV without TB placed on INH				FY20				
		Q1	Q2	Q3	Q4	Total placed on INH (#)	Total PLHIV without TB (#)	PLHIV placed on INH (%)	Target (%)	Achieve-ment rate (%)
Kasaï	Kasaï-Central	141	159	175	138	613	684	89.6	100	89.6
	Kasaï-Oriental	616	417	634	498	2,165	2,927	74.0	100	74.0
	Lomami	22	21	96	82	221	227	97.4	100	97.4
	Sankuru	167	101	-	124	392	459	85.4	100	85.4
Total Kasaï		946	698	905	842	3,391	4,297	78.9	100	78.9
Katanga	Haut-Katanga	1450	1,142	2,123	3191	7,906	14,409	54.9	100	54.9
	Haut-Lomami	319	139	297	336	1,091	2,280	47.9	100	47.9
	Lualaba	666	749	1,105	1221	3,741	4,160	89.9	100	89.9
Total Katanga		2,435	2,030	3,525	4,748	12,738	20,849	61.1	100	61.1
Eastern Congo	Sud-Kivu	190	277	259	318	1,044	1,387	75.3	100	75.3
	Tanganyika	270	135	112	130	647	1,077	60.1	100	60.1
Eastern Congo Total		460	412	371	448	1,691	2,464	68.6	100	68.6
Total General		**3,841**	**3,140**	**4,801**	**6,038**	**17,820**	**27,610**	**64.5**	**100**	**64.5**

Source: Routine data from HMIS-PNLT

Lessons Learned

- The quarterly organization of the epidemiological review of TB at the provincial level makes it possible to assess the performance of the CSDTs and the CPLT in achieving results and to direct interventions towards problem areas.
- Community participation in active TB case-finding activities, especially among at-risk populations such as miners and contacts of confirmed TB cases, improves detection of people with TB, improves access to diagnosis and treatment, and reduces the risk of disease transmission.
- The involvement of health care providers in the implementation of innovative strategies for active TB screening (investigation of contact subjects, active search for TB cases in populations at risk) makes it possible to reduce the risk of missing TB cases and improves detection of TB cases.
- When TB control partners work together at all levels of the health system, this synergy allows for good coordination and improves program performance. USAID IHP supports monthly meetings of the MDR-TB Coordination Unit (CCTM) at the national level and quarterly meetings of the TB/HIV Task Force at the provincial level.

- **5,358 Congolese** gained access to potable drinking water
- **125 local leaders** received training in upkeep, maintenance, and governance of the community water supply systems newly rehabilitated via USAID IHP support.
- **1,803 Congolese** gained access to a functioning, hygienic family latrine
- **87 health facilities** in Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central have identified priority WASH improvement needs and are ready for implementation

WATER, SANITATION, AND HYGIENE

DRC is one of 20 USAID priority countries for investments in water security, sanitation, and hygiene, and USAID IHP is one of two USAID/DRC WASH improvement implementation models. USAID IHP's target WASH indicators are (1) people gaining access to basic drinking water and sanitation services to combat the morbidity of children under 5 from poor WASH conditions; and (2) the improvement of the quality of care and infection prevention through improved WASH at health facilities.

During FY20, USAID IHP implemented two main WASH strategies in the Eastern Congo and Kasaï regions, following delays in FY2019 and amidst COVID-19 and robust procurement processes in FY2020: community-based WASH activities in Sud-Kivu and Kasaï-Oriental and health facility-focused WASH activities in Sud-Kivu, Kasaï-Oriental, Kasaï-Central, and Lomami. Halfway through the year, USAID IHP began transitioning to the new WASH strategy based on USAID's recommendations: phasing out community-based WASH and focusing attention on the clean clinic approach, a health facility-focused set of eight steps (see Table 37) to improve awareness, adoption and sustainability of WASH interventions. The clean clinic approach also includes basic renovation and small and very-small scale construction of basic sanitation infrastructure, such as latrines. USAID IHP conducts the clean clinic approach in health centers in the four aforementioned provinces with a focus on priority ZS targeted for full support.

Table 37. Clean clinic approach	
Step-by-step process	**Clean clinic approach standards**
Step 0. Decision of the health facility management committee Step 1. Mutual commitment Step 2. Baseline external evaluation of the health facility (Knowledge, attitudes, and perceptions survey) Step 3. Local governance and training of providers Step 4. Self-assessment Step 5. Planning for improvements Step 6. Implementation of improvements Step 7. Post-action assessment and maintenance plan Step 8. Certification Post-Certification	1. The health facility has an established and functional Hygiene and Sanitation Committee. 2. The health facility has permanent water supply. 3. The health facility has access to hygienic and functional latrines with sufficient hand-washing stations and showers. 4. The health facility correctly manages medical waste. 5. The health facility staff wash their hands properly at critical times. 6. The staff of the health facility know the patterns of transmission of nosocomial infections and their prevention methods. 7. The health facility is cleaned at least once a day with water and detergent.

Over the course of the year, USAID IHP coordinated with other implementing partners to ensure sound coverage and efficient resource allocation for WASH improvements across the sector.

Specifically, USAID IHP coordinated with the Food for Peace program to train water management committees in Kasansa ZS, Kasaï-Oriental, building on efforts from Catholic Relief Services' Budakadidi program. USAID IHP also worked with Mercy Corps in Sud-Kivu to use their water quality assessment results to inform USAID IHP's gravity flow water distribution system rehabilitation works in Katana and Miti-Murhesa ZS.

USAID visit in Kasaï-Oriental (latrine building). Source: Abt Associates for USAID IHP. Photo taken before COVID.

Rehabilitated WASH facilities in Communities

Direct: ✔ 2.6.2 **Indirect:** ✔ 2.6.3

USAID IHP engaged construction services to rehabilitate and establish water supply systems to benefit over 7,500 people in the Eastern Congo and Kasaï regions. Specifically, the Program contracted three local vendors to (1) rehabilitate a gravity flow water distribution system in Lwiro, MIti-Murhesa ZS in Sud-Kivu, (2) rehabilitate and extend a gravity flow water distribution system in Kabamba, Katana ZS in Sud-Kivu, and (3) construct one borehole each in five villages (Ntendu, Tshitshimu, Bena Yombo, Bena Kalemba and Kamuala) of the Kasansa ZS in Kasaï-Oriental.

Initially delayed due to national COVID-19 travel restrictions, by Q3, USAID IHP launched the gravity flow water distribution systems' works in Sud-Kivu. By the end of FY20, USAID IHP completed and assessed the quality of these works. The assessments have yielded a few corrections to be implemented in FY21 in advance of the official completion, but already, these systems are providing 5,358 Congolese people with access to potable drinking water.

In addition, the Program created and executed an emergency plan to launch borehole construction works in Kasaï-Oriental, which were delayed due to COVID-19 but successfully launched in Q4. By the end of FY20, USAID IHP completed construction of three boreholes and will complete all five boreholes by the first quarter of FY21, per agreement with USAID.

Lastly, to ensure sound upkeep, maintenance, and governance of these community water supply systems, USAID IHP facilitated training of 125 ZS-level leaders: 30 water management committee members each in Katana, Sud-Kivu (including eight women), 30 in Miti-Murhesa, Sud-Kivu (including 11 women), and 65 people (including 50 water management committee members, 10 leaders and five nurses) in Kasaï-Oriental. Trainings focused on: local governance, water management committee member roles and responsibilities, financial management, income-generating activities, conflict management, community action plans, and business plans. They also provided information about the law on water and *Entités Territoriales Décentralisées* (ETDs, Decentralized Territorial Entities).

Provided Support to Communities to Build and Improve Family Latrines and Handwashing Stations in Targeted ZS

Direct: ✔ 2.6.3

USAID IHP complemented water supply system rehabilitation works in Sud-Kivu and Kasaï-Oriental (described above) with community engagement to build or rehabilitate family latrines and handwashing stations.

USAID IHP community awareness activities launched in Q1 with five target villages in Kasansa ZS in Kasaï-Oriental, where 568 latrines were initially needed. Over the course of FY20, USAID IHP visited and sensitized 3,289 households on using local material to build latrines. By the end of FY20, 2,919 (88.8 percent) of these households[4] newly had functioning latrines, including 1,850 with improved latrines, and 1,884 with latrines with suitable small houses; in total, 19,173 Congolese people of Kasaï-Oriental

[4] In Kasai-Oriental, these 2,919 households were reported at the household, rather than individual, level and therefore are not included in Table 38 or our annual target detailed in Annex A.

benefitted from this support. These Program-supported households also invested in wash basins, garbage pits, family showers, and sanitation and plot maintenance.

The Program expanded community sensitization activities to Miti-Murhesa and Katana ZS in Sud-Kivu, partnering with the DPS and ECZS to visit 1,004 households in nine villages during Q2 and 953 households in seven villages in Q3. In Q3, the Program also ensured coordination and harmonization with the USAID FFP project so USAID IHP only targeted villages not already benefitting from donor support for basic sanitation. Over a six-month span, USAID IHP reached 11,524 community members in Sud-Kivu—5,912 in Q2 and 5,612 in Q3—including 5,900 women, increasing their awareness of the importance of rehabilitating or building family latrines and handwashing stations.

As a result of USAID IHP support, by the end of FY20, 20,976 Congolese people, including 925 women, were sensitized on using local material to build latrines. Of those sensitized, 1,803 people gained access to a basic sanitation service in FY20 as a result of USAID IHP assistance. This includes Q4 results during which 198 people gained access to a functioning, hygienic family latrine in Q4and a total of 273 new latrines were installed (163 in Miti-Murhesa ZS and 110 in Katana ZS).

Table 38. Number of people gaining access to a basic sanitation service as a result of USG assistance (#2.6.3)

Region	Province	ZS	Village	Sensitized FY2020	Achieved Access FY2020	Target FY 2020	Achievement rate (%)
Kasaï	Kasaï-Oriental	Kasansa	Tshitshimu	6,691		N/A	N/A
			Ntendu	6,859			
			Bena Yombo	720			
			Kalemba	2,155			
			Kamuala	2,748			
		Total		**19,173**			
Eastern Congo	Sud-Kivu	Miti-Murhesa	Buloli2	303	303	930	193.9
			Matete	398	398		
			Lwiro	349	349		
		Katana	Kahusi	94	94		
			Murambi	63	63		
			Busharanyambi	249	249		
			Bulindi Ngoma	247	247		
		Total		**1,803**	**1,803**		
Total				**20,976**	**1,803**	**930**	**193.9%**

Source: Project Monitoring Report

In addition to the above interventions, USAID IHP raised community-level awareness on good WASH practices through mini-campaigns aligned with global celebrations for World Water Day and Global Hand Hygiene Day. For World Water Day, USAID IHP supported 30 RECOs plus ECZS and local radio

stations to sensitize approximately 1,112 households on the importance of drinking water consumption and water treatment methods. On Global Hand Hygiene Day, USAID IHP implemented an awareness campaign, aligned with the 2020 theme "SAVE LIVES: Clean your hands."

Implemented Different Steps of the Clean Clinic Approach in Selected ZS

Indirect: ✔ 2.6.4

In FY2020, USAID IHP launched implementation of the clean clinic approach, which aims to reduce the rate of infections at health facilities through improved WASH infrastructure and practices in the Kasaï and Eastern Congo regions. USAID IHP continued the clean clinic approach in Sud-Kivu, Kasaï-Oriental, and Kasaï-Central—previously implemented by UNICEF and the USAID Maternal and Child Survival Program—and initiated the clean clinic approach in Lomami. The Program adapted technical assistance tools from previous implementers to develop an eight-step approach for improving MOH adoption and ability to increasingly, independently assess WASH needs, execute key WASH improvements, and promote good WASH practices for sustainability beyond the project. USAID IHP ensured engagement and coordination of this locally-oriented intervention through a one-day workshop with the MOH *Bureau Hygiène et Salubrité Publique* (Hygiene and Public Health Office) to harmonize different aspects of the adapted clean clinic approach.

USAID IHP progressively engaged 87 health centers in the four provinces over the course of FY20. The Program initiated the clean clinic approach with awareness-raising activities at the DPS, BCZS, health facility, and community levels and the data-informed selection of target health facilities based on WASH access needs and ZS support needs identified in the baseline service delivery mapping survey findings. The Program also facilitated a workshop to prioritize WASH needs and develop WASH improvement implementation plans. USAID IHP supported the Directorate of Public Hygiene and Public Health to conduct training workshops for providers in target DPS and conduct clean clinic approach self-assessments. Following those steps, by the end of FY20, USAID IHP had supported 87 health centers to plan for and conduct preparatory activities in advance of WASH improvements. The Program had also launched a procurement process to ensure quality WASH infrastructure improvements across health centers, which will begin in Q1 of FY21 (see box).

Improvements Identified across Facilities

Construction and rehabilitation improvements include latrines, bathrooms, ash pits, connection of a fountain system, and installation of a water tank, incinerators, and placenta pits. Materials needed for these improvements include dustbins for waste management, handwashing stations (bucket with tap and wastewater collection basin), PEV kit, sanitation kits, and communication posters with awareness messages.

Table 39. Number of health facilities selected for the clean clinic approach in FY2020

DPS	Target ZS in FY2020	ZS supported in FY2020	Health centers selected in FY2020
Sud-Kivu	11	6	17
Lomami	5	3	30
Kasaï-Oriental	13	2	15
Kasaï-Central	9	3	25
Total	38	14	87

In **Sud-Kivu**, USAID IHP supported the DPS and ECZS to select 17 health centers for the clean clinic approach in Miti-Murhesa, Walungu, Mubumbano, and Kaziba ZS. The program also trained ECZS staff, including one woman, as trainers; ECZS trainers then trained 60 providers, including 15 women, on key WASH practices and implementation of the clean clinic approach. A total of 85 people, including 27 women, were trained in FY20.

In **Lomami**, USAID IHP collaborated with the ECZS to select 30 health centers in Kanda, Luputa, and Mwene Ditu ZS for the clean clinic approach. Additionally, the Program trained 17 members of the DPS and ECZS, including one woman, as clean clinic approach trainers and supported the training of 150 clinical and community providers, including 51 women.

In **Kasaï-Oriental**, USAID IHP worked with the ECZS to select 15 health centers in Kasansa and Mpokolo ZS for the clean clinic approach. The Program provided technical and financial support for training 17 DPS, BHSP, and ECZS representatives from two ZS. The trainers then trained 75 providers, including 24 women.

In **Kasaï-Central**, USAID IHP launched clean clinic approach activities at the very end of Q2 and continued in Q3 with training 19 trainers from the DPS and ECZS from Kananga, Luiza and Ndekesha ZS; the trainers subsequently trained 125 providers. The Program worked with 25 health centers to prepare for WASH improvements.

USAID visit in Kasaï-Oriental (clean water). Source: Abt Associates for USAID IHP. Photo taken before COVID.

Following trainings, USAID IHP supported trained providers from all four provinces to assess their health centers for WASH needs and to develop WASH improvement plans. By the end of FY20, hygiene and sanitation committees from 82 supported health centers had installed garbage cans, handwashing basins, and garbage pits and maintained existing latrines. The Program provided these materials plus handwashing devices, personal protective equipment, sanitation kits, and cleaning products to these health centers and trained 435 hygiene and sanitation committee members—five members from each health center—on their use.

Lessons Learned

- The DPS of target provinces are particularly interested in the clean clinic approach to reduce infection rates, improve staff morale, and encourage adoption of good hygiene practices in health facilities and at home. Also, USAID IHP's promotion of the step-wise clean clinic approach, coupled with financial support, has incentivized active involvement of health facility providers, ECZS and the DPS/BHSP to assume ownership of clean clinic approach initiatives.

- The clean clinic approach training helped strengthen the capacities of the CODESA, ECZS and DPS/BHSP managers to manage nosocomial and epidemic infections, especially relevant during the COVID-19 pandemic. The clean clinic approach has also created an enabling environment for IPC associated with care in participating health centers.
- Providing technical assistance on the criteria and the use of suitable materials for constructing a hygienic latrine can motivate communities to invest in their own latrines and complementary health care improvements. In the absence of substantial resources, for instance, the community can assist with raising awareness and close monitoring. Further, community members may seek available alternatives: 168 households built hygienic family latrines with recycled materials.

4. OBJECTIVE 1

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

Community scorecard pretest, Kasaï-Oriental. (*Credit:* Abt Associates for USAID IHP.) Photo taken before COVID.

- **All DPS and ZS** developed FY2020 annual operational plans aligned with national and provincial budgets and validated across stakeholders
- **2,874 CACs** revived through USAID IHP assistance
- Nine provincial health inspector (Inspections Provinciales de la Santé) units successfully audited 100-plus percent of their annual target facilities
- **Nine provinces** exceeded MOH target of 80 percent data completeness in DHIS2, with all but two provinces achieving greater than 90 percent
- USAID IHP supported health facilities to reduce incidence of at least one stock-out to an average of **49.4 percent**

Throughout FY20, USAID IHP conducted activities to promote a stronger health system in the DRC, working with the central-level MOH, provincial and ZS-level governing bodies, health facility-level administrators, and community-level leaders. The Program provided technical and financial support to these actors focused on developing competencies and sustainable systems in leadership and management, governance, accountability, coordination, and data for decision-making.

During FY20, USAID IHP planned 482 Objective 1 activities in support of the MOH's implementation of the PNDS 2019-2022. The Program implemented 352 of these activities, achieving a completion rate of 73 percent despite challenges posed by the COVID-19 pandemic during the second half of FY20 and also the availability of MOH and other health teams to implement planned activities. Key FY20 activities included institutional capacity-building activities; technical and financial support for more transparency and accountability, including at the community level; improved coordination across health system stakeholders and implementing partners; better availability, quality, and management of health data and related tools; more responsive and equitable human resources for health; stronger coordination for the effective and timely distribution of essential medicines to health facilities; and improved collaboration with varying levels of DRC's health system.

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

USAID IHP's institutional capacity building (ICB) activities spanned nine DPS and 26 ZS and ranged from conducting ICB assessments to providing technical support to DPS and ZS as they developed and implemented ICB plans. USAID IHP additionally provided in-kind financial support for the operating expenses of provincial and zonal health authorities.

Conducted PICAL Assessments in a Few ZS

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

USAID IHP used the PICAL tool to support ZS to assess themselves in four dimensions of institutional capacity: administrative, demand for institutional performance, organizational learning, and systems strengthening. USAID IHP originally planned to conduct PICAL assessments in 45 ZS, five ZS per province, in FY20, but due to COVID-19-related restrictions, it was only possible to complete a subset of 26 ZS.[5] The Program trained approximately six *encadreurs provinciaux polyvalents* (multidisciplinary provincial supervisors) per ZS on how to implement the PICAL assessments and analyze results. Following the onset of the COVID-19 pandemic, the Program adapted to virtual trainings that permitted a relaunch of PICAL assessments with minimal USAID IHP support. **Error! Reference source not found.** summarizes results from the year's PICAL analyses: total PICAL scores and then the average score for each of the four PICAL dimensions. Results show that all assessed ZS require institutional capacity support across the four PICAL dimensions, with most falling in the range of deficient, nascent, or emerging institutional capacity on average. Key ZS PICAL assessment findings highlight:

- Limited organizational and management capacity
- Limited human resources management
- Poor working conditions

[5] Two ZS assessments were conducted in 2019: one in Haut-Katanga and one in Lualaba. Also, Tanganyika conducted four assessments instead of the planned five for budget reasons.

- Lack of anti-corruption measures
- Lack of dissemination of basic guidelines, templates and policies
- Lack of adequate DPS oversight, training and supervision
- Near-total dependence on external financing

Following PICAL analyses, USAID IHP provided technical support to all 26 ZS to develop ICB plans that address each ZS's priority areas for capacity building. Common challenges noted across ICB plans included poor financing; inability to hire qualified personnel; and lack of learning-oriented, needs-based organizational planning.

Table 40. Results of PICAL institutional analyses FY20: ZS average scores

DPS	ZS	Total PICAL score (of 20) by ZS	Average PICAL dimensional score by ZS
Haut-Katanga	Kafubu	4.7	1.2
	Kapolowe	6.4	1.6
	Kenya	4.9	1.2
	Katuba	8.8	2.2
	Kampemba	7.0	1.7
Tanganyika	Kongolo	3.6	0.9
	Kalemie	4.9	1.2
	Kabalo	3.1	0.8
	Kansimba	7.6	1.9
Kasaï-Oriental	Bipemba	6.5	1.6
	Cilundu	8.5	2.1
	Kabeya Kamuanga	8.8	2.2
	Mpokolo	8.0	2.0
	Bibanga	7.2	1.8
Lomami	Kalenda	8.0	2.0
	Kanda-kanda	6.1	1.5
	Mwene Ditu	6.2	1.6
Lualaba	Fungurume	5.5	1.4
	Manika	8.4	2.1
	Dilala	5.9	1.5
Haut-Lomami	Kabongo	3.6	0.9
	Kamina	6.3	1.6
	Kabondo Diande	3.2	0.8
	Kayambe	2.6	0.6
	Malemba Nkulu	3.5	0.9
Sankuru	Dikungu	5.4	1.4

Source: Program Monitoring Report

The last column of Table 40 presents each ZS' average PICAL score by domain on a 5-point scale (Scale: 0 = Deficient; 1 = Nascent; 2 = Emerging; 3 = Consolidating; 4 = Mature; 5 = Continuously Improving).

Rows shaded in red fell below the nascent range and rows shaded with blue reached an emerging score.

USAID IHP also worked with all nine DPS to continue implementing FY19 ICB plans, and to advocate for resources to continue building DPS capacity and reassessing progress. Domestic resource mobilization strategies that USAID IHP is either implementing or will explore with the DPS include:

- Advocate with the national and provincial government for the increase of the budget allocated to health

- Empower DPS teams to monitor existing mechanisms for disbursing funds allocated to the health sector at central and provincial levels.
- Involve ETDs in the financing of the health sector at the local level
- Support the DPS and ZS to ensure efficient allocation, disbursement, and expenditure of household financial contributions to the health system (e.g., out-of-pocket payments)

The DPS continue increasing ownership of the PICAL assessment process and resulting ICB plans, a key means of sustaining ICB results in the long term. For example, USAID IHP support to the Lualaba DPS to formalize the contrat unique in February 2020 with TFPs, local leaders, and private mining companies has since resulted in $1.1 million in local resources mobilized, including over $500,000 dedicated to local health spending.

Supported the 2020 PAO Process at the DPS Level and in the ZS in Collaboration with Other Stakeholders

Indirect: ✓ 1.1.1

Over the course of FY20, USAID IHP worked with DPS to further involve provincial governments and ETDs in advocacy efforts to obtain local-level health sector financing. During the FY20 PAO process, provincial ministries were invited to participate and clarify the provincial budget allocated to health as well as their mechanisms for disbursing funds. In addition to convening various stakeholders for these critical health financing dialogues, USAID IHP support ultimately improved management of available financial resources for the health sector through the *contrat* unique signing process, described further under the IR 1.4 section. Following advocacy with local officials, the ETDs participated in the planning process and provided support for the financing of the FY20 PAOs in certain ZSs (Lualaba and Haut-Katanga).

At the operational level, USAID IHP worked with ZS officials during the FY20 PAO process to identify and cost community-based funding (i.e., household contributions) in each ZS, and to ensure this main source of health sector financing was highlighted in each FY20 PAO, reinforced through USAID IHP's support to national- and provincial-level PAO missions. USAID IHP also facilitated the engagement of BCZS and health facility managers to improve disbursement, use, and management of financial resources.

Following advocacy with local officials, the ETDs participated in the planning process and provided support for the financing of the 2020 PAOs in certain ZSs (Lualaba and Haut-Katanga cases described in our previous reports)

Table 41. DPS and ZS where USAID IHP supported operational costs, FY20

Region	DPS / province	# ZS
Eastern Congo	Sud-Kivu	27
	Tanganyika	4
Kasaï	Kasaï-Central	4
	Kasaï-Oriental	15
	Lomami	12
	Sankuru	5
Katanga	Haut-Katanga	10
	Haut-Lomami	16
	Lualaba	8
TOTAL		101

Supply chain training on InfoMed for DPS, Lualaba. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Provided In-kind Financial Support to Select Operating Costs of the DPS and Some ZS

Indirect: ✔ 1.1.1 ✔ 1.1.2

Beyond technical support, USAID IHP provided in-kind financial support to all nine DPS and 101 ZS—the relatively accessible ZS out of the Program's target 179 ZS—for their routine operations during FY20 (see Table 41). The Program's support focused on each office's expressed needs but overall ensured that ECDPS and ECZS could focus on their health systems' essential activities. In the last two quarters of FY20, this support was vital as the COVID-19 pandemic reduced operational capacities of most national and international organizations, which, in turn, affected the beneficiary DPS and ZS.

In FY2021, this in-kind support will continue, and USAID IHP aims to expand to more ZS through new operational and financial mechanisms such as mobile money scale-up.

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

Finalized Planning and Preparations for Complaints and Accountability Hotline Platform to Increase Transparency and Reporting on Abuse

Indirect: ✔ 22 ✔ 1.1.2 ✔ 1.2.1 ✔ 1.2.2 ✔ 1.2.3 ✔ 1.2.4

During FY20, USAID IHP designed the complaints and accountability hotline for health facilities, a resource that will allow health workers and community members to report suspected issues of fraud, abuse, and corruption. The Program completed the design for and successfully implemented a hotline phone survey in Kasaï-Central and Sankuru to better understand health workers' perceptions of fraud and corruption and how to address them. USAID IHP used the survey results, summarized in the Quarter 3 report, to finalize the hotline survey and plan for the FY2021 hotline pilot. In FY2021, USAID IHP will work with the Integrated Governance Activity to pilot the hotline in two provinces—Kasaï-Central and Lomami—before expanding to all nine provinces.

Provided Support to Quarterly Trips of IPS Missions for Audit Control and Oversight of ZS

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

USAID IHP supported IPS in all nine provinces to conduct audit and control missions in a total of 72 unique ZS. DPS and USAID IHP determined which ZS to audit based on a dual approach: (1) USAID corridor ZS (on average, five ZS per province) and (2) ZS that alerted issues of fraud and abuse linked to health system management. For the latter, USAID IHP support focused on alerts related to BCZS- and FOSA-related medication management alerts.

Table 42. Percentage of DPS and health zones supported by the program that are audited with USAID IHP DRC technical and/or financial support

Province	Q1	Q2	Q3	Q4	FY20	Comment
Kasaï-Central	7	0	0	6	**7**	Note: This table denotes the number of unique ZS that received USAID IHP support, though several ZS received support in several quarters following issues of fraud and abuse that prompted follow-up audits.
Kasaï-Oriental	1	6	5	6	**11**	
Lomami	2	2	4	4	**11**	
Sankuru	2	5	5	1	**11**	
Haut-Katanga	0	7	0	0	**5**	
Haut-Lomami	4	4	1	3	**7**	
Lualaba	0	6	8	5	**8**	
Tanganyka	3	0	4	0	**7**	
Sud-Kivu	4	0	1	4	**5**	
Total	**23**	**30**	**28**	**29**	**72**	

Source: Project Monitoring Report

Across quarters, IPS missions focused on routine monitoring activities while also addressing specific needs as they arose. For instance, in Q1, IPS missions in Sankuru helped identify and investigate issues with a diversion of medications destined for health facilities. In Q2, IPS missions also assessed management and cash collections from the sale of medications and ultimately improved the rate of collection. In Q3 and Q4, IPS missions monitored compliance with COVID-19 health measures.

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

Complementing the Program's technical and financial support to government health bodies at varying levels of the DRC's health system, USAID IHP also strengthens community organizations to ensure that community-level health care services are properly functioning. USAID IHP support focuses on CACs and CODESA through the following activities.

Provided Support to Revitalizing CACs in Selected ZS with Integration of Gender

Indirect: ✔ 1.3.2 ✔ 1.3.3

In partnership with the MOH and provincial DPS, USAID IHP revived 2662 CACs across all nine provinces in FY20, including180 women-led CACs. Cumulatively, USAID IHP has revived a total of 3,964 CACs since project start. See Table 43 for more details. A USAID priority activity, USAID IHP also supported these CACs by training 2,179 RECO from the CACs, including 1,049 women, in roles and responsibilities, community dynamics, and gender mainstreaming. The Program also worked with CACs to understand challenges they face and find ways to overcome them. For instance, USAID IHP continued supporting a community-level HMIS to facilitate sharing data from the community in DHIS2. Finally, the Program worked with revitalized CACs to use the community scorecard as a community accountability tool.

Table 43. USAID IHP support for revitalization of CAC

Province	Revitalized CAC				Achievement rate (%)
	Cumulative prior to FY20 Quarter 4	During FY20 Quarter 4	Total for FY20	Target for FY20	
Haut-Katanga	158	0	0	200	0
Haut-Lomami	50	0	0	50	0
Lualaba	32	0	15	105	14
Kasaï-Central	880	0	880	550	160
Kasaï-Oriental	1,003	980	980	940	104
Lomami	285	0	271	1,282	21
Sankuru	100	0	100	800	13
Sud-Kivu	243	92	318	350	91
Tanganyika	123	18	98	1,134	9
Total	**2,874***	**1,090**	**2,662**	**5,411**	**49**

Source: Project Monitoring Report

*USAID IHP supported revitalization of 2,874 CACs from project inception through FY20 Quarter 3.

Provided Technical and Financial Support to CODESA Monthly Meetings in Selected ZS

Indirect: ✔ 1.3.1 ✔ 1.3.2

USAID IHP supported *Comité de Gestion* (COGE, Management Committee) meetings—attended by RECO, ECZS and other political and administrative authorities, and community leaders—across provinces, with extended support to accessible *aires de santé* near USAID IHP offices. The Program supported COGE meetings for 72 CODESA in Lomami, Haut-Katanga, and Haut-Lomami in Quarter 1; 76 in Lomami, Sud-Kivu, and Tanganyika in Quarter 2; and 188 CODESA in Lomami, Sankuru, Kasaï-Oriental, Haut-Katanga, Haut-Lomami, Lualaba, and Sud-Kivu in Quarter 3. Among routine activities and

key areas of training, the COGE meetings served as opportunities to highlight the importance of engaging RECO in health area development activities and reinforce social accountability for community development. Lastly, ECZS and USAID IHP technical staff supported CACs to develop and validate community action plans, integrating community action plans for COVID-19.

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

Provided Support for the Implementation of the *Contrat Unique* of the DPS

Indirect: ✔ 1.4.2

USAID IHP supported all nine DPS in launching their *contrat unique*, a document (i.e. virtual basket fund) intended to support DPS in transparently consolidating and pooling sources of financial support. The Program assisted the DPS by coupling the development and implementation of the *contrat unique* with existing 2020 PAO development, validation, and monitoring activities. The Program also provided this technical and financial support to DPS based on their specific needs. For instance, in Kasaï-Oriental, USAID IHP and DPS leaders co-organized a mini-workshop on the *contrat unique* to build stakeholders' understanding of the process and spark collaborative opportunities, especially to assess DPS funding sources and mitigate any future challenges. One major reported challenge was limited domestic funding from national and subnational DRC government sources.

By the end of Quarter 4, USAID IHP effectively supported the seven DPS (Kasaï-Oriental, Lomami, Haut-Katanga, Haut-Lomami, Lualaba, Sud-Kivu, and Tanganyika) where the Program is the lead technical and financial partner for the *contrat unique* process to formally signed their *contrat unique*. USAID IHP will continue support to the Sankuru and Kasaï-Central DPS for formal signatures early in FY2021.

Facilitated Technical and Coordination Meetings with DPS and Other USAID Partners

Indirect: ✔ 1.4.1 ✔ 1.4.3 ✔ 1.5.2

USAID IHP coordinated varying health system actors and development partners in Kinshasa and the provinces to improve awareness of and collective responses to priority issues for the MOH, DPS, and other health system actors.

Contributed Technically and Financially to the DPS Semi-annual Review Meeting

Indirect: ✔ 1.4.1 ✔ 1.4.3

USAID IHP provided technical and in-kind financial support to six DPS—Lomami, Kasaï-Oriental, Sud-Kivu, Haut-Katanga, Kasaï-Central, and Tanganyika—to review major primary health care activities during FY20. ECZS, ECDPS, and partners attended these reviews, during which they identified primary health care issues and strategies to address them and developed recommendations to improve health outcomes in key indicators. USAID IHP provides follow-up technical assistance in response to these reviews, to address issues such as health data management at primary health care sites and stock-outs of essential medicines and drugs.

Supported Partner Coordination Meetings at the Central Level

Indirect: ✔ 1.1.2 ✔ 1.1.13 ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 2.1.26

USAID IHP facilitated collaborative efforts and consultative meetings with technical and financial partners to facilitate knowledge sharing, minimize duplication of effort, and ensure harmonized technical assistance approaches in provinces where multiple partners contribute to a shared objective.

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

Provided Technical and Financial Support to DPS for the Organization of Quarterly Data Validation Meetings

Indirect: ✔ 1.5.1 ✔ 1.5.2 ✔ 1.5.3 ✔ 1.7.2

During FY20, USAID IHP supported six provinces (Lualaba, Lomami, Haut-Katanga, Kasaï-Central, Kasaï-Oriental and Sud-Kivu) in organizing meetings for integrated data validation. During these meetings, participants including ECDPS, providers, and managers, reviewed the data for inconsistencies, errors, and potential issues with key health indicators. Following these meetings, the DPS developed data improvement plans to mitigate errors and re-emphasize data quality. USAID IHP will support the DPS of Sankuru, Tanganyika, and Haut-Lomami in FY21.

Provided Financial Support to Monthly Monitoring Meetings at the ZS and *Aire de Santé* Levels

Indirect: ✔ 1.5.3 ✔ 1.7.2

USAID IHP provided in-kind financial support to a total of 78 BCZS and 517 *aires de santé* in the nine provinces to hold routine meetings on health data quality assurance. During these meetings, BCZS and *aires de santé* staff validated collected health data to encode them into DHIS2. Table 44 summarizes USAID IHP support throughout FY20. During the third and fourth quarters of FY2020, the Program focused on supporting monthly monitoring meetings as possible at the *aire de santé* level in lieu of the COVID-19 pandemic. Through this support, some provinces, including Lomami, Kasaï-Oriental, Sud-Kivu and Tanganyika, were able to hold these meetings.

Table 44. Summary of FY20 ZS and aire de santé monitoring meetings

Provinces	ZS	*Aires de santé*	Participants	Women
Kasaï-Oriental	6	94	581	249
Lomami	15	0	1,173	96
Haut-Katanga	5	116	720	130
Haut-Lomami	5	0	172	27
Lualaba	15	0	849	68
Sud-Kivu	4	15	304	113
Tanganyika	8	0	528	136
Sankuru	5	11	2,235	128
Kasaï-Central	15	281	416	83
Total	78	517	6,978	1,030

Source: Project Monitoring Report.

Note: As can be seen in the table above, a total of 6,978 participants, including 1,030 women, participated in these meetings during FY20. Thus, Multidisciplinary provincial supervisors and some program staff were sent out to provide technical support.

Trained DPS and ZS Cadres in the Data Quality Supervision Tool (DQST)

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.3

In Quarter 3, USAID IHP supported the Haut-Katanga DPS in empowering 10 DPS and 10 ECZS executives (including two women) to use the RDQA tool and the DQST. This support improved control of data quality; participants confirmed they acquired skills for drafting reports, organizing meetings for data analysis and validation, and using the DQST. In Quarter 4, USAID IHP trained 39 executives (27 men, 12 women) including 10 from the DPS and 29 from 16 ZS including Kipushi, Panda, Kapolowe, Kikula, Lubumbashi, Kampemba, Kenya, Sakania, Kafubu, Kamalondo, Katuba, Kikula, Kilwa, Kisanga, and Ruashi Tshamilemba in the use of data quality control tools (RDQA and DQST).

This training enabled the executives of the Katanga DPS and ZS, like the training participants from other provinces, to carry out RDQA and OSQD missions in the ZS and the health facilities, which resulted in plans to improve the quality of data collected from health facilities.

Provided Support to Data Quality Control Field Visits

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.3

USAID IHP provided routine technical and financial support to DPS to conduct data quality control visits at ZS and health facility levels. Table 45 summarizes coverage across FY20. As of the end of Quarter 3, BCZS and health facilities' ability to implement basic data quality assurance measures remained a challenge identified through these visits. USAID IHP has collaborated with ECZS to address this challenge through correction and improvement plans with each health facility that the ECZS will monitor.

Specific improvements were made regarding the maintenance of data collection and transmission tools provided to the BCZS for encoding, compilation, and quality assurance and addressing the causes of discrepancy between the data contained in the registers and those found on DHIS2. Finally, these visits made it possible to raise the awareness of nurses on the correct use of management tools.

Table 45. BCZS and facility field visits conducted by province in FY20

Province	ZS	BCZS	General referral hospitals	Reference health centers	Health centers	Health posts	# facilities	DHIS2 indicators	Project indicators
Haut-Katanga	12	12	2	3	37	0	42	4	0
Haut-Lomami	11	11	11	22	0	0	33	8	8
Kasaï-Oriental	6	6	0	18	0	0	18	4	0
Lomami	5	5	4	15	0	0	19	5	0
Kasaï-Central	15	15	0	0	30	0	30	4	3
Sankuru	5	5	0	0	10	0	10	4	3
Tanganyika	3	3	3	9	0	0	12	4	0
Sud-Kivu	9	9	8	0	18	0	26	5	5

Source: Project Monitoring Report

This activity will continue in FY21 to make it possible to carry out these missions in other ZS that have not yet received feedback and finish developing improvement plans for health data quality.

Ensured Availability of Internet Connection for the DPS and ZS (Purchased data for 3G and 4G or VSAT connection)

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

USAID IHP provided in-kind financial support to ensure that DPS and ZS have working internet connections, enabling them to securely, completely, and promptly enter and transmit health information to the DHIS2 platform. Internet connectivity also makes it possible for DPS and ZS to use the full functionality of DHIS2, including for monitoring data quality and analyzing health data to inform decisions. This solution was originally envisioned as a mixed approach including 3G, 4G, or VSAT connections. However, many target ZS are not covered by 3G or 4G networks, or would have such slow connections that they would not be viable. Thus, USAID IHP determined that VSAT connections were the most sustainable solution for continuous internet connectivity and timely entry into DHIS2. The VSAT connections also benefit supply chain activities that rely on data entry into the logistics management information system (LMIS). By the end of Quarter 3, more than half of target ZS had functional VSAT connections.

During Quarter 4, the Program completed the reactivation of VSAT connections in the ZS of the nine supported provinces. This investment in stable internet connectivity made it possible to maintain and exceed satisfactory levels of routine and prompt data submission into DHIS2.

Overall, during FY20, USAID IHP-supported provinces exceeded the MOH threshold of 80 percent data submitted into DHIS2 with an average rate of 94.5 percent. The provinces of Kasaï-Oriental, Lomami, Kasaï-Central, Sankuru, and Sud-Kivu exceeded 95 percent. However, promptness remains a problem: only three provinces had an average on-time submission rate higher than 80 percent (Kasaï-Oriental, Lomami, and Kasaï-Central).

Community action group discussion, Sankuru. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Printed and Disseminated Health Facility Management Tools (registers, index cards, report templates, and others)

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

AS OF THE END OF QUARTER 3, USAID IHP LAUNCHED PROCESSES IN ALL NINE PROVINCES TO PRINT AND DISTRIBUTE SNIS MANAGEMENT TOOLS TO THE DPS AND ZS. TOOLS INCLUDE VARIOUS REGISTERS FOR HEALTH FACILITIES AND FORMS FOR MATERNITY, ANC, AND OTHER REPORT TEMPLATES. USAID IHP CONTINUES TO ASSESS WAYS TO MEET THE VOLUME AND DISTRIBUTION NEEDS OF ALL TARGET BENEFICIARIES, WHICH REQUIRE NEW PRINTED MATERIALS EVERY TWO TO THREE MONTHS. DURING THE FOURTH QUARTER, THE PROGRAM INITIATED A MAJOR PROCESS TO EQUIP ALL ZS AND DPS WITH THE TOOLS. ALL THE PROVINCES ARE SUPPLIED, AND THESE ESSENTIAL TOOLS FOR DATA AVAILABILITY ARE AVAILABLE DOWN TO THE HEALTH CENTER LEVEL. TO MAINTAIN AVAILABILITY, USAID IHP WILL WORK WITH PROVINCES TO QUANTIFY WHICH STANDARD TOOLS UPDATED BY THE MOH THEY NEED AND HOW MANY OF EACH THEY WILL NEED STARTING IN THE FIRST QUARTER OF FY2021.IR 1.6: IMPROVED MANAGEMENT AND MOTIVATION OF HUMAN RESOURCES FOR HEALTH

Provided Orientation to DPS Staff on Gender-based HRH Planning and Deployment

Indirect: ✔ 1.6.1

In FY20, USAID IHP worked with the Tanganyika ECDPS to integrate gender as a key dimension of HRH planning and deployment. This technical assistance culminated with an orientation workshop in Quarter 3, during which USAID IHP oriented 19 staff (including eight women), including on the importance of gender integration. The Program will follow up on recommendations from the workshop during the planned FY21 gender audit.

Provide Technical Assistance to DPS in the Design of Incentive Systems for Human Resources

Indirect: ✔ 1.6.1

During FY20, USAID IHP worked with the Tanganyika DPS to design an HRH incentives approach that would be funded solely by local resources, building local capacity to prioritize programming needs based on availability of domestic resources. In FY2021, USAID IHP will scale up this approach in other provinces to stimulate the recruitment and retention of key health system personnel.

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

In FY20, 49.4 percent of USAID IHP-supported health facilities experienced at least one incidence of a stock-out of one or more tracer commodities. The tracer commodities include the following, listed here (with the Program Area to which they are related): Depo Provera (FP/RH), oral rehydration solution (ORS, Child Health), Oxytocin injectable (MNCH), iron-folic acid (Nutrition), Artesenuate Amodiaquine (Malaria), Rifampicine + Isoniazide (TB). In Quarter 4, 46.3 percent experienced at least one incidence of

a stock-out. This indicator did not change significantly from Quarter 3 (44.7 percent) or Quarter 2 (43.2 percent), but has a lower achievement rate compared to Quarter 1 (30 percent). Performance varied between quarters but the Program far exceeded its annual target of 67.7 percent for this indicator. A significant improvement can be seen from the Program baseline which showed 71.1 percent of health facilities reporting stock-outs. Further details on the availability of tracer commodities and these Program areas, as well as impacts to the performance for related indicators, can be found in the respective Program Area sections of this report.

Financially and Technically Supported the GTM and Management of Supplies and Stocks Activities

Indirect: ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

Throughout FY2020, USAID IHP held regular coordination meetings with GHSC-TA. These meetings focused on preventing the stock-out of essential medicines and MNCH supplies. These meetings also served as an opportunity to harmonize perspectives and jointly support the *Groupes de Travail Médicaments* (GTM, Essential Drugs Working Group). The GTM regularly conducts meetings to discuss the management of drug supplies and stocks in the nine provinces. In Q2, the group committed to supporting joint supervision of ZS in order to have a common understanding of the supply chain at the last mile and develop solutions together. Additional technical support activities included:

- Stock inventory review in the *centres de distribution régionale* (CDR, regional distribution centers, the ZS warehouse, and FOSA) and monitor distributions to the ZS. Where the information is available, stocks in the pipeline are included in the analysis.
- Tracking of ZS credit lines. In Quarter 3, USAID IHP supported seven DPS in preparing memoranda signed by the Chef de Division that explain how ZS allocate credit to health facilities and how ZS funds needed to procure medicines are replenished.
- Monitoring of data completeness for managing FOSA and BCZS stock reports in LMIS/DHIS2/InfoMED and copying and distributing normative logistics management tools.

Throughout FY2020, USAID IHP conducted trainings in order to improve the capacity of the DPS to better manage the supply chain. In Quarter 1, in collaboration with the *Programme Nationale d'Approvisionnement en Medicaments* (PNAM, National Drug Supply Program) the DPS, and GHSC-TA, the Program completed InfoMed trainings in the four provinces in the Kasaï region. All 179 target ZS have now been trained on the use of InfoMed. In Quarter 2, through partner IPlus Solutions, USAID IHP worked with PNAM to conduct the preparatory work for the training-of-trainers in supply chain management and the community-based Informed Push Distribution Model. The planned pilot in 32 targeted ZS was delayed due to COVID-19 but will be rolled out in FY2021. The training will also be available online via the *Académie Logistic RDC*. During this period, the Program continued to support ZS in InfoMed post-training, which significantly improved the completeness of health facility LMIS reports; completeness of these reports soared from 29.3 percent last quarter to 61 percent in Quarter 2. *[DHIS2, HF LMIS, accessed on April 23, 2020].* To continue training inventory management personnel under the conditions imposed by the COVID-19 pandemic, PNAM and IPlus Solutions uploaded various training modules to the *Académie Logistic RDC* online platform. The USAID IHP and GHSC-TA staff and some experts from PNAM carried out the first test of the platform. The activity aimed to provide feedback on the participants' user experience.

The community in Tubuluku works together to fill out the community scorecard evaluating their local health care services. Source: Abt Associates for USAID IHP. Photo taken before COVID.

USAID IHP, jointly with DPS and GHSC-TA, conducted routine monitoring and supervision visits at the ZS and their health facilities on various aspects of the supply chain. In Quarter 3, USAID IHP teams and DPS conducted joint monitoring visits to 32 ZS across the nine provinces. The purpose of these visits was to monitor the use of management tools; reporting in the LMIS, DHIS2/InfoMed; and use of the *Plans de Distribution de ZS* tool and ZS distribution plan. To ensure that the necessary tools for this work were available, the Program routinely printed supply chain management tools locally and distributed them across all nine provinces.

Ensured the Transport of Commodities by RECO in Difficult-to-Access *Aires de santé* (Last-Mile Drug Transport)

Indirect: ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 1.7.1 ✔ 1.7.2 ✔ 1.7.3 ✔ 1.7.4

In Quarter 2, IPlus Solutions led the development of a last-mile product distribution guide that showed the accessibility of targeted beneficiary sites, mapped partners involved in drug supply, and designed the distribution plan for each ZS. The accessibility of each *aire de santé* and health facility was characterized according to four criteria: distance between BCZS and health facility, state of the road, presence of geographic obstacles, and security context. The Program worked throughout FY2020 to develop a financial model to implement the approaches described in the product distribution guide. It is anticipated that this model will be launched at the start of FY2021. In the meantime the Program worked to find different ways to deliver medicines. Throughout FY2020 the Program supported transportation of products to health facilities of a few ZS using Program vehicles.

Overall, the number and percentage of USG-assisted service delivery points that experienced stock-outs was lower than expected at 3,219 (49.4 percent) out 6,517 USG-assisted service delivery points (the

FY20 overall target was 67.7 percent). This represents an achievement rate of 127 percent. All provinces exceeded their targets for reduction in the incidence of stock-outs in relation to the target (an overall performance rate of 27 percent). The best performance was Lualaba's at 41 percentage points lower than the target for reduction, while Sankuru's stock-out rate was only 4 percentage points lower than its target.

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

Organize a Monthly Review of Good Practices on Gender Mainstreaming

Indirect: ✔ 1.8.1

In FY20, several provinces organized exchange sessions on good practices for integrating gender into programs. Please find details of this activity in the Gender section of this report.

Participate in the Meetings of the 6 Technical Commissions of the CNP-SS

Indirect: ✔ 1.1.1 ✔ 1.4.3 ✔ 1.5.1 ✔ 1.5.3

At the central level, USAID IHP participated in 12 monthly meetings of the *Comité National de Pilotage du Secteur de la Santé* (CNP-SS, National Health Sector Steering Committee) financing commission. During all these meetings, USAID IHP placed particular emphasis on respecting central-level commitments for financing DPS and ZS. USAID IHP discussions with the MOH demonstrated the importance of the MOH central level's firm commitment to improving the health budget allocated to the provinces, noting that in the absence of such, the efforts of technical and financial partners alone would be diluted. USAID IHP noted that the central government, through the MOH, needs better defined health financing options in order to sustainably reduce dependence on external financing. This is an area of technical assistance that USAID IHP will further pursue in FY21.

Strengthened Collaboration with the Ministry of Health

Indirect: ✔ 1.8.1

USAID IHP collaborates regularly with the central-level MOH and with the *Secrétaire Général*, DGOGSS, and *Direction d'Etudes et Planification* (DEP, Planning Directorate) in particular. In FY20, hallmark areas of collaboration were:

1. Together with the SG, USAID IHP presented the results of the first year of USAID IHP to the SG, USAID, other SG officials, and other technical and financial partners. The SG's recommendations resulting from these discussions were taken into account in USAID IHP FY2021 workplanning. USAID IHP also actively participated in monthly meetings convened by the SG to monitor project implementation in support of the MOH.
2. With the DGOGSS, the anchor point of the program in the MOH, there is continuous interaction in the planning, monitoring, and implementation of program activities in support of the MOH. The Director General of DGOGSS regularly participated in program activities, and USAID IHP ensured

that the DGOGSS was empowered and leading ownership of health systems strengthening activities including the PICAL approach and development and validation of the community scorecard tool.

3. At the DEP level, USAID IHP is highly regarded and has remained the main technical and financial partner supporting the annual PAO process that the DEP conducts. In addition, USAID IHP-developed approaches for PAO support were regularly discussed within the Governance Commission of the CNP-SS to stimulate MOH ownership. Finally, the Program ensured alignment of PAO support with that of the *contrat unique* process in the seven DPS where USAID IHP led *contrat unique* implementation.
4. USAID IHP facilitated the participation of the central-level MOH, namely the *Secretaire General*, DGOGSS, and DEP, to establish a *Commission Mixte*, a committee charged with the support of the organizational and logistical elements of the nine provincial-level external assessments that are underway by PwC. The objective of these assessments is to use criteria established by USAID regulations to evaluate the DPS' financial, organizational and managerial capacity, pursuant to determining their ability to effectively manage subcontract funds from USAID. This process is part of an internal USAID required process dubbed a Determination and Finding (D&F), which must be completed and a positive verdict rendered before USAID IHP is authorized to award subcontracts that provide financial resources to the DPS. This collaboration, which is facilitated by the Program and includes PwC in their role as assessor, helped secure broader support from the MOH to consider adopting and replicating the assessment process as part of a more comprehensive health systems strengthening approach in non-USAID IHP-supported provinces. This would allow for a more thorough institutional capacity assessment of DPS and ZS characteristics such as leadership, HR management, and information systems and, along with the PICAL assessments that are currently underway as part of the Program, would guide the strengthening of decentralization in the health sector to inform future capacity building interventions.

USAID IHP also provided support to central and provincial levels to enhance their communications capacity, and generate regular updates to constituents in the form of web pages (e.g., Tumblr) and newsletters. See Annex C for an associated success story.

Lessons Learned

- USAID IHP support to CACs to develop and implement community action plans that integrate the approach of conducting a PICAL assessment, analyzing the results, and using the results to develop and implement an institutional capacity building plan has contributed to improved operational planning processes at the DPS level, and the MOH is considering adoption at a national level.
- Coupling the PAO and *contrat unique* development processes was a more efficient means for DPS to understand their priority operational needs, rationalize funding, and engage domestic and international partners to sign on to the *contrat unique*.
- Domestic resource mobilization for health through ETD engagement in Lualaba and Haut-Katanga provides tangible examples of the potential for community-level appropriation and community-led sustainability of health services improvements.
- USAID IHP's close collaboration with the MOH, guided by USAID IHP's approach of promoting Congolese leadership through partnership and technical assistance, has improved engagement with health system actors at all levels and enabled the Program to position itself as a key and credible partner to the MOH.

- The reproduction and distribution of service delivery and data quality management tools are essential to the complete and timely submission of health service delivery data into DHIS2, LMIS, and other health information systems. The experience of decentralizing the activity to the provinces has yielded better results in terms of costs and delivery time.
- The ownership of InfoMed by the DPS and the ZS is essential for the improvement of stock visibility at the CDR, ZS, and FOSA levels as well as the improved planning and quantification of needs and better distribution of products at all levels.
- USAID IHP Supply Chain Advisors' field visits have revealed many challenges and low capacity related to the management of information by ZS managers. Logistics data are inconsistently collected and rarely used to make adequate logistics decisions. In FY21, supervisory visits, trainings, and pharmacists' reviews will focus on addressing these challenges. There will be a particular focus on data quality, promptness, and completeness.

5. OBJECTIVE 2

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

A new acceptor come for a specific counseling and insertion of Jadelle by a provider at the maternity of the General Reference Hospital of Dikungu, in Sankuru. (*Credit:* Abt Associates for USAID IHP) Photo taken before COVID.

- Supported training of **43 staff** on the application of DQI and conducted quality service delivery assessment of **81 health facilities** in three provinces
- Trained **664 health workers** on infection prevention and control for COVID-19 and EVD
- Launched **45 audio job aids** focused on iCCM and IPC best practices for health workers and assessed comprehension of key messages
- Supported the treatment of **5,365 survivors of sexual violence**
- Supported efforts to extend flat-rate pricing for health services in Sud-Kivu and Haut-Lomami and assessed implementation of flat-rate pricing for services in **34 health facilities** in Haut-Katanga and Sud-Kivu

In the PNDS 2019–2022, the MOH calls for each partner to help increase access to integrated, comprehensive, continuous, and quality health services at the health facility and community levels. Through Objective 2 activities, USAID IHP supports the MOH to increase quality service delivery for integrated, comprehensive, and continuous services through trainings and services at these levels.

In FY20, USAID IHP implemented various strategies for capacity building of service providers, including training in IMNCI, family planning, and malaria. The Program supported clinical placements and mentorship in hospitals and model health centers for maternal and newborn health. At the community level, USAID IHP strengthened services at iCCM sites and through *distributeurs de base communautaire* (community-based distributors), screened for malnutrition and TB cases, and directly observed therapy DOT in the community.

Most activities are described in Chapter 3 (Program Areas). With a few exceptions, this section of the report describes activities implemented in FY20 that are not linked to the indicators described in the Program Areas chapter.

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

Support Supervisory Visits of Executives from Specialized Directorates and Programs at the National Level to the DPS

Indirect: ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 2.4 ✔ 2.1.14 ✔ 2.1.15 ✔ 2.1.16 ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 2.1.26

In Q2, USAID IHP provided financial and technical assistance to the PNLP and PNLT at the national level to support the provinces. The PNLT conducted a supervisory visit to the Sankuru DPS to: (1) promote the optimal organization of TB case management in the Bena-Dibele ZS; (2) ensure that all screened TB and rifampicin-resistant TB (RR-TB) patients effectively started their treatment; and (3) actively search for TB and RR-TB cases among TB and RR-TB contact subjects. The PNLP conducted a supervisory mission in four provinces (Haut-Lomami, Lualaba, Sankuru, and Tanganyika). The purpose of the mission was to contribute to the improvement of malaria case management and treatment. The executives noted satisfactory compliance with the DOT with S/P strategy in the health facility they visited. Although planned for Q3 and Q4 in FY20, this activity could not take place due to COVID-19 travel restrictions. In early FY21, USAID IHP will organize supervisory visits of executives from the national level to the DPS.

Provide Support to Dissemination of Norms and Guidelines to the Different Provinces

Indirect: ✔ 12 ✔ 19 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.5 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 2.6 ✔ 2.7

As a result of the COVID-19 pandemic, in FY20 Q2, several MOH technical health area programs revised their guidelines for activity implementation. USAID IHP participated in review meetings with PRONANUT and shared with provinces the updated directives and national-level standards for service delivery that the WHO established for the following programs and interventions: the PEV, PNLT, PNLP, and the *Programme National d'Elimination du Choléra. et de Lutte contre les autres Maladies Diarrhéiques* or PNECHOL-MD (malaria and iCCM sites). In Q2 and Q3, USAID IHP, as part of its COVID-19 response, helped with the management and coordination of provincial meetings. USAID IHP also supported the

nine DPS in disseminating guidelines for COVID-19 care parameters that apply to MNCH, nutrition, RH/FP, TB, and malaria programs.

Provide Support to Implementation of the Integrated Quality Improvement Approach (DQI) to Identify Bottlenecks and Propose Solutions

Indirect: ✔ I8 ✔ I.1.1 ✔ I.2.1 ✔ I.2.2 ✔ I.4.3 ✔ 2.8

The MOH in DRC uses the *Demarche de Qualité Intégré* (DQI) tool for assessing quality of care at the health facility level. The tool is implemented as part of the DQI approach, which includes two components: (1) training staff on the DQI approach to improve the quality of services and entry of DQI data into DHIS; and (2) application of the DQI approach to identify the challenges and to develop relevant solutions to those challenges.

Training on the DQI Approach

In Q3, USAID IHP provided financial and technical support to Lomami and Sud-Kivu to train 24 people—17 ECDPS members, one IPS staff member, and six ECZS members from six ZS—on application of the DQI. This training enabled these two provinces to set up a pool of DQI trainers and supervisors. The DQI was implemented in six ZS in Lualaba Province. The assessment portion of the DQI covered the quality of services delivered by the evaluation and quality improvement teams (EEAQ) at BCZS and general referral hospitals and evaluation and quality improvement units at health facilities. USAID IHP field advisers served on these teams.

In Q4, USAID IHP provided financial and technical support to Kasaï-Central and Lomami to train 19 people—11 ECDPS members, five IPS staff members and three others—on application of DQI. This was followed by the organization of DQI workshops to improve the quality of care in health facilities according to MOH standards and guidelines). The Program conducted assessments in four ZS in Kasaï-Central and in five ZS in Lomami. As shown in Table 46, a total of 43 people were trained in FY20 Quarters 3 and 4 (40 men; three women).

Table 46. Number of health workers trained in IPTp with USG funds (Indicator 2.1.14)

Province	DPS		IPS		BCZ		Autres		Total		
	Men	Women	M	W	M	W	M	W	M	W	Général
Kasaï-Central	12	2	1	1	0	0	3	0	16	3	**19**
Lomami	2	0	1	0	6	0	0	0	9	0	**9**
Sud-Kivu	12	0	3	0	0	0	0	0	15	0	**15**
Total	**26**	**2**	**5**	**1**	**6**	**0**	**3**	**0**	**40**	**3**	**43**

Source: Project Monitoring Report

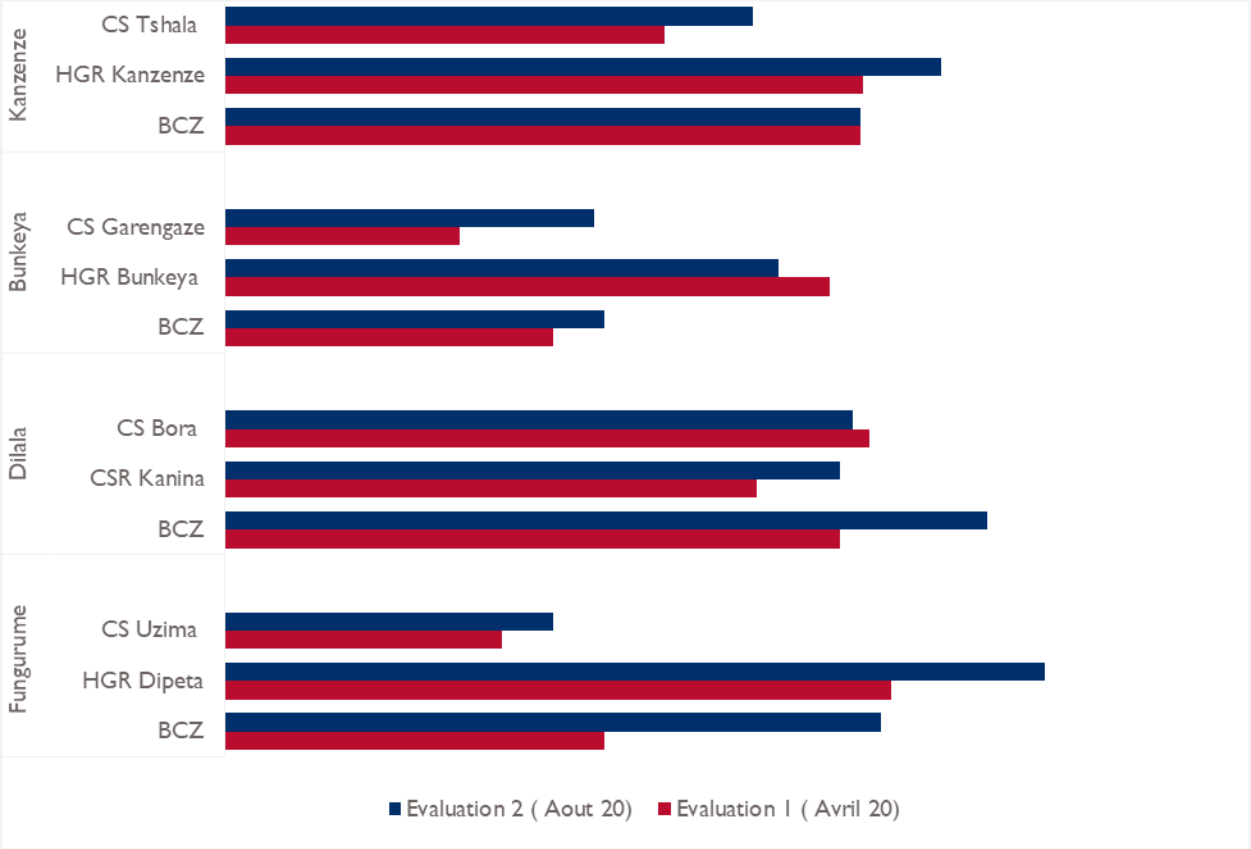
Identifying Challenges and Solutions through the DQI Approach

In Quarter 3, the DPS conducted assessments for a total of 18 facilities in six ZS in Lualaba: six health centers, six hospitals, and six BCZS. At the BCZS and hospitals, factors inhibiting the quality of service are insufficient human resources and inadequate governance and leadership (e.g., low numbers of meetings with minutes and poor follow-up on recommendations). The health centers also present major bottlenecks to quality service, especially low levels of community participation; poor management organization (e.g., absence of signs identifying services inside the health facilities); and non-compliance with care protocols. Overall, the evaluations showed good quality services in the six general referral hospitals, but health centers need to improve their quality of care. Following the assessments, the

evaluation and quality improvement teams developed improvement plans tailored for each health facility; after three months, the ZS management team will evaluate these improvement plans with support from the DPS team.

In Q4, USAID IHP supported the application of the DQI tool by the EEAQs in the ZS, HGR, and health centers in 63 structures in 17 ZS (17 BCZS, 18 hospitals, and 28 health facilities) in Kasaï Central, Lualaba, and Sud-Kivu. In Kasaï-Central and Sud-Kivu, it was the EEAQ's first evaluation, while in Lualaba it was the second. As shown in Figure 3, most structures improved their score for service quality.

Figure 3. Results from subsequent evaluations of the DQI application in 12 health structures (Lualaba Province) between April and August 2020 (X axis = percentage score out of 100)



Source: USAID IHP

Provided Training for Health Workers on Infection Prevention and Control (IPC) for COVID-19 and EVD

Indirect: ✔ 2.5

In FY20, to ensure staff and community protection against infections, especially in the context of COVID-19 and EVD, USAID IHP supported a series of IPC trainings (including the use of IPC kits) in all nine provinces. As shown in Table 47 below, a total of 664 health workers were trained (184 women and 480 men), with Sud-Kivu having the most number of providers trained, followed by Kasaï-Oriental. These nurses, doctors, hygienists, and RECOs were primarily from frequently visited health facilities. Analysts from the DPS *Bureaux d'Hygiène et Salubrité Publique* (Hygiene and Public Health Offices)

facilitated. Participants learned IPC techniques to reduce the risk of infections associated with health care. USAID IHP distributed IPC materials to 189 health facilities in eight provinces (distribution in Sankuru occurred in Q4). IPC materials included headgear, infrared thermometers, medical gowns, plastic aprons, plastic boots, household gloves, surgical gloves, masks, protective glasses, garbage bins, wheelbarrows, safety shoes, rakes, spades, and decontamination containers.

Table 47. People trained in IPC, by province, health provider category and gender

Health provider categories	K-C		K-O		LOM		SAN		H-K		H-L		LUA		TAN		S-K		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Doctors	1	5	0	0							1	8	1	1	0	6	1	5	4	25
Nurses	26	54	18	94	12	49	2	22	11	14	8	32	9	35	24	36	38	73	148	409
Lab technicians	0	0	0	0	0	0	0	0	0	0	0	0	3	10	0	2	0	0	3	12
RECO	0	0	0	0	0	0	0	0	0	0	0	0	11	15	0	0	0	0	11	15
Hygienists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	13	0	0	15	13
Pharmacists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Admin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	5	0	0	3	5
Subtotals	27	59	18	94	12	49	2	22	11	14	9	40	24	61	42	63	39	78	184	480
Total	**86**		**112**		**61**		**24**		**25**		**49**		**85**		**105**		**117**		**664**	

Source: Project Monitoring Report

Lessons Learned

- The consistent application of the DQI tool in the health facilities helped providers identify the obstacles to improved quality services; the regularity of the evaluation exercise was important in helping the ZS improve service quality.
- IPC training for COVID-19 reinforces the importance of IPC overall in the health facilities.
- The creation of hygiene committees in the hospitals benefits IPC, as it helps ensure local sustainability of the response.

CBD training, Kasaï-Central. Source: Abt Associates for USAID IHP. Photo taken before COVID.

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

Launched Module of Audio Job Aids Focused in iCCM and IPC

Indirect: ✔ 2.1.1 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 2.1.14 ✔ 2.1.15 ✔ 2.1.16 ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 2.1.26 ✔ 2.1.26

Because Viamo is a consortium partner on USAID IHP, the Program is leveraging Viamo's 42502 nationwide service to support frontline workers by providing access to on-demand job aids. Audio job aids are audio recordings that are accessible by calling Viamo's 42502 service. When they access the platform, health workers across the country can review training materials and take comprehension quizzes for free by using a Vodacom subscriber identity module (SIM card). USAID IHP developed 30 of these messages in FY20 with 15 audio job aids for iCCM launched in Q1 and 15 others on IPC, launched in Q2. As messages were uploaded on the service, the DPS in the provinces where USAID IHP focuses its activities were made aware of the information's availability and were tasked to disseminate the information across the ZS and *aires de santé.*

To encourage health workers to call back into the service month after month, every month a "best practice of the month" message was also featured on the 42502 service. A total of 6,622 calls were made to the 42502 service between July and September 2020 to access the audio job aids content. USAID IHP included a comprehension quiz at the end of each audio job aid message to measure how well health workers understood the IPC procedures. Quiz scores averaged around 48 percent, so USAID IHP analyzed the comprehension questions and suggested ways to improve impact, including better translations for technical words in Kikongo and Tshiluba, more concise messages to help with retention, and addition of key messages in quiz questions to improve scores. Please see Objective 3 for more details about the listening clubs that are using the 42502 service.

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

Developed the Referrals Tracking mHealth App

Indirect: ✔ 2.3.1 ✔ 2.3.3

In FY20, the Program developed the digital mHealth referral tracker (mReferral) to collect data on patients referred from SSCs to health facilities and the number of patients who arrived at the referred facility, coordinate transfers for emergency cases, and facilitate timely reporting. Following the field visit carried out in February and March 2020 in Haut-Katanga and in Tanganyika and based on the pilot conducted with users of the mReferral tracker, USAID IHP continued efforts in refining the user interface and functionality of the system. These efforts focused on finalizing the system's functionality, which will allow agents at RECO sites to request help from their supervisors when needed through a "contact" option.

The next steps in making the mReferral system operational are procurement of a shortcode from the Communications Authority for SMS-based communications as part of the referral system, more testing of the tracker's new functionalities with end-users, and the training of additional users in the provinces.

Although domestic travel has resumed in the DRC, the Program is considering options to use a remote training model for this activity due to the COVID-19 pandemic.

Provided Community Based Organizations with Guidance for Disseminating Messages on Identification of Danger Signs and Criteria for Referral

Indirect: ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 ✔ 14 ✔ 19 ✔ 2.6 ✔ 2.7 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 2.2.2 ✔ 2.2.3 ✔ 2.3.1 ✔ 3.1.1 ✔ 3.2.2

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

In Q2, to engage the community in the fight against child and maternal mortality. USAID IHP provided technical and financial support for training 103 community actors and leaders, including 54 men and 49 women, in Haut-Katanga. The community leaders include pastors, clergymen, teachers, local political authorities, and RECO. All were trained on danger signs and referral criteria for children under 5 and for pregnant women. Trainees then raised awareness about these danger signs in their communities.

In Q3, in Tanganyika and Haut-Lomami, those trained visited 1,239 households and reached 7,018 people, including 4,095 women. The trained community members identified 74 children under 5 and pregnant women with danger signs and referred them to health facilities. In Q4, USAID IHP supported the training of 376 people (224 men and 152 women) in Haut-Katanga and Sankuru Provinces. In Sankuru, those trained visited 650 households and reached 3,967 people. The trained community members identified 16 people with danger signs and referred them to health facilities. In Sud-Kivu, USAID IHP reproduced 212 flipcharts to disseminate messages in 106 villages in 15 ZS.

Lessons Learned

- Awareness-raising of danger signs at the community level allows community members to be able to identify them and to refer possible cases early to a health facility, which helps contribute to the reduction of infant mortality.

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

Organize Training for Providers on Provision of Youth and Adolescent-friendly Services

Indirect: ✔ 2.4.2

In Q3 USAID IHP supported the *Programme National de Santé des Adolescents* (PNSA, National Adolescent Health Program) to train clinical providers on adolescent and youth sexual and reproductive health. This activity took place in Haut-Katanga (5 health facilities in one ZS), Kasaï-Oriental (21 health facilities in three ZS), and Lualaba (12 health facilities in one ZS), for a total of 38 health facilities supported. A total of 59 clinical providers, including 23 women, took part in the training in Q3. In Q4, a total of 20 clinical providers (14 men and six women), took part in the training and represented 18 health facilities in the Kananga ZS in Kasaï Central. The training used a competency-based approach to

improve attitudes and interpersonal communication skills of providers caring for adolescents and young people at health facilities and in the community.

Train Young Peer Educators for Adolescent and Youth Sexual and Reproductive Health Services

Indirect: ✔ 2.4.2

In Q2, USAID IHP supported the organization of a training on *Santé sexuelle et reproductive des adolescents et des jeunes* (SSRAJ, sexual and reproductive health for youth) for 18 young adolescents, (4 men and 14 women), in coordination with the *DPS Programme des Jeunes et Adolescents* in Lualaba ZS. The objective of this activity was to educate young people and adolescents on sexual and reproductive health issues. In Q3, in Kasaï-Oriental, USAID IHP supported communications training of 47 peer educators of adolescents and young people, including 27 women, in four ZS. This activity impacted 20 health facilities, five per ZS. In Q4, USAID IHP supported the PNSA's peer educator trainings for a total of 75 people (33 men; 42 women) in 38 health facilities in two ZS in Haut-Katanga and Kasaï-Central (respectively). The PNSA provided this training to strengthen peer educators' understanding of the stages of an educational talk and the characteristics of adolescence and adolescent development, while increasing their sensitivity to the needs of their peers and giving them more information on adolescent and youth sexual and reproductive health.

Conducted SGBV Training for Health Workers

Indirect: ✔ 2.4.3

In FY20, USAID IHP collaborated with the PNSR to provide technical and financial support to five DPS—Haut-Katanga, Sankuru, Lomami, Kasaï-Oriental, and Kasaï-Central—to establish a pool of locally based trainers in sexual- and gender-based violence (SGBV), positive masculinity, and gender integration at the DPS. The Program then supported SGBV training for health providers in the same provinces. By the end of FY20, USAID IHP established 10 fully trained officials from the DPS in Haut-Katanga, including three women. The Program also provided the trained trainers with teaching materials—including post-exposure prophylaxis (PEP) kits, mirrors, combs, and envelopes—to facilitate training in the ZS. Due to limited funds, there were insufficient materials and trainers, which slowed the extension of these activities to other sites in the DPS and ZS.

In FY20, the Program enabled SGBV training of 150 providers (including 50 women) across 19 ZS in the DPS of Lomami (nine women and 17 men), Haut-Katanga (21 women and 23 men), Kasaï-Central (three women and 22 men), Kasaï-Oriental (seven women and 19 men) and Sankuru (10 women and 20 men). SGBV training focused on psychosocial and gender-informed care. SGBV training not only reinforced provider capacity for service provision in this field, but has also helped ensure documentation of SGBV cases at the health facility level.

Although some women participated in the provider training, inadequate attention to the gender balance in provider selection poses a potential issue. This could have a negative impact in the clinical and psychological care and the availability of data collection and clinical care tools for direct SGBV care at the health facility level. To meet this challenge, the Program is in the process of developing a strategy to: (1) conduct a landscape assessment of SGBV stakeholders at the provincial level that prioritize gender equity and women's participation; (2) provide technical and financial support to the capacity building of non-governmental organizations (NGOs) and community-based organizations (CBOs) on SGBV; (3) set

up and train a network of champions for gender promotion; (4) support the ZS in the analysis of SGBV data at monitoring meetings; and (5) conduct advocacy with the PNSR and other partners to procure PEP kits in the ZS.

In FY20, USAID IHP noted more reported cases of sexual violence in Sud-Kivu. A total of 5,365 survivors of sexual violence benefited from treatment in health facilities, out of the 4,324 targeted for the province. Performance for indicator #2.1.27 followed a positive trend from Q1 to Q4 in FY20 and brought the achievement rate to 124.1 percent of the Program's annual target.

Table 48. Number of women treated for gender-based violence (#2.1.27)

Region	Province	2019	Q1	Q2	Q3	Q4	Achieved	Target (%)	Achievement rate (%)
Eastern Congo	Sud-Kivu	372	907	1,318	1,525	1,615	5,365	4,324	124.1

Source: Routine data from HMIS

Several activities contributed to this indicator's strong performance:

- Landscape assessment of health facilities that treat cases of sexual violence with fistula complications in Kaziba ZS.
- Awareness-raising campaign on women's rights and socio-cultural barriers that limit access to health care for rural women in Walungu, highlighting the benefits of early use of health facilities for women who are victims of rape.
- Supply of PEP kits by the Global Fund/BDOM/Cordaid HIV Programme in Sud-Kivu.
- Transport of PEP kits from the central PNSR office to ZS with USAID IHP financial support.

In FY21, the Program's planned SGBV activities are to:

- Assess the current state of SGBV workers at the provincial level to have information on the extent of interventions that support survivors of violence before forming the training pools.
- Establish a pool of trainers on GBV at the provincial level, focusing on positive masculinity and gender integration. Implementation will follow the two-day training at the provincial level.
- Support provider training and post-training on the medical and psychosocial management of survivors of SGBV. ZS providers targeted after the initial assessment will be trained by the pools with support from the national level, followed by a post-training follow-up within three months.
- Provide technical and financial support for the capacity building of NGOs and CBOs on SGBV. Local facilitators (members of local NGOs, CBOs, and RECOs) will be trained on the topic to ensure awareness.
- Ensure the availability of PEP kits and other SGBV inputs in collaboration with other partners working in the target provinces.

Data analysis and validation training, Lomami. Source: Abt Associates for USAID IHP. Photo taken before COVID.

IR 2.5: INCREASED AVAILABILITY OF INNOVATIVE FINANCING APP

Disseminate the Flat Rate Pricing Strategy (*tarification forfaitaire*)

Indirect: ✔ 2.5.1

In support of DRC program policies and strategies for innovative financing, USAID IHP systematically identifies opportunities to raise awareness of the health system's unsustainable dependency on external resources. In Quarters 2 and 3, USAID IHP supported efforts to extend flat-rate pricing for health services in Sud-Kivu and in Haut-Lomami, which was piloted during monthly review meetings. At the end of these missions, the health facilities that were visited posted rates for care and services; COGE members were made aware of the posted rates; and guidelines were made available to members of the ZS management committees, who were mobilized to broadly disseminate the flat-rate pricing to CACs and CODESA. In Q4, USAID IHP assessed the implementation of flat-rate pricing for services in 34 health facilities (10 HGR and 24 CS) in 10 ZS in Haut-Katanga and Sud-Kivu. The objectives were to: (1) evaluate the level of execution of the recommendations since the last supervision visit from the provincial level; (2) determine the impact of the application of the flat-rate pricing based on the use of health services in health facilities during the first half of 2020; and (3) identify bottlenecks for the implementation of the flat rate and the management of resources.

With USAID IHP financial and technical support, the MOH conducted an evaluation of earlier activities to document the application and the effects of the flat rate on the functioning of health facilities with a view to reframing the national strategy. While the *tarification forfaitaire* is the national strategy for flat-

rate pricing of services provided at the community level, the application of the strategy faces a number of obstacles in the health system, including:

- Drugs are frequently out of stock in health facilities.
- Costs are often fixed in a unilateral fashion—the community is not involved in determining/setting the costs.
- Pharmacy revenue is not collected as part of the flat-rate pricing package, and almost all revenue goes toward staff bonuses.
- Flat-rate pricing is expensive compared to the previous rates and is not applicable for the entire population; certain communities still favor traditional healers.
- Private structures offer the same services at a lower cost than the services proposed in the negotiated pricing.

Strengthened Existing Health Insurance System (*Mutuelles de santé*)

Indirect: ✔ 2.5.1

In FY20, Q2, USAID IHP supported an exploratory visit to the Kilwa ZS, identified four *mutuelles de santé,* and assessed their needs for capacity-building support. The four *mutuelles* identified were: (1) ADAM, an exclusive *mutuelle* fund for general referral hospital workers; (2) UMOJA in Dubie's *aire de santé*; (3) Kilwa Teachers' *mutuelle;* and (4) a *mutuelle* fund for the disabled.

In Q3, in Haut-Katanga, USAID IHP supported a baseline assessment of the teachers' *mutuelle* organization in the Ruashi ZS, headquartered at the Patient Kiwele High School in the city of Lubumbashi. The biggest challenge for proper functioning of this health insurance organization is irregular contributions from members. USAID IHP identified the need to support training for members and awareness-raising among the population on risk-sharing to make the *mutuelle* viable.

In Q4, in USAID IHP supported the Haut-Katanga DPS in conducting a knowledge, attitudes, and practice (KAP) survey on the existing *mutuelles* in the Kilwa and Ruashi ZS to define the elements of viability. The survey results show that households give their lack of financial resources as the main reason for their non-participation in a *mutuelle*. Other factors relate to the poor quality of care provided, distrust of health personnel, and previous negative experience. There is also distrust toward those in charge of the *mutuelles*, the lack of information regarding membership terms and contributions, and lack of information on the package of services that the *mutuelles* offer.

The next step will be to share the results of the KAP survey with other stakeholders (ECZ of Kilwa and Ruashi, *mutuelles de santé,* and DPS), with the goal of reinforcing these *mutuelles* going forward.

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

Rehabilitated WASH Facilities in Communities

Direct: ✔ 2.6.2 **Indirect:** ✔ 2.6.3

Over the course of FY2020, USAID IHP technical assistance provided 5,358 Congolese people (including 2,968 women) with access to basic drinking water services, as shown in Table 49. This result represents 107.2 percent of the annual target.

Table 49. Number of people gaining access to basic drinking water services as a result of USG assistance (#2.6.2)

Region	Province	Q1	Q2	Q3	Q4	Achieved FY2020	Target (%) FY 2020	Achievement rate (%)
Eastern Congo	Sud-Kivu	0	0	0	5,358	5,358	5,000	107.2

Source: Collected through Project Monitoring Reports as the Household Survey could not capture the information as defined.

Provided Support to Communities to Build and Improve Family Latrines and Handwashing Stations in Targeted ZS

Direct: ✔ 2.6.3

As shown in Table 50, USAID IHP support also ensured that 1,803 Congolese people, including 925 women, now have access to basic sanitation services, an achievement rate of 193.9 percent of the annual target.

Table 50. Number of people gaining access to a basic sanitation service as a result of USG assistance (Indicator 2.6.3)

Region	Province	Q1	Q2	Q3	Q4	Achievements FY2020	Target (%) FY 2020	Achievement rate (%)
Eastern Congo	Sud-Kivu	0	0	0	1,803	1,803	930	193.9

Source: Collected through Project Monitoring Reports as the Household Survey could not capture the information as defined.

In total, USAID IHP supported the establishment or rehabilitation of 273 latrines in seven target villages in the health zones of Katana (AS Kabamba) and that of Miti-Murhesa (AS Lwiro) in Sud-Kivu.

Lastly, during FY20, USAID IHP successfully facilitated health facility selection, trainings, self-assessments, and WASH improvement plans in 87 health centers in Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central through the clean clinic approach. In FY21, USAID IHP will build on this foundation by renovating or constructing basic sanitation infrastructure (Indicator 2.6.4).

See Program Areas chapter, WASH for more details.

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

In FY20, USAID IHP supported the following routine meetings to share knowledge and best practices among USAID, the MOH, and other implementing partners, across program areas: the CTMP-PF

(national and provincial levels), malaria task force, TB meetings, IMNCI coordination meetings, and nutrition partner meetings. Below is a summary of key meetings supported in FY20, as well as several other meetings (joint USAID and USAID IHP; USAID and other implementing partners; and national conferences and fora).

Participated in Meetings, Workshops, and Reviews of Specialized MOH Programs

Indirect: ✔ 2 ✔ 3 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.4 ✔ 2.6 ✔ 2.7 ✔ 2.1.1 ✔ 2.2.1 ✔ 2.4.2 ✔ 2.1.14 ✔ 2.1.15 ✔ 2.1.16 ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 2.1.26 ✔ 2.1.26 ✔ 2.7.1

Provided Financial Support to Activities of the CTMP-PF

In Q1, as part of its support for the CTMP-PF, USAID IHP provided technical and financial support to the Fourth National Conference to Reposition Family Planning. The conference supported the objective of recruiting 120 million new users of modern contraceptive methods. The GDRC committed to family planning as part of its development strategy and set a budget line item for the 2019-2020 fiscal year at the national and provincial levels. International donors and partners also committed to providing additional funding to enable the DRC to reach its FP objectives.

In Q2, all provinces except for Haut-Lomami shared the recommendations from the conference. USAID IHP provided technical and financial support for organizing monthly meetings of the CTMP-PF in the supported provinces. In Q3, CTMP-PF in Kasaï-Central, Kasaï-Oriental, Lomami, Haut-Katanga, Lualaba, and Tanganyika held monthly meetings. The monthly meetings are an ideal format for coordinating FP activities, encouraging contributions from various stakeholders to boost FP activities in the province, ensuring availability of contraceptives during COVID-19, and identifying strategies for improving modern contraceptive prevalence in the DPS.

In Q4, the CTMP-PF committee was established in the Haut-Lomami province. In addition, five provinces organized CTMP-PF meetings: Haut-Lomami, Sankuru, Kasaï-Oriental, Tanganyika and Sud-Kivu. USAID IHP also provided support for the evaluation of the Fourth National Conference to Reposition Family Planning, preparations for evaluating the DRC's 2014–2020 national strategic plan for FP, and development of the new 2021–2024 strategic plan.

Lessons learned: increased knowledge of strategies for engaging religious and community leaders in FP; use of FP as a "Demographic Dividend" strategy in the DRC6; expansion of FP stakeholders; and increased contraceptive prevalence in Kasaï-Oriental despite the COVID-19 pandemic.

Support Technically and Financially the TB / HIV Task Force Quarterly Meetings

In FY20, USAID IHP provided technical and financial support for the quarterly organization of the TB/HIV task force meetings in the target provinces to help maintain provincial-level coordination of TB/HIV co-infection cases between the TB and HIV programs to ensure synergy across these interventions.

In Q1, the Kasaï-Central TB/HIV task force meeting was attended by 20 people including 13 men and seven women representing six partner organizations (USAID IHP, Cordaid, Union Congolaise des

[6] On July 18, 2018, in a State of the National address, President Kabila made a strong statement in support of family planning: "It is urgent to work now on controlling the demographic growth by implementing a bold policy for family planning, which will allow us to fulfil our demographic dividend for the integrated growth of our country." Source: Advancefamilyplanning.org

Organisations des Personnes vivant avec le VIH (UCOP+), Congolese Union of Organizations of People with HIV), Hope for Life (EPVI), Food for Peace, and the Programme National Multisectoriel de Lutte contre le Sida (PNMLS, National Multisectoral AIDS Control Program). A quarterly meeting of the TB/HIV task force was also held in Kalemie in Tanganyika. In Sud-Kivu, the TB/HIV task force meeting was attended by 30 people, including 22 men and eight women.

In Q3, in Kasaï-Central, Lomami, Lualaba, and Sankuru, USAID IHP provided technical and financial support for a TB/HIV collaboration meeting between PNLT and the PNLS, convened quarterly by the DPS and attended by other MOH partners. Meeting participants discussed evaluation of recommendations from the previous meeting and of joint TB/HIV activities in the ZS, drug inventory levels, and the development of an improvement plan.

In Q4, all provinces except Haut-Lomami organized TB/HIV task force meetings. The focus of these meetings was the evaluation of TB performance and the identification of causes and factors for underperformance. The following lessons learned were discussed:

- The low detection of TB cases is multifaceted and requires synergistic interventions of several partners working in the province.
- Issues with sample transport for suspected MDR-TB remain a major cause of poor screening for TB.

Inability to hold monitoring meetings for diagnosis and treatment health centers (*centres de diagnostic et traitement*, CSDTs) decreases the motivation of CSDT providers.

Support IMNCI Coordination Meeting

In Q4, USAID IHP supported two IMNCI coordination meetings where the MOH and its partners discussed the post-Barcelona forum road map, which focuses on pneumonia in children and the repositioning of IMNCI as a strong advocate for child health.

National Malaria Control Program

In FY20 Quarter 1, USAID IHP participated in the costing workshop on malaria interventions, finance and gap analysis in Kisantu, and the 2019-2023 Malaria Strategic Plan validation workshop. In Quarter 2, USAID IHP implemented the following meetings and events related to malaria:

- A workshop to finalize the 2020-2023 PNLP Strategic Plan.
- A training on the electronic version of the Outreach Training and Support Supervision (OTSS) tool in Lubumbashi.
- A conference call with PMI's Impact Malaria (headquarters and DRC teams) on the clinical portion of the Health Network Quality Improvement System tool and technical support to adapt the clinical portion of this document to the context and language for use.
- A briefing session with the Haut-Katanga Provincial Multipurpose Team on the key elements of supervising health facilities on malaria control.
- Provider training on the malaria package in Mulongo ZS by introducing the malaria reduction process at the *aire de santé* level. This is already being promoted in some provinces supported by USAID IHP. (See Chapter 3, Malaria, for more on the malaria reduction process).

A mother and her child after curative care at Olenga health center. Source: Abt Associates for USAID IHP. Photo taken before COVID

In Quarter 4, USAID IHP provided financial and technical support to the activities of the malaria working group in collaboration with PMI's Impact Malaria. USAID IHP also provided financial and technical support to a workshop that focused on revising the PNLP's norms and directives.

Nutrition Program

USAID IHP staff at the national and provincial levels participated in three nutrition coordination meetings in Quarters 3 and 4. The objective of these meetings was to ensure coordination and monitor implementation of activities at the provincial level.

Joint Technical Meetings USAID and USAID IHP

In Quarter 2, USAID's and USAID IHP's management teams recommended joint technical meetings to strengthen coordination and communication between the two teams. The meetings would help USAID IHP anticipate details about questions arising from the quarterly report, and obtain strategic and technical guidance from USAID on implementation of interventions and planning for FY2021. In Quarter 3, USAID IHP organized joint technical meetings for MNCH, gender, RH/FP, nutrition, WASH, and TB. These meetings included regular updates on activities to combat COVID-19. Actions taken included bi-monthly monitoring of 10 quality indicators for TB interventions and development of targets for MNCH and WASH indicators. In Quarter 4, the main goal of the joint technical meetings was to identify and discuss relevant activities to include in the FY21 workplan. The availability of FP/RH and malaria supplies/materials were also topics of discussion. The joint technical meetings helped enormously in facilitating the workplan process and the understanding of activities proposed for FY21. USAID approved the workplan before the end of September.

Joint Technical Meetings IHP and Other USAID Partners

To improve activity coordination, USAID held the following meetings with USAID implementing partners and other partners at the national and provincial levels:

- **USAID implementing partners:** Measure Malaria, Impact Malaria, *Programme de Développement d'Assistance Alimentaire*, DFAP of Catholic Relief Services, Food for the Hungry, Mercy Corps, GHSC-TA, Breakthrough Action; Fistula Care, Advancing Nutrition, International Red Cross.
- **Other partners**: PDSS, E2A, UNICEF, Jhpiego, Cordaid, religious organizations, and for-profit private organizations.

Joint technical meetings with the partners helped to leverage efforts; avoid duplication of interventions on the ground; and improve synergies in program implementation. Some examples include: (1) rationalization of fees for supervision activities for vaccination in Kasaï-Oriental and Lomami, which are also financed by UNICEF; (2) rationalization of fees for monitoring certain aires de santé financed by Food for the Hungry in Tanganyika Province; and (3) coordination of FP commodities between E2A and USAID IHP to avoid stockouts. USAID IHP also put in place a nutrition consultation framework with Food for Peace for better coordination of nutrition, FP, and WASH activities (once per quarter in Sud-Kivu and during Quarter 1 in Tanganyika) and WASH activities (once per quarter in Sud-Kivu and Quarter 1 in Tanganyika).

Provided Technical and Financial Contribution to Every Newborn Action Plan (ENAP) Based on November 2019 Forum Recommendations

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

In Quarter 1, the program provided technical assistance through participation in the first National Resource Mobilization Forum for the ENAP in November. The Forum was attended by 56 people (13 women and 43 men), including political and administrative authorities, civil society organizations, implementing partners and donors, DPS and IPS executives, and health service providers. Delegations from the provinces (government, parliament, DPS) participated alongside their national-level counterparts to advocate for the mobilization of MNCH funds. In Quarter 2, USAID IHP provided technical and financial assistance for Sud-Kivu's Provincial Forum on resource mobilization for implementing the ENAP. Although USAID IHP planned to support four provinces, only Sud-Kivu was able to hold this activity. The other three (Lomami, Lualaba, and Haut-Katanga) were unable to organize a forum due to scheduling conflicts with the political decision-makers. The forum served as an important opportunity to gain the buy-in of decision-makers and partners in the fight against neonatal mortality and to integrate neonatal health activities in the PAO.

Participate in Monitoring and Evaluation Meetings for the Kinshasa Declaration (vaccination):

In Quarter 2, USAID IHP participated in a workshop on the development of the immunization system strengthening plan, organized by the Sankuru DPS with the support of VillageReach in Sankuru province. The workshop focused on assessing the supply chain and improving the availability of vaccines and immunization inputs, an appropriate solution to improve PEV-related logistics in this part of the province. In Quarter 4, USAID IHP supported meetings in Tanganyika, Sankuru, and Sud-Kivu to follow up on vaccination activities related to the Kinshasa Declaration.

Supported the Congress of the Congolese Society of Gynecology and Obstetrics

In FY20, USAID also IHP provided financial support to the Congolese Society of Gynecology and Obstetrics, which aims to improve healthcare by evaluating the quality of gynecology-obstetrics care and services and disseminating WHO guidelines. This support strengthens collaboration between the Program and technical specialists in maternal health.

6. OBJECTIVE 3

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

VIVA campaign activity, Haut-Katanga. (*Credit:* Abt Associates for USAID IHP) Photo taken before COVID.

- Celebrated World Pneumonia Day, World Toilet Day, International Women's Day and World Malaria Day
- Held **112 mini-campaigns** across all nine provinces, which raised awareness of **927,240 people** (575,214 women and 352,214 men) and referred **198,604 people** to health services.
- Collaborated with Breakthrough Action on design and launch of VIVA Campaign.
- Led workshops for translating COVID-19 awareness materials into local languages in nine provinces.

During FY20, USAID IHP supported the implementation of awareness-raising strategies aimed at encouraging the adoption of health-promoting behaviors and the use of services in target health facilities. The Program supported these activities in all nine provinces, in combination with activities related to improving the supply and delivery of quality health services. This approach consisted of the joint design and implementation with Breakthrough Action of the VIVA Campaign (formerly Health Family Campaign) which guides the Program's overall social and behavior change activities. These integrated approaches included: the celebration of international health days; the organization of mini-campaigns, and community forums, the organization of awareness-raising campaigns against the EVD and prevention of COVID-19, organizing focus groups and leveraging influencers to address barriers to healthy behaviors, the strengthening of collaboration with civil society organizations. The Program also continued to build networks among groups of people committed to the promotion of rights for women and girls, and gender equality.

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

During FY20, USAID IHP supported the implementation of awareness-raising strategies aimed at encouraging the adoption of health-promoting behaviors and the use of services in target health facilities. The Program supported these activities in all nine provinces, in combination with activities related to improving the supply and delivery of quality health services. This approach consisted of the joint design and implementation with Breakthrough Action of the VIVA Campaign (formerly Health Family Campaign) which guides the Program's overall social and behavior change activities. These integrated approaches included: the celebration of international health days; the organization of mini-campaigns, and community forums, the organization of awareness-raising campaigns against EVD and prevention of COVID-19, organizing focus groups and leveraging influencers to address barriers to healthy behaviors, the strengthening of collaboration with civil society organizations. The Program also continued to build networks among groups of people committed to the promotion of rights for women and girls, and gender equality.

Provided Technical and Financial Support to Advocacy and Celebrations of World Days or National Days

Direct: ✔ 3.1.1 **Indirect:** ✔ 4 ✔ 5 ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 2.3.1 ✔ 2.3.2 ✔ 2.6.3 ✔ 2.6.4 ✔ 3.1 3.2 ✔ 3.1.1 ✔ 3.2.2 ✔ 3.4.1

As a part of an ongoing effort to increase awareness about health and disease risks, link people to services and engage the community, USAID IHP continued to support the celebration of world days and national day events and activities.

World Pneumonia Day

USAID IHP, along with other donors, provided technical and financial support for World Pneumonia Day organized under the theme "Fighting Pneumonia and Saving a Child." USAID IHP provided financial support to the MOH through the directorate of the *Programme National de lutte contre les Infections Respiratoires Aigues* (PNIRA, National Program for the Fight against Acute Respiratory Infections). Additionally, USAID IHP sent push voice messages on behalf of the MOH to promote World Pneumonia Day. The Program provided technical and financial support to celebrations in ZS in Sankuru. Awareness campaign activities focused on pneumonia prevention measures. In total, nurses conducted 480

household visits, 12 focus groups, and four public awareness-raising sessions. The campaign reached 1,969 people, including 1,175 women and 794 men.

Listening Clubs Spread Community Health Messages

In Tshimayi, 20 community members get together each week to call the 42502 phone service. Listening over speakerphone, they get important public health messages about the importance of vaccinations, maternal health, and, recently, prevention measures for COVID-19. This listening club—one of 18 in Kasaï-Central province—then spreads the messages to their own communities, informing their friends, families, and neighbors about the week's topic.

"The listening club has changed us and our entire community," said Bernadette Kapinga, a member of the Tshimayi Listening Club. "Previously people did not observe protective measures against COVID-19. However, things have changed as we go to teach communities about different ways of protecting themselves. One of the most noticeable behavior changes is that previously, families washed all their hands in one bowl before eating but now they line up and use running water for handwashing."

Available anywhere in the country, this phone service provides important health information in clear terms, all in Tshiluba, one of the country's four national languages. Because of their success in changing health behavior in their communities, USAID IHP will establish 60 new listening clubs in other provinces in 2021.

World Toilet Day

USAID IHP provided technical and financial support to the celebration of World Toilet Day in four provinces under the theme "Act and Leave No One Behind." In Kasaï-Central, the Program supported three DPS led advocacy meetings for the MCZS and heads of various departments of the General Referral Hospital. In Lomami, local political and administrative authorities, traditional chiefs, and heads of educational institutions committed to supporting ZS and DPS efforts to build hygienic toilets and end open defecation. USAID IHP helped the ZS organize three awareness days to promote hygienic toilets. RECO conducted 1,614 household visits, reaching 608 people, and as a result, households built 159 hygienic latrines and made structural improvements to 104 toilets. In Sankuru two DPS managers, four members from the ZS management team, four nurses from targeted hospitals, and 14 RECO led health education sessions in health facilities and advocated for the facilities to build and rehabilitate hygienic latrines. RECO reached a total of, 1,124 people (599 women and 525 men) and organized 14 guided visits to model households to raise awareness of the importance of building latrines and using them in a hygienic manner. In Sud-Kivu, USAID IHP provided technical support for a ceremony where political and administrative authorities and the DPS encouraged the community to get involved in raising awareness for the construction of hygienic latrines.

International Women's Day

On March 8, 2020, the DRC celebrated International Women's Day. The program technically and financially supported the celebration in Haut-Katanga and Sud-Kivu. Key topics of discussion included women's issues related to access to reproductive health care, women's economic empowerment, child marriage, and the main innovations introduced into the Family Code in the DRC. More than 548 people participated (436 women and 112 men). Students from participating schools asked the Bourgmestres to facilitate the return of young mothers to school. In Sud-Kivu, the provincial *Ministère du Genre, Famille et Enfant* (MGFE, Minstry of Gender Family and Children) facilitated discussion forums on promoting

respect for gender equality and the harmful consequences of gender-based violence and the low rate of use of maternal and child health services. They were attended by 124 participants.

World Malaria Day

The DRC celebrated World Malaria Day under the theme "Zero Malaria Starts with Me." The Program technically and financially supported the celebration in five provinces: Haut-Katanga, Haut-Lomami, Kasaï-Central, Lualaba, and Sankuru. Celebrations took place in two phases: the first included the official kick-off by local political and administrative authorities; the second included an awareness campaign and referral of cases to health facilities and iCCM sites. In opening remarks, local political and administrative authorities (Bourgmestres and Territorial Administrators) insisted on prevention of malaria especially for the most vulnerable groups: pregnant women and children under 5. They issued a call to action for using ITNs, RDTs, and intermittent preventive treatment (IPT) for pregnant women and urged care-seeking for fever, especially for children under 5. Across the five provinces, the awareness campaign sensitized a total of 106,826 people. The Program supported the DPS and the ZS to brief RECO and deploy them into communities, where they conducted household visits to pregnant women and referred them to health facilities. Among women reached, 1,276 attended ANC visits and received S/P. The campaign also referred 1,864 children under 5 with fever to the health centers, where 1,452 tested positive for malaria and received treatment.

Supported Technically and Financially the Organization of World Breastfeeding Week

Indirect: ✔ 3.1.1 ✔ 3.2.2 ✔ 3.3.1

The DRC celebrated World Breastfeeding Week under the theme "stronger with breast milk only." The program technically and financially supported the celebration of this day across all nine provinces. The launch of the celebration was made by the Health Minister in Kinshasa and the provincial ministers in their respective provinces. In their addresses, authorities emphasized the cognitive and health benefits of breastfeeding for infants and their mothers. A strong appeal was made to the community to support these efforts. There were 639,972 people sensitized, including 422,719 women and 217,253 men. The Program supported the DPS and ZS to brief the RECO on the merits of exclusive breastfeeding and the techniques of communication so they could sensitize pregnant women in maternities and hospitals. RECO then encouraged 13,568 pregnant women and 9,568 breastfeeding women to breastfeed their children exclusively for six months.

Restarted and Continued Implementation of the Community Champions Model

Direct: ✔ 3.1.1 ✔ 3.1.2 **Indirect:** ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 2.4 ✔ 2.5 ✔ 2.1.2 ✔ 3.2.2 ✔ 3.3.1

During FY20, the Program leveraged the community champions approach focused on community engagement and leadership. USAID IHP uses this approach to promote community mobilization for social and behavioral change in target populations and to improve access to priority health services. Throughout the year, the Program supported the relaunch of community champions models across nine provinces. The engagement strategy for this initiative focused on bringing the health sector (i.e. registered nurses and DPS) together with key local stakeholders such as CBOs, NGOs, community leaders, the schools and churches.

Sensitizing farmers returning from fields. Source: USAID IHP. Photo taken before COVID.

In Haut-Katanga in Q1, USAID IHP supported the creation of three community champions. The ZS management team and other stakeholders collaborated with registered nurses to develop a workplan to meet challenges at the ZS and *aire de santé* levels. A total of 25 community agents and leaders (eight women and 17 men) were trained on the champion community approach. In Q4, the Program supported experience-sharing sessions of three community champions in Lubumbashi, facilitated by the DPS communication unit. Thirty people took part in these exchanges—including nursing staff and community leaders (18 men and 12 women)—sharing knowledge related to priority health and sanitation problems in the community, presenting their achievements and challenges, and redefining roles and responsibilities.

In Lualaba in Q1, the Program supported the organization of family planning and awareness-raising activities with four active community champion leaders. The campaign reached 13,019 people with family planning messages (8,661 women and 4,358 men) and referred 1,450 people to health facilities (1,125 women and 325 men). In Q3, the Program supported ongoing community champion activities, including six community champions to organize awareness sessions for 3,281 people (2,133 women and 1,148 men) on the importance of ANC and malaria prevention; these sessions also referred 112 pregnant women to health facilities for appropriate care.

In Sud-Kivu in Q1, the Program supported community champions across two ZS where 32 members took part in the planning meeting with ZS support. In Q3, the Program supported the relaunch of one community champion initiative and established an eight-member transition committee of five men and four women. In Q4, the Program supported updating action plans for two community champions, whom the ZS team supported to develop their six-month action plans. A briefing on essential family practices and awareness techniques was organized for 80 members, including 48 men and 32 women.

In Kasaï-Central in Q1, USAID IHP technically supported the evaluation of community champion action plans. In Q2, USAID IHP supported the revitalization of two community champions and two more in Q3, as well as renewal of two steering committees with the election of six women among the 14 members. In Q3, steering committees for two community champions developed new action plans. In Q4 the program supported the renewal of four community champions. In addition to their support for health activities, these champions work in other sectors such as agriculture, livestock, and income-generating activities including the fight against gender-based violence.

In Tanganyika, in Q2 key stakeholders came together to develop a workplan to address health challenges and other issues in their ZS and launch a steering committee. In total, 44 people (22 men and 22 women) participated in this training session. The Program supported ongoing activities in Q3 where community champions worked to raise awareness of 472 pregnant women and referred 186 to health facilities; 92 of these women received ANC and S/P, and 64 tested positive for malaria and were treated.

Supported to Raise Awareness about the EVD Outbreak and COVID-19

Direct: ✔ 3.1.1 **Indirect:** ✔ 3.2.2 ✔ 3.3.1

Involving local authorities, traditional leaders, and health professionals helped increase community understanding of disease risks and preventive measures, such as the creation of handwashing stations. Community members acknowledged the need for similar activities to share information about measures to avoid epidemics.

- During Q1 in Sud-Kivu, USAID IHP continued to support the broadcasting of community radio spots to raise awareness for the EVD epidemic. USAID IHP also supported the DPS to raise EVD awareness and brief 33 community health workers from four health areas. In addition, the Program supported a three-day door-to-door campaign that reached 775 students (461 girls and 314 boys), 25 teachers (four women and 21 men), and 5,891 people in households, villages and churches (3,170 women and 2,721 men).
- In Q2, The program supported the efforts of the DPS to strengthen the COVID-19 prevention and response action plan. In Kasaï-Central, Lomami, and Tanganyika, USAID IHP supported a series of awareness-raising activities on EVD and COVID-19. In addition, the DPS selected 113 community mobilizers (54 women and 59 men) and deployed them to the field. More than 550 leaflets in the local language have been distributed and 20 banners posted in public places. A total of 1,945 people (758 women and 1,187 men) were reached by the message transmitted by the RECO and 350,000 people through local media. In Lomami, USAID IHP contributed to the establishment of a provincial multi-sectoral committee for the fight against epidemics, in this case COVID-19.
- In Q3, the Program supported DPS efforts to strengthen the COVID-19 disease prevention and response action plan in all nine provinces by improving people's attitudes and priority behaviors, including social distancing and good hygiene practices. The DPS led workshops for translating COVID-19 awareness materials into local languages in all provinces. Community members, public radio station managers, and members of civil society attended these workshops. The Program also supported printing and distribution of 5,500 leaflets and 1,180 posters and broadcast awareness messages through community and public radio stations. The DPS trained 315 RECO to act as town criers and 26 journalists to spread messages about the risks of contamination and methods of prevention. Additionally, in Sud-Kivu, USAID IHP supported 24 community forums on COVID-19 in six ZS for 159 people, including 73 women. These forums focused on transmission modes,

consequences, and preventive measures. Participants then spread these messages to 1,945 people, including 758 women.

- In Q4, the Program continued to support DPS efforts to carry out COVID-19 disease prevention and protection activities in all nine provinces. USAID IHP supported a series of awareness-raising actions to improve attitudes and priority behaviors of the population in the face of the pandemic. COVID-19 awareness materials have been reproduced in local languages with USAID IHP support and distributed for awareness raising in all provinces, including 23,670 leaflets and 7,463 posters. Community radio, political and administrative authorities, and local leaders have played strong roles in raising awareness through dissemination of messages and the supervision of community mobilization teams.

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

Provided Support to Q&A Game Competitions in Secondary Schools

Direct: ✔ 3.1.1 ✔ 3.3.1 **Indirect:** ✔ 3.2.2

Throughout FY20, USAID IHP provided technical and financial support for quiz competitions to improve young people's knowledge of adolescent and youth sexual and reproductive health and connect them to services if necessary. Topics included sexual responsibility, contraception, prevention of sexually transmitted infections and HIV, prevention of youth violence, and avoidance of harmful sexual behaviors. Students have expressed that the competitions and quizzes are useful way to keep discussions going on these topics. In Q1, USAID IHP supported a quiz competition for students in Kalemie, Tanganyika where 41 students participated (20 boys and 21 girls). In Q2, a quiz competition in six secondary schools in three ZS in Kasaï-Central drew 360 students (258 male and 102 female). In Q3 another quiz competition drew 130 students (68 boys and 62 girls) in Tanganyika.

Provided Technical and Financial Support to Mini-campaigns

Direct: ✔ 3.1.1 **Indirect:** ✔ 2 ✔ 3 ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 12 ✔ 13 ✔ 14 ✔ 15 ✔ 16 ✔ 17 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.4 ✔ 2.5 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 2.1.17 ✔ 2.1.18 ✔ 2.1.19 ✔ 2.1.20 ✔ 2.1.21 ✔ 2.1.22 ✔ 2.1.23 ✔ 2.1.24 ✔ 2.1.25 ✔ 3.1 ✔ 3.1.3 ✔ 3.2.2 ✔ 3.3.1

Throughout FY20, USAID IHP leveraged mini-campaigns to increase knowledge and connect people to services around the following key health areas: antenatal care (ANC), family planning, TB, infant young child feeding IYCF, gender, and WASH. Mini-campaigns promote behaviors essential for improving health outcomes and connect people to health facilities for services; they are easily adapted to the specific needs of the community. Providers, RECO, and community leaders (including political and administrative authorities) are trained in communication skills and engaged at different levels and the mini-campaigns. Community leaders trained on identification of suspected TB cases and transport of samples to sites contribute to infection control. RECO support awareness sessions at households, markets and churches to share key messages such as the correct use of ITNs and the importance of family planning and provide referrals for services. Providers are trained in counseling skills, which are incorporated in relevant follow-up. To promote ANC, registered nurses follow up with pregnant women to ensure they attend their appointments. In FY20, 112 mini-campaigns were held across all nine provinces, which raised awareness of 927,240 people (575,214 women and 352,214 men) and referred 198,604 people to health services.

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

Organized Focus Groups

Indirect: ✔ 2 ✔ 3 ✔ 2.1 ✔ 2.2 ✔ 2.3 ✔ 2.1.1 ✔ 2.1.10 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 3.1.1 ✔ 3.2.2 ✔ 3.3.1

During FY20, USAID IHP supported the organization of focus groups. Participant feedback offered valuable insights for the Program in understanding and addressing barriers to accessing services and adopting key health behaviors. During Q1, focus groups gathered information from women on their understanding and use of ANC services and exclusive breastfeeding services, including 10 focus groups of 6-12 pregnant and lactating women in Kasaï-Central. These groups explored behaviors related to the adoption or barriers to family planning throughout the first three quarters. During Q1, in two ZS of Haut-Lomami, the Program supported preparation of the data collection method and provided financial and logistical support for 18 focus groups that included 24 women and 24 men, including young people, to gather opinions on family planning services. In Q3, USAID IHP supported organization of 56 focus groups to gather opinions of 679 young people, including 248 girls and 431 boys, on the low use of sexual and reproductive health services in Haut-Katanga, Kasaï-Central, Kasaï-Oriental, Lomami, Sankuru, Sud-Kivu, and Tanganyika. In Q4, USAID IHP technically and financially supported the organization of 50 focus groups (10 in Kasaï-Central, 25 in Sankuru and 15 in Sud-Kivu) to collect the opinions of the population on the low use of contraceptive methods. A total of 570 people (community and religious leaders, providers, RECO, and community members) from nine ZS participated. Several interesting opinions emerged. Women said the main causes of low contraceptive use are lack of interest, side effects of some modern contraceptive methods, and especially male refusal. Men reported being unaware of the benefits of FP. Young people shared that insufficient information on the different methods and lack of support measures are the main reasons for the low use of the methods.

World Breastfeeding Week activity, Sankuru. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Organized Community Forums

Direct: ✔ 3.3.1 **Indirect:** ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 19 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 3.2.2

Community forums are another strategy the Program leveraged during FY20 to engage communities, share vital information, and connect people to health services. Community members, community leaders, local government officials RECO and providers participated in these meetings. During Q1, the topic was encouraging women to give birth in health facilities. The forum in Tanganyika drew 41 people, including 17 men and 24 women. In Q2 in Lualaba and Sud-Kivu, forums were held to discuss youth health issues including STIs, early marriage, and birth spacing. In Lualaba, forums were attended by 300 adults (162 men and 138 women). In Sud-Kivu, the Program supported four community forums that brought together 50 young people, including 27 girls and women.

Provide Technical Support to ECZS to Map Key Influencers and Develop a Commitment Plan

Indirect: ✔ 4 ✔ 5 ✔ 6 ✔ 7 ✔ 8 ✔ 9 ✔ 10 ✔ 11 ✔ 12 ✔ 13 ✔ 19 ✔ 2.1.2 ✔ 2.1.3 ✔ 2.1.4 ✔ 2.1.5 ✔ 2.1.6 ✔ 2.1.7 ✔ 2.1.8 ✔ 2.1.9 ✔ 2.1.11 ✔ 2.1.12 ✔ 2.1.13 ✔ 2.6.2 ✔ 2.6.3 ✔ 2.6.4 ✔ 3.1.1 ✔ 3.1.3 ✔ 3.2.2 ✔ 3.3.1

In Q1, in Haut-Katanga and Haut-Lomami, USAID IHP supported the DPS to map key influencers in seven ZS. In total, 274 people took part in this activity, including 30 people (six women and 24 men) from two ZS in Haut-Katanga, and 244 people (56 women and 188 men) from five ZS in Haut-Lomami. In Q3, the Program supported the Haut-Katanga DPS to organize exchange sessions with 350 community, religious, and traditional leaders and other influential community members (including 132 women and 218 men) to identify priority health problems. Based on the synthesis of the exchanges with participants, the following priority problems emerged: high costs for care, poor access to drinking water, low use of ANC and post-natal care services, poor household waste management, and poor detection rates for TB. The DPS developed an engagement plan to share with the ZS for further improvement. In Q4, in Tanganyika, USAID IHP supported the DPS to identify influencers and organize information and orientation sessions to better understand their role; 120 people (87 men and 33 women) participated in this activity. Leader signed deeds of commitment to meet health challenges in the ZS.

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

Held Coordination Meetings with Breakthrough Action

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

USAID IHP and Breakthrough Action organized working meetings throughout FY20 to support collaboration on the VIVA campaign (formerly the Healthy Family Campaign). The Program worked throughout the year to address challenges related to coordination with Breakthrough Action, both at the national and provincial levels. This collaboration focused initially on the development of a joint workplan, which included finalizing design, launching and implementing the campaign. The Program supported this campaign through multiple strategies throughout the year, following the human-centered design approach developed by Matchboxology, which adapts prototypes and integrates existing tactics such as mini-campaigns.

Youth community debate forum, Kasaï-Central. Source: Abt Associates for USAID IHP. Photo taken before COVID.

In Q1, during a meeting with Breakthrough Action, USAID IHP and the DPS on the development of a joint workplan, the DPS Haut-Katanga made a commitment to integrate into its 2020 PAO priority activities of the capacity building plan resulting from the SBC analysis. In Q2, USAID IHP and Breakthrough Action collaborated on issues related to the launch and implementation of the VIVA campaign and the organization of adaptation workshops in four provinces: Haut-Katanga, Kasaï-Central, Lomami and Sud-Kivu. During this period, USAID IHP, Breakthrough Action, and the DPS held five working meetings in the four provinces and launched the campaign in Lubumbashi, which will serve as a model for launches in other provinces. In Q3, USAID IHP and Breakthrough Action held coordination meetings in three provinces (Kasaï-Central, Kasaï-Oriental, and Sud-Kivu) on VIVA campaign implementation strategies, including plans for training of trainers and developing communication activities. The Program provided support for strategic roll-out and continued refinement of potential SBC materials. In Kasaï-Central, the workshop focused on harmonizing terms of reference for training registered nurses in three ZS, to be approved by the DPS. In Kasaï-Oriental, the workshop assigned responsibilities for organizing community stakeholder briefings on the VIVA campaign in six ZS. In Sud-Kivu, the workshop focused on harmonizing perspectives on implementation of VIVA campaign strategies, in particular training of trainers from the DPS and ZS in two pilot ZS. In Sud-Kivu, staff also covered implementation strategies of the VIVA campaign, to begin in Q4 with DPS training-of-trainers, followed by training stakeholders in two pilot ZS. In Q4, USAID IHP and Breakthrough Action continued their support for DPS to train ZS and community actors in three provinces (Haut-Katanga, Kasaï-Oriental and Sud-Kivu). In these provinces, technical meetings were held to set up a mechanism for training additional ZS actors for the VIVA campaign and the community planned by USAID IHP for

the third year. In FY21, the Program will renew their commitment to improved coordination with Breakthrough Action by executing on a shared workplan and continuing with national and provincial level meetings.

Organized Meetings of the Communication Task Force and Shared Experiences with DPS and Civil Society

Indirect: ✔ 2.7.1 2.7.3 3.4.1

Throughout the year, USAID IHP supported opportunities for DPS and civil society to share experiences related to health behaviors the Program is addressing through community activities and service delivery. These meetings were intended to better understand complex challenges and leverage tools as solutions. In Q1, in Kasaï-Central, USAID IHP provided technical and financial support for the monthly review meeting where the ZS, health facilities, schools, CODESA, churches, cooperatives, higher education institutions shared positive practices related to gender mainstreaming. Participants noted the key lesson was involving civil society in raising community awareness and in finding solutions to health problems made it easier to discuss and address complex issues related to gender. Following the review, all participants agreed to implement the action plan on gender mainstreaming and continue to hold monthly meetings. In Haut-Lomami, USAID IHP provided technical and financial support for a Communication Task Force meeting to coordinate health communication activities at the DPS level, define the role of each organization, and develop an action plan. Meeting participants developed a roadmap for an effective launch of community mobilization activities for health and gender promotion.

During Q3, USAID IHP supported two experience-sharing meetings with the DPS and civil society in Sud-Kivu and Tanganyika. The objective of the activity was to strengthen the capacities of the DPS and ECZS managers to document interventions successfully implemented in the ZS. In Tanganyika, this activity helped participants understand and master the process of writing a success story. Nineteen ANC and ECZS managers joined in these sharing meetings and practice sessions.

During Q4, USAID IHP supported an experience-sharing meeting with DPS and civil society in the provinces of Sud-Kivu and Tanganyika, attended by 55 people including 22 women and 33 men. This meeting consisted of officially presenting and installing the new elected committees of the Communication Task Force of these two DPS, sharing the reference TORs setting up new committees, advocating with technical and financial partners for their various support, presenting the VIVA campaign, and validating a workplan for October to December 2020.

Established and Formed a Network of Champions for Promotion of Gender

Indirect: ✔ 24 ✔ 2.1.27 ✔ 2.4.2 ✔ 2.7.1 ✔ 3.3.1

In Q2, the PNSR and MCZS facilitated a network of champions for gender promotion in Haut-Katanga. In Q3, the Program supported exchange meetings with the DPS on gender mainstreaming in Sud-Kivu, Sankuru, and Tanganyika. In Sud-Kivu, these meetings encouraged DPS managers to integrate the gender dimension in deployment of human resources. The head of the Health Division of Sud-Kivu, DPS members, the Gender and Family Division, and the civil society representative of Sud-Kivu reiterated individual and collective commitments to lead advocacy for gender mainstreaming in recruitment of DPS human resources. In Sankuru, sessions were facilitated by two PNSR managers in the presence of the Territorial Administrator of Lodja and the Head of the Sector. Participants included men and women representing local associations working on gender promotion. In Tanganyika, participants attended the

PNSR's experience exchange meeting on gender mainstreaming in communities by and through the CBOs and the ZS.

In Q4, USAID IHP supported development of a Gender Sensitive Communication Plan on Malaria Prevention to help ZS promote the importance of key health behaviors and services. Participants included 180 people—107 men and 83 women. In Q1 in Haut-Katanga, USAID IHP supported organization of a knowledge-building session for the network of champions, including 16 participants (nine men and seven women), on addressing obstacles preventing the promotion of equality within their community.

Lessons Learned

- Membership of community-based organizations and traditional leaders in sensitization sessions through mini campaigns persuades a large number of the target population and improves the use of services. Involving traditional leaders facilitates understanding of more complex topics such as those related to gender, which helps somewhat to reduce gender inequalities.
- Inter-institutional collaboration at the provincial level between the DPS and other sectoral divisions makes it possible to have the same understanding on gender issues and to share information in the community for behavior and attitude change.
- Lack of dissemination of the new Family Code means that community members, especially in rural areas, are unaware of the rights of women and girls to have access to health services. Increasing awareness of this code can help promote access to health services for women and girls.
- For the VIVA campaign, setting up steering committees at central and provincial levels to lead the campaign is useful to develop joint implementation plans and improve collaboration among partners.
- Bringing together community champions and RECO around common objectives intensifies implementation of community activities. They work together to plan community activities, distribute roles and responsibilities, and conduct joint evaluations.
- World Malaria Day provided an opportunity to remind pregnant women, husbands/partners, and the community of the benefits of ANC so they can receive malaria prevention services and seek care for children under 5 suffering from fever.
- Participants appreciated new communications prototypes, including the baby basket and quizzes in the markets. Each ZS developed its VIVA campaign action plan with the new awareness materials for behavior change and promotion of essential family practices.
- During the training, engaging journalists in translation of local messages helped them understand the relevance of exclusive breastfeeding, resulting in dissemination of messages at no extra cost.

7. REPORTING ON ADDITIONAL AREAS

GENDER

In FY20, USAID IHP advocated for the creation of and supported the newly established Gender Unit at the Ministry of Health to develop their national gender integration action plan and advised approaches for the VIVA campaign. USAID IHP established gender champions networks in five provinces consisting of men and women committed to promoting gender equality. The Program also supported the implementation of action plans for the established gender champion networks. These action plans focused on changing behavior to ensure equal access to health services and other resources at the community level. USAID IHP participated in monthly meetings of the gender thematic group, protection cluster and sub-cluster groups focused on sexual- and gender-based violence (SGBV), and fostered monthly community reviews on good gender integration practices. USAID IHP also provided technical and financial support for the revitalization of CACs in four ZS in Kasaï-Oriental and two ZS in Kasaï-Central. Finally, the Program integrated modules on gender and women's rights and supported the DPS in Lomami and Sankuru provinces to orient their senior staff on gender integration in their human resource deployment plan.

Despite challenges resulting from the COVID-19 pandemic, the Program adapted certain activities due to the Government of the DRC (GDRC)-imposed social distancing requirements: these included the gender audits and gender champion network awareness-raising activities. To accommodate COVID-19-related requirements, the Program reduced the number of participants for certain meetings/trainings, moved meetings/trainings to a virtual format when possible, and in certain cases, postponed activities to a future date. The development of the MOH gender audit survey protocol and subsequent data collection, which was to be conducted in collaboration with the Ministry of Gender, Family, and Children, was delayed due to COVID-19 travel restrictions from Kinshasa to the provinces. The audit has been postponed to FY21.

Gender training, Kasaï-Oriental. Source: Abt Associates for USAID IHP. Photo taken before COVID.

To ensure SGBV victims' access to basic social services, in particular mental and physical health services, USAID IHP supported the training of 150 service providers (including 50 women) in 19 ZS in the DPS of Lomami, Haut-Katanga, Kasaï-Central and Kasaï-Oriental and Sankuru. At the provincial level, the Program continued to support community review meetings on gender to facilitate sharing, learning, and networking on gender inclusion in program implementation. *Please see our success story highlighting achievements in gender in Annex C.*

Fostered Monthly Community Reviews on Good Gender Integration Practices

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

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

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

Participation in the Biannual Gender Review

In Quarter 1 of FY20, USAID IHP held the biannual gender review of the Lomami DPS on October 2019 in Mwene Ditu, which was attended by 32 DPS and MCZS senior staff. The review of the Kasaï-Oriental DPS, held October 15-20 in Mbuji Mayi, was attended by 48 men and nine women. Participants included senior staff of the DPS and specialized programs representatives of the provincial MOH, 19 MCZS, and other technical and financial partners of the DPS, all of whom participated in the gender awareness-raising session that was part of the review. For these biannual reviews, USAID IHP provided participants with guidance on gender-sensitive approaches in their PAO implementation cycles, starting with developing gender-sensitive indicators; planning activities that take into account the specific needs of men, women, girls and boys; balancing gender considerations from the start of activity implementation to the monitoring and evaluation stage.

DPS Senior Staff Orientation Workshop for Gender Equality in Human Resources

In Lomami, the gender breakdown across all health personnel categories (from 2015 to date) is 74 percent men and 26 percent women. The majority of women are found in amongst midwives and nurses, whereas men comprise all of the MCZS and the majority of the general practitioner categories. To improve gender balance in the recruitment and deployment of staff of the various DPS institutions (IR 1.6), in FY20 Quarter One, USAID IHP supported the organization of a senior staff orientation workshop for gender equality in human resources in Lomami and Sankuru provinces.

The goals of the workshop were to (1) provide guidance to relevant DPS and BCZS management team members on gender concepts, the importance of gender mainstreaming, and legal provisions that guarantee equal rights for men and women to participate in management; (2) highlight major challenges

in implementing gender equality in recruitment; and (3) develop an action plan to heighten awareness of in gender inclusion when recruiting staff in ZS.

Three working groups from the workshop identified problems inherent in gender in Lomami and Sankuru, their root causes, possible solutions and actions. Discussions and questions around the gender mainstreaming action plan generated the following recommendations, which are still under discussion (noting that the retirement process does not fall under the responsibility of the MOH):

- Prioritize recruitment of women with a higher level of education to motivate those with a lower level of education;
- Depoliticize recruitment in various public services;
- Support staff retirement at retirement age (65 years old) and respect parity in staff replacement;
- Provide transport logistics to help those that work far from urban centers; and
- Discourage any requirement of a marriage certificate as a condition for woman's employment.

Creation of Gender Unit in the MOH and Support to Gender Unit Operationalization

In Q1 of FY20, USAID IHP supported an analysis that examined gender integration at the level of the Secretary General of the MOH, which determined gender integration needed to be further improved institutionally. This led to the establishment of the Gender Unit, based on the recommendation of the Ministry of Gender, Family and Child, to monitor application of legal provisions for gender equality and draw attention to the rights and skills of women within the MOH. The Gender Unit is intended to create a work environment to foster personal and professional growth, individually and collectively, for sustainable development of human resources.

In Q2, USAID IHP supported organization of the Ministry of Health's Gender Awareness Workshop from February 28-March 1, 2020 to help operationalize the new Gender Unit. Workshop objectives were to: 1) monitor implementation of recommendations from the gender mainstreaming workshop at the General Secretariat of Health on August 20-21, 2019; and 2) introduce the Gender Unit's facilitators. The workshop was attended by 22 experts (six men and 16 women) including two from USAID, two from the MGFE, 15 from the MOH, and a representative of the Congolese National Radio, as the media play a crucial role in changing mentalities.

Following the workshop, USAID IHP provided support to the Gender Unit in developing its first action plan for 2020. Already, Sud-Kivu has a temporary committee in place following the Gender Awareness workshop; the DPS is working to integrate more women in leadership roles. In Fy21, USAID IHP will support the Gender Unit in helping the DPS establish its own provincial-level gender units and will further support the operationalization of the Gender Unit, including the review of their 2020 action plan and the validation of their 2021 action plan.

Addressed Gender in the VIVA Campaign Validation Workshop

During the four-day VIVA campaign validation workshop in Q2, USAID IHP guided participants on gender-sensitive approaches for developing campaign messages and tools. The gender-sensitive methodology takes into account specific needs of men, women, girls, and boys from a root cause analysis to develop communication tools to increase chances of behavior transformation.

Observations from the workshop included: 1) promotion of women's rights is not prioritized in this MOH communication program and 2) Breakthrough Action, in partnership with USAID IHP, needs to support a gender training for implementation of the VIVA campaign that includes MOH communication program staff. The VIVA campaign is being conducted in collaboration with the MOH with USAID IHP technical and financial support.

Fostered Monthly Community Reviews on Good Gender Integration Practices

To address gender sensitivity in the day-to-day operations of state-run and private health structures and community-based organizations, USAID IHP supported monthly community reviews of good gender integration practices in the ZS of Kamina (Haut-Lomami), Ndekesha (Kasaï-Central), Tshumbe and Lodja (Sankuru) and Kalemie (Tanganyika) in Quarters 1 and 2. These reviews have the following objectives: 1) increase gender sensitivity of actors at the personal, interpersonal and community level within their respective organizations by clarifying key gender concepts; analyze the gender equality situation in organizations and structures; and 2) share good practices and examples of experiences that integrate gender sensitivity into work with survivors of gender-based violence, including sexual violence. The sessions allow participants to share experiences and discuss social norms, positive masculinity, and gender equality and their influences on attitudes and relationships between and among community members. No monthly community reviews were held in Quarters 3 or 4.

Set Up Gender Champions Networks

The gender champion model seeks to integrate a network of gender champions in communities within ZS to increase the representation of women in public and community institutions. The purpose of establishing gender champion networks and training their members is to improve priority health attitudes and behaviors at the individual, family, and community levels. The model allows for a better understanding of the benefits of respecting the rights of others, especially the rights of women, and the importance of women's participation in decision-making processes, including decisions on access to health care. USAID IHP piloted the gender champions network model in two ZS in FY20 Quarter 1, expanded it to two additional provinces in Quarter 2, and expanded it to a total of five provinces by the end of Quarter 3. The Program also supported the election of steering committee members for each network. There were no additional gender champions networks set up in Quarter 4.

Other Achievements

- Seven provincial USAID IHP gender focal points participated in five webinar sessions on USAID IHP's gender strategy.
- Trained new USAID IHP staff on Do No Harm on gender integration and mainstreaming, before starting in their positions.
- Integrated the sub-cluster on SGBV coordination mechanism in Tanganyika, working in partnership with the United Nations Population Fund.
- Ensured that a gender focal person was designated in each USAID IHP provincial office among existing staff.
- Trained project staff (mainly provincial gender focal points) and health officials in the monitoring and use of gender-sensitive indicators, such as the review of sex-disaggregated data.

- USAID IHP integrated modules on women's and girls' rights, as well as the benefits of women's participation in community management and well-being, into CAC and CODESA trainings, information and awareness sessions.
- Conducted impact analysis of Covid-19 containment measures on SGBV; USAID IHP continues to monitor COVID-19 impact in particular on SGBV.
- After Kasaï-Oriental incorporated the module on the roles and responsibilities of men and women in the community, the number of women occupying leadership positions in CACs increased from 115 to 251 by the end of Quarter 3. This helped improve results for USAID IHP Indicator #1.3.3 (number of community service organizations (CSOs)/CODESA supported by the program that are woman-led or with a mission focus on gender equality and/or GBV).

Lessons Learned

- Community review meetings have helped increase women's leadership roles in CBOs and community structures at the ZS level. Specifically, they have allowed more women to be elected and to participate as elected members of steering committees. This is a direct result of the Program's support for the revitalization of CACs and CODESA and established champion communities.
- USAID IHP's engagement in the humanitarian and protection coordination mechanism in Tanganyika presents an opportunity to further identify needs for service provider training on SGBV support.
- The involvement of the senior MOH officials is essential to ensure increased gender sensitivity in planning, implementing and monitoring at the provincial level. The gender equality trainings will continue at the ZS level in collaboration with the MOH Gender Unit.

CONFLICT SENSITIVITY

NB: Due to COVID-19 restrictions and national mandates, few activities were conducted in Q4; Virtual program follow up and mentoring activities continued where possible.

In Q1, USAID IHP reviewed the conflict sensitivity and do no harm implementation strategy to prepare to operationalize it beginning in FY20, Q2. The review included ensuring the results of the conflict sensitivity and do no harm analysis were well understood and ready to translate into forthcoming activities. In January 2020, USAID IHP launched the design process of the second conflict sensitivity analysis. Building on lessons learned from the first analysis, the project team adjusted the methodology to include additional data collection methods such as key information interviews (KII) with a program staff sample and an e-survey for the wider staff and partner stakeholder group. In February and March 2020, the project team collected data through 49 focus group discussions and 45 key informant interviews in all USAID IHP provinces.

In addition, the team administered the staff and partner perception e-survey to collect information on perceived behaviors and practices that may have inadvertently caused harm. This supplementary information, not collected during the first analysis due to the limited number of activities implemented at that time, enhances the project's ability to ensure that it is sensitive to conflicts and that Do No Harm principles are effectively integrated and applied throughout program implementation.

In Quarter 2, the project team identified 38 staff and partners from all USAID IHP provinces to participate in the Training of Trainers on *Do No Harm* & Conflict Sensitivity scheduled for May 2020. The training was intended to increase participants' ability to understand risks in the context in which the

project is implemented and to ensure that their behaviors and practices applied *Do No Harm* principles toward the community, which was identified as a critical technical capacity gap during the second CSA. In light of the COVID-19 pandemic, the project team began adapting the delivery mechanisms of the trainings of trainers to ensure timely and impactful knowledge transfer while adhering to governmental and public health guidance on social distancing and travel. USAID IHP shared capacity through a series of virtual engagements between smaller groups of program staff. In addition, as an alternative to planned regional workshop(s), the program is in the process of establishing an *IHP Community of Practice* (COP) through which USAID IHP can facilitate and support local partners to continue engagement and dialogue.

In Q3, USAID IHP analyzed the data from the Program's second conflict sensitivity analysis (CSA). Building on lessons learned from the first CSA, the second analysis builds on data collected from 313 key informants and participants in 64 focus group discussions, and from 49 participants in the perception survey conducted in Quarters 2 and 3. The analysis also served as an opportunity to evaluate the first CSA and develop the second conflict sensitivity and Do No Harm implementation strategy.

Conflict-Sensitivity Integration and Community Acceptance

- **Project staff self-reported their comprehension and their application of conflict sensitivity principles in their work.** The vast majority of staff reported that project leadership and project staff understand and support/apply conflict-sensitivity in their work (87 percent agreed for leadership and 96 percent for project staff). Most also agreed that staff are encouraged to report negative impacts of the project (83 percent) signaling that opportunities exist to discuss conflict-sensitivity at the field level.
- **Respondents self-reported community acceptance of USAID IHP.** Respondents reported overwhelmingly that staff have positive relationships with local organizations and acceptance by communities. This highly positive response occurs despite lower scores for systematic engagement with communities; for example, only 38 percent agreed that community feedback was regularly collected and analyzed and 41 percent agreed that communities were oriented on Do No Harm and reported easily to the project on impact of project on conflict.

Resource Transfers

- **Respondents agreed that USAID IHP is strengthening health services, but responses were mixed on whether those efforts led to more engaged local heath staff**. Project staff strongly believe the project is strengthening the health system and not delivering parallel services (91 percent of respondents in agreement), however respondents were mixed on whether health staff are more or less engaged than before the project (only 52 percent of respondents agreeing that health staff are more engaged than before the project). On this question, respondents were split nearly down the middle as to whether the local health staff (not part of the project) were more engaged in delivering services than before the project.
- **Respondents perceived USAID IHP did not negatively impact existing community tensions**. Project staff generally did not perceive the project to have reduced tensions between groups (29 percent of respondents believing tensions had been reduced) or they did not know if there had been an impact on the reduction of violence (36 percent of respondents). Very few

project staff (7 percent of respondents) reported the project had caused an increase on tensions in the community.

Implicit Ethical Messages

- **Staff reported relatively positive engagement and behaviors when interacting with beneficiaries and communities.** Overall, staff reported quite positive engagement and behaviors when interacting with beneficiaries and communities. The majority of respondents (95 percent+ of respondents) reported treating clients in a respectful and fair manner. They also noted that staff work well together and use the resources of the project in a responsible manner.
- **Staff reported consistently high responses for the behavior and actions of the EEI.** This series of questions pertains to how project EEI teams' behaviors and actions may reinforce or reduce tensions between groups in the community. Overall, responses were consistently high for the behavior and actions of the EEI. The lower scores were similar to staff survey in terms of transparency of information with communities along with representativeness of project staff. Similar to the above, these answers may have been affected by desirability bias.

Eastern Congo Region

In Sud-Kivu, findings suggested the most important conflict involved (1) customary power and (2) tensions between farmers and cattle breeders from different ethnic groups.

This high-level conflict manifested in kidnapping and armed groups aligning themselves with one of the main ethnic groups. In Tanganyika, findings documented tensions between the Bantu and Twa/Pygmee ethnic groups, sometimes escalating to open violence.

Kasaï Region

Kasaï-Central findings suggested two key conflicts: (1) customary conflict and (2) tensions between returning Congolese refugees from Angola and the host population.

Informants reported conflicts involving land, fishing, mining, religion, and the problematic administration of the health sector, although they also reported that these conflicts are generally localized and resolved peacefully.

Findings from Kasaï-Oriental demonstrated three main conflicts that have increased community tensions: (1) problematic administration of the health sector, (2) customary conflict pertaining to land and mining, and (3) the multiplicity and inconsistency of road taxes for motorbikes and bicycles plus the increase in illicit taxation barriers.

Lomami data revealed three conflicts, the main one being between two major ethnic groups (Bakete and Baluba), linked to complex customary power arrangements and the location of certain health services. Informants in Sankuru reported no significant conflicts linked to ethnicity, geography, or land.

Katanga Region

Lualaba findings suggested customary conflicts, linked to family heritage/lineage, as the main source of tension in communities, which occasionally transforms into localized violence.

In Haut-Lomami, the key source of community tensions was the origin of individuals (shore of the river/lake and land). Informants also cited (1) customary conflicts and (2) targeted kidnapping.

In Haut-Katanga, informants identified various localized community conflicts such as (1) unequal distribution of power between the Bantu and the Twa, (2) permanent and recurrent hostility between people from Kasaï and Luba Kat, and (3) permanent conflict between southerners and northerners in greater Katanga. However, those localized conflicts do not result in broader community tensions.

Do No Harm Training of Trainers

USAID IHP identified all Program staff and partner participants for a virtual Do No Harm training of trainers. The training will increase participants' understanding of contextual risk factors in local implementation settings and ensure that the Program supports Do No Harm behaviors and practices. USAID IHP will conduct this training in FY21.

Recommendations

Project Implementation

The national, regional and provincial management teams have an important role to play to translate conflict sensitivity, do no harm and gender transformation ideas into daily practices and behaviors. In order for USAID IHP to be truly conflict sensitive, management teams can immediately take actions with dedicated support from the IRC's Conflict Sensitivity thematic lead (STTA).

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

Program and Health Staff Capacity

1. Establish a Program-wide Community of Practice—a virtual space to exchange ideas and strategies to decrease community tension.
2. Increase USAID IHP focal point training opportunities on conflict sensitivity, Do No Harm, and gender transformation to ensure sufficient capacity to analyze context and behavior.
3. Introduce routine practices in conflict resolution, negotiation, and Do No Harm to promote conflict sensitivity champions.
4. Identify Conflict Sensitivity and Do no harm focal points, and sensitize them on their terms of reference.
5. Organize a province-specific workshop of the conflict sensitivity results.
6. Operationalize the Conflict Sensitivity Implementation Strategy to the specificity of their province.
7. Adapt conflict monitoring tools to make them fit-for-purpose to their province/specific conflict(s)
8. Encourage frequent interaction between the focal points and the Conflict Sensitivity thematic lead.

Project Management Processes

1. Enhance focus on the collection and analysis of community feedback, and take action based on that feedback, to ensure that USAID IHP programming and staff are responsive to the Congolese population and health sector staff.

2. Strengthen community feedback mechanisms to provide a way for the Congolese population to constructively engage with USAID IHP staff to proactively address misperception and tensions.
3. Develop and implement a conflict and Do No Harm monitoring tool and dashboard to continuously capture community tensions and conflicts that may impact USAID IHP results and that the Program may inadvertently impact.

In sum, the second CSA and subsequent implementation strategy confirms that USAID IHP is generally sensitive to the conflict and adapting to conflict-sensitive risks as they evolve. Continued time and effort investment by USAID IHP staff and local stakeholders is necessary to ensure gains are capitalized year after year in order for the program to not only does no harm, but deliberately supports communities to facilitate their own conflict sensitivity and peace building initiatives.

ENVIRONMENTAL MITIGATION AND MONITORING

USAID IHP incorporates environmental compliance measures and environmentally-friendly practices in activity implementation based on the Program's approved Environmental Mitigation and Monitoring Plan (EMMP) and Climate Risk Mitigation Plan (CRMP). Most notably, these plans guide USAID IHP's efforts to mitigate the environmental impacts of program interventions, especially those expected from renovation and small- and very small-scale construction of infrastructure, medical waste, shipping, and travel.

During FY20, USAID IHP implemented and supported the following major activities related to environmental measures and regulations:

- Clean clinic approach: In Sud-Kivu, Lomami, Kasaï-Oriental, and Kasaï-Central, USAID IHP conducted training of trainers and then supported training of providers and health and health and hygiene committees—established with USAID IHP support—in the adoption of good environmental protection measures. Training topics focused on sanitation and management of medical and biomedical waste and also included WASH in health care settings, sound WASH management practices, facility management and additional areas of related to environmental compliance. See more in the WASH section of the report and also the EMMR annex.
- Rehabilitation of gravity flow water distribution systems: USAID IHP developed and distributed a checklist of recommended environmental mitigation measures for local stakeholders in Sud-Kivu to monitor and address, in line with the EMMP. USAID IHP anticipates providing this resource to local stakeholders in Kasaï-Oriental, where the Program's water supply work is ongoing, in FY21.
- Supply chain management training: USAID IHP designed a supply chain management training course, including a module on pharmaceutical waste management, for ZS-level pharmaceutical management teams in all USAID IHP-supported ZS. In addition, USAID IHP developed posters with key messages for biomedical and pharmaceutical waste management, and the Program will distribute them to health facilities in FY21. See more in the Objective 1 section of the report.
- Office management and supply, and transportation: USAID IHP implemented facility management measures in its own offices to promote judicious use of resources, management of waste (e.g., electronic waste), reduced plastic waste, and reduced paper waste. In addition, to mitigate the spread of COVID-19, USAID IHP enhanced office operations to include signs and physical barriers in offices, restricted numbers of people that could be present in the office building and in a given office at any one time, and work-from-home measures to support reduced numbers of staff in the office. A

by-product of these measures was reduced vehicle use and fuel consumption where such measures were in place, especially in Kinshasa.

Please reference Annex G for the Program's Environmental Mitigation and Monitoring Report.

8. ACTIVITY RESEARCH, MONITORING, AND EVALUATION

Over the course of FY20, the RME team has supported the program through activities and guidance to produce data to improve implementation strategies and approaches.

Project Monitoring Report Indicator Assessment

USAID IHP has 118 indicators and corresponding performance indicator reference sheets (PIRS) that were approved by USAID in Nov 2018. Many of these definitions need to be updated by USAID IHP to better reflect the reality of data collection. As USAID IHP implements the program and reports on activities using the AMEP, the Program has documented changes to indicator definitions or new issues. Indicators for which more precise DHIS2 sources have been identified are documented in the footnotes of the MSRT table in Annex A. *Annex B contains notes on Annex A FY2020 Annual Report Data*

During FY20 and particularly in Q4, USAID IHP began a robust evaluation process to review indicators and their relationship to the intended, desired results and achieved results of program implementation. The Program organized a multi-day workshop that split the technical teams into result areas, led by the Research, Monitoring and Evaluation (RM&E) team. The teams used specially developed tools to review and document aspects of each indicator measured using the Project Monitoring Report (PMR). These indicators are unique to USAID IHP, and no other source of data collection exists. The teams assessed the PMR indicators for usefulness and progress toward desired USAID IHP results. The teams then evaluated set targets against program performance to date and the feasibility of targets. They discussed whether current definitions of program indicators allow the Program to accurately measure performance, and proposed changes where they did not. The teams also proposed new targets based on the realities of implementation and the evolving needs of MOH partners and USAID objectives.

USAID IHP has finalized all revised documents and tools including AMEP, PIRS, and Performance Indicator Tracking Table (PITT) and will share them with USAID in the first quarter of FY21 for approval. These updated tools will document real-world data collection and management for the Program to ensure reliable and replicable results and better inform the technical teams of progress towards achieving goals and addressing bottlenecks.

Data Driven Workplanning

The indicator review sessions laid the foundation for RME guidance and data-driven workplanning. USAID IHP cross-referenced validated or revised indicators in the development of the Y3 workplan to ensure scheduled activities will meet desired results. The Program used data acquired throughout the year to track activity implementation, better informing technical leads which activities were successfully implemented on time, and which were delayed or cancelled due to COVID-19 and should be rescheduled or redesigned (for example, as remote training).

Completed the Baseline Service Delivery Mapping Survey, the Baseline Household Survey, and Related Reports

During FY20, USAID IHP completed the data collection, analyses, and refined resulting reports for the Program's two baseline reports: the service delivery mapping report and the household survey report. For each report, USAID IHP details major achievements below:

Mapping test, Kinshasa. Source: Abt Associates for USAID IHP. Photo taken before COVID.

Service delivery mapping report

1. **Updated data analyses, integration, and interpretation**: USAID IHP has updated all available data, formulating comments and monitoring the integration of feedback by the Consultant working on the report.
2. **Addition of new sections**: USAID IHP has added details and clarifications on the limitations, conclusions, recommendations and next steps.
3. **Finalization of the ZS report model**: USAID IHP developed a report model for use at the provincial and ZS levels, to facilitate further use of the mapping data to inform planning for Program technical assistance, particularly at the DPS/provincial level.
4. **Presentation of data on the M&E platform and DPS Dashboard**: Data from the Service Delivery Mapping Survey has been integrated into two key DHIS2 instances: the MOH's DPS Dashboard and USAID IHP's M&E platform for ease of reference and use of data.

USAID approved the finalized report on October 19, 2020. However, the **ZS model report** was produced by USAID IHP as a reference for provinces in their analysis and writing and especially to guide dissemination and presentation of the results of the Service Delivery Mapping.

Household survey report

1. Updated data analyses and interpretation: USAID IHP updated the preliminary report to address USAID's comments on the first report.
2. Addition of SBC (social behavior change) analyses and data: As USAID IHP has collaborated with Breakthrough Action to identify priority areas for further SBC analyses, the Program refined Breakthrough Action's draft analysis and incorporated it into the report.
3. Addition of final analyses from Breakthrough Action, refinement and formatting continued into the third and fourth quarter.

4. Given problems encountered in immunization data processing, the Program will completely update all data for children under 5 and submit for approval in the first quarter of FY21.

Ongoing Research with Geopoll

USAID IHP conducted several design sessions to develop and finalize questionnaires for SMS and Computer Assisted Telephone Interviewing (CATI) surveys. The first is for the Transparency and Oversight in Health Services Survey. This questionnaire established the initial framework for this cross-cutting survey under IR 1.2 for the Program's M&E plan, which explores perceptions of provincial health workers on transparency and accountability in management and information workers have about performance management, policies and procedures.

USAID IHP conducted a design session to develop questionnaires for the cross-cutting Evidence of Gaps of CSOs Survey under IR 1.3, which will identify gaps in civil society organizations' management procedures and practices. The Program will disseminate results and findings during the second quarter of FY21.

The RM&E team also identified additional research questions in different health areas: family planning/reproductive health, malaria and WASH, for which the Program began to develop ad hoc, rapid surveys. By the end of Quarter 3, Geopoll and the RM&E team finalized concept notes and questionnaires for these additional research questions. The Program launched surveys for family planning/reproductive health and malaria in the last quarter of FY20; results will be available in the first quarter of FY21.

Program Learning Activities Take Shape

USAID IHP held a learning session on June 17, 2020, bringing together the Abt Associates headquarters team and the DRC-based technical and RM&E team. The session shared results of the Community Health Services Survey—finalized with Geopoll and USAID IHP stakeholders—to help formulate intervention strategies and approaches. Geopoll and the RM&E team gathered observations and feedback from participants, which focused on aspects of the methodology and sampling.

Using this feedback, the Program refined the model for internal dissemination, to be rolled out in a series of learning sessions in Y3. These short-format sessions are directed to different audiences within USAID IHP: program areas, provinces and technical.

Finalization of the M&E Platform

USAID IHP's M&E Platform generates and compiles data for use and analysis during reporting. During FY20, the team made improvements to streamline generation of the Annex A, MSRT table and improve the data entry interface for PMR indicator data. The team also developed generic dashboards for PMR, service provider mapping survey data and household survey data; and setting automated complex computations that are not possible using the MOH's instance of DHIS2.

A training session is scheduled during the M&E staff retreat in December 2020 for USAID IHP provincial M&E managers to enter monitoring indicator data directly in the Platform. Originally delayed due to COVID-19, this training will have remote training materials and user guides for additional, ongoing support.

Survey Development with Viamo

USAID IHP supported implementation of a survey on Socio-cultural Barriers to Family Planning from April 6 to May 19, 2020. The objective of the survey was to identify socio-cultural reasons for using or not using contraceptive methods in five provinces with low rates of contraceptive use, per preliminary results of the Program's survey. Through the Viamo platform, the survey consisted of a series of automatic calls with target questions to achieve 200 complete responses, divided into 40 responses per province. Viamo shared the results of this survey with program staff involved in formulating strategies and approaches for the activities.

Also in FY20, USAID IHP supported implementation of the knowledge, attitudes and practices (KAP) malaria survey via SMS to assess the reach and impact of malaria messages through Viamo's 42502 service. These messages include "how malaria is transmitted" and "the importance of sleeping under an insecticide-treated net". with malaria chapter to reference results

9. LESSONS LEARNED

- **Coordinate technical assistance to ensure complementarity of activities at the province level**. During the Annual Review of the PNDS 2019-2022, the MOH asked USAID IHP staff to reflect on the value add of technical assistance, particularly in light of the multiple donors and donor-funded activities in Program locations. The MOH requested the Program coordinate with other donor-funded programs, to avoid duplication and ensure complementarity. Although USAID IHP already collaborates extensively with key USAID implementing partners, to an external observer such as the MOH, Program technical assistance resources require better coordination or pooling at the province level. To address this, USAID IHP has since held technical meetings with MOH and other partners and with USAID and other implementing partners working in overlapping provinces to ensure synergies. The preparation of the USAID IHP FY21 workplan included careful consideration of, and coordination with, provincial priorities, proposed activities and targets, and the workplan structure neatly fits into the PAOs of the national, provincial, and zonal level programs to minimize MOH transaction costs of partner planning. Finally, USAID IHP has played a lead enabling role in several provinces for implementation of their respective *contrats uniques*, virtual basket funds developed to improve coordination of donor support and enhance financing of PAOs.
- **Sustain available epidemic preparedness and response expertise.** Although the EVD (Ebola) epidemic did not directly affect USAID IHP provinces, all of them had developed epidemic preparedness and response plans. The Program leveraged expertise when the COVID-19 pandemic required similar planning, ahead of a possible crisis. Epidemic preparedness is an essential function of a health system, and it cannot be left unattended until a crisis emerges. This requires fundamental rethinking of the responsibilities in funding maintenance of core preparedness capabilities, which cannot be disconnected within an integrated system. USAID IHP rapidly mobilized in response to the MOH's request for specific contributions to the GDRC's COVID-19 response plan. The Program applied lessons learned from EVD and conducted three key activities: organization of coordination meetings for COVID-19 preparedness; support for surveillance activities and production of data analysis tools; and community-level SBC/awareness-raising activities and tools. USAID IHP also leveraged WASH capacity-building activities in communities, health facilities, and DPS/ECZS to reinforce good hygiene practices and IPC measures relevant for COVID-19.
- **Recognize role of internal communication to foster adaptations within the health system.** Starting in late March 2020, USAID IHP received guidance from the various MOH programs that guide our technical activities (MNCH, RH/FP, TB, malaria, nutrition and WASH) on how to adapt and maintain programmatic integrity in the emerging COVID-19 context. This timely guidance demonstrated the importance of programmatic leadership and coordination—a critical function at the national level. Often, individual programs are tasked with expensive re-orientation/re-training, but incorporating national-level guidance into local-level procedures and processes should be a simple program management function requiring only effective internal communication. As part of USAID IHP's support to GDRC's COVID-19 response, the Program helped the MOH update and disseminate COVID-19 guidelines across USAID IHP health areas and supported implementation of precautions/safety measures to ensure that activities could continue, with some minimal modifications.
- **Build on national-level investments, strategies and policies to further health system reforms and improvements.** USAID IHP supported the organization of administrative council

meetings to facilitate the adoption of the 2020 PAOs at the national, DPS, and ZS levels so DPS could align with the PNDS 2019-2022. Coupled with the PAO, the *contrat unique* process was launched to promote more accountability and partner engagement. This process received special support from the multidisciplinary national supervisor and made it possible to obtain commitments from stakeholders who backed the PAO 2020 process in the nine targeted provinces. As a virtual basket fund, the *contrat unique* has served to improve coordination in donor funding at the provincial level, in support of PAO. This tool has also helped visualize and recognize donor financing, minimizing overlapping or duplicative investments.

- **Prioritize and domestically fund provinces' institutional-strengthening plans.** Institutional self-assessments and subsequent planning for institutional strengthening laid out in USAID IHP's FY21 workplan are gaining traction beyond all expectations. A similar organizational development approach was previously conducted with Ministry of Health Directorates, with Kinshasa-based hospitals and even with the Kinshasa School of Public Health. Now, demand for such assessments reaches beyond to the health zones and CSOs, and as USAID IHP supports implementation, the Program empowers stakeholders to lead the process and "own" the results, resulting improvement plans, and subsequent self-assessments. A key assumption is that institutional strengthening plans of the provinces will inform Program planning. However, USAID IHP cannot fund or support these types of activities indefinitely. Province-based institutional assessments and strengthening plans need to be owned by all province partners, and such plans should incorporate contributions by other partners. Investment commitments are needed from leadership at the national and provincial levels; securing domestic resources will not only help prioritize these activities but ensure their sustainability. The *contrat unique* can help with this, as a starting point, and USAID IHP is working closely with province-based stakeholders to learn of viable opportunities for domestic resource mobilization, for example with the ETDs and health financing reforms via the *mutuelles de santé.*
- **Integrated activities across program areas and health areas helps ensure programmatic and cost efficiencies.** USAID IHP often works with the same stakeholders across different activities, so integration helps in reaching communities with cross-cutting messaging. Examples:
  - USAID IHP leverages touch points with key beneficiaries to increase knowledge of complementary interventions. For instance, provider training on essential MNCH capacity building includes content on nutrition essentials for pregnant and breastfeeding women and infants. Nutrition trainings with RECO leverage their community standing to include awareness-raising for sensitizing populations in malnutrition detection and intervention.
  - Malaria in pregnancy and access to family planning have overlapping target audiences. In FY20, USAID IHP leveraged integrated messaging in mini-campaigns and community champions to maximize reach and reinforce linkages along the continuum of care to combat malaria in pregnant women, and boost referrals to ANC and family planning services.
  - USAID IHP collaborates with the VIVA campaign, which promotes key messages and behaviors across health areas, as well as gender integration. This dovetails with strategies such as the community champion model and mini-campaigns, chosen in part due to their adaptability to different health messaging.
  - Supply chain interventions are integral to provide essential medicines across the health areas the Program supports and address root causes of inefficiencies in the health system. In FY20, the Program supported management tools and distribution plans for commodities at the ZS level

and for their respective health facilities, and trained inventory management personnel. A training-of-trainers in supply chain management is planned for the DPS in FY21.

- The RME team facilitated a number of learning activities that shared knowledge across program areas and areas of expertise, including dissemination of the results of the Community Health survey to the senior management team in Kinshasa and the home office. The presentation generated discussions, contributed to workplanning, and served as a prototype for future presentations to ensure continued collaborative use of program data.

ANNEX A: PERFORMANCE INDICATORS, TARGETS, AND ACHIEVEMENTS (ANNUAL)

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
Goal	**Sustainably improved ability of the DRC health system to deliver quality services by building the leadership, management, and technical capacity of Congolese institutions and communities**											
1	IHP DRC Impact: MMR, U5MR, Neonatal MR, Infant MR, TB case notification rate, malaria mortality rate, CPR, and acute and chronic malnutrition rates*	Impact†			N/A	N/A	N/A					
		Kasaï			N/A	N/A	N/A					
		Katanga			N/A	N/A	N/A					
		Eastern Congo			N/A	N/A	N/A					
2	FP: Percentage of married women using any modern method of contraception	Outcome	10.8%	N/A	N/A	N/A	N/A			EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	10.9%	N/A	N/A	N/A	N/A			EDM 2019		
		Katanga	14.3%	N/A	N/A	N/A	N/A			EDM 2019		
		Eastern Congo	5.3%	N/A	N/A	N/A	N/A			EDM 2019		
3 Fee Proxy	FP: Number of acceptors new to modern contraception in USG-supported family planning service delivery points (PROXY)	Outcome	848549	900226	428555	1320634	146.7%	N/A	N/A	DHIS 2	Overall, USAID IHP achieved a completion rate well above 100%, but two provinces in the Kasaï region (Kasaï-Central and Lomami) had low achievement rates.	In FY2021, USAID IHP will implement these activities in Kasaï-Central and Lomami: – Training / retraining of CBDs and providers; – Supervision of CBDs, support for training supervision in the ZS and joint supervision of PNSR and ZS; – Supply of FP inputs and DBC management tools; – Make available SNIS management tools (registry and canvas).
		Kasaï	368326	390757	178207	541605	138.6%	N/A	N/A	DHIS 2		
		Katanga	272927	289548	149302	480153	165.8%	N/A	N/A	DHIS 2		
		Eastern Congo	207296	219921	101046	298876	135.9%	N/A	N/A	DHIS 2		
4 Fee	MNCH: Percentage of children 0-59 months of age for whom treatment/advice was sought for acute respiratory infection	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
5 Fee Proxy	MNCH: Number of children under five years of age that received treatment for an acute respiratory infection from an appropriate provider	Outcome	1143154	1212772	331932	1316048	108.5%	N/A	N/A	DHIS 2	We achieved a 108.5% overall completion rate in USAID IHP-supported provinces; however, two provinces had low achievement rates (Sankuru and Haut-Lomami).	In FY2021, USAID IHP will implement the following activities: - Trainings on PCIMNE clinics and flow charts for the health facility providers and SSC for RECO sites to strengthen their capacity in the use and rational prescription of drugs; - Make the sites of care functional; if necessary, create them. - Make inputs available at care sites and in the FOSA.
		Kasaï	569695	604389	166508	636945	105.4%	N/A	N/A	DHIS 2		
		Katanga	229925	243927	74959	292050	119.7%	N/A	N/A	DHIS 2		
		Eastern Congo	343534	364456	90465	387053	106.2%	N/A	N/A	DHIS 2		
6 Fee	MNCH: Percentage of children 0-59 months for whom treatment/advice was sought for diarrhea	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
7 Fee Proxy (Standard /PPR)	MNCH: Number of cases of child diarrhea treated in USG-supported programs (PROXY)	Outcome	1041286	1104700	307338	1048082	94.9%	N/A	N/A	DHIS 2	In FY2020, most provinces did not reach their targets with the exception of Lualaba (111.1%) and Haut-Katanga (101.8%). The low performance for this indicator can be explained by the weak supply of drugs leading to stock-outs at health facilities.	In FY2021, USAID IHP will implement the following activities to improve this indicator: - Supply FOSA and community care sites with ORS and zinc; - Train the MCZ, IT, and RECO in PCIME; - Make the SNIS management tools available.
		Kasaï	476895	505938	132645	427536	84.5%	N/A	N/A	DHIS 2		
		Katanga	239799	254402	83004	297896	117.1%	N/A	N/A	DHIS 2		
		Eastern Congo	324592	344360	91689	322650	93.7%	N/A	N/A	DHIS 2		
8 Contract	MNCH: Percentage of children age 12-23 months who received all basic vaccinations	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
9 Fee Proxy	MNCH: Number of children less than 12 months of age who received three	Outcome	1157027	1227490	355030	1329873	108.3%	N/A	N/A	DHIS 2	Progress for this indicator is 101.9% overall; in three provinces, rates are	In FY2021, USAID IHP will implement the following activities to improve this indicator:

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	doses of pentavalent vaccine (PROXY)	Kasaï	479997	509229	147359	561888	110.3%	N/A	N/A	DHIS 2	acceptable rates but below 100% (Kasaï-Central, Sankuru, and Sud-Kivu).	– Make vaccines available and support the supply of oil to fuel refrigerators to store immunizations; – Support an increased number of immunization sessions; – Strengthen joint supervision with the EPI program in the ZS and FOSA; – Support advanced strategies.
		Katanga	344494	365474	115657	423916	116.0%	N/A	N/A	DHIS 2		
		Eastern Congo	332536	352787	92014	344069	97.5%	N/A	N/A	DHIS 2		
10	MNCH: Number of children less than 12 months of age who received measles vaccine from USG-supported programs	Outcome	1115918	1183877	350949	1314978	111.1%	N/A	N/A	DHIS 2,	Progress for this indicator is 111.1% overall.	In FY2021, USAID IHP will implement the following activities to improve this indicator, as with indicator 9: – Make vaccines available and support the supply of oil to fuel refrigerators to store immunizations; – Support an increased number of immunization sessions; – Strengthen joint supervision with the EPI program in the ZS and FOSA; – Support advanced strategies.
		Kasaï	478162	507282	147490	557660	109.9%	N/A	N/A	DHIS 2,		
		Katanga	330445	350569	114346	424451	121.1%	N/A	N/A	DHIS 2,		
		Eastern Congo	307311	326026	89113	332867	102.1%	N/A	N/A	DHIS 2,		
11	MNCH: Percentage of children less than 12-23 months of age who received measles vaccine from USG-supported programs	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
12 Fee	MNCH: Percent of pregnant women attending at least four antenatal visits with a skilled provider from	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	USG-supported health facilities											
13 Fee Proxy	MNCH: Number of pregnant women attending at least 4 antenatal care visits with a skilled provider (PROXY)	Outcome	778425	825831	262906	959566	116.2%	N/A	N/A	DHIS 2	Achievement rates for this indicator were satisfactory in all provinces supported by USAID IHP.	In FY2021, USAID IHP will work to improve the quality of ANC services and increase the number of women seeking ANC services. Activities will include training of providers in SONU; conducting FP/ANC mini-campaigns; and implementing champion communities strategies.
		Kasaï	418461	443945	131097	492930	111.0%	N/A	N/A	DHIS 2		
		Katanga	174119	184723	68758	239234	129.5%	N/A	N/A	DHIS 2		
		Eastern Congo	185845	197163	63051	227402	115.3%	N/A	N/A	DHIS 2		
14 Fee	MALARIA: Percent of children under 5 years of age for whom treatment/advice was sought for fever	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
15 Fee Proxy	MALARIA: Number of children under 5 years of age with confirmed malaria who received treatment for malaria from an appropriate provider in USG-supported areas (PROXY)	Outcome	2868866	3043580	872044	3591320	118.0%	N/A	N/A	DHIS 2	In FY2020, the Program exceeded its targets for this indicator with an overall achievement rate of 118%. Eastern Congo, however, did not reach its target (99.2%).	In FY2021, USAID IHP will work to maintain the gains made in FY2020. Priority activities include: - Organize community campaigns to promote prevention and connect caregivers to services; - Organize the training for correct case management for malaria - Provide support to improve supervision - Ensure availability at FOSA and iCCM community care sites with malaria commodities related to prevention (ITNs) and treatment (ACTs) and diagnostics (RDTs)
		Kasaï	1397311	1482407	421884	1763454	119.0%	N/A	N/A	DHIS 2		
		Katanga	681602	723112	242851	996784	137.8%	N/A	N/A	DHIS 2		
		Eastern Congo	789953	838061	207309	831082	99.2%	N/A	N/A	DHIS 2		
16 Fee	MALARIA: Proportion of children 0-59	Outcome	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	months who slept under an Insecticide treated net (ITN) the previous night	Eastern Congo	UA	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
17 Fee Proxy	MALARIA: Number of insecticide-treated nets (ITN) distributed during antenatal and/or child immunization visits (PROXY)	Process	1163227	1222086	307324	1143159	93.5%	N/A	N/A	DHIS 2	This indicator achievement (93.5%) was satisfactory, although there is a large regional disparity in completion rates. Katanga exceeded its targets at 130.4% though Kasaï achieved 89.7% and Eastern Congo achieved 78.6%. During FY2020, the Program faced challenges related to the fact that the OCC quarantined a batch of ITNs; the issue has now been resolved, but it delayed distribution throughout the year. In Q3 and Q4 the delivery of ITNs far exceeded targets in several provinces as part of a catch-up effort. Transportation problems in Eastern Congo led to continued difficulties for ITN delivery and thus a lower achievement rate.	With ITNs that are now available, the Kasaï region will be able to catch up on their ITN delivery in Q1 of FY2021. The Program is working on solutions to use local stocks and improved planning to better anticipate seasonal challenges related to poor road conditions and other transportation challenges that are frequent in Eastern Congo.
		Kasaï	552961	580941	139577	520905	89.7%	N/A	N/A	DHIS 2		
		Katanga	217673	228687	80296	298250	130.4%	N/A	N/A	DHIS 2		
		Eastern Congo	392593	412458	87451	324004	78.6%	N/A	N/A	DHIS 2		
18 Fee	Improved satisfaction by clients/citizens with the services they receive: % of individuals reporting	Outcome	66.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is meant to be collected with the household survey.
		Kasaï	69.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	70.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	56.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	satisfaction with health center services											
19 Fee	Number of Basic Emergency Obstetric and Neonatal Center (BEmONC) or Comprehensive Emergency Obstetric Center (CEmONC) sites available in each province	Output	410	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is intended to be reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	99	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	218	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	93	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
20 Fee	Documentation and publication of operational research in peer reviewed journal	Process	N/A	1	N/A	0	0%	N/A	N/A	Project monitoring report	We did not meet our target for this indicator.	We are currently preparing a manuscript with the intention to publish.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
21 Fee	Conflict Sensitivity Analysis and Implementation Strategy	Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator has been completed. The revised Conflict Sensitivity Analysis and Implementation Strategy was submitted October 19, 2018, and approved by USAID on October 24, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
22 Fee	Percent of targeted facilities with quality improvement action plans documented and	Outcome	N/A	100%	N/A	93%	93%	2996	3237	Project monitoring report	We achieved our targets in Katanga and Eastern Congo but we fell short in Kasaï.	
		Kasaï	N/A	100%	N/A	82%	82%	1108	1349	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	being implemented	Katanga	N/A	100%	N/A	100%	100%	985	985	Project monitoring report		
		Eastern Congo	N/A	100%	N/A	100%	100%	903	903	Project monitoring report		
23 Fee	Capacity Development Approach	Output	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator has been completed. The Capacity Development Approach was submitted October 5, 2018, and approved by USAID on November 11, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
24 Fee	Gender Analysis and Gender Implementation Strategy	Process	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This indicator has been completed. The Gender Analysis and Implementation Strategy was submitted November 2, 2018, and approved by USAID on December 10, 2018.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
Result 1:	**Strengthened health systems, governance, and leadership at provincial, health zone, and facility levels in target health zones**											
1.1 Fee	Annual score derived from PICAL for USG-supported provincial health divisions	Output	1.72	2.7	N/A	1.5	55.6%	N/A	N/A	Project monitoring report	The scores for FY2020 are for DPS and ZS that newly underwent the PICAL process this year, rather than a follow-up evaluation of the DPS and ZS originally evaluated via the baseline. These data points are therefore not comparable: the	In FY2021, the Program will: – Conduct the evaluation of interventions carried out in the DPS following the strengthening plan established after the PICAL analysis. – Support workshops on the use of the PICAL tool, followed by institutional analysis in 5 ZS each in Kasaï-Central, Lomami,
		Kasaï	1.66	2.7	N/A	1.7	63.0%	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Katanga	1.47	2.5	N/A	1.4	56.0%	N/A	N/A	Project monitoring report	FY2020 DPS and ZS have not yet benefitted from the activities following the initial PICAL assessment that would merit re-evaluation and theoretically improved scores.	Sankuru, and Sud-Kivu, which were delayed due to COVID-19. Additionally, USAID IHP and USAID need to determine how to assess and interpret PICAL scores over time given initial PICAL assessments were implemented in a progressive fashion, and interventions/support vary from institution to institution.
		Eastern Congo	1.97	3.0	N/A	1.2	40.0%	N/A	N/A	Project monitoring report		
1.2	Percent of annual Provincial action plans and budgets aligned with National action plans and budgets (expected contract result)	Outcome	N/A	100%	N/A	100%	100%	9	9	Project monitoring report	All provinces supported by USAID IHP have a plan and budget aligned at the national level and budget.	In FY2021, the Program will: - Support capacity building in financial management for DPS and target ZS by equipping a pool of national coaches - Support provinces to facilitate disbursements to provincial and local authorities. - Evaluate each province's PAO 2020 execution status and support DPS to develop their PAO 2021 in all ZS, integrating lessons learned from FY2019 and FY2020. - Support the DPS with the contrat unique process to strengthen stakeholder commitment to improving institutions.
		Kasaï	N/A	100%	N/A	100%	100%	4	4	Project monitoring report		
		Katanga	N/A	100%	N/A	100%	100%	3	3	Project monitoring report		
		Eastern Congo	N/A	100%	N/A	100%	100%	2	2	Project monitoring report		
1.3	Percentage of health zones with annual action plans and budgets that are aligned with provincial action plans and budgets (expected contract result)	Outcome	N/A	100%	N/A	89.9%	89.9%	161	179	Project monitoring report	On average, 89.9% of USAID IHP-supported ZS have a plan and budget aligned at the provincial level and budget. Katanga achieved 100% of its target.	In FY2021, USAID IHP will: - Support capacity building in financial management for target ZS by equipping a pool of national coaches - Evaluate each province's PAO 2020 execution status and support the DPS to develop their PAO 2021 in
		Kasaï	N/A	100%	N/A	79.2%	79.2%	61	77	Project monitoring report		
		Katanga	N/A	100%	N/A	100.0%	100.0%	57	57	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Eastern Congo	N/A	100%	N/A	95.6%	95.6%	43	45	Project monitoring report		all ZS, integrating lessons learned from FY2019 and FY2020.
IR 1.1:	**Enhanced capacity to plan, implement, and monitor services at provincial, health zone, and facility levels**											
1.1.1	Percentage of DPS and health zones that have used data to produce their annual plans data analysis (expected contract result)	Outcom e	N/A	100%	N/A	84.9%	84.9%	152	179	Project monitoring report	In FY20, USAID IHP supported all 9 DPS and 179 ZS to produce annual plans informed by available data, however the Program fell short of securing all resulting reports by August 2020 per the indicator definition.	In FY2, the Program will continue support to all DPS and ZS to produce data-informed annual plans that adhere to the indicator criteria.
		Kasaï	N/A	100%	N/A	79.2%	79.2%	61	77	Project monitoring report		
		Katanga	N/A	100%	N/A	100.0%	100.0%	57	57	Project monitoring report		
		Eastern Congo	N/A	100%	N/A	75.6%	75.6%	34	45	Project monitoring report		
1.1.2	Percentage of targeted sub-national health level divisions that successfully implement 80% of resourced action plan activities (expected contract result)	Outcom e	N/A	20.0%	N/A	0%	0.0%	0	9	Project monitoring report	Given the MOH's fiscal year that follows the calendar year, these results will not be available until the end of FY2021 Quarter 1.	N/A
		Kasaï	N/A	20.0%	N/A	0%	0.0%	0	4	Project monitoring report		
		Katanga	N/A	20.0%	N/A	0%	0.0%	0	3	Project monitoring report		
		Eastern Congo	N/A	20.0%	N/A	0%	0.0%	0	2	Project monitoring report		
1.1.3	Number of Results Based Financing (RBF) grants signed (expected contract result)	Outcom e	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	Per the updated PWS dated 13 June 2020, we will no longer do this activity.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
IR 1.2:	**Improved transparency and oversight in health service financing and administration at provincial, health zone, facility, and community levels**											
1.2.1	Score for financial management sub-domains of the PICAL assessment for provincial health divisions (contract deliverable)	Outcome	2.3	3.3	N/A	1.6	48.5%	N/A	N/A	Project monitoring report	The scores for FY2020 are for DPS and ZS that newly underwent the PICAL process this year, rather than a follow-up evaluation of the DPS and ZS originally evaluated via the baseline. These data points are therefore not comparable: the FY2020 DPS and ZS have not yet benefitted from the activities following the initial PICAL assessment that would merit re-evaluation and theoretically improved scores.	In FY2021, the Program will: – Conduct the evaluation of interventions carried out in the DPS following the strengthening plan established after the PICAL analysis. – Support workshops on the use of the PICAL tool, followed by institutional analysis in 5 ZS each in Kasaï-Central, Lomami, Sankuru, and Sud-Kivu, which were delayed due to COVID-19. Additionally, USAID IHP and USAID need to determine how to assess and interpret PICAL scores over time given initial PICAL assessments were implemented in a progressive fashion, and interventions/support vary from institution to institution.
		Kasaï	2.3	3.3	N/A	1.9	57.6%	N/A	N/A	Project monitoring report		
		Katanga	3.0	4.0	N/A	1.5	37.5%	N/A	N/A	Project monitoring report		
		Eastern Congo	2.0	3.0	N/A	1.5	50.0%	N/A	N/A	Project monitoring report		
1.2.2	PICAL assessment accountability sub-domain score for provinces and health zones receiving USG assistance (contract deliverable)	Output	2.0	3.1	N/A	1.7	55%	N/A	N/A	Project monitoring report	The scores for FY2020 are for DPS and ZS that newly underwent the PICAL process this year, rather than a follow-up evaluation of the DPS and ZS originally evaluated via the baseline. These data points are therefore not comparable: the FY2020 DPS and ZS have not yet benefitted from the activities following the initial PICAL assessment that would	In FY2021, the Program will: – Conduct the evaluation of interventions carried out in the DPS following the strengthening plan established after the PICAL analysis. – Support workshops on the use of the PICAL tool, followed by institutional analysis in 5 ZS each in Kasaï-Central, Lomami, Sankuru, and Sud-Kivu, which were delayed due to COVID-19. Additionally, USAID IHP and USAID need to determine how to assess and interpret
		Kasaï	1.8	2.8	N/A	1.9	68%	N/A	N/A	Project monitoring report		
		Katanga	2.0	4.0	N/A	1.7	43%	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Eastern Congo	2.5	3.5	N/A	0.8	23%	N/A	N/A	Project monitoring report	merit re-evaluation and theoretically improved scores.	PICAL scores over time given initial PICAL assessments were implemented in a progressive fashion, and interventions/support vary from institution to institution.
1.2.3	Percentage of DPS and Health Zones supported by the program that are audited with USAID IHP DRC technical and/or financial support (contract deliverable)	Output	N/A	100%	16.2%	40.2%	40.2%	72	179	Project monitoring report	USAID IHP provides audit support each quarter to a number of ZS based on DPS priorities and requests, which has not historically aligned with audit support to each ZS.	In FY2021, the Program will: – Provide support to quarterly trips of IPS for audits and oversight of ZS, with a focus on target ZS per province, as detailed in the Y3 workplan
		Kasaï	N/A	100%	22.1%	51.9%	51.9%	40	77	Project monitoring report		
		Katanga	N/A	100%	14.0%	35.1%	35.1%	20	57	Project monitoring report		
		Eastern Congo	N/A	100%	8.9%	26.7%	26.7%	12	45	Project monitoring report		
1.2.4	Number of tickets on the fraud and complaints hotline issue tracker (expected contract result)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This activity has not yet begun.	We are in the process of finalizing the technical development with Viamo for the implementation of the activity in Kasaï-Central and Lomami
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
IR 1.3:	**Strengthened capacity of Community Service Organizations (CSOs) and community structures to provide health system oversight**											
1.3.1	Percentage of active CCSOs/CODESAs in health zones fully supported by the program, which receive financial support (contract deliverable)	Output	N/A	5.0%	0.0%	7.8%	156.3%	250	3200	Project monitoring report	FY2020 results are explained by the variation in existing CSOs/CODESAs operations in each region. In Katanga, for instance, many CSOs/CODESAs were already supporting community activities with resources from other sources while, in comparison, Kasaï and	In FY2021, the Program will: – Provide technical and financial support for the organization and monthly holding of CODESA meetings in a few ZS – Engage CODESA in the Grants program: in favor of the organization of community transport
		Kasaï	N/A	5.0%	0.0%	7.1%	142.9%	94	1316	Project monitoring report		
		Katanga	N/A	5.0%	0.0%	1.5%	30.9%	15	971	Project monitoring report		
		Eastern Congo	N/A	5.0%	0.0%	15.4%	308.9%	141	913	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
											Eastern Congo	
1.3.2	Number and Percentage of supported CSOs/CODESAs using accountability tools (such as scorecards and audit reports) to monitor and / or demand improvement of financial management and/or service delivery (contract deliverable) (contract deliverable)	Outcom e	N/A	100.0%	0	N/A	N/A	N/A	N/A	Project monitoring report	This activity has not yet begun.	Finalize the evaluation of the financial management of the DPS
		Kasaï	N/A	100.0%	0	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	100.0%	0	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	100.0%	0	N/A	N/A	N/A	N/A	Project monitoring report		
1.3.3 Fee (Standard: CDCS-#)	Number of community service organizations (CSOs)/Health Area Development Committees (CODESAs) supported by the program that are woman-led (contract deliverable)	Outcom e¥	217	N/A	N/A	116	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	68	N/A	N/A	29	N/A	N/A	N/A	EDL 2019		
		Katanga	105	N/A	N/A	59	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	44	N/A	N/A	28	N/A	N/A	N/A	EDL 2019		
IR 1.4:	**Improved effectiveness of stakeholder coordination at the provincial and health zone levels**											
1.4.1	Percent of stakeholders who agree that their views are reflected in planning/policy processes	Output	41.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	44.6%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	40.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	37.2%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
1.4.2 (Standard: CDCS-#)	Percent of coalitions or networks strengthened to fulfill their mandate as a result of USG	Output	N/A	100%	44.4%	41.7%	42%	371	890	Project monitoring report	USAID IHP contributed to capacity building of 42% of the networks and/or coalitions identified and targeted	In FY21, the Program will continue this support by targeting networks and/or coalitions in proportion to the number of ZS in each target province across the Program's
		Kasaï	N/A	100%	94.1%	87.5%	88%	21	24	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	assistance (contract deliverable)	Katanga	N/A	100%	40.0%	50.0%	50%	7	14	Project monitoring report	during FY20, providing them with technical and/or financial support to fulfill their mandates. More than 90% of this support was concentrated in Eastern Congo where such networks and coalitions were identified as experienced and particularly dynamic in supporting a broad cross-section of community needs, especially in health. Notably, we supported CODESA, coalitions, and networks (VIVA campaign); the CTMP platform (FP technical assistance); and water committees (WASH technical assistance), among other organizations active in USAID programmatic areas (e.g., TB, FP/RH, nutrition, MNCH, and malaria). The COVID-19 pandemic and associated operational challenges limited the Program's reach relative to what was planned.	3 regions. The Program is also implementing internal planning and operational measures to improve coverage across ZS.
		Eastern Congo	N/A	100%	41.6%	40.3%	40%	343	852	Project monitoring report		
1.4.3	Annual score of provincial level health divisions in PICAL sub-dimension 2.6 to assess for use of	Output	0.86	1.9	N/A	0.3	15.8%	N/A	N/A	Project monitoring report	The scores for FY2020 are for DPS and ZS that newly underwent the PICAL process this year, rather than a follow-up evaluation of	In FY2021, the Program will: – Conduct the evaluation of interventions carried out in the DPS following the strengthening plan established after the PICAL

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	inclusive stakeholder feedback to inform decision-making and implementation (contract deliverable)	Kasaï	1.75	1.8	N/A	0.5	27.8%	N/A	N/A	Project monitoring report	the DPS and ZS originally evaluated via the baseline. These data points are therefore not comparable: the FY2020 DPS and ZS have not yet benefitted from the activities following the initial PICAL assessment that would merit re-evaluation and theoretically improved scores.	analysis. – Support workshops on the use of the PICAL tool, followed by institutional analysis in 5 ZS each in Kasaï-Central, Lomami, Sankuru, and Sud-Kivu, which were delayed due to COVID-19. Additionally, USAID IHP and USAID need to determine how to assess and interpret PICAL scores over time given initial PICAL assessments were implemented in a progressive fashion, and interventions/support vary from institution to institution.
		Katanga	2.00	2.0	N/A	0.3	15.0%	N/A	N/A	Project monitoring report		
		Eastern Congo	2.00	2.0	N/A	0.0	0.0%	N/A	N/A	Project monitoring report		
IR 1.5:	**Improved disease surveillance and strategic information gathering and use**											
1.5.1	Annual PICAL score of sub-national level health divisions assessed for information management capacity to monitor and inform their strategies (contract deliverable)	Output	1.4	2.4	N/A	1.3	54.2%	N/A	N/A	Project monitoring report	The scores for FY2020 are for DPS and ZS that newly underwent the PICAL process this year, rather than a follow-up evaluation of the DPS and ZS originally evaluated via the baseline. These data points are therefore not comparable: the FY2020 DPS and ZS have not yet benefitted from the activities following the initial PICAL assessment that would merit re-evaluation and theoretically improved scores.	In FY2021, the Program will: – Conduct the evaluation of interventions carried out in the DPS following the strengthening plan established after the PICAL analysis. – Support workshops on the use of the PICAL tool, followed by institutional analysis in 5 ZS each in Kasaï-Central, Lomami, Sankuru, and Sud-Kivu, which were delayed due to COVID-19. Additionally, USAID IHP and USAID need to determine how to assess and interpret PICAL scores over time given initial PICAL assessments were implemented in a progressive fashion, and interventions/support vary from institution to institution.
		Kasaï	2.4	2.4	N/A	1.5	62.5%	N/A	N/A	Project monitoring report		
		Katanga	2.2	2.2	N/A	1.3	59.1%	N/A	N/A	Project monitoring report		
		Eastern Congo	2.6	2.2	N/A	1.1	50.0%	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
1.5.2	Percentage of USG supported provinces and health zones with MAPEPI DHIS2 reporting rates > 95% (expected contract result)	Output	16.2%	20.2%	27.4%	29.1%	143.8%	52	179	DHIS 2	MAPEPI reporting remains low in USAID IHP-supported provinces. Kasaï region has the highest average reporting rate, at 43%.	In FY2020, USAID IHP will prioritize the following activities to improve this indicator: - Train the BCZS in MAPEPI; - Support the organization of MAPEPI meetings in the ZS; - Improve the MAPEPI data transmission circuit; - Supply the FOSA with data management tools.
		Kasaï	18.2%	22.2%	40.3%	42.9%	193.1%	33	77	DHIS 2		
		Katanga	15.8%	19.8%	19.3%	19.3%	97.5%	11	57	DHIS 2		
		Eastern Congo	13.3%	17.3%	15.6%	17.8%	102.8%	8	45	DHIS 2		
1.5.3	Percentage of targeted DPS, ECZS and FOSA teams that use real-time data dashboards in routine management tasks (contract deliverable)	Output	N/A	100.0%	0.0%	0.0%	0.0%	0	179	Project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	100.0%	0.0%	0.0%	0.0%	0	77	Project monitoring report		
		Katanga	N/A	100.0%	0.0%	0.0%	0.0%	0	57	Project monitoring report		
		Eastern Congo	N/A	100.0%	0.0%	0.0%	0.0%	0	45	Project monitoring report		
IR 1.6:	**Improved management and motivation of human resources for health**											
1.6.1	Average score of provinces and health zones assessed for HR management monitoring systems (contract deliverable)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Push on the consensus between USAID and MoH on the approach.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
1.6.2	Number of DPS/ECZS health workers trained in Human Resources Management using iHRIS (expected contract result)	Output	N/A	188	0	0	0.0%	N/A	N/A	Project monitoring report	We have not yet started this activity.	Consultation with the Ministry for the programming of the activity
		Kasaï	N/A	81	0	0	0.0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	60	0	0	0.0%	N/A	N/A	Project		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
										monitoring report		
		Eastern Congo	N/A	47	0	0	0.0%	N/A	N/A	Project monitoring report		
1.6.3	Number of ECDPs who have been coached according to Ministry of Health guidelines for Human Resources Management (expected contract result)	Output	N/A	9	0	10	111%	N/A	N/A	Project monitoring report	We have not yet started this activity.	Consultation with the Ministry for the programming of the activity
		Kasaï	N/A	4	0	0	0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	3	0	10	333%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	2	0	0	0%	N/A	N/A	Project monitoring report		
1.6.4	Number of providers who have benefited from using the Pathways to Change tool to improve their attitudes and behaviors (expected contract result)	Output	N/A	NA	NA	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started this activity.	Finalize the technical development with Matchboxology for the implementation and find consensus with MoH
		Kasaï	N/A	NA	NA	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	NA	NA	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	NA	NA	N/A	N/A	N/A	N/A	Project monitoring report		
IR 1.7:	**Increased availability of essential commodities at provincial, health zone, facility, and community levels**											
1.7.1 (Standard: CDCS)	Number and percentage of USG-assisted service delivery points that experience a stock out of selected tracer commodities at any time during the reporting period (contract deliverable)	Output	71.7%	67.7%	46.3%	49.4%	127.1%	3219	6517	DHIS 2	In FY2020, USAID IHP exceeded its targets for this indicator. Passing its goal of 4,200 commodity stockouts, there were only 3,703 at the end of FY2020. Haut-Lomami, however, had the lowest performance.	In FY2021, USAID IHP will continue to make tracer commodities available in health facilities to prevent stock shortages. Plans are in place to roll out a financial mechanism which will support more efficient delivery of commodities at the last mile, further supporting the availability of essential commodities.
		Kasaï	77.9%	73.9%	50.2%	55.8%	124.4%	1466	2626	DHIS 2		
		Katanga	61.4%	57.4%	39.8%	40.9%	128.7%	1025	2506	DHIS 2		
		Eastern Congo	76.0%	72.0%	50.5%	52.6%	127.0%	728	1385	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
1.7.2	Percent of USG supported health zones with LMIS reporting rates > 95% (expected contract result)	Output	32.4%	36.4%	25.1%	29.1%	79.8%	52	179	DHIS 2	The data reporting system remains satisfactory in all USAID IHP-supported provinces, though the provinces of Lualaba (79.6%) and Sankuru (88.3%) in Kasaï had relatively weak performances.	In FY2021, the Program plans to: - Train the ECZS and registered nurses in HMIS and DHIS2; - Strengthen supervision; - Support monthly reviews at the ZS and aire de sante levels; - Provide technical Internet support to allow for the encoding of data.
		Kasaï	42.9%	46.9%	31.2%	39.0%	83.1%	30	77	DHIS 2		
		Katanga	31.6%	35.6%	21.1%	22.8%	64.1%	13	57	DHIS 2		
		Eastern Congo	15.6%	19.6%	20.0%	20.0%	102.0%	9	45	DHIS 2		
1.7.3	Percent of supported sub-national level health divisions with a documented and budgeted distribution plan (expected contract result)	Output	N/A	60%	38.5%	52.0%	86.6%	93	179	Project monitoring report	In FY2020, the Program achieved a rate of 86.6% for this indicator. Overall, 56% or 116 ZS out of 179 have benefited from a documented and budgeted distribution plan. The following provinces have low rates: Kasaï-Central (31%), Lomami (38%), Sankuru (25%), and Haut-Lomami (75%).	In FY2021, the Program plans to: - Train the ECZS and registered nurses in HMIS and DHIS2; - Strengthen supervision; - Support monthly reviews at the ZS and aire de sante levels; - Provide technical Internet support to allow for the encoding of data.
		Kasaï	N/A	60%	50.6%	53.2%	88.7%	41	77	Project monitoring report		
		Katanga	N/A	60%	29.8%	50.9%	84.8%	29	57	Project monitoring report		
		Eastern Congo	N/A	60%	28.9%	51.1%	85.2%	23	45	Project monitoring report		
1.7.4	Percentage of Health Zones with improved conditions of medicines storage according the planned renovation (expected contract result)	Output	1.3%	N/A	N/A	N/A	N/A	N/A	179	Project monitoring report	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	77	Project monitoring report		
		Katanga	1.8%	N/A	N/A	N/A	N/A	N/A	57	Project monitoring report		
		Eastern Congo	2.4%	N/A	N/A	N/A	N/A	N/A	45	Project monitoring report		
IR 1.8:	**Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue**											
1.8.1 (Standard DR.3.1-3)	Number of consensus-building forums (multi-party, civil/security	Output	N/A	9	25	25	278%	N/A	N/A	Project monitoring report	We exceeded our overall target but fell short in Kasaï and Katanga.	In FY2021, the Program plans to: - Provide funding for the organization of quarterly

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	sector, and/or civil/political) held with USG assistance (contract deliverable)	Kasaï	N/A	4	0	0	0%	N/A	N/A	Project monitoring report		partner coordination meetings at the DPS level in the Kasaï region – Organize a monthly review of good practices on gender mainstreaming in several provinces – Organize a second edition of the Training on decentralization of the health sector in Haut-Katanga
		Katanga	N/A	3	0	0	0%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	2	25	25	1250%	N/A	N/A	Project monitoring report		
Result 2:	**Increased access to quality, integrated health services in target health zones**											
2.1 CDCS (Standard /PPR)	FP: Couple years of protection (CYP) in USG-supported programs	Outcome	1,000,409	1061334	396859	1351421.8	127.3%	N/A	N/A	DHIS 2	In FY2020, USAID IHP achieved 114% of this indicator.	In FY21, USAID IHP will implement the following activities: – Retrain FP providers in the two Kasaï provinces (Kasaï-Central and Lomami) – Train / Retrain service providers; – Provide FP supplies to providers.
		Kasaï	383,777	407148	134105	446910.0	109.8%	N/A	N/A	DHIS 2		
		Katanga	329,122	349165	133856	477569.8	136.8%	N/A	N/A	DHIS 2		
		Eastern Congo	287,511	305021	128898	426942.1	140.0%	N/A	N/A	DHIS 2		
2.2	FP: Couple years of protection (CYP) after exclusion of LAM and Standard days methods (SDM) for FP in USG-supported programs	Outcome	937,735	994843	371692	1257163.8	126.4%	N/A	N/A	DHIS 2	In FY2020, USAID IHP achieved 126.4% of this indicator. All regions exceeded their targets for the year.	In general, LAM and standard days methods approaches are underutilized by clients. In FY21, USAID IHP will conduct sensitization and awareness-raising activities during the FP mini-campaigns to encourage these two methods as part of the broader FP package.
		Kasaï	360,468	382421	124895	413556.1	108.1%	N/A	N/A	DHIS 2		
		Katanga	303,164	321626	123274	437239.7	135.9%	N/A	N/A	DHIS 2		
		Eastern Congo	274,103	290796	123523	406367.9	139.7%	N/A	N/A	DHIS 2		
2.3	FP: Number of counseling visits for FP/ RH as result of USG support	Output	192,080	1125282	1021	8375	0.7%	N/A	N/A	DHIS 2	For either new or repeat users of family planning methods, clients must first be sensitized/informed on different FP methods, then counseled specifically on the	The following corrective actions are proposed in FY21: 1) integrate this indicator into the service provider reporting tool for proper monitoring; 2) adapt FP messages during sensitization to benefit from individual counseling, in
		Kasaï	150,200	488446	389	4393	0.9%	N/A	N/A	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Katanga	26,796	361935	632	2466	0.7%	N/A	N/A	DHIS 2	method chosen. This is in line with the required free and informed choice for all FP clients. It should be noted that not all FP clients that are sensitized or provided information on FP methods, are then automatically counted as the people counseled on FP methods.	support of adherence to the method of one's choice and 3) make available the full range of contraceptive methods during mass sensitization activities.
		Eastern Congo	15,084	274901	0	1516	0.6%	N/A	N/A	DHIS 2		
2.4 (Standard: CDCS)	MALARIA: Percent of pregnant women who received doses of sulfadoxine/ pyrimethamine (S/P) for Intermittent Preventive Treatment (IPT) during ANC visits	Outcom e	67%	80%	68.9%	73.0%	91.2%	1174699	1609808	DHIS 2	USAID IHP's performance for this indicator was satisfactory but fell short, reaching 91.2% overall.	In Year 3, the program will focus on awareness raising activities at the community level, in particular open-door days. Provider knowledge of the ANC/IPTp calendar influences performance for this indicator. Refresher trainings will be planned in low-performing areas to build capacity. The Program also plans to follow-up on these refresher trainings with strong supervision.
		Kasaï	70%	80%	68.4%	75.5%	94.4%	504974	668803	DHIS 2		
		Katanga	64%	80%	70.7%	69.2%	86.5%	358643	518559	DHIS 2		
		Eastern Congo	62%	80%	67.6%	73.6%	92.0%	311082	422446	DHIS 2		
2.5 (Standard: CDCS)	Percentage of population who use selected facilities	Outcom e¥	42.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	43.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	43.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	36.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
2.6	Percentage of Health centers supported by the USG implementing interventions to support the minimum package of activities (contract deliverable)	Outcom e¥	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	0.1%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	0%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
2.7	Percentage of hospitals supported by the USG implementing interventions to support the complementary package of activities. (expected contract result)	Outcome	0.70%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	0.50%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	1.40%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	0.50%	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
2.8	Percentage of supported health facilities using MOH QoC tool (contract deliverable)	Output	16.8%	52.3%	1.6%	1.6%	3.1%	56	3402	Project monitoring report	We have not started this activity.	N/A
		Kasaï	13.7%	43.2%	1.5%	1.5%	3.5%	17	1131	Project monitoring report		
		Katanga	22.3%	35.7%	2.0%	2.0%	5.7%	18	891	Project monitoring report		
		Eastern Congo	14.9%	99.6%	1.5%	1.5%	1.5%	21	1380	Project monitoring report		
2.9 (Standard: CDCS)	Percentage of population reporting improved availability of selected services	Outcome¥	25.3%	N/A	N/A	N/A	N/A	1465	5790	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	27.5%	N/A	N/A	N/A	N/A	750	2729	EDM 2019		
		Katanga	27.3%	N/A	N/A	N/A	N/A	508	1861	EDM 2019		
		Eastern Congo	17.3%	N/A	N/A	N/A	N/A	207	1200	EDM 2019		
IR 2.1:	**Increased availability of quality, integrated facility-based health services**											
2.1.1 (Standard)	FP: Percent of USG-assisted service delivery sites providing FP counseling and/or services	Output	60.6%	63.0%	N/A	70.5%	111.9%	4587	6505	DHIS 2	Performance for this indicator remained low at around 60.6% in all supported USAID IHP provinces. Haut-Lomami (12.3%), Lomami (33.4%) and Kasaï-Oriental (38.0%) had the lowest performance.	USAID IHP will implement the following activities to address this underperformance: – Train registered nurses in FP; – Make data management tools available (registers and cards); – Strengthen the formative supervision in the ZS, aires de sante, and communities; – Train CBDs in counseling techniques.
		Kasaï	58.2%	65.9%	N/A	64.1%	97.3%	1681	2621	DHIS 2		
		Katanga	53.8%	58.5%	N/A	71.9%	122.9%	1796	2499	DHIS 2		
		Eastern Congo	75.6%	77.6%	N/A	80.1%	103.3%	1110	1385	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
2.1.2	MNCH: Percentage of pregnant women attending at least one antenatal care (ANC) visit with a skilled provider from USG-supported health facilities	Output	95.7%	100%	102.6%	97.1%	97.1%	1609808	1658165	DHIS 2	In FY20, 1,509,860 women used ANC services, against a target of 1,597,795. This represents an achievement rate of 94%. While this is satisfactory, the standard is 100%.	Corrective actions include: - Strengthen services with emphasis in Sankuru province (88.4%), Tanganyika (83.7%) and Haut-Lomami (89.0%) - Educate communities about the benefits of ANC services.
		Kasaï	96.3%	100%	102.1%	97.5%	97.5%	668803	685872	DHIS 2		
		Katanga	91.3%	100%	104.2%	97.9%	97.9%	518559	529887	DHIS 2		
		Eastern Congo	100.1%	100%	101.4%	95.5%	95.5%	422446	442406	DHIS 2		
2.1.3	MNCH: Percentage of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Outcome¥	75.4%	90%	86.6%	81.9%	91.0%	1358382	1658165	DHIS 2	Performance for this indicator is low at 88.1% overall. 5 out of 9 provinces have a rate of less than 90%: (Tanganyika (43.8%), Haut-Lomami (66.7%), Sankuru (89.1%), Lomami (86.2%) and Kasaï-Oriental (89.6%).	Corrective actions include: - Train provinces with low maternity performance at lower risk; - Sensitize communities; - Rehabilitate maternity wards; - Conduct supportive supervision.
		Kasaï	82.6%	90%	88.9%	85.6%	95.1%	586795	685872	DHIS 2		
		Katanga	69.6%	90%	92.4%	85.5%	95.0%	452836	529887	DHIS 2		
		Eastern Congo	70.7%	90%	76.0%	72.0%	80.1%	318751	442406	DHIS 2		
2.1.4 (PPR)	MNCH: Number of women giving birth who received uterotonics in the third stage of labor (OR immediately after birth) through USG-supported programs	Output	140458	242341	44082	160284	66.1%	N/A	N/A	DHIS2	The achievement rate for this indicator was at 63% for all HGRs in USAID IHP-supported provinces. Normally, the denominator of this indicator should correspond to the number of births 1,266,320 (see 2.1.3) as all women who give birth should benefit from the GATPA.	Corrective actions include: - To supply maternity wards with uterotonics; - Train midwives in SONU; - Strengthen supervision on the use of the partograph; - Train ECZS and ITs on the complementary module to allow ITs to report on the indicator.
		Kasaï	19244	33321	7045	25873	77.6%	N/A	N/A	DHIS2		
		Katanga	37395	67366	13911	50530	75.0%	N/A	N/A	DHIS2		
		Eastern Congo	83819	141654	23126	83881	59.2%	N/A	N/A	DHIS2		
2.1.5 (Standard /PPR)	MNCH: Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Output	33509	35550	8740	31777	89.4%	N/A	N/A	DHIS 2	For this indicator, USAID IHP achieved a completion rate of 89.0%.	Corrective actions include: - Train / retrain midwives in resuscitation techniques; - Provide post-training supervision and formative supervision.
		Kasaï	9818	10416	2140	8166	78.4%	N/A	N/A	DHIS 2		
		Katanga	14450	15330	4146	14366	93.7%	N/A	N/A	DHIS 2		
		Eastern Congo	9241	9804	2454	9245	94.3%	N/A	N/A	DHIS 2		
2.1.6	MNCH: Number of postpartum/newborn visits within three days of birth	Output	1121703	1190014	364144	1350181	113.5%	N/A	N/A	DHIS 2	The achievement rate of 113.5% for this indicator was satisfactory in all the	Corrective options include: - Lift the option for 6 hours or three days. (What?)
		Kasaï	525049	557024	154941	588025	105.6%	N/A	N/A	DHIS 2		
		Katanga	336949	357469	125664	454003	127.0%	N/A	N/A	DHIS 2		
		Eastern	259705	275521	83539	308153	111.8%	N/A	N/A	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	in USG-supported programs	Congo									provinces supported by USAID IHP.	
2.1.7 (CDCS)	MNCH: Number and percentage of newborns receiving essential newborn care through USG-supported programs	Output	91.5%	100%	94.6%	94.2%	94.2%	1301124	1380769	DHIS 2	In FY2020, 1,204,775 newborns benefited from essential newborn care out of a target of 1,291,295 (93.3% achievement). Tanganyika (86.3%) and Lomami (88.1%) underperformed compared to the rest of the provinces.	In FY2021, USAID IHP will direct efforts specifically to these two provinces (examples include post-training follow-up; clinical care monitoring) and also retrain the care providers.
		Kasaï	91.8%	100%	93.6%	93.6%	93.6%	558491	596669	DHIS 2		
		Katanga	89.7%	100%	94.8%	93.7%	93.7%	436512	465869	DHIS 2		
		Eastern Congo	93.2%	100%	96.2%	96.2%	96.2%	306121	318231	DHIS 2		
2.1.8 (PPR)	MNCH: Number of newborns receiving antibiotic treatment for infection from trained health workers through USG-supported programs	Output	212375	225309	43594	172846	76.7%	N/A	N/A	DHIS 2	The number of newborns on antibiotics is still low, for a completion rate of 81%. Kasaï-Central (59.4%) and Sankuru (42.8%) had the lowest performance.	Corrective actions explained for the above indicator, in particular training and support for the providers, will help improve performance for this indicator.
		Kasaï	98016	103985	16856	70801	68.1%	N/A	N/A	DHIS 2		
		Katanga	89734	95199	21948	81895	86.0%	N/A	N/A	DHIS 2		
		Eastern Congo	24625	26125	4790	20150	77.1%	N/A	N/A	DHIS 2		
2.1.9	MNCH: Drop-out rate in DTP-HepB-Hib3 among children less than 12 months of age	Output	5%	4.0%	5.1%	5.1%	126.8%	70786	1395544	DHIS 2	In general, the dropout rate is considered satisfactory as long as it is not above 10%. Particular attention should be paid to Lualaba and Haut-Katanga, where performance was low for this indicator.	Corrective actions: we plan to conduct trainings for this service focusing in particular on Lualaba and Haut-Katanga. We will also focus on increased community sensitization on the importance of vaccinations.
		Kasaï	5%	4.0%	3.4%	3.6%	90.2%	20834	577607	DHIS 2		
		Katanga	7%	5.0%	6.7%	6.5%	129.9%	29438	453354	DHIS 2		
		Eastern Congo	5%	4.0%	5.7%	5.6%	140.7%	20514	364583	DHIS 2		
2.1.10 (Standard /PPR)	NUTRITION: Number of individuals receiving nutrition-related professional training through USG supported nutrition programs	Outcome	N/A	3695	964	3123	84.5%	N/A	N/A	Project monitoring report	The achievement rate for nutrition trainings is 84.5%; the highest rate achieved was in Sankuru which, after working with the local head of DPS, we promoted training activities in IMNCI, training in revitalized preschool consultation, and IYCF. Lomami and	In FY2021, USAID IHP will work to establishment of pools of trainers in IMNCI and the other noted key nutrition interventions in the provinces (especially in Haut-Katanga, Lualaba, Lomami, Kasaï-Central, Kasaï-Oriental, and Tanganyika).
		Kasaï	N/A	1739	434	1571	90.3%	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Katanga	N/A	1135	116	930	81.9%	N/A	N/A	Project monitoring report	Lualaba exceeded the target by 100%. Kasaï-Central, Haut-Lomami, Haut-Katanga, Tanganyika, and Sud-Kivu had low achievement rates due to COVID-19 restrictions. Many trainings, especially those for which the trainers are Kinshasa-based (IMNCI community interventions especially) were unable to take place as provinces because there were no provincial trainers to implement them.	
		Eastern Congo	N/A	821	414	622	75.8%	N/A	N/A	Project monitoring report		
2.1.11 (Standard /PPR)	NUTRITION: Number of children under-five (0-59 months) reached by USG-supported nutrition programs	Output	520956	2226517	N/A	2764804	124.2%	N/A	N/A	DHIS 2	Overall, USAID IHP achieved 124.2% of this target, with especially high rates in Lomami and Sankuru. Kasaï-Oriental, Haut-Katanga, Lualaba, Sud-Kivu also exceeded 100%. These high-performing provinces also had high attendance rates at preschool consultations. Haut-Lomami, which had a low rate of 43%, is among the provinces with low attendance at preschool consultations.	In FY2021, USAID IHP will carry out the data audit, particularly in the provinces of Loamami and Sankuru, and also monitor the availability of vit-A in health facilities.
		Kasaï	175472	987119	N/A	1452322	147.1%	N/A	N/A	DHIS 2		
		Katanga	133310	620767	N/A	552668	89.0%	N/A	N/A	DHIS 2		
		Eastern Congo	212174	618631	N/A	759814	122.8%	N/A	N/A	DHIS 2		
2.1.12 (Standard)	NUTRITION: Number of children under two (0-23 months) reached	Outcome	620698	775872	N/A	803279	103.5%	N/A	N/A	DHIS 2	With the exception of Sud-Kivu, all other provinces performed well under this	Next steps for FY2021 include supporting community sensitization on nutritional interventions and making data
		Kasaï	294527	368158	N/A	410642	111.5%	N/A	N/A	DHIS 2		
		Katanga	143759	179699	N/A	177485	98.8%	N/A	N/A	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	with community-level nutrition interventions through USG-supported programs	Eastern Congo	182412	228015	N/A	215152	94.4%	N/A	N/A	DHIS 2	indicator.	management tools available.
2.1.13 (Standard /PPR)	NUTRITION: Number of pregnant women reached with nutrition interventions through USG-supported programs	Output	1432281	1519511	431973	1609808	105.9%	N/A	N/A	DHIS 2	THIS DOES NOT MATCH DATA: We achieved our targets for this indicator.	Next steps: - To continue to supply the FOSAs with in iron + folate acid.
		Kasaï	603904	640681	176994	668803	104.4%	N/A	N/A	DHIS 2		
		Katanga	432196	458517	140659	518559	113.1%	N/A	N/A	DHIS 2		
		Eastern Congo	396181	420313	114320	422446	100.5%	N/A	N/A	DHIS 2		
2.1.14	MALARIA: Number of health workers trained in IPTp with USG funds	Output	N/A	1958	204	1677	85.6%	N/A	N/A	Project monitoring report	In FY2020, USAID IHP achieved 135% of its targets for this indicator. There were a few underachieving provinces: Kasaï-Oriental at 61.3%; Haut-Katanga at 63.1% and Tanganyika at 56.0%. Haut-Katanga and Tanganyika had difficulties carrying out their trainings in Q3 due to COVID-19 restrictions. Kasaï-Oriental had planned to catch up in Quarter 4 but still fell short of their annual target. They will catch up in the first quarter of FY2021.	Training will continue throughout the next year with a focus on low performing provinces.
		Kasaï	N/A	943	167	1061	112.5%	N/A	N/A	Project monitoring report		
		Katanga	N/A	662	17	385	58.2%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	353	20	231	65.4%	N/A	N/A	Project monitoring report		
2.1.15	MALARIA: Number of health workers trained in case management with ACTs with USG funds	Output	N/A	1811	116	1351	74.6%	N/A	N/A	Project monitoring report	We did not meet our targets for this indicator; COVID-19 restrictions made travel difficult.	Planned trainings from FY20 that didn't take place will be held in Year 3. Overall trainings in Year 3 will focus on lowest performing provinces.
		Kasaï	N/A	980	116	925	94.4%	N/A	N/A	Project monitoring report		
		Katanga	N/A	505	0	292	57.8%	N/A	N/A	Project monitoring		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
										report		
		Eastern Congo	N/A	326	0	134	41.1%	N/A	N/A	Project monitoring report		
2.1.16	MALARIA: Number of health workers trained in malaria laboratory diagnostics (Rapid Diagnosis Tests (RDT) or microscopy) with USG funds	Output	N/A	1811	112	1347	74.4%	N/A	N/A	Project monitoring report	The targets for Year across the three regions was 92.5%. Both Eastern Congo (102.3%) and Kasaï (116.2%) exceeded their targets with Katanga achieving only 55.2%. Difficulties with domestic travel related to COVID-19 as well as poor road conditions contributed to the poor performances in Katanga.	Planned trainings from FY20 that didn't take place will be held in Year 3. Overall trainings in Year 3 will focus on lowest performing provinces.
		Kasaï	N/A	980	116	925	94.4%	N/A	N/A	Project monitoring report		
		Katanga	N/A	505	0	292	57.8%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	326	0	134	41.1%	N/A	N/A	Project monitoring report		
2.1.17	TB: TB notification rate through USG-supported programs	Output	126	150	154.9	144.2	96.2%	49279	34165336	DHIS 2	The average notification rate for the second year is 96.2%, we note one case notification in Q4 of the year with 154.9%	To improve the notification of TB cases in ZSs, USAID IHP will intensify the technical support of 9 CPLTs supported by the program, in the implementation of active approaches to detecting cases of TB in the community, particularly among populations. such as prisoners, minors (mine workers), displaced persons, etc. the population. such as prisoners, miners (mine workers), displaced persons, etc.
		Kasaï	126	150	156.0	136.5	91.0%	20980	15365788	DHIS 2		
		Katanga	156	150	208.0	202.3	134.9%	19542	9659872	DHIS 2		
		Eastern Congo	94	150	99.7	95.8	63.9%	8757	9139676	DHIS 2		
2.1.18 PPR	TB: Number of patients diagnosed with TB that have initiated first-line treatment. (PPR)	Output	61974	82476	21637	77890	94.4%	N/A	N/A	DHIS 2	We notice an increase in the number of cases diagnosed with TB and put into first-line treatment in Q4 of the year with a completion	Provide supportive supervision especially in underperforming provinces. Ensure TB drug and supplies are available.
		Kasaï	28508	39353	11153	38332	97.4%	N/A	N/A	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Katanga	21823	29256	7008	26455	90.4%	N/A	N/A	DHIS 2	rate at the year of 94.4%. Lomami and Kasaï-Central have put all of the diagnosed patients on treatment. Haut-Katanga and Tanganyika have a performance of less than 90%.	
		Eastern Congo	11643	13867	3476	13103	94.5%	N/A	N/A	DHIS 2		
2.1.19	TB: Therapeutic success rate through USG-supported programs	Output	64.7	95	93.4	91.9	96.7%	40385	43951	DHIS 2	We saw a therapeutic success rate of 91% for a completion rate of 96.7% for the target set at 95% The treatment success rate has progressed gradually from Q1 to Q4. the following provinces experienced a rate> or equal to 100%/: Kasaï-Oriental, Lomami, Sankuru and Haut-Lomami. Haut-Katanga province has a low rate.	To improve the treatment success rate in the poorest performing provinces, in particular Haut-Katanga, support must focus on the regular supply of TB medicines, in particular anti-tuberculosis drugs (mainly SR) from the FOSA for the management of Tuberculosis patients, the strict application of directly observed treatment (DOT) in these facilities and in the community (community DOT) and the recovery by community workers of patients treated but lost to follow-up.
		Kasaï	55.5	95	97.4	96.0	101.0%	18121	18877	DHIS 2		
		Katanga	76.7	95	90.2	88.5	93.2%	14420	16290	DHIS 2		
		Eastern Congo	63.7	95	91.1	89.3	94.0%	7844	8784	DHIS 2		
2.1.20 (Standard)	TB: HL.2.4-1 Number of multi-drug resistant (MDR) TB cases detected	Outcom e	405	720	99.0	329	45.7%	N/A	N/A	DHIS 2	Number of multidrug-resistant tuberculosis (MDR) cases detected increased from Q1 to Q4. the provinces of Kasaï-Oriental and Haut-Lomami are the ones with the most cases of MDR; the other provinces have a rate <60%.	To improve the number of MDRs in the poorest performing provinces, support should focus on active campaigns and screening.
		Kasaï	190	288	54.0	162	56.3%	N/A	N/A	DHIS 2		
		Katanga	158	308	35.0	122	39.6%	N/A	N/A	DHIS 2		
		Eastern Congo	57	124	10.0	45	36.3%	N/A	N/A	DHIS 2		
2.1.21	TB: Number of multi-drug resistant TB cases that have initiated second line treatment	Outcom e¥	237	329	71	241	73.3%	N/A	N/A	DHIS 2	The number of MDRs put on second-line treatment increased during the year from Q1 to Q4, only the province of Sankuru	The Program aims to put all MDR patients on treatment. Continue supplying Health Training with Medicines and Inputs Perform formative supervision
		Kasaï	130	162	32	111	68.5%	N/A	N/A	DHIS 2		
		Katanga	77	122	32	100	82.0%	N/A	N/A	DHIS 2		
		Eastern Congo	30	45	7	30	66.7%	N/A	N/A	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
											put all MDR patients on treatment.	
2.1.22	TB: Therapeutic success rate for RR-/MDR-TB through USG-supported programs	Output	TBD	75.0	79.2	78.3	104%	263	336	DHIS 2	The therapeutic success rate has changed dramatically during the year; the completion rate at the end of the year is 104%. The provinces of Kasaï-Central, Haut-Katanga and Tanganyika have low rates of therapeutic success.	Put all patients on treatment; Continue offering training, medicines, supplies and formative supervision.
		Kasaï	TBD	75.0	88.2	83.6	111%	122	146	DHIS 2		
		Katanga	TBD	75.0	67.6	72.7	97%	101	139	DHIS 2		
		Eastern Congo	TBD	75.0	66.7	78.4	105%	40	51	DHIS 2		
2.1.23	TB: Percentage of under five children who received (or are receiving) INH prophylaxis through USG-supported programs	Output	5717	100%	80.2%	72.1%	72.1%	17541	24327	DHIS 2	17,541 children aged 0-5 years were put on prophylactic treatment with INH after exclusion of the active form of TB, i.e. 72.1% (17.541 / 24.327), representing a completion rate of 72.1% compared to the target of 100%. This proportion increased from Q2 to Q4. The Provinces of Kasaï-Oriental, Haut-Katanga and Tanganyika have a proportion of greater than 60%.	Support the training of physicians in the HGR on the radiological diagnosis of TB in children, the briefing on the new WHO guidelines on prophylactic treatment, the use of the Keith Edouard scorecard and the use pediatric TB screening algorithms, support for providers during supervision visits.
		Kasaï	2713	100%	93.5%	85.2%	85.2%	8395	9855	DHIS 2		
		Katanga	1784	100%	66.5%	60.8%	60.8%	6060	9968	DHIS 2		
		Eastern Congo	1220	100%	76.7%	68.5%	68.5%	3086	4504	DHIS 2		
2.1.24	TB: Percentage of new-enrolled HIV-positive patients without TB who received (or are receiving) INH prophylaxis through USG-supported	Output	54	100%	75.6%	64.5%	64.5%	17820	27610	DHIS 2	Of a total of 27,610 newly enrolled PLHIV in whom TB was excluded, 17,820 PLHIV, or 64.5% (17,820 / 27,610), were put on Isoniazid (INH) prophylaxis remain positive during	To improve the use of INH prophylaxis in Y 3, USAID IHP will strengthen synergy with other partners supporting the management of TB-HIV co-infection, participate in provincial coordination meetings of joint TB-HIV activities and those relating to
		Kasaï	48	100%	81.8%	78.9%	78.9%	3391	4297	DHIS 2		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	programs	Katanga	59	100%	74.1%	61.1%	61.1%	12738	20849	DHIS 2	the year from Q1 to Q4. Haut-Katanga and Lomami have a low percentage of newly enrolled PLHIV.	the provincial TB-HIV task force, support the CPLT to popularize the updated guidelines on the "One Stop Shop" strategy, and support the activities of community-based organizations operating in the context of co-infection TB-HIV.
		Eastern Congo	44	100%	80.9%	68.6%	68.6%	1691	2464	DHIS 2		
2.1.25	TB: Percentage of new-enrolled HIV-positive patients screened for TB through USG-supported programs	Outcome	64.7	100%	89.3%	76.6%	0.765628121	38335	50070	DHIS 2	Percentage of new HIV-positive patients screened for tuberculosis 76.6% in all 9 provinces supported by PROSANI. Kasaï-Central and Lomami have low rates <60%.	In the third year, the program was to support the FOSA to detect 100% of new HIV-positive cases.
		Kasaï	55.5	100%	72.0%	61.3%	0.613386308	12042	19632	DHIS 2		
		Katanga	76.7	100%	91.5%	88.6%	0.886078143	20456	23086	DHIS 2		
		Eastern Congo	63.7	100%	84.5%	79.4%	0.793933624	5837	7352	DHIS 2		
2.1.26	TB: Number of individuals trained in any component of the World Health Organization Stop TB strategy with USG funding.	Output	N/A	1640	942	1041	63.5%	N/A	N/A	Project monitoring report	Number of people trained in any part of the World Health Organization's Stop TB strategy is 1041. All provinces were trained this year.	Training will be supported through supervision in all provinces.
		Kasaï	N/A	801	332	408	50.9%	N/A	N/A	Project monitoring report		
		Katanga	N/A	599	388	411	68.6%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	240	222	222	92.5%	N/A	N/A	Project monitoring report		
2.1.27 (PPR)	GBV: Number of women treated for gender-based violence. PPR.	Outcome	8318	6932	2988	9611	138.6%	N/A	N/A	DHIS 2	The numbers of women treated for violence exceeded the target set for the year (138.7%). We observe a strong increase in the provinces of Kasaï-Central (288.5%), Sankuru (201.5%) and Tanganyika 187.6%.	Next step: - Awareness at the community level - Advocacy with the politico-administrative authorities
		Kasaï	2056	1714	950	2924	170.6%	N/A	N/A	DHIS 2		
		Katanga	599	499	169	581	116.4%	N/A	N/A	DHIS 2		
		Eastern Congo	5663	4719	1869	6106	129.4%	N/A	N/A	DHIS 2		
2.1.28	GBV: Number of surgical fistula	Output	N/A	100	0	0	0%	N/A	N/A	Project monitoring	We have not yet started this activity.	N/A

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	repairs provided with USG-assistance									report		
		Kasaï	N/A	20	0	0	0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	20	0	0	0%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	60	0	0	0%	N/A	N/A	Project monitoring report		
2.1.29	GBV: Number of surgical fistula repairs provided with USG-assistance that remained closed after discharge	Output	N/A	TBD	0	0	0%	N/A	N/A	Project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	TBD	0	0	0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	0	0	0%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	0	0	0%	N/A	N/A	Project monitoring report		
IR 2.2	**Increased availability of quality, integrated community-based health services**											
2.2.1 (Standard /PPR)	FP: Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year	Output	N/A	2400	N/A	1003	41.8%	N/A	N/A	DHIS2 (MC)	The number of CHWs trained is satisfactory during the year: 70.0%. The following provinces have not trained this year: Kasaï-Central, Kasaï-Oriental, Haut-Katanga, Sud-Kivu and Haut-Lomami province.	Continue training in the provinces with poor performance.
		Kasaï	N/A	855	N/A	581	68.0%	N/A	N/A	DHIS2 (MC)		
		Katanga	N/A	600	N/A	325	54.2%	N/A	N/A	DHIS2 (MC)		
		Eastern Congo	N/A	945	N/A	168	17.8%	N/A	N/A	DHIS2 (MC)		
2.2.2	Percent of target population who report that they are able to access the basic health services available to their community (contract deliverable)	Output	19.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	21.3%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Katanga	22.7%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	11.5%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
2.2.3	Percent of citizens	Impact	58.8%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	This indicator is	This data is collected with the

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	reporting improvement and equity in service delivery of local level institutions with USG assistance (contract deliverable)	Kasaï	59.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019	reported in Y1, Y4, and Y7.	household survey.
		Katanga	63.9%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
		Eastern Congo	49.0%	N/A	N/A	N/A	N/A	N/A	N/A	EDM 2019		
2.2.4	Number of Integrated Community Case Management (iCCM) sites in USG-supported communities (expected contract result)	Output	1275	1825	475	848	46.5%	N/A	N/A	EDL 2019	The number of ICCM sites supported by the project is still low, ie a rate of 45% (829). Only Haut-Lomami and Lualaba performed well.	Continue to support health care sites as planned, especially for the provinces with poor performance.
		Kasaï	299	889	192	323	36.3%	N/A	N/A	EDL 2019		
		Katanga	243	476	122	363	76.3%	N/A	N/A	EDL 2019		
		Eastern Congo	733	460	161	162	35.2%	N/A	N/A	EDL 2019		
2.2.5	Proportion of supervisory visits performed during the quarter to relais	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the service provider mapping survey.
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	EDL 2019		
IR 2.3:	**Improved referral system from community-based platforms to health centers and reference hospitals**											
2.3.1	Number of individuals referred to supported health facilities by relais and CBDs (contract deliverable)	Output	61034	63500	16746	57967	91.3%	N/A	N/A	Project monitoring report	The number of patients referred to the health center by the relais is satisfactory: 57,967 or 91.3%. The following provinces show poor performance: Kasaï-Oriental, Lomami and Tanganyika.	Next step: – Carry out supportive supervision and post-training follow-up; – Make the reference and cross-reference tools available.
		Kasaï	33073	34409	10672	36925	107.3%	N/A	N/A	Project monitoring report		
		Katanga	8286	8621	2670	9592	111.3%	N/A	N/A	Project monitoring report		
		Eastern Congo	19675	20470	3404	11450	55.9%	N/A	N/A	Project monitoring report		
2.3.2	Number of individuals referred by relais/CBDs that were received by supported health facilities (completed referrals) (expected contract result)	Output	350457	371800	148082	521676	140.3%	N/A	N/A	DHIS 2	The number of cases referred by community relays to exceed the target of 40.3%. All provinces have exceeded the target.	We have updated targets for Y3. WE will maintain progress.
		Kasaï	241407	256109	91854	324687	126.8%	N/A	N/A	DHIS 2		
		Katanga	44385	47088	31374	105840	224.8%	N/A	N/A	DHIS 2		
		Eastern Congo	64665	68603	24854	91149	132.9%	N/A	N/A	DHIS 2		
2.3.3	Number of women	Output	TBD	2400	N/A	N/A	N/A	N/A	N/A	DHIS2	This data is not yet	N/A

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	transported for facility delivery (contract deliverable)									(MC)	available. The module complementaire was delayed due to COVID-19.	
		Kasaï	TBD	855	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		Katanga	TBD	600	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
		Eastern Congo	TBD	945	N/A	N/A	N/A	N/A	N/A	DHIS2 (MC)		
IR 2.4:	**Improved health provider attitudes and interpersonal skills at facility and community levels**											
2.4.1	Average attitudes and interpersonal skills score as measured by the Provider / User checklist at supported health facilities (expected contract result)	Output	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report	This activity has not yet begun.	N/A
		Kasaï	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
2.4.2	Number of supported facilities offering a package of youth-friendly family planning services (contract deliverable)	Output	55	40	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	7	25	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	21	15	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	27	0	N/A	N/A	N/A	N/A	N/A	EDL 2019		
2.4.3	Number of supported facilities offering a package of comprehensive SGBV services (contract deliverable)	Output	149	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the mapping survey.
		Kasaï	60	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Katanga	29	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
		Eastern Congo	60	N/A	N/A	N/A	N/A	N/A	N/A	EDL 2019		
IR 2.5:	**Increased availability of innovative financing approaches**											
2.5.1	Number of innovative financing tools piloted (contract deliverable)	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	Activity not yet started due to lack of agreement with USAID and MoH.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
IR 2.6:	**Improved basic facility infrastructure and equipment to ensure quality services**											
2.6.1 (Fee, CDCS)	Percentage of targeted health care facilities receiving infrastructure and/or equipment support	Outcome	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not yet started corresponding activities.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
2.6.2 (Standard /PPR)	HL.8.1-1 Number of people gaining access to basic drinking water services as a result of USG assistance	Outcome	N/A	7500	N/A	5358	71%	N/A	N/A	Project monitoring report	Due to the limited availability of input materials at the local level, the shift in Program strategy in Q3 from community-based WASH to the clean clinic approach, and restricted movements related to COVID-19, these activities launched only in Q3 in Sud-Kivu and Q4 in Kasaï-Oriental, with activities slated to continue into FY21 Q1 in both provinces. During this period alone the province of Sud-Kivu had 38,514 people who had access to basic drinking water services thanks to the assistance of the American government to more than the 5,000 planned at the start of the program.	To improve this indicator, USAID IHP will continue implementation of community-based rehabilitation works in Sud-Kivu and Kasaï-Oriental.
		Kasaï	N/A	2500	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	5000	N/A	5358	107%	N/A	N/A	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
2.6.3 (Standard /PPR)	WASH: HL.8.2-2 Number of people gaining access to a basic sanitation service as a result of USG assistance	Outcome	N/A	930	N/A	20976	2255.5%	N/A	N/A	Project monitoring report	We have reported here the number of people who gained physical access to basic sanitation as a result of USAID assistance.	We have relevant activities scheduled in Y3.
		Kasaï	N/A	N/A	N/A	19173	N/A	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	930	N/A	1803	193.9%	N/A	N/A	Project monitoring report		
2.6.4 (Standard /PPR)	WASH: HL.8.2-4 Number of basic sanitation facilities provided in institutional settings as a result of USG assistance	Outcome	N/A	340	N/A	N/A	0	N/A	N/A	Project monitoring report	Clean clinic approach activities in 82 facilities advanced to the improvements implementation stage, which is pending procurement of local vendor services for the construction and oversight of basic sanitation facilities. This activity is expected to continue through FY2021.	We have relevant activities scheduled in Y3.
		Kasaï	N/A	180	N/A	N/A	0	N/A	N/A	Project monitoring report		
		Katanga	N/A	N/A	N/A	N/A	0	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	160	N/A	N/A	0	N/A	N/A	Project monitoring report		
IR 2.7:	**Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue**											
2.7.1	Number of knowledge sharing workshops supported (contract deliverable)	Output	N/A	9	2	4	44.4%	N/A	N/A	Project monitoring report	Four knowledge sharing workshops were held in two provinces: one in Haut-Lomami, two in Sankuru and one Kasaï-Central.	We have knowledge sharing workshops scheduled in Y3.
		Kasaï	N/A	4	2	3	75.0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	3	0	1	33.3%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	2	0	0	0.0%	N/A	N/A	Project monitoring report		
2.7.2	Number of strategies / policies that have been updated from good practices and	Output	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report	We have not been able to do this yet.	N/A
		Kasaï	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	lessons learned									report		
		Katanga	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	N/A	N/A	N/A	N/A	N/A	Project monitoring report		
2.7.3	Number of success stories developed	Output	N/A	36	6	41	113.9%	N/A	N/A	Project monitoring report	The indicator did not reach the target. Out of 36 stories planned, USAID IHP produced 23, achieving a completion rate of 63.9%. Many provinces have low rates or no stories produced (Tanganyika, Haut-Katanga, Haut-Lomami, Sankuru and Sud-Kivu). Two were done at the national level	In Year 3, the USAID IHP will continue to build capacity of the technical staff and the ECZS to write the success stories.
		Kasaï	N/A	16	3	13	81.3%	N/A	N/A	Project monitoring report		
		Katanga	N/A	12	1	5	41.7%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	8	2	12	150.0%	N/A	N/A	Project monitoring report		
Result 3:	**Increased adoption of healthy behaviors, including use of health services, in target health zones**											
3.1	Percentage of USG-supported health zones that demonstrate improvement in key accelerator behavior indicators	Outcome	8.6%	N/A	N/A	8.6%	N/A	767	8960	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	10.1%	N/A	N/A	10.1%	N/A	415	4098	EDM 2019		
		Katanga	9.4%	N/A	N/A	9.4%	N/A	270	2860	EDM 2019		
		Eastern Congo	4.1%	N/A	N/A	4.1%	N/A	82	2002	EDM 2019		
3.2	Percentage of children under age 2 living with the mother who are exclusively breastfed, age 0-5 months	Outcomeβ	UA	N/A	N/A	76.7%	N/A	355	463	EDM 2019	This indicator is reported in Y1, Y4, and Y7.	This data is collected with the household survey.
		Kasaï	UA	N/A	N/A	81.3%	N/A	191	235	EDM 2019		
		Katanga	UA	N/A	N/A	71.2%	N/A	104	146	EDM 2019		
		Eastern Congo	UA	N/A	N/A	73.2%	N/A	60	82	EDM 2019		
IR 3.1:	**Increased practice of priority healthy behaviors at the individual, household, and community levels**											
3.1.1 Fee	Percentage of health areas reached by Healthy Family Campaign SBC campaigns	Output	N/A	7.3%	12.1%	21.6%	295.4%	690	3200	Project monitoring report	USAID exceeded its targets for VIVA campaign activities across all three Regions.	USAID IHP focused on design and launch of the campaign in FY20. In Year 3 the Program will focus on implementation.
		Kasaï	N/A	12.7%	11.4%	23.4%	184.3%	308	1316	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
		Katanga	N/A	6.4%	11.2%	17.8%	278.4%	173	971	Project monitoring report		
		Eastern Congo	N/A	5.2%	14.1%	22.9%	440.2%	209	913	Project monitoring report		
3.1.2	Percentage of trained community mobilizers active at community level (contract deliverable)	Output	0	100%	84.7%	98.3%	98.3%	807	821	Project monitoring report	93.8% of health zones had SBC campaigns of the Healthy Family Campaign. Kasaï-Central, Haut-Lomami, Lualaba and Tanganyika. did not organize Healthy Family Campaigns in their respective ZS.	We plan to organize the Healthy Family Campaign in ZS of the provinces of: Kasaï-Central, Haut-Lomami, Lualaba and Tanganyika.
		Kasaï	0	100%	79.1%	84.9%	84.9%	513	604	Project monitoring report		
		Katanga	0	100%	100.0%	100.0%	100.0%	64	64	Project monitoring report		
		Eastern Congo	0	100%	100.0%	150.3%	150.3%	230	153	Project monitoring report		
3.1.3	Number of facilities providers trained in interpersonal communication skills	Output	N/A	648	116	155	23.9%	N/A	N/A	Project monitoring report	The number of service providers trained in interpersonal communication skills is still low 155 from the two provinces Haut-Katanga 39 people and Sud-Kivu 116.	Train other provinces in interpersonal communication skills.
		Kasaï	N/A	354	0	0	0.0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	177	0	39	22.0%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	117	116	116	99.1%	N/A	N/A	Project monitoring report		
IR 3.2:	**Increased use of facility- and community-based health services**											
3.2.1	Number of targeted communities that have access to real-time information about availability of health services in their catchment areas (contract deliverable)	Output	N/A	TBD	0	0	0.0%	N/A	N/A	Project monitoring report	We have not yet started this activity.	N/A
		Kasaï	N/A	TBD	0	0	0.0%	N/A	N/A	Project monitoring report		
		Katanga	N/A	TBD	0	0	0.0%	N/A	N/A	Project monitoring report		
		Eastern Congo	N/A	TBD	0	0	0.0%	N/A	N/A	Project monitoring report		
3.2.2	Number of	Output	TBD	108	59	109	100.9%	N/A	N/A	Project	Across the three	For Year 3, the Program will

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
	awareness campaigns designed, implemented, and evaluated with community participation. (contract deliverable)									monitoring report	provinces, the Program reached it's target for this activity for FY20. Targets in Eastern Congo were exceeded but not met in Kasaï and Katanga.	look into the lower rates of achievement for Kasaï and Katanaga and evaluate barriers that may have prevented them achieving their targets. In Year 3, USAID IHP will ensure this activity is achieved across the three provinces.
		Kasaï	TBD	48	23	41	85.4%	N/A	N/A	Project monitoring report		
		Katanga	TBD	36	17	29	80.6%	N/A	N/A	Project monitoring report		
		Eastern Congo	TBD	24	19	39	162.5%	N/A	N/A	Project monitoring report		
IR 3.3:	**Reduced socio-cultural barriers to the use of health services and the practice of key healthy behaviors**											
3.3.1 Fee	Percentage of health areas reached by Healthy Family Campaign SBC events with messages disseminated targeting youth and other vulnerable groups per year	Output	N/A	27.4%	N/A	13.4%	48.9%	428	3200	Project monitoring report	USAID IHP was behind some of the scheduled activities for the Healthy Family Campaign (VIVA) for FY20. The Program worked on campaign design as well as launch and initial roll-out for the campaign. Year 3 will include additional activities such as reaching vulnerable groups.	USAID IHP and Breakthrough Action have developed an implementation plan for Year 3 for the VIVA campaign which should allow the Program to catch-up and achieve planned targets for the campaign in the next year.
		Kasaï	N/A	29.4%	N/A	21.3%	72.4%	280	1316	Project monitoring report		
		Katanga	N/A	47.8%	N/A	13.2%	27.6%	128	971	Project monitoring report		
		Eastern Congo	N/A	2.7%	N/A	2.2%	80.0%	20	913	Project monitoring report		
IR 3.4:	**Strengthened collaboration between central and decentralized levels through sharing of best practices and contributions to policy dialogue**											
3.4.1	Percentage of CSO organizations participating in experience-sharing / lessons learned event held at the ZS community participation day or provincial task force communication meetings	Output	N/A	100.0%	93.3%	122.2%	N/A	55	45	Project monitoring report	USAID IHP achieved its target for this activity in FY20. Throughout the year, USAID supported the opportunity for members of the DPS and civil society to share their meet and share experiences related to health behaviors the Program was working to address through community activities and service delivery. These meetings were	While USAID IHP achieved its target for this indicator in FY20, The Program will review coverage in Kasaï and Katanga to understand why the rates of achievement were lower in these areas and how the Program can assure all provinces achieve their target in Year 3.
		Kasaï	N/A	100.0%	55.0%	85.0%	N/A	17	20	Project monitoring report		
		Katanga	N/A	100.0%	20.0%	60.0%	N/A	9	15	Project monitoring report		
		Eastern Congo	N/A	100.0%	280.0%	290.0%	N/A	29	10	Project monitoring report		

Technical areas, illustrative indicators		Region*	Baseline FY 2017	FY 2020 annual target	Achieved Q4	Achieved FY 2020	% achieved FY 2020	Numera-tor	Denomi-nator	Data sources	Observations	Corrective actions
											an opportunity to better understand the challenges related particularly to complex topics and leverage different tools that help share those learnings and turn them into solutions.	

Footnotes:

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

4, 6, 8, 11, 12, 16: the baselines for these indicators are under review and they have been updated for this report as "UA" or unavailable.
1.1, 1.2.1, 1.2.2, 1.4.3: for PICAL indicators, we used the average of the first evaluation scores from Y1 and the predecessor, HFG project) for the baselines.
1.3.1: The denominator was determined by assuming one CODESA for each aire de santé.
1.5.2, 1.7.1, and 1.7.2: In the annual report, the data in the Mission Standard Reporting Template for these indicators is the average of the quarters. All other data is cumulative unless otherwise defined in the PIRS.
1.7.1: We use the percentage change to report this indicator because the target is a reduction in the number of facilities reporting a stock-out of any key tracer commodity during the reporting period.
2.1.9: this data was intended to come from the household survey but we identified a DHIS2 indicator, *Taux d'abandon Penta 1-Penta 3*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.
2.1.12: this data was intended to come from the household survey but we identified a DHIS2 indicator, *B 8.1 Enfants dont les mères ont reçu ANJE*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.
2.1.13: this data was intended to come from the household survey but we identified a DHIS2 indicator, *CPN1*, that accurately reports this value and we have used this data source every quarter/year since the Y1Q1 report.
2.1.17–2.1.26: The PNLT has not yet validated the data. Therefore it has not been made available to us. We will update this table when the data is available.
2.1.23: PNLY is reporting this as a number and not a percentage. We have requested to report this as a number instead of a percentage to align with their data.
2.1.28- 2.1.29: This data comes directly from the hospital and was not shared at the time the report was submitted. We will update the MECC as soon as it is made available.
2.3.1: We used data from the DHIS2 indicator *Refere vers CS* for this indicator and will propose to update the PIRS in future reports.
2.6.1- 2.6.4 will be collected through project monitoring reports because the Household survey could not capture the information as defined.

ANNEX B: NOTES ON ANNEX A FY2020 ANNUAL REPORT DATA

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

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

We extracted data in this table from DHIS2 on Oct 23, 2020; they represent FY2020 including Quarter 4 (July- September 2020). The data was originally disaggregated by province. We reorganized the data into the regions for this table. The province data will be entered into the Monitoring, Evaluation and Coordination Contract (MECC) database.

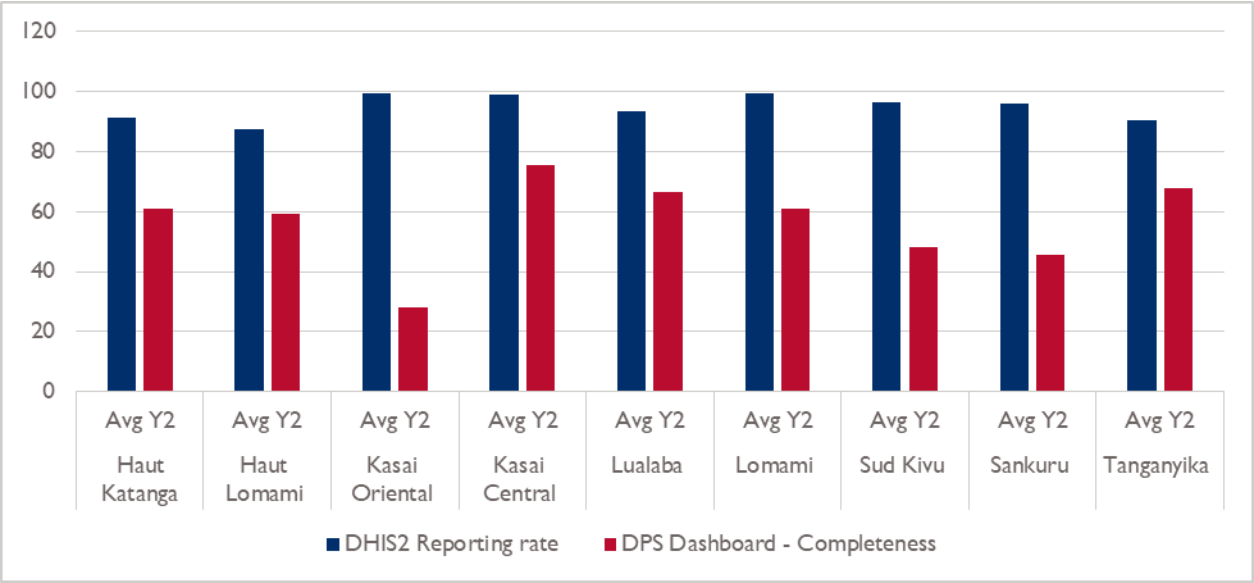
Since the start of the project, the MOH's health information system has recorded 179 ZS in Program provinces, which adds one ZS to the number counted in the proposal and contract. The additional zone is Kowe in Haut-Katanga. The program has always operated in all 179 health zones.

DATA COMPLETENESS: MECC AND MSRT DATA TABLES

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

Because of this systemic flaw, USAID IHP has developed as part of the DPS Dashboard and M&E platform a "true" data completeness and timeliness measure. The data completeness dashboard looks at the status of data fields submitted. If any required fields are empty or incomplete when submitted, the data completeness dashboard will not count that the data as complete and on time. We present the discrepancies between the "completeness" reported through the MOH's SNIS DHIS2 and the completeness measured through this new definition captured by the DPS Dashboard.

Figure 4. Quarter averages of data completeness from two sources



Source: SNIS DHIS2 and DPS Dashboard, accessed 12/2/220 for data Oct 2019- Sep 2020 downloaded Oct 23, 2020, basic services data set.

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

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

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

Table 51. Annual datasets

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

ADDITIONAL NOTES ABOUT THE DATA IN THE MSRT TABLE

We use "N/A" (not applicable) to identify fields where there is no data because the relevant activities have not yet started and produced data. We also use N/A to note data that isn't applicable due to the

indicator definitions, for example, for indicators measuring numbers, we fill the numerator and denominator with N/A. We also use N/A to note data that should be coming from the supplementary module (the *module complementaire*). There is no reliable way to collect this information until the system is operational, in FY20. We use the "observations" and "corrective actions" columns to clarify why there is no data.

We are validating the baselines for indicators 4, 6, 8, 11, 12, 16 so these have been noted as UA, or unavailable, at this time. We anticipate that we will have the baselines in the MSRT table for the Y3Q1 report.

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

Determination of Baseline Values

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

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

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

Since the FY20 Quarter 1 report, however, baselines have been updated using the service delivery mapping and household survey data reported in the first submission of these reports. We have also used PMR data when possible. The baselines for indicators 4, 6, 8, 11, 12, 16 originating from the household surveys will be updated when validation is finalized; we have marked these baselines as UA, or unavailable at present.

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

Determination of Targets

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

For the indicators derived from HMIS, specifically DHIS2, we applied PNDS 2019–2022 targets. We obtained these by calculating trends over the reported data from 2017 and 2018, using the IHPplus final report and knowledge of HMIS data. For custom indicators, we will continue to set targets according to

planned activities, in collaboration with USAID and government partners. Some indicators do not have targets because we are responding to MOH and GDRC needs.

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

Quarterly targets are noted as N/A if an indicator is reported annually. Annual targets are noted as N/A for data that is reported only in Years 1, 4 and 7, through service delivery and mapping survey data collection.

ANNEX C: SUCCESS STORIES

1. Better communications build trust in health system
2. Promoting leadership at all levels to fight COVID-19
3. Making gender inclusion a reality in health governance

SUCCESS STORY

Better communications build trust in health system

Trainings and mentorship in storytelling and social media enable levels of governments to improve transparency and health messaging

A capture of the Lubumbashi Health Zone tumblr page that features monthly updates, pictures of providers at trainings, and a tab for the public to ask questions.

"Imagine in the COVID-19 period, no one was using tools like the WhatsApp group, blog and Facebook page created as a result of the training.... These tools have allowed us to send messages, share documents and discuss essential practices."

Delphin Kabalika
Communications Coordinator
Haut-Katanga

The Lubumbashi Tumblr page features an attractive picture of a health center and a poster about cholera prevention. Scrolling down reveals monthly updates and pictures of providers receiving training and follow-up supervision. Through this page, launched in March 2020, the health zone of Lubumbashi in the Democratic Republic of the Congo is communicating directly with its patients while informing the community of upcoming events, like mini-campaigns to encourage more women to attend prenatal consultations.

Throughout 2020, USAID IHP conducted group trainings and individualized mentorship to improve internal and external communications capacity within four provincial health districts (DPS) and 16 health zones—and even within the Ministry of Health. High-quality communications help governments at all levels reach a wider audience, demonstrate transparency, and raise the quality of health interventions for the Congolese people.

Following training on how to write success stories, the provincial health division of Mwene-Ditu recently documented the process of improving their assisted birth rate. In Haut-Katanga, the Program trained DPS staff in digital communications, which "has allowed us to give better visibility of our activities both at the level of the DPS and the health zones," said head of the DPS, Dr. Jean-Marie Kafwembe.

Recently, trainees started creating WhatsApp groups so participants can share successful communications material and best practices—including with other provinces and health zones. These channels proved particularly helpful to convey rapidly changing information during the COVID-19 pandemic.

Meanwhile, the Ministry of Health contacted USAID IHP for communications assistance after receiving the Program newsletter. Following training and mentorship, the Ministry will launch its own newsletter in early 2021 to feature success stories, highlight successful campaigns, and spotlight outstanding health zones and provincial health divisions—many of which will have written their own success stories after Program training.

At every level, USAID IHP has designed these capacity-building efforts with sustainability in mind. The Program has trained exemplary provincial health divisions to mentor other DPS and health zones and encouraged providers to write their own success stories. Robust communications are crucial to sharing information while building trust and participation in the DRC's health system.

SUCCESS STORY

Promoting leadership at all levels to fight COVID-19

USAID passes along tools and information for rural provinces to detect and prevent coronavirus spread

A man organizes portable handwashing stations to distribute to 22 general referral hospitals in Kasaï-Oriental province.

"At the end of this sensitization, we in turn sensitized the faithful of our congregations by reminding them to respect barrier measures. To date, 689 households have handwashing kits, and we have encouraged [the] population to make masks... which are required for participation in Mass. We say thank you to USAID IHP for its support."

- Father Erick Mwila

Shortly after the Democratic Republic of Congo confirmed its first case of COVID-19 in March 2020, the USAID Integrated Health Project launched a multi-pronged effort to support the government at all levels in combatting coronavirus spread.

From March to September, USAID IHP conducted sensitization, communication, and technical support COVID prevention and detection activities in 1,938 health areas in its nine target provinces. The Program supported 222 technical coordination meetings and 78 epidemiological surveillance meetings; provided training for 331 providers and 4,108 community health workers; and made available to health facilities 48,244 copies of communication and awareness materials on COVID-19—translated into local languages.

Each of these interventions addressed the needs of a specific health area, health zone, or provincial health department while prioritizing accessibility and relevance. At the health zone level, IHP USAID staff taught community members how to sew masks to create safe and affordable protective equipment, and they trained four religious leaders in the Kamina health area on the importance of handwashing. These leaders, in turn, informed their congregations and distributed handwashing kits received from the Program.

At provincial and national levels, technical coordination meetings with the Ministry of Health and project partners covered patient care, epidemiological surveillance and resource mobilization. Both the Ministry of Health and USAID IHP built on experiences in epidemic control from the recently ended Ebola outbreak, applying best practices in treating highly contagious viruses, and offering technical expertise and logistics support to provinces, departments, and health zones.

In early September 2020, the provincial government of Haut-Katanga awarded IHP USAID IHP a certificate of merit for its COVID-19 interventions. This commendation, presented to the provincial Program management, recognized exemplary leadership in interventions to manage the coronavirus pandemic.

SUCCESS STORY

Making gender inclusion a reality in health governance

At multiple levels, USAID supports women's committees to guide integration of women in health planning and implementation

The Sud-Kivu Women's Committee celebrates the International Day of Women's Rights on March 8th, 2020.

"[F]or a long time mass activities were reserved for men, but now we are also participating in them and providing our support."

- Ms. Claudine Zawadi, Data Manager, Provincial Coordination Fight against Malaria, Sud-Kivu

Gender inequalities pervade health structures in the Democratic Republic of Congo, from the Ministry of Health to the provincial health districts (DPS). The Sud-Kivu DPS is no exception: of its 1,384 health workers in 2020, a paltry 12 percent are women, and all leadership positions are held by men.

In March 2020, as International Women's Day approached, USAID's Integrated Health Program (USAID IHP) supported an orientation on gender inclusion for officials of Sud-Kivu's DPS. The session on deploying human resources and activity implementation drew 52 people, including 35 women.

After these fruitful discussions, the head of the Sud-Kivu DPS, Dr. Gaston Lubambo, with the support of USAID IHP helped establish a six-person women's committee to advise on gender integration throughout the DPS. The committee ensures that women are involved in planning and implementing field missions with various technical and financial partners. The committee also conducted a gender evaluation to assess progress on DPS commitments, in particular the involvement of women in decision-making and gender inclusion in the health zones. Two women have had further training and now take part in the meetings of the DPS executive team.

Now the committee's vice president, Dr. Lubambo praised the ongoing integration of "women from all social strata of the DPS, from sweeper to doctor, nurses and administrative staff. I decided that first day … to show my interest in the issue of inclusion, including in the recruitment process. Now all women are involved in all decisions taken at the provincial level."

At the national level, USAID IHP is collaborating with the Ministry of Gender, Family and Children to support the Ministry of Health to conduct an analysis on gender norms and their impact on access to health services and products, the quality of health services, and care-seeking behaviour.

Furthermore, the Ministry of Health's National Gender Unit developed its first action plan in February, and USAID IHP trained all members. The National Gender Unit continues to work with the project to establish provincial Gender Units in nine DPS during the first half of 2021. By systemically integrating gender into the day-to-day administration at different layers of the health system, each of these units will ensure women's voices are heard throughout and help guide interventions.

ANNEX D: STAFF HIRED DURING FY2020 QUARTER 4

Position/title	Employee name	Gender	Start date	Contractor
Kinshasa Office				
Procurement Assistant	*Margueritte Fatuma*	*Female*	*23 July 2020*	*Abt Associates*
HR Officer	*Gaelle Wandey*	*Female*	*7 September 2020*	*Abt Associates*
Procurement Assitant	*Stephie Mopende*	*Male*	*14 July 2020*	*Abt Associates*
Director of Operations	*Jeffrey Gould*	*Male*	*September 3, 2020*	*Abt Associates*
Director of Finance	*Alioune Wade*	*Male*	*August 15, 2020*	*Abt Associates*
Kasaï Regional Office				
Kasaï-Central Province Office located in Kananga				
Bookkeeper-Kabinda	*Miriam Ndayi*	*Female*	*19 August 2020*	*Abt Associates*
Operations Manager-Lodja	*Andre Bokama*	*Male*	*19 August 2020*	*Abt Associates*
Eastern Congo Regional Office				
Sud-Kivu Province Office located in Bukavu				
NA	*NA*	*NA*	NA	NA
Katanga Regional Office				
Haut-Katanga Province Office located in Lubumbashi				
M&E Manager	*Freddy David Mukeba*	*Male*	*28 September 2020*	*Abt Associates*

ANNEX E: DELIVERABLES SUBMITTED IN FISCAL FY2019

Deliverable	Submitted	Comments
Fiscal FY20019 Annual Report	Submitted October 30, 2019; Approved February 4, 2020.	Uploaded to DEC.
Fiscal FY20018 Quarter 4 Financial Report	Submitted October 30, 2019; Approved November 1, 2019.	Not a DEC deliverable.
Gender Analysis and Implementation Strategy: FY20	Submitted October 15, 2019; Approved October 25, 2019.	Uploaded to DEC.
Fiscal FY2020 Quarter 1 Financial Report	Submitted January 28, 2020; Approved February 10, 2020.	Not a DEC deliverable.
Fiscal FY2020 Quarter 1 Report	Submitted February 28, 2010; Approved May 20, 2020.	Uploaded to DEC.
Fiscal FY2020 Quarter 2 Financial Report	Submitted April 30, 2020. Approved May 5, 2020.	Not a DEC deliverable.
Fiscal FY2020 Quarter 2 Report	Submitted May 29, 2020; Approved July 17, 2020.	Uploaded to DEC.
Fiscal FY2020 Quarter 3 Report	Submitted August 29, 2020; Approved September 25, 2020.	Uploaded to DEC.
Fiscal FY2020 Quarter 3 Financial Report	Submitted July 27, 2020; Approved August 6, 2020.	Not a DEC deliverable.
Year 3 Annual Workplan	Submitted September 1, 2020. Approved September 30, 2020	Uploaded to DEC.
Gender Analysis and Implementation Strategy: Year 3	Submitted September 1, 2020. Approved September 30, 2020	Uploaded to DEC.
Environmental Mitigation and Monitoring Plan: Year 3	Submitted September 1, 2020. Approved September 30, 2020	Uploaded to DEC.
Climate Risk Mitigation Plan: Year 3	Submitted September 1, 2020. Approved September 30, 2020	Uploaded to DEC.
Conflict Sensitivity Analysis and Implementation Strategy: Year 3	Submitted September 1, 2020. Approved September 30, 2020	Uploaded to DEC.

ANNEX F: COVID ACTIVITIES

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	3.4: Organize meetings with BA	Tanganyika	Week 2 May 2020	BA staff could not travel to Tanganyika because of travel restrictions.	Activity was rescheduled to July 2020 (teleconference).	None.
Abt	2.1: Support briefings of clinical staff on pediatric TB, specifically on screening for TB in children	Sankuru	Feb-20	Trainers could not travel to Sankuru initially due to political instability and then due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR 2.1: Implement Mashako plan	Lomami	Week 2 April 2020	Facilitators could not travel to Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR2.1: Reinforce trainers' skills in PCIMNE and flowcharts	Lomami	Week 1 June	Facilitators could not travel to Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR1.1: Train ZS executives in Management of primary health care	Lomami	End of May 2020	This activity required the participation of national-level representatives from the DGOSS of the MSP. Because of COVID-19 travel restrictions, they could not travel as intended.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR2.1: Support the training of CSDT providers in the care of mothers and children with pediatric TB	Lomami	Q2	Facilitators could not travel to Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR1.1: Host a workshop to update the analysis for sensitivity to conflict, do no harm, and scenario planning	Lomami	Q2	Facilitators could not travel to Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in inter-provincial exchanges in Kasaï about do no harm .
Abt	IR1.6: Technical and financial support of a training for OHADA software usage	Lomami	March Week 3 2020	Facilitators could not travel to Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Activity will be delayed to later.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 1.8: Organize a monthly exchange of best practices on the inclusion of gender in programming	Kasaï-Central	Week 3 March 2020	COVID-19 restrictions limit the number of participants in a group gathering.	Monthly meeting held in September 2020	Delay in activity implementation and reporting
Abt	IR 2.1. Provide support to implementation of DQI in identifying bottlenecks and proposing solutions	Kasaï-Central	Week 3 April 2020	Trainers from Kinshasa could not travel to Kasaï-Central due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR 3.1: Organize multimedia communication campaigns - for vulnerable groups on key practices	Kasaï-Central	Week 5 March 2020	BA staff could not travel to Kasaï-Central because of travel restrictions related to COVID-19.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR 3.1: Support the evaluation of PF mini-campaigns with community participation	Kasaï-Central	Week 3 March 2020	Travel restrictions due to COVID-19.	Activity occurred in June and July 2020	Delay in activity implementation and reporting
Abt	IR 3.2:.Train RECOs in communication techniques, key practices and signs of danger	Kasaï-Central	Week 4 March 2020	Travel restrictions due to COVID-19.	Activity completed 2nd week of June 2020	Delay in activity implementation and reporting
Abt	IR 1.1: Train members of the ECDPS in Primary Health Care Management	Haut-Lomami	Week 2, Week 3 April 2020	Trainers from Kinshasa could not travel to Haut-Lomami due to COVID-19 travel restrictions.	Activity delayed to early Fy21.	Cannot be completed under current state of emergency, targeted people are to participate in distribution of mosquito nets.
Abt	IR 1.1: Organize a workshop to update conflict sensitivity analysis, including Do No Harm assessment and scenario planning	Sud-Kivu	4/23/2020-4/28/2020	Large gathering for training cancelled/restrictions on international travelers into DRC.	Training of the ECDP & East Region USAID IHP staff will be postponed to FY21.	Delay in activity implementation and reporting
Abt	IR 1.1:Technically and financially support semi-annual CA meetings in the ZS	Sud-Kivu	Apr-20	Flights in Sud-Kivu province cancelled due to provincial government's decision. This activity was supposed to be CA meetings in Lulingu and Shabunda ZS.	Activity delayed to early Fy21.	Delay in activity implementation and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 1.1.: Train members of the ECDPS in management of primary health care	Lomami	Week 2, May	This activity required the participation of national-level representatives from the DGOSS of the MSP. Because of COVID-19 travel restrictions, they could not travel as intended.	Activity delayed to early Fy21.	Delay in activity implementation and reporting
Abt	IR 1.1: Conduct institutional analyses in the ZS	Kasaï-Central	Week 3 April 2020	The TRG team could not travel to Lomami due to travel restrictions.	Activity delayed to early Fy21.	Delay in the completion of institutional analysis.
Abt	IR 1.1.Evaluate the PICAL process in the DPS and 5 ZS	Kasaï-Central	Week 3 April 2020	The TRG team could not travel to Lomami due to travel restrictions.	Activity delayed to early Fy21.	Delay in the evaluation of recovery plans from the DPS and ZS
Abt	IR 1.1: Evaluate the PICAL process in the DPS and 5 ZS	Tanganyika	Week 1, June 2020	The TRG team could not travel to Lomami due to travel restrictions.	Activity delayed to Fy21.	Delay in the evaluation of recovery plans from the DPS and ZS
Abt	IR 1.3: Implement community performance bulletin in ZS covered by updated CAC	Kasaï-Central	Week 4 May 2020	Large gathering cancelled as per DPS/government restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting
Abt	IR 1.4: Provide technical and financial support for the semi-annual CPP meeting of the DPS	Sud-Kivu	Apr-20	Flights in Sud-Kivu province cancelled due to provincial government's decision.	Meeting held Sept 2, 2020	Delay in activity implementation and reporting
Abt	IR 1.4: Provide technical and financial support for the Thematic Groups meetings (DPS level)	Sud-Kivu	4/20/2020-4/24/2020	Large gathering cancelled as per DPS/government restrictions.	Thematic Groups meetings at DPS level have been organized in May, July and August 2020	Delay in activity implementation and reporting
Abt	IR 1.4: Provide technical and financial support to the organization and implementation of semi-annual reviews of the DPS's SSP activities	Lualaba	Week 2, April	Gatherings larger than 20 people are prohibited due to the pandemic.	Activity implemented Week 2 June 2020	Delay in activity and reporting
Abt	IR 1.5: Provide technical and financial support to DPS for the organization of quarterly data validation meetings	Kasaï-Oriental	Feb-20	Large gathering for training not supported for public health reasons.	Activity held in July.	Delay in activity and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 1.7: Support training in drug and medical waste management and correct use of SIGL tools	Kasaï-Oriental	Apr-20	Large gathering for training not supported for public health reasons.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 1.7: Support trainings in medication management, medical waste management and correct usage of SIGL tools	Lualaba	Week 4 May 2020	Facilitators could travel to Lualaba due to government travel restrictions.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 1.7: Financially and technically support the Essential Drugs Working Group (Groupe de Travail Médicament -GTM) and GAS activities	Sud-Kivu	4/20/2020-4/24/2020	Large gathering cancelled as per government restrictions.	Essential Medecines Working Group (GTM) held meetings in May, July, August and September 2020.	Delay in activity and reporting
Abt	IR 2.1: Strengthen the capacity of trainers in IMNCI and flow charts	Kasaï-Oriental	Dec-19	Large gathering for training not supported for public health reasons. Also trainer could not travel due to State of Emergency.	Activity held in early Sept.	Delay in activity and reporting
Abt	IR 2.1: Strengthen the capabilities of providers in PCIMNE and flow chart	Kasaï-Oriental	Jun-20	Large gathering cancelled as per government restrictions.	Activity held in early Sept.	Delay in activity and reporting
Abt	IR 2.1 : Train providers in blood transfusion safety	Kasaï-Oriental	Week 2 April	Large gathering cancelled as per government restrictions.	Trainings completed in 3 sites.	Delay in the implementation of the capacity strengthening activity for DPS executives
Abt	IR 2.1: Support the training of of CSDT providers in mother and child care with pediatric TB	Kasaï-Oriental	Week 2 April	National-level experts including x-ray technicians chosen by the PNT national administration, could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1 : Organize training for Hospital Providers in Comprehensive EmONC	Haut-Lomami	Week 4 March 2020	Training requires national level trainers and the state of emergency does not allow for inter-provincial travel .	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1: Provide financial and technical support to training on monitoring and evaluation	Haut-Lomami	Week 4 July 2020	The training requires national level trainers and the state of emergency does not allow for inter-provincial travel.	Activity delayed to Fy21.	Delay in activity and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 2.18: Support a briefing for care staff of pediatric TB, specifically on diagnosis in children	Haut-Lomami	Week 2 August	The training requires national level trainers and the state of emergency does not allow for inter-provincial travel.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1: Train ECDPS members in primary care management	Kasaï-Oriental	Week 2 April	This activity required the participation of national-level representatives from the DGOSS of the MSP. Because of COVID-19 travel restrictions, they could not travel as intended.	Activity delayed to Fy21.	Delay in the implementation of the capacity strengthening activity for DPS executives.
Abt	IR 2.1: Train HGR providers in clinic guides, therapeutics, and PCIMNE TETU	Kasaï-Oriental	Week 3 April	This activity required the participation of national level facilitators from the PNIRA who could not arrive in Mbujimayi by plane.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1: Train HGR providers in clinic guides, therapeutics, and PCIMNE TETU	Lomami	Originally planned for after March 2020	Facilitators could not travel to Lomami due to government travel restrictions	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1: Train DPS and IPS executives in DQI	Kasaï-Central	Week 3 April 2020	Trainers from Kinshasa could not travel to Kasaï-Central due to COVID-19 travel restrictions.	Activity completed with provincial trainers	Delay in activity and reporting
Abt	IR 2.1: Support the usage of the DQI to identify bottlenecks and propose appropriate responses	Tanganyika	Week 3 June 2020	Trainers from Kinshasa could not travel to Kasaï-Central due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Ongoing problems in the service delivery quality in the ZSs.
Abt	IR 2.1: Organize the training of hospital providers in SONU	Tanganyika	Week 3 May 2020	Participants could not come to Bukavu due to travel restrictions	Activity delayed to Fy21.	Delays in service delivery quality training.
Abt	IR 2.1: Provide FP training for DPS and ZS staff	Tanganyika	Originally planned for 3rd week of March 2021	Trainers from Kinshasa could not travel to Tanganyika due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in the training of provincial trainers
Abt	IR 2.1: Support the training of CSDT training in the care for mother and child with pediatric TB	Tanganyika	Week 2 June 2020	Trainers from Kinshasa could not travel to Tanganyika due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Persistent difficulties of pediatric TB.
Abt	IR 2.1: Support a training for care staff on pediatric TB, specifically diagnosis of TB in children	Tanganyika	Originally planned for 3rd week of April 2020	Trainers from Kinshasa could not travel to Tanganyika due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Impact on the reporting of TB cases, especially in children.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 2.2:Train/re-train RECOS from SSC in IMNCI	Kasaï-Oriental	Week 4 April	Activity requires participation from national level experts including facilitators from the PNIRA who could not travel to Mbujimayi.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.4: Organize the gender audit in the DPS and ZS	Haut-Lomami	Week 4 June 2020	This activity requires national level executives and the state of emergency does not allow for inter-provincial travel.	Activity delayed to Fy21.	Delay in the implementation of the activity.
Abt	IR 2.40: Organize the gender audit in the DPS and ZS	Tanganyika	Originally planned for Week 3 of May 2020	This activity requires national level executives and the state of emergency does not allow for inter-provincial travel.	Activity delayed to Fy21.	Delays in gender integration at the DPS and ZS level.
Abt	IR 3.1: Support functional Champion Communities and RECO on gender, use of ANC and Malaria services	Kasaï-Oriental	Mar-20	Large gathering for training not supported for public health reasons.	Completed in Week 2 May	Activity will be delayed to later.
Abt	IR 3.1: Technical and financial support for the organization of Breastfeeding Weeks and Days	Haut-Lomami	Week 4 March 2020	Gatherings larger than 20 people are prohibited due to the pandemic.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 3.1: Technical and financial support for the organization of Breastfeeding Weeks and Days (Celebration JMT 2020)	Lualaba	March Week 3 2020	Gatherings larger than 20 people are prohibited due to the pandemic.	Activity implemented in Week 4 of April	Delay in activity and reporting in Q2
Abt	IR 3.1:Technical and financial support for the organization of Breastfeeding Weeks and Days (Celebration JMT 2020)	Tanganyika	International day against TB planned for 4th week of March 2020 ; International Day against malaria planned for 4th Week of April 2020	Large gathering cancelled as per government restrictions.	Activity delayed to Fy21.	Days not celebrated; impact on the sensitization and consequent adoption of healthy behaviors around malaria and TB.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 3.1: Organize a HFC multimedia communications campaign - for vulnerable groups on key practices	Tanganyika	Week 3 June 2020	National-level participants could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Persistence of certain socio-cultural barriers and practices in the community.
Abt	IR 3.1: Create a community communications plan and media plans for the HFC campaign in collaboration with BA	Tanganyika	Originally planned Week 3 June 2020	BA staff could not come to Tanganyika because ofCOVID-19 travel restrictions.	Activity not rescheduled	Project fell short of targets for this indicator.
Abt	IR 3.1.Organize a HFC multimedia communications campaign	Tanganyika	Week 3 March 2020	BA staff could not come to Tanganyika because of COVID-19 travel restrictions.	Activity not rescheduled	Project fell short of targets for this indicator.
Abt	IR 3.1: Support technically and financially mini-campaigns for TB detection	Sud-Kivu	March 24-27-2020	Large gathering cancelled as per government restrictions.. This activity was supposed to be realized in Bukavu jail.	Activity delayed to Fy21.	Indicators impacted are: TB notification rate through USG- supported programs and number of multi-drug resistant (MDR) TB cases detected
Abt	IR 3.2:.Support the Question/Response contest in secondary schools	Kasaï-Central	Week 2 May 2020	Large gathering cancelled as per government restrictions.	Activity delayed to Fy21.	Activity completed in certain Health Zones, only.
Abt	IR 3.2: Provide technical and financial support to mini-campaigns - active case finding of tuberculosis	Sud-Kivu	March 24-2020	Large gathering cancelled as per government restrictions. This activity was supposed to be a mass campaign in a mining location (Misisi-ZS Kimbi Lulenge).	Activity held in June 2020.	Possible impact on number of TB notification case rate.
Abt	IR 3.4: Organize experience sharing sessions for the Task Force and OSC meetings	Haut-Lomami	Week 4 March 2020	Gatherings of more than 20 people are prohibited by the state of emergency	Activity completed in Week 4 March 2020 with fewer people in meeting	Delay in activity and reporting
Abt	IR. 1.5: Organize a training on information management and surveillance of sick	Kasaï-Central	Week 4 March 2020	Trainers from Kinshasa could not travel to Kasaï-Central due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR.1.1: Hold a workshop to update the analysis on conflict sensitivity, Do No Harm and scenario planning	Kasaï-Central	Week 3 April 2020	Travel restrictions due to COVID-19.	Activity delayed to Fy21.	Delay in activity and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR.1.4: Contribute technically and financially to the organization of biannual activity reviews with the DPS.	Kasaï-Central	Week 4 March 2020	Travel restrictions due to COVID-19.	Activity completed with 3 groups in order to reduce gathering sizes	Delay in activity and reporting
Abt	IR.2.1: Support the active testing of TB for vulnerable groups	Kasaï-Central	Week 3 April 2020	Travel restrictions due to COVID-19.	Activity completed with changed methodology	Delay in activity and reporting
Abt	IR.3.1: Organize multimedia HFG campaigns on key family practices (handwashing, use of latrines)	Kasaï-Central	Week 4 March 2020	Travel restrictions due to COVID-19.	Activity delayed to Fy21.	Delay in the implementation of the activity but BA is currently working on it
Abt	IR 3.1: Provide support for the organization of multimedia campaigns based on HFC prototypes - for vulnerable groups on key practices	Haut-Katanga	Week 3 March 2020	Travel restrictions due to COVID-19.	Activity delayed to Fy21.	Impact on the monthly evaluation of activity implementation and the improvement of certain indicators
Abt	IR 3.2: Provide support to Q&A games competitions in secondary schools	Haut-Katanga	Week 4 September 2020	Schools were closed for COVID-19 and only opened for finalist exams which did not allow for the planned activities.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR1.1: Host a workshop to update the analysis for sensitivity to conflict, do no harm, and scenario planning	Sankuru	Apr-20	Trainers could not travel to Sankuru due to political instability and then due to COVID-19.	Activity delayed to Fy21.	Delay in activity and reporting
Abt	IR 2.1: Train DPS and IPS staff in Integrated Quality Improvement Approach (DQI)	Haut-Katanga	Week 2 January 2020	Trainers from Kinshasa could not travel to Haut-Katanga due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Impact on the monthly evaluation of activity implementation and improving the quality of ZS data.
Abt	IR 1.1: Train ECDPS members in Primary Health Care Management	Haut-Katanga	Week 1 December 2019	Trainers from ECDPS in Kinshasa could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
Abt	IR 2.1: Train hospital level providers on clinical and therapeutic guidelines re: IMNCI and Emergency Triage Assessment and Treatment (ETAT)	Haut-Lomami	Week 3 June 2020	The training requires national level trainers and the state of emergency does not allow for inter-provincial travel	Activity delayed to Fy21.	Delay in activity and reporting
i+solutions	1.7: Support training in drug and medical waste management and correct use of SIGL tools.	Sud-Kivu	Apr-20	Large gathering for training cancelled/restrictions on international travelers into DRC.	iPlus solutions is in the process of organizing an online course with the PNAM. They hope to organize this training in September 2020.	Performance for three 1.7 indicators was impacted (Percentage health zones with LMIS reporting rates > 95 percent of USG-supported health zones with a documented and budgeted distribution plan).
i+solutions	1.7: Organize pilots of community based IPM approach in 32 health zones	TBD	Mar-20 start	Training in supply chain management has been postponed. IPM can only start once that training has been effectuated.	Activity delayed to Fy21.	Training of RECO involved in IPM activities, to good storage practices and precautions in the transport of products has been delayed to year 3
IRC	IR 3.2: Support the Question/Response contest in secondary schools	Lualaba	March Week 4 2020	Schools were closed because of the state of emergency.	Activity was rescheduled to Week 4 May 2020 but could not happen because schools were still closed.	Delay in activity implementation and reporting
IRC	IR 1.7: Support training in drug and medical waste management and correct use of SIGL tools	Haut-Katanga	Week 3 March 2020	This training was scheduled for the end of September, but the provincial team has not received any direction to ensure it happens.	Week 4 September 2020	Impact on the monthly evaluation of activity implementation and on the improvement of the management of MEG in the FOSA.
IRC	IR 2.1: Strengthen the capacity of PCIMNE and ordinogram trainers at the DPS level	Lualaba	Jun-20	National-level facilitators could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.1: Train HGR providers in clinical and therapeutic guides and PCIMNE TETU (Manika , Dilala, Fungurume, Lualaba, Kanzenze)	Lualaba	Jul-20	National-level trainers could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
IRC	IR 2.1: Train DPS and ZS executives as PF trainers	Lualaba	Jul-20	National-level trainers could not travel due to COVID-19 travel restrictions.	Nov-20	Delay in activity implementation and reporting
IRC	IR 1.1: Training ECDPS members in Primary Health Care Management	Haut-Lomami	Apr-20	National-level trainers could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.1: 2 Organize the training of hospital providers (in SONU C: Practice of Caesarean section) (ZS Kaniama, Kabongo and Malemba)	Haut-Lomami	Mar-20	National-level trainers could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.1: Train HGR providers in clinical and therapéutic guides and PCIMNE TETU (ZS Kabongo, Kabondo dianda, Kamina, Malemba and Kinkondja)	Haut-Lomami	Jun-20	National-level trainers could not travel due to COVID-19 travel restrictions.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.4: Organize gender audit in DPS and Sante areas in Kamina, Malemba, Kabongo, Kabondo dianda and Kinkondja)	Haut-Lomami	Jun-20	This audit will allow us to collect information related to the genre, from which a tool will be produced and presented to USAID	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.5: Vulgarize the flat-rate strategy, (ZS Kabongo, Kabondo dianda, Kamina, Malemba and Kinkondja)	Haut-Lomami	Jun-20	As economic accessibility is a foundation in the demand for community-based services, the extension of this tariff is an important element that will help negotiate prices and gain community membership and ownership of health care activities.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 3.1 : Provide technical and financial support to the Celebration of International Women's Day)	Haut-Lomami	Mar-20	This activity is already planned in year 3, since the period has passed, we will wait until next March to realize it	Activity delayed to Fy21.	Delay in activity implementation and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
IRC	IR 3.4: Ensure the organization of experience-sharing sessions in communication task forces and CSO meetings:	Haut-Lomami	Mar-20	This activity will help improve the involvement of Community Leaders in managing health activities	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR.1.7: Develop and distribute posters of simple waste management principles in Kenya, Kapolowe, sakania, Lubumbashi, Kikula, Kipushi, Kisanga, Kilwa, Kampemba,Rwashi and Lukafu	Haut-Katanga	Apr-20	The distribution of posters will raise awareness for bio-medical waste management and improve the adoption of universal precautions	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR. 1.1: Provide technical and financial support to CAs for the mid-term evaluation of the OAP (27 SZs)	Haut-Katanga	Apr-20	This evaluation is needed to understand the evolution of the activities planned in the OAP for the first 6 months in order to identify and rectify their issues	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR.2.1: Training HGR providers in clinical and therapeutic guide in CIIM TETU (Kenya, Kisanga, Kikula, Sakania, Kilwa)	Haut-Katanga	Apr-20	This activity needs to be held in order to improve the management of cases referred by primary structures, in accordance to the PCIME approach, it strengthens clinical quality by respecting protocols.	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR. 2.1 152 Strengthen the capabilities of DPS's executive teams on coaching ZS and Nutrition Community (ANJE, CPSr, NAC, SNSAP and PCIMA)	Haut-Katanga	Apr-20	Building the coaching capacity of the DPS's executive teams will allow us to have a team equipped at the DPS level to ensure the close follow-up and ongoing training of providers	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 2.1:Support training for CSDT providers on the care of the mother-child couple on pediatric TB	Haut-Katanga	Apr-20	There is still a need to train CSDT providers as TB screening in children remains low and reading radiological *clichets* in children by CSDT clinicians is still an issue	Activity delayed to Fy21.	Delay in activity implementation and reporting

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
IRC	IR.2.1: Support the briefing of health care workers on pediatric TB specifically on TB screening in children (Lubumbashi, Kenya, Kisanga, Kikula, Sakania, Kilwa, Kipushi and Rwashi)	Haut-Katanga	Apr-20	There is still a need to train CSDT providers as TB screening in children remains low and reading radiological *clichets* in children by CSDT clinicians is still an issue	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR.2.6: Supply hospitals that have included TETU in emergency kits (Kenya, Kisanga, Kikula, Sakania, Kilwa)	Haut-Katanga	May-20	Emergency kit staffing will improve clinical quality in Hospitals	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR 3.1: Give tenchnic and financial support in the organization of SMAM (JMT) of Kenya, Kapolowe, sakania, Lubumbashi, Kikula, Kipushi , kisanga, Kilwa, Kampemba ,Rwashi and Lukafu	Haut-Katanga	Apr-20	This activity will allow us to popularize the message of the importance of early detection of tuberculosis messages in the community	Activity delayed to Fy21.	Delay in activity implementation and reporting
IRC	IR3.2.301: Provide support to Q&A games competitions in secondary schools	Haut-Katanga	Jun-20	Schools were closed for COVID-19 and only opened for finalist exams which did not allow for the planned activities.	Activity delayed to Fy21.	Delay in activity and reporting
IRC	IR 3.1: Provide technical and financial support for the organization of SMAM (World Tuberculosis Day) (Manika , Dilala, Fungurume, Lualaba, Kanzenze and Bunkeya)	Lualaba	Mar-20	Gatherings larger than 20 people are prohibited due to the pandemic.	Oct-20	Delay in activity and reporting
IRC	IR 3.2: Provide support to Q&A games competitions in secondary schools	Haut-Katanga	Jun-20	Schools were closed for COVID-19 and only opened for finalist exams which did not allow for the planned activities .	Jan-21	Delay in activity and reporting
IRC	IR 2.1: Support the health care staff briefing on pediatric TB, specifically on TB screening in children	Haut-Lomami	August 2020	Gatherings larger than 20 people are prohibited due to the pandemic.	Nov-21	Low detection of TB in children due to a lack of information.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
IRC	IR.3.1: Technical and financial support for mini-campaigns - after DBC training (ZS Kadutu)	Sud-Kivu	Mar-20	Gatherings larger than 20 people are prohibited due to the pandemic.	Oct-20	Delay in activity and reporting
IRC	IR.3.4:.Support regional meetings to share best practices among DPS in the region.	Sud-Kivu	Mar-20	Gatherings larger than 20 people are prohibited due to the pandemic.	Sep-20	Delay in activity and reporting
Matchboxology	Health facility staff inter-personal skills training and solutions ToT workshop (x6 provinces)	Kasaï Region	Aug-20	Restrictions on international travelers into DRC, trainer travel prohibited.	Sep-2020 to Oct-2020	Delay in activity and reporting
Matchboxology	Health facility staff inter-personal skills training and solutions ToT workshop (x6 provinces)	Katanga Region	Aug-20	Restrictions on international travelers into DRC, trainer travel prohibited.	Fy21 Q1	Delay in activity and reporting
Matchboxology	Health facility staff inter-personal skills training and solutions ToT workshop (x6 provinces)	Eastern Congo Region	Aug-20	Restrictions on international travelers into DRC, trainer travel prohibited.	Fy21 Q1	Delay in activity and reporting
TRG	1.1: Support the organization of a Team Building workshop	Lomami	Week 2 May 2020	International STTA from TRG could not travel to Lomami due to COVID-19 travel restrictions.	FY21 Q1	Delay in activity implementation and reporting
TRG	IR 1.1: Leadership Management and Coaching Workshops at the provincial level for Tanganyika	Tanganyika	Fy20	This workshop was programmed for Q3 and was delayed due to travel restrictions.	FY21 Q1	Target will be achieved in FY21 instead of FY20.
TRG	IR 1.1: Leadership Management and Coaching Workshops at the provincial level for Kasaï-Central	Kasaï-Central	Fy20	This workshop was programmed for Q3 and was delayed due to travel restrictions.	FY21 Q1	Target will be achieved in FY21 instead of FY20.
TRG	IR 1.1: Leadership Management and Coaching Workshops at the provincial level for Sankuru	Sankuru	Fy20	Due to political leadership issues on the provicial level and COVID pandemic this workshop needed to be delayed.	FY21 Q1	Target will be achieved in FY21 instead of FY20.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
TRG	IR 1.1: PICAL Assessment Training for Sud-Kivu including one ZS PICAL assessment	Sud-Kivu	Fy20	This workshop was programmed for Q3 and was delayed due to travel restrictions.	FY21 Q1	The delays in these workshops had downstream implications on the provinces' ability to conduct ZS level PICAL assessments. These assessments will need to be conducted in FY21.
TRG	IR 1.1: PICAL Training for Kasaï-Central including one ZS PICAL assessment	Kasaï-Central	Fy20	This workshop was programmed for Q3 and was delayed due to travel restrictions.	FY21 Q1	The delays in these workshops had downstream implications on the provinces' ability to conduct ZS level PICAL assessments. These assessments will need to be conducted in FY21.
TRG	IR 1.1: PICAL Training for Sankuru including one ZS PICAL assessment	Sankuru	Fy20	Due to political leadership issues on the provincial level and COVID pandemic this workshop needed to be delayed.	FY21 Q2	The delays in these workshops had downstream implications on the provinces' ability to conduct ZS level PICAL assessments. These assessments will need to be conducted in FY21.
TRG	IR 1.1: Kinshasa-based Leadership, Management and Coaching workshop (management focus)	Kinshasa	Fy20	This workshop was to be facilitated by TRG consultants Graeme Frelick and Dorothea Hertzberg and was canceled due to COVID related international travel bans.	FY21 Q1 (but dependent on international travel restrictions)	This activity will hopefully occur next fiscal year when travel restrictions are lifted and it's deemed safe to travel.
TRG	IR 1.1: Two ZS PICAL assessments DPS Lomami	Lomami	Fy20	Due to COVID travel restrictions this workshop was delayed.	FY21 Q1	Due to COVID target results will be achieved in FY21 instead of FY20.
TRG	IR 1.1: One ZS PICAL assessments DPS Tanganika	Tanganyika	Fy20	DPS Tanganika only allotted funds for 4 PICAL assessments in Y2.	FY21 Q1	Due to COVID target results will be achieved in FY21 instead of FY20.
TRG	IR 1.1: Two ZS PICAL assessments DPS Lualaba	Lualaba	Fy20	Due to COVID travel restrictions this workshop was delayed.	FY21 Q1	Due to COVID target results will be achieved in FY21 instead of FY20.

Organization name	Brief activity description (IR/Sub-IR)	Province	Original implementation timeframe	Reason for delay/cancellation/change	Revised implementation timeframe	Impact on achieving targets/deliverables? If so, which one(s)?
TRG	IR 1.1: Five ZS PICAL assessments DPS Kasaï-Central	Kasaï-Central	Fy20	Due to COVID travel restrictions this workshop was delayed.	FY21 Q2	Due to COVID target results will be achieved in FY21 instead of FY20.
TRG	IR 1.1: Five ZS PICAL assessments DPS Sud-Kivu	Sud-Kivu	Fy20	Due to COVID travel restrictions this workshop was delayed.	FY21 Q2	Due to COVID target results will be achieved in FY21 instead of FY20.
TRG	IR 1.1: Four ZS PICAL assessments DPS Sankuru	Sankuru	Fy20	Due to political issues and COVID travel restrictions this workshop was delayed.	FY21 Q2	Due to COVID target results will be achieved in FY21 instead of FY20.
Viamo	IR 2.3 Improved referral system from community-based platforms to health centers and reference hospitals	June-August 2020	TBD	Travel restrictions outside Kinshasa due to COVID-19 did not allow for the piloting and training of the mReferral app with end-users in Katanga province as per planned.	Activity delayed to Fy21.	Delay in activity implementation and reporting
Viamo	IR 1.2: Accountability hotline to improve the transparency and oversight in health service financing and administration at provincial, health zone, facility, and community levels	Kasaï-Central and Sankuru	April- September 2020	The MoH was yet to give its formal approval to setup the accountability hotline.	FY21- Oct 2020- Sep 2021	Delay in activity and reporting
Viamo	IR 2.1: Create a remote training curriculum on malaria and distribute it to community health workers via push interactive voice response (IVR) calls.	TBC	Jul - Sep 20	Content development workshop for mobile curriculum was delayed due to the availability of participants and did not happen until the second half of September 2020.	Jan-Mar 2021	Delay in activity and reporting

ANNEX G: ENVIRONMENTAL MITIGATION AND MONITORING REPORT

ENVIRONMENTAL MITIGATION AND MONITORING REPORT (EMMR)

PROJECT/ACTIVITY DATA

Project/Activity Name:	USAID's Integrated Health Program (USAID IHP)
Geographic Location(s) (Country/Region)**:**	Democratic Republic of the Congo
Implementation Start/End Dates:	May 26, 2018–May 29, 2025[7]
Contract/Award Number:	72066018C02001
Implementing Partner(s):	Abt Associates, International Rescue Committee, Pathfinder International, BlueSquare, Training Resources Group, Mobile Accord/Geopoll, i+Solutions, Viamo, Matchboxology
Tracking ID:	
Tracking ID/link of Related IEE:	DRC_Health_Portofolio_IEE: https://ecd.usaid.gov/repository/pdf/45611.pdf
Tracking ID/link of Other, Related Analyses:	

ORGANIZATIONAL/ADMINISTRATIVE DATA

Implementing Operating Unit(s): (e.g. Mission or Bureau or Office)	USAID/Democratic Republic of the Congo (USAID/DRC)
Lead BEO Bureau:	
Prepared by:	Rio MALEMBA
Date Prepared:	November 18, 2020
Submitted by:	USAID IHP
Date Submitted:	December 7, 2020

ENVIRONMENTAL COMPLIANCE REVIEW DATA

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

PURPOSE

Environmental Mitigation and Monitoring Reports (EMMRs) are required for USAID-funded projects when the 22CFR216 documentation governing the project impose conditions on at least one project/activity component. EMMRs ensure that the ADS 204 requirements for reporting on environmental compliance are met. EMMRs are used to report on the status of mitigation and

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

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

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

SCOPE

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

This EMMR includes the following:

1. A succinct narrative description of the EMMP implementation and monitoring system, any updates to the system, any staff or beneficiary trainings conducted on environmental compliance, lessons learned, and other environmental compliance reporting details.

2. EMMR table summarizing the status of mitigation measures, any outstanding issues relating to required conditions, and general remarks.

3. Attachments such as photos of mitigation measures and activities, waste disposal logs, water quality data, etc.

USAID REVIEW OF EMMR

Approval:		
	[NAME], Activity Manager/A/COR [required]	Date
Clearance:		
	[NAME], Mission Environmental Officer [as appropriate]	Date
Clearance:		
	[NAME], Regional Environmental Advisor [as appropriate]	Date
Concurrence:		
	[NAME], _____ Bureau Environmental Officer [as required]	Date

DISTRIBUTION:

PROJECT/ACTIVITY SUMMARY

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

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

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

ENVIRONMENTAL COMPLIANCE MONITORING AND REPORTING

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

LESSONS LEARNED

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

- The inclusion of health providers as members of the facility-level hygiene and sanitation committees revealed the lack of attention and knowledge among providers on good practices in environmental compliance, including around biomedical waste.
- As the Program implements various WASH interventions, it is essential to develop a context-specific Water Quality Assurance Plan that integrates water supply needs and considerations.
- USAID IHP's implemented mitigation measures related to office management and supply as well as transportation of personnel and supplies have been especially beneficial in lieu of the COVID-19 pandemic and related implementation challenges in these areas.

EMMR TABLE FOR USAID IHP (FY2020 ANNUAL REPORT)

Project/activity/ sub-activity	Mitigation measure(s)	Summary field monitoring/issues/resolution (i.e. monitoring dates, observations, issues identified and resolved)	Outstanding issues, proposed resolutions
Activity 1:			
Education, technical assistance, training to improve access to and delivery of health care.	1. Ensure that training/ curricula/ supervision addresses appropriate management practices concerning proper handling of medical waste. 2. Ensure that training addresses correct water and sanitation practices. 3. Ensure that capacity development addresses maintenance of health clinic grounds. 4. Ensure that training addresses prevention of transmission of HIV/AIDS and other blood-borne pathogens in health-care settings, including availability of post-exposure prophylaxis (PEP) and guidelines.	With the aim of reducing the risk of health care-related illnesses for patients, staff and caregivers as well as environmental protection measures, the program has provided training for providers in the adoption of good practices by staff, visitors and patients. This training focused on the sanitation and management of biomedical waste and other aspects related to WASH in accordance with the framework of the clean clinic approach in the provinces of Kasaï-Oriental, Kasaï-Central, Lomami and Sud-Kivu. During this training, USAID IHP focused on (i) the management of excreta, sewage and rainwater, waste and the environment in relation to sanitation in a health center and (ii) the logical sequence of the biomedical waste management process (minimization; separation; collection, handling and transport; storage / warehousing as well as treatment and disposal). In this context, the program supported the training of 150 clinical and community providers (51 women) from 30 health centers selected from 3 ZS in Lomami, 75 providers (24 women) from 15 health centers selected from two ZS in Kasaï- Oriental, 125 clinical and community providers (41 women) from 25 health centers in 3 ZS in Kasaï-Central and 85 providers (27 women) from 12 health centers in 3 ZS in Sud-Kivu. In 82 HCs, the various Hygiene and Sanitation Committees have started implementing improvements with the installation of garbage cans, hand washing devices, garbage pits, latrine maintenance ... and USAID IHP has provided in addition the bins, hand washing devices, protective equipment, sanitation kits, cleaning products ... And the 5 members of each Hygiene and Sanitation Committee of 87 CS or 435 people, have have been made aware, by the Health Zones coordinators, about the use and use of these materials. These 87 CS cover 4 provinces, i.e. 17 for the province of Sud-Kivu, 15 for Kasaï-Oriental, 25 for Kasaï-Central and 30 for Lomami province.	The implementation of improvements in health centers by service providers is real proof of the adoption of good practices for environmental compliance. It will be even more so with the WASH books that will be made available by USAID IHP.
Activity 2:			
Procurement,	1. Apply guidance on posting	USAID IHP applies the MOH guidelines on the treatment of	

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storage, and management of public health commodities, including pharmaceuticals and supply chain strengthening activity.	procedures on waste and storage management at health facilities. 2. Provide guidance manual on incinerator and waste pit operation to hygienists and operators. 3. Apply MOH guidance on remitting expired drugs.	chemical waste (drugs and laboratory inputs): registers of unused drugs, quarantine of products until recovery by BCZ or immediate transfer to BCZ for destruction. USAID IHP conducted supply chain training for the 179 ZS Pharmaceutical Management Teams (MCZs and Pharmacists) supported by USAID IHP. This training includes a module on pharmaceutical waste management. In addition to the training, USAID IHP worked on posters summarizing key messages in biomedical and pharmaceutical waste management. These posters will be distributed to health facilities.	
Activity 3:			
Provision of long-lasting insecticidal nets for vector control.	Train beneficiaries on proper use of bed nets, and on risks of improper use or disposal, especially in ecologically-sensitive areas, including lakes and rivers.	Training of providers from 6 regions (Omendjadi, Katakokombe, Lusambo, Wembonyama, Dikungu and Lodja) of Sankuru on malaria and the correct and regular use of LLINs. Providers were retrained on the prevention, diagnosis and treatment of malaria in pregnant women in the health zones of LODJA, DIKUNGU AND WEMBONYAMA, 70 trained including 62 men and eight women Distribution of LLINs in certain ZSs of Haut-Lomami province in Q1 but no specific training on the use of LLINs. Only a few providers in the Kamina and Baka health zones were trained in malaria during the first trimester with a preventive component on the LLIN. 45 providers including 13 men and 32 women were trained.	
Activity 4:			
Construction and improvement of water and sanitation systems.	1. Submit water quality assurance plan (WQAP) to USAID when potable water systems are constructed. 2. Sensitize the community on hygiene as it relates to water handling and storage. 3. Use piping and water collector material of the recommended quality: PE, PVC, HDPE. 4. Ensure water conservation measures: efficient taps, reduced leakages due to use of high quality high density polyethylene (HDPE) fittings.	As part of the rehabilitation of WASH infrastructure in communities, USAID IHP has signed a contract with the company Travaux et Commerce General (TRASCO) for the drilling of five boreholes in five villages of the ZS of Kasansa in Kasaï-Oriental, a contract with Conception d'Ingenerie d'Action et Construction (CIAC) for the rehabilitation of the gravity water system at Kalengo in the ZS of Miti-Murhesa in Sud-Kivu and a contract for the rehabilitation / extension works of the gravitation system running water in Kabamba in the Katana ZS with the Butshia Construction Technical Group (GTBC) in Sud-Kivu. During the implementation of this work, the environmental requirements relating to the performance of this type of work were observed. it is: - development of the water quality assurance plan, - sensitization of the community on the conservation of nature and	

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	5. Install safety taps at all water supply points: valve chambers built to section off segments of the pipelines in case pipes burst, safety valves at water reservoirs. 6. Conduct proper maintenance of pipes and storage tanks. 7. Exclude livestock from water points. 8. Employ water disinfection methods, which include chlorination, chloramination, ozone, solar, and ultraviolet disinfection. 9. Conduct water testing and treatment via a competent water specialist using standard methods for nitrate, bacteria, arsenic, and other suspected contaminants 10. Monitor water quality at system start-up, after 1 month, and annually after that. 11. Post signage at water points with messages on sustainable use of water.	the management of water as limited resources. This contributes to the protection of water sources and the integrated management of watersheds. -Water point management committees have been set up to sensitize communities on hygiene with regard to water handling and storage. -The installation of PVC pipes of the recommended quality -Construction of standpipes is underway with attention paid to water conservation measures, such as ensuring that faucets are efficient and fittings of high quality.-Construction of standpipes is underway with attention paid to water conservation measures, such as ensuring that the taps are efficient and the fittings of high quality. USAID IHP has planned to support the process of analysis of physico-chemical and bacteriological parameters by DPS. This process is ongoing and results are expected in Q1 2021.	
Activity 5:			
Office management and supply.	1. Ensure careful planning and implementation of sustainable practices for resource usage and waste minimization: 2. Use electricity wisely. 3. Reduce, reuse, recycle. 4. Use environmentally friendly office products. 5. Use non-toxic cleaning products. 6. Make eco-friendly food choices. 7. Allow staff to sometimes work from home.	Some provisions have been made by USAID IHP in its facilities, namely: (i) Judicious use of electricity by all staff; (ii) collection of electronic waste, such as used printer cartridges, by certain suppliers; (iii) installation of water fountains in offices to reduce the use of bottled water and thus reduce plastic waste; (iv) the use of electric hand dryers in the bathrooms of the Kinshasa office to reduce wasted paper; (v) two-sided printing of documents to reduce paper consumption and therefore paper waste; and (vi) availability of hygiene products in office sanitation facilities. With the advent of COVID-19, the DRC government has taken action, including social distancing and compliance with restrictions imposed in accordance with its guidelines. this is how the program	

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	8. Aim for paperless office.	allowed staff to work from home, that is, telework, as a preventive measure against the spread of COVID-19. This decision helped to minimize the use of paper, waste production and electricity in the Kinshasa office mainly but also in the provincial offices to a lesser extent.	
Activity 6:			
Transportation of personnel and supplies.	1. Adjust mobility of staff concepts, include walking short distances versus being dropped at destination. 2. Purchase fuel-efficient vehicles, planning to avoid unnecessary trips, management of order quantities.	As part of this environmental impact mitigation measure, staff were encouraged to walk short distances on foot. Also, the use of certain vehicles with low fuel consumption has been reduced to a minimum. In an effort to mitigate the spread of COVID-19, work practices by USAID IHP staff have resulted in reduced vehicle use and fuel consumption, particularly in Kinshasa.	
Activity 7:			
Funding private sector acquisition of diagnostic and treatment equipment.	1. Ensure due diligence investigation of the environmental record and practices of each private party. 2. Ensure training recipients on proper use and disposal of equipment at end of life, and on the risks of improper use and disposal. 3. Ensure training recipient on the environmental risk related to the activity.	After the acquisition and distribution, in the second quarter, of diagnostic and treatment equipment to a few selected health facilities in Bukavu, Sud-Kivu, USAID IHP had to train 85 providers in Sud-Kivu, 125 providers in Kasaï -Central, 150 in Lomami and 75 in Kasaï-Oriental for the management of biomedical waste. Biomedical waste is waste resulting from diagnostic, surveillance, preventive, curative or palliative treatments. The training detailed the five stages of waste management: 1. minimization, 2. sorting / separation, 3. collection / transport, 4. storage and 5. treatment / disposal.	
Activity 8:			
Very small-scale construction or rehabilitation (less than1000m^2 total disturbed area) with no complicating factors.	The mitigation measures relating to this activity will be implemented in the first quarter of year 3 during the completion of the installations relating to the clean clinic.		

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Activity 9:			
Small-scale construction.	No mitigation measures required since as there were no small scale construction in Y2.		
Activity 10:			
Sub-grant activities.	No mitigation measures are required as there were no sub-grant activities for Y2.		
Activity 11:			
Activity 12:			

Additional Comments

ATTACHMENTS

USAID REVIEW OF EMMR

Approval:	[NAME], Activity Manager/A/COR [***required***]	Date
Clearance:	[NAME], Mission Environmental Officer [***as appropriate***]	Date
Clearance:	[NAME], Regional Environmental Advisor [***as appropriate***]	Date
Concurrence:	[NAME], _____ Bureau Environmental Officer [***as appropriate***]	Date

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