

# Project AXxes

IMA / ECC / CRS / WVI

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## Annual Report

**September 18, 2006 – September 30, 2007**

Integrated Health Services Project (Project AXxes)  
USAID Cooperative Agreement No: 623-A-00-06-00058-00  
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## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMSTL	Active Management of the third Stage of Labor
ANC	Antenatal care
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BCZS	Bureau Central de la Zone de Santé (Health Zone Central Office)
CCIA	Coordination Committee Inter Agency
CDT	Centre de Dépistage et Traitement (TB testing & treatment center)
C-IMCI	Community-Based Integrated Management of Childhood Illness
CODESA	Comité de Développement et Santé (Health & Development Comity)
COSA	Comité de Santé (Health center management comity)
COP	Chief of party
CRS	Catholic Relief Services
CYP	Couple Years of Protection
DOCS	Doctors on Call for Service (a.k.a. HEAL Africa)
DPT	Diphtheria Polio Tetanus
DMO	District Medical Office
DOTS	Directly Observer Treatment Strategy
DRC	Democratic Republic of Congo (also DR Congo)
ECC	The Protestant Church of Congo
EPI	Expanded Program on Immunization
FBO	Faith-Based Organizations
FP	Family Planning
GBV	Gender Based Violence
GAVI	Global Alliance for Vaccines and Immunizations
GESIS	Computerized health information system
HGR	General Reference Hospital
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HZ	Health Zone
HZMT	Health Zone Management Team
ICC	Interagency Coordination Committee
IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illness (PCIME in French)
IPT	Intermittent Preventive Treatment
IPS	Inspection Provinciale de la santé (Provincial Health Office)
ITNs	Insecticide Treated Mosquito Nets
IUD	Intra Uterine Disposal
JHU	Johns Hopkins University
KPC	Knowledge Practice Coverage study
LLIN	Long-Lasting Insecticide-treated Nets (also known as ITNs)
MCZ	Health Zone Medical (Medecin chef de Zone)
MID	Medical Inspector of the District

M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organizations
ORT	Oral Rehydration Therapy
PCIME	IMCI in English – Integrated Management of Childhood Illness
PEV	Programme Elargie de Vaccination (EPI in English)
PMA	Paquet Minimum d'Activité (Minimum Package of Assistance)
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNLMD	Programme National de Lutte contre les maladies diarrhéiques
PNLS	Programme National de Lutte contre le SIDA (National AIDS Program)
PNLT	Programme National de Lutte contre la Tuberculose (National TB Program)
PNTS	Programme National de Transfusion sanguine (National Blood Safety Program)
PNLP	Programme National de la lutte contre le Paludisme (National Malaria Program)
PNSR	Programme National de la Santé de la Reproduction (National RH Program)
POPHI	Prevention of Postpartum Hemorrhage Initiative
PPH	Prevention of Postpartum Hemorrhage
PRONANUT	National Program for Nutrition
RHS	Reproductive Health Services
SANRU	Health Development Program of ECC based on the SANRU I, III & III projects
SPHK	School of Public Health in Kinshasa
STI	Sexually Transmitted Infections
SNIS	Système National d'Information Sanitaire (National Health Information System)
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of trainers
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
VCT	Voluntary Counseling and Testing
VFR	Vaginal Fistula Repair
WHO	World Health Organization
WRC	World Relief Corporation
WVI	World Vision International

## **I. Executive Summary**

The Integrated Health Services Project (Project AXxes) is a joint project implemented by Interchurch Medical Assistance (IMA) in collaboration with partners - World Vision (WV), The Protestant Church of Congo (ECC) and Catholic Relief Services (CRS). AXxes is a three-year \$42 million dollar USAID-financed primary health care project designed to revitalize the national system of primary health care in 57 health zones across the DRC. The project runs from September 18, 2006 to September 17, 2009.

The main goal of this project is to provide integrated development assistance for Primary Health Care (PHC) to fifty-seven (57) Health Zones (HZs) of Eastern and Southern Congo for a population of approximately 7.5 million. Within this area ECC and CRS each work in twenty-one health zones and WV works in fifteen health zones (see Annex 1). For some of these HZs, such as Kayamba in the Kamina district, it is the very first time they have received comprehensive development based assistance. This is a big challenge because the infrastructure dating back to the colonial period is poor and finding quality (**competent**) human resources is rare.

AXxes provides health zone development assistance based on the “Appui Global” strategy of the Ministry of Health through three major components.

Component A: Increase access to, quality of, and demand for multi-sectoral, integrated PHC

Component B: Increased Capacity to the health zone and the referral system

Component C: Increased capacity of national health programs and provincial/district offices

### **Major Achievements**

Major achievements for year one can be summarized as follows:

#### *Activities*

- Signed agreements between IMA, implementing partners (ECC, CRS and WVI) and with technical assistance partners (JHU, MSH, HKI, BASICS, BASICS Immunization, World Relief, Brown Consultants, IMCK and Panzi).
- Operationalized regional/district project offices
- Signed contracts with Health Zones/IPS, which are the institutional framework for the project implementation.
- Conducted rapid assessments of the Health Zones at the beginning of the implementation to ascertain the strengths and weakness of each assisted HZ.
- Conducted a baseline KPC in all health zones
- Supported development of HZ action plan and financed those action plans
- Organized and supported the Administrative council (CA) meetings in Health Zones.
- Conducted several training workshops for health personnel on topics necessary for the implementation of the Ministry of Health (MOH) minimum package of activities (such as

reproductive health and family planning, maternal and new born care, tuberculosis, nutrition, disease surveillance, malaria, curative care and drug supply management, vaccination and supervision systems)

- Facilitated the training workshop with Helen Keller International of 10 Health Zone Leadership Teams in improved delivery of routine Vitamin A services
- Supported the Vitamin A and Mebendazole campaigns
- Facilitated the implementation of the baseline KPC survey in 21 health zones in Sud Kivu
- Rehabilitated health facilities, constructed incinerators, built latrines and water sources
- Started PMTCT implementation process including training of trainers.
- Supported actively the organization and implementation of the health zone census with all major stakeholders
- Contributed to the integrated immunization/malaria campaign with UNICEF
- Initiated and implemented two pilot projects in partnership with World Relief and Innovative Resources Management, to strengthen community structures
- Identified local NGOs to submit three-year projects focused on capacity building as part of “Promising Partners Grants Management”
- Responded to four epidemics: cholera in Bukavu and Katanga, measles in Uvira and hemorrhagic fever (Ebola) in Kasai Province.
- Provided equipment such as motorcycles, generators, and refrigerators and started to provide medicines and medical material, particularly blood transfusion test kits
- Conducted a two stage training with MSH for implementing partners and ISP staff in “Transforming Managers into Leaders”
- Reinforced the government health information system (SNIS)

### **Main challenges**

The generalized insecurity in South Kivu and particularly in a several HZs remains the main challenge. In addition, the third quarter was marked by the withdrawal of MERLIN from Project AXxes and the subsequent transfer of their Sud Kivu health zones to CRS, many of which have problems of geographical accessibility as well as inadequate poorly maintained facilities.

Coordinating AXxes activities with the other NGOs who do not share the same development approach and philosophy (i.e. *Emergency*) as Project AXxes is still another challenge in many Health Zones.

The delay in the provision of essential medicines and other equipment impacted not only the credibility of the project but also project implementation itself.

## II. Table of Planned Activities and Actual Accomplishments

Activities	Quarter				%	Comments
	1	2	3	4		
<b>Component A: Increase access to, quality of, and demand for multi-sectoral, integrated PHC</b>						
<b>1. Increase access to HC</b>		x..				
Provide each HC and HGR with care protocols		x..			50%	RH, FP, Blood safety and Malaria protocols are already used in several HZs. In Kolwezi, Kasais and Haut Lomami the IMCI protocols have been introduced after IMCI training. The complete ordinogram is revised and has been ordered
Train each HGR and HC staff in correct use of curative care protocols ( ordinogramme)			x		50%	Done during PMA training in Kolwezi, Haut Lomami and Kasais, planned in October for South Kivu.
Provide each HGR and HC with essential drugs			x..		10%	Few drugs distributed, more awaited
Equip at least 60% HC/HZ with mini Kits			x..		50%	Distribution ongoing
Equip each HGR with HGR kits and surgical boxes			x..		50%	Distribution on going
<b>2. Reinforce referral system</b>			x..			
Promote use of protocols			x..		50%	Done during supervision for R.H, IMCI, blood safety and malaria for which protocols are available, waiting for curative protocols (ordinogram) already modified and ordered
Establish preferential tarification for referred patients ( at least 20% less than other patient)			x..		50%	6 HGRs out of 12 apply this system, others are in discussions
Equip geographical strategic HC of reference			x..		50%	Distribution of medical supplies has started.
Establish episodic Payment system			x..		65%	Zones have reached consensus and await drugs for application
Rehabilitate HGR and at least 2 HC/ HZ				x..	40%	Rehabilitation of selected HCs, Incinerators and HGR maternities are ongoing
<b>3. Establish blood testing &amp; grouping at HGRs &amp; CSR</b>		x..				
Train HGRs & CSR Lab Staff in screening for transfusion-transmissible infections, blood grouping, compatibility testing, the storage and transportation of blood products		x			87%	13 TOTs were trained and they trained another 174 laboratory staff out of the 200 planned.
Encourage the HZ team to educate, motivate, recruit and retain low-risk blood donors, especially the volunteer non-remunerated blood donors from low-risk population		x..			50%	The promotion of this was stressed during PMA training in Kolwezi, Kasais and Haut Lomami. The PNTS has distributed guidelines in all HZ give directives on how to promote blood donations
Provide HGR with adequate HIV, HBs, HCV et RPR and blood group tests, and transfusion supplies			x..		100%	Materials have been distributed in HGR
Ensuring that assisted HZs follow current PNTS guidelines on the clinical use of blood transfusions			x..		100%	Guidelines are available in HGR and RHCs. It is supervised monthly
Providing training in the clinical use of blood including alternatives to transfusion and in how to prevent transfusions by early treatment of all conditions that could result in need for transfusions (obstetrical complications, anemia, trauma)			x..		80%	Topics covered during laboratory training and reinforced during PMA training
<b>4. Establish PMCT</b>		x..				
Recruit a consultant for developing PMTCT implementation program		x			100%	Browns consultants were recruited and their project proposal received USAID approval. The implementation phase is in process now.
Begin PMCT implementation in HGR and selected HC			x..		20%	Selected HZs, recruitment of PMTCT is ongoing. Additional Supplies are being ordered, 20 people from 3 HZ of Kasai Occidental were trained and the next trainings are already planned
<b>5. Integrate Zinc treatment in treatment of diarrhea</b>		x..				

Activities	Quarter				%	Comments
	1	2	3	4		
Facilitate workshop for zinc		x..			100%	Axxes through HKI in collaboration with BASICS, MSH, Unicef and WHO helped the PNLMD to organize workshops on Zinc and lead the MOH to accelerate implementation process
Conduct a pilot program to test for acceptance of the provision of Zinc and low-osmolarity ORS for children with diarrhea will also be implemented by HKI in several HZs during the year one			x..		40%	12 HZs (4 in Haut Lomami, 4 in South Kivu and 4 in Kolwezi).As Zinc tablets are already available for these HZs, HKI in collaboration with PNLMD is briefing providers before starting implementation. So far the 4 HZs of Kolwezi have participated in the Zinc briefing facilitated by HKI
TOT for Zinc , Vit A and ORT integration ( HKI)			x..		100%	33 staff from 4 target HZs have been trained
Int'l Trip: South-South visit to ZN program (HKI)			x		100%	The MOH staff ( PNLMD, Pronanut), HKI TA and a CRS representative have visited Madagascar and provided feedback about good practices and lessons learned from this trip
Workshop to review / elaborate BCC messages on Zinc			x..		80%	Done in collaboration with with BASICS, MSH and other partners like Unicef and WHO under the lead of PNLMD. Materials must be produced.
<b>6. Clinical IMCI (C-IMCI)</b>			x			
Train HZMTs as TOT, HGR and HC staff in IMCI including management of Diarrhea, ARI, fever, Measles, malnutrition and other child diseases			x..		50%	Done during PMA in Kolwezi, Kasais and Haut Lomami. Scheduled for the end of October for South Kivu
Provide HC with IMCI drug package including ORS, Zinc, ACT and antibiotics...			x..		0%	Waiting for drugs. Zinc tablets are already available for the 12 pilot HZs for 3 months.
Provide HGR and HC with protocols and IMCI forms			x..		50%	IMCI protocols have been introduced after IMCI training
<b>7. Integrate C-IMCI in collaboration with World Relief</b>			x..			
Train C IMCI team ( 4 pers from HZMT and 1 pers from the community) as trainers			x..		20%	To be done in November. Currently reviewing and producing training and BCC materials in Kinshasa in collaboration with Basics and PNLMD. World relief already trained people from 2 south Kivu pilot HZs.
Support Selected relays training			x..		20%	To be done in November. Currently reviewing and producing training and BCC materials in Kinshasa in collaboration with Basics and PNLMD
Facilitate the Reproduction of available and proven educational materials (flipcharts, tip cards, posters, pamphlets, etc)			x..		50%	Done for most of the materials (malaria, Reproductive health...) Need to complete with the remaining material especially for Reproductive health, Key family practices, New born care and PMTCT
Increase Community Awareness of Behaviors Related to Childhood Illnesses through relays				x..	10%	Done through existing relays and through the HC BCC program. This program will be reinforced after training of different CIMCI and relays scheduled for November
<b>8. Development of Water Sources and Promotion of Hygiene and Sanitation</b>			x..			
Training of water and sanitation coordinators				x..	65%	37 Water & sanitation of 57 AXxes HZ are trained with different sources of financing: 25 by UNICEF 14 in south Kivu, 9 in Haut Lomami and 2 in Kolwezi and the other by Sanru III AXxes is following up to replicate training in other HZs.
Rehabilitation of existing/build community water wells				x..	11%	The process of identification of sources is almost completed in most areas. The rehabilitation of 19 sources is in progress in South. Kivu. Efforts must be made to accelerate this activity. Around 171 sources were expected in year one
Promote Construction of latrines in health centers and incinerators in hospitals				x..	70%	5 incinerators in Kolwezi are complete and 7 in South Kivu are in progress
<b>9. Improve malaria treatment at HC and HGR</b>		x..				
Provide each HGR and each HC with national protocols		x			100%	Provided and trained on their usage during PMA training

Activities	Quarter				%	Comments
	1	2	3	4		
Improve laboratory capacity in diagnosing malaria including provision of labo supplies and training for each HGR and selected HC laboratory staffs in collaboration with MSH		x..			70%	174 lab staff trained and supplies distribution in progress
Training HZMTs, each HC and HGR staff in management of malaria including preventive aspects			x..		60%	Training done during PMA training. Awaiting for South Kivu
Provide each HZ with ACT			x..		0%	Awaiting drugs
Provide HGR and HC with other malaria drugs (quinine, Fansidar)			x..		25%	SP for IPT provided in HZs
<b>10. Improve and promote malaria prevention</b>			x..			
Training HZMTs, each HC and HGR staff in management of malaria including preventive aspects			x..		60%	Training done during PMA training. Awaiting for South Kivu
Integrate IPT as part of FANC in each health center			x..		70%	All of the HZs have been provided with SP and the activity is being integrated in almost all health structures
Develop social marketing activities for LLINs			x..		100%	In Kolwezi as it was the first time to receive LLINs, a social marketing training was done. In ECC HZs the activity was easily integrated. AXxes will sell at \$0.50 each at HCs.
Provide an average of 2800 LLINs/year/HZ that will be sold at subsidized price (05 \$) to the targeted population ( pregnant women and child under five)			x..		60%	180,000 nets have been imported this year with AXxes funds. Through collaboration with UNICEF an estimated 400,000 more nets were distributed in AXxes HZs in south Kivu
Diffuse keys messages on malaria through community relay			x..		10%	Reactivation of community relays ongoing. The diffusion of key messages is ongoing but will be reinforced during relay training scheduled in November
Develop communication program focused on home care, care seeking and recognition of signs of danger that include BCC materials et relay training			x..		20%	The program will be integrated in November with the development of the CIMCI program. However the “malaria boite a image” are already distributed at the health centers.
Supervise activities			x..		80%	Provincial coordinators and supervisors provided integrated supervisions monthly to HZs included malaria activities. LLIN distribution during the campaign was actively supervised in collaboration with supervisors from the central level
<b>11. Promote good nutritional practices</b>			x..			
Promote early and exclusive breastfeeding, appropriate weaning practices, (Initiative Hopitaux Amis des bebe)			x..		80%	Topic covered during RH and PMA training. Monitoring and following up are continuous
Support the diffusion of nutrition key messages through HZ team, HGR, HC and Community-IMCI relays			x..		50%	PMA and IMCI training raised awareness to HZMT and other health personnel in Kolwezi, Kasai and Haut Lomami.
Reinforce growth monitoring by distributing card, equipping facilities with scales, height boards and registers for growth monitoring;			x..		80%	Incorporated in RH and IMCI training of TOT and other health workers. Growth monitoring promotion tools and equipment have been distributed in all HZs. Scale are part of HC mini kits
<b>12. Increase VIT A and Iron coverage among targeted population</b>		x..				
Workshop on Vit A		x			100%	Done in Bukavu with the support of HKI and Pronanut. CRS and ECC teams with 2 IPS representatives from targeted HZs participated.
Micro planning at all levels, beginning with health centers;			x		100%	Done and submitted to MIPs for consolidation
Support distribution of vitamin A plus mebendazole through both special campaigns and routine services;			x..		100%	All of the AXxes implementing partners participated actively in the organization and implementation of the vitamin A campaign with HKI's support

Activities	Quarter				%	Comments
	1	2	3	4		
Integrate Iron distribution to all pregnant and lactating women;			x..		100%	The activity distributed iron and folic acid in all facilities. Follow up and supervision of this activity is required to ensure that all pregnant women are receiving iron and folic.
Conduct a pilot program to increase Vit A demand by the community			x..		80	HKI in collaboration with CRS and ECC trained HZMTs from the pilot HZs The training of senior nurses and relay is going on. BCC Material and relay guides are already developed.
<b>13. Integrate the RED, REHA, REC approaches including training of HZMTs and HC staff</b>		x..				
Support Micro plan process for each health area and the for each HZ		x..			100%	Done for all HZs and submitted to MIPs for consolidation
Encourage and Support census of population in each health area		x..			50%	Census done in South Kivu. Not yet completed in Katanga, Kasai, Haut Lomami and Sankuru
Provide HZ with refrigerator fuel		x..			100%	Refrigerator fuel is supplied according to HZ need
Support HC to develop outreach activities ( bike and cold chain boxes, management tools)		x..			80%	Distributed bikes, management tools and refrigerators. Waiting for cold boxes
Participate in CCIA meetings		x..			100%	Active participation ongoing
Provide Cold chain equipment (solar refrigerator) and supplies for each HZ according to the results of need assessment In collaboration with Unicef			x..		80%	Distributed refrigerators following the need assessment results. More refrigerators will be added next year. Waiting for cold boxes.
Recruit for each cluster a technician for repairing existing refrigerators			x..		100%	Done at the all clusters and work has started
Train HZMTs and HC staff in PEV Activities			x..		50%	Done during PMA training in Kolwezi, Kasais and haut Lomami, AXxes plans joint supervision with PEV
Organize accelerated immunization in the health zones with low coverage			x..		70%	Done in the western and south districts with the support of UNICEF. Currently in progress in Bunkeya and WHO plans to conduct it in Bunyakiri. In ECC Hzs Children recovery was achieved during the integrated immunization campaign
Provide each HC with BCC materials in collaboration with UNICEF			x..		15%	Following up is on going with UNICEF
Diffuse immunization messages through community relay			x..		15%	C-IMCI training planned in November. Community relay reactivation on going
Reinforce immunization diseases Surveillance system by training staff and relays and providing HC with technical forms The new M&E will be a big opportunity			x..		70%	HZMTs in Kolwezi, Kasais and Haut Lomami were trained in Surveillance system during the PMA. But this training must be reinforced with SIMR training.
Support epidemic response			x..		100%	CRS and WVI responded actively to Cholera epidemic in several HZs (Katana, Lubudi, Kadutu, Uvira and Ruzizi) ECC has provided technical assistance, protection materials, medicine and means to investigate contact cases for Ebola epidemic in Kasai
Promote injection safety in each HC by communication providing selected HC with incinerator			x..		30%	16 of 57 expected incinerators are built (11 in South Kivu with CRS and 5 in Kolwezi are complete)
Integrate DQS practices in the routine of HZ functioning			x..		50%	In progress in South Kivu, Kasai and haut Lomami. To follow up and integrate with PEV in Kolwezi.
<b>14. Integrate Family Planning and services in each HC and HGR supported by the project</b>		x..				
Organize RH workshops with the national program on modules and protocols		x			100%	Done in collaboration with IRH and under the lead of the National program. Modules and protocols were produced
Train HZMTs ( 4/HZ) as TOT and the they will train HC staffs (2/HC) and HGR staffs (4/HGR) in RH/FP		x..			100%	232 TOTs and 1278 health personnel trained

Activities	Quarter				%	Comments
	1	2	3	4		
Provide and secure PF commodities to the selected structures		x..			100%	Have provided IUD, gloves, condoms, cycle bids, consultation forms and contraceptive pills
Provide HC and HGR with PF and STIs protocols		x..			80%	STI protocols to reviewed with the National program and distributed
Integrate PMTCT and Voluntary Counseling and Testing (VCT) as part of Family Planning services in HGR (1/HZ) : 20 sites 1st year			x..		15 %	In progress: Training done for 4 Hz. Planning for extension ready and supplies ordered. Activity delayed due to need for approval of procedures
Introduce RH/PF monitoring activities in each HZ			x..		70%	Monitoring is done in collaboration with, AXXes COP, implementing partners, IRH and MOH. Tools for tracking commodities have been distributed and are in use
Improve collaboration with UNFPA		x..			70%	Have started contacts with UNFPA. Contacts are done at different levels; central and provincial.
<b>15a. Improve Antenatal Care</b>		x..				
Train HZMTs, HC and HGR staffs		x..			100%	232 TOTs and 1278 health personnel trained
Facilitate the provision of the minimum package of activities for antenatal in each Health Center This package include: detection of High risk pregnancy, IPT, LLINs, Iron-folic acid, Tetanus toxoid, Screening and treatment for ISTs, FP information and commodities, Health information		x..			80%	Medical supplies and training have been done. Work performance in HGRs and HCs is monitored and supervised. SP is distributed but still waiting for IST drugs
Support Heath center in organizing outreach visits for the population up to 5 km ( bikes, cold chain and other commodities)		x..			80%	Distributed bikes, management tools and refrigerators. Waiting for cold boxes. In some HZs bikes must be added
Provide HC with STIs drug according to the PNLs therapeutic regiments			x..		0%	Awaiting drugs
Integrate Behavior Change Communications (BCC) on reproductive health in HC and through Community-Based Integrated Management of Childhood Illness (C-IMCI)			x..		30%	It was part of the RH/PF training and nurses are organizing educational session before ANC. The activity is not yet developed at the community level.
<b>15b. Improve Intrapartum Care</b>		x..				
Train HZMTs, HC and HGR staffs and midwives on birth management including management of third stage of Labor		x..			100%	232 TOTs and 1278 health personnel trained
Promote appropriate prevention of PPH in each maternity			x..		100%	Done and supervised in routing neonatal activities
Provide each maternity with birth kits and birth management tools			x..		50%	Birth management tools are available and well used and awaiting birth kits in the majority of maternities. 37 delivery kits were already provided in some ECC HZs.
Provide and promote appropriate use of oxytocin in each maternity			x..		0%	Awaiting Oxytocin
Provide HGR and selected HC with blood safety commodities			x..		100%	Distributed in all structures
Rehabilitate maternities			x..		30%	Work is progressing well
Improve emergency surgical services in HGR and other strategically placed health facilities			x..		30%	Materials received and being distributed
<b>15c. Improve Postpartum Care</b>		x..				
Train HZMTs, HC and HGR staffs and midwives in maternal and newborn health and nutrition		x..			100%	232 TOTs and 1278 health personnel trained
Promote appropriate management of PPH in each maternity			x..		70%	On going and supervised monthly
Provide HC and HGR with Post partum management tools					100%	Done
Provide maternity with Vitamin A in collaboration with UNICEF,HKI and PRONANUT			x..		30%	Manika and Lualaba already distribute the vit.A from UNICEF. In some maternities they are using Vit A left from the campaign but quantity is insufficient.
<b>16. Increase availability and improve quality of essential newborn care services</b>		x..				

Activities	Quarter				%	Comments
	1	2	3	4		
Train HZMTs, HC and HGR staffs and midwives in Newborn care		x..			100%	Done during RH training
Provide each maternity with Newborn essential care protocols		x			100%	Protocols were distributed to all maternities
Develop a program of communication on essential newborn care based on interpersonal communication through facility and community health workers and the mass media In collaboration with UNICEF and BASICS			x..		10%	In progress in collaboration with Basics support (component C)
Promote in each maternity Newborn essential care including clean cord care, drying, keeping mother and infant warm (kangourou), early/exclusive breastfeeding, basic newborn resuscitation techniques where indicated			x..		60%	Done during RH training. Following up continuously during supervision
Provide maternities with antibiotics for neonatal infections & supplies			x..		0%	As soon as AXxes drugs are available
<b>17. GBV interventions and fistula reparation</b>		x				
Identify NGOs ( local and international) which are involved in GBV activities in field		x			100%	Identified some LNGOs and proposals developed
Elaborate and diffuse key educational messages regarding the prevention of gender discrimination			x..		20%	In progress in collaboration with MOH and UNFPA
Promote gender objectives for staff composition and participation in trainings and activities			x..		25%	In progress. Will be an important part of CIMCI and CODESA training in November. So far AXxes partners are raising awareness on this issue when organizing trainings and supervising HZMTs
Set Strict criteria for the minimum proportion of women among the village health activists and CODESA/COGE members			x..		5%	Sensitization for women participation is going on. However, their participation is still low
Select strategic HGR where obstetric fistula services will be developed		x..			100%	10 HGRs are already selected : Mwangeji, Songa Mulongo, & Kansenia in Katanga; Shabunda, Kitutu & Panzi hospital in S Kivu; Lodja, Dibindi In Kasai oriental & Tshikaji in Kasai Occidental
<b>18. Improve TB detection</b>		x..				
Collaborate closely with the national program		x..			80%	Contacts have been done and collaborative work is ongoing.
Improve labo staff capacity and provide labo supplies			x..		60%	13 TOT and 174 lab technicians trained. Awaiting lab materials for CDT
Reinforce the capacity of HZ teams to implement the TB program by training them in supervision within the normal activities of the HZ and DOTS			x..		50%	Done during PMA training in Kolwezi, Kasai and Haut Lomami, planned in October for South Kivu
Put in place or reinforce 3 geographically well distributed "Centre de Depistage et de Treatment (CDTs)" in each HZ; providing them with microscopes and needed lab consumables			x..		20%	Selection of CDT done. Waiting for equipment and materials
Promote TB program and CB-DOTS will be done through relays with BCC materials and via radio			x..		10%	Ongoing but poorly. Program to be developed by using CIMCI relays and peer educators
Support the implementation of community-based DOTS (CB-DOTS) strategy with the active participation of local communities in providing the treatment supervision through community relays			x..		10%	Ongoing but poorly. Program to be developed by using CIMCI relays and peer educators and CODESA
Provide HZ with PATI 4				x..	50%	Supported by TB national program, HZMT in Kolwezi and in ECC HZs have been trained and apply. Activity must be reinforced in South Kivu.
<b>Component B: Increased Capacity to the health zone and the referral system</b>						
<b>1. Develop Human Resources of HZMT, including training and supervision</b>	x..					
Establish HZMT training strategy with MOH	x				100%	Done in collaboration with 11 <sup>th</sup> direction
Print HZ training modules with WHO	x				100%	Done in collaboration with 11 <sup>th</sup> direction

Activities	Quarter				%	Comments
	1	2	3	4		
Identify training pools and trainers	x				100%	Done in collaboration with 11 <sup>th</sup> direction
Begin training of HZMTs		x..			100%	Done in collaboration with 11 <sup>th</sup> direction
TA visit (MSH: Ntumba) for AXxes partners Leadership training			x			Trained key AXxes staff, MIPs and MIDs in leadership development program phase 1 and 2. The last phase will be held in Kinshasa in november
Train HC staff in PMA			x		50%	Done in Kolwezi, Kasais et Haut Lomami and delayed in South Kivu because of census and the combined campaign
Begin financing HZ operations		x..			100%	
Support Monthly HC supervision by HZMT			x..		100%	
Train HCs to increase referral rate during the PMA session			x..		50%	Done in Kolwezi, Kasais et Haut Lomami and delayed in South Kivu because of census and the combined campaign
Train hosp staff to increase back referrals			x..		50%	Done in Kolwezi and delayed in south Kivu because of census and the combined campaign
Train doctors in VFR for key referral hospitals			x	x	50	Currently, 4 Doctors and 4 nurses from Mwangeji HGR, Kansenia, Shabunda and Kitutu hospitals are attending the training at Panzi hospital. At the same time 4 other doctors from Lodja, Dibindi, Songa and Mulongo are attending the training at Tshikaji hospital Training of 2 doctors and 2 nurses at Panzi in progress
Improve drug Supply Mgmt to reduce stock outs			x..		75%	Training of TOT in drug management done, distribution of management tools for tracking done, Depots established
<b>2. Reinforce HZ co management and community participation</b>		x..				
Establish/Activate HZ Admin Councils		x..			100%	Reactivated and approved HZ/AXxes 2007 plans
Establish contracts & co-mgmt principle with HZs		x			100%	Contract signed
Reinforce CODESA to become functional			x..		65%	Reactivation and on the job training is ongoing. Part of CIMCI training in November
Activate CODESAs with balanced gender participation			x..		5%	Still poor participation of women. AXxes is sensitizing. The CODESA revitalization program will start in November
Train NGOs in proposal development & mgmt and Fund multisectoral IGAs to support HC				x..	0%	Not yet
<b>3. Establish and reinforce M&amp;E in Health Zone</b>	x..					
Conduct rapid assessments in all 60 HZs	x				100%	Done in the first quarter 2007
Develop electronic indicators form for Implementing partners	x					
TA visit (JHU: Nkossi) to begin M&E dashboard	x				70%	Dashboard beta expected in November
Provide HZ with collection data tools (fiches, SNIS, Cal, protocols...)		x..			100%	Have provided SNIS reporting forms and other forms including calendars.
Facilitate KPC surveys in selected HZs		x	x		100%	Done in all HZs. Report being written
Integrate PMP report in the project		x..			100	Done and going well
Encourage HZMT monthly reviews w/ providers & COGE		x..			100%	On going actively and well
Implement HC complete HIS monthly reporting		x..	x..		100%	SNIS reporting is used and now MOH in Katanga province is reviewing SNIS format with other partners
TA visit (JHU: Nkossi) to test/install M&E system		x			70%	Ongoing. Development of software to facilitate analyzing and sharing information in process
Integrate GESIS in HZ ( training and provision of computers)			x..		40%	In progress in Katanga and Kasai Occidental. HZMTs trainings scheduled for November in Kasai oriental
Submit quarterly program and financial reports	x	x	x	x	100%	Done
<b>Consortium and Project Management Functions</b>						
Finalize subcontracts with implementing partners	x				100%	Done
Establish project offices and key personnel	x	x			100%	Done

Activities	Quarter				%	Comments
	1	2	3	4		
Develop and diffuse administrative and finance procedures ( Procedure Manual Workshop)	x				100%	Done
Finalize/Approve year one work plan with USAID	x				100%	Done
TA visit (IMA: Baer) for budget & startup activities	x	x			100%	Done
Operationalize regional project offices	x	x			100%	Done
Technical Implementation Workshop	x				100%	COP
Order computers, meds, cold chain, ITNs, etc	x	x			100%	COP
Develop and diffuse technical procedures		x			80 %	Sectorial plans, and directives on training, supervisions, ICMCI, watsan already sent. The whole document to adapted and send before the second year
Hold quarterly meeting with implementing partners		x			100%	4 quarterly meetings held
Distribute locally procured project commodities		x..			100%	Done
Int'l Trip: Participation in GHC, CCIH & IMA Confs		x			100%	Done
Distribute of externally procured commodities			x..		80%	In progress
Prepare Annual Program and Financial Reports				x	100%	Done
<b>Component C: Increased capacity of national health programs and provincial/district offices</b>						
Facilitate provincial/district meetings		x..			20%	Waiting for the Provincial and district "Fiche techniques". So far AXxes contributed to facilitate Comite de pilotage for Kasai east and Katanga, PEV review in Lubumbashi
Participate in HZ CA meetings		x..			100%	Almost all of the CA meeting were held and district or provincial levels participates
Supervise HZs at least once per year by central level			x..		80%	Axxes facilitated the supervision of RH/PF, PNLS national program in South Kivu and in Kolwezi
Improve SNIS reports completude et promptitude		x..				All of the HZ received forms and reports to the Province level.
Trips to support provincial/district level		x..				PNLS and RH/PF program were supported by AXxes to support province level and supervise HZ in south Kivu
Develop priority MOH support plan		x..			100%	Done and approved
Conduct MOH needs assessment		x..			100%	Done
Facilitate policy & topical mtgs & workshops		x..			70%	AXxes facilitate : New born task force, IMCI review meeting and RH/PF meeting on tools harmonization
Implement MOH technical support plan		x..				Waiting for the Provincial and district "Fiche techniques"
Identify ST TA for selected topics		x..			100%	Basics for PEV and New Born, JHU for SNIS and Surveillance, Browns for PMTCT, MSH for leadership, HKI for nutrition and Zinc, HPSK for management and surveillance
Facilitate task forces for selected topics			x..		70	AXxes facilitate : New born task force, IMCI review meeting and Zinc task force
Proposed candidates for UNIKIN SPH	x				100%	All successfully completed their studies
Train MOH in strategic planning, finances, mgmt.			x..		80%	First step of training on leadership were organized
Hire MOH Technical Advisors		x..			60%	In progress for BASICS, HPSK

### III. Commentary on Work Plan Activities Component A

#### 1. Increase access to HC

*Training in correct use of curative care protocols (ordinogramme):* Training was done as part of IMCI and PMA was achieved in four pools for all the HZMT members in September 2007. The training covered management of transmissible diseases, nutrition, water and sanitation standards and curative care. In south Kivu the training is planned for October 2007.

Publishing of the ordinogramme was delayed because of the recent revision by the Ministry of Health (MOH). The project will make them available in General Hospitals (HGRs) and Health Centers (HCs) as soon as they are ready. Reproductive Health (RH) and Malaria management protocols are already available in HCs and HGRs. The project is now focusing on their utilization. It has been observed that most of the health personnel do not use or refer to them. In some HZs, nurses had difficulty understanding the protocols. They are important tools of the MOH necessary for facilitating the day to day work in hospitals and health centers, so emphasis will continue to be placed on their utilization.

*Provision of essential drugs, mini kits, equipment and surgical boxes:* There were major delays in getting the essential medicines waiver for the project. The request for a waiver was submitted October 19, 2006 but was not totally approved until the end of June 2007. This has meant that only air freighted medicines and cost share medicines from WVI GIK and IMA member agencies have been distributed in the zones. Most of the first year drug order arrived at the end of September and has been delivered to the various drug depots. The mini kits, and surgical boxes, birth control kits and DIU insertion kits have been, or are in the process, of being distributed to health centers.

WV and ECC received GIK donation. The GIK included cardinal health materials and equipment, consumable medical supplies and nutritional supplements. The items were distributed to HCs. *“The medical supplies received from WV, supplements Government efforts in ensuring accessibility to health care services with appropriate tools”* said the acting MID in Katana, Dr. Claude Ntabuyantwa



**Figure 1: Transporting GIK to project area**

Management Sciences for Health (MSH) has provided pharmaceutical management support to the AXxes project during the first project year. The initial activity involved an evaluation of the regional pharmaceutical depots and pharmaceutical management partners in Kamina, Kolwezi and Bukavu in May 2007. The objective of these assessments was to better understand the local capacity and infrastructure for pharmaceutical and financial (particularly related to credit programs) management and to identify areas for improvement. During the assessments the depots in Kamina and Bukavu were found to be functional with differing pharmaceutical management capacity. In Kolwezi there was no existing regional pharmaceutical depot structure. A meeting was held with local AXxes project and health sector partners to develop a plan. The local Catholic diocese agreed to allow use of their old depot building and to supply a member of their congregation to assist the district pharmacist to manage the depot. World Vision, the local AXxes partner will be responsible for furnishing the depot.

During the period of July - September 2007, MSH prepared and finalized the pharmaceutical management training materials and credit line monitoring tools for AXxes supported depots and Health zones. The first training was carried out in Bukavu by Gabriel Bukasa from MSH, Patrick Cizungu, the provincial pharmacist inspector, Ben Munongo from AXxes Project and Don Padgett from IMA. The basic training materials were the MOH pharmaceutical management guidelines and the credit line monitoring tool named SULIC. The three day training was attended by 28 health workers including participants from the Bukavu pharmaceutical depot, staff from 4 out of 5 health districts, staff from 2 health zones, CRS and World Vision staff in the South Kivu province.

In Katanga province, MSH conducted training with Mr. Daniel Ngeleka, the provincial pharmacist inspector and Don Padgett from IMA targeting the Kolwezi health district. Participants included 29 health workers from Kolwezi health district including staff from the Kolwezi pharmaceutical depot, 7 health zones and World Vision staff. A second training in Katanga province undertaken by MSH was held in Kamina along with Dr. Eburnabo from ECC/AXxes and Mr. Omari from Haut-Lomami health district. Twenty-two health workers from the regional medical store, the Kamina district and 4 health zones attended this workshop.

The main objective of these trainings was to enable depot and health facility staff to appropriately manage essential medicines using the pharmaceutical management technical guidelines previously developed by the MOH with support from MSH. Specifically, attendees had to be able to:

- correctly quantify medicine requirements
- prepare order documents
- ensure drug quality to the degree required at their level (appropriate storage)
- correctly manage medicines (inventory management)
- develop the monthly pharmaceutical management report
- monitor pharmaceutical credit lines

The methodology was participative, based on using the pharmaceutical management technical guidelines, and included sharing of field experiences to enhance the training program. At the end of each training session, attendees planned subsequent training programs for health centers of each health zone of their respective districts which will take place in October and November 2007.

The next step is to conduct quarterly supervisory visits to AXxes supported depots, health zone central offices and a sample of health facilities. In order to ensure regular supervision by the provincial team, the AXxes project should plan support to the provincial pharmacist inspector for regular supervision to these regional depots, health zone central offices and health facilities.

## **2. Reinforce referral system**

*Establishment of preferential tariffs for referred patients:* World Vision (WV) AXxes is actively discussing with each HZ appropriate and sustainable ways of establishing preferential tariffs. HZs are agreeable to the system but each HZ is setting up its unique rate based on where it is situated and the ability of the communities to participate. In Katana HGR for instance the referred patient pays half of the set rate and after 10 days of admission, a patient would pay only 25% of the set rate. In Kalehe, with IRC support, the referred patient does not pay any fees at the HGR. In Bunkeya, the referred patient pays 80% of the set rate. Lubudi HGR which belongs to CIMENKAT (A cement factory) agrees also to reduce the rate by 20% for referred patients starting October 07. Most health centers are waiting for the drug credit system to be in place before they start preferential tariffs.

*Establishment of episodic payment system:* In South Kivu, all HZs have already agreed and have set the rate at an average of \$1.00 for children under five years of age and \$1.50 for adults. In Kolwezi, all HZs have agreed the rate of \$1.50 for simple episode without antibiotics and \$2.00 for episodes needing antibiotics. Most urban zones think that the episode payment system is inappropriate and will not succeed because of the many private facilities operating in the area. Some plan to set specific rates on particular episodes and specific rates per act. This activity is also dependant on the drug credit system to be in place before it is fully implemented.

*Rehabilitation of health facilities:* Rehabilitation of selected health centers, HGR maternities and incinerators is ongoing. Prior to rehabilitation, a detailed assessment of need was done in the project area to decide where and which health centers are most in need of rehabilitation. During the assessment, it was observed that there were other organizations/institutions doing construction or rehabilitation of some health facilities in the project area. In Minova for instance, WHO is planning to rehabilitate the maternity at Minova HGR for about \$18,000 and a new HGR is being constructed with funding from CARITAS. In Kolwezi, BCCO (World Bank Fund for Reconstruction of DRC) has provided funding of approximate \$50,000 for rehabilitating Kanina HC in Dilala. Based on these observations necessary adjustments were made which included selecting new areas or rehabilitating part of the structures based on other ongoing work by other partners. A full list of rehabilitation progress is in annex 8.






**Figure 2: Construction of incinerator in Lualaba**

rehabilitate the maternity at Minova HGR for about \$18,000 and a new HGR is being constructed with funding from CARITAS. In Kolwezi, BCCO (World Bank Fund for Reconstruction of DRC) has provided funding of approximate \$50,000 for rehabilitating Kanina HC in Dilala. Based on these observations necessary adjustments were made which included selecting new areas or rehabilitating part of the structures based on other ongoing work by other partners. A full list of rehabilitation progress is in annex 8.

In some areas community leaders have mobilized stakeholders to support the work by collecting and transporting sand, rock and bricks. Community members have also participated in providing labor for making burnt bricks, bringing water and other locally available materials. Participation of the community is speeding up the entire rehabilitation work.

**Figure 3: Before and After Picture of Rehabilitation Projects**

<b>MATERNITY OF SWIMA HC – NUNDU HZ</b>	
BEFORE	PROCESS ONGOING

<b>MATERNITY OF KALUNDU ETAT HC- UVIRA HZ</b>	
<b>BEFORE</b>	<b>PROCESS ONGOING</b>
	
<b>MATERNITY AND KAVIMVIRA RHC- UVIRA HZ</b>	
<b>BEFORE</b>	<b>PROCESS ONGOING</b>
	

### 3. Establish blood testing & grouping at HGRs & CSR

*Training of HGRs & CSR lab staff:* MSH's consultant, Grace Kahenya, made two visits to the DRC in March and April 2007. The first trip was to conduct a rapid baseline assessment of laboratories capacity and capability to perform HIV testing, malaria testing, TB smear microscopy and blood transfusion services. She also worked with AXxes staff to develop an appropriate curriculum for the training course and reference material. The second visit was to provide technical support for the training of trainers in laboratory organisation, management, HIV testing, malaria testing, TB smear microscopy and blood transfusion services. In total, 174 lab staff members were trained. The strengths and weakness of the course were reviewed with the key facilitators. The above activities were undertaken in collaboration with AXxes staffs, Ministry of Health, Catholic Mission Hospitals and the School of Public Health.

*Low-risk blood donors system:* This system has not started yet. People have volunteered to donate blood but they have many questions and issues regarding their status, confidentiality and some demand payment. The project is setting up an appropriate education to the general public on blood donation and counseling. Other plans include awareness raising in institutions, churches and schools and networking with the national blood transfusion program and other partners in the project areas.

**Table 1: Blood Safety Kits**

RPR welcome syfacard-r 8E58-01
Hepatitis B HBsAg Determine
Hepatitis C rapid test Genelabs
CPD-a bag 35ml for 250ml blood + taking set
CPD-a bag 63ml for 450ml blood + taking set
Bloodgroup anti A 200 tst monoclonal 10ml
Bloodgroup anti B 200 tst monoclonal 10ml
Bloodgroup anti A/B 200tst monoclonal 10ml
Bloodgroup anti D 200 tst monoclonal 10ml
Determine HIV Tests

*Blood testing:* The project has provided HIV test, blood safety and grouping kits to HZs according to the national standards for blood testing. Management tools for safe blood tests have also been distributed and are in use.

#### **4. Establish PMCT**

*Training in PMCT:* The PMCT programme started with the training of personnel from Kananga with Mutoto, Tshikaji and Lubondaie HZs September 27 to October 07. The training was done by the AXxes PTME Co-ordinator, Brown Consultants, Dr. Nick Kilese of UNC, the MCP and the PNLs Western Kasai. Training in other areas will start soon.

*Integration of PMCT in 120 sites:* PMCT activities have started in 9 sites in the Kasai and will start in another 51 sites in the next three months.

#### **5. Integrate Zinc treatment in treatment of diarrhea**

*Study trip to Madagascar:* The AXxes facilitated study trip to Madagascar (one of the African countries which is advanced in integrating Zinc in treatment of diarrhea) was organized by HKI in the fourth quarter. The trip had representatives from the MOH, HKI and CRS. The purpose of this trip was to learn from experiences of Madagascar in order to facilitate the integration of Zinc in Congo. The two week trip allowed the team to better understand all of the necessary stages of the process, the challenges and problems that can be faced during the implementation as well as possible solutions that could be undertaken. Good practices learned included strong political commitment and participation of community members, particularly women. What was learned will be adapted to the Congolese perspective and national/local context.



**Figure 5: The team in field visit in the southern region of Madagascar**



**Figure 5: DRC team in courtesy visit with the Secretary General of the MoH in Madagascar**

*Pilot program for Zinc and low-osmolarity ORS:* Ten HZs have been selected for piloting Zinc integration. Basic training by HKI and PRONANUT was undertaken in the target HZs. The objective of the training was to update standards for management of diarrhea, including the new innovation for Zinc and low-osmolarity ORS. Particular emphasis was put on the assessment of a sick child and correct identification and classification of appropriate treatment. The training was also linked to IMCI training skills. The target groups for this training were nurse supervisors, doctors, nutrition supervisors and HGR nurses. UNICEF has provided the first load of zinc so the program will start shortly.

## 6. Clinical IMCI

A 12-day combined training in clinic IMCI and PMA was conducted in Kolwezi, Kananga, Kinkondja and Kamina. Topics covered were IRA, diarrhea and fever management as well as growth monitoring promotion. The HZMT members went on to train other health personnel in their respective HZs. In South Kivu, the training is planned for October as there was an ongoing vaccination campaign and population census taking place at the planned time.

## 7. Integrate C-IMCI in collaboration with World Relief

*World Relief:* CRS staff and key personnel from the IPS and the HZ of Mumbumbano went on a field visit to *Kibogora* (Rwanda) to learn more about the World Relief “care group” approach and the conditions needed to make it successful. One of the main recommendations identified for success was the participation of women because of their motivation and their ownership in health community activities

Identification of promoters who will be trained by the team that went to Kibogora and will then train the RECO is the next step. Strong advocacy with the local authorities seems to be necessary in order to revitalize the community relays.

*IRM:* the partnership with IRM can be summarized into two major stages:

1. Conducting initial site visits in 8 Health Zones, in order to identify the final HZs in which income generating activity will be implemented. The criteria of selection are based on the functionality of the HZ itself, its accessibility, and the existence of functional CODESA. The following CODESA/HZ have been selected:
  - CODESA of LUMU in *Health Zone of BAGIRA*
  - CODESA of IZIRANGABO in *Health Zone of WALUNGU*
  - CODESA of BURUZA in *Health Zone of MUBUMBANO*
  - CODESA of SANGE in *Health Zone of RUZIZI*
  - CODESA of KABIMBA in *Health Zone of UVIRA*
2. Conducting a series of trainings at the selected Health Zones for the CODESA members (PRESICODESA, Secrétaire CODESA, Trésorier) Nurses Supervisors, and RECO to elaborate strategic planning. Three HZs (UVIRA, RUZIZI, Mumbumbano) out of five have been trained:
  - UVIRA: 4 Aires de Santé
  - RUZIZI : 3 Aires de Santé
  - MUMBUMBANO :3 Aires de Santé

As outcomes from these trainings, each CODESA now has 1) a ten- year strategic plan focused on resource mobilization, capacity building and partnership with potential stakeholders/partners in their Aires de Santé 2) a development plan for a five year period 3) an action plan for three years.

The CODESAs are now in the process of formalizing their partnership with the HZs. The next steps will be the completion of the training for the two other HZ, and a participatory diagnosis of the types of IGA they will be implementing.

*Micro DEVRU*: Similar steps to the IRM work were done in the Kasais. Five health zones were visited and three CODESAs were chosen from each zone to pilot IGA activities to reinforce the financing of health clinics and improve nutrition in the area. Development agents were identified at each health zone that can work with the CODESAs. Since AXxes can not use USAID funds for agricultural activities, funds from Micro DEVRU will be used for seeds, tools and improved palms. AXxes funds will be used to support training and supervising the development agents at each health zone, and for trainings and supervision done by the development agents in each zone.



**Figure 6: Meeting with CODESA in Lubondaie HZ**

## 8. Development of Water Sources and Promotion of Hygiene and Sanitation

**Table 2: % of Population with Non Potable Water source**

S.K Ouest	65%
Tshilenge	60%
Kananga	56%
Lulua	52%
Kamina	48%
Kolwezi	46%
Malemba NK	43%
S.K Sud	41%
S.K Centre	37%
Mbuji Mayi	11%
S.K Nord	10%
Bukavu	2%
Total	39%

Rehabilitation of water sources is a community based activity which is progressing well. Rehabilitation/construction of water sources is done by the community with technical expertise from community water technicians trained by UNICEF and SANRU in previous years. In each HZ, the HZMT and community representatives selected water sources requiring rehabilitation, giving priority to those areas with more pressing needs. Increasing awareness on the importance of clean water was done by MCZs and local leaders. Key messages describing the current water situation, water borne diseases and its effect to families were provided. As a result people were mobilized to support the work. Water committees have been formed in the

selected areas and are responsible for mobilizing resources for maintenance and sustaining water sources, protection of water sources and coordination of water users. As rehabilitation is continues, the project is planning to train these water committees and selected members from communities who will be responsible for technical maintenance of water sources.



**Figure 7: Getting water from a capped spring**

To reinforce water and sanitation activities, ECC applied for and received \$850,000 from UNICEF for a “Clean Village” program in 9 Katanga and 7 South Kivu HZs. The program will finance an extra 320 spring cappings and 37,000 improved pit latrines in AXxes zones.

## 9. Improve malaria treatment at HC and HGR

Malaria is the primary cause of morbidity and mortality in the project area. This year, the project has concentrated on strengthening the health system through capacity building for surveillance, malaria case management and prevention activities which included distribution of Long Lasting Impregnated Nets (LLINs).

Treatment is done using the national protocols which are available in all HCs and HGRs. In addition, training was done on management of malaria cases during PMA training. The project has been following up on treatment in health facilities and found out that there are some challenges as regards to the treatment of malaria. There are HCs which still use anti malarial drugs such as Chloroquine that are no longer registered on the national drug list for malaria. Furthermore, in some HCs where ACT is available, patients are reluctant to take both Amodiaquine and Artemisinin at the same time. They say that they get bad side effects. In other HZs, especially those with many private owned facilities, patients are being provided with Quinine drips even for simple malaria. The baseline KPC found that only 10% of malaria cases are being treated correctly with ACTs. AXxes is strengthening its follow up mechanism and support to address all these improper practices in order to ensure compliance to MOH national policies.

## 10. Improve and promote malaria prevention

*Integration of IPT as part of FANC:* The project provides Intermittent Preventive Treatment to pregnant women. The project distributes SP along with the LLINs to women attending prenatal clinics (FANC) increasing their participation. The project has started discussions with communities and health personnel in the project area on how to ensure that malaria prevention activities are sustainable even when support from AXxes ends.

*Distribution of LLINs:* The project has distributed 211,000 LLINs to regional offices and most of them have made it to the health zones. Special training is being conducted for the targeted population before they receive the nets. The training covers how to use nets at home, how to maintain nets (washing and drying) and other malaria prevention practices.

AXxes is selling LLINs at \$0.5 to the target population of children under 5 and pregnant women.

AXxes played an important role in the success of the ITN and Measles campaign in South Kivu. It participated actively with UNICEF and PSI in all the planning and organizing of the campaign in

**Table 3: Use of Malaria Prevention Methods**

District	% Children Using ITN	% Women Using ITN	% Women Receiving IPT
Bukavu	50.2%	50.2%	53.3%
Lulua	35.0%	38.8%	51.3%
S.K Centre	22.1%	23.2%	53.4%
S.K Nord	21.8%	22.1%	28.3%
S.K Ouest	21.8%	25.3%	44.3%
S.K Sud	20.7%	24.2%	53.6%
Kananga	20.0%	20.0%	48.0%
Tshilenge	18.2%	18.2%	42.4%
Haut Lomami	17.2%	17.6%	40.3%
Kolwezi	13.5%	17.0%	21.7%
Mbuji Mayi	10.6%	13.6%	28.6%
Total	21.6%	23.6%	39.8%

Bukavu. 630,000 nets were distributed in 28 health zones of which 24 are AXxes assisted health zones. In addition to the provision of 50,000 ITNs for the campaign, the Project AXxes:

- delegated facilitators (from Kinshasa and south Kivu) for the microplanification
- supported the participation of deputy director of PNLP for briefing of key personnel before the campaign and for the supervision of the campaign in South Kivu
- Participated in the launch of the campaign
- Ensured the supervision of the campaign through WVI and CRS teams

*Communication program for home care of malaria:* The project uses community relays to provide information to the community on early recognition of signs and symptoms of malaria and encourage people to seek prompt treatment for malaria symptoms. Community relays also create awareness on preventive measures including use of treated nets and reducing vector breeding sites around homes.

## 11. Promote good nutritional practices

**Table 4: Early and Exclusive Breastfeeding**

District	Early Breastfeeding	Exclusive Breastfeeding
Bukavu	79%	45%
S.K Sud	65%	38%
S.K Nord	55%	38%
Kolwezi	44%	30%
Haut Lomami	49%	29%
S.K Ouest	42%	25%
Kananga/Lulua	80%	18%
S.K Centre	60%	15%
Mbuji Mayi	78%	9%
Tshilenge	81%	4%
Average	57%	29%

*Nutrition messages through health facilities and Community-IMCI relays:* Health personnel were trained on nutrition during Reproductive Health and IMCI training. The project is strengthening the BCC for good nutritional practices, including time to start weaning children so that breastfeeding is not compromised. The CODESA and community relays and caregivers are also provided with information regarding proper nutrition for stronger and healthy bodies. 31% of the children are moderately or severely malnourished in the area of the project so much more needs to be done (see discussion in KPC section). HKI will work with AXxes partners in year two to strengthen the nutrition messages and activities of the project.

*Promotion of early and exclusive breastfeeding:* Only about half the women practice early breastfeeding and less than a third do it exclusively for the first six months. Promotion of correct breastfeeding practices is done during neonatal consultations and vaccinations but more needs to be done. Also mothers are informed on eating well and balanced meal to enable production of adequate milk.



**Figure 8: Malnourished child in Mutoto**

## 12. Increase Vitamin A and Iron coverage among targeted population

*Vitamin A and mebendazole campaigns:* The project in collaboration with PRONANUT, UNICEF and HKI facilitated Vitamin A and mebendazole campaigns as planned by the MOH. AXxes played a major role in supporting the planning and implementation of campaigns in the project area. The overall

objective of these campaigns was to provide Vitamin A supplementation to children between 6 – 59 months.

The first campaign was conducted in November 2006 and the second in May 2007. Both campaigns had coverage in the mid 90s with coverage reaching 104 percent in Kolwezi. The coverage for mabendazole during the two campaigns went from 31% in November 2006 to 89% in May 2007. The vaccination team conducted awareness raising by informing mothers and caretakers about the importance of Vitamin A, vaccinations, and where to take their children to get vaccinated.

*Participation in CCIA meetings:* The project has provided support in conducting and participation in CCIA meetings at the Provincial level. The meetings have mainly discussed issues concerning population census, reviewing partner's activities in the Provinces, review of epidemiology situation in the project areas, EPI activities including review of logistics and best ways to improve vaccination campaigns.

*Repair of existing refrigerators:* Technicians to do repairs were identified and began the work in July 2007. Implementing partners have made significant progress in this activity over the last quarter. The technician started work in July, and has been working fulltime since installing the new refrigerators, checking and repairing old refrigerators and training the Nurse Supervisors in charge of PEV in each visited HZ.

*Accelerated immunization program:* This has been planned in the areas with low coverage. Activities include training of community relay on vaccination techniques and facilitating their visits to carry out vaccination. The target areas are Mulongo, Kitenge, Malemba-Nkulu and Fugurume in Katanga and Kalogo and Western South Kivu in South Kivu (see map in Annex 6).

*Diffuse immunization messages through community relay:* This is routinely done by community relay in the project area. Sensitization of the community is done to increase participation in immunizations even when campaigns are not taking place. Sensitization teaches caregivers about the importance of vaccinating their children and about the calendar of vaccinations. The work of community relay is hampered by their lack of motivation, however. The project is providing promotional T-shirts and caps to all community relays not only as a promotional and visibility strategy but also as a motivational strategy.

*Response to epidemics:* Responding to the threat and outbreak of epidemic diseases is one of the many interventions of Project AXxes in USAID supported health zones. This report highlights several of the outbreaks which occurred this past quarter and successes achieved and challenges confronted by the Project AXxes consortium members.

The **World Vision** consortium member reported five major outbreaks of cholera this past quarter located in two AXxes supported zones. These epidemics which recorded approximately 120 cases and five deaths were from two health zones: Katana in South Kivu Province and Kolwezi in Katanga Province.

The project worked with the Provincial team to plan how to respond. In South Kivu other partners contributed including WHO (provided 250 liters of ringer lactate and 500 packets of ORS), IRC (provided 250 liters of ringer lactate, 600 packets of ORS, 10 plastic buckets, 10 kg Chlorine, 20 liters

Creoline and 20 cups). WV AXxes trained 50 community relay on how to sensitize on issues related to hygiene, sanitation and water purification. Also 20 nurses were trained in cholera riposte strategies.

The project was assisted by WHO in South Kivu and UNICEF in Katanga which contributed supplies of intravenous fluids and oral rehydration salts to affected communities. The AXxes team was instrumental in training over 300 community health care workers and teachers to not only screen and manage cases but to do village-to-village awareness and surveillance.

Project workers are currently focusing on potable water supplies, construction of latrines, and ongoing surveillance & promotion of BCC activities to prevent further outbreaks in these areas.

**AXxes/CRS** confronted several outbreaks of cholera in their South Kivu AXxes-supported zones as well this quarter. The South Kivu province has been plagued by a series of outbreaks (cumulatively over 2700 cases since January 2006), and this past quarter in a heightened response to a growing epidemic the Governor of South Kivu appointed a provincial crisis committee and named AXxes partner CRS to a leading role.

Noting a long trend in disease outbreaks, CRS working in collaboration with USAID supported programs (AMITIE and AXxes) targeted a new prevention strategy focusing on community education and water purification and protection.



**Figure 9: Chlorinating Water in Bukavu**

The following outcomes have been achieved to date: 56 persons have been trained and designated as ‘chlorinators’ in 19 strategically located places, 8000 copies of BCC material have been produced in local languages and distributed, community health care workers including AMITE PPV and OEV workers have been mobilized to disseminate messages, and thousands of packets of chlorine purification solution (PUR) have been distributed to households at risk.

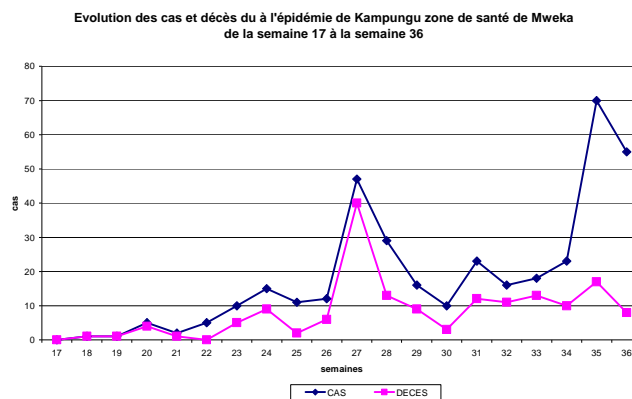
CRS also experienced an outbreak of **measles** in the Project AXxes supported South Kivu health zone of Uvira this past quarter. Over 1080 cases were registered with 6 deaths from this vaccination-preventable disease.

CRS, the AXxes team, and WHO rapidly responded to the outbreak identifying the ‘at risk group’ (unvaccinated children in certain ‘aires de sante’ between the age of 12-59 months), vigorously reinforced the EPI activities in those effected areas, augmented supplies of fuel and bicycles for vaccine delivery and supervision, and heightened BCC promotional activities.

AXxes/ECC consortium partner confronted an outbreak of hemorrhagic fever (Ebola) in one of its health zones (Bulape) in the Kasai Province of DRC in September 2007.

Acknowledged by the Minister of Health for ‘a rapid and comprehensive response to this crisis’, the USAID-AXxes team has been credited with averting a major epidemic in that health zone.

As of this writing there is a documented decline in new cases of this epidemic which by WHO initial reports involved over 185 suspect cases and numerous deaths, making it potentially the 2<sup>nd</sup> largest global outbreak of Ebola in history. Read Success Story at end of section.



#### 14. Integrate Family Planning and services in each HC and HGR supported by the project

*Training for RH/FP:* Several trainings have been done starting with HZMTs in March 2007. 232 members of the HZMTs from 60 HZs participated. Members of the HZMTs went on to train health personnel in HGRs and HCs in May 2007. A total of 1278 health workers from AXxes assisted health zones were trained. These trainings were conducted in collaboration with IPSs and the National Program of Reproductive Health.

*Implementation of FP in health facilities:* Family planning activities have been integrated in the Reproductive Health Services in most health facilities. The project has distributed contraceptives, male condoms, IUD and STI kits. Women have been informed on the importance of child spacing during clinic consultations, the risks of poor birth spacing, and risks of pregnancy at an early age and the importance of attending antenatal care. Community relay also continue to create awareness to other members of the community including men. The project has improved supervision and the linkage of activities done by the health structures with those done by community relays and Tradition Birth Attendants (TBAs) in the community.

**Table 5: Knowledge and Use of Contraceptive Methods**

DISTRICT	% of women who have heard of FP	% using a modern method of FP	% using a natural method of FP	Total % of women practicing FP
Tshilenge	32.1%	9.7%	13.0%	22.7%
Mbuji Mayi	49.2%	6.9%	28.0%	34.9%
Haut Lomami	41.1%	6.0%	12.0%	18.0%
Kolwezi	43.0%	3.5%	21.5%	25.0%
Bukavu	60.0%	9.7%	25.0%	34.7%
Sud Kivu Centre	49.0%	3.3%	8.7%	12.0%
Sud Kivu Nord	36.0%	2.4%	5.2%	7.6%
Sud Kivu Ouest	30.0%	4.7%	10.3%	15.0%
Sud Kivu Sud	35.7%	3.5%	6.0%	9.5%
Kananga	45.0%	4.2%	28.0%	32.2%
Lulua	38.0%	4.2%	27.0%	31.2%
Average	41.7%	5.3%	16.8%	22.1%

*RH/FP monitoring activities:* The project works in collaboration with The Institute for Reproductive Health of Georgetown University (IRH) to monitor family planning activities in the HZs. Issues followed up include the correct use of RH/FP forms, child spacing activities and use of modern and natural methods of contraceptives. The project also monitors the stock of RH/FP commodities to ensure that it does not run out of stock and that they are used correctly.

In August, a team composed of the PNSR (National and South Kivu), COP/AXxes, IRH and CRS organized a joint supervision to: 1) assess the training of health workers 2) assist the team for the problem-solving at the start up 3) test and validate supervision tools and 4) identify focal point SMNN/PF in the HZ and brief them about the main intervention



**Figure 10: Joint RH/FP supervision in the pharmacy of Sange Etat**

The main recommendations from that field visit are: 1) To accompany HZMT and health workers in the implementation : organization of the FP services, tools, data gathering and data analysis, and completion of the rumor 2) Ensure the effective start-up of FP activities in the assisted HZ 3) Ensure the distribution of FP commodities to the Health facilities 4) Discuss with IPS about how to make the distribution of commodities as quick as possible 5) Improve FP data base 6) Contribute to the revitalization of task force RH/FP in the province 7) Reinforce joint supervision RH/FP AXxes-MOH

*Improve collaboration with UNFPA:* Several contacts have been made with UNFPA in all districts to discuss family planning and SGBV activities. UNFPA promised to provide available Family planning materials when required.

## **15. Improve Antenatal, Intrapartum and Postpartum Care**

*Training in improved antenatal care:* During RH training antenatal training was also covered. Pregnant and lactating mother receive, vitamin A, iron and folic supplementation to prevent low birth weights of children at birth. Community relays are being mobilized and supported to provide care seeking and care giving messages in the community.

*STI program:* The project is implementing the syndromique approach of STIs management. Some medical supplies have been provided but this activity is dependent on the availability of drug to be fully functional. Health workers trained caretakers attending health centers on early diagnosis and treatment of STIs.

*Prevention and management of PPH:* Training on this activity was incorporated during RH training. Maternities were encouraged to apply PPH management with available supplies such as Oxytocin although not yet supplied by the project. Other care activities for PPH are also observed.

*Improve emergency surgical services:* Basic minor surgical kits have been distributed in the health centers and hospital surgical kits and equipment have just arrived. The project is also rehabilitating maternities and few surgical theatres.

*Post partum management program:* Some aspects of post partum management are being practiced such as promotion of exclusive breastfeeding, and proper hygiene and care during delivery. The number of women attending post partum consultations is increasing. The situation in maternities is still poor,

however, because of inadequate beds and bedclothes, drugs and equipment. The project is rehabilitating and equipping some of the selected maternities in the project area.

*Vitamin A for maternal health:* It was decided that Vitamin A for women during post delivery visits should be systematic in all the maternities. Vitamin A was available during the last campaign, but this quantity was not enough to cover the maternity routine needs for all the women that have delivered. HKI has now provided Vitamin A for this purpose in AXxes HZs.

## **16. Increase availability and improve quality of essential newborn care services**

*Training for newborn care:* The training for newborn care was incorporated in the RH training.

*Communication program for newborn care:* Messages are diffused in each facility for pregnant women during FANC lessons on safe motherhood. The messages will be revised this coming year with the assistance of BASICS.

*Newborn care in health facilities:* Activities include early and exclusive breastfeeding, maintenance of cleanliness and caring for the child cord as well as management of newborn illnesses.

## **17. GBV interventions and fistula reparation**

*Program for the prevention of gender discrimination:* AXxes has just started developing a program on GBV. In the Katanga province, where this is an acute problem, a team has just finished the first phase of meetings with 5 HZs located around Malemba-Nkulu. A GBV workshop was organized at Kinkondja, and had 20 participants from the five health zones. The goal of the workshop was to: 1) Identify consequences or types of gender based violence and define strategies to address violence within the community, and 2) integrate GBV activities in the Health Zones in to their activity package.



**Figure 11: Workshop on GBV in Kinkondja**

*Obstetric fistula services:* There are many causes of vaginal fistulas in the project area particularly in South Kivu. The main causes include unattended child births and sexual assaults. Currently the project has selected 8 doctors and 8 nurses for training in surgical fistula repair. The training has started at Panzi hospital in South Kivu and at Tshikaji hospital in Kasai. When the training is finished in six months, ten hospitals among the 57 HZs will have active VFR programs. The project is also facilitating health centers and hospitals to manage cases received in the centers with timely referrals to appropriate hospitals.

## **18. Improve TB detection**

*Training for TB management:* The TB component is managed in collaboration with National Program for TB. This year, the TB coordination program in Katanga Province organized training for HZMTs and health care providers in March 2007. The training focused on the PATI 4 protocol (treatment of TB case). AXxes incorporated TB treatment in PMA training in August for Kasai and Katanga HZs. A total of 211 participants, from HGRs and HCs successfully participated in the training. Training in other areas is planned.

*Establishment of CDT centers:* AXxes has continued with existing CDTs which are strategically positioned in the project area in accordance with the National Program for Tuberculosis (PNT). AXxes also collaborates with Foundation Damien in carrying out activities in these centers. Foundation Damien pays primes for health personnel in the CDTs.

*CB-DOTS program:* The plan was to train community relay on CB-DOTS so they can give correct information to patients and communities. The training has not been done yet.

## **IV. Commentary on Work Plan Activities Component B**

### **Develop Human Resources of HZMT, including training and supervision**

*HZMT management training:* Training of the Health Zones Management Teams (HZMTs) on topics necessary for implementing Ministry of Health (MOH) Primary Health Care (PHC) minimum package of activities was conducted during the second quarter of the project. Participants were the MCZ, MDC, Health Zone Administrator (AGZ), Administrator of Reference Hospital (AGH), Director of Nursing (DN) and Health Zone Nurse Supervisor (IS). The training was facilitated by trainers from the MOH.

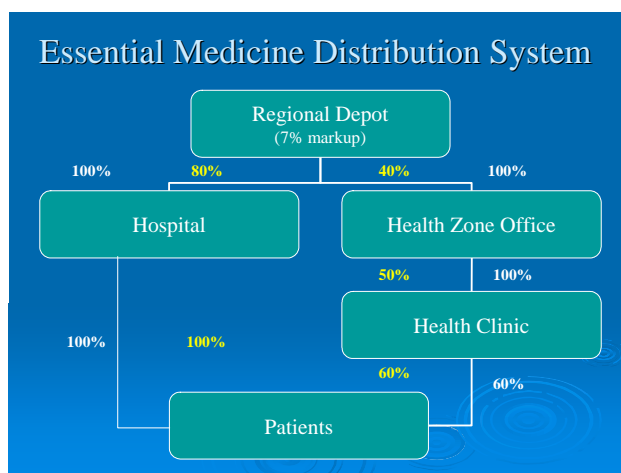
*PMA training:* The training covered a number of topics necessary for routine treatment of illnesses in the health facilities. Topics included use of curative protocol, malaria, IRA, TB, and Diarrhea treatment. 306 health providers (doctors, nurses and supervisors) were trained in Katanga and the Kasias. In South Kivu, PMA is planned in October 2007.

*Supervision by HZMT and partners:* Supervision of activities in HZs, HGRs and HCs has improved since the beginning of the project. AXxes has reinforced its collaborative actions with the HZMTs and routinely supervises jointly with the HZMT. Observed issues are discussed and feedback given to those supervised. Also there is improvement in the contact and communication between personnel in health facilities and members of the HZMTs. Between 65% and 73% of the planned supervisions happen regularly (see annex 9). Security issues and displacement of the HZMT are the major impediments to more complete supervision. The project is now putting more effort into joint supervision with teams from the Provinces and Districts, with supervision that is more qualitative than just quantitative.

*Drug supply management:* AXxes is implementing a drug management system that gives a line credit for essential medicine purchases directly to the health centers and hospitals. The credits are based on health care utilization rates at the institutions. There is a cost recovery of 40% at the health center and 80% at the hospitals which goes back to the depots for later purchases by the health centers and hospitals. MSH and IMA consultant Don Padgett help develop the tracking system and did the training. Project AXxes has agreements with three central depots in Bukavu, Kananga and Kamina,

and is opening depots in Kolwezi and Lodja to implement the program. The program is just starting now that the medicines have arrived.

WV AXxes with support from AXxes Program Manager had detailed discussions with IRC which plans to provide free health care in Kalehe Health Zone in South Kivu. The discussion was to find out the most rational way to work together in the area without jeopardizing our objectives of providing sustainable health care for all in the area. Finally it was agreed that AXxes will not open a drug credit for Kalehe because of incompatibility of philosophies for cost recovery of the two partners (AXxes and IRC). IRC plans to cover the drug needs for all HCs and HGR based upon requisitions. Their first order for 6-month drug needs will arrive soon. IRC support is expected to continue until 2010.



*Diseases Surveillance system:* Health care providers have been trained in epidemiologic monitoring during PMA training. This skill will be used as they monitor disease using the SNIS reports in the project area. Disease surveillance is also being integrated into the HIS dashboard system which will greatly decrease the time it takes for epidemics to be identified.

### **Reinforce HZ co management and community participation**

*HZ Admin Councils:* Administrative Councils (CAs) have been revived in just about all HZs. Some assisted HZs had never organized their CAs before. AXxes provided informal training about the project activities and CAs approved HZ/AXxes year 2007 work plans. Administrative Councils meet twice per year.

*Finance training:* In April 2007, Project Accountants were trained as TOT in financial management and the use of standard financial tools. Later, each implementing partner organized the financial training for health zones in financial and accounting policies and procedures. A total of 335 (MCZ, Administration officers from HZs and accountants) were trained. Topics covered included accounting operations for activities implemented by AXxes, management of incomes accrued from medicines and mosquito nets, allocation of funds and putting in place financial tracking system for the project, including reporting tools.

*Co-mgmt contracts with HZs:* Contracts with HZs were signed in the second quarter. Implementing partners started by sharing with teams from the HZs about the project and together they reviewed the contract and adjustments were made before final document was signed.

*CODESAs functionality and gender balanced:* Many CODESAs were inactive when the project began. The project had to work with the community in order to reactivate CODESAs in each HC. Gender balance is still weak but is improving. AXxes achieved its first year target of getting 5% of the CODESAs to have 50% of their membership women.

*Training of local NGOs:* The project has received applications from Local NGOs for small grant management. The NGOs developed their proposals on what health interventions they intend to do for health in the area of the project. The proposals were submitted to USAID for review. Because of travel conflicts, the proposals will be reviewed and NGOs selected in late October.

### **Establish and reinforce M&E in Health Zone**

*Rapid assessments of HZs:* A rapid assessment was conducted in all AXxes assisted health zones at the beginning of the project. The data was analyzed and discussed with the partners during partner meetings. The assessment results were used to develop HZ profiles to enable provision of appropriate support and equipment to each HZ.

*M&E system:* The statistical monitoring and evaluation of AXxes is done through two tools; the SNIS forms provided by the MOH and supplemental information for project indicators developed by the AXxes M&E staff. AXxes is working closely with the 5<sup>th</sup> directions team from MOH in developing an improved reporting system that is computerized at the zone level (GESIS). The new system incorporates the project indicators into the government system. It has been put in place in East Kasai and a workshop was held to plan how to integrate the new GESIS in Katanga Province. A workshop for South Kivu is planned. In 2008 the GESIS will be put in place throughout AXxes assisted zones. AXxes is providing the equipment and is helping the MOH with the training.

During the year the AXxes COP (key personnel) team made several field visits to assure that the project implementation was being carried out in a way that would facilitate the success of the project. All of the AXxes partners were supervised and mentored by the COP team for technical, administrative and logistical support. The supervisions helped the partners develop the same understanding and vision of the project and organize their staff and offices according to the project requirements. During the supervisions some HZs were visited in order monitor their progress and learn firsthand what the issues were. Some joint supervisions were organized with USAID staff, MOH and other partners like IRH. Full details of the supervision visits are in annex 9.

## **V. Commentary on Work Plan Activities Component C**

One strength of project AXxes compared to most health projects previously supported by the USAID is component C, the support to the central and intermediate MOH level. For practical reasons, this component was divided in to two parts: 1) Priority activities and 2) MOH central level support through international technical assistance groups.

The first part of AXxes component C, covering priority activities, was approved in May 2007. This part relates to the provincial and district MOH level support activities. These activities are directly linked to the AXxes health zone activities. Most of them are related to provincial and district level fundamental functions like HZ supervisions, review meetings, HZ data management, policies and strategy dissemination, and holding HZ administrative councils in order to approve HZ action plans. The MOH provincial and districts teams are still elaborating the technical plans to start realizing these activities. The following component C activities have been organized during year one:

- Provincial/ District MOH needs assessment and provision of equipment and materials
- Leadership development training
- Support to the organization of the “Comite de Pilotage” for Kasai oriental and Katanga
- Support to MOH for supervision

- Support for PEV review meeting in Lubumbashi
- Support for Micro planification and organization of the ITN and Measles campaign in Bukavu
- Work with MIPs and MIDs on the AXxes component C
- Support for UNIKIN SPH training
- Zinc program activities with HKI and PNLMD

The second part of Component C relates to the technical assistance of the targeted MOH programs and directions. This part was only approved at the end of year one but the AXxes team did some preliminary work in order to facilitate its implementation. The following activities were organized

- Development of SOW of TAs
- Work plan with 4<sup>th</sup> direction
- Support for Policy & topical workshops: New born care strategies, Reproductive health tools harmonization
- Central level support for SNIS

*Provincial/district logistic support:* A rapid needs assessment was done to identify Provincial/ District MOH needs in terms of equipment and materials for the M&E system and supervision activities. From this assessment, Project AXxes provided all 14 selected districts and 4 provinces with motorcycles (helmet included), generators (except Katanga MOH office which didn't need a generator as electricity is almost permanent). IT equipment including desktop, printer, and photocopier have been ordered for all of the district and provincial MOH offices.



**Figure 12: Reception by His Excellency Provincial Minister of Health and the MIP of materials for Component C.**

*Provincial/district meetings:* Most of the 2<sup>nd</sup> quarter BTD and BTP were already planned and organized when the AXxes component C was approved so it was not possible to give financial support for their organization. However the AXxes provincial coordinators participated actively in all of those meetings. AXxes is now financing the third BTD in different districts. Despite this delay, AXxes supported the following meetings in provinces:

1) Support to the organization of the Comite de Pilotage of Kasai oriental and katanga

AXxes has contributed to support the material and the technical organization of two meetings of the “comité de pilotage” of Kasai oriental. The first was primarily focused on the diffusion of SRSS (the

new strategy for strengthening the DRC health system) and on the orientation of the provincial action plan. AXxes participated actively in the meeting and worked with the MOH Provincial teams and other partners (UNICEF, FED9, and Coopi) on the elaboration of the provincial action plan. The second meeting was focused on the review of performance indicators of each district. AXxes also participated in the meeting of the comite de pilotage of Katanga.

## 2) Support for PEV review meeting in Lubumbashi

The AXxes team participated actively in CCIA meetings to prepare for the PEV review meeting in Lubumbashi. The main goal of the meeting was to evaluate activities realized during the first semester and to adjust strategies and approaches in order to achieve the expected national DPT3 coverage (80%). The AXxes PM participated in the meeting. While in Lubumbashi, discussions were held with the PEV director and Dr Michel Othepa from Basics (JSI) on reinforcing PEV capacity through technical assistance from BASICS Immunization. From this discussion a SOW for JSI TA was elaborated and approved by both PEV and AXxes. In collaboration with UNICEF and WHO, AXxes contributed to transportation and accommodation fees for AXxes supported Provincial MOH staff to attend this meeting. Some important points that came out of the meeting were:

- Why, despite polio immunization campaign, is Wild Polio virus still circulating, especially in Equator province?
- The organization of campaigns in equator must be improved by reinforcing supervision, providing materials in time and sanctioning MCZ and PEV staff who are stealing funds from the campaign
- Most provincial and districts CCIA's are not functional
- The management of PEV at the central and provincial level must change and some people that are not performing must be let go.

Considering the points above, it appears clearly that AXxes has a role to play through component C (TA for PEV, Supervision subsidies and support for Provincial staff, support for CCIA and provincial meetings) and the support of EPI in the HZs (support for cold chain and supervision)

*Leadership development training:* MSH has conducted a leadership development program (LDP) this past year in the AXxes project. The MSH consultant, Jana Ntumba, worked with the AXxes team to build the facilitation team, set up the training center, and determined facilitator team assignments. In June 2007, she led the implementation of first LDP Workshop (covering an overview of leadership, leadership practices - scanning and focusing - and management practices - planning) and coached facilitator team members new to LDP.

In September 2007, MSH worked with the AXxes team to design the second workshop, building not only on the first workshop but also on the work done during the interim period. She led the implementation of the second LDP Workshop with the co-facilitators working as a collaborative team. (The workshop covered aligning and mobilizing, developing an action plan, mobilizing stakeholders to commit resources, preparing monitoring and evaluation plans, transforming complaints into requests, getting commitment and motivation, not just compliance, coaching to support others, exploring roles in teamwork, reviewing Work Climate Assessment results, success factors in managing change, strengthening trust, coaching teams through breakdowns, and leadership commitments) with the co-facilitators working as a collaborative team. A debriefing meeting was held with the AXxes team and included planning for the interim period of monitoring and evaluation as well as initial planning for the third LDP workshop.

*SNIS support:* The AXxes M&E team is working with the SNIS department of the 5<sup>th</sup> direction on improving and integrating GESIS in the provincial MOH offices. So far two workshops were held in Kasai Oriental and Katanga with the technical and financial support of AXxes and other partners, especially FED 9. The global objective was the adaptation of SNIS tools proposed by the national level following the provincial specificities.

Those workshops led to:

- the development and adaptation of the data collection and transmission tools
- Filling out manual procedures
- The list of minimal data needs for the province.

The interest for AXxes in this process is to ensure that all of the key indicators of the project are taken in account and are integrated in all forms and tools. Trainings for key personnel and care providers in the field are scheduled for the end of October and AXxes will provide necessary support for training of trainers and for the training in AXxes HZs. The same process is scheduled in November for the provinces of South Kivu and Kasai Occidental.

Another important part of the M&E work was start with meetings between the JHU TA team, AXxes M&E staff and other stakeholders; FED 9, PARSS, DEP, World Bank and others. The goal of the meetings was to harmonize the development of the software which will allow MOH and partners to access and analyze SNIS information at different levels. JHU was asked to take the lead on developing this system.

*Policy & topical workshops:* Three important workshops were supported and organized by Project AXxes during year one: Reproductive health tools harmonization, New born care strategies, and Zinc policy integration workshops

#### Reproductive health tools harmonization

In collaboration with the national program and IRH, Project AXxes has organized a 7 day workshop which:

- redefined the content of training for key personnel and HC teams
- Determined directives, norms and protocols for reproductive health services
- Elaborated pedagogic tools for training
- Identified BCC tools and supports to be used in reproductive health services and in the community
- Developed up to date forms and registers to be used in reproductive health services

#### AXxes New born care strategies

Project AXxes supported the organization of a workshop on New born care with the technical support of BASICs and the participation of MOH experts and other partners interested in new born care; UNICEF, WHO, CARE and others. The purpose of the workshop was to obtain a consensus on key newborn strategies. After obtaining this consensus on strategies, a task group on newborn care was put in place and this group developed directives and norms on new born care, training curriculum and modules, M&E tools and BCC tools on newborn care. The group had started working on those different topics and the workshop for adopting these documents is currently taking place.

## Zinc integration workshops

Project AXxes, through HKI, participated actively in the different meetings and workshops on the Zinc implementation program organized in collaboration with MSH, BASICS, UNICEF, WHO under the direction of PNLMD. Those meetings were held to determine the implementation policy and strategies. To facilitate the integration at the provincial and district level, workshops are being held for briefing key personnel and care providers on the use of zinc and ORS with low osmolarity before starting implementation of zinc in 12 pilot HZs.

Based on the expected needs established by, HKI and PNLMD, AXxes has already provided Zinc tablets to the targeted health zones. Those Zinc tablets came from UNICEF and can cover only three months. Another quantity of Zinc tablets has been ordered by AXxes to continue the supply.

*UNIKIN SPH training:* In its strategy of increasing the functional capacity of provincial/district health offices, the project supported six MPH candidates from province or district offices at the Public Health School of Kinshasa (SPHK). Six candidates were selected: two candidates by province for those with more than 10 HZs like Katanga and south Kivu and 1 candidate by province for those with less than 10 HZs. At the time Kasai oriental had only 2 HZs in the project so no one was selected from there. All of the candidates were recommended by the MIP and had to meet all of the SPHK criteria. They signed a contract with AXxes accepting to work in their position after completing training. All of the selected candidates have successfully completed their training and have returned to their districts and provinces.

**Table 6: Profile of candidates Attending the School of Public Health**

Candidate	Province	Position
Crispin Batubenga	Kasai Occidental	Chief of 5 <sup>th</sup> Bureau of Health Provincial division
Adalbert Ngandwe	Katanga	Chief of 4 <sup>th</sup> bureau of Health Provincial division
Lievin Buhendwa	South Kivu	Chief of Antenne PEV in Bukavu
Jean Batiste Shuli	Maniema	Chief of Health district of Kindu
Jean de Dieu Kamungu	South kivu	Chief of health district centre
Jean Claude Simbi	Katanga	Responsible of 2 <sup>nd</sup> cellule in health district of Haut Lomami

*Technical Advisors for MOH:* Scopes of work and budgets have been developed for MSH, BASICS, JSI, and JHU. Now that this part of the project has been approved, contracts will be signed and the work will begin.

## **VI. Consortium and Project Management**

*AXxes implementation structure:* Because of increased assistance from DFID and World Bank into the Maniema region, USAID decided to move assistance from Maniema to other health zones that have greater need. On May 15<sup>th</sup> assistance was stopped in the ten zones Project AXxes assisted in Maniema. Since this was two thirds of the zones where Merlin was the implementing partner, it was decided that it would be best for the project if Merlin handed over the five remaining zones it was assisting in South Kivu to CRS. Approval for the budget for the new health zones was not given until the end of year one, so activity in the seven new zones is just starting.

Because of the geographical distribution of health zones in the Kasais and Katanga, and the high supervision needs of the zones, AXxes/ECC has, or will, open five coordination offices. Currently there are offices in Kananga and Kamina and new offices are opening in Lodja, Mbuji Mayi and Kinkondja. CRS and WVI will continue with their coordination offices at Bukavu and Kolwezi.

*Development and diffusion of technical procedures:* The project has had two workshops and four partner's meetings during the year to develop and disseminate standard technical and administrative procedures. Both technical and procedural manuals have been produced and are in use by the implementing partners.

*Central order of commodities:* There have been many delays in the ordering and shipping of materials. The waiver for bed nets and vehicles was not approved until February and for medicines in June, so these items only arrived in the fourth quarter of the project. Other items were ordered on time but many of the containers were held up because of the Matadi port strike and changing regulations in the government customs clearance process. So far 28 containers and 7 air shipments have been received and processed. There are another three containers that were purchased with year one funds that have not yet arrived.

*Distribution of materials:* One of the major challenges of the AXxes project is the distribution of project materials across a geographic area as large as the eastern half of the United States and characterized by poor roads, dysfunctional railways and unreliable air transportation. Every step in the distribution process causes weeks of delay. For this reason bulk commodities like medicines and nets are being brought in directly to Bukavu and Lubumbashi as well as the normal route through Kinshasa. In most cases this has shortened the distribution time but sometimes it has created new delays like containers getting stuck in Dar Es Salam.

In the Katanga region a contract with ATLAS Logistics/Handicap International Partnership Katanga was signed to take advantage of their UNDP grant that covers shipping of humanitarian goods in the region. With this partnership, ATLAS Logistics / Handicap International have already carried building supplies and other materials for rehabilitation work and building water sources. Thanks to this partnership, AXxes could save about \$80,000 on transport fees and can speed up their shipments.

*International trips: Participation in GHC, CCIH & IMA Conferences:* There have been two administrative meeting in New Windsor during the year; one in March and the other smaller one in September. AXxes personnel have also assisted in the following international training and conference:

- Training: Optimal management of drug purchasing for HIV/AIDS – Holand
- Conference: Management of EPI in Central Africa - Liberville

*Environmental Impact Compliance:* AXxes has developed a form from guidelines found on the USAID website for monitoring IEE compliance at the health zone (annex 13). Not all health zones are in compliance yet but the project is constructing incinerators and educating personnel on their use.

## VII. Security Report

There was insecurity in Kaniola, Bunyakiri and Kalonge HZs, especially in May 2007. Insecurity was due to the hostile activities of the Rasta group which is a break away group of FDLC. Some project activities have been delayed but no activity has ceased because of the violence. WV and CRS have HF equipment in their project vehicles and other security measures are enforced.

Security issues do not only concern armed violence in Congo. The poor state of small privately owned airplanes in Congo causes a great risk to project personnel. For destinations such as Kamina, Malemb-Nkulu and Lodja there has been no choice but to use these airlines. On September 3 a crash occurred in Malemba-Nkulu with the ECC Medical Coordinator on board (different than accident pictured). He sustained only minor injuries but others were seriously hurt and some killed in the crash.



**Figure 13: Plane crash on September 24, 2007 in Malemba-Nkulu (no AXxes personnel or material were involved)**

## VIII. KPC Study

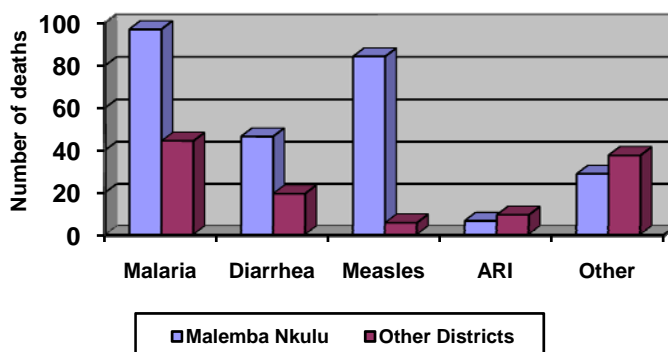
The baseline KPC study was carried out in the months of May and June. At that point work in Maneima had stopped but the budget for the new zones in the Sankuru region was approved. So the study was done in the 51 health zones. In 42 health zones 96 households were sampled per zone and in 9 zones 200 households were sampled to increase the power of the study. The study was facilitated by survey consultants from Kinshasa, who trained and supervised the entire exercise. Data entry personnel were recruited locally and data was analyzed centrally by IMA. A

**Table 7: Infant and Child Mortality by District**

District	Infant Mortality	CI +/-	Child Mortality	CI +/-
Mbuji Mayi	33	45	114	80
Kananga / Lulua	55	47	131	69
Kolwezi	65	32	96	38
Tshilenge	114	151	285	215
Bukavu	73	49	146	66
Sud Kivu Centre	73	43	153	60
Sud Kivu Sud	97	44	193	59
Sud Kivu Nord	147	47	225	56
Sud Kivu Ouest	195	51	322	60
Haut Kamina	97	61	216	84
Lomami Malemba Nk	215	66	382	78
Total	117	16	210	20

complete report of the study is being written but some of the highlights of the study will be presented in this report.

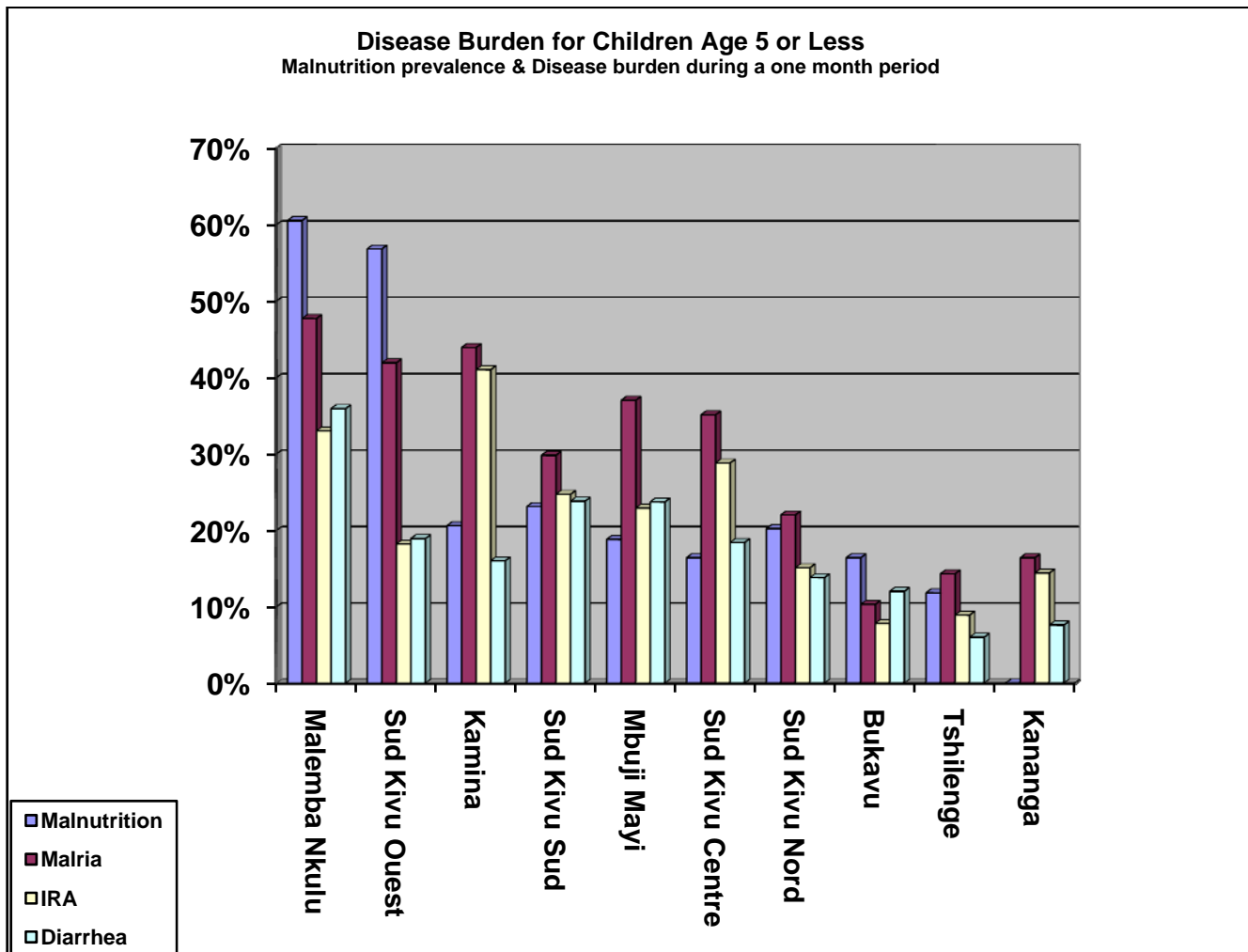
**Causes of Mortality in Children Under Six Years of Age**



*Mortality data:* Overall the estimated infant mortality in AXxes assisted health zones is a little below the national average of 126 and the estimated child mortality is about the same as the national average of 213. One of the most shocking findings of the study was the extreme variation of the estimated infant and child mortality between districts. In some

areas the infant mortality is about one fourth the national average but in the sub-district of Malemba-Nkulu and South Kivu West it is double the national average. AXxes will be doing a follow-up assessment of this issue (see map in Annex 3).

An analysis of what is causing the high mortality in Malemba-Nkulu shows that it is mostly due to malaria, measles and diarrhea. Measles is exceptionally high compared to other districts. AXxes has adjusted its intervention in the district to double bednet distribution, prioritize the cold chain and vaccination activity, and concentrate on the “Clean Village” program in the area. Similar emphasis will be used in Western South Kivu.

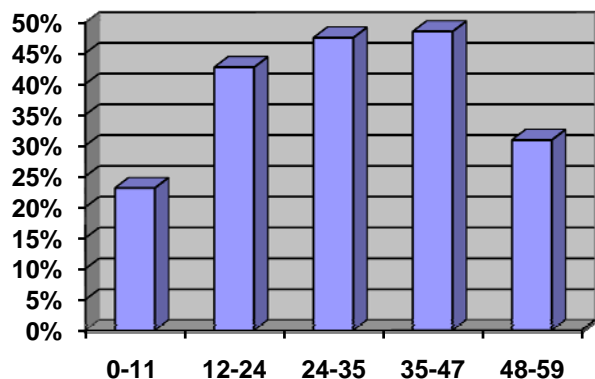


The morbidity graph above shows where the medical challenges are for this project. There is extremely high malnutrition in Malemba-Nkulu and South Kivu West, Malaria is high in all districts where there has not been an extensive distribution of LLINs, and there are picks of ARI in several districts. Project AXxes will be adjusting its interventions zone by zone to address these needs in the coming year.

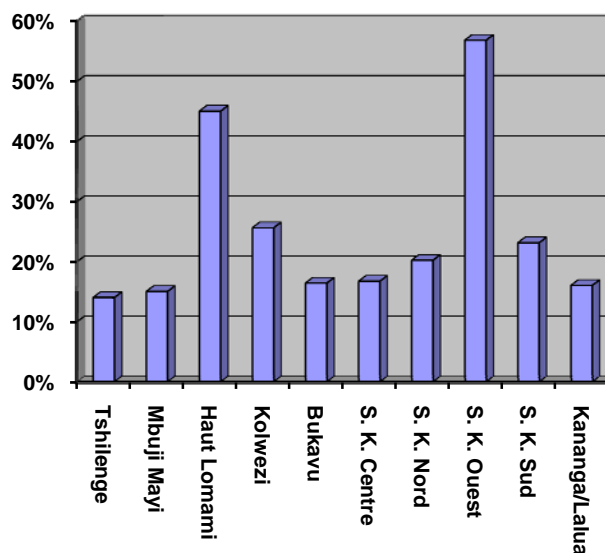
*Nutritional Status:* Overall the nutritional status is not worse than the national average of 38% (2002 MIC2) but it is a major problem for some areas. The average for moderate and severe malnutrition in

AXxes assisted zones is 31 % with it spiking in the Western South with 57% and in Haut Lomami with 45%. In the sub-district of Malemba-Nkulu, malnutrition is 60.5%. The malnutrition by age distribution shows classic signs of low food availability and poor child feeding practices.

**Malnutrition by Age Group**



**Percent Malnutrition by District**



*Utilization of services:* A major emphasis of Project AXxes is access to health care. For this reason the KPC looked extensively at utilization rates and what factors influence the decision to use which service.

**Table 9: Health Care Utilization Rate and Price by District**

District	Utilization Rate	Average Price
Sud Kivu Centre	71%	\$1.11
Sud Kivu Nord	65%	\$2.43
Sud Kivu Sud	60%	\$2.32
Kolwezi	56%	\$4.76
Sud Kivu Ouest	54%	\$2.47
Haut Lomami	53%	\$2.77
Bukavu	53%	\$2.45
Mbuji Mayi	38%	\$5.86
Kananga / Lulua	35%	\$2.22
Tshilenge	35%	\$4.83
Average	43%	\$2.57

**Table 8 : Where People Go for Treatment and How Much it Costs**

Where People Go for Treatment		Average Price
Health Center	44%	\$3.57
Self Treatment	23%	\$1.65
No Treatment	15%	\$0.00
Hospital	8%	\$8.46
Private Clinic	6%	\$4.77
Traditional Healer	4%	\$0.37

Table 8 shows that most people use the public service health centers when they are sick. The biggest competition to health centers is self medication which costs less than half of what the health centers charge on average. AXxes' goal of bringing down the cost of health care to \$1.50 per episode of illness will make it very competitive with self medication and less than one third the cost of private clinics.

Price is not the only or the most important factor people use in deciding where to go for health care. The KPC found that confidence in the treatment accounts for 48% of the decision, geographic location accounts for 33% and cost for 21%.

## IX. Program Performance Indicators

It is difficult to get a precise analysis of the project progress this first year. Because of the withdrawal of assistance from Maniema the project effectively worked in only 50 health zones, with a population of about 7.3 million this first year. The target numeric indicators for year one were based on a population of 8 million so they are not an accurate way of judging the progress of the project. Both the numeric and the percentage indicators are dependant on the completeness of the reports which is 80%, based on the median number of report completeness. Despite these weaknesses in the data, an estimate of project progress can be made. The following table gives a ranking of indicators based on the percentage of the target indicator that was achieved.

**Table 10: Year One Progress on Performance Indicator**

<b>Year One Progress on Performance Indicator</b>	<b>% of Target</b>
Number of ITN distributed	226%
Percent of children under the age of five, received LLINs in targeted health zones	222%
TB detection rate	191%
Percent /Number of children under the age of five with ARI/pneumonia are cared for correctly by health structures following national policy	157%
Percent /Number of children under the age of five with diarrheal illnesses are cared for correctly by health structures following national policy guidelines	157%
Percentage of health zones that have monthly reviews with health providers, health zone team and COGE members	145%
Percent of health centers supervised by health zone team each month	142%
Percent of SNIS report sent to government on time	138%
DPT3 coverage	137%
Percent of SNIS reports completely filled out	124%
Percent of drop-out DPT1/DPT3	122%
Proportion of children receiving measles vaccination	120%
Percent (%) of population served	118%
Number of women receiving Active Management of the Third Stage of Labor (AMSTL)	112%
Percent of health zones team supervised by health district/province project staff team each quarter	112%
Percent of children 12-59 months have received mebendazole during each campaign.	111%
Proportion children 6-59 months receiving Vitamin A Campaign	107%
Percent of Health center with Integrate Reproductive Health Services (RHS) and child spacing in their routine activities	105%
Number people trained in (RH) Reproductive Health and Child Spacing / FP	104%
Number of people trained in maternal and newborn health & nutrition	104%
Percent of CODESA with 50% women membership	104%
Rate / Number of antenatal care (ANC) visits	103%
Proportion births attended by skilled personnel	102%
Percent of blood transfusions tested for HIV and blood grouping	100%
Percent of functioning CODESAs	98%
Percent of pregnant women visiting health centers receive iron supplements.	95%
Percent of functioning COGEs	93%
Percent of pregnant women received VAT2 or 5 doses of VAT	88%
Average cost of a visit to a CS in targeted HZs	88%

Number people trained/in Management of PHC	88%
Number of newborns receiving essential newborn care	88%
Rate of use of health services	86%
Percent of Health center with syndromique approach of STIs management	86%
Number persons trained/in place for services (cumulative)	78%
Percent of pregnant women tested deliberated for HIV	76%
Percent of health zones with an action plan approved by the CA	75%
Number health clinics built or rehabilitated (non-cumulative)	72%
Rate / Number of postnatal care (ANC) visits	71%
Rate of people benefited a postpartum/newborn visits the next 3 days following delivery	71%
Percent of pregnant women in targeted health zones receive IPT	69%
Number of individuals counseled on FP/RH	56%
Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP at any time during the reporting period	54%
Percent of pregnant women, received LLINs in targeted health zones	54%
Percent of Health center with integrate PMTCT services in their routine activities	50%
Proportion children 6-59 months receiving Vitamin A Routine	45%
Number of persons trained in the use of "Ordinogramme "PMA (cumulative)	44%
Number of people trained in malaria treatment	44%
Percent of CODESAs that financially support health centers	44%
Number of USAID funded ITN distributed	44%
Number of people that have seen or heard a specific FP/RH message	41%
Couple years of protection (CYP) for FP (cumulative)	37%
Percent of pregnant who benefited a counseling at the PMTCT center	33%
Percent of referral information back to health centers	31%
Percent of lactating women using exclusive breastfeeding for first 6 months	29%
Percent of neonatal deaths	23%
Percent of patients refer to hospitals following proper treatment protocols	6%
Percent of children with diarrhea that have received zinc in the pilot areas	0%
Number of NGOs supported	0%

About half of the indicators reached the targets set for year one, despite many of the indicators being excessively optimistic. The areas that made the most progress in year one were LLTN distribution (because of the collaboration with UNICEF), family planning services, vaccination coverage, TB detection, SNIS reporting and women's participation in CODESAs.

*LLTN Distribution:* The distribution of LLTNs was much higher than planned because AXxes was able to convince UNICEF to do their distribution in predominately AXxes assisted health zones. The nets were given away free with much less health education that is normally done in the health center, so it remains to be seen how this distribution will impact the number of children sleeping under nets.

*Family Planning:* The number of health centers that have family planning services has more than doubled from 238 in the second quarter to 875 in the fourth. In conjunction with this the couple years of protection has increased from 2,602 to 11,114. A total of 1,525 people were trained in reproductive health. This is 104% of the target for the year.

Vaccination Coverage: Increased supervision, “micro planification” and reinforcement of the cold chain have caused the vaccination coverage to improve for Measles and DPT3. In the third quarter 16 zones had less than 70% coverage of DPT3 and now only 9 have less than 70%. Several zones in lower South Kivu have made significant gains going from below 40% coverage to more than 70% coverage. The zone of Mulongo in the Malemba-Nkulu had the worst with coverage of only 23% (see map in Annex 6).

Table 11: Performance Indicator	Year 1 Target		Quarter 2			Quarter 3			Quarter 4		
	%	Nber	%	Nber	# HZs	%	Nber	# HZs	%	Nber	# HZs
Measles coverage	70%	180,587	70%	45,002	60	84%	43,950	43	96%	45,114	47
DPT3 coverage	60%	154,788	61%	38,697	60	78%	40,749	43	83%	43,262	47
Percent of drop-out DPT1/DPT3	10%	25,799	7%	4,440	24	18%	2,104	43	3%	1,309	47

Tuberculosis: The tuberculosis program needs a lot of attention. Many zones are not reporting on relative indicators and more than half that are reporting have a detection rate less than 70%. Four of the zones in the Malemba Nkulu seem to have epidemic levels of TB with a detection rate of more than 140% of what is expected (see map in Annex 7).

## X. Conclusion

In the first year of Project AXxes the major emphasis has been to create a working health structure, to start or reinforce the activities that would have the highest impact on morbidity and mortality and assessing the health and infrastructure needs. Since many of the health zones in the project have not had development assistance before, and have been functioning somewhat outside the national health system, it was a significant challenge to bring them up to an administratively functional level. Now that the zones have trained management teams, functioning administrative councils and action plans, the implementation of all health actives in the zone will go much smoother.

The first step in starting and reinforcing essential services was training. The project trained 3,022 people during the year in 13 categories of activity (see annex 12). Many of the trainings required multiple training sites to reach everyone that needed training. It is regrettable that there were such delays in waivers, budget approvals, and shipping. As a result, the medicines and supplies were not available for the newly trained health workers to fully implement what they had learned. In retrospect, earlier emphasis would have been put on infrastructure repairs and community activities that were not so dependent on imported materials, if it was know at the beginning of the year that the shipments would be delayed.

The assessments took time and money but they were essential to understanding the real needs of the population served. Too many projects push a standard package of goods and activities without sufficient understanding of what inputs are really needed to make a difference. In year two, with a health infrastructure in place, trained personnel with sufficient materials and equipment, and a clear understanding of the needs, the impact of the project should be much higher.

**ANNEX1: PROGRAM PERFORMANCE INDICATORS**

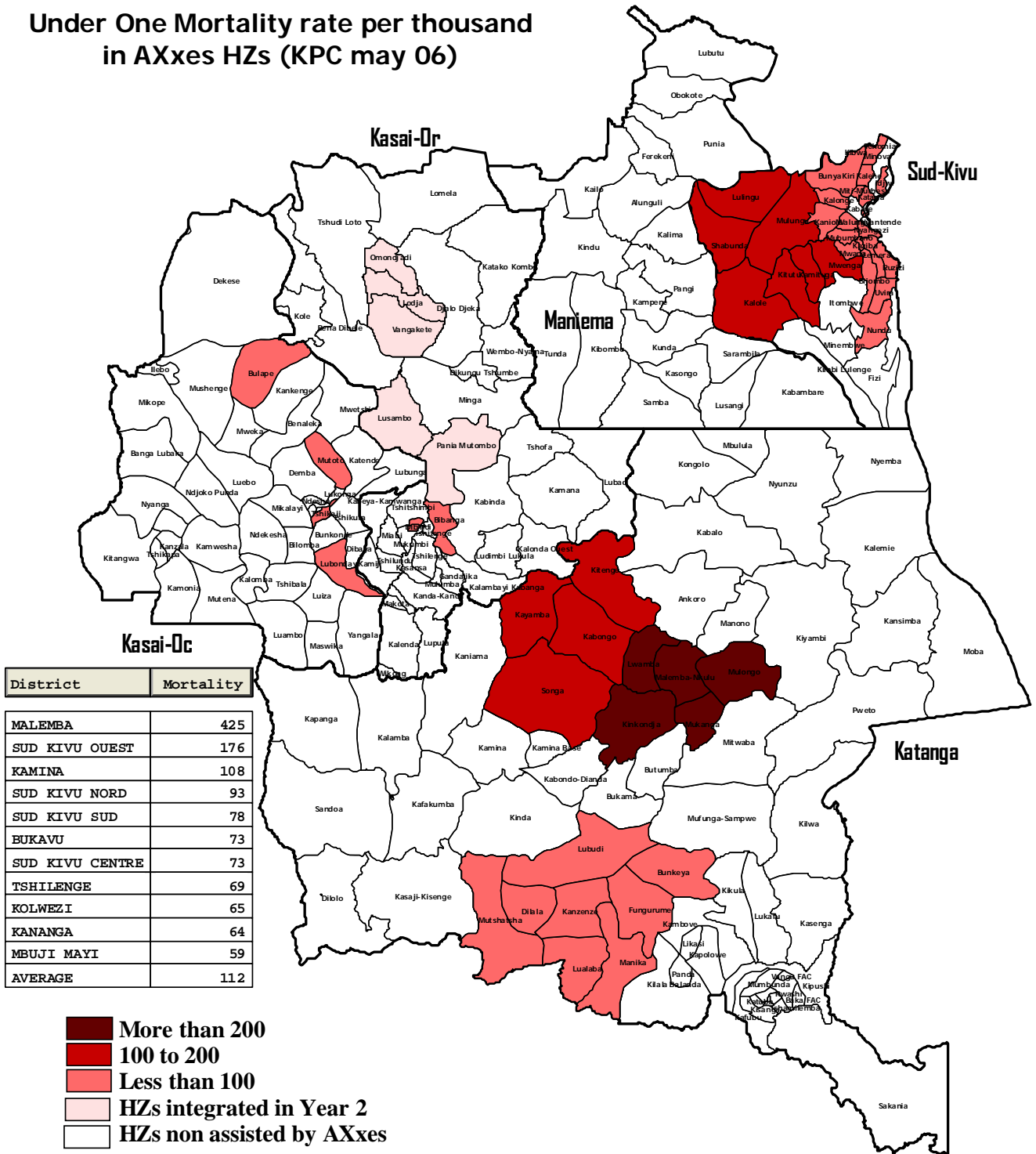
Objectives/ Activities	Performance Indicator	1st year goal		Quarter 4		HZ #	Annual		
		%	Number	%	Number		%	Number	
<b>Component A: Increased access to, quality of, and demand for multi-sectoral, integrated PHC</b>									
Increased access to integrated Primary Health Care	Percent (%) of population served *	60%		71.0%		47	71.0%		
	Nbr health clinics built or rehabilitated (non-cumulative)		50		6	45		36	
	Rate of use of health services	35%		29.9%		40	30.0%	0	
	Nbr people trained/in Management of PHC	Nbr of women				0	45		36
		Nbr of men				0	45		281
		Total		360		0	45		317
	Nbr of persons trained in the use of "Ordinogramme "PMA (cumulative)	Nbr of women				41	45		152
		Nbr of men				93	45		389
		Total		1224		134	45		541
Improve Reproductive Health, treatment of STIs & the practice of Child Spacing	Couple years of protection (CYP) for FP (cumulative)		30000		4614	29	37.0%	11114	
	Percent of Health center with Integrate Reproductive Health Services (RHS) and child spacing in their routine activities	80%	816	84.0%	857	46	84.0%	857	
	Nbr people trained in (RH) Reproductive Health and Child Spacing / FP	Nbr of women							442
		Nbr of men							1083
		Total		1464	0.0%			0.0%	1525
	Number of individuals counseled on FP/RH	5%	77396	3.2%	9222		2.8%	26074	
	Number of people that have seen or heard a specific FP/RH message **	40%	1212288		10872			18968	
Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP at any time during the reporting period	5%	<60	4.2%	45	25	9.2%	214		
Improve the service delivery & outcome of Maternal & Newborn Care	Proportion births attended by skilled personnel	60%	177408	60.1%	32236	40	61.4%	109562	
	Rate / Number of antenatal care (ANC) visits	80%	236544	79.1%	42632	40	82.3%	141816	
	Rate / Number of postnatal care (ANC) visits	40%	118272	32.9%	17569	40	28.3%	45167	
	Percent of pregnant women received VAT2 or 5 doses of VAT	70%	206976	63.0%	33631	40	61.9%	104860	
	Rate of people benefited a postpartum/newborn visits the next 3 days following delivery	40%	118272	32.9%	17569	40	28.3%	45167	
	Number of newborns receiving essential newborn care	60%	177408	47.8%	11533	16	52.7%	34811	
	Nbr of women receiving Active Management of the Third Stage of Labor (AMSTL)	40%	118272	43.7%	7089	20	44.7%	7094.5	
	Percent of pregnant women visiting health centers receive iron supplements.	70%	206976	74.7%	38772	40	66.4%	33053	
	Percent of Health center with syndromique approach of STIs management	50%	510	40.1%	349	26	42.8%	330	
	Percent of neonatal deaths *	4%		0.9%	294	40	0.9%	931	
	Number of vaginal fistula repairs				118	20		242	
	Percent of newborns receiving antibiotic treatment for infection	80%		2.6%	86	30		392	
Increase the	Proportion of children receiving measles vaccination	70%	180587	96.0%	45114	47	84.0%	123638	

Objectives/ Activities	Performance Indicator		1st year goal		Quarter 4		HZ #	Annual	
			%	Number	%	Number		%	Number
coverage of Immunizations	DPT3 coverage		60%	154788	82.7%	43262	47	82.0%	117804
	Percent of drop-out DPT1/DPT3		10%		2.6%	1309	47	8.2%	10580
	Percent of diseases related to vaccinations are detected and reported within 14 days.		60%		ND				
Improve family Nutrition & coverage or utilization of Micronutrients	Proportion children 6-59 months receiving Vitamin A Campaign		90%	1197504				96.0%	1730373
	Proportion children 6-59 months receiving Vitamin A Routine		10%	133056	3.3%	51634	25		59584
	Percent of children 12-59 months have received mebendazole during each campaign.		80%	946176			25	89.0%	671.369
	Percent of children with diarrhea that have received zinc in the pilot areas		20%		ND		15		ND
	Percent of lactating women using exclusive breastfeeding for first 6 months		40%	118272	ND				ND
	Percent of lactating women use appropriate weaning practices from 6 months		30%	88704	ND				ND
	Number of people trained in maternal and newborn health & nutrition		Nbr of women				0		442
Nbr of men						0		1083	
Total				1464		0		1525	
Promote & improve the use of Integrated Management of Childhood Illnesses both in Clinics & the Community	Percent /Number of children under the age of five with ARI/pneumonia are cared for correctly by health structures following national policy		60%		94.0%	15755	20	94.0%	41923
	Percent /Number of children under the age of five with diarrheal illnesses are cared for correctly by health structures following national policy guidelines		60%		99.0%	9048	20	94.0%	33555
	Number of water supply improved ( Non- cumulative) USAID financed			120	0.0%	0	46		0
	Number of water supply improved ( Non- cumulative) non-USAID financed				0.0%	0	46		
Reduce the incidence of Malaria, especially among pregnant women & children under five	Number of people trained in malaria treatment		Nbr of women			41	45	152	
			Nbr of men			93	45	389	
			Total		1224		134	45	541
	Nbr of households with at least one ITN		20%	246400					
	Nbr of ITN distributed					558081	27	45.0%	558081
	Nbr of USAID funded ITN distributed		20%	246400		107925	27	9.0%	107925
	Percent of pregnant women in targeted health zones receive IPT		70%	206976	49.5%	25757	40	48.0%	77806
	Percent of pregnant women, received LLINs in targeted health zones		20%	59136	42.0%	25211	27	10.8%	25918
Percent of children under the age of five, received LLINs in targeted health zones		20%	295680	44.1%	529765	27	44.4%	533359	
Increase the detection & treatment of Tuberculosis	TB detection rate		70%	7762	136%	1428	20	134%	5199
	TB cure rate		80%	6209	ND			ND	
	% of patient with tuberculosis tested for HIV		20%	387	ND			ND	
	% of laboratory had <5% of poor result		90%		ND			ND	
	Resistant cases to tuberculosis drugs (Yes or No)		No			33	20		
Reduce incidence of	Percent of blood transfusions tested for HIV and blood grouping		100%		100%		46	100%	
	Percent of Health center with integrate PMTCT services in their routine activities			20					10

Objectives/ Activities	Performance Indicator	1st year goal		Quarter 4		HZ #	Annual	
		%	Number	%	Number		%	Number
HIV & Assure Blood Safety	Percent of pregnant who benefited a counseling at the PMTCT center	50%		23.5%	3285	10	16.5%	5273
	Percent of pregnant women tested deliberated for HIV	50%		44.0%	1444	10	37.8%	1991
	Percent of pregnant women informed about their result			40.0%	587	10	35.1%	698
	Percent of (New) mother VIH +, received Névirapine			0.5%	3	10	0.6%	5
Develop a Multi- sectoral approach to promote stabilization of health system & community	Average cost of a visit to a CS in targeted HZs		\$1.50		\$1,70	40		
	Percent of CODESAs that financially support health centers	5%		1.6%	15	40	2.2%	88
	Percent of CODESA with 50% women membership	5%		5.2%	48	40	2.3%	91
<b>Component B: Increased Capacity to the health zone and the referral system</b>								
Improve Planning & Governance	Percent of health zones with an action plan approved by the CA	90%	54	95.0%		30	67.7%	
	Percentage of health zones that have monthly reviews with health providers, health zone team and COGE members	50%	30	90.0%		30	72.5%	
Develop Human Resources, including training & supervision	Nbr persons trained/in place for services (cumulative)		2630		446	0		2056
	Percent of health centers supervised by health zone team each month	60%	612	90.0%	2535	35	85.0%	
	Percent of health zones team supervised by health district/province project staff team each quarter	60%	36	54.1%	963	35	67.0%	
Improve Transparency & Accountability	Percent of functioning COGEs	70%	42	37.0%	51	40	65.1%	229
	Percent of functioning CODESAs	50%	510	61.3%	1142	40	48.9%	2473
Dev. & improve Drug Supply Management	Percent of health facilities reporting stock outs of indicator medicines	30%	306					
Develop & implement an effective Health Information Systems	Percent of SNIS reports completely filled out	70%	714	90.6%	584	40	86.8%	474
	Percent of SNIS report sent to government on time	60%	612	86.2%	520	40	82.8%	427
Reinforce Community participation in the health care system	Percent of functioning community health workers	15%	12320					
Improving the Health Referral System	Percent of patients refer to hospitals following proper treatment protocols	60%		4.6%	13233	40	3.6%	36482
	Percent of referral information back to health centers	60%		23.3%	2917	40	18.7%	6411
Build capacity of local NGOs	Number of NGOs supported		5					

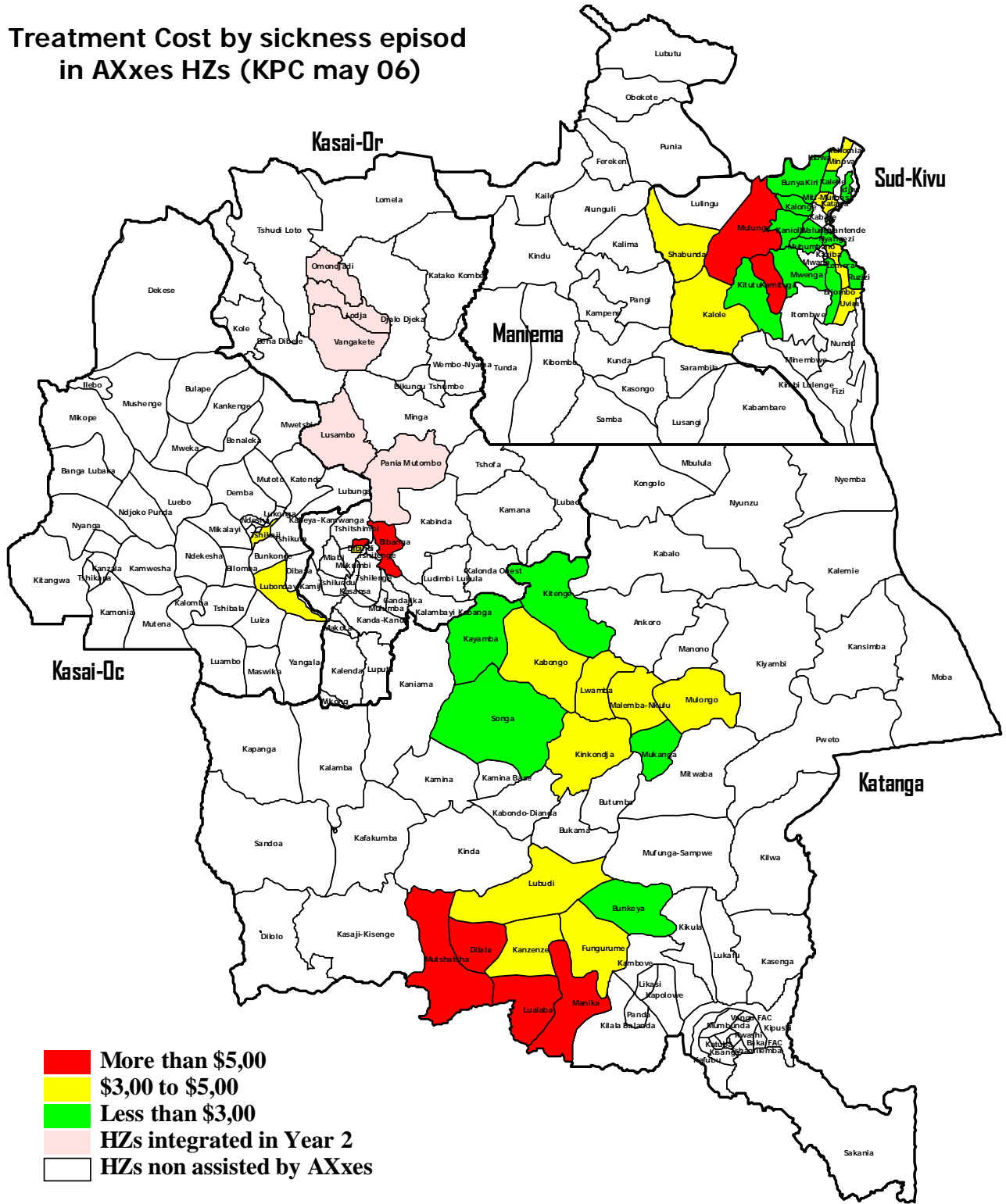


**Under One Mortality rate per thousand  
in AXxes HZs (KPC may 06)**



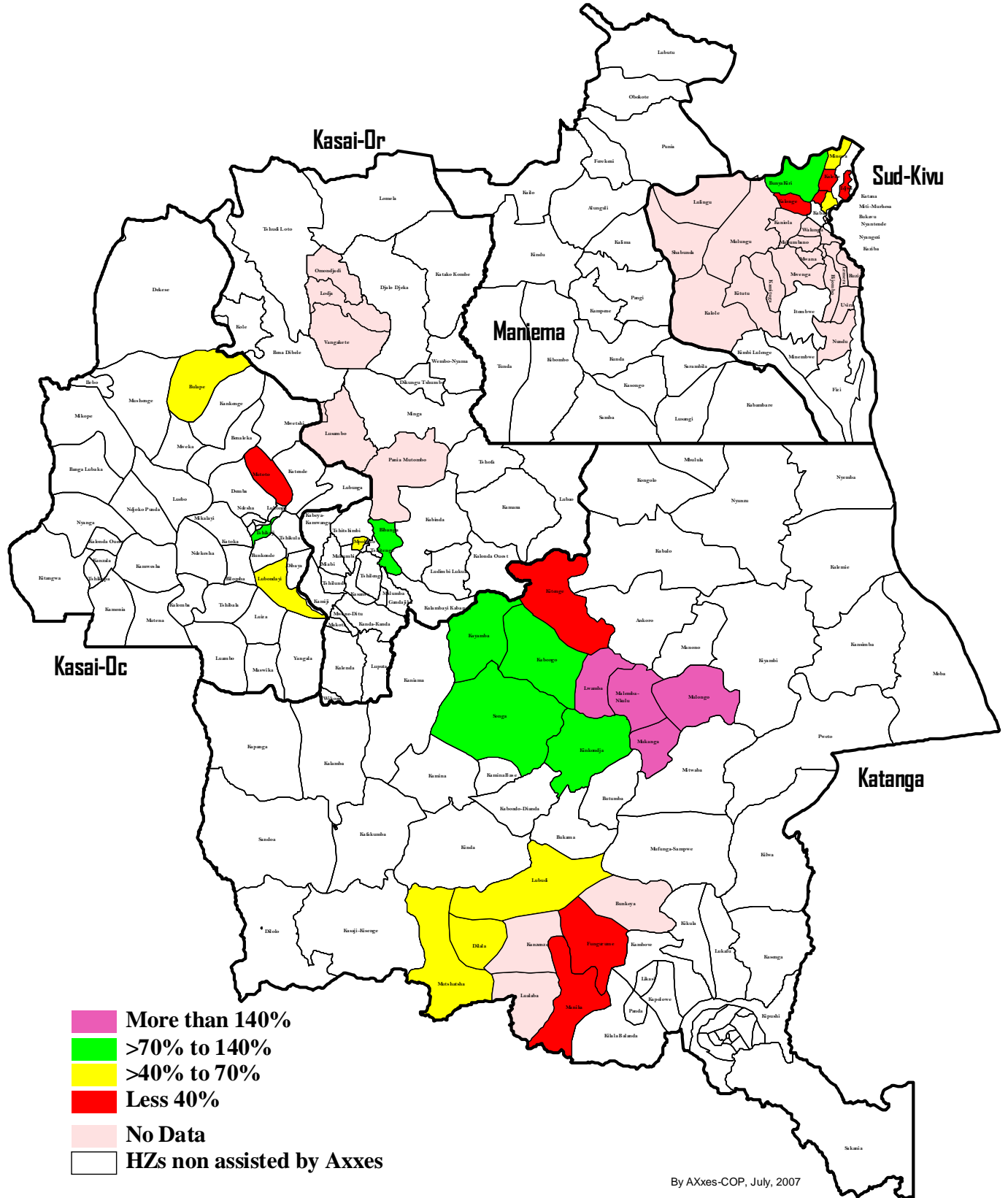


### Treatment Cost by sickness episod in AXxes HZs (KPC may 06)





# ANNEX 7: TUBERCULOSIS DETECTION RATE



## ANNEX 8: HEALTH FACILITIES SCHEDULED FOR REHABILITATION

### Health Facilities Scheduled for Rehabilitation

Province	District	Health Zone	Structure	Name	% complete
KOC	Kga	Tshikaji	HGR	Pavillon pédiatrie	100%
KOC	Kga	Tshikaji	CS	Mamu Mwilu	100%
KOC	Kga	Tshikaji	CS	Mbumba	100%
KOC	Kasai	Bulape	HGR	Pavillon maternité	100%
KOC	Kasai	Bulape	CS	Yolo	100%
KOC	Kasai	Bulape	CS	Mbelo	100%
KOC	Lulua	Mutoto	HGR	Pavillon maternité	100%
KOC	Lulua	Lubondai	HGR	Pavillon maternité	100%
KOC	Lulua	Lubondai	CS	Dibwe dieto	100%
KOC	Lulua	Lubondai	CS	Katambwe	100%
KOR	Tshilenge	Bibanga	HGR	Pavillon maternité	50%
KOR	Tshilenge	Bibanga	CS	Lukangu	0%
KOR	Tshilenge	Bibanga	CS	Manja	0%
KOR	Tshilenge	Mpokolo	HGR		100%
Katanga	H-Lomami	Mulongo	HGR	Pavillon pédiatrie	30%
Katanga	H-Lomami	Mulongo	HGR	Pavillon maternité	0%
Katanga	H-Lomami	Mulongo	CSR	Kabamba	0%
Katanga	H-Lomami	Mulongo	CS	Ngoya	0%
Katanga	H-Lomami	Kayamba	HGR/CSR	Bâtiment	50%
Katanga	H-Lomami	Kayamba	BCZS	Bâtiment	0%
Katanga	H-Lomami	Kayamba	CS	Kibila	0%
Katanga	H-Lomami	Kayamba	CS	Mudindwa	0%
Katanga	H-Lomami	Lwamba	HGR		0%
Katanga	H-Lomami	Lwamba	CS	Kyapwa	0%
Katanga	H-Lomami	Lwamba	CS	Lubinda	0%
Katanga	H-Lomami	Songa	HGR	Pavillon maternité	50%
Katanga	H-Lomami	Songa	CS	Muleba	0%
Katanga	H-Lomami	Songa	CS	Samba	0%
Katanga	H-Lomami	Malemba-Nkulu	HGR	5 bâtiments	0%
Katanga	H-Lomami	Malemba-Nkulu	CS	Kabwe M	0%
Katanga	H-Lomami	Malemba-Nkulu	CS	Mutombo Lupichi	0%
Katanga	H-Lomami	Mukanga	HGR	Pavillon maternité	0%
Katanga	H-Lomami	Mukanga	HGR	Pavillon chirurgical	0%
Katanga	H-Lomami	Mukanga	BCZS		0%
Katanga	H-Lomami	Mukanga	CS	Kasenga I	0%

Katanga	H-Lomami	Mukanga	CS	Mukaya	0%
Katanga	H-Lomami	Mukanga	CS	Kimwenze	0%
Katanga	H-Lomami	Mukanga	CS	Mukaya	0%
Katanga	H-Lomami	Kabongo	HGR		50%
Katanga	H-Lomami	Kabongo	CS	Kyondo	0%
Katanga	H-Lomami	Kabongo	CS	Lwakidi	0%
Katanga	H-Lomami	Kitenge	HGR		0%
Katanga	H-Lomami	Kitenge	CS	Bekisha	0%
Katanga	H-Lomami	Kitenge	CS	Fwila	0%
Katanga	H-Lomami	Kinkondja	HGR		30%
Katanga	H-Lomami	Kinkondja	CS	Mangi II	0%
Katanga	H-Lomami	Kinkondja	CS	Masangu	0%
Katanga	Kolwezi	Bunkeya	HGR	Maternite, Chirurgi	5%
Katanga	Kolwezi	Bunkeya	CS	Kateba	10%
Katanga	Kolwezi	Bunkeya	CS	Kikobe	10%
Katanga	Kolwezi	Dilala	CS	Musonoi	40%
Katanga	Kolwezi	Dilala	CS	Luilu	20%
Katanga	Kolwezi	Fungurume	CSR	Dipeta	10%
Katanga	Kolwezi	Fungurume	CS	Kando	0%
Katanga	Kolwezi	Kanzenze	CSR	Walemba	70%
Katanga	Kolwezi	Kanzenze	CS	Kamoa	0%
Katanga	Kolwezi	Lualaba	CS	Mibanze	0%
Katanga	Kolwezi	Lualaba	CS	Pwibwe	10%
Katanga	Kolwezi	Manika	CSR	Manika	70%
Katanga	Kolwezi	Manika	CS	Kasulo	0%
Katanga	Kolwezi	Mutshatsha	CSR	Maisha	10%
Katanga	Kolwezi	Mutshatsha	CS	Yanva	0%
Katanga	Kolwezi	Lubudi	HGR	Maternite	0%
Katanga	Kolwezi	Lubudi	CS	Lubudi	20%
Katanga	Kolwezi	Lubudi	CS	Mbebe	0%
S. Kivu	Nord	Bunyakiri	HGR	Maternite	40%
S. Kivu	Nord	Bunyakiri	CS	Lwana	0%
S. Kivu	Nord	Bunyakiri	CSR	Bitale	60%
S. Kivu	Nord	Idjwi	HGR	Movu(Maternite)	40%
S. Kivu	Nord	Idjwi	CS	Mishimbwe	30%
S. Kivu	Nord	Idjwi	CS	Mafula	40%
S. Kivu	Nord	Kalehe	HGR	Matternite	50%
S. Kivu	Nord	Kalehe	CSR	Bushushu	60%
S. Kivu	Nord	Kalehe	CS	Lushebere	80%
S. Kivu	Nord	Kalonge	HGR	Maternite+PTME	60%

S. Kivu	Nord	Kalonge	CSR	Chaminunu	40%
S. Kivu	Nord	Kalonge	CS	Cholobera	40%
S. Kivu	Nord	Katana	HGR	Maternite	40%
S. Kivu	Nord	Katana	CSR	Birava	30%
S. Kivu	Nord	Katana	CSR	Ihimbi	30%
S. Kivu	Nord	Minova	CS	Bulenga	80%
S. Kivu	Nord	Minova	CS	Nyamasasa	0%
S. Kivu	Nord	Minova	CSR	Kalungu	80%
S. Kivu	Nord	Miti-Murhesa	CSR	Kavumu	70%
S. Kivu	Nord	Miti-Murhesa	CH	Murhesa	90%
S. Kivu	Nord	Miti-Murhesa	CS	Buhandahanda	100%
S. Kivu	Sud	Uvira	CS	Kavimvira	85%
S. Kivu	Sud	Uvira	CS	Kalundu Etat	80%
S. Kivu	Sud	Uvira	CS	Kalundu Cepac	0%
S. Kivu	Sud	Ruzizi	CS	SangeEtat	95%
S. Kivu	Sud	Ruzizi	CS	SangeEtat Maternite	90%
S. Kivu	Sud	Nundu	CS	Maternite Swima	85%
S. Kivu	Sud	Nundu	CS	Kaboke II	0%
S. Kivu	Sud	Hauts Plateaux	CS	Katanga	0%
S. Kivu	Sud	Hauts Plateaux	CS	Mugogo	0%
S. Kivu	Sud	Hauts Plateaux	CS	Kitoga	0%
S. Kivu	Sud	Lemera	HGR	Bloc Echo/Radiographie	85%
S. Kivu	Sud	Lemera	CS	Luvungi 2	0%
S. Kivu	Sud	Lemera	CS	Narunanga	0%
S. Kivu	Ouest	Mwenga	CS	Sungwe	0%
S. Kivu	Ouest	Mwenga	CS	Kitamba	0%
S. Kivu	Ouest	Mwenga	CS	Iganda	0%
S. Kivu	Ouest	Kamituga	HGR	Pediatric Urgences	0%
S. Kivu	Ouest	Kamituga	CS	Kele Sidem	0%
S. Kivu	Ouest	Kamituga	CS	Kimbaguiste	0%
S. Kivu	Centre	Kaziba	CS	Ngali	0%
S. Kivu	Centre	Kaziba	CS	Kafinjo	0%
S. Kivu	Bukavu	Ibanda	CS	Ch Cah	0%
S. Kivu	Bukavu	Ibanda	CS	Ceca Nguba	0%
S. Kivu	Bukavu	Bagira	HGR	Bagira	0%
S. Kivu	Bukavu	Bagira	CS	Cigurhi	0%
S. Kivu	Centre	Walungu	CS	Walungu	0%
S. Kivu	Centre	Walungu	CS	Ikoma	0%
S. Kivu	Bukavu	Kadutu	CS	Nyamululagira	0%
S. Kivu	Bukavu	Kadutu	CS	CecaMweze	0%

S. Kivu	Bukavu	Kadutu	CS	Ciriri	0%
S. Kivu	Centre	Kaniola	CS	Cagala	0%
S. Kivu	Centre	Mubumbano	CS	Muzinzi	0%
S. Kivu	Centre	Mubumbano	CS	Tubimbi	0%
S. Kivu	Centre	Mwana	CS	Buhamba	0%
S. Kivu	Centre	Mwana	CS	Kakwende	0%
S. Kivu	Centre	Nyangezi	HGR	Nyangezi	0%
S. Kivu	Centre	Nyangezi	CS	Kalunga	0%
S. Kivu	Ouest	Kalole	HGR	Maternite	0%
S. Kivu	Ouest	Lulingu	CS	Lolo	0%
S. Kivu	Ouest	Lulingu	CS	Milenda	0%
S. Kivu	Ouest	Lulingu	CS	Nduma	0%
S. Kivu	Ouest	Kitutu	CS	Kakenenge	0%
S. Kivu	Ouest	Kitutu	HGR	Kitutu	0%
S. Kivu	Ouest	Kitutu	BCZS	BczsKitutu	0%
S. Kivu	Ouest	Mulungu	CS	Nzovu	0%
S. Kivu	Ouest	Mulungu	CS	Kolula	0%
S. Kivu	Ouest	Mulungu	HGR	Mulungu	0%
S. Kivu	Ouest	Shabunda	CS	Miswaki	0%
S. Kivu	Ouest	Shabunda	CS	Byankungu	0%
S. Kivu	Ouest	Shabunda	CS	Kasa	0%

## ANNEX 9: SUPERVISION AT HEALTH ZONES

Sorted from most to least supervised health zones

Region	Partner	Health Zone	Health Centers	April		May		June		July		August		September	
				HC Supv.	%	HC Supv.	%	HC Supv.	%	HC Supv.	%	HC Supv.	%	HC Supv.	%
S. Kivu	CRS	Bagira	9	8	89%	6	67%	9	100%	9	100%	9	100%		0%
S. Kivu	CRS	Kaziba	13	12	92%	11	85%	12	92%	13	100%	13	100%		0%
S. Kivu	CRS	Mwana	9	5	56%	8	89%	8	89%	9	100%	9	100%		0%
S. Kivu	CRS	Nyangezi	11	11	100%	9	82%	10	91%	11	100%	11	100%		0%
K. Oc.	ECC	Mutoto	14	14	100%	14	100%	14	100%	14	100%	14	100%	14	100%
K. Oc.	ECC	Tshikaji	12	12	100%	12	100%	12	100%	11	92%	12	100%	8	67%
K. Or.	ECC	Bibanga	17	13	76%	13	76%	16	94%	10	59%	17	100%	9	53%
K. Or.	ECC	Mpokolo	15	15	100%	15	100%	15	100%	12	80%	15	100%	10	67%
Katanga	ECC	Kayamba	13	13	100%	8	62%	11	85%	9	69%	13	100%		0%
Katanga	ECC	Kitenge	19	19	100%	19	100%	18	95%	17	89%	19	100%		0%
Katanga	ECC	Lwamba	18	18	100%	18	100%	15	83%	13	72%	18	100%		0%
Katanga	ECC	Mukanga	19	8	42%	19	100%	15	79%	14	74%	19	100%		0%
Katanga	ECC	Mulongo	15	15	100%	15	100%	5	33%	14	93%	15	100%		0%
Katanga	ECC	Songa	29	29	100%	26	90%	26	90%	28	97%	29	100%		0%
Katanga	WV	Bunkeya	7	3	43%	3	43%	3	43%	7	100%	7	100%	6	86%
Katanga	WV	Manika	13	3	23%	3	23%	10	77%	13	100%	13	100%	13	100%
S. Kivu	WV	Katana	16	11	69%	7	44%	16	100%	16	100%	16	100%	14	88%
Katanga	ECC	Malemba Nkulu	18	16	89%	17	94%	13	72%	15	83%	17	94%		0%
S. Kivu	CRS	Mubumbano	15	8	53%	10	67%	13	87%	13	87%	14	93%		0%
S. Kivu	CRS	Ibanda	14	13	93%	12	86%	13	93%	14	100%	13	93%		0%
S. Kivu	CRS	Lemera	21	14	67%	14	67%	16	76%	12	57%	19	90%		0%
S. Kivu	CRS	Kamituga	20	14	70%	12	60%	15	75%	19	95%	18	90%		0%
S. Kivu	WV	Minova	10	8	80%	7	70%	7	70%	10	100%	9	90%	8	80%
S. Kivu	CRS	Uvira	17	16	94%	13	76%	17	100%	16	94%	15	88%		0%
Katanga	WV	Lubudi	16	6	38%	9	56%	11	69%	12	75%	14	88%	15	94%
Katanga	WV	Kanzenze	15	5	33%	10	67%	11	73%	11	73%	13	87%	12	80%
S. Kivu	CRS	Ruzizi	14	8	57%	9	64%	13	93%	12	86%	12	86%		0%
S. Kivu	CRS	Kaniola	12	7	58%	8	67%	10	83%	11	92%	10	83%		0%
S. Kivu	CRS	Nundu	21	19	90%	17	81%	18	86%	21	100%	17	81%		0%
Katanga	ECC	Kabongo	26	21	81%	10	38%	20	77%	16	62%	21	81%		0%
Katanga	WV	Dilala	10	3	30%	6	60%	10	100%	8	80%	8	80%	8	80%
S. Kivu	CRS	Walungu	24	22	92%	20	83%	22	92%	20	83%	19	79%		0%
Katanga	WV	Fungurume	17	9	53%	9	53%	10	59%	12	71%	13	76%	13	76%
S. Kivu	WV	Idjwi	21	15	71%	14	67%	13	62%	14	67%	16	76%	10	48%
Katanga	ECC	Kinkondja	24	17	71%	21	88%	24	100%	24	100%	17	71%		0%
S. Kivu	CRS	Mwenga	17	10	59%	10	59%	12	71%	13	76%	12	71%		0%
S. Kivu	WV	Kalehe	10	9	90%	8	80%	10	100%	10	100%	7	70%	7	70%
K. Oc.	ECC	Bulape	15	5	33%	4	27%	13	87%	12	80%	9	60%	0	0%
K. Oc.	ECC	Lubodayi	20	11	55%	12	60%	11	55%	16	80%	12	60%	16	80%
S. Kivu	WV	Kalonge	15	5	33%	7	47%	10	67%	9	60%	9	60%	10	67%
S. Kivu	WV	Miti Murhesa	17	10	59%	9	53%	9	53%	9	53%	9	53%	4	24%
Katanga	WV	Lualaba	14	10	71%	8	57%	10	71%	7	50%	7	50%	8	57%
S. Kivu	CRS	Mulungu	15		0%		0%	7	47%	7	47%	7	47%		0%
Katanga	WV	Mutshatsha	13	3	23%	7	54%	8	62%	7	54%	6	46%	8	62%
S. Kivu	CRS	Hauts Plateaux	20	11	55%	11	55%	12	60%	6	30%	8	40%		0%
S. Kivu	WV	Bunyakiri	23	10	43%	13	57%	7	30%	9	39%	8	35%	5	22%
S. Kivu	CRS	Kadutu	16	15	94%	12	75%	8	50%	10	63%	5	31%		0%
S. Kivu	CRS	Kalole	15		0%		0%		0%		0%		0%		0%
S. Kivu	CRS	Kitutu	15		0%		0%		0%		0%		0%		0%
S. Kivu	CRS	Lulingu	15		0%		0%	12	80%		0%		0%		0%
S. Kivu	CRS	Shabunda	15		0%		0%		0%		0%		0%		0%
Average Supervision by HZMT			819	529	65%	525	64%	600	73%	595	73%	549	67%	198	24%

## ANNEX 10: SUPERVISION BY HEALTH ZONE AND IMPLEMENTING PARTNER

District	Partner	Area	Number	April		May		June		July		August		September	
				Supv.	%	Supv.	%	Supv.	%	Supv.	%	Supv.	%	Supv.	%
Bukavu	Crs	HZs	3	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Bukavu	Crs	HGRs	3	3	100%	3	100%	3	100%	2	67%	3	100%	2	67%
Bukavu	Crs	HCS	6	4	67%	5	83%	4	67%	4	67%	6	100%	4	67%
S.K Centre	Crs	HZs	6	6	100%	5	83%	6	100%	6	100%	6	100%	6	100%
S.K Centre	Crs	HGRs	6	6	100%	5	83%	6	100%	6	100%	4	67%	4	67%
S.K Centre	Crs	HCS	12	10	83%	8	67%	7	58%	10	83%	9	75%	10	83%
S.K Ouest	Crs	HZs	7	2	29%	3	43%	4	57%	4	57%	4	57%	6	86%
S.K Ouest	Crs	HGRs	5	2	40%	2	40%	4	80%	3	60%	4	80%	4	80%
S.K Ouest	Crs	HCS	14	4	29%	6	43%	10	71%	11	79%	10	71%	14	100%
S.K Sud	Crs	HZs	5	4	80%	5	100%	4	80%	4	80%	4	80%	4	80%
S.K Sud	Crs	HGRs	3	3	100%	2	67%	3	100%	2	67%	3	100%	3	100%
S.K Sud	Crs	HCS	10	7	70%	8	80%	7	70%	10	100%	8	80%	9	90%
Haut Lomami	Ecc	HZs	9	9	100%	9	100%	0	0%	0	0%	6	67%	4	44%
Haut Lomami	Ecc	HGRs	6	4	67%	2	33%	0	0%	0	0%	4	67%	4	67%
Haut Lomami	Ecc	HCS	181	11	6%	10	6%	0	0%	0	0%	18	10%	18	10%
Pool Kananga	Ecc	HZs	4	4	100%	4	100%	4	100%	4	100%	4	100%	4	100%
Pool Kananga	Ecc	HGRs	4	4	100%	4	100%	4	100%	4	100%	4	100%	4	100%
Pool Kananga	Ecc	HCS	61	12	20%	14	23%	7	11%	12	20%	9	15%	12	20%
Mbuji Mayi	Ecc	HZs	1	1	100%	0	0%	1	100%	1	100%	1	100%	1	100%
Mbuji Mayi	Ecc	HGRs	1	1	100%	0	0%	1	100%	1	100%	1	100%	1	100%
Mbuji Mayi	Ecc	HCS	15	4	27%	0	0%	6	40%	5	33%	3	20%	4	27%
Tshilenge	Ecc	HZs	1	1	100%	0	0%	1	100%	1	100%	1	100%	1	100%
Tshilenge	Ecc	HGRs	1	1	100%	0	0%	1	100%	1	100%	1	100%	1	100%
Tshilenge	Ecc	HCS	17	3	18%	0	0%	4	24%	3	18%	4	24%	4	24%
Kolwezi	Wvi	HZs	8	3	38%	8	100%	8	100%	4	50%	8	100%	3	38%
Kolwezi	Wvi	HGRs	6	3	50%	5	83%	6	100%	2	33%	4	67%	3	50%
Kolwezi	Wvi	HCS	99	2	2%	10	10%	14	14%	10	10%	12	12%	8	8%
S.K Nord	Wvi	HZs	7	7	100%	7	100%	7	100%	6	86%	7	100%	5	71%
S.K Nord	Wvi	HGRs	6	6	100%	6	100%	6	100%	4	67%	6	100%	4	67%
S.K Nord	Wvi	HCS	110	8	7%	12	11%	16	15%	8	7%	14	13%	10	9%
Average Supervision Of		HZs	51	40	78%	44	86%	38	75%	33	65%	44	86%	37	73%
Average Supervision Of		HGRs	41	33	80%	29	71%	34	83%	25	61%	34	83%	30	73%
Average Supervision Of		HCS	525	65	12%	73	14%	75	14%	73	14%	93	18%	93	18%

## ANNEX 11: Project Supervision Goals

<b>FIRST QUARTER</b>			
<b>Responsible/ participants</b>	<b>Sites visited</b>	<b>Goals</b>	<b>Comments</b>
COP and Program Manager	South Kivu	To inform administrative and health authorities of the project and the expected results and their respective roles	The objective of these field visits was successful. The current AXxes partners' organigrams are one of the results of these missions. The implication of different MIPs in the activities of the project is also another result.
	Katanga	To harmonize interventions with other partners in field (IRC, Unicef, OMS, FED 9, Meltzer, GTZ, Louvain development...)	
	Mbuji Mayi	To evaluating and improving the organization put in place by axxes partners.	
<b>SECOND QUARTER</b>			
<b>Responsible/ participants</b>	<b>Sites visited</b>	<b>Goals</b>	<b>Comments</b>
M&E officer	Kasaï occidental (Ndemba) et Katanga (Kamina)	To ensure supervision and follow up of the trainings in management of PHC for the HZMT and to facilitate the training in SIS, Evaluation et Operational research	It was very important to ensure this follow up because it was the first time for our partners in field to organize this kind of session with a large number of participants.
			It was also important to make sure that project objectives and indicators are well integrated as part of the training.
	Bukavu	To help AXxes partners to have the same understanding of AXxes indicators and help them to prepare for the KPC	All of the AXxes indicators and KPC protocol were discussed with partners and feedback was given
Program Manager, COP & Usaid team	Bukavu	Review of indicators and key interventions with AXxes partners	We took the opportunity of all partners being in Bukavu to discuss technical issues with USAID. Two health zones were also visited.
		Visits of Health zones (Walungu and Nyangezi)	Orientations on how partners must organize their work were given
Operations Manager	Bukavu and Kolwezi	Organize the drug provision system based on the existing depots	Work with partners and other to define the mechanisms of restocking drugs after the first provision by the project.
	& Lubumbashi	To supervise WVI team especially on logistic and management aspects	This mission was important to help WVI to adapt their organization toward AXxes objectives. WVI started with a weak structure but now they are well organized.
Program Manager	Lubumbashi and Kolwezi	Supervise WVI Provincial coordinators and visit HZs	This mission followed immediately the one done by the Operations manger in order to correct some technical aspects and help WVI to become more effective in the field.
		Discuss component C with MID	

<b>THIRD QUARTER</b>			
<b>Responsible/ participants</b>	<b>Sites visited</b>	<b>Goals</b>	<b>Comments</b>
M&E	Kolwezi	Supervise KPC activities in WVI office and in HZs (Manika and Kanzenze)	The new PMP data base was developed after meeting with USAID data manager. It was necessary to orient the partners to the new system.
		Supervise WVI coordinators on database organization and discuss on routine indicators collection	
MSH expert and AXxes Operation Manager	Bukavu Katanga (Kolwezi et kamina)	To evaluate the drug provision in the each province and find strategies to reinforce the system	This is part of MSH's scope of work to provide technical assistance to AXxes
		Supervise AXxes partners project activities	
M& E officer	Bukavu	Supervision of the WVI and CRS team	This data base take in incorporates all indicators required by USAID and the MOH SNIS
		Install the new data base soft ware and train them to use it	
PHSK experts	Bukavu	Supervise the organization of lab training in field by CRS and WVI	In collaboration with MSH and the School of Health Public Kinshasa this supervision was organized to make sure of the quality of training
		Supervise some HGR lab staff	
PF point focal in collaboration with MOH and IRH	Bukavu & Uvira	Supervise Family planning activities at CRS and WVI coordination and	After HR/FP training and dispatching of commodities, it was necessary to check how things are organized in the field and assure that the commodities were distributed correctly
		Ensure follow up in field	
<b>FORTH QUARTER</b>			
<b>Responsible/ participants</b>	<b>Sites visited</b>	<b>Goals</b>	<b>Comments</b>
AXxes RH/FP focal point and experts from 5th direction, PNLS, Basics New born TA, Program SR &PF / PMTCT	BUKAVU	To evaluate the organization of ANC, maternities, postpartum care, new born care, PMTCT activities, communication activities for mother and newborn health in the community and elaborate an orientation plan and recommendations	This mission was both a field assessment and a supervision of AXxes partners on the organization of these activities
Program manager	Bukavu	WVI supervision	
		Work on component C with IPS team	
Don Padgett (IMA) & Gaby Bukasa (MSH)	Bukavu, Kolwezi, Kananga et Kamina	Supervise and train Axxes implementing partners and teams in computer assisted drug management	HZ teams and existing depot manager were also associated in this training/supervision

## ANNEX 12: TRAINING ACHIEVED BY AXXES IN YEAR ONE

Period	Component	Categories	Total Trained	Men Trained	Women Trained
Jan-Feb	Management SSP	MCZ, MDH, AG ZS, AG HGR, DN, IS	302	268	34
March	PEV Microplanning	MCZ, MDH, AG ZS, AG HGR, DN, IS, IT	78	71	
March	TOT SR/PF	MCZ, MDH, Resp MAT, DN, IS	232	178	54
April	SR/PF for HCs	IT	1278	960	318
April-May	Training of trainers in financial management	General Assembly of co-ordinations, Project Accountant	9	7	2
April	Training of Lab trainers	Lab staff	13	12	1
May-June	Training in financial Management	MCZ, MDH, AG ZS, AG HGR, Accountant	148	121	27
	Training in financial Management	Accountant and nurses	187	160	27
June	Training in Routine Vitamin A	MCZ, MDH, IS, IT	33	33	0
June	Access Indicator Base	Provincial Co-ordinator, General Assembly, Logistician	5	4	1
June	Leadership phase I	Provincial Co-ordinator, MIPs, MIDs, COP team	38	33	5
	Leadership phase II	Provincial Co-ordinator, MIPs, MIDs, COP team	30	28	2
July	Lab training	CSDT and HGR/ CSDT and GR Lab staff	174	150	24
July	Enlarged Vaccination Programme	MCZ, MDH, DN, IS	36	34	2
August	PMA/IMCI	MCZ, MDH, DN, IS	85	71	14
	PMA/IMCI	Nurses	221	148	63
Sept	Drug gestion training	MCZ, AG ZS, AG HGR, Resp pharm ZS, et HGR	130	120	10
September	Zinc briefing	MCZ, MDH, DN, HZ nutritionist, responsible for pediatric	23	19	4
Total			3022	2417	588

### Comments

- PHC and RH/PF training were organized in Maniema before the zones were removed from the project.
- PMA/IMCI training is not yet done in South Kivu.
- PEV micro planning training was organized by PEV except for ECC zones
- Training in financial Management for nurses was organized only in WVI health zones. The other partners are preparing to do it in year two
- Zinc briefing is in progress, it is done only in Kolwezi

In addition to these trainings others training were organized by the other partners and MOH like :

- Water and sanitation with UNICEF in 19 HZs
- Micro planification training by PEV in all zones except for district of Haut Lomami
- TB training in South Kivu,
- Training on TETU(Tri, Evaluation et Traitement des Urgences) and IMCI in south Kivu by WHO

### ANNEX 13: ENVIRONMENTAL COMPLIANCE AT HEALTH ZONES (IEE)

Elements/Actions	CRS																				
	Bagira	Hauts Plateaux	Ibanda	Kadutu	Kalole	Kamituga	Kaniola	Kaziba	Kitutu	Lemera	Lulingu	Mubumbano	Mulungu	Mwana	Mwenga	Nundu	Nyangezi	Ruzizi	Shabunda	Uvira	Walungu
<b>Written plans and procedures</b>																					
Are there internal rules for generation, handling, storage, treatment, and disposal of healthcare waste.	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are there clearly assigned staff responsibilities that cover all steps in the waste management process.	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is there staff waste handling training curricula or a list of topics covered.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are there waste minimization, reuse, and recycling procedures.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Staff Training, Practices, and Protection</b>																					
Do staff exhibit good hygiene, safe sharps handling, proper use of protective clothing, proper packaging and labeling of waste, and safe storage of waste?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Do staff know the correct responses for spills, injury, and exposure?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there protective clothing available for workers who move and treat collected infections waste such as surgical masks and gloves, aprons, and boots.	Y	N	Y	Y	N	Y	N	Y	N	Y	N	N	N	Y	N	N	N	N	N	N	Y
Are soap and, ideally, warm water readily available workers to use and can workers be observed regularly washing.	N	N	Y	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	Y
Are workers vaccinated for against viral hepatitis B, tetanus infections, and other endemic infections for which vaccines are available.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Handling and Storage Practices</b>																					
Are there temporary storage containers and designated storage locations.	Y	N	Y	Y	N	Y	Y	N	N	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does the facility have good inventory practices for chemicals and pharmaceuticals, i.e.: use the oldest batch first and open new containers only after the last one is empty	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is general waste separated from infectious/hazardous waste?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is sharp waste (needles, broken glass, etc.) collected in separate puncture-proof containers?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are other levels of segregation being applied e.g. hazardous liquids, chemicals and pharmaceuticals, PVC plastic, and materials containing heavy metals ?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is the location of temporary storage containers distant from patients or food?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Treatment Practices</b>																					

<i>Elements/Actions</i>	CRS																					
	Bagira	Hauts Plateaux	Ibanda	Kadutu	Kalole	Kamituga	Kaniola	Kaziba	Kitutu	Lemera	Lulingu	Mubumbano	Mulungu	Mwana	Mwenga	Nundu	Nyangezi	Ruzizi	Shabunda	Uvira	Walungu	
Are wastes collected daily?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	
Are wastes being burned in the open air, in a drum or brick incinerator, or a single-chamber incinerator?	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y
If not are they being buried safely (in a pit with an impermeable plastic or clay lining)?	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y
Is the final disposal site (usually a pit) surrounded by fencing or other materials and in view of the facility to prevent accidental injury or scavenging of syringes and other medical supplies?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
If the waste is transported off-site, are precautions taken to ensure that it is transported and disposed of safely?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Construction-Related Aspects of Development Projects</b>																						
Does not offend local population or damage local social fabric	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause one or more of a set of adverse environmental impacts typical of roads, including erosion, changing water tables, or providing access for illegal landclearing, logging or poaching	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not destroy or harm plants or animals of ecological, cultural, and/or economic importance	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not destroy or harm important scenic, archeological or cultural/historical site	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not destroy or harm valuable and sensitive ecosystems and organisms	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause erosion and damage to terrestrial and aquatic ecosystems during construction or use	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not degrade forest, contributing to flooding potential	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Water and Sanitation</b>																						
Does not cause destruction of the natural resource	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause destruction of aquatic life	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause loss of economic productivity	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause loss of recreation areas	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause increase in vector-borne diseases	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause contamination of standing water with fecal matter, solid waste, etc., leading to health problems	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause soil erosion/sedimentation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause alteration of ecosystem structure & function and loss of biodiversity	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N



<i>Elements/Actions</i>	ECC														
	Bulape	Lubondayi	Mutoto	Tshikaji	Bibanga	Mpokolo	Kabongo	Kayamba	Kinkondja	Kitenge	Lwamba	Malemba Nkulu	Mukanga	Mulongo	Songa
<b><i>Written plans and procedures</i></b>															
Are there internal rules for generation, handling, storage, treatment, and disposal of healthcare waste.	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Are there clearly assigned staff responsibilities that cover all steps in the waste management process.	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Is there staff waste handling training curricula or a list of topics covered.	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Are there waste minimization, reuse, and recycling procedures.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b><i>Staff Training, Practices, and Protection</i></b>															
Do staff exhibit good hygiene, safe sharps handling, proper use of protective clothing, proper packaging and labeling of waste, and safe storage of waste?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Do staff know the correct responses for spills, injury, and exposure?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Is there protective clothing available for workers who move and treat collected infections waste such as surgical masks and gloves, aprons, and boots.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are soap and, ideally, warm water readily available workers to use and can workers be observed regularly washing.	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Are workers vaccinated for against viral hepatitis B, tetanus infections, and other endemic infections for which vaccines are available.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b><i>Handling and Storage Practices</i></b>															
Are there temporary storage containers and designated storage locations.	Y	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	Y		Y	Y	N	N	N	N	N	N	N	N	N	N	N
Does the facility have good inventory practices for chemicals and pharmaceuticals, i.e.: use the oldest batch first and open new containers only after the last one is empty	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is general waste separated from infectious/hazardous waste?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Is sharp waste (needles, broken glass, etc.) collected in separate puncture-proof containers?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Are other levels of segregation being applied e.g. hazardous liquids, chemicals and pharmaceuticals, PVC plastic, and materials containing heavy metals ?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is the location of temporary storage containers distant from patients or food?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b><i>Treatment Practices</i></b>															
Are wastes collected daily?	Y	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N
Are wastes being burned in the open air, in a drum or brick incinerator, or a single-chamber incinerator?	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N
If not are they being buried safely (in a pit with an impermeable plastic or clay lining)?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N

<i>Elements/Actions</i>	ECC														
	Bulape	Lubondayi	Mutoto	Tshikaji	Bibanga	Mpokolo	Kabongo	Kayamba	Kinkondja	Kitenge	Lwamba	Malemba Nkulu	Mukanga	Mulongo	Songa
Is the final disposal site (usually a pit) surrounded by fencing or other materials and in view of the facility to prevent accidental injury or scavenging of syringes and other medical supplies?	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
If the waste is transported off-site, are precautions taken to ensure that it is transported and disposed of safely?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Construction-Related Aspects of Development Projects</b>															
Does not offend local population or damage local social fabric	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause one or more of a set of adverse environmental impacts typical of roads, including erosion, changing water tables, or providing access for illegal landclearing, logging or poaching	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm plants or animals of ecological, cultural, and/or economic importance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm important scenic, archeological or cultural/historical site	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm valuable and sensitive ecosystems and organisms	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause erosion and damage to terrestrial and aquatic ecosystems during construction or use	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not degrade forest, contributing to flooding potential	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Water and Sanitation</b>															
Does not cause destruction of the natural resource	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause destruction of aquatic life	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause loss of economic productivity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause loss of recreation areas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause increase in vector-borne diseases	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause contamination of standing water with fecal matter, solid waste, etc., leading to health problems	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause soil erosion/sedimentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause alteration of ecosystem structure & function and loss of biodiversity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Elements/Actions	WV														
	Bunkeya	Dilala	Fungurume	Kanzenze	Lualaba	Lubudi	Manika	Mutshasha	Bunyakiri	Idjwi	Kalehe	Kalonge	Katana	Minova	Miti Murhesa
<b>Written plans and procedures</b>															
Are there internal rules for generation, handling, storage, treatment, and disposal of healthcare waste.	N	Y	N	N	N	N	N	N	Y	N	Y	N	Y	N	Y
Are there clearly assigned staff responsibilities that cover all steps in the waste management process.	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	Y
Is there staff waste handling training curricula or a list of topics covered.	N	N	N	N	N	N	N	N	Y	N	Y	N	Y	N	Y
Are there waste minimization, reuse, and recycling procedures.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Staff Training, Practices, and Protection</b>															
Do staff exhibit good hygiene, safe sharps handling, proper use of protective clothing, proper packaging and labeling of waste, and safe storage of waste?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Do staff know the correct responses for spills, injury, and exposure?	Y	Y	N	N	N	Y	N	N	Y	N	Y	N	Y	N	Y
Is there protective clothing available for workers who move and treat collected infections waste such as surgical masks and gloves, aprons, and boots.	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Are soap and, ideally, warm water readily available workers to use and can workers be observed regularly washing.	N	N	N	N	N	N	N	N	N	Y	Y	N	Y	N	N
Are workers vaccinated for against viral hepatitis B, tetanus infections, and other endemic infections for which vaccines are available.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
<b>Handling and Storage Practices</b>															
Are there temporary storage containers and designated storage locations.	N	Y	N	N	N	N	Y	N	Y	N	Y	N	Y	N	Y
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does the facility have good inventory practices for chemicals and pharmaceuticals, i.e.: use the oldest batch first and open new containers only after the last one is empty	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Is general waste separated from infectious/hazardous waste?	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N
Is sharp waste (needles, broken glass, etc.) collected in separate puncture-proof containers?	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N
Are other levels of segregation being applied e.g. hazardous liquids, chemicals and pharmaceuticals, PVC plastic, and materials containing heavy metals ?	N	N	N	N	N	N	N	N	N	N	Y	N	Y	N	N
Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Is the location of temporary storage containers distant from patients or food?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
<b>Treatment Practices</b>															
Are wastes collected daily?	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Are wastes being burned in the open air, in a drum or brick incinerator, or a single-chamber incinerator?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
If not are they being buried safely (in a pit with an impermeable plastic or clay lining)?	N	N	N	N	N	N	N	N	N		N	N		N	N

<i>Elements/Actions</i>	<b>WV</b>														
	Bunkeya	Dilala	Fungurume	Kanzenze	Lualaba	Lubudi	Manika	Mutshatsha	Bunyakiri	Idjwi	Kalehe	Kalonge	Katana	Minova	Miti Murhesa
Is the final disposal site (usually a pit) surrounded by fencing or other materials and in view of the facility to prevent accidental injury or scavenging of syringes and other medical supplies?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
If the waste is transported off-site, are precautions taken to ensure that it is transported and disposed of safely?	N	N	N	N	N	N	N	N	N	N	Y	N	Y	N	N
<b>Construction-Related Aspects of Development Projects</b>															
Does not offend local population or damage local social fabric	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause one or more of a set of adverse environmental impacts typical of roads, including erosion, changing water tables, or providing access for illegal landclearing, logging or poaching	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm plants or animals of ecological, cultural, and/or economic importance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm important scenic, archeological or cultural/historical site	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not destroy or harm valuable and sensitive ecosystems and organisms	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause erosion and damage to terrestrial and aquatic ecosystems during construction or use	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not degrade forest, contributing to flooding potential	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Water and Sanitation</b>															
Does not cause destruction of the natural resource	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause destruction of aquatic life	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause loss of economic productivity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause loss of recreation areas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause increase in vector-borne diseases	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause contamination of standing water with fecal matter, solid waste, etc., leading to health problems	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Does not cause soil erosion/sedimentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Does not cause alteration of ecosystem structure & function and loss of biodiversity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

## ANNEX 14: DISTRIBUTION OF PROJECT MATERIALS (CUMALATIVE)

			Matériels/Equipements				SNIS					
Region	Health Zone	CS	Moto	Generator	Bicycle	Hors bord	SNIS CS	SNIS BCZ	SNIS HGR	Ordinogramme A,B,C	Fiches de référence	Registre Consultations Curatives
KOC	Tshikaji	12	3	0			346	18	16	0	2000	20
KOC	Bulape	15	3	1			432	18	16	0	2000	20
KOC	Mutoto	13	0	1			374	18	16	0	2000	20
KOC	Lubondai	19	3	0	8		547	17	16	0	3000	30
KOC	Bibanga	14	3	1	4		403	18	16	0	1750	21
KOC	Mpokolo	15	3	1	16		432	18	16	0	4599	23
KAT	Mulongo	15	2	1		1	461	16	15	0	1094	24
KAT	Kayamba	13	2	1			374	16	15	0	1861	20
KAT	Lwamba	18	2	1			230	16	15	0	1880	12
KAT	Songa	15	1	1			835	16	15	0	2701	44
KAT	Malemba-Nkulu	7	3	1		1	461	16	15	0	3637	24
KAT	Mukanga	13	2	1	15	1	461	16	15	0	4485	24
KAT	Kabongo	14	1	0			720	16	15	0	4672	36
KAT	Kitenge	16	1	1			576	16	15	0	4733	30
KAT	Kinkondja	18	1	1	1		662	16	15	0	5065	35
K. Or.	Dibindi											
K. Or.	Lodja											
K. Or.	Lusambo											
K. Or.	Omendjadi											
K. Or.	Pania Mutombo											
K. Or.	Vanga Kete Ototo											
<b>Distributed to HZs</b>			<b>30</b>	<b>12</b>	<b>44</b>	<b>3</b>	<b>7314</b>	<b>251</b>	<b>231</b>	<b>0</b>	<b>45477</b>	<b>383</b>
<b>Quantity Received by ECC</b>			<b>30</b>	<b>12</b>	<b>44</b>	<b>3</b>	<b>7315</b>	<b>251</b>	<b>240</b>	<b>0</b>	<b>49000</b>	<b>385</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>3523</b>	<b>2</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>96%</b>	<b>0%</b>	<b>93%</b>	<b>99%</b>
Katanga	Kanzenze	15	2	0	11	0	400	16	18	0	1000	20
Katanga	Bunkeya	7	2	0	8	0	400	16	9	0	1000	20
Katanga	Mutshatsha	13	2	1	11	0	400	16	9	0	1000	20
Katanga	Lualaba	14	2	1	16	0	400	16	6	0	1000	20
Katanga	Lubudi	16	2	1	3	0	400	16	27	0	1500	30
Katanga	Fungurume	17	2	1	20	0	400	16	18	0	1500	30
Katanga	Dilala	10	2	0	16	0	400	16	18	0	1500	30
Katanga	Manika	13	2	0	15	0	400	16	18	0	1500	30
S. Kivu	Kalonge	15	2	1	12	0	500	13	1	0	2500	21
S. Kivu	Kalehe	10	1	0	8	0	500	13	1	0	2833	21
S. Kivu	Minova	10	1	0	8	0	500	13	1	0	2833	21
S. Kivu	Bunyakiri	23	2	1	8	0	500	13	1	0	2833	21
S. Kivu	Katana	16	1	0	8	0	500	13	1	0	2833	21
S. Kivu	Miti	17	1	0	8		500	13	1	0	2500	21
S. Kivu	Idjwi	21	1	1	12	0	300	13	1	0	2833	30
<b>Distributed to HZs</b>			<b>25</b>	<b>7</b>	<b>164</b>	<b>0</b>	<b>6500</b>	<b>219</b>	<b>130</b>	<b>0</b>	<b>29165</b>	<b>356</b>
<b>Quantity Received by WV</b>			<b>25</b>	<b>7</b>	<b>180</b>		<b>6682</b>	<b>220</b>	<b>178</b>	<b>0</b>	<b>34000</b>	<b>355</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>16</b>	<b>0</b>	<b>182</b>	<b>1</b>	<b>48</b>	<b>0</b>	<b>4835</b>	<b>-1</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>91%</b>		<b>97%</b>	<b>100%</b>	<b>73%</b>		<b>86%</b>	<b>100%</b>
Maniema	Pangi	12	3	1	5	0	102	7	7	0	1061	22
Maniema	Kailo	15	3	1	6	0	116	7	7	0	1212	25

			Matériels/Equipements				SNIS					
Region	Health Zone	CS	Moto	Generator	Bicycle	Hors bord	SNIS CS	SNIS BCZ	SNIS HGR	Ordinogramme A,B,C	Fiches de référence	Registre Consultations Curatives
Maniema	Kalima	16	3	1	6	0	124	7	7	0	1288	26
Maniema	Kampene	14	3	1	5	0	109	7	7	0	1136	23
Maniema	Alunguli	6	2	1	2	0	44	7	7	0	455	9
Maniema	Kindu	10	2	1	4	0	73	7	7	0	758	16
Maniema	Ferekeni	6	3	1	3	0	58	7	7	0	606	12
Maniema	Obokote	9	3	1	4	0	80	7	7	0	833	17
Maniema	Lubutu	19	3	1	7	0	138	7	7	0	1439	30
Maniema	Punia	12	3	0	6	0	116	7	7	0	1212	25
<b>Distributed to HZs</b>			<b>28</b>	<b>9</b>	<b>48</b>	<b>0</b>	<b>960</b>	<b>70</b>	<b>70</b>	<b>0</b>	<b>10000</b>	<b>205</b>
<b>Quantity Received Merlin</b>			<b>28</b>	<b>9</b>	<b>132</b>	<b>0</b>	<b>3460</b>	<b>100</b>	<b>100</b>		<b>24000</b>	<b>340</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>84</b>	<b>0</b>	<b>2500</b>	<b>30</b>	<b>30</b>	<b>0</b>	<b>14000</b>	<b>135</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>36%</b>		<b>28%</b>	<b>70%</b>	<b>70%</b>		<b>42%</b>	<b>60%</b>
S. Kivu	Bagira	22	0	0	0	0	260	21	18	0	2000	12
S. Kivu	Kadutu	11	2	1	0	0	570	21	24	0	2500	17
S. Kivu	Ibanda	14	3	1	9	0	380	21	18	0	500	20
S. Kivu	Nyangezi	10	3	1	0	0	200	21	18	0	1500	5
S. Kivu	Kaziba	15	3	1	0	0	300	18	18	0	3500	10
S. Kivu	Walungu	11	3	1	7	0	640	18	18	0	4400	24
S. Kivu	Kaniola	7	2	1	0	0	370	18	18	0	2500	19
S. Kivu	Mubumbano	10	3	1	0	0	280	18	18	0	2000	24
S. Kivu	Mwana	19	3	1	0	0	550	18	18	0	2500	11
S. Kivu	Ruzizi	15	3	1	6	0	380	18	18	0	2000	22
S. Kivu	Lemera	20	2	1	12	0	410	18	18	0	3500	27
S. Kivu	Uvira	25	1	1	15	0	620	18	18	0	3000	24
S. Kivu	Bijombo	10	3	1	12	0	630	18	18	0	3500	29
S. Kivu	Nundu	15	2	1	21	0	630	18	18	0	4500	45
S. Kivu	Kamituga	20	3	1	9	0	510	18	18	0	2500	27
S. Kivu	Mwenga	22	3	1	9	0	300	18	18	0	3000	11
S. Kivu	Kalole	15	2	1	0	0	500	6	6	0	1000	23
S. Kivu	Kitutu	26	2	1	0	0	500	6	6	0	1000	23
S. Kivu	Lulingu	15	2	1	0	0	300	6	6	0	2800	27
S. Kivu	Shabunda	21	1	1	0	0	400	6	6	0	1000	23
S. Kivu	Mulungu	22	2	1	0	0	500	6	6	0	1000	23
<b>Distributed to HZs</b>			<b>48</b>	<b>20</b>	<b>100</b>	<b>0</b>	<b>9230</b>	<b>330</b>	<b>324</b>	<b>0</b>	<b>50200</b>	<b>446</b>
<b>Quantity Received by CRS</b>			<b>48</b>	<b>20</b>	<b>100</b>	<b>0</b>	<b>9230</b>	<b>330</b>	<b>324</b>	<b>0</b>	<b>50200</b>	<b>446</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>		<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>0%</b>	<b>100%</b>	<b>100%</b>
<b>Total Distributed to HZs</b>			<b>131</b>	<b>48</b>	<b>356</b>	<b>3</b>	<b>24004</b>	<b>870</b>	<b>755</b>	<b>0</b>	<b>134842</b>	<b>1390</b>
<b>Total Quantity Received</b>			<b>131</b>	<b>48</b>	<b>456</b>	<b>3</b>	<b>26687</b>	<b>901</b>	<b>842</b>	<b>0</b>	<b>157200</b>	<b>1526</b>
<b>Total Balance</b>			<b>0</b>	<b>0</b>	<b>100</b>	<b>0</b>	<b>2683</b>	<b>31</b>	<b>87</b>	<b>0</b>	<b>22358</b>	<b>136</b>
<b>Total % Distributed</b>			<b>100%</b>	<b>100%</b>	<b>78%</b>	<b>100%</b>	<b>90%</b>	<b>97%</b>	<b>90%</b>	<b>0%</b>	<b>86%</b>	<b>91%</b>

			SNIS					OUTILS GESTION					
Region	Health Zone	CS	Calendriers Axes	Fiches de Monitoring	ARI Timer	Determine sec trans	Fiches Techniques Securité transfusionnelle	RUMER	Registre Cons. Méd/HGR	Fiches tech Gestion Méd CS	Fiches tech Gestion Méd HGR	Fiches tech Gestion Méd BCZS	Fiches de stock
KOC	Tshikaji	12	100	38	25	1000	31	20	1	18	2	2	2000
KOC	Bulape	15	100	46	31	800	41	20	2	23	2	2	2000
KOC	Mutoto	13	100	43	27	400	36	20	1	20	2	2	2000
KOC	Lubondai	19	100	63	31	1000	52	30	2	29	2	2	2000
KOC	Bibanga	14	125	40	29	500	39	4	2	21	2	2	2000
KOC	Mpokolo	15	175	50	29	1200	41	23	2	23	2	2	2000
KAT	Mulongo	15	125	50	33	300	70	24	2	24	2	2	2000
KAT	Kayamba	13	125	40	27	500	55	20	2	20	2	2	2000
KAT	Lwamba	18	125	30	17	500	63	12	2	12	2	2	2000
KAT	Songa	15	250	90	59	1100	41	43	2	43	2	2	2000
KAT	Malemba-Nkulu	7	125	50	33	1000	19	24	2	24	2	2	2000
KAT	Mukanga	13	125	50	33	1300	40	24	2	24	2	2	2000
KAT	Kabongo	14	250	80	51	1300	40	38	2	28	2	2	2000
KAT	Kitenge	16	250	60	41	1300	45	30	2	30	2	2	2000
KAT	Kinkondja	18	250	70	41	1600	45	35	2	35	2	2	2000
K. Or.	Dibindi												
K. Or.	Lodja												
K. Or.	Lusambo												
K. Or.	Omendjadi												
K. Or.	Pania Mutombo												
K. Or.	Vanga Kete Ototo												
<b>Distributed to HZs</b>			<b>2325</b>	<b>800</b>	<b>507</b>	<b>13800</b>	<b>658</b>	<b>367</b>	<b>28</b>	<b>374</b>	<b>30</b>	<b>30</b>	<b>30000</b>
<b>Quantity Received by ECC</b>			<b>2500</b>	<b>800</b>	<b>522</b>	<b>13800</b>	<b>663</b>	<b>385</b>	<b>30</b>	<b>385</b>	<b>30</b>	<b>30</b>	<b>35000</b>
<b>Balance</b>			<b>175</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>5</b>	<b>18</b>	<b>2</b>	<b>11</b>	<b>0</b>	<b>0</b>	<b>5000</b>
<b>% Distributed</b>			<b>93%</b>	<b>100%</b>	<b>97%</b>	<b>100%</b>	<b>99%</b>	<b>95%</b>	<b>93%</b>	<b>97%</b>	<b>100%</b>	<b>100%</b>	<b>86%</b>
Katanga	Kanzenze	15	125	44	31	500	20	20	2	19	2	1	2250
Katanga	Bunkeya	7	125	44	15	500	20	20	2	19	2	1	2250
Katanga	Mutshatsha	13	125	44	27	500	20	22	1	19	1	1	2250
Katanga	Lualaba	14	125	44	29	500	20	20	1	19	1	1	2250
Katanga	Lubudi	16	125	44	33	300	20	25	2	18	2	1	2250
Katanga	Fungurume	17	125	44	37	500	15	25	2	19	2	1	2250
Katanga	Dilala	10	125	44	40	300	25	25	1	19	1	1	2250
Katanga	Manika	13	125	44	27	600	25	25	2	19	2	1	2250
S. Kivu	Kalonge	15	180	63	25	500	10	25	2	20	1	1	3000
S. Kivu	Kalehe	10	180	63	25	500	10	25	2	15	1	1	1500
S. Kivu	Minova	10	180	63	25	500	10	25	2	15	1	1	3000
S. Kivu	Bunyakiri	23	180	63	25	500	10	25	2	28	1	1	2000
S. Kivu	Katana	16	180	63	28	1000	10	25	2	20	1	1	2000
S. Kivu	Miti	17	180	63	25	1000	10	25	2	20	1	1	1500
S. Kivu	Idjwi	21	180	63	25	1000	10	25	2	28	1	1	2000
<b>Distributed to HZs</b>			<b>2260</b>	<b>793</b>	<b>417</b>	<b>8700</b>	<b>235</b>	<b>357</b>	<b>27</b>	<b>297</b>	<b>20</b>	<b>15</b>	<b>33000</b>
<b>Quantity Received by WV</b>			<b>2250</b>	<b>800</b>	<b>478</b>	<b>8700</b>	<b>269</b>	<b>357</b>	<b>30</b>	<b>354</b>	<b>27</b>	<b>29</b>	<b>51000</b>
<b>Balance</b>			<b>-10</b>	<b>7</b>	<b>61</b>	<b>0</b>	<b>34</b>	<b>0</b>	<b>3</b>	<b>57</b>	<b>7</b>	<b>14</b>	<b>18000</b>
<b>% Distributed</b>			<b>100%</b>	<b>99%</b>	<b>87%</b>	<b>100%</b>	<b>87%</b>	<b>100%</b>	<b>90%</b>	<b>84%</b>	<b>74%</b>	<b>52%</b>	<b>65%</b>
Maniema	Pangi	12	46	107	31	0	0	21	2	0	0	0	0
Maniema	Kailo	15	49	114	33	0	0	24	2	0	0	0	0
Maniema	Kalima	16	49	114	33	0	0	26	2	0	0	0	0

			SNIS					OUTILS GESTION					
Region	Health Zone	CS	Calendriers Axes	Fiches de Monitoring	ARI Timer	Determine sec trans	Fiches Techniques Securité transfusionnelle	RUMER	Registre Cons. Méd/HGR	Fiches tech Gestion Méd CS	Fiches tech Gestion Méd HGR	Fiches tech Gestion Méd BCZS	Fiches de stock
Maniema	Kampene	14	46	107	31	0	0	23	2	0	0	0	0
Maniema	Alunguli	6	15	36	11	0	0	9	2	0	0	0	0
Maniema	Kindu	10	30	71	21	0	0	15	2	0	0	0	0
Maniema	Ferekeni	6	33	78	23	0	0	12	2	0	0	0	0
Maniema	Obokote	9	33	78	23	0	0	17	2	0	0	0	0
Maniema	Lubutu	19	58	135	39	0	0	29	2	0	0	0	0
Maniema	Punia	12	52	121	35	0	0	24	2	0	0	0	0
<b>Distributed to HZs</b>			<b>411</b>	<b>961</b>	<b>280</b>	<b>0</b>	<b>0</b>	<b>200</b>	<b>20</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Quantity Received Merlin</b>			<b>1141</b>	<b>1211</b>	<b>483</b>	<b>4000</b>	<b>0</b>	<b>335</b>	<b>30</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Balance</b>			<b>730</b>	<b>250</b>	<b>203</b>	<b>4000</b>	<b>0</b>	<b>135</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>36%</b>	<b>79%</b>	<b>58%</b>			<b>60%</b>	<b>67%</b>				
S. Kivu	Bagira	22	0	0	15	300	31	12	1	20	2	2	1788
S. Kivu	Kadutu	11	0	0	21	1200	42	18	3	28	2	2	2458
S. Kivu	Ibanda	14	0	0	29	800	58	22	2	38	3	3	3352
S. Kivu	Nyanzezi	10	104	27	19	400	0	15	1	0	0	0	0
S. Kivu	Kaziba	15	207	54	0	100	0	31	2	0	0	0	0
S. Kivu	Walungu	11	216	48	42	400	85	33	3	56	4	4	4917
S. Kivu	Kaniola	7	156	14	23	100	0	18	1	0	0	0	0
S. Kivu	Mubumbano	10	204	36	25	100	0	20	2	0	0	0	0
S. Kivu	Mwana	19	204	36	13	400	27	11	2	0	2	1	0
S. Kivu	Ruzizi	15	120	24	23	900	46	18	1	31	2	2	2682
S. Kivu	Lemera	20	120	24	35	400	70	28	2	46	4	4	4023
S. Kivu	Uvira	25	120	36	29	4300	58	23	2	38	3	3	3352
S. Kivu	Bijombo	10	0	0	42	0	85	42	2	56	4	4	4917
S. Kivu	Nundu	15	106	47	40	2100	81	32	2	54	4	4	4693
S. Kivu	Kamituga	20	120	120	29	500	0	22	2	0	4	0	0
S. Kivu	Mwenga	22	120	120	31	200	0	25	2	0	0	0	0
S. Kivu	Kalole	15	146	50	58	0	116	22	2	0	0	0	0
S. Kivu	Kitutu	26	146	50	44	0	0	22	2	0	0	0	0
S. Kivu	Lulingu	15	146	50	38	0	77	24	2	0	0	0	0
S. Kivu	Shabunda	21	146	50	35	0	70	22	2	0	0	0	0
S. Kivu	Mulungu	22	146	50	0	0	30	22	2	3	0	1	800
<b>Distributed to HZs</b>			<b>2527</b>	<b>836</b>	<b>591</b>	<b>12200</b>	<b>876</b>	<b>482</b>	<b>40</b>	<b>370</b>	<b>34</b>	<b>30</b>	<b>32982</b>
<b>Quantity Received by CRS</b>			<b>2527</b>	<b>836</b>	<b>600</b>	<b>27600</b>	<b>876</b>	<b>482</b>	<b>40</b>	<b>370</b>	<b>34</b>	<b>30</b>	<b>33000</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>9</b>	<b>15400</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>18</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>99%</b>	<b>44%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Total Distributed to HZs</b>			<b>7523</b>	<b>3390</b>	<b>1795</b>	<b>34700</b>	<b>1769</b>	<b>1406</b>	<b>115</b>	<b>1041</b>	<b>84</b>	<b>75</b>	<b>95982</b>
<b>Total Quantity Received</b>			<b>8418</b>	<b>3647</b>	<b>2083</b>	<b>54100</b>	<b>1808</b>	<b>1559</b>	<b>130</b>	<b>1109</b>	<b>91</b>	<b>89</b>	<b>119000</b>
<b>Total Balance</b>			<b>895</b>	<b>257</b>	<b>288</b>	<b>19400</b>	<b>39</b>	<b>153</b>	<b>15</b>	<b>68</b>	<b>7</b>	<b>14</b>	<b>23018</b>
<b>Total % Distributed</b>			<b>89%</b>	<b>93%</b>	<b>86%</b>	<b>64%</b>	<b>98%</b>	<b>90%</b>	<b>88%</b>	<b>94%</b>	<b>92%</b>	<b>84%</b>	<b>81%</b>

			OUTILS GESTION										
Region	Health Zone	CS	Quittancier	Journa recettes CS	Journal depenses CS	Journa recettes BCZS	Journal depenses BCZS	Journal Ventilation HGR	Journal recettes HGR	Journal depenses HGR	Bons Sortie caisse	Bons entrée caisse	Livre de caisse
KOC	Tshikaji	12	12	12	12	5	5	5	5	5	18	18	18
KOC	Bulape	15	15	15	15	5	5	5	5	5	18	18	18
KOC	Mutoto	13	13	13	13	5	5	5	5	5	16	16	16
KOC	Lubondai	19	19	19	19	5	5	5	5	5	18	18	18
KOC	Bibanga	14	14	14	14	5	5	5	5	5	17	17	17
KOC	Mpokolo	15	14	14	14	5	5	5	5	5	2	1	18
KAT	Mulongo	15	25	25	25	5	5	5	5	5	2	1	16
KAT	Kayamba	13	20	20	20	5	5	5	5	5	2	1	18
KAT	Lwamba	18	23	23	23	5	5	5	5	5	2	1	18
KAT	Songa	15	15	15	15	5	5	5	5	5	2	1	18
KAT	Malemba-Nkulu	7	7	7	7	5	5	5	5	5	2	1	18
KAT	Mukanga	13	13	13	13	5	5	5	5	5	2	1	18
KAT	Kabongo	14	14	14	14	5	5	5	5	5	2	1	18
KAT	Kitenge	16	16	16	16	5	5	5	5	5	2	1	18
KAT	Kinkondja	18	18	18	18	5	5	5	5	5	2	1	18
K. Or.	Dibindi												
K. Or.	Lodja												
K. Or.	Lusambo												
K. Or.	Omendjadi												
K. Or.	Pania Mutombo												
K. Or.	Vanga Kete Ototo												
<b>Distributed to HZs</b>			<b>238</b>	<b>238</b>	<b>238</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>107</b>	<b>97</b>	<b>265</b>
<b>Quantity Received by ECC</b>			<b>238</b>	<b>239</b>	<b>239</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>300</b>	<b>300</b>	<b>300</b>
<b>Balance</b>			<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>193</b>	<b>203</b>	<b>35</b>
<b>% Distributed</b>				<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>36%</b>	<b>32%</b>	<b>88%</b>
Katanga	Kanzenze	15	0	9	18	0	2	4	4	4	18	9	18
Katanga	Bunkeya	7	0	5	5	0	1	1	1	1	7	5	7
Katanga	Mutshatsha	13	0	9	13	0	2	4	4	4	14	13	14
Katanga	Lualaba	14	0	9	15	0	2	0	0	0	21	20	21
Katanga	Lubudi	16	0	10	10	0	2	3	3	3	17	20	17
Katanga	Fungurume	17	0	10	10	0	1	3	3	3	15	10	13
Katanga	Dilala	10	0	8	19	0	2	6	6	6	17	10	18
Katanga	Manika	13	0	9	15	0	2	6	6	6	20	25	20
S. Kivu	Kalonge	15	0	19	12	9	0	4	4	0	18	15	18
S. Kivu	Kalehe	10	0	12	7	9	0	4	4	0	12	15	12
S. Kivu	Minova	10	0	13	8	9	0	4	4	0	13	15	13
S. Kivu	Bunyakiri	23	0	28	17	9	0	4	4	0	16	20	14
S. Kivu	Katana	16	0	19	12	9	0	4	4	0	18	17	18
S. Kivu	Miti	17	0	20	13	9	0	4	4	0	19	17	19
S. Kivu	Idjwi	21	0	25	16	9	0	4	4	0	23	20	23
<b>Distributed to HZs</b>			<b>0</b>	<b>205</b>	<b>190</b>	<b>63</b>	<b>14</b>	<b>55</b>	<b>55</b>	<b>27</b>	<b>248</b>	<b>231</b>	<b>245</b>
<b>Quantity Received by WV</b>			<b>0</b>	<b>216</b>	<b>216</b>	<b>75</b>	<b>58</b>	<b>75</b>	<b>75</b>	<b>31</b>	<b>263</b>	<b>263</b>	<b>263</b>
<b>Balance</b>			<b>0</b>	<b>11</b>	<b>26</b>	<b>12</b>	<b>44</b>	<b>20</b>	<b>20</b>	<b>4</b>	<b>15</b>	<b>32</b>	<b>18</b>
<b>% Distributed</b>				<b>95%</b>	<b>88%</b>	<b>84%</b>	<b>24%</b>	<b>73%</b>	<b>73%</b>	<b>87%</b>	<b>94%</b>	<b>88%</b>	<b>93%</b>
Maniema	Pangi	12	0	0	0	0	0	0	0	0	0	0	0
Maniema	Kailo	15	0	0	0	0	0	0	0	0	0	0	0
Maniema	Kalima	16	0	0	0	0	0	0	0	0	0	0	0

			OUTILS GESTION										
Region	Health Zone	CS	Quittancier	Journa recettes CS	Journal depenses CS	Journa recettes BCZS	Journal depenses BCZS	Journal Ventilation HGR	Journal recettes HGR	Journal depenses HGR	Bons Sortie caisse	Bons entrée caisse	Livre de caisse
Maniema	Kampene	14	0	0	0	0	0	0	0	0	0	0	0
Maniema	Alunguli	6	0	0	0	0	0	0	0	0	0	0	0
Maniema	Kindu	10	0	0	0	0	0	0	0	0	0	0	0
Maniema	Ferekeni	6	0	0	0	0	0	0	0	0	0	0	0
Maniema	Obokote	9	0	0	0	0	0	0	0	0	0	0	0
Maniema	Lubutu	19	0	0	0	0	0	0	0	0	0	0	0
Maniema	Punia	12	0	0	0	0	0	0	0	0	0	0	0
<b>Distributed to HZs</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Quantity Received Merlin</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>													
S. Kivu	Bagira	22	0	0	0	0	2	2	2	2	8	8	8
S. Kivu	Kadutu	11	0	0	0	0	3	3	3	3	12	12	12
S. Kivu	Ibanda	14	0	0	0	0	4	0	4	4	16	16	16
S. Kivu	Nyangezi	10	0	0	0	0	3	3	3	3	11	11	11
S. Kivu	Kaziba	15	0	0	0	0	5	5	5	5	21	21	21
S. Kivu	Walungu	11	0	0	0	0	6	6	6	6	23	23	23
S. Kivu	Kaniola	7	0	0	0	0	3	3	3	3	13	13	13
S. Kivu	Mubumbano	10	0	0	0	0	3	3	3	3	14	14	14
S. Kivu	Mwana	19	0	0	0	0	2	2	2	2	7	7	7
S. Kivu	Ruzizi	15	0	0	0	0	3	3	3	3	13	13	13
S. Kivu	Lemera	20	0	0	0	0	5	5	5	5	19	19	19
S. Kivu	Uvira	25	0	0	0	0	4	4	4	4	16	16	16
S. Kivu	Bijombo	10	0	0	0	0	6	6	6	6	23	23	23
S. Kivu	Nundu	15	0	0	0	0	5	5	5	5	22	22	22
S. Kivu	Kamituga	20	0	0	0	0	4	4	4	4	16	16	16
S. Kivu	Mwenga	22	0	0	0	0	4	4	4	4	17	17	17
S. Kivu	Kalole	15	0	0	0	0	0	8	8	8	32	32	32
S. Kivu	Kitutu	26	0	0	0	0	6	6	6	6	24	24	24
S. Kivu	Lulingu	15	0	0	0	0	0	5	5	5	21	21	21
S. Kivu	Shabunda	21	0	0	0	0	50	5	5	5	19	19	19
S. Kivu	Mulungu	22	0	0	0	0	5	5	5	5	19	20	22
<b>Distributed to HZs</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>123</b>	<b>87</b>	<b>91</b>	<b>91</b>	<b>366</b>	<b>367</b>	<b>369</b>
<b>Quantity Received by CRS</b>			<b>0</b>	<b>349</b>	<b>0</b>	<b>90</b>	<b>123</b>	<b>87</b>	<b>91</b>	<b>91</b>	<b>366</b>	<b>367</b>	<b>369</b>
<b>Balance</b>			<b>0</b>	<b>349</b>	<b>0</b>	<b>90</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>				<b>0%</b>		<b>0%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>			<b>100%</b>	<b>100%</b>
<b>Total Distributed to HZs</b>			<b>238</b>	<b>443</b>	<b>428</b>	<b>138</b>	<b>212</b>	<b>217</b>	<b>221</b>	<b>193</b>	<b>721</b>	<b>695</b>	<b>879</b>
<b>Total Quantity Received</b>			<b>238</b>	<b>804</b>	<b>455</b>	<b>240</b>	<b>256</b>	<b>237</b>	<b>241</b>	<b>197</b>	<b>929</b>	<b>930</b>	<b>932</b>
<b>Total Balance</b>			<b>0</b>	<b>361</b>	<b>27</b>	<b>102</b>	<b>44</b>	<b>20</b>	<b>20</b>	<b>4</b>	<b>208</b>	<b>235</b>	<b>53</b>
<b>Total % Distributed</b>			<b>100%</b>	<b>55%</b>	<b>94%</b>	<b>58%</b>	<b>83%</b>	<b>92%</b>	<b>92%</b>	<b>98%</b>	<b>78%</b>	<b>75%</b>	<b>94%</b>

			Santé de Reproduction et PF										
Region	Health Zone	CS	Fiche CPN (x1000)	Fiche CPON (x1000)	Partogramme (x500)	Fiche Cons P.F (1000)	Registre Cons P.F (jeu x...filles)	Carte RDV ND	Regis. CPN	Registre CPON	Registre Accouchements	Depo Provera	Lo-femenal
KOC	Tshikaji	12	1500	1500	1500	500	15	700	20	20	20	3200	4800
KOC	Bulape	15	2000	1500	1500	1000	20	700	20	20	20	2400	2400
KOC	Mutoto	13	1500	1500	1500	500	20	600	20	20	20	1200	1200
KOC	Lubondai	19	2500	2000	2000	1000	30	1000	30	30	30	3200	2400
KOC	Bibanga	14	1848	1593	1593	1000	2	800	21	20	21	1200	1200
KOC	Mpokolo	15	4856	4185	4185	2500	23	1700	23	20	23	2800	1200
KAT	Mulongo	15	1155	995	948	600	24	500	24	24	24	1200	2400
KAT	Kayamba	13	1965	1694	1647	1000	20	1000	20	20	20	1200	1200
KAT	Lwamba	18	1986	1711	1665	1000	12	1000	12	12	12	1200	2400
KAT	Songa	15	2852	2458	2415	2000	44	1400	44	43	44	3200	2400
KAT	Malemba-Nkulu	7	3841	3310	3263	1000	24	1500	24	24	24	2400	2400
KAT	Mukanga	13	4736	4081	4034	1300	24	2000	24	24	24	2800	2400
KAT	Kabongo	14	4934	4252	4205	1300	38	2000	38	38	38	8400	3600
KAT	Kitenge	16	4998	4307	4261	1300	30	1200	30	30	30	2800	3600
KAT	Kinkondja	18	5348	4609	4562	1300	35	1400	34	35	35	5400	6000
K. Or.	Dibindi												
K. Or.	Lodja												
K. Or.	Lusambo												
K. Or.	Omendjadi												
K. Or.	Pania Mutombo												
K. Or.	Vanga Kete Ototo												
<b>Distributed to HZs</b>			<b>46019</b>	<b>39695</b>	<b>39278</b>	<b>17300</b>	<b>361</b>	<b>17500</b>	<b>384</b>	<b>380</b>	<b>385</b>	<b>42600</b>	<b>39600</b>
<b>Quantity Received by ECC</b>			<b>46500</b>	<b>39500</b>	<b>39500</b>	<b>17500</b>	<b>382</b>	<b>17500</b>	<b>385</b>	<b>385</b>	<b>385</b>	<b>65600</b>	<b>40800</b>
<b>Balance</b>			<b>481</b>	<b>-195</b>	<b>222</b>	<b>200</b>	<b>21</b>	<b>0</b>	<b>1</b>	<b>5</b>	<b>0</b>	<b>23000</b>	<b>1200</b>
<b>% Distributed</b>			<b>99%</b>	<b>100%</b>	<b>99%</b>	<b>99%</b>	<b>95%</b>	<b>100%</b>	<b>100%</b>	<b>99%</b>	<b>100%</b>	<b>65%</b>	<b>97%</b>
Katanga	Kanzenze	15	1500	1000	1000	0	4	0	0	10	30	0	1600
Katanga	Bunkeya	7	1500	1000	1000	0	4	0	15	10	20	1000	1600
Katanga	Mutshatsha	13	1000	1000	1000	0	4	0	15	10	30	0	1600
Katanga	Lualaba	14	1500	1000	1500	0	4	0	15	10	30	500	1600
Katanga	Lubudi	16	1500	1500	1500	0	4	0	20	13	40	1500	1600
Katanga	Fungurume	17	2000	2500	1500	0	4	0	30	13	40	1000	1600
Katanga	Dilala	10	2000	1500	1500	0	4	0	30	13	40	0	1600
Katanga	Manika	13	2000	1500	1500	0	4	0	30	13	40	0	1600
S. Kivu	Kalonge	15	1500	2500	2250	517	5	1000	18	35	23	0	1200
S. Kivu	Kalehe	10	1500	2500	2250	517	5	1000	18	35	23	0	1200
S. Kivu	Minova	10	1500	2583	2250	517	5	1000	18	35	23	0	1200
S. Kivu	Bunyakiri	23	1500	2500	2250	517	5	1500	18	35	23	0	1200
S. Kivu	Katana	16	1500	2583	2250	517	5	1500	18	35	14	0	1200
S. Kivu	Miti	17	1500	2583	2250	517	5	1000	18	35	20	0	1200
S. Kivu	Idjwi	21	1500	2500	2500	517	12	1500	16	36	21	0	1200
<b>Distributed to HZs</b>			<b>23500</b>	<b>28749</b>	<b>26500</b>	<b>3619</b>	<b>74</b>	<b>8500</b>	<b>279</b>	<b>338</b>	<b>417</b>	<b>4000</b>	<b>21200</b>
<b>Quantity Received by WV</b>			<b>32000</b>	<b>28749</b>	<b>28500</b>	<b>8000</b>	<b>352</b>	<b>8500</b>	<b>355</b>	<b>355</b>	<b>420</b>	<b>21400</b>	<b>22800</b>
<b>Balance</b>			<b>8500</b>	<b>0</b>	<b>2000</b>	<b>4381</b>	<b>278</b>	<b>0</b>	<b>76</b>	<b>17</b>	<b>3</b>	<b>17400</b>	<b>1600</b>
<b>% Distributed</b>			<b>73%</b>	<b>100%</b>	<b>93%</b>	<b>45%</b>	<b>21%</b>	<b>100%</b>	<b>79%</b>	<b>95%</b>	<b>99%</b>	<b>19%</b>	<b>93%</b>
Maniema	Pangi	12	1491	24	1325	352	22	0	22	24	22	232	0
Maniema	Kailo	15	2222	27	1975	525	25	0	25	27	25	346	0

			Santé de Reproduction et PF										
Region	Health Zone	CS	Fiche CPN (x1000)	Fiche CPON (x1000)	Partogramme (x500)	Fiche Cons P.F (1000)	Registre Cons P.F (jeu x...ffles)	Carte RDV ND	Regis. CPN	Registre CPON	Registre Accouchements	Depo Provera	Lo-femenal
Maniema	Kalima	16	1937	29	1722	457	26	0	26	29	26	301	0
Maniema	Kampene	14	2266	26	2014	535	23	0	23	26	23	352	0
Maniema	Alunguli	6	1210	10	1076	286	9	0	9	10	9	188	0
Maniema	Kindu	10	2250	17	2000	531	15	0	16	17	16	350	0
Maniema	Ferekeni	6	1227	14	1090	290	12	0	12	14	12	191	0
Maniema	Obokote	9	1438	19	1278	339	17	0	17	19	17	224	0
Maniema	Lubutu	19	2355	32	2093	556	30	0	30	32	30	366	0
Maniema	Punia	12	1605	27	1426	379	25	0	25	27	25	250	0
<b>Distributed to HZs</b>			<b>18001</b>	<b>225</b>	<b>15999</b>	<b>4250</b>	<b>204</b>	<b>0</b>	<b>205</b>	<b>225</b>	<b>205</b>	<b>2800</b>	<b>0</b>
<b>Quantity Received Merlin</b>			<b>26501</b>	<b>10225</b>	<b>28999</b>	<b>8550</b>	<b>339</b>		<b>340</b>	<b>340</b>	<b>320</b>	<b>11550</b>	<b>0</b>
<b>Balance</b>			<b>8500</b>	<b>10000</b>	<b>13000</b>	<b>4300</b>	<b>135</b>	<b>0</b>	<b>135</b>	<b>115</b>	<b>115</b>	<b>8750</b>	<b>0</b>
<b>% Distributed</b>			<b>68%</b>	<b>2%</b>	<b>55%</b>	<b>50%</b>	<b>60%</b>		<b>60%</b>	<b>66%</b>	<b>64%</b>	<b>24%</b>	
S. Kivu	Bagira	22	3000	2500	1000	500	0	250	15	14	10	1207	1283
S. Kivu	Kadutu	11	3000	2500	2000	500	0	375	21	19	14	1618	2446
S. Kivu	Ibanda	14	3000	2500	1000	500	0	250	26	16	23	1543	1869
S. Kivu	Nyangezi	10	1000	500	1500	500	0	250	9	7	3	1143	798
S. Kivu	Kaziba	15	1000	500	3000	750	0	500	19	14	7	1406	828
S. Kivu	Walungu	11	1000	2500	4500	750	0	500	24	38	21	2721	1038
S. Kivu	Kaniola	7	3000	2500	1500	500	0	250	26	25	16	1513	1038
S. Kivu	Mubumbano	10	3000	2500	2000	500	0	250	29	29	21	1722	1255
S. Kivu	Mwana	19	3000	2500	2500	500	0	500	18	18	10	921	1096
S. Kivu	Ruzizi	15	3000	2500	1500	500	0	500	23	26	21	1559	1972
S. Kivu	Lemera	20	3000	2500	2500	750	0	500	35	36	23	2243	1273
S. Kivu	Uvira	25	3000	2500	2000	750	0	375	31	33	21	1926	837
S. Kivu	Bijombo	10	3000	2500	3000	750	0	500	37	41	29	2457	932
S. Kivu	Nundu	15	3000	2500	3000	750	0	500	39	41	30	2483	1119
S. Kivu	Kamituga	20	3000	2500	3000	750	0	375	43	34	24	2265	1436
S. Kivu	Mwenga	22	1000	500	3500	750	0	500	12	19	9	1876	1476
S. Kivu	Kalole	15	1000	0	1000	950	27	0	23	23	23	1938	1430
S. Kivu	Kitutu	26	1000	0	1000	950	27	0	23	23	23	1877	968
S. Kivu	Lulingu	15	1800	2000	2200	500	27	0	27	23	23	1916	1262
S. Kivu	Shabunda	21	1000	0	1000	950	27	0	23	23	23	1938	1430
S. Kivu	Mulungu	22	1000	0	1000	950	27	0	23	23	23	1962	1614
<b>Distributed to HZs</b>			<b>45800</b>	<b>36000</b>	<b>43700</b>	<b>14300</b>	<b>135</b>	<b>6375</b>	<b>526</b>	<b>525</b>	<b>397</b>	<b>38234</b>	<b>27400</b>
<b>Quantity Received by CRS</b>			<b>45800</b>	<b>36000</b>	<b>43700</b>	<b>14300</b>	<b>135</b>	<b>6375</b>	<b>526</b>	<b>525</b>	<b>397</b>	<b>38234</b>	<b>27400</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>		<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Total Distributed to HZs</b>			<b>133320</b>	<b>104669</b>	<b>125477</b>	<b>39469</b>	<b>774</b>	<b>32375</b>	<b>1394</b>	<b>1468</b>	<b>1404</b>	<b>87634</b>	<b>88200</b>
<b>Total Quantity Received</b>			<b>150801</b>	<b>114474</b>	<b>140699</b>	<b>48350</b>	<b>1208</b>	<b>32375</b>	<b>1606</b>	<b>1605</b>	<b>1522</b>	<b>136784</b>	<b>91000</b>
<b>Total Balance</b>			<b>17481</b>	<b>9805</b>	<b>15222</b>	<b>8881</b>	<b>434</b>	<b>0</b>	<b>212</b>	<b>137</b>	<b>118</b>	<b>49150</b>	<b>2800</b>
<b>Total % Distributed</b>			<b>88%</b>	<b>91%</b>	<b>89%</b>	<b>82%</b>	<b>64%</b>	<b>100%</b>	<b>87%</b>	<b>91%</b>	<b>92%</b>	<b>64%</b>	<b>97%</b>

			Santé de Reproduction et PF						PALUDISME				
Region	Health Zone	CS	Ovrette	DIU	Condoms	Condoms Féminin	Tests RPR/cpn	Collier du Cycle Français	Moustiquaires I.I.	Registre I.T.N -5ans	Registre I.T.N femmes enceintes	Registre Rapport Mensuel ITN	Boite image paludisme
KOC	Tshikaji	12	4800	50	42000	500	3	100	5000	18	18	18	18
KOC	Bulape	15	2400	50	36000	500	3	98	5600	23	23	23	23
KOC	Mutoto	13	1200	25	12000	500	3	98	1600	20	20	20	20
KOC	Lubondai	19	2400	50	36000	500	3	100	5500	29	29	29	28
KOC	Bibanga	14	1200	50	9000	500	4	100	6300	22	22	22	21
KOC	Mpokolo	15	1200	25	24000	500	4	100	3000	27	27	27	23
KAT	Mulongo	15	2400	50	21000	500	2	95	0	36	36	36	24
KAT	Kayamba	13	1200	50	12000	500	3	95	2800	30	30	30	20
KAT	Lwamba	18	2400	50	12000	500	3	96	0	33	33	33	12
KAT	Songa	15	2400	50	30000	500	3	95	6400	23	23	23	44
KAT	Malemba-Nkulu	7	2400	50	24000	500	3	95	0	11	11	11	24
KAT	Mukanga	13	2400	50	33000	500	3	95	0	20	20	20	24
KAT	Kabongo	14	3600	75	45000	500	2	97	6200	21	21	21	38
KAT	Kitenge	16	3600	50	39000	500	2	100	900	24	24	24	30
KAT	Kinkondja	18	6000	75	45000	500	3	100	6000	27	27	27	33
K. Or.	Dibindi												
K. Or.	Lodja												
K. Or.	Lusambo												
K. Or.	Omendjadi												
K. Or.	Pania Mutombo												
K. Or.	Vanga Kete Ototo												
<b>Distributed to HZs</b>			<b>39600</b>	<b>750</b>	<b>420000</b>	<b>7500</b>	<b>44</b>	<b>1464</b>	<b>49300</b>	<b>364</b>	<b>364</b>	<b>364</b>	<b>382</b>
<b>Quantity Received by ECC</b>			<b>42000</b>	<b>750</b>	<b>423000</b>	<b>9000</b>	<b>41850</b>	<b>4700</b>	<b>49300</b>	<b>375</b>	<b>375</b>	<b>375</b>	<b>382</b>
<b>Balance</b>			<b>2400</b>	<b>0</b>	<b>3000</b>	<b>1500</b>	<b>41806</b>	<b>3236</b>	<b>0</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>0</b>
<b>% Distributed</b>			<b>94%</b>	<b>100%</b>	<b>99%</b>	<b>83%</b>	<b>0%</b>	<b>31%</b>	<b>100%</b>	<b>97%</b>	<b>97%</b>	<b>97%</b>	<b>100%</b>
Katanga	Kanzenze	15	1300	25	15000	400	873	310	1000	25	0	20	20
Katanga	Bunkeya	7	1300	25	15000	500	933	310	1000	7	0	7	20
Katanga	Mutshatsha	13	1300	25	15000	400	1240	308	1000	25	0	20	10
Katanga	Lualaba	14	1300	25	15000	500	1376	360	1000	25	0	20	20
Katanga	Lubudi	16	1300	25	15000	600	1418	365	1000	25	0	20	20
Katanga	Fungurume	17	1300	25	15000	400	1697	360	1000	10	0	10	20
Katanga	Dilala	10	1300	25	15000	600	1786	397	1000	25	0	20	28
Katanga	Manika	13	1300	25	15000	600	3114	387	1100	25	0	20	28
S. Kivu	Kalonge	15	1200	25	18000	428	1700	457	1000	0	0	17	17
S. Kivu	Kalehe	10	1200	25	16000	428	1700	457	1000	0	0	11	12
S. Kivu	Minova	10	1200	20	17000	428	1700	457	1000	0	0	12	12
S. Kivu	Bunyakiri	23	1200	25	17000	428	1900	518	1000	0	0	24	25
S. Kivu	Katana	16	1200	20	17000	428	2500	457	1000	0	0	17	20
S. Kivu	Miti	17	1200	20	18000	428	2200	457	1000	0	0	17	17
S. Kivu	Idjwi	21	2400	50	17000	428	1900	517	1000	0	0	24	25
<b>Distributed to HZs</b>			<b>20000</b>	<b>385</b>	<b>240000</b>	<b>6996</b>	<b>26036</b>	<b>6117</b>	<b>15100</b>	<b>167</b>	<b>0</b>	<b>259</b>	<b>294</b>
<b>Quantity Received by WV</b>			<b>12000</b>	<b>400</b>	<b>288000</b>	<b>8000</b>	<b>29842</b>	<b>6300</b>	<b>15100</b>	<b>186</b>	<b>0</b>	<b>325</b>	<b>348</b>
<b>Balance</b>			<b>-8000</b>	<b>15</b>	<b>48000</b>	<b>1004</b>	<b>3806</b>	<b>183</b>	<b>0</b>	<b>19</b>	<b>0</b>	<b>66</b>	<b>54</b>
<b>% Distributed</b>			<b>167%</b>	<b>96%</b>	<b>83%</b>	<b>87%</b>	<b>87%</b>	<b>97%</b>	<b>100%</b>	<b>90%</b>		<b>80%</b>	<b>84%</b>
Maniema	Pangi	12	0	21	12672	0	0	0	0	0	0	0	0
Maniema	Kailo	15	0	31	18884	0	0	0	0	0	0	0	0
Maniema	Kalima	16	0	27	16467	0	0	0	0	0	0	0	0

			Santé de Reproduction et PF						PALUDISME				
Region	Health Zone	CS	Ovrette	DIU	Condoms	Condoms Féminin	Tests RPR/cpn	Collier du Cycle Français	Moustiquaires I.I.	Registre I.T.N -5ans	Registre I.T.N femmes enceintes	Registre Rapport Mensuel ITN	Boite image paludisme
Maniema	Kampene	14	0	31	19259	0	0	0	0	0	0	0	0
Maniema	Alunguli	6	0	17	10285	0	0	0	0	0	0	0	0
Maniema	Kindu	10	0	31	19129	0	0	0	0	0	0	0	0
Maniema	Ferekeni	6	0	17	10426	0	0	0	0	0	0	0	0
Maniema	Obokote	9	0	20	12220	0	0	0	0	0	0	0	0
Maniema	Lubutu	19	0	33	20019	0	0	0	0	0	0	0	0
Maniema	Punia	12	0	22	13640	0	0	0	0	0	0	0	0
<b>Distributed to HZs</b>			<b>0</b>	<b>250</b>	<b>153001</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Quantity Received Merlin</b>			<b>10800</b>	<b>450</b>	<b>219421</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Balance</b>			<b>10800</b>	<b>200</b>	<b>66420</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>0%</b>	<b>56%</b>	<b>70%</b>								
S. Kivu	Bagira	22	1145	16	14807	525	9	218	0	0	0	12	20
S. Kivu	Kadutu	11	1490	20	19799	1002	36	299	0	0	0	17	27
S. Kivu	Ibanda	14	1450	20	18915	765	28	408	0	0	0	23	37
S. Kivu	Nyangezi	10	1111	16	14064	327	12	172	0	0	0	15	0
S. Kivu	Kaziba	15	1377	20	17319	339	3	344	0	0	0	30	0
S. Kivu	Walungu	11	2712	40	33692	425	12	599	0	0	0	30	54
S. Kivu	Kaniola	7	1392	20	17642	425	3	206	0	0	0	18	0
S. Kivu	Mubumbano	10	1164	24	21184	514	3	223	0	0	0	20	0
S. Kivu	Mwana	19	868	12	11311	449	12	120	0	0	0	14	32
S. Kivu	Ruzizi	15	1456	20	19073	808	27	326	0	0	0	18	30
S. Kivu	Lemera	20	2200	32	27631	512	12	490	0	0	0	27	45
S. Kivu	Uvira	25	1906	28	23753	343	129	408	0	0	0	23	37
S. Kivu	Bijombo	10	2441	36	30318	381	0	599	0	0	0	33	54
S. Kivu	Nundu	15	2454	36	30605	458	63	572	0	0	0	32	52
S. Kivu	Kamituga	20	2212	32	27881	588	15	258	0	0	0	23	37
S. Kivu	Mwenga	22	1359	28	24732	604	6	275	0	0	0	24	0
S. Kivu	Kalole	15	2259	40	18391	585	0	817	0	0	0	45	0
S. Kivu	Kitutu	26	2227	40	17684	396	0	395	0	0	0	35	0
S. Kivu	Lulingu	15	2248	40	3554	519	0	545	0	0	0	30	0
S. Kivu	Shabunda	21	2259	40	18391	585	0	490	0	0	0	27	0
S. Kivu	Mulungu	22	2272	40	18674	661	0	260	0	0		32	0
<b>Distributed to HZs</b>			<b>38002</b>	<b>600</b>	<b>429420</b>	<b>11211</b>	<b>370</b>	<b>8024</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>528</b>	<b>425</b>
<b>Quantity Received by CRS</b>			<b>38002</b>	<b>600</b>	<b>429420</b>	<b>11220</b>	<b>370</b>	<b>8024</b>	<b>21000</b>	<b>0</b>	<b>0</b>	<b>528</b>	<b>425</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>21000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>		<b>100%</b>				<b>100%</b>	
<b>Total Distributed to HZs</b>			<b>97602</b>	<b>1985</b>	<b>1242421</b>	<b>25707</b>	<b>26450</b>	<b>15605</b>	<b>64400</b>	<b>531</b>	<b>364</b>	<b>1151</b>	<b>1101</b>
<b>Total Quantity Received</b>			<b>102802</b>	<b>2200</b>	<b>1359841</b>	<b>28220</b>	<b>72062</b>	<b>19024</b>	<b>85400</b>	<b>561</b>	<b>375</b>	<b>1228</b>	<b>1155</b>
<b>Total Balance</b>			<b>5200</b>	<b>215</b>	<b>117420</b>	<b>2513</b>	<b>45612</b>	<b>3419</b>	<b>21000</b>	<b>30</b>	<b>11</b>	<b>77</b>	<b>54</b>
<b>Total % Distributed</b>			<b>95%</b>	<b>90%</b>	<b>91%</b>	<b>91%</b>	<b>37%</b>	<b>82%</b>	<b>75%</b>	<b>95%</b>	<b>97%</b>	<b>94%</b>	<b>95%</b>

			PALUDISME		PEV/CPS							
Region	Health Zone	CS	Registre Rapport Annuel I.T.N	Fiches Techniques P.N.L.P.	Registre Form. PEV 1	Registre Form. PEV 2	Registre Form. PEV 3	Registre Form. PEV 4	Carnet Fiches pointage PEV	Registre vacc PEV	Fiches de CPS	Registre CPS
KOC	Tshikaji	12	1	18	48	3	18	18	48	18	2000	20
KOC	Bulape	15	1	23	60	3	18	18	60	23	2000	20
KOC	Mutoto	13	1	20	52	3	18	18	52	20	1500	20
KOC	Lubondai	19	1	29	76	3	18	18	76	28	2500	30
KOC	Bibanga	14	1	21	56	3	18	18	115	21	1935	21
KOC	Mpokolo	15	1	23	60	3	18	18	120	23	5084	23
KAT	Mulongo	15	1	24	68	3	18	18	64	24	1173	23
KAT	Kayamba	13	1	21	56	3	18	18	80	20	2022	20
KAT	Lwamba	18	1	23	36	3	18	18	92	12	2044	12
KAT	Songa	15	1	44	120	3	18	18	100	44	2950	44
KAT	Malemba-Nkulu	7	1	24	68	3	18	18	64	24	3986	24
KAT	Mukanga	13	1	24	68	3	18	18	67	24	4924	24
KAT	Kabongo	14	1	24	104	3	18	18	92	38	5135	38
KAT	Kitenge	16	1	30	84	3	18	18	100	30	5200	30
KAT	Kinkondja	18	1	30	96	3	18	18	92	33	5565	35
K. Or.	Dibindi											
K. Or.	Lodja											
K. Or.	Lusambo											
K. Or.	Omendjadi											
K. Or.	Pania Mutombo											
K. Or.	Vanga Kete Ototo											
<b>Distributed to HZs</b>			<b>15</b>	<b>378</b>	<b>1052</b>	<b>45</b>	<b>270</b>	<b>270</b>	<b>1222</b>	<b>382</b>	<b>48018</b>	<b>384</b>
<b>Quantity Received by ECC</b>			<b>15</b>	<b>382</b>	<b>1100</b>	<b>45</b>	<b>280</b>	<b>280</b>	<b>1339</b>	<b>382</b>	<b>48000</b>	<b>385</b>
<b>Balance</b>			<b>0</b>	<b>4</b>	<b>48</b>	<b>0</b>	<b>10</b>	<b>10</b>	<b>117</b>	<b>0</b>	<b>-18</b>	<b>1</b>
<b>% Distributed</b>			<b>100%</b>	<b>99%</b>	<b>96%</b>	<b>100%</b>	<b>96%</b>	<b>96%</b>	<b>91%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
Katanga	Kanzenze	15		19	70	3	15	8	20	19	1000	20
Katanga	Bunkeya	7	0	20	70	3	15	8	5	19	1000	15
Katanga	Mutshatsha	13	0	20	45	1	10	8	70	20	1000	15
Katanga	Lualaba	14	0	19	70	3	15	7	70	19	1000	20
Katanga	Lubudi	16	0	23	60	3	15	20	70	15	2000	20
Katanga	Fungurume	17	0	19	70	3	15	7	20	18	2000	20
Katanga	Dilala	10	0	20	80	4	20	8	70	20	2000	20
Katanga	Manika	13	0	22	80	0	20	8	70	20	2000	20
S. Kivu	Kalonge	15	0	20	40	1	5	5	102	10	2000	30
S. Kivu	Kalehe	10	0	15	22	1	5	5	102	8	2000	24
S. Kivu	Minova	10	0	15	22	1	5	5	102	8	2000	24
S. Kivu	Bunyakiri	23	0	28	50	1	5	5	102	16	2000	30
S. Kivu	Katana	16	0	20	40	1	5	5	102	17	2000	24
S. Kivu	Miti	17	0	20	40	1	5	5	102	10	2000	24
S. Kivu	Idjwi	21	0	28	50	1	5	5	102	16	3000	40
<b>Distributed to HZs</b>			<b>0</b>	<b>308</b>	<b>809</b>	<b>27</b>	<b>160</b>	<b>109</b>	<b>1109</b>	<b>235</b>	<b>27000</b>	<b>346</b>
<b>Quantity Received by WV</b>			<b>15</b>	<b>330</b>	<b>1030</b>	<b>45</b>	<b>275</b>	<b>275</b>	<b>1233</b>	<b>349</b>	<b>35000</b>	<b>395</b>
<b>Balance</b>			<b>15</b>	<b>22</b>	<b>221</b>	<b>18</b>	<b>115</b>	<b>166</b>	<b>124</b>	<b>114</b>	<b>8000</b>	<b>49</b>
<b>% Distributed</b>				<b>93%</b>	<b>79%</b>	<b>60%</b>	<b>58%</b>	<b>40%</b>	<b>90%</b>	<b>67%</b>	<b>77%</b>	<b>88%</b>
Maniema	Pangi	12	0	0	0	0	0	0	0	0	2121	20
Maniema	Kailo	15	0	0	0	0	0	0	0	0	2424	22
Maniema	Kalima	16	0	0	0	0	0	0	0	0	2576	24

			PALUDISME		PEV/CPS							
Region	Health Zone	CS	Registre Rapport Annuel I.T.N	Fiches Techniques P.N.L.P.	Registre Form. PEV 1	Registre Form. PEV 2	Registre Form. PEV 3	Registre Form. PEV 4	Carnet Fiches pointage PEV	Registre vacc PEV	Fiches de CPS	Registre CPS
Maniema	Kampene	14	0	0	0	0	0	0	0	0	2273	21
Maniema	Alunguli	6	0	0	0	0	0	0	0	0	909	8
Maniema	Kindu	10	0	0	0	0	0	0	0	0	1515	14
Maniema	Ferekeni	6	0	0	0	0	0	0	0	0	1212	11
Maniema	Obokote	9	0	0	0	0	0	0	0	0	1667	15
Maniema	Lubutu	19	0	0	0	0	0	0	0	0	2879	27
Maniema	Punia	12	0	0	0	0	0	0	0	0	2424	22
<b>Distributed to HZs</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20000</b>	<b>184</b>
<b>Quantity Received Merlin</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>35000</b>	<b>299</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15000</b>	<b>115</b>
<b>% Distributed</b>											<b>57%</b>	<b>62%</b>
S. Kivu	Bagira	22	1	21	58	2	15	15	47	20	3000	13
S. Kivu	Kadutu	11	1	28	79	3	21	21	64	27	3000	18
S. Kivu	Ibanda	14	1	39	108	5	28	28	87	37	3000	21
S. Kivu	Nyangezi	10	1	0	0	0	0	0	58	0	2000	6
S. Kivu	Kaziba	15	1	0	0	0	0	0	117	0	4000	12
S. Kivu	Walungu	11	1	57	159	7	41	41	128	54	6000	34
S. Kivu	Kaniola	7	1	0	0	0	0	0	70	0	1000	21
S. Kivu	Mubumbano	10	1	0	0	0	0	0	0	0	1000	29
S. Kivu	Mwana	19	1	31	0	0	0	0	41	17	1000	17
S. Kivu	Ruzizi	15	1	47	87	2	23	23	70	30	3000	24
S. Kivu	Lemera	20	1	39	130	4	34	34	105	45	3000	29
S. Kivu	Uvira	25	1	57	108	5	28	28	87	37	3000	27
S. Kivu	Bijombo	10	1	40	159	5	41	41	128	54	3000	38
S. Kivu	Nundu	15	1	0	152	7	39	39	122	52	3000	37
S. Kivu	Kamituga	20	1	0	0	6	0	0	87	0	3000	29
S. Kivu	Mwenga	22	1	0	0	0	0	0	93	0	2000	16
S. Kivu	Kalole	15	1	0	0	0	0	0	175	0	2000	23
S. Kivu	Kitutu	26	1	0	0	0	0	0	134	0	2000	23
S. Kivu	Lulingu	15	1	0	0	0	0	0	117	0	2400	23
S. Kivu	Shabunda	21	1	0	0	0	0	0	105	0	2000	23
S. Kivu	Mulungu	22	1	3	27	0	15	11	2	10	2000	23
<b>Distributed to HZs</b>			<b>21</b>	<b>362</b>	<b>1067</b>	<b>46</b>	<b>285</b>	<b>281</b>	<b>1837</b>	<b>383</b>	<b>54400</b>	<b>486</b>
<b>Quantity Received by CRS</b>			<b>21</b>	<b>362</b>	<b>1067</b>	<b>46</b>	<b>285</b>	<b>281</b>	<b>1837</b>	<b>383</b>	<b>54400</b>	<b>486</b>
<b>Balance</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>% Distributed</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Total Distributed to HZs</b>			<b>36</b>	<b>1048</b>	<b>2928</b>	<b>118</b>	<b>715</b>	<b>660</b>	<b>4168</b>	<b>1000</b>	<b>149418</b>	<b>1400</b>
<b>Total Quantity Received</b>			<b>51</b>	<b>1074</b>	<b>3197</b>	<b>136</b>	<b>840</b>	<b>836</b>	<b>4409</b>	<b>1114</b>	<b>172400</b>	<b>1565</b>
<b>Total Balance</b>			<b>15</b>	<b>26</b>	<b>269</b>	<b>18</b>	<b>125</b>	<b>176</b>	<b>241</b>	<b>114</b>	<b>22982</b>	<b>165</b>
<b>Total % Distributed</b>			<b>71%</b>	<b>98%</b>	<b>92%</b>	<b>87%</b>	<b>85%</b>	<b>79%</b>	<b>95%</b>	<b>90%</b>	<b>87%</b>	<b>89%</b>