Project AXxes

IMA/ECC/CRS/WVI/MERLIN

USAID

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Quarterly Report

September 18 – December 31, 2006

Integrated Health Services Project (Project AXxes)

USAID Cooperative Agreement No: 623-A-00-06-00058-00

Democratic Republic of Congo

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Acronyms

AIDS	Aquired Immuno-deficiency Syndrom
AMITIE	Aids Mitigation Initiative to Enhance Care and Support of PLHIV and OVC
ARI	Acute Respiratory Infection
BCZ	Bureau Central de Zone
CODESA	Comite de Dévelopment et Sante
CRS	Catholic Relief Services
ECC	Eglise du Christ au Congo
ECZ	Equipe-Cadre de Zone (health zone management staff)
HGR	Hopital General de Reference
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IMA	Interchurch Medical Assistance
IPT	Intermittent Preventive Therapy
LLITN	Long Lasting Instecticide-treated bed-net
MCZ	Medecin-Chef de Zone
MOH	Ministry of Health
OVC	Orphans and Vulnerable Children
PLWHA	People Living with AIDS
PSI	Population Services International
RRM	Rapid Response Mechanism
SMI	Santé Maternel et Infantile
WHO	World Health Organization

I. INTRODUCTION

AXxes is a three-year $40 million dollar USAID-financed primary health care project designed to revitalize the national system of primary health care in 60 health zones across the DRC. It is implemented by a consortium of international NGOs including IMA as the prime recipient with ECC, CRS, World Vision and Merlin as implementing partners.

The first quarter of Project AXxes has been mainly devoted to administrative start-up activities but has also seen Project AXxes partners directly involved in programmatic activities such as the Vitamin A and Mebendazole campaigns in AXxes supported health zones, as well as emergency response to the cholera epidemic in Bukavu.

Major challenges encountered over the course of the first quarter were due mainly to security concerns surrounding the second round of Presidential elections and the subsequent announcement of the outcome. This resulted in delays in scheduling key start-up activities such as the Project AXxes implementation workshop. Nevertheless, all major activities planned for the first quarter were accomplished. Additional challenges concern the coordination with other NGOs already active in AXxes health zones. Some AXxes implementing partners faced some initial resistance to their presence that has since been overcome. Coordinating AXxes activities with the other NGOs who do not share the same development philosophy as Project AXxes will remain a challenge in many health zones.

II. TABLE OF PLANNED ACTIVITIES AND ACTUAL ACCOMPLISHMENTS

Table I indicates the progress made this quarter toward accomplishing the planned activities as outlined in the work plan:

Table 1: First Quarter Work plan

Objective	Activity	Status
Management	Finalize subcontracts with implementing partners	Complete
Management	Operationalize regional project offices	Complete
Reporting	Procedure Manual Workshop	Complete
Reporting	Technical Implementation Workshop	Complete
Management	TA visit (IMA: Baer) for budget & startup activities	Complete
Monitoring	TA visit (JHU: Nkossi) to begin M&E dashboard	Complete
Improved Planning by MOH, MIP & MID	Proposed candidates for UNIKIN SPH	Complete
Improved HZ	Conduct rapid assessments in all 60 HZs	95% Complete
Management	Establish project offices and key personnel	Complete
Improved Support Systems	Assess equipment/computer needs for DMOs	Complete
HR & Supervision	Establish HZMT training strategy with MOH	Complete
HR & Supervision	Identify training pools and trainers	Complete
Procurement	Order computers, meds, cold chain, ITNs, etc.	In progress
HR & Supervision	Print HZ training modules with WHO	In progress
Improved Support Systems	Assess rehab, equip., computer needs for depots	In progress
Management	Finalize/Approve year one work plan with USAID	In progress
HIV/Aids	Recruit consultant for implementing PMTCT	Not done

III. COMMENTARY ON PLANNED ACTIVITIES AND ACCOMPLISHMENTS

1. Finalize and Sign Contract between IMA and Consortium Partners

Sub-grant agreements with ECC, CRS and World Vision were finalized in December 2006 and the sub-grant agreement with Merlin was finalized in early January 2007. It took longer than expected to get sub-grant agreements signed with all implementing partners. The partners had to adjust their staffing patterns, decrease their administrative cost and put in cost share to comply with IMA guidelines. Sub-grant agreements with technical assistance partners are in review. It is expected that agreements with Johns Hopkins University and Management Sciences for Health will be completed in the 1st quarter of 2007.

2. Establish Project Offices

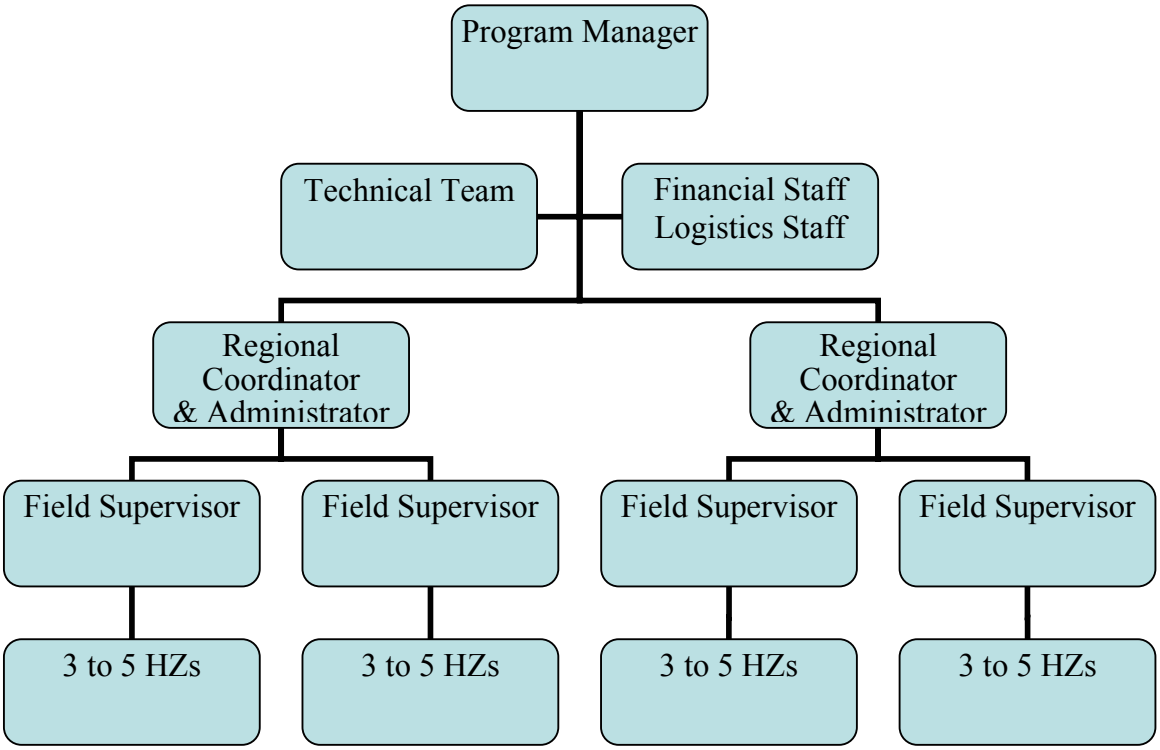
Project offices were established in all districts. The district offices are in Kananga, Kamina, Kolwezi, Bukavu and Goma. By the third quarter, the Goma office will move to Bukavu and a small auxillary office will open in Uvira.

3. Hire Key Personnel

All key personnel at the national level have been hired except for the financial manager. After extensive testing of candidates, a financial manager has been identified and will start work upon approval by USAID.

All consortium partners have hired qualified personnel for key positions. Most of the Regional Coordinators are local doctors with MPH degrees. The partners have structured their programs to give adequate assistance and supervision to the health zones without replacing the government structure. The basic structure of each partner is illustrated in figure 1.

Figure 1: Implementing Partner Structure



4. AXxes Implementation Workshops

Two workshops were organized by the AXxes COP team during the first semester. The first workshop, held in the first week of October, focused on administrative aspects of project start-up. A procedural manual was produced from the workshop that will be used to standardize the administrative activities of all the partners.

The second workshop, held in late November, focused on the programmatic strategy and approach of Project AXxes implementation. The latest Ministry of Health and US Government guidelines were integrated into the AXxes strategy. A CD of all presentations was given to participants at the end of the workshop and a technical manual from the workshop is being produced.

5. Finalize the Year One Work Plan

A work plan for Project AXxes was submitted to USAID before November 15. After comments from their technical team, the work plan was expanded. The new version is now being reviewed by the USAID health team.

6. Component C: Support to MOH

A proposal has been submitted to USAID for how Project AXxes should support the Ministry of Health. The proposal is still being discussed but some essential activities have already been conducted. The AXxes COP team has visited four of the five district offices. Discussions were held about their expectations and needs. The consensus was that AXxes should work extensively at the district and provincial level, strengthening their capacity to improve the health care system. As part of the capacity building, six doctors working at the provincial level have been enrolled in the school of public health.

A recurring theme with MOH staff is the lack of incentive payments for government employees. We explained that the project would cover much of their operating costs allowing other sources of revenue to cover salaries. The idea of CODESAs doing income-generating activities to support salaries at the health center level was also discussed.

7. Preparation for training.

Meetings have been held with the MOH and WHO to develop a training strategy for Project AXxes. It was decided to divide the 30-day training proposed by the government in two training sessions, one for management and the other for technical issues. Training will start January 22. Printing of the training modules was not possible in the first quarter because of delays in getting authorization from MOH to print the material.

8. Purchase of Equipment, Medicines, Printed Material and LLITNs

An assessment of everything that needs to be ordered in year one has been done. Items that can be bought locally, and do not need authorization from USAID, have been or are in the process of being ordered. Items that need to be bought internationally are being priced.

When and if the waivers or authorizations are approved by USAID, medicines, vehicles, motorbikes and bed nets will be purchased.

9. Medicine Depot System

Medicine depots that can serve as distribution sites for essential medicines in Lubumbashi, Kananga, Mbuji Mayi, and Bukavu have been visited. The Bukavu depot has the potential to serve 27 of the health zones in project AXxes. When the waiver has been granted, agreements can be signed with these depots to help in the distribution of medicines. A depot will need to be opened in the Kolwezi area. Discussions have been started with the Methodist Church to reopen their depot in Kolwezi for the project.

10. PMTCT Program

The scope of work for the PMTCT program has been submitted to the USAID reproductive health team in early December. When there is a response from them, IMA will contact and choose a technical assistance partner for this program.

IV. RAPID ASSESSMENTS OF HEALTH ZONES

A needs assessment was conducted in different Health Zones during the second half of October; a modified standard questionnaire from the Ministry of Health was used.
The objectives of the exercise were as follows:

1. To classify different HZ in 3 groups:
    a. Well functioning Health Zones
    b. Marginally functional health Zones
    c. Non functional health Zones.
2. To determine the existing resources
3. To determine the management capacity of different BCZ and hospital including information system capacity
4. To determine the level of different performance indicators
5. To determine the need of training and supervision for different categories of personnel and different strategies

The data for all AXxes assisted zones was centralized at the COP level, cleaned up and analyzed. The data was totally or partially collected in 57 out of the 60 Zones. The three health zones in South Kivu that were not visited were inaccessible because of rains and will be assessed during the month of January. There was some missing and inaccurate data due to lack of use of management tools and lack of a well functioning information system. This weak point was addressed during the November workshop.

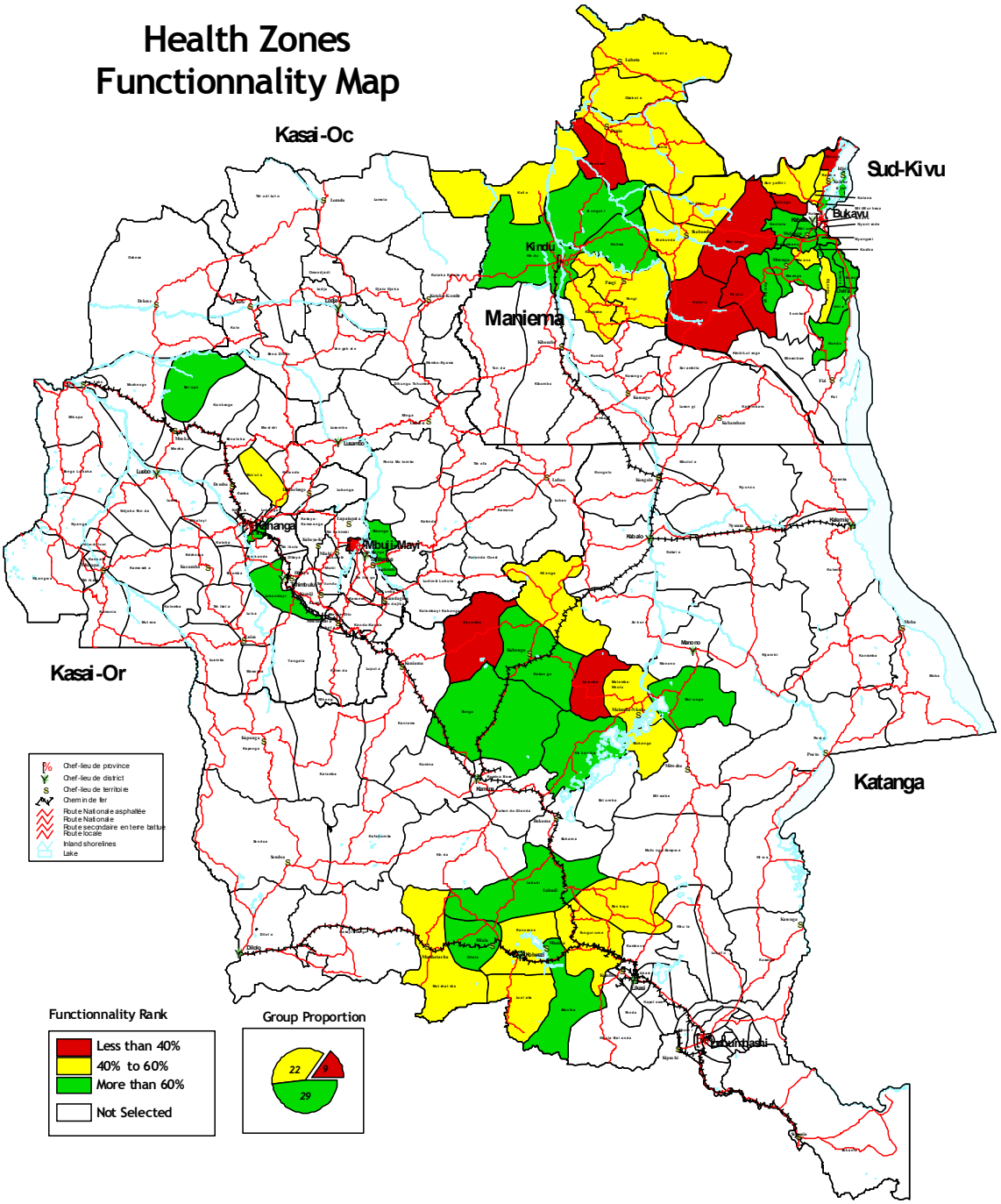
1. Functionality of Health Zones

The functionality of health zones was based on four groups of criteria:

1. ECZ functionality (4 elements, total score 4, one for each element)
2. HGR functionality (5 elements, total score 5, one for each element)
3. Percent of population served (max. score 4, 0-49=1; 50-69 =2; 70-89=3, > 89 =4)
4. PMP indicators (5 elements, with a total of score of 5, one score per indicator)
    - Rate of use of health services
    - DPT3 coverage

- Proportion of births attended by skilled personnel
- Percent of blood transfusions tested for HIV and blood grouping.
- Percent of pregnant women in targeted health Zones who had received IPT.

Using these criteria, of the health zones assisted by Project AXxes: 59% are functional**,** a little less than half (28) of the zones are highly functional, 23 are moderately functional and 9 are non functional. In general, the zones in Eastern South Kivu are the most functional and the health zones in Maniema and western South Kivu are the least functional. The following health zone functionality map illustrates the functionality of the zones.



2. Existing Resource in the Health Zones

There is a great deal of variation in the resources found in the health zones. The first year's order of equipment has been adjusted zone by zone to assure that there is a standard minimum quantity of working equipment in each zone. Taking into account what is already in the zones allowed the standard equipment list (existing plus purchases) to be 30% to 40% more than what is budgeted for. (See Annex 2)

3. Management Capacity of Different BCZ and Hospitals, Including the Health Information System Capacity

In general the resources management is very weak, especially management of medicine and finances. Less than 20% of HZ have and use medicine management documents and a lot of confusion relative to the principle of medicine management was found. Less than 15% HZ reported their finances, most of them giving only incomplete and partial information. The information system exists. Most of HZ teams fill out the government SNIS forms, but with many missing data, some improper definition of indicators, and confusion between numbers, rates and proportions.

4. Level of Performance Indicators

The first quarter indicators for Project AXxes are found in Annex 1. Forty-five zones reported their statistics; 12 for three month and 33 for 2 months. Since the less functional zones did not report, the average indicators in annex 1 are likely higher than they actually are. Important information gleaned from the assessment that is not part of the performance indicators is present here.

Population: the average reported health zone population is 130,245. Zones vary in size from 40,922 to 263,411. The population figures are often known to be very inaccurate. There will be a census done in the third quarter at which time many of the indicators will need to be adjusted.

Existence "Equipe cadre de la Zone" (ECZ): 100 % of Health Zones reported having a functional ECZ. The composition varied from 2 to 23 members. Based on the MOH criteria, only 25% are truly functional.

Status of BCZ building: The health zones declared that 40% of buildings need rehabilitation and 60% of the HZs requested a new building.

Health Center Services Offered by Partner Cluster:

Activities	CRS	ECC	WV	Merlin
General Consultations	98.5%	100 %	93 %	99 %
SMI services	98.5%	100 %	89 %	82 %
Vaccinations	98.5%	100 %	89 %	93 %
Family Planning	77%	80 %	78 %	74 %
Laboratory facility	61%	70 %	48 %	66 %

Epidemiology:

The data from the assessment did not give much epidemiological detail but the following disease patterns were noted.

- Predominate morbidity : Malaria, ARI, Diarrhea, STI/SIDA, Malnutrition and TBC
- Causes of mortality : Malaria, ARI, AIDS, Cholera, Measles, Meningitis, Anemia
- Potential epidemic diseases: Measles, Cholera, Meningitis, Typhoid Fever,

General hospital:

Three Health Zones do not have general hospitals; Mpokolo, Mukunga and Lualaba. Almost 100% of General hospitals have integrated the complementary activities package. Less than 10 % have emergency medicine services.

5. Training of different categories of personnel

Only some of the health zone teams gave information about their training. The information that was gathered is being used to adjust the training program for the project during the second quarter. The following table gives a summary of what was reported.

Function	***Number reporting***	***Proportion trained in primary health care***
MCZ	57	68%
AGZS	49	46%
ISSSP	11	54%
MDH	46	25%
AGH	31	16%
DN	38	10%

V. ADDITIONAL ACTIVITIES CONDUCTED DURING THE FIRST QUARTER

Although focused primarily on project start-up activities during the first quarter, AXxes partners mobilized quickly to contribute to two critical activities in South Kivu and Katanga; the vitamin A and mebendazole campaigns and the response to the cholera epidemic in the urban health zones of Bukavu.

1. *Vitamin A and Mebendazole Campaign*

In South Kivu, CRS participated in the planning and implementation of the vitamin A and mebendazole campaign held from November 8-11, 2006. In consultation with the *Inspection Provinciale de la Sante* and UNICEF, and in light of the limited operational capacity of the CRS/AXxes team at this stage in the project, CRS decided to contribute to the campaign in the following manner:

- Produce 25 banderoles and 3000 posters for community awareness and education regarding the purpose and dates of the campaign. These materials were delivered to IPS and distributed throughout the province.
- Contribute $200 to pre-finance the shipment of vitamin A and mebandazole to CRS/AXxes health zones that are obtainable only by airplane. This money was reimbursed by the IPS.
- Contribute $500 for the transportation of campaign materials and personnel throughout the CRS/AXxes zones.
- Contribute $280 for the supervision of the campaign activities in two CRS/AXxes health zones which were not supported by UNICEF

In addition to the above, CRS represented project AXxes in the following:

- All campaign planning sessions
- The Governor's opening ceremony
- Radio talk shows promoting the campaign

CRS also conducted a supervision of the campaign activities in coordination with the IPS office of nutrition. We noted the following factors:

- The campaign planning did not begin until 7 days before the start date. This is insufficient time to correctly plan a provincial campaign.
- The supervision teams were hampered by insufficient means of transportation.
- It is difficult to estimate the material needs for the campaign given the unreliable population figures. This contributed to a rupture of stock in certain zones and a surplus in others.
- There exists some resistance on the part of the population to the supplementation in vitamin A and mebendazole. Some community members believe that it causes the child to become sick. For the most part, these concerns were addressed by the campaign supervisors.

The results of the campaign for the CRS/AXxes zones are included in the table below:

Results of November Vitamin A and Mebendazole Campaign
in CRS/AXxes Health Zones

Health Zone	Number of Children Supplemented in Vitamin A		Number of Children De-wormed	
	6-59 months	Coverage	1-5 years	Coverage
Kadutu	49 599	110.70%	44 322	111.40%
Ibanda	48 799	105.20%	44 401	107.70%
Bagira	31 814	110.30%	18 691	94.20%
Walungu	31 814	110.30%	28 639	111,80%
Mubanbano	25 458	116.00%	22 642	116.20%
Kaniola	20 892	95.00%	18 373	94.00%
Kaziba	15 617	98.10%	13 775	97.40%
Nyangezi	15 987	116.70%	14 265	117.20%
Mwana	15 847	77.80%	14 016	77.50%
Uvira	43 567	122.90%	38 183	121.30%
Lemera	23 131	103.20%	20 204	101.50%
Ruzizi	22 097	104.10%	19 448	103.20%
Haut-Plateau	12 539	79.60%	10 882	77.80%
Nundu	32 831	155.90%	26 395	141.10%
Mwenga	17 141	111.40%	15 236	111.50%
Kamituga	24 948	118.80%	22 408	120.10%

Source: Inspection Provinciale de la Sante; Office of Nutrition, Dec. 2006

Interpretation of results:

In terms of absolute numbers, the campaign was successful in supplementing 432,081 children with vitamin A and 371,880 children with mebendazole in the 16 CRS/AXxes zones. However, it is clear from the above figures that the denominators for the coverage calculations are incorrect. In some cases, the estimated total population to be supplemented was exceeded by the actual number supplemented by 56%. This is a wide margin of error that makes the above figures largely irrelevant for interpreting coverage rates. To address this, AXxes will conduct a census during the third quarter. This will be a valuable activity for all of the actors working in the heath field in South Kivu.

In conclusion, we should note that both UNICEF and the MIP expressed their appreciation to AXxes for its collaboration and contribution during the campaign.

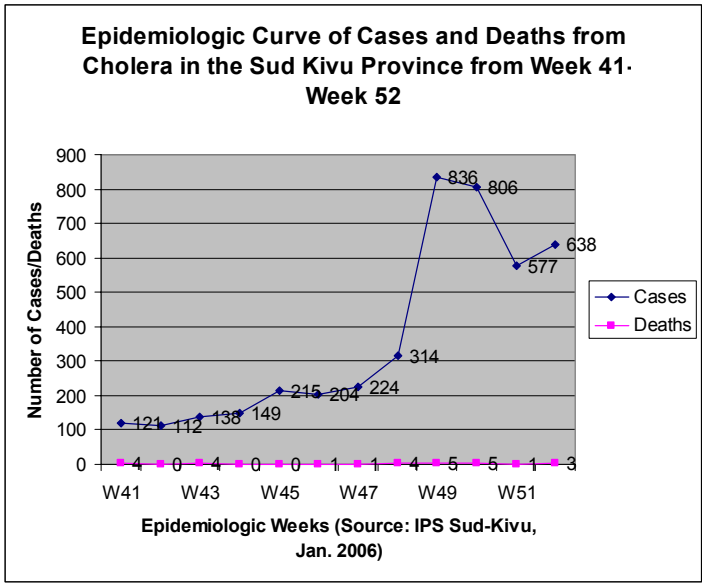
In Katanga, World Vision participated in the PEV coordinated meeting held on December 15 to discuss the results of the Vitamin A/Mebendazole campaign conducted in November 2006. The results were satisfactory and better than that of the May 2006 campaign. In summary, the November campaign reached an overall coverage of 87.4% for Vitamin A and 88.06% for Mebendazole for entire Province. All Districts attained the coverage above 80% except Tanganyika District where it only covered 59%. In Kolwezi, AXxes project area, the coverage for the November 06 campaign is 90.7% Vitamin A and 91.7% Mebendazole compared to 85.6% Vitamin A and 84.9% Mebendazole in the May 2006 campaign. Another positive point was involvement of partners including WV, UNICEF, MSF, WHO and ACF.

The main weaknesses were firstly, inadequate quantity of micronutrients supplied by UNICEF and data collection tools from MOH in Kinshasa. In addition, the above-mentioned, arrived late in all vaccination posts. Secondly, the vaccination announcement carried the wrong dates – that of the previous campaign conducted in Kinshasa. It implies that people in some areas especially where the vaccination dates were not corrected, got incorrect information on the days for campaign. Participants recommended that Microplanification for vaccination is important and needs to be done early enough so that vaccination tools and supplements are sufficient and timely transported to vaccination posts before the campaign. It was also recommended that posters carrying vaccination messages have to be manufactured in the Province to ensure that they carry the correct message. This project will work with MOH and other stakeholders to facilitate early Microplanification particularly in targeted areas so that next campaigns do not experience similar problems.

2. *Response to the Cholera epidemic in the urban health zones of Bukavu*

In South Kivu, outbreaks of cholera can occur several times a year. In 2006, three outbreaks have occurred. The first outbreak occurred during Weeks 1-14 and resulted in 760 cases and 7 deaths. The second occurred during Weeks 30-36 and resulted in 541 cases and 3 deaths. The most recent outbreak began during Week 41 and continues to the present. This recent outbreak has been the most severe, resulting in 1477 cases and 14 deaths.

During Week 48, the governor of South Kivu declared that a cholera epidemic threatened the health of the population of Bukavu and quickly established a committee to combat the epidemic. CRS was selected as a member of the committee along with other major health NGOs and UN agencies.



The GoDRC and WHO combined their efforts to send 2.5 tons of medicines and other equipment to the Cholera Treatment Center at the Hospital of Bukavu where MSF-Holland was tasked with coordinating the treatment of the cholera cases. UNICEF and IRC, as their RRM partner in South Kivu, agreed to support the treatment centers in the hospitals of Panzi (Ibanda HZ) and Ciriri (Kadutu HZ).

Seeing that the curative activities were largely under control, the CRS response to the epidemic was to combine the resources of the USAID-funded AMITIE and AXxes projects to promote the prevention of new cases via community education and targeted water-chlorination activities.

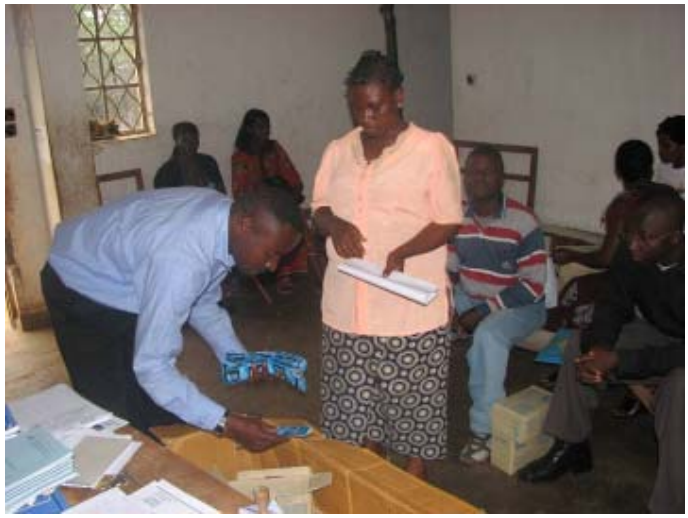
Working in collaboration, the AXxes and AMITIE medical coordinators designed the following intervention:

- Collaborate with the Red Cross to mobilize 56 chlorinators to 19 strategically-selected water distribution points
- Print educational material for general distribution to the wider community and targeted distribution to the most vulnerable population (OVC and PLWHA)
- Mobilize the AMITIE network of volunteers to educate the community, and particularly PVV and OEV, on cholera prevention

- In collaboration with PSI, train AMITIE Home Volunteers in the correct usage of the water purification product "PUR"
- Purchase "PUR" and distribute it via the AMITIE Home Volunteers to PLWHA beneficiaries

56 chlorinators were stationed at 19 water distribution points selected based on the population served and the number of new cases arising from the geographic area. The chlorinators served to educate the community on cholera prevention while also treating the water gathered by the population at the distribution points.

CRS/AXxes printed 8000 copies of the IPS-approved "Key Cholera Prevention Messages" and other hygiene and sanitation documents in both French and Swahili. These were distributed via a joint activity between CRS and the IPS Comite de Mobilisation Sociale.

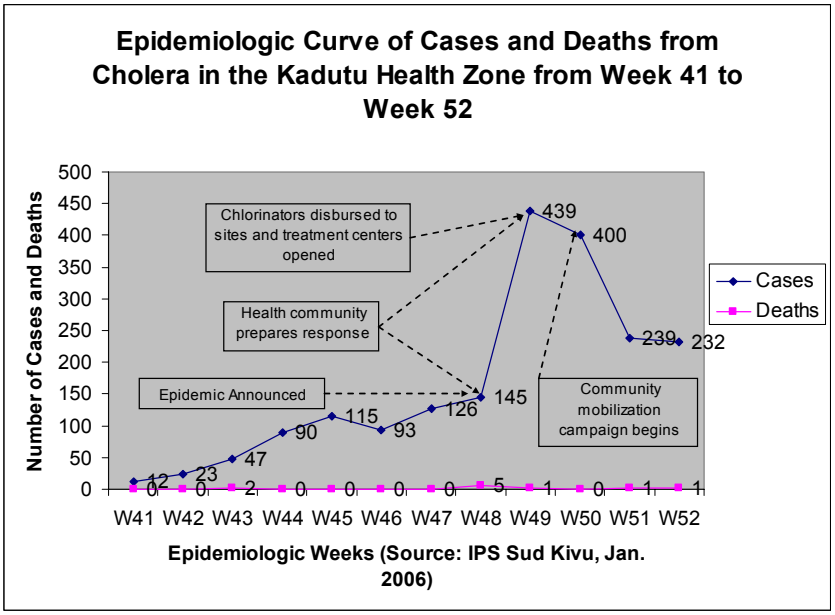


The AMITIE project functions via an established network of volunteers. The OVC and PLWHA beneficiaries are especially vulnerable to disease due to their precarious health and socio-economic conditions. Consequently, epidemics of infectious disease are particularly threatening to these populations and merit a targeted approach to prevent illness. To that end, the AXxes and AMITIE

medical coordinators organized special training sessions for the Home Volunteers during educational material was explained and distributed to the Home Volunteers for subsequent transmission to PLWHA and OVC beneficiaries. In addition, CRS approached PSI to request training for the Home Volunteers on the use of the water purification product "PUR". PSI immediately agreed and conducted the training the following day. CRS/AXxes then purchased 10,000 packets of "PUR" and distributed enough to each Home Volunteer for every PLWHA enrolled in the AMITIE program to purify a 10-day supply of drinking water for themselves and their family.

Results of the Cholera Intervention:

The health zone of Kadutu is the center of the most recent epidemic. It is also a common zone of intervention for the AMITIE and AXxes projects. As such, it is the best zone in which to attempt to view impact of the intervention. The results below demonstrate that the overall intervention by all of the responders has been successful in attenuating the spread of the epidemic, although the announcement and subsequent response arrived too late to prevent a steep increase in cases between weeks 48-50.



Regarding the CRS intervention alone, it is impossible to separate its effect independent of the other actions being led by other responders, but it is reasonable to conclude that the decrease in cases beginning with Week 49 is partly attributable to the quick response by the CRS AXxes and AMITIE teams.

2x2 Table of Incidence and Case-Fatality Rates Among the AMITIE and General Population of Kadutu

	Incidence Rate	Case Fatality Rate
Amitie Population	0.29%	14.2%
General Population	0.75%	0.51%

As for the PLWHA and OVC beneficiaries of the AMITIE project, CRS recorded seven cases of cholera and one death, representing an infection rate of .3% and a case-fatality rate of 14.2% compared with an infection rate and case-fatality rate of less than 1% in the general population. The lower infection rate amongst the AMITIE beneficiaries could be attributed to the efforts made by the Home Volunteers to educate their beneficiaries on water purification and cholera prevention, while the increased case-fatality rate among the PLWHA and OVC population most likely demonstrates the reduced capacity of this population to resist the effects of the disease. However, these conclusions are based on the small sample of

AMITIE beneficiaries who became infected with cholera and thus may not be representative.

Lessons Learned and Recommendations:

- Monitor the situation of potential epidemics on a weekly basis. Do not delay organizing a response.
- Prepare a stock of cholera treatment drugs and supplies for a rapid contribution towards making cholera treatment centers operational.
- Negotiate with Proctor and Gamble to receive a free shipment of PUR for rapid distribution to vulnerable populations in the event of a waterborne disease epidemic.
- Include cholera prevention messages in IMCI activities.

Annex 1: Performance Indicators

Project AXxes Performance Indicators for October and November 2006			
Activities	**Performance Indicator**	**Results**	**First year goal**
Component A: Increased access to, quality of, and demand for multi-sectoral, integrated PHC			
Increased access to integrated Primary Health Care	Nbr health clinics built or rehabilitated (non-cumulative)	2	**50**
	Percent (%) of population served	41%	**50%**
	Percentage of use of curative health services	32%	
Improve Reproductive Health, treatment of STIs and the practice of Child Spacing	Couple years of protection (CYP) for FP (cumulative)	ND	**40k**
	Prevalence of use of family planning	3%	**5%**
	Percent of Health centers with Integrate Reproductive Health Services (RHS) and child spacing in their routine activities	74%	**60%**
Improve Water and sanitation supply	Number of water supplies improved	1	
Improve the service deliver and outcome of Maternal and Newborn Care	Proportion births attended by skilled personnel	61%	**40%**
	Rate of people who benefited a postpartum/newborn visit the next 3 days following delivery	60%	
	Number of people trained in maternal and newborn health & nutrition	ND	
	Rate of women receiving Active Management of Third Stage of Labor	35%	
	Percent of Health center with syndromique approach of STIs management	17.5%	**50%**
	Percent of neonatal deaths	ND	**4%**
	Number of vaginal fistula repairs	2	
	Percent of pregnant women visiting health centers receive iron supplements.	73%	**70%**
	Percent of lactating women visiting health centers receive iron supplements.	3.4%	**70%**
Increase the coverage of Immunizations	Proportion of children receiving measles vaccination	74.5%	**69%**
	DPT3 coverage	80%	**55%**
	Percent of drop-out DPT1/DPT3	ND	**18%**
	Percent of diseases related to vaccinations are detected and reported within 14 days.	6.7%	**60%**
Improve family Nutrition and coverage or utilization of Micronutrients	Proportion children 6-59 months receiving Vitamin A	96%	**90%**
	Proportion of children with diarrhea receiving Oral Rehydration Therapy (ORT)	ND	**40%**
	Percent of children 12-59 months have received mebendazole during each campaign.	31%	**90%**
	Percent of children with diarrhea in the pilot areas have received zinc	0%	**20%**

Promote and improve the use of Integrated Management of Childhood Illnesses both in Clinics and the Community	Percent of children under the age of five with diarrheal illnesses are cared for correctly by health structures following national policy guidelines	ND	
	Percent of households in targeted health zones have access to potable water	ND	**35%**
	Percent of households in targeted health zones adopt three key hygiene practices (use of potable water, use of latrines, and hand-washing)	ND	**30%**
Reduce the incidence of Malaria, especially among pregnant women and children under five	Nbr severe malaria treated appropriately within 24 hrs	ND	**60%**
	Percent of pregnant women in targeted health zones receive IPT	36%	**70%**
	Number of LLIN distributed	ND	
Increase the detection and treatment of Tuberculosis	TB detection rate		
	TB cure rate		
Assure Blood Safety	Percent of blood transfusions tested for HIV and blood grouping	95%	**99%**
Develop a Multi-sectoral approach to promote stabilization of health system and community	Average cost of a visit to a CS in targeted HZs	ND	**1.5 $**
	Percent of CODESAs that financially support health centers	3.2%	**5%**
	Percent of CODESA with 50% women membership	12%	**50%**
Component B: Increased Capacity to the health zone and the referral system			
Improve Planning and Governance	Percent of health zones with an action plan approved by the CA	80%	**90%**
	Percentage of health zones that have Quarterly reviews with health providers, health zone team and COGE members	66%	**90%**
Develop Human Resources, including training and supervision	Nbr persons trained/in place for services (cumulative)	ND	**2630**
	Percent of health centers supervised by health zone team each month	57%	**60%**
	Percent of health zones team supervised by health district/province project staff team each quarter	10%	**60%**
Improve Transparency and Accountability	Percent of functioning COGEs	ND	**70%**
	Percent of functioning CODESAs	39%	**50%**
Develop and improve Drug Supply Management	Percent of health facilities reporting stock outs of indicator medicines	43%	**30%**
	Percent of SNIS reports completely filled out	36%	**70%**

Develop and implement an effective Health Information Systems	Percent of SNIS reports completely filled out	36%	**70%**
	Percent of SNIS report sent to government on time	20%	**60%**
Reinforce Community participation in the health care system	Percent of functioning community health workers	ND	**30%**
	Percent of functioning CODESAs	39%	**50%**
Improving the Health Referral System	Percent of health centers that refer patients to hospitals following proper treatment protocols	10%	**60%**
	Percent of hospitals that referral information back to health centers	4%	**60%**
Build capacity of local NGOs	Number of NGOs supported	0	**5**

Annex 2: Existing Equipment in Health Zones

Region	Health Zone	Moto	IT Kit	Serial Printer plus setup	HF Radio plus access.	Generator	Typewriter Standard	Refrigerator w/ freezer	Refrigerator HGR	Large Cold Box	Vaccine Carrier	Bicycle	Microscope HGR	HGR Gloves/Gauzes Kit	Microscope CS	Solar Lighting system kit	HC Minikit	Operating table	Consultation table	Birthing table	Basic Delivery Set	Laparotomy Surgery Set	Hernia Surgery Set	Caesarean Surgery Set	Appendicectomy Surgery Set	Autoclave	Incinerator	Operating Lamp
K. Oc.	Tshikaji	3	0	0	0	1	0	2	5	2	24	19	4	0	8	7	0	4		2	8	10		4	0	1	1	3
K. Oc.	Bulape	0	0	0	0	0	0	11	1	1	0	33	2	0	8	7	0	2		1	6	2		1	0	2	0	2
K. Oc.	Mutoto	3	0	0	0	0	0	2	0	2	28	14	1	0	1	0	0	1		1	0	0		0	0	1	1	0
K. Oc.	Lubondai	0	1	1	0	2	1	4	0	2	19	13	2	0	7	6	0	2		0	2	2		2	0	0	0	1
K. Or.	Bibanga	0	1	1	1	0	1	2	0	0	40	10	2	0	7	1	0	1		1	2	4		2	2	0	0	1
K. Or.	Mpokolo	0	0	0	0	0	0	1	0	1	10	0	0	0	2	0	0	0		0	0	0		0	0	0	0	0
Katanga	Mulongo	0	0	0	0	0	0	5	1	6	0	24	2	0	4	5	0	0		0	0	1		2	1	0	1	0
Katanga	Kayamba	1	0	0	0	0	0	3	0	2	24	37	1	0	1	0	0	0		0	0	3		3	1	0	0	1
Katanga	Lwamba	1	0	0	0	0	0	5	1	4	32	8	1	0	7	0	0	0		0	1	1		1	1	1	1	0
Katanga	Songa	2	0	0	0	0	0	6	0	5	29	29	2	0	4	7	0	2		1	1	2		2	1	0	0	2
Katanga	Malemba Nkulu	0	0	0	0	0	0	2	1	2	16	16	2	0	10	2	0	1		0	3	1		1	1	1	1	1
Katanga	Mukanga	0	0	0	0	0	0	1	0	3	0	0	0	0	10	0	0	0		0	0	0		0	0	0	0	0
Katanga	Kabongo	3	1	1	0	1	1	5	0	4		44	2	0	7	8	0	2		2	2	2		2	2	0	0	0
Katanga	Kitenge	2	0	0	0	0	0	6	0	2	60	32	0	0	2	0	0	0		0	0	0		0	0	0	0	0
Katanga	Kinkondja	4	0	0	0	0	0	9	0	3	44	44	1	0	10	6	0	0		3	0	1		2	1	0	1	0
Katanga	Kanzenze	2	0	0	0	1	0	7	1	2	45	16	1	0	9	1	0	1		1	1	1		1	1	1	0	1
Katanga	Bunkeya	1	0	0	0	1	1	3	1	0	28	6	2	0	1	3	0	1		3	2	2		2	2	0	2	1
Katanga	Mutshatsha	2	0	0	0	0	0	4	1	2	38	14	2	0	5	0	0	1		2	1	1		1	1	1	1	1
Katanga	Lualaba	4	0	0	0		0	5		5	0	28		0	5		0											
Katanga	Lubudi	3	0	0	0	0	1	8	2	1	1	24	3	0	1	0	0	1		1	1	1		1	1	0	0	2
Katanga	Fungurume	3	0	0	1	0	1	2	0	2	5	1	1	0	0	0	0	1		1	0	0		0	0	2	0	0
Katanga	Dilala	2	0	0	0	1	0	3	0	0	66	13	2	0		0	0	0		0	0	0		0	0	1	3	2
Katanga	Manika	3	0	0	0	1	1	2	1	2	30	40	5	0	2	0	0	3		3	1	2		2	4	1	1	3
Maniema	Pangi	1	0	0	1	0	0	2	0		2	14	1	0	3		0	0		0	5	1		1	0	0	0	0
Maniema	Kailo	0	0	0	1	0	0	10	1	11	35	42	1	0	0		0	0		0	0	0		0	0	0	1	0
Maniema	Kalima	0	1	1	1	0	0	4		7	7		1	0	1		0			2	2	0		0	0	1	0	0
Maniema	Kampene	1	0	0	1	0	1	2	0	1	120	10	2	0	3		0	2		1	7					1	0	2

Maniema	Alunguli	0	0	0	1	0	0	4	0	1	21	3	2	0	1		0	0		2	4	1		1	1	1	1	0
Maniema	Kindu	0	0	0	1	0	1	3	3	0	154	14	1	0	6		0	0		2	7	16		0	0	0	2	0
Maniema	Ferekeni	0	1	1	1	0	0	2	0	2	40	6	2	0	5		0	1		1	9	2		1	0	0	0	2
Maniema	Obokote	0	0	0	1	0	0	3	0	8	42	20	2	0	3		0	0		0	10	0		0	1	0	0	
Maniema	Lubutu	0	0	0	1	0	0	7	0	5	152	33	2	0	4		0	1		0	7	1		2	1	0	0	1
Maniema	Punia	0	1	1	1	1	0	4	0		48	0	1	0	12		0	1		1	12	1		1	0	0	0	1
S. Kivu	Ibanda			0										0			0									0	0	0
S. Kivu	Kadutu	1	1	1	0	0		1	1	0	9	2	1	0	10	0	0	2		1						0	1	0
S. Kivu	Mwana	0	0	0	0	0		1	4	0	0	9	2	0	11	0	0	1		2						0	0	0
S. Kivu	Nyangezi	0	1	1	1	0		0	0	4	32	13	0	0	8	0	0	0		0						1	0	0
S. Kivu	Kaziba	0		0	2	0		0	5	4	70	12	4	0	9	0	0	0		1	5	2		5	3	2	1	2
S. Kivu	Walungu	0	0	0	1	0		0	1	2	62	3	0	0	14	0	0	2		3	4	1		3	1	1	0	0
S. Kivu	Kaniola	1	0	0	0	0		1	0	2	57	0	1	0	1	0	0	1		1	2	1		3	1	0	0	1
S. Kivu	Mubumbano	0	0	0	0	0		0	0	5	32	7	0	0	9	0	0	0		0	9	2		3	1	1	0	1
S. Kivu	Kalonge	1	1	1	0	0	1	5	0	0	7	8	1	0	8	4	0	1		2	2	1		3	0	0	1	0
S. Kivu	Kalehe	2	2	2	0	0	1	4	0	5	30	0	1	0	10	13	0	1		2	5	2		4	4	0	0	1
S. Kivu	Minova	3	0	0	0	0	1	0		1	0	5	1	0	3	0	0	1		1	5	1		2	1	0	0	0
S. Kivu	Bunyakiri	3	0	0	0	2	2	3	1	15	0	8	2	0	12	0	0	3		0	3	0		2	0	1	1	2
S. Kivu	Katana		0	0		1			3			4	3	0	15	0	0	1		1	6	1		2	2	1	1	2
S. Kivu	Miti	0	1	1	1	1	0	2		1	0	7		0	11	0	0											
S. Kivu	Idjwi	3	1	1	1	1	2	5	2	6	12	10	1	0	27	62	0	2		2	3	1		3	1	3	1	2
S. Kivu	Kitutu	1	0	0	1	0	1			1				0			0											0
S. Kivu	Lulingu	1	1	1	1	0	1	7	1	1	12	0	1	0	0		0	0		1	6	1		2	0	0	1	0
S. Kivu	Kalole	1	0	0	1	0	1			1				0			0										0	0
S. Kivu	Shabunda	2	0	0	1	0			1	9	60	9	6	0	0		0	2		2	8	3		3	1	2	1	1
S. Kivu	Mulungu	0	0	0	1	0				1				0			0										0	0
S. Kivu	Kamituga			0		0		0	0	0	0	0	0	0	0		0	0		0	0	0		0	0	0	0	0
S. Kivu	Mwenga			0		0								0			0											
S. Kivu	Uvira	4	2	2	0	0		2		6	132	0		0	0		0									0	0	0
S. Kivu	Bijombo	0	0	0	0	0		0		1	60	0		0	12		0									0	0	0
S. Kivu	Nundu	1	0	0	1	0		6	1	7	28	6	0	0	6		0	0		1	1	1		1	1	0	1	0
S. Kivu	Lemera	0	0	0	0	0		1		8	146	5	0	0	8		0	0		0				0	0	0	0	0
S. Kivu	Ruzizi	0		0	1	0		1		1	25	6		0	7		0									0	0	0
Total		65	16	16	25	14	19	178	39	169	1,934	721	77	0	330	132	0	45	0	51	153	75	0	71	38	27	26	39
Current average		1.1	0.3	0.3	0.4	0.2	0.3	3.0	0.7	2.8	32.2	12.0	1.3	0.0	5.5	2.2	0.0	0.8	0.0	0.9	2.6	1.3	0.0	1.2	0.6	0.5	0.4	0.7
Min after purchases		3	1	1	1	1	1	1	1	1	17	12	2	4	3	4	12	1	4	5	4	1	2	3	2	1	1	1