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FINAL PERFORMANCE EVALUATION

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SUBJECT:
INTEGRATED HEALTH PROJECT IN THE DEMOCRATIC REPUBLIC OF CONGO

At the request of the United States Agency for International Development (USAID), this publication was prepared independently by International Business and Technical Consultants, Inc. (IBTCI) and written by Swati Sadaphal and Annette Bongiovanni.

Final Performance Evaluation
Integrated Health Project in the Democratic Republic of Congo

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
AOP	Annual Operational Plan (Health Zone Plan *Annuel Operationnel*)
ARI	Acute respiratory infection
ASF	*Association de Santé Familiale* (Association of Family Health)
ASSP	*Accès aux Soins de Santé Primaire* (Access to Primary Health Care)
BC	*Bureau de Coordination* (IHP Coordination Bureau)
BCC	Behavior change communication
BCG	Bacillus Calmette-Guerin vaccine
CA	*Conseil d'Administration* (Administration Council)
CBO	Community-based organization
CDF	*Franc Congolais* (Congolese Franc)
CDR	Regional Distribution Center
CHW	Community health worker
C-IMCI	Community-based integrated management of childhood illness
CODESA	*Comité de Développement Sanitaire* (Health Development Committee)
CPA	Complementary package of activities
DFID	The Department for International Development
DHS	Demographic and health survey
DPS	*Division Provinciale de la Santé* (Provincial Division of Health)
DRC	Democratic Republic of Congo
DTP	Diphtheria, tetanus, pertussis
FBO	Faith-based organization
FBR	*Financement Basé sur les Résultats* (same as RBF)
FEDECAME	*Fédération des Centrales d'Approvisionnements en Médicaments Essentiels* (Federation of Essential Medicine Procurement Agencies)
FOSACOF	Fully functional service delivery point
FP	Family planning
GDRC	Government of the Democratic Republic of Congo
GRH	General reference hospital
HC	Health center
Hep B	Hepatitis B
HF	Health facility
HIV	Human immunodeficiency virus
HZ	Health Zone
ECZ	Health Zone Management Team
IBTCI	International Business & Technical Consultants, Inc.
IEC	Information, education, and communication
IHP	Integrated Health Project
IMCI	Integrated management of childhood illnesses
IR	Intermediate Result
IRC	International Rescue Committee
ITN	Insecticide-treated bed net
KAP	Knowledge, attitudes, and practices
KII	Key informant interview
LDP	Leadership Development Program
LLITN	Long-lasting insecticide-treated bed net
LMIS	Logistics Management Information System
LQAS	Lot quality assurance sampling
M&E	Monitoring & Evaluation
MDR-TB	Multi-drug resistant TB
MCH	Mother and child health
MNCH	Maternal, newborn, and child health
MOU	Memorandum of Understanding
MPA	Minimum package of activities
MSH	Management Sciences for Health
MSP	*Ministère de la Santé Publique* (Ministry of Public Health)
NGO	Non-governmental organization
NHDP	National Health Development Plan
NTD	Neglected tropical disease
ORS	Oral rehydration salts
OSC	Overseas Strategic Consulting, Ltd.
PLHIV	People Living with HIV and AIDS
PMP	Performance Monitoring Plan
PMTCT	Prevention of mother-to-child transmission of HIV

PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PP	Presumed pneumonia
PSI	Population Services International
RBF	Results-based financing (see FBR)
RDT	Rapid diagnostic test
RH	Reproductive health
SDP	Service Delivery Point
SIAPS	System for Improved Access to Pharmaceuticals
SNIS	National Health information System of the DRC
SP	Sulfadoxine-pyrimethamine
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TT	Tetanus Toxoid
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens' Fund
USAID	United States Agency for International Development
USD	US Dollars
USG	United States Government
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Definitions

Minimum package of activities (MPA): MPA includes curative, preventive, promotional, and community outreach activities provided by a versatile team of health center staff, who are themselves supervised by the health zone management steam. MPA is to be provided at all health centers. The term MPA-plus refers to the IHP support to MPA services.

Complementary package of activities (CPA): The complementary package of activities (CPA) includes the full MPA and the preventive, curative, and promotional activities that are organized within the framework of internal medical services, surgery, gynecology, obstetrics, and pediatrics. Management-related activities such as management of hospital health information; human, material, and financial resources; action research and supervision of health zone personnel are also included. CPA is to be provided at all general reference hospitals. The term CPA-plus refers to the IHP support to CPA services.

Halo bias: Responses filtered through a desire to provide favorable answers to some questions more than others.

Intra-interviewer bias: Responses with questionable accuracy due to cultural or language difficulties between zones.

Recall bias: Responses with questionable accuracy of recall. Recall bias is pronounced, for example, concerning medications obtained at a health clinic during a childhood illness.

Respondent bias: Responses filtered through a lens of the perceived advantage or disadvantage that might follow a particular response.

EXECUTIVE SUMMARY

Evaluation Purpose

International Business and Technical Consultants, Inc. (IBTCI) was contracted by the United States Agency for International Development in the Democratic Republic of the Congo (USAID/DRC) in December 2012 to conduct multiple external evaluations of Integrated Health Project (IHP or PROSANI, for the French acronym). USAID/DRC aimed to conduct a performance evaluation of IHP and a rigorous impact evaluation of IHP's results-based financing (RBF) pilot activity. These evaluations respond to USAID's new evaluation policy released in February 2011.

This IHP performance evaluation seeks to assess whether IHP has achieved its planned results at the end of the five-year implementation period, including improved access and availability of quality health services, and to understand how it is perceived and valued. IBTCI has conducted three previous IHP evaluations under the USAID/DRC contract, including the IHP Performance Evaluation, 2013,[1] Baseline Study for the Pilot RBF Impact Evaluation, 2013 and the Midterm Assessment of the Pilot RBF activity in 2014. This evaluation report presents only the final IHP performance evaluation results; the impact evaluation of the Pilot RBF component of IHP is presented as a separate evaluation report. The IHP performance evaluation's main audience is the USAID/DRC Mission, specifically the Program Office and Health Team; the implementing partner Management Sciences for Health (MSH) and its consortia; the *Ministère de la Santé Publique* (MSP) (Ministry of Public Health), and other stakeholders focused on DRC's health system development.

Project Background

The five-year IHP supported the DRC's National Health Development Plan (*Plan National de Développement Sanitaire* (PNDS), MSP, 2011–2015). The IHP's main goal was to improve the enabling environment for and increase the availability and use of high-impact services, products, and practices for family planning (FP), maternal, newborn, and child health (MNCH), nutrition, malaria, and tuberculosis (TB), Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), and water, sanitation, and hygiene (WASH) in target health zones (HZs). IHP was implemented by MSH and its partners the International Rescue Committee (IRC), and Overseas Strategic Consulting Ltd (OSC). IHP had two components: Component 1 corresponded to the first strategic focus of the DRC's PNDS, which is to strengthen the HZs' capacity to deliver high-impact services and products by addressing both the supply and demand sides of services; Component 2 corresponded to creating an enabling environment for strong HZs, with particular emphasis on leadership and governance and the provision of resources.

Under Component 1, there were three intermediate results (IRs):

> IR 1: Access to and availability of minimum package of activities plus/complementary package of activities plus (MPA-plus/CPA-plus) services in target HZs increased
>
> IR 2: Quality of MPA-plus/CPA-plus services in target HZs increased
>
> IR 3: Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target HZs

The fourth intermediate result, under Component 2, was:

> IR 4: Health sector leadership and governance in target provinces improved

1. While the conventional approach to a baseline study of a development program is to conduct it early in the program life, several administrative factors impeded this from happening. IBTCI was consigned by USAID/DRC to start this evaluation in 2013.

IHP worked in four of the DRC's original 11 (now 26) provinces: Kasaï Occidental, Kasaï Oriental, Katanga,[2] and South Kivu. IHP partnered with the MSP, many bilateral and multinational donors, faith-based organizations (FBOs), and non-governmental organizations (NGOs) to implement MPA-/CPA-plus. It also provided technical assistance for specialized health systems, strengthening interventions at all levels. IHP established eight provincial level coordination offices, or *Bureaux de Coordination* (BCs), to facilitate project implementation at HZs and the assisted health facilities' level (i.e., Health Centers (HCs) and General Referral Hospitals (GRHs.)) The project worked in 78 target HZs[3] and provided varying levels of support to 1,476 facilities (1,398 HCs and 78 GRHs). HIV and AIDS activities were implemented in Katanga province. WASH activities were concentrated in nine HZs instead of the original 80 assisted HZs.

Evaluation Questions, Methods, and Limitations

This final IHP performance evaluation is intended to answer the following key questions:

1. *To what extent has the project improved access to and availability of the minimum package of activities-plus/complementary package of activities-plus (MPA-plus/CPA-plus) services and products in target HZs?*
2. *Has the project improved the quality of key family health care services in target HZs?*
3. *Have knowledge, attitudes, and practices to support health-seeking behaviors increased in target HZs?*
4. *Has health sector leadership and governance in the four target provinces improved?*
5. *What are the external factors that hamper IHP activities from delivering better results?*
6. *How is IHP perceived and valued?*

The IHP performance evaluation is a prospective, non-experimental design (pre- and post-intervention) covering all four target provinces, with measurements taken at baseline and endline. MSH and its partners conducted a baseline study (IHP Phase I Baseline) on knowledge, practices and coverage of key health areas to evaluate demand for key family health services (Phase I) in May 2011. That study was accomplished through a household survey representative of MSH's BCs. A baseline health facility survey (Phase II (2013), conducted by IBTCI) provided benchmark data and information on the supply side of health services (MPA-plus) at the HCs and GRHs in the IHP targeted sites. The endline evaluation (2015) data collection methodology included a quantitative component (household survey, health facility surveys, client exit interviews) and a qualitative component (document review and key informant interviews (KIIs)). The total sample size of respondents at the endline evaluation includes: 96 health facilities (73 HCs and 23 GRHs); 1,704 households, 366 health center clients; and 123 key informants. The key informants included staff at HCs and GRHs; health managers from the MSP at national, provincial, district, and zonal levels; members of CODESAs (health development committees); community health workers (CHWs); managers and specialists working at IHP Kinshasa and field offices; representatives from IHP partners, Systems for Improved Access to Pharmaceuticals and Services (SIAPS), United Nations Population Fund (UNFPA), and USAID/DRC program staff. The health facility sampling was carried out using the Lot Quality Assurance Sampling (LQAS) method to select twelve facilities per coordination office.[4] The household sample selection followed a simple, two-stage cluster survey sampling of the catchment population of the selected facilities. The household respondents were women who had a child aged 0–23 months (if she had more than one child in that age group, the mother was interviewed in reference to her youngest child). Convenience sampling was used to select respondents for the client exit interviews and for key informant interviews. The endline evaluation data collection was implemented from May to September 2015.

The non-experimental pre/post intervention evaluation design does not account for non-IHP program influences on outcomes. Since non-IHP program sites were not compared with the IHP program sites, causal attribution is not possible. Baseline/endline comparison of outcome indicators can be influenced by some unobserved confounders, although these were minimized by using the same survey instruments, survey teams, and sampling frame. The main confounding factors, such as socio-demographic factors, were adjusted during the multivariate analysis. The time period between baseline and endline health facility surveys is very short (about two years) to observe any major changes in the health service coverage indicators. There is possible recall bias for the household/client interviews data on self-reported health status. Nonetheless, the recall period was only two weeks to minimize bias, while allowing for a reasonable sample size. The health provider interviews in the facility survey might be subject to respondent bias. Halo bias may be a factor since providers might have reported what they *should* do instead of what they *actually* do. To mitigate these biases, the questionnaire included some measures of direct observation.

2. Kasaï Occidental, Kasaï Oriental, and Katanga provinces have since been partitioned into 10 new provinces.

3. Of the initial 80 HZs, IHP dropped the Kalehe HZ (Bukavu) due to insecurity concerns and due to negotiations with other donors (for example, to have DFID-assisted *Accès aux Soins de Santé Primaire* (ASSP) take over Tshikaji) and therefore Tshikaji HZ (Kasaï Occidental) was dropped at USAID's request; and the revision of HZs that led to the split of Dikungu-Tshumbe HZ into two separate zones (Dikungu and Tshumbe).

4. The survey was administered across eight 'lots' or IHP BCs, three health zones per BC and four health facilities per health zone.

Findings

Access to and availability of MPA-plus and CPA-plus services and products

IHP's key activities under Intermediate Result (IR 1) were to improve access and availability of facility-based and community-based MPA-plus and CPA-plus health services and products. The IR 1 target was to offer MPA-plus (in HCs) and CPA-plus (in GRHs only) services in at least 80% of the targeted facilities (1509 HCs and 80 GRHs) by the end of IHP's five-year period of performance. However, based on the IHP performance evaluation recommendations at the end of 2013, IHP adjusted the IR 1 target to achieve expected results in at least 1,082 HCs and 64 GRHs (this target represents 80% of the current IHP-supported health facilities) and to decrease the number of supported MPA and CPA services components. The revised list of the MPA-plus/CPA-plus is included in the main body of this report, in Table 5, page 21. The health facilities provide a range of MPA-plus services including preventive, curative, and community health promotion services and products. MPA services provision is the major function of the HCs.

MPA-plus preventive services: The HC (n=73) survey results showed that the access and availability of child immunization, antenatal care (ANC), and FP services were maintained at high coverage levels (≥80%) between 2013 and 2015. The availability of services for growth and development monitoring for children under 5 improved by 9%; although not statistically significant, the coverage level was 78%. Similarly, the postpartum care services were available in 77% of surveyed HCs.

MPA-plus curative services: The access and availability of child health curative services (integrated management of childhood illnesses (IMCI)) were maintained at 100% coverage levels. The coverage for deworming or Vermiosis services showed a marked 36% improvement. A coverage level of 78% was seen for treatment services for deworming and sexually transmitted infections (STIs). The availability of nutritional rehabilitation is below 50%, but although not statistically significant, there is an improvement in the coverage by 11%. About 78% of the HCs provided normal childbirth and postpartum services, although most deliveries are facilitated by a traditional birth attendant (TBA) from the surrounding community. Availability of referral services for obstetrics complications remained low, at 46%. The availability of services related to blood transfusion, HIV and AIDS, and TB treatment and care at the HCs remained low (below 50%) without any significant changes between 2013–2015, whereas the availability for minor surgeries services was maintained at high coverage levels (96%).

MPA-plus health promotional services: The availability of health promotional services for health behaviors (ref: MPA list available to the evaluation team) related to condoms, food hygiene, and sanitation, exclusive breastfeeding, oral rehydration for diarrhea, and distribution of long-lasting insecticide-treated bed nets (LLITNs) for malaria prevention, were maintained at high coverage levels. The availability of health promotion services related to improvement of latrines demonstrated a significant increase of 24%, whereas iodized salt consumption promotion was reduced by 11% (not statistically significant).

MPA-plus services related products: The availability of stock for LLITNs, condoms, contraceptives, and vaccines on the day of survey was lower compared to the baseline, with a significant decrease in oral contraceptive pills and injectables. The availability of information, education, and communication (IEC) materials related to pre/postnatal care, maternal nutrition, breastfeeding, vaccination, vitamin A, and malaria improved significantly. However the availability of IEC materials for prevention and treatment of STIs and acute respiratory infections was reduced. Sixty percent of HCs routinely prescribed iron and folic acid, and 76% provided vitamin A to antenatal women, similar to the results seen at the baseline. About 64% of HCs conducted health information sessions on postpartum care, not a significant change from the baseline. Distribution of insecticide-treated bed nets in the community was reduced significantly by 13% at endline. IHP Annual Report 2014 highlighted that there was a chronic year-long shortage of LLITNs in the targeted HZs and the situation improved gradually in 2015 (IHP Project Year 5, Q3 April–June Report, 2015). However, Kamina, Kole, Tshumbe, and Kolwezi coordination offices were still facing LLITNs stockouts (this period coincided with the health facility survey in 2015).

CPA-plus services: CPA services provision is the major function of the hospitals. The GRH survey results (n=23) showed that the access and availability of services related to emergency obstetrics, prevention of prevention of mother-to-child transmission (PMTCT) services, genital fistula prevention, and consultations of HIV-positive patients remained at the coverage level between 49% and 79%. The availability of long-acting and permanent methods of family planning improved, but not at a statistically significant level. TB diagnosis and treatment, as well as blood transfusion services at GRHs, were maintained at high coverage levels (≥80%) between 2013 and 2015.

MPA- or CPA-related accessibility factors: About 88% of health facilities remain open seven days a week. The facilities (HCs or GRHs) did not show any significant changes in the number of any particular type of health worker. All (100%) of GRHs and 8% of HCs had at least one doctor,[5] 95% of GRHs and

5. The MSP norm does not require a physician to be based in each HC.

80% of HCs had at least one nurse A2 or A1,[6] 73% of GRHs and 65% of HCs had at least one nurse A3, 52% of GRHs and 15% of HCs had at least one certified birth attendant, and 56% of GRHs and 65% of HCs had at least one lay midwife/village birth attendant. Household survey results show that, in all, only 55% of mothers had at least one contact with any type of health worker (i.e., access to a health worker) in the month preceding the survey, very little change from the baseline (58%). All KII respondents said that IHP had improved access of the target population to the available health services and products substantially during the five years of the project's lifespan. On probing, 90% of KIIs highlighted IHP's support in provision of medication and medical supplies to the target health facilities in the form of providing direct subsidies and collaboration with other partners, including SIAPS. Other major reasons for improved access and availability provided were: IHP's health service provider's technical trainings (72% of KIIs); establishment of the community outreach sites (54% of KIIs); and renovation support for HCs and GRHs (50% of KIIs).

Quality of key family health care services

Facility operations and management: The analysis of quality indicators related to facility operations and management show that the health facility staff reportedly received refresher training in technical areas during the past 3 years. Facility supervision by MSP staff in the past 2 years also improved significantly. The average number of outpatient attendance at HCs during the past 12 months was about 2,749 in 2015 compared to 2,250 in 2013. The average nurse-to-catchment population ratio is 0.27 per 1000 in 2015, same as in 2013. The predominant sources for the resupply of medicines and medical supplies from HZ offices and Regional Distribution Centers (CDRs) was 53%, followed by international NGOs (24%), and private suppliers (23%). The delays in supply of drugs and medicines, including contraceptives, continued at similar rates (88% in 2015, 85% in 2013). There was a significant reduction in the predominant causes of delay reported due to "CDRs being depleted," while the reported reason of "inadequate transportation" increased significantly. There were no significant changes in basic facility infrastructure. However, there were major declines in the availability of continuous water supply in the facility building (i.e., piped water supply; a water container with a tap is not included) and access to transportation at all times. Only 34% of HCs reportedly had access to transportation at all times and the most common method was a bicycle (70%), followed by a 4-wheel drive vehicle (25%) and a motorcycle (5%). The availability of disinfectant for infection control improved by 7%. There was a significant decline in "boiling" and at the same time, an improvement seen in "autoclave or dry/steam heat" as the predominant method of sterilization. Similarly, there was a significant change in the type of medical waste management used by the health facilities. The predominant method of medical waste disposal in 2015 was incineration (67%). Clients exiting the HCs were asked to report their level of satisfaction for the services received on the day of their HC visit. Ninety-two percent (92%) of mothers with children aged 0-56 months expressed satisfaction with the overall quality of services received. The perception of waiting time to see a service provider being appropriate decreased significantly. Other perception of quality-of-care variables (level of privacy in the examination room, the amount of time the service provider spent with the client, and the service provider attitude toward the client) remained at more than 90% satisfaction levels. Ninety-three percent (93%) of KII respondents said that IHP had improved the quality of key family services in the targeted HZs since the project started. Some 79.2% of KIIs reported improvements in the quality of facility services. During the performance evaluation conducted in 2013, 72% of key informants stated that the quality of key family service had improved since IHP started implementation, while 25% of informants said that service quality was about the same. The main reasons for quality improvement provided were IHP's assistance with facility supervision (72%), health worker training, use of facility management tools at facilities (51%), provision of subsidies for vehicles, mediations, equipment, and fuel (51%), facility renovation provided by IHP (33%)—and 25% mentioned the fully functional service delivery point (FOSACOF) training had made a real difference in the range and quality of the services provided at the related facilities.

Quality of childhood illness-related services: Malaria, diarrhea, and pneumonia are major morbidity and mortality factors in children under five years. IHP aimed to support IMCI and improve the quality-of-care provision related to childhood illnesses. Household survey (n=1704) findings show that, in the two weeks preceding the survey, 35% of children under 23 months reportedly suffered from a cough or presumed pneumonia (PP), 38% reportedly suffered from fever or suspected malaria, and 31% of children reportedly suffered from diarrhea. About 26% of mothers of children with PP reported difficulty in breathing and sought treatment in a health facility. At the facility, 81% of children with PP were treated with antibiotics, significantly higher than the IHP baseline household survey results of 61%. The DRC Ministry of Health recommended guidelines in cases of child fever is to provide antimalarial medication. Only 34% of children with fever who came to a health facility received antimalarial treatment. Fifty-six percent (56%) of mothers of children with diarrhea gave oral rehydration therapy (ORT) to her child. Only 14% of children with diarrhea received zinc supplements. Contact with a health care worker in the month preceding the survey was mostly associated with a child who had either fever, PP, or diarrhea and was brought to the health facility for appropriate treatment. On

6. The education of nurses is either A1, A2, or A3, where A1 consist of three year university degree (Bac plus 3 years), A2 consist of four year secondary school (Bac) and A3 is two year secondary school (Bac minus 2 years). According to MSP norms, A1 and A2 can be Chief Nurse in a health facility.

multivariate analysis, only mothers' literacy was found connected to children receiving appropriate care in a facility as compared with other demographic variables.

Quality of maternal, newborn, and child health services: On examining the quality of maternal, newborn, and child health service indicators, the household survey results show that 93% of women reported receiving antenatal care. About 78% of mothers received at least one dose of Tetanus Toxoid (TT) injection and 50% of mothers with children aged 0–23 months received at least two doses of TT vaccination while pregnant. Forty-five percent (45%) of mothers reported that the HC nurse had assisted during childbirth. A nurse-midwife *(accoucheuse)* assisted 19% of women, 17% of births were assisted by a *sage-femme*, 5% by a doctor, 8% by other family members, and 6% were assisted by a TBA.[7] The mothers and newborns examined within three days after childbirth improved significantly between baseline and endline (18% vs. 27%). Similarly, mothers receiving vitamin A supplements within two months of childbirth improved by 11%. About 73% of mothers with children aged 12–23 months reported that they either currently have a vaccination card or have had in the past. Only 12% provided vaccination cards with written records. The vaccination rates remained at 30–60% with similar coverage rates of Polio-Diphtheria, Tetanus, and Pertussis (DTP1) and Hepatitis B (Hep B) vaccines. Similarly, the measles and yellow fever vaccination coverage rates were low.

Knowledge, attitudes, and practices (KAP) supporting health-seeking behaviors

KAP related to family planning: Household survey (n=1704) results show that 89% of women knew at least one method of modern contraceptive,[8] a significant improvement from the baseline (83%). The modern contraceptive use by non-pregnant mothers with a child aged 0–23 months increased significantly from 8 to 13%. The most common method used was male condoms (61%), followed by injections (16%) and pills (14%).

KAP related to maternal, newborn, and child health: Ninety-three percent (93%) of women reported receiving antenatal care. Forty-nine percent (49%) of mothers reported that they had at least four antenatal consultations while pregnant with their youngest child, compared to 43% at the baseline—a significant improvement. The prevalence of facility births[9] remained high at 86%. According to 43.2% of KII respondents, counseling training provided by IHP for the increased delivery of FP/reproductive health (RH) services had resulted in improved health-seeking behaviors related to family planning, maternal, and child health care services. About 28% of women had heard about genital fistula at the endline, compared to 37% at the baseline, which is significantly lower.

KAP related to child nutrition: Ninety-six percent (96%) of mothers reported breastfeeding their child at 6–23 months. Breastfeeding initiation within the first hour after birth was 51% and exclusive breastfeeding for children 0–6 months was 54% at the endline; the rates are similar to the baseline (52%). At the endline, about 88% still continue to breastfeed after 6 months of child's age and 81% of mothers gave other food or liquid to the child besides breast milk at the endline. Similar rates were seen at the baseline survey.

KAP related to HIV and AIDS and malaria: Fourteen percent (14%) of surveyed mothers, assessed through six knowledge questions on the household survey,[10] showed a thorough understanding of HIV. This is not a statistically significant decrease from the baseline (18%). However, 56% of mothers reported receiving HIV test results in the past 12 months, which is a significant increase from the baseline (37%). Significant improvements were seen in LLITN use. Seventy-three (73%) percent of pregnant women, and 56% of children under 23 months, slept under an LLITN the night before the survey versus 47% and 32% at baseline respectively.

KAP related to WASH: The presence of soap for hand washing in the household remained low, at about 50%. Forty-two percent (42%) of households used nothing at all and 8% used ash or mud for hand washing. Fifty-six percent (56%) reported using an improved water source;[11] only 4% used a water purification method. Fourteen percent (14%) of households did not use any kind of toilet. Pit latrines without slabs were used in 76% of households and only 8% of households had flushing toilets or pit latrines with covers.

Eighty-seven percent (87%) of KII respondents said that health-seeking behaviors in the target communities had improved. About 61.2% of KII respondents noted that the increased delivery of both facility- and community-based IEC/Behavior Change Communication (BCC) activities, including WASH. Some 57.6% of respondents said that CODESAs had promoted the use of the available health services through health education sessions held in community and the CODESAs' referrals of complicated cases to HCs. Also, 7.2% of respondents considered IHP's results-based financing (RBF) initiative as a key intervention that improved health-seeking behaviors successfully in the zones where it was implemented.

Health sector leadership and governance

According to 72% of KII respondents, health sector leadership and governance had improved. Upon probing, the predominant

7. A *sage-femme* is an MSP-affiliated traditional birth attendant who the MSP has invited to attend births in health centers. A TBA is an attendant available from within the community, not authorized by the MSP. In both cases, they may have little or no formal training.
8. Modern methods of contraceptive include the pill, female and male sterilization, IUD, injectable, implants, male and female condoms and emergency contraception.
9. Facility births indicator data provides self-reported information on whether the childbirth occurred in a health center, it does not provide the information whether the childbirth was assisted by a skilled personnel.
10. Household survey (Module 1.4, Questions VS2-7)
11. Covered water sources or tap supply.

reason provided was the Leadership Development Program training (LDP) and tools provided by IHP (54% of KIIs). Health facility managers and staff members took more initiatives to both plan and implement service delivery. Some 72% of respondents said that HZ and provincial managers had learned skills to solve their operational problems and develop action plans using the available resources, without needing much oversight from senior managers. Some 61.2% of respondents said that there was increased ownership of and accountability in targeted areas based on IHP's support in promoting use of decision-making tools. A review of IHP annual reports indicated that IHP's LDP was designed specifically for health sector staff and managers who had major roles in HZ strengthening. The staff trained in LDP carried out leadership projects in collaboration with stakeholders at various levels to improve key family health services delivery. In Project Year 4, a total of 189 LDP were implemented and 94% of the LDP projects had attained their expected results by the end of that year.

HZ managers carried out most of the monthly and quarterly supervisory activities of the health facilities, while IHP provided technical support. This included accompanying the managers on their visits and offering fuel and funding subsidies to facilitate supervision (72% of KIIs). Health facility survey results described earlier show significantly improved monthly facility supervision rates. Some 21.6% of KII respondents said the establishment of Community Champions by the IHP had strengthened CODESA participation and representation in planning of health services awareness generation activities, including vaccination campaigns in the target areas. Community Champions strategy, initiated in Project Year 4, involved training a select number of motivated community members in management and leadership skills such as developing an action plan, defining targets, and incorporating sustainability strategies for health awareness and action. By the end of Year 4, 15 Community Champions were established. Review of the IHP yearly and quarterly reports indicated that IHP provided technical and financial support to all 78 targeted HZs for the development of annual operational plans (AOPs). In year 2013, 99% of target HZs had developed AOPs. At end of 2014-Q3, 65% of HZs and at the end of 2015-Q3, 56% of HZs had developed their AOPs validated by their respective *Conseil d'Administration* (CA).[12] The reports noted that the pace of development of AOPs is inconsistent among HZs due to operational time conflict challenges between HZ management teams (ECZs) and Division Provinciale de la Santé/Provincial Division of Health (DPS) in planning advisory board meetings to validate draft AOPs.

External factors hampering IHP activities from delivering better results

Some 68.4% of KII respondents said that the lack of a functional Logistics Management Information System (LMIS) in HZs and at facilities to order and track medicines and medical supplies had been the biggest constraint on the delivery of MPA/CPA services encountered over the five years of IHP. According to 61.2% of KII respondents, the delayed procurement and delivery of medicines, medical supplies, contraceptives, and medical equipment from CDRs had a negative impact on the delivery of services at HCs, GRHs, and in the surrounding communities. IHP's annual and quarterly reports indicated that the SIAPS project supports IHP in ensuring the availability of essential medicines in health facilities. Frequent stockouts of essential medicines and supplies occurred throughout the IHP implementation due to procurement-related delays from the suppliers, International Dispensary Association and the HZs' respective regional distribution centers (CDRs).

The poor infrastructure of targeted facilities, including the lack of durable, standard equipment based on MSP standards, was considered by 64.8% of respondents to have negatively affected service delivery. Poor health facility infrastructure is also noted from the facility survey results. There was no change in infrastructure variables between baseline and endline surveys. Only 27% of health facilities had a source of electricity and there was a major decline in the availability of continuous water (i.e., piped water supply, a water container with a tap is not included) in the facility building (35% in 2015 vs. 51% in 2013). Some 46.8% of respondents said poor road conditions and the lack of appropriate vehicles for the difficult road trips in the targeted zones had decreased the ability to carry out regular quarterly/monthly supervision activities. Thirty-two percent (32.4%) of respondents highlighted the lack of MSP-paid salaries and living allowances ("primes") for the majority of service providers.

From the document review, it was revealed that the IHP faced continued implementation challenges due to security issues, particularly in the South Kivu province. The routine data quality audits conducted by IHP identified major data inconsistencies between facility records and the national health information system (SNIS) in all provinces. Major inaccuracies were noted in the basic health facility data records and data reporting forms. There is no system for routine data checks, monitoring, and data feedback on the reported SNIS data.

12. The CA is a health sector administrative body, typically comprised of health zone head physician, reference hospital director, DRC territorial administrator, donor representatives working in the zones.

Perceptions of IHP

IHP strengths: Some 86.4% of KII respondents said that IHP's timely delivery of subsidies for monthly and quarterly supervisory visits and meetings, including at the CODESA level, had promoted provider and community ownership of the integrated programmatic activities. Overall, the technical assistance and training provided by IHP was considered by all KII respondents to be excellent. A review of IHP annual reports 2011–2014 indicated that IHP provided competency-based trainings on various clinical and facility management topics to health staff, including nurses, mid-wives, community health workers, and HZ managers. Health facility survey data showed a significant increase in the percentage of facility staff reporting being trained in the past three years (100% in 2015 vs. 89% in 2013). Some 43.2% of respondents were impressed with the quality and experience of IHP's technical advisors and managers at both the provincial and regional levels and at their ability to facilitate planning for and management of service delivery. Some 27.8% of respondents said the trainings by IHP, including FOSACOF training and clinical trainings (particularly IMCI) of staff at targeted health facilities, was one of the project's real strengths. Some 18% of respondents felt that IHP's Community Champions strategy was remarkably successful, greatly appreciated in the targeted zones, and the initiative can be replicated elsewhere. Some 18% of respondents said that IHP's renovation of and provision of equipment at targeted HCs had strengthened their capacity to deliver quality health services. Finally, 18% of respondents said that the existence of IHP's policies and norms for the establishment of quality standards was one of the project's strengths. The support by IHP under the RBF intervention was appreciated and it was hoped that IHP will continue this intervention to ensure the sustainability of health services in the target communities.

IHP weaknesses: All KII respondents (100%) said that the IHP had insufficient budgetary resources to address the need for facility renovations and that the procurement and delivery of medicines and medical supplies provided to the assisted facilities in the targeted HZs did not satisfy the need, due to poor quantification of needs by those same facilities. Another weakness of the IHP identified by 39.6% of respondents was the lack of establishing a functional LMIS at all the targeted HCs and GRHs, meaning that monthly and quarterly stock quantification and status reporting did not occur on a regular basis. Some 18% of respondents said that IHP's work plan did not include all the priorities that were reflected in the annual work plans (AOP) of the HZs IHP had targeted. Some 14.4% of respondents cited IHP's lack of technical assistance and support for the implementation of WASH activities in all the targeted zones as a distinct weakness.

Conclusions and Recommendations

EVALUATION QUESTION 1:

To what extent has the project improved access to and availability of MPA-plus and CPA-plus services and products in the targeted health zones?

Conclusions:

- According to the vast majority of stakeholders interviewed, IHP improved access and availability of MPA-plus and CPA-plus services and products.
- Access to and availability of antenatal care, family planning, child vaccination services, and integrated management of childhood illnesses were sustained at high coverage levels in IHP-supported health facilities.
- IHP interventions supported the significant improvement of the care and treatment of worm infestation and the promotion of improved latrines.
- During the life of the project there was a marked and significant increase in the availability several health promotion materials.

Recommendations:

- Provide additional technical assistance support and material support (including budgetary support) to service delivery points to improve the availability and access to MPA-plus and CPA-plus services and products.

EVALUATION QUESTION 2:

Has the project improved the quality of key family services in targeted health zones?

Conclusions:

- IHP has improved the quality of key family services by supporting facility personnel training and regular supervision.
- The coverage of nutrition, HIV, malaria, TB, and WASH services is low. However, the quality of these services where they are available is improving.
- IHP introduced effective infection control practices and improved the availability of medications. However, there is no change in the basic infrastructure of the health facilities and frequent stockout of medications and vaccines occured during the life of the project.
- As the facility client volume has increased, the number of health facility staff has remained unchanged. The nurse-to-population ratio is far below the WHO recommendation of at least 2 nurses per 1000 population.

Recommendations:

- Continue competency-based trainings to service providers.
- Assume a more holistic and comprehensive approach to monitoring the quality of care, incorporating health-seeking behaviors as well as other proximate determinants such as personnel and structural inputs.
- Support development of supply-chain management in the IHP-supported HZs and facilities.
- Support facility renovations with durable local materials to conform to standards and improve basic amenities.
- Considering IHP activities are increasing the quantity of services provided, forward planning by the MSP is warranted to meet this demand with an adequate supply of nurses deployed in the health facilities.

EVALUATION QUESTION 3:

Have knowledge, attitudes, and practices to support health-seeking behaviors increased in targeted health zones?

Conclusions:

- Health-seeking behaviors of the target populations has improved for an array of preventive and curative services in catchment areas of project-assisted health facilities.
- Health practices for postnatal care and WASH related activities in target areas were not improved.

Recommendations:

- Support the development and dissemination of innovative BCC approaches that can contribute to behavior change and increased demand for services.
- Prioritize and provide needed technical support to project-assisted HZs in WASH-related activities with increased collaboration of the target communities to ensure sustainability. Promotion of slab-covered latrines and proper hand washing should be the top priorities.

EVALUATION QUESTION 4:

Has the health sector leadership and governance in the four targeted provinces improved?

Conclusions:

- Health sector leadership and governance in target areas (provinces, HZs, health facilities, and the related communities) has improved in the past five years.

Recommendations:

- Expand provision of LDP training to all levels (DPS, HZs, health facilities, and community levels) of the country's health system.
- Ensure and increase timely involvement of the national and provincial level health authorities in the development of integrated work plans that include HZs' AOPs.
- Continue support of development of community organizations with training in LDP and support for the establishment and expansion of Community Champion activities to support CHWs activities in the communities.
- Strengthen the capacities of provincial and HZ management teams to improve the quality of data analysis and evidence-based decision-making.

EVALUATION QUESTION 5:

What are the external factors that hamper IHP activities from delivering better results?

Conclusions:

- IHP faced a wide range of external factors that hampered integrated delivery of services. The majority of those factors were external and beyond the implementing partners' capacity to address.

Recommendations:

- Support increased coordination among donors to systematically improve the country's supply chain system for medicines, medical/laboratory supplies, and equipment.
- Work with the Federation of Essential Medicine Procurement Agencies (FEDECAME), CDR, the DPS and target HZs on integration of services, improved quantification, procurement, storage, and distribution of needed medicines and medical supplies to functioning health facilities in the target HZs.
- Mobilize additional resources from other development partners to support coordinated development of all of the country's HZs.

EVALUATION QUESTION 6:

How is the IHP perceived and valued?

Conclusions:

- IHP's supported the implementation of PNDS in the target provinces.
- IHP support with direct implementation of most of the components of the PNDS was appreciated by the MSP and the development partners.
- IHP trainings and capacity-building that included FOSACOF, LDP training and application, renovation, and the overall system strengthening are highly valued and appreciated.
- IHP weaknesses, while pertinent, were not substantial, nor were they an impediment to positive progress.

Recommendations:

- USAID should build on the positive accomplishments of the IHP to expand service delivery of high impact interventions to other target areas in the target provinces.
- USAID should also coordinate its development efforts with other donors, including MSP, so that all the identified gaps for service delivery can be addressed with adequate budgets to ensure optimum coverage of the target population with access and availability of primary health care services.

Evaluation Purpose and Questions

Evaluation purpose

In September 2010, the United States Agency for International Development (USAID)/Democratic Republic of Congo (DRC) awarded the five-year $139,767,129 Integrated Health Project (IHP or PROSANI in French), Cooperative Agreement #AID-OAA-A-10-00054, to Management Sciences for Health (MSH) and its partners International Rescue Committee (IRC) and Overseas Strategic Consulting Ltd (OSC). The five-year IHP (October 2010–September 2015) supports the DRC National Health Development Program (*Plan National de Développement Sanitaire,* or PNDS) and has two components,"Health Services" and "Other Health Systems," that are designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 78 health zones (formerly 80) in four of the DRC's original 11 (now 26) provinces: Kasaï Occidental, Kasaï Oriental, Katanga,[13] and South Kivu.

International Business and Technical Consultants, Inc. (IBTCI) was contracted by USAID/DRC in December 2012 to conduct multiple external evaluations of IHP. USAID/DRC requested a performance evaluation of IHP and a rigorous impact evaluation of IHP's results-based financing (RBF) pilot activity. These evaluations respond to USAID's new evaluation policy released in January 2011. The IHP performance evaluation assesses whether IHP has achieved its planned results at the conclusion of the five-year implementation period, and to understand how it is perceived and valued. The results and recommendations from this study will inform future programming of USAID/DRC's health portfolio. This evaluation report presents only the final IHP performance evaluation results; the impact evaluation of the pilot RBF component of IHP is presented as a separate evaluation report.

13. Kasaï Occidental, Kasaï Oriental, and Katanga provinces have since been partitioned into 10 new provinces.

Intended audience

The main intended audience of the IHP performance evaluation is the USAID/DRC Mission (specifically the Program Office and the Health Team) the implementing partners (MSH and its consortium of partners that includes the *Ministère de la Santé Publique* (MSP), and other stakeholders that are active in the country's health sector. USAID/DRC will use the knowledge generated about the magnitude and determinants of the IHP's performance to refine future IHP designs and/or introduce improvements into future health development programs.

Evaluation questions

The IHP performance evaluation was guided by the following questions:

1. *To what extent has the project improved access to and availability of the minimum package of activities-plus/ complementary package of activities-plus (MPA-plus/CPA-plus) services and products in target health zones?*
2. *Has the project improved the quality of key family health care services in target health zones?*
3. *Have knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones?*
4. *Has health sector leadership and governance in the four target provinces improved?*
5. *What are the external factors that hamper IHP activities from delivering better results?*
6. *How is IHP perceived and valued?*

A complete description of this evaluation's statement of work is provided in Annex A.

The IHP performance evaluation is a prospective non-experimental design (pre- and post-intervention) covering all four target provinces, with measurements taken at baseline and endline. The design and implementation of the evaluation was closely coordinated with USAID/DRC and MSH. Due to a

number of factors, including inevitable changes in evaluation teams and the fact that IBTCI was hired to start this evaluation in late 2012, data collection for the baseline evaluation was conducted after two years of program implementation. MSH and its partners conducted a baseline household survey (IHP Phase I Baseline) on knowledge, practices and coverage of key health areas to evaluate demand for key family health services (Phase I) in May 2011. In line with USAID/Washington's Evaluation Policy (2011), USAID/DRC sought an external contractor for Phase II to focus on the supply side of health services, including the quality, accessibility, and availability of key family health interventions provided in the targeted facilities. (The MSH 2011 household survey had collected data only on the demand side per women of reproductive age). The baseline health facility survey, Phase II conducted by IBTCI in 2013, provided benchmark data and information on the supply side of health services (MPA-plus) at the HCs and GRHs in the IHP HZs for the following priority health services, namely: preventive, curative, promotional, and facility management support. MPA-plus services cover family planning (FP), maternal, newborn, and child health (MNCH), nutrition, malaria, tuberculosis (TB), human immunodeficiency virus (HIV) and acquired immunodeficiency virus (AIDS), and water, sanitation, and hygiene (WASH). (See definitions, page vi, and Table 5, page 21, for detail on what MPA-plus and CPA-plus services entail.)

The endline evaluation (2015) data collection methodology includes quantitative component (household survey, health facility surveys, client exit interviews) and qualitative component (document reviews and key informant interviews). The final evaluation (2015) compared findings with the MSH Phase I household survey baseline (2011) and IBTCI Phase II study (2013) to answer the final performance evaluation questions.

Project Context

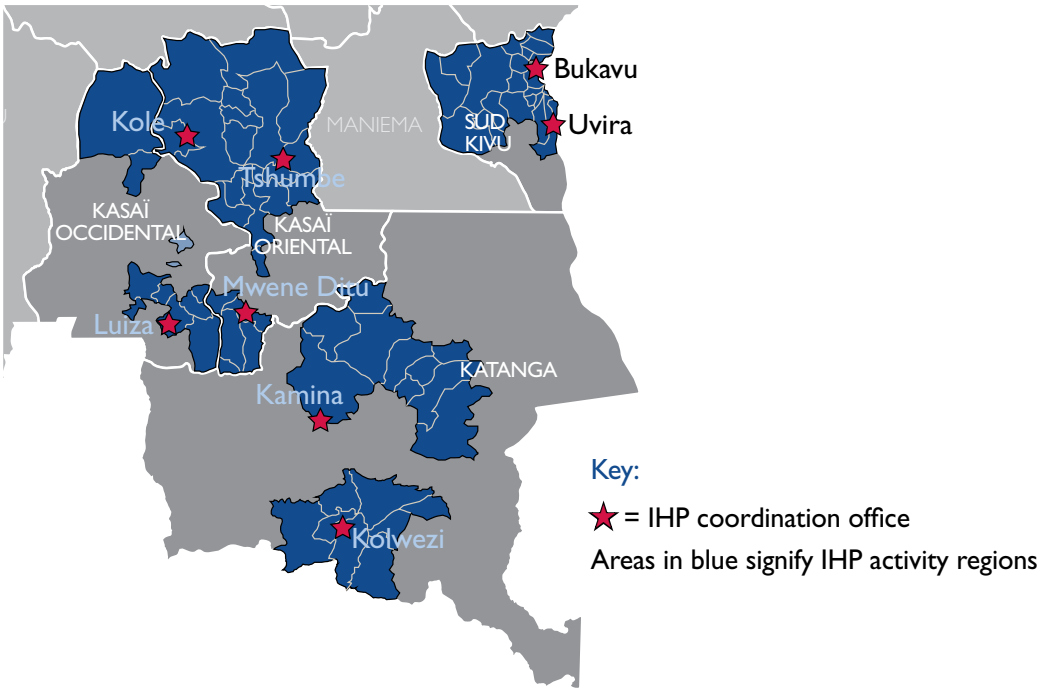
The DRC is a fragile country in need of considerable development and reconstruction across sectors. The conflict that broke out in the region in the 1990s engulfed the nation in a decade of political, economic, and social turmoil from which it is slowly, and gradually, recovering. Given the nation's vast land area and immense mineral and precious metal deposits, it has the potential to be a major economic player on the continent. Unfortunately, the country has historically struggled on two fronts—the first being the monetization of these resources (the DRC is ranked 184th out of 189 countries for the "ease of doing business") and the second, the conversion of financial capital into successful and stable political, economic, and health care institutions (The World Bank Group, 2016). The *per capita* Gross National Income is estimated to be $380, and is one of the lowest in the world (The World Bank, 2014). An estimated 63% of the nation's 74 million inhabitants live below the poverty line.

The DRC is an unfortunate example of a country that has struggled to translate what economic growth it has experienced through exportation of natural resources to international markets into better health and human development results. The country has a United Nations Development Program (UNDP) Human Development Index (HDI) score of .433, ranking it 176th out of 188 countries. Fortunately, the country's HDI has been on the rise since 2000. In 2011, the country was ranked at the bottom of the list (United Nations Development Programme, 2015). Due to the population size, age demographics (52% of the population is under 15), magnitude of poverty, and history of violent political instability, the health system is nascent and vulnerable (Ministry of Monitoring, Planning and Implementation of the Modern Revolution; Ministry of Public Health; ICF International, 2014).

The centralized system of coordination among health facilities, called the zone-based service, was designed 30 years ago. The country has struggled to actually implement a system that meets the needs of its population. Improving the quality and use of essential health services at the national level is a key component of the Government of the DRC's strategy to reduce poverty; it is also an essential goal of the MSP. Several reforms are currently under way to improve health system performance. In 2006, the MSP introduced the Health System Strengthening Strategy which was designed to organize, integrate, and fortify a health system. Plagued with limited financing, ineffective management of resources, and dismal transportation infrastructure, the country faced multifaceted challenges to the successful delivery of basic health services to a population spread across an immense geographic area. A new PNDS (2011–2015) was developed in March 2010. At present, the health system in the DRC has three tiers: 1) a central level, which includes the MSP and provides health care policy and oversight; 2) an intermediate level, which consisted of 11 provincial health departments until June 2015, when the country was divided into 26 provinces and 48 administrative health districts; and 3) the peripheral level, which consists of 516 HZs, comprised of over 8,126 health centers and 376 GRHs (Ministry of Public Health, 2010).

The five-year IHP supported the GDRC's PNDS for 2011–2015. The PNDS delineates four strategies to: 1) strengthen the HZs; 2) support the HZs in human resources for health, drug supply, health financing system, rehabilitation/reconstruction of infrastructure, and provision of equipment, and health information systems; 3) strengthen governance and leadership in the health sector; and 4) improve inter-sectoral

Figure 1. Map of IHP areas of activity



collaboration. The IHP's main mission was to improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for FP, MNCH, nutrition, malaria, and TB, HIV and AIDS, and WASH in target HZs (Management Sciences for Health, 2010–2015).

IHP had two components. Component 1 corresponded to the first strategic focus of the DRC's PNDS, which is to strengthen the HZs' capacity to deliver high-impact services, and products by addressing both the supply and demand sides of services. Under Component 1, the goals were: 1) to increase access and availability of key family health care services, as defined by MPA-plus/CPA-plus; 2) to improve quality of MPA/CPA-plus services; and 3) to increase knowledge and practices that support health-seeking behaviors. Under Component 1, there were three intermediate results (IRs) (Management Sciences for Health, 2010–2015):

> IR 1: Access to and availability of a minimum package of activities plus/complementary package of activities plus (MPA-plus/CPA-plus) services in target HZs increased
>
> IR 2: Quality of MPA-plus/CPA-plus services in target HZs increase
>
> IR 3: Knowledge, attitudes, and practices (KAP) to support health-seeking behaviors increased in target HZs

Component 2 of the project corresponded to the DRC's PNDS' second strategic pillar in six priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new technologies; and improved health system management. The expected outcomes under this component are strengthened leadership and governance, and improved provision of resources. The fourth intermediate result under Component 2 was:

> IR 4: Health sector leadership and governance in target provinces improved

The IHP's cooperative agreement document does not specifically describe the project's "theory of change." The overarching technical strategy used by IHP to integrate activities across health system sectors, levels, and geography is "people-centered health systems strengthening." At the heart of the strategy is outreach to providers, health authorities, community organizations, and families with evidence-based techniques they can use to impact the health system in ways they experience as meaningful and sustainable. The detailed IHP Results Framework is provided in Annex B. IHP worked with many bilateral and multinational donors, faith-based organizations (FBOs), and non-governmental organizations (NGOs) to implement MPA/CPA-plus; IHP staff provided additional technical assistance for specialized health systems strengthening interventions at all levels (Management Sciences for Health, 2010–2015).

IHP established eight provincial level coordination offices or IHP *Bureaux de Coordination* (BCs) to facilitate project implementation at HZs and the assisted health facilities (i.e., HCs and GRHs).[14] The project worked in 78 target HZs

14. These coordination bureaus are also referred to as "Supervision Areas" as described in the *MSH Baseline Survey Report*, August 2011.

and provided varying levels of support to 1,476 facilities (1,398 HCs and 78 GRHs). Of the initial 80 HZs, IHP dropped Kalehe HZ (Bukavu) due to security concerns. At USAID's request, the Department for International Development (DFID)-assisted *Accès aux Soins de Santé Primaire* (ASSP) took over Tshikaji HZ in Kasaï Occidental Province. The revision of HZs led to the split of Dikungu-Tshumbe HZ into two separate zones (Dikungu and Tshumbe) (Management Sciences for Health, 2010–2015).

During the implementation phase of IHP (from 2011 to 2015), there were some notable changes in the overall population of the DRC. According to the most recent Demographic and Health Survey (DHS, 2013–14), women of reproductive age have an average of 6.6 children, a slight increase from 2007 (6.3%). In urban areas, the fertility rate is 5.4 children per woman, compared to rural areas (7.3). A woman with a secondary education has on average 2.9 children, while a woman with no education has 7.4, a truly staggering gap that highlights the key role education plays in positive health outcomes. Twenty-three percent (23%) of all children under 5 are severely stunted, an indication of severe malnutrition. The country has seen a successful push for increased vaccination coverage, with 45% of all children aged 12–23 months receiving all recommended vaccines (one dose each of Bacillus Calmette-Guerin vaccine (BCG) and measles, and three doses each of DTP/Pentavalent and polio). Six percent (6%) of that same demographic has received no vaccinations. Remarkably, the under-5 mortality rate has decreased since 2007, from 148 to 104/1000 live births, a significant and commendable achievement. Here again, there is considerable variation between provinces. South Kivu has the highest under-5 mortality rate: 139 per 1,000, while North Kivu has the lowest, 65 per 1,000 (Ministry of Monitoring, Planning and Implementation of the Modern Revolution; Ministry of Public Health; ICF International, 2014).

There has been a significant emphasis on FP education, with 88% of women and 95% of men reporting knowledge of at least one modern FP method. However, this knowledge has not motivated the desired behavior, as only 8% of married women are using a modern method and contraceptive use has remained virtually unchanged since 2007. Another perplexing challenge is that of the maternal mortality rate. The maternal mortality rate is inversely related to the percentage of births assisted by a skilled provider. However, 80% of births were assisted by a skilled provider in the five years before the DHS 2013–14 survey, and during the same period there were 846 maternal deaths per 100,000 live births (Ministry of Monitoring, Planning and Implementation of the Modern Revolution; Ministry of Public Health; ICF International, 2014).

Although HIV testing has nearly doubled since 2007, approximately 80% of the population, both male and female, has never been tested for HIV. HIV prevalence among the adult population aged 15–49 is estimated at 1.2% and has not changed since 2007. Twenty-three percent (23%) of children aged 6–59 months tested positive for malaria, and 17% of children under 5 had diarrhea in the two weeks before the survey. Fifteen percent (15%) of those children received no treatment at all (Ministry of Monitoring, Planning and Implementation of the Modern Revolution; Ministry of Public Health; ICF International, 2014).

While the DRC is still facing complex health challenges across program elements, there has been notable progress made on a variety of significant indicators related to its population health. If the nation continues on its path toward stability, it will continue to attract increased private investment and permit greater donor engagement, which will enable the nation to provide for its citizens and reach its considerable potential.

EVALUATION METHODS AND LIMITATIONS

Evaluation Design

The IHP performance evaluation methodology employed a prospective non-experimental design (pre- and post-intervention) covering all eight of IHP's coordination offices. The evaluation used a mix of quantitative and qualitative methods. The quantitative methodology was designed to examine temporal changes in key outcome indicators between the baseline and endline. These methods included health facility surveys, household surveys, and client exit interviews. To ensure comparability of findings, the quantitative methodology used the same survey instruments and sampling frame during the baseline and endline data collection. The qualitative method was designed to provide an in-depth and better understanding of the dynamics of change from the perspectives of program beneficiaries, communities, and program implementers, among others. Annex C provides survey questionnaires and the semi-structured KII instrument used during the evaluation. The unit of analysis of the health facility survey is by BCs and type of facility (HC or GRH). The unit of analysis of the household survey is by coordination office. The unit of analysis of the client exit survey is by the type of client—women of reproductive age, pregnant women, and mothers with children aged 0–59 months attending the facility. The qualitative methods included document review and key informant interviews (KIIs) with 123 respondents.

Evaluation Team

The endline performance evaluation team included Annette Bongiovanni, Team Leader; Swati Sadaphal, Evaluation Specialist/Data Analyst; and Jean-Lambert Mandjo Aholoma, IHP Specialist/Survey Coordinator. Armand Utshudi, Public Health Specialist carried out the KIIs, and fieldwork was supported by six Field Supervisors. A team of six data collectors and 12 interviewers carried out the health facility surveys, client exit interviews, and household surveys. Whenever possible, nurses and doctors were used as data collectors. Logistical and administrative support was provided by staff based in Kinshasa and the IBTCI home office. The team selected interviewers and data collectors on the basis of their skills, experience in conducting surveys, familiarity with the interview locations, and knowledge of the local language/dialect of the survey sites. Once in the provinces, the survey team divided into three sub-teams in order to maximize the geographic reach of the evaluation study (Annex D: Field Implementation Plan). Each sub-team included one supervisor overseeing two data collectors (focused on the facility surveys and client exit interviews) and two interviewers (focused on the household survey) per survey site. All questionnaires were conducted in French or local languages. In each IHP coordination office, a new team of data collectors and interviewers was selected to ensure that the data collection team had local citizens who knew the local languages and cultures. In addition, the local personnel helped the evaluation team to navigate into undocumented/unmarked remote areas. The endline data collection period was from May to September 2015.

Sampling Strategy

Facility survey

The Lot Quality Assurance Sampling (LQAS) method was used to select facilities for the facility survey. The survey was administered across eight "lots" or coordination offices, which reflect almost the same IHP implementation structure of the eight IHP coordination offices located in the project target areas. For the selection of the sample, the LQAS sampling framework originally included a random selection of approximately 19 sites (health facilities)[15] for interviews in each coordination office, for a total of 152 sites that could be surveyed for the entire area covered by the project. The sample size was determined with a precision level of 92% and 95% confidence intervals. Later, due to resource constraints, it was decided to select 3 HZs from each coordination office and 9 HCs, including one GRH from each HZ. This constituted a total of 72 sample health facilities with an equal distribution across the eight coordination offices. Due to the lower statistical power with a sample size of 72 health facilities, an additional 24 health facilities (one more HC in each HZ) were included to confirm an acceptable confidence level of approximately 90% over a total of (72+24) 96 facilities.

Household survey

The Household Survey was administered to a sample of 25 randomly selected households in each health center's catchment area or Health Area.[16] A household is defined as a domestic unit consisting of the members of a family who live together, along with non-relatives, and where at least one member is a mother (the respondent) of a child aged 0–23 months. Interviewed households were selected using a simple, two-stage cluster survey sampling approach. For each Health Area, a list of villages within five kilometers distance from the HC was created.[17] One village from each Health Area was randomly selected from the village list. After randomly selecting a village in the health area, the survey team proceeded to a predefined point (such as the village chief's home) and selected the first household at that starting point. The person answering the door at the household was asked if there was a mother with a child aged 0–23 months available for interview. If there was an eligible respondent, that household was selected for completion of interview, assuming the woman did not decline. If the woman had more than one child aged 0–23 months, the interview was conducted in reference to the youngest child among them. After the interview, the interviewers were instructed to follow the predefined strategy guided by their supervisor (i.e., go to the n^{th} household in X direction). When an eligible respondent was not present in the household to receive the interviewer, the interviewer returned later in the day. If on the repeat visit the respondent was unavailable or was not willing to be interviewed, the interviewer went to the very next household to determine if there was an eligible respondent. This process continued until all 25 household interviews in the predetermined direction were completed for the selected village. The unit of analysis of the household survey is by coordination office.

Client exit survey

Respondents for the client survey were selected by convenience sampling method to include women of reproductive age, pregnant women, and mothers with children aged 0–59 months attending the facility. Women departing the HC after receiving the health service were screened to determine if they were of reproductive age (15–49 years) and available for and agreed to be surveyed. All consenting and eligible women were given the client exit interview. The unit of analysis of the client exit survey is by the type of client—women of reproductive age, pregnant women, and mothers with children aged 0–59 months attending the facility.

Key informant interviews

A total of 123 semi-structured in-depth interviews were conducted across all of the coordination offices with: health managers and other professionals at HCs and GRHs; staff from the MSP at national, provincial, district, and zonal levels; members of CODESAs (health development committees or community councils) and community health workers (CHW); managers and specialists working at IHP field offices; IHP partners; and the USAID/DRC health team (see Table 1, below). A list of interviewees is found in Annex E, List of Persons Interviewed. The key informant interviews were conducted in French and Lingala and transcribed into English for subsequent analysis.

Table 1. Number of key informant interviews by respondent level

Level of health system	
National	12
Provincial	24
Health zone	47
Community/health facility	40
Total	123

15. A health facility is defined as a fixed structure where health services are provided to the communities residing in nearby areas. Health facilities include health centers and general reference hospitals.
16. The MSP catchment populations are comprised of Health Zones. Each Health Zone is comprised of approximately 15–20 Health Areas.
17. A limit of five kilometers was imposed to ensure the village could be reached within a reasonable time frame so as to complete data collection.

Data Collection Methods

Document review

The evaluation team reviewed various documents from MSH and USAID, including the IHP household baseline survey conducted by MSH in 2011, DRC IHP quarterly/annual reports from 2011–2015, training materials, and all other documents related to IHP development and implementation. The document review provided a foundation for understanding and developing operational strategies for the evaluation. The health facility survey questionnaires, client exit interviews, and key informant interview guide were designed based on evaluation questions. The documents were used to assess the coverage and the extent of project interventions and implementation during data analysis and triangulation. Annex F, Reference List and Annex K, Bibliography, provide a list of IHP program documents and other references used by the team.

Facility survey

A structured facility questionnaire with mostly close-ended and some open-ended questions was used to collect information. The facility survey focused on MPA-plus services, as they are supposed to be provided at all HCs and GRHs in the 78 target zones (see Annex G for an initial and revised list of MPA-plus and CPA-plus services). The facility survey was used to collect data on the following analytical domains:

- Availability of health services.
- Quality of care provision in priority health service areas that included family planning, maternal health, child health, HIV and AIDS, TB, and malaria interventions.
- General quality of facility including infrastructure, and facility operations including patient attendance, availability of supplies, equipment, and personnel.

The facility questionnaire included questions for data collectors to record facility observations notes on infrastructure, medications and documentation reviews. Some direct observation was built-in the tool as well. Annex H provides further detail on the baseline and endline health facility sample distribution. About 92% of the facilities surveyed at the baseline were surveyed again at the endline. Some 8% of health facilities were substituted due to the fact that IHP was no longer supporting those facilities. The majority (87%) of facilities were located in rural areas, 1% in semi-urban and 12% in urban areas of the target provinces.

During baseline data collection, a change was made due to rebel activity in one coordination office to include 73 HCs and 23 GRHs, still totaling 96 facilities. The same selected facilities sample at baseline were surveyed again in the endline sample. The sample size achieved was twelve facilities (three HCs and one GRH in each of the three HZs) in each coordination office.

Household survey

The household survey collected information on socio-demographic characteristics of households, mothers' perspectives on the quality of care, and knowledge, attitudes, and practices with regard to key family care service-seeking behaviors. The survey questionnaire included separate modules to collect specific data on children who had been sick, due to presumed pneumonia or fever/suspected malaria or diarrhea in the past two weeks preceding the survey. A total of 1,704 household respondents completed the household questionnaire. Table 2, opposite, provides the distribution of household surveyed in each coordination office. All respondents (100%) were mothers of children aged 0–23 months between the ages of 15 and 55 years. About 85% of households were rural. The average age of the respondent mother was 27 years (SD: ±7 years, range 15¬55 years) and the mean age of her youngest child was 9.8 months (SD: ±6.7 months). Only 39% of respondent mothers could read and write; 13% could not read and 45% could neither read nor write.

Client exit survey

All consenting and eligible women were administered the client exit interview at each HC surveyed. A structured questionnaire comprised of four modules with open- and closed-ended questions was used. A total of 366 clients participated across the eight coordination offices (Table 3).

Summary of evaluation methodology and sample size

A summary of the evaluation methodology including total sample size resulting from each data collection method in 2013 and 2015 is presented in Table 4, opposite.

Ethical considerations

As part of the training, the entire data collection and data entry team was trained on how to maintain the ethical aspect of the evaluation and in particular, the protection of human subjects. Oral informed consents, read through a written document, were administered to inform respondents of the purpose, process, potential risks, use, and confidentiality of the information and their right to refuse to participate at any time. Health facility managers were interviewed in private in a facility consultation room. Clients were interviewed at a short distance from the facility, but out of hearing range from facility staff. Mothers of

Table 2. Household sample size distribution by coordination office		
Site N°.	IHP coordination office	Total households, n (%)
1	Luiza	198 (12%)
2	Mwene-Ditu	222 (13%)
3	Kole	201 (12%)
4	Tshumbe	207 (12%)
5	Kolwezi	225 (13%)
6	Kamina	225 (13%)
7	Bukavu	204 (12%)
8	Uvira	222 (13%)
Total		1,704

Table 3. Number of respondents for client exit surveys, 2015		
Site N°.	IHP coordination office	Number interviewed, n (%)
1	Luiza	38 (10%)
2	Mwene-Ditu	49 (13%)
3	Kole	24 (7%)
4	Tshumbe	44 (12%)
5	Kolwezi	75 (20%)
6	Kamina	35 (10%)
7	Bukavu	57 (16%)
8	Uvira	44 (12%)
Total		366

Table 4. Summary of evaluation methodology and sample size		
Evaluation design component	Baseline evaluation	Endline evaluation
Evaluation sites	8 IHP coordination offices	8 IHP coordination offices
Data collection timeline	April – August 2013	May – September 2015
Methodology (sample size)‡	■ Health facility surveys (n=96 HFs: 73 HCs, 23 GRHs) ■ Client Exit Interviews at HCs (n=293) ■ Household survey (n=208, conducted by MSH, 2011) ■ Key Informant Interviews (n=85) ■ Document review	■ Health facility surveys (n=96 HFs: 73 HCs, 23 GRHs) ■ Client Exit Interviews at HCs (n=366) ■ Household survey in the health areas of the HCs (n=1,704) ■ Key Informant Interviews (n=123) ■ Document review
‡The non-response rate for all quantitative surveys as well as key informant interviews was nil.		

children aged 0–23 months were interviewed at their home to ensure privacy. Respondents did not receive any form of inducement or incentive to participate in the study and survey teams reiterated their external role to IHP/PROSANI and the MSP. The information collected was anonymous and no personal identification, such as names, was collected which could be used for tracing purposes after the data collection. The electronic database was kept in password-protected computers, used only by the senior evaluation team members. Additionally, unique identifiers were used in place of respondent's names in the final database.

Pilot testing and training of data collection team

Pilot testing and training of Field Supervisors was held during April 6–10, in Mitendi, near Kinshasa. Among the six supervisors, two served in that role during the IHP baseline evaluation and two served as research assistants during the RBF Midterm Assessment. A five-day training was organized to accommodate different methodologies, including presentation of key terms, concepts, and procedures, item-by-item review of questionnaires, mock (pair) interviews, questions and answers, role-play, and feedback sessions. The training was assisted by training manuals, questionnaire modules, and forms and checklists. In the field, for each coordination office a new group of data collectors and interviewers was trained and selected, so surveys could be conducted in local languages. All selected data collectors and interviewers went through a three-day practical survey training in the coordination office with one day devoted to the facility survey, one day focused on the household survey, and the last day focused on the client exit survey.

Another layer of data quality control came from the IBTCI home office. Data quality assurance field visits were conducted by the senior evaluation team members to participate in the Field Supervisor training and supervise the pilot study, monitor the trainings of data collectors and interviewers, as well as in providing technical inputs during direct observation of the data collection. The data from the paper questionnaires were computerized using MS-Excel® by six experienced Data Entry Administrators at IBTCI home office under the direct supervision of the Evaluation Specialist. Double data entry was

employed for about 10% of the survey questionnaires. Data cleaning and post-data entry coding were also part of the data quality assurance procedures. Incomplete responses, missing values, or outliers were handled using standard data quality assurance techniques including dummy variables, checking for data variance, and data normality using statistical analysis.

Data analysis

Quantitative data analysis focused primarily on comparing key outcome indicators between the baseline and endline using descriptive statistics and multivariate methods. A data analysis plan was created, reviewed, and decisions made about which measures and indicators would be calculated to answer each evaluation question (Annex I, Quantitative Data Analysis Plan). STATA version 12 was used for analysis of performance indicators. Analysis of the facilities' performance indicators focused on availability, accessibility, and quality of care for key MPA-plus services. Availability and accessibility of MPA-plus and CPA-plus services indicators were labeled as poor (0–49%), improving (50–79%), or good (≥80%). The MPA-plus and CPA-plus services indicators and facility operations indicators (i.e., infrastructure, staff characteristics, equipment, material inventory, and facility supervision) for all health facilities surveyed are calculated as an aggregate. The data were coded to include variable names; value codes and labels were defined for each question in survey questionnaires. Baseline and endline survey data for health facilities were appended to create a combined database for pre/post IHP comparison analysis. Weighted average coverage per indicator (MSH's *Baseline Household Survey Report, 2011*) were compared with the endline household survey results. MSH's Baseline Household Survey used a cross-sectional population-based survey to assess the health conditions of young children (aged 0–23 months), their mothers, and women of reproductive age living in IHP target areas. The survey used the LQAS methodology with a parallel sampling strategy.[18]

The principal procedure for final performance data analysis involved descriptive statistics on each variable at baseline and endline, making comparisons between the two, and testing whether there are any significant differences (calculated as p<=0.05 and p>0.05 to >=0.10). All associations/correlations/differences were tested for significance. A p-Value of <0.05 suggests statistical significance. p-Values are based on a chi-squared ($\mathcal{X}^2$) test of the difference between pre/post data. Logistic regression was used to adjust for confounding factors (ages, literacy level, residence), as deemed necessary. The primary disaggregation analysis of the facility survey data is by coordination office. The data were then disaggregated by the coordination office and type of facility (HC or GRH). Quality of care (treatment outcome indicators for childhood illnesses), knowledge, attitude, and practices indicators were calculated as an aggregate first by including survey data from all coordination offices and then disaggregated by coordination office for client exit and household surveys. In analyzing the qualitative information, the aim was to identify common themes and convergent and divergent ideas in the transcribed documents. The qualitative data was analyzed using Atlas-Ti version 7. The processes included coding, summarizing, categorizing, and constantly triangulating the various sources of information. A thematic analysis of these qualitative data was conducted by examining frequencies of specific responses to the six evaluation questions, and dominant themes were then calculated.

Limitations and Constraints

The non-experimental pre/post intervention evaluation design does not account for non-IHP program influences on outcomes. Because non-IHP program sites are not compared with the IHP program sites, causal attribution is not possible. Baseline/endline comparison of outcome indicators can be influenced by some unobserved confounders, although these were minimized by using the same survey instruments, survey teams, and sampling frame. The main confounding factors such as demographic factors (mother's age, urban or rural residence, mother's literacy level) were adjusted during the multivariate analysis. To improve the comparability and reliability of endline household survey data, the same instrument designed by MSH was utilized and the household sample size was increased. The validity of survey data was examined by comparing with the latest DRC DHS reports (2013–2014). The time period between baseline and endline health facility surveys is too short (about two years) to observe any other major changes in the health service coverage indicators since the beginning of the project.[19]

As in any other behavioral study, information on health practices and behaviors among household respondents and HC clients may subject to social desirability bias. Halo bias may be a factor since providers might have reported what they should do instead of what they actually do. There is possible recall bias for the household and client exit interviews data on self-reported health status. Questions for which responses are least likely to be accurate include those on recall of medications obtained at a HC during a childhood illness. Nonetheless, the recall period in the household survey was only two weeks to minimize bias, yet still

18. Parallel sampling strategy in LQAS is used to make sure that at least 19 of a group are included in a sample, and then use the decision rule to see if the group differs significantly from the average or threshold.

19. While the conventional approach to a baseline study of a development program is to conduct it early in the program life, several administrative factors impeded this from happening. IBTCI was consigned by USAID/DRC to start this baseline study in 2013.

enough to allow for a reasonable sample size. The health provider interviews in the facility survey might be subject to respondent bias. To mitigate these biases, the questionnaire included some measures of direct observation (e.g., display boards for cost of services, facility registers and reporting documents, verification of medication and vaccine inventory stocks).

As noted, a different group of data collectors and interviewers were selected and trained in each coordination office. This approach introduces the potential for intra-interviewer bias. If we were to have had the same team collect data at all sites, we likely would have introduced respondent bias. Local respondents might not have been comfortable speaking openly and honestly with interviewers who did not share their culture and language. Moreover, the questions would have to have been asked via a third party, such as a local leader who spoke French. This would have introduced interviewer bias, since the team would not know what was being asked of the respondents. Thus, the approach that would introduce the least amount of interviewer (and respondent) bias was to employ local field personnel. The Field Supervisors remained the same throughout all study sites.

EVALUATION FINDINGS

EVALUATION QUESTION 1:

To what extent has the project improved access to and availability of MPA-plus and CPA-plus services and products in the targeted health zones?

Overview

IHP's key activities under intermediate result (IR 1) were to improve access to and availability of facility-based and community-based MPA and CPA-plus health services and products. At the start of IHP, the IR 1 target was as follows: at least 80% of targeted HCs and GRHs will offer MPA-plus and CPA-plus in targeted HZs by the end of IHP's five-year performance period (see Table 5, opposite). However, based on the *IHP Performance Evaluation* (2013) recommendations, IHP immediately adjusted the target under IR1 to reduce the number of health facilities and decreased the number of supported MPA and CPA services components.

The findings for this first evaluation question are derived from an analysis of the quantitative data included in the facility survey, and the relevant qualitative data from the KIIs taking into consideration the adjustments made to the MPA and CPA services. Annex J provides detailed quantitative analysis tables, including analysis disaggregated by the survey sites (n=12) for each coordination office.

Facility survey findings

Availability of MPA-plus services

The health facilities provide a range of MPA-plus services including preventive, curative, and community health promotion services and products. The disaggregated analysis below presents the MPA-plus services offered in the health centers (n=73) only, since the provision of MPA services provision is the major function of the HCs.

Preventive services: All HCs surveyed provided antenatal, child immunization, and FP services. The access and availability of child health preventive services, including adult and child immunization services, were maintained at high coverage levels (≥80%) between 2013 and 2015 (Table 6, page 22). Similarly, availability of antenatal care and FP services was maintained at high coverage levels. Growth and development monitoring services for children under 5 improved by 9%, although this is not statistically significant between the two surveys. The availability of postpartum care services does not show significant statistical improvement between 2013 and 2015.

Curative services: The availability of child health curative services (IMCI) was maintained at high coverage levels. Normal childbirth delivery services do not show statistically significant improvement. The availability of minor surgery services was maintained at high coverage levels. The coverage for deworming (Vermiosis) services showed a marked improvement by 36% between years 2013 and 2015. The availability of nutritional rehabilitation is below 50%, but there is an improvement (although not statistically significant) in the coverage by 11%. Sexually transmitted infections (STI) treatment and care services availability do not show statistically significant improvement. The availability of services related to blood transfusion, HIV and AIDS, and TB diagnosis and treatment remained low (below 50%) without any significant changes between 2013 and 2015. HIV and AIDS testing and prevention of mother-to-child transmission (PMTCT) services improved in Kamina (14% in 2013 to 75% in 2015). In Kolwezi, PMTCT remained unchanged at 78% coverage level. The coverage level for TB diagnosis and treatment services improved in Kamina (83%) and remained lowest in Tshumbe (33%).

Health promotion services: The availability of health promotion services related to improvement of latrines demonstrated a significant increase of 24%. Promotion services for iodized salt consumption reduced by 11% compared to baseline, but this was not statistically significant. Other health promotional services related to condom promotion, hygiene and sanitation, exclusive breastfeeding, oral rehydration for diarrhea, and insecticide-treated bed nets (LLITNs) for malaria prevention were maintained at high coverage levels.

Availability of CPA-plus services

The analysis presented here is limited to the specialized CPA-plus services provision in the GRHs (n=23), since CPA services provision is the major function of the hospitals. The survey results show that the access and availability of services related to emergency obstetrics, PMTCT, fistula prevention, and

Table 5. MPA and CPA services (revised v2014) for IHP implementation	
MPA services at health centers	
Preventive activities	■ Monitoring growth and development of children under 5 ■ Antenatal consultations (ANC) ■ Family planning consultations ■ Postnatal consultations ■ Extended vaccination program
Curative services	■ Curative care ■ Screening and treatment of chronic illnesses (TB, leprosy, diabetes, AIDS, etc.) ■ Nutritional rehabilitation ■ Small medical and surgery interventions (minor surgeries) ■ Natural deliveries
Health promotion services	Activities for the promotion of healthy behaviors: ■ Use of condoms ■ Sanitation ■ Exclusive breastfeeding ■ Healthy eating, nutritional, and cooking habits ■ Use of iodized salt ■ Social marketing and distribution of LLITNs ■ Hygienic latrines ■ Oral hydration therapy, etc.
Management and other activities	■ Resource management (human, material, financial) ■ Continuing education/training of personnel ■ Supervision of health leaders (meetings, field visits) ■ Management of health information
Community activities	■ Measures for food sanitation ■ Capture and management of springs, wells, supply of drinking water, community water treatment ■ Vector control: use of LLITNs, trapping of flies and mosquitoes ■ Exclusive breastfeeding ■ Support for orphans ■ Gardening, fish farming, livestock breeding
CPA services at general reference hospitals	
CPA includes preventive, curative, and promotional activities that are organized within the framework of internal medical services, surgery, gynecology, obstetrics, and pediatrics. CPA also includes management-related activities (management of hospital health information; human, material, and financial resources; action research; and supervision of health zone personnel). In addition, it includes: ■ The various reviews of a reference laboratory ■ Medical imaging ■ Equipment sterilization ■ Rehabilitation activities	

Table 6. Access and availability of MPA services at health centers (2013, 2015)				
	2013 n=73	2015 n=73	% Difference	*p-value*
Preventive MPA services				
Facility offers child health preventive services	99%	100%	1%	0.30
Growth & Development monitoring (< 5 years)	69%	78%	9%	0.15
Immunization for children	100%	100%	0%	1.00
Facility offer antenatal care	97%	100%	3%	0.20
Facility offers postpartum care	74%	77%	3%	0.70
Facility offers FP services	99%	99%	0%	1.00
Curative MPA services				
Facility offers child-health curative services	100%	100%	0%	1.00
Facility offers nutritional rehabilitations	33%	44%	11%	0.15
Facility offers STI treatment and referrals	66%	73%	7%	0.30
Care and treatment of HIV	42%	42%	0%	1.00
Care and treatment of TB	45%	48%	3%	0.20
Care and treatment for HIV patients	15%	21%	6%	0.40
Care and treatment of other neglected tropical diseases	37%	31%	-6%	0.45
Care and treatment of worm infestation or Vermiosis**	42%	78%	36%	0.00
Facility offers normal labor services	74%	78%	4%	0.25
Facility offers blood transfusions	12%	12%	0%	1.00
Facility offers minor surgery	89%	96%	7%	0.70
Health promotional MPA services				
Condom promotion	96%	99%	3%	0.20
Hygiene and sanitation promotion	93%	90%	-3%	0.20
Exclusive breastfeeding promotion	97%	97%	0%	1.00
Food hygiene and safety promotion	90%	86%	-4%	0.24
Iodized salt consumption promotion	42%	31%	-11%	0.15
Improvement of latrines promotion**	66%	90%	24%	0.04
Oral rehydration in diarrhea promotion	96%	93%	-3%	0.20
LLITN for malaria prevention	97%	90%	-7%	0.70

Source: *Health center surveys, 2013 and 2015*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10. Red font indicates significant result.
Red shading denotes coverage of less than 50% achievement of target, yellow denotes coverage between 49 and 79%, green denotes coverage more than 80% (this is the target coverage for IHP).

Table 7. Access and availability of CPA services at GRHs surveyed (2013, 2015)				
	2013 n=23	2015 n=23	% Difference	*p-value*
Specialized CPA-plus services				
Provide emergency obstetrics services	74%	74%	0%	1.00
Provide PMTCT consultations	65%	52%	-13%	0.36
Offer HIV test for PMTCT	65%	52%	-13%	0.36
Offer ARVs to mother & child for PMTCT	52%	52%	0%	1.00
Offer long acting and permanent FP methods	39%	57%	18%	0.23
Provide HIV consultations	78%	74%	-4%	1.00
Offer TB diagnosis and treatment	87%	87%	0%	1.00
Offer blood transfusion services	96%	96%	0%	1.00
Gives fistula prevention information	65%	52%	-13%	0.36

Source: *Health center surveys, 2013 and 2015*
Key: Red shading denotes coverage of less than 50% achievement of target, yellow denotes coverage between 49 and 79%, green denotes coverage more than 80% (this is the target coverage for IHP).

consultations for HIV-positive patients remained at the coverage level between 49 and 79%. The availability of long-acting and permanent methods of FP improved, but not to a statistically significant level. TB diagnosis and treatment, as well as blood transfusion services, at GRHs were maintained at high coverage levels (≥80%) between 2013 and 2015 (Table 7).

Availability of MPA-plus service-related products

Health centers (n=73) survey results show the availability of stock for LLITNs, condoms, contraceptives and vaccines on the day of survey was lower compared to the baseline, with significant decreases in oral contraceptive pills and the injectable (Table 8, next page). Overall, the availability of information, education and communication (IEC) materials related to various technical areas of MPA-plus services ranged from 10% (adolescent reproductive health) to 79% (family planning and maternal health). The availability of IEC materials related to antenatal/postnatal care, maternal nutrition, breastfeeding, vaccination, vitamin A and malaria improved significantly. However, the availability of IEC materials for prevention and treatment of STIs and acute respiratory infections were significantly reduced at the endline.

Facility characteristics related to access

Information was collected using the facility survey on the facility time of operations, staff characteristics, cost of services, and outreach services. About 88% of health facilities remain open seven days a week from 7:00 AM to 3:30 PM. All facilities with maternity units remain open 24 hours a day. The health facilities (HCs or GRHs) did not show any significant changes in the numbers of any type of health workers (doctor, nurse A1, nurse A2, nurse A3, and community liaisons). All (100%) of GRHs and 8% of HCs had at least one doctor,[20] 95% of GRHs and 80% of HCs had at least one Nurse A2 or A1,[21] 73% of GRHs and 65% of HCs had at least one nurse A3, 52% of GRHs and 15% of HCs had at least one certified birth assistant, and 56% of GRHs and 65% of HCs had at least one lay midwife/ village birth attendant. Only 24% (23/96) of facilities display prices for the available services. Out of the 15 HCs and 8 GRHs that displayed costs, the median cost of an initial visit in an HC was 750 Congolese Francs (CDF) or $0.81 United States dollars (USD) (min. 500 CDF – max. 2500 CDF) and in a GRH, the median cost was1500 CDF or $1.60 USD (min. 500 CDF - max. 2850 CDF). Sixty percent (60%) of HCs routinely prescribed iron and folic acid, 76% provided vitamin A to antenatal women, and 64% conducted a health information session on postpartum care, similar to the results seen at the baseline. Distribution of insecticide-treated bed nets in the community reduced significantly by 13% at endline. *IHP Annual Report, 2014* highlighted that there was a chronic year-long shortage of LLITNs in the targeted HZs; the situation improved gradually in 2015 *(IHP Project Year 5, Q3 April-June Report, 2015)*. However, Kamina, Kole, Tshumbe, and Kolwezi coordination offices were still facing LLITN stockouts (this period coincided with the health facility survey 2015).

20. The MSP norm does not require a physician to be based in each HC.
21. The education of nurses is either A1, A2, or A3, where A1 consist of three year university degree (Bac plus 3 years), A2 consist of four year secondary school (Bac) and A3 is two year secondary school (Bac minus 2 years). According to MSP norms, A1 and A2 can be Chief Nurse in a health facility.

Table 8. Access and availability of MPA services-related products at health centers (2013, 2015)				
Products	2013 n=73	2015 n=73	% Difference	*p-value*
Availability of LLITNs, family planning methods, and vaccines				
Facility has LLITNs in stock today	49%	49%	0%	0.72
Facility has condoms in stock today	83%	82%	-1%	0.85
Facility has oral contraceptives pills in stock today**	83%	56%	-27%	0.00
Facility has injection Depo-Provera in stock today**	79%	65%	-14%	0.02
Facility has DTP vaccine in stock today	31%	22%	-9%	0.29
Facility has oral polio vaccine in stock today	29%	22%	-7%	0.36
Facility has measles vaccine in stock today	32%	25%	-7%	0.36
Availability of IEC materials on family planning, child health, and reproductive health services				
Family planning	71%	79%	8%	0.25
Prenatal/postnatal care*	67%	79%	12%	0.09
Safe motherhood (childbirth)	45%	55%	10%	0.25
Prevention/treatment of HIV and AIDS**	29%	47%	18%	0.03
Prevention/treatment of STIs*	45%	30%	-15%	0.06
Maternal nutrition**	37%	58%	21%	0.01
Monitoring child's nutrition and weight	58%	56%	-2%	0.86
Breastfeeding**	36%	71%	35%	0.00
Prevention of diarrheal illnesses**	21%	64%	43%	0.00
Acute Respiratory Infections**	63%	25%	-38%	0.00
Malaria**	51%	78%	27%	0.00
Vaccination**	38%	77%	39%	0.00
Vitamin A**	10%	55%	45%	0.00
Adolescent reproductive health	12%	10%	-2%	0.60

Source: *Health center surveys, 2013 and 2015*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10. Red font indicates significant result.

The availability of referral services for obstetrical complications remained low at 46%, compared to 45% at baseline; this change was not significant. Household survey results show that, in all, 55% of mothers had at least one contact with any kind of health worker, very little change from the baseline (58%). However, contact with a nurse increased by 7% by the endline survey (40% vs. 33%), whereas contact with a CHW (14%) was found to be the same as baseline (12%). A literate mother and rural residence were found to play a key role in whether mothers had contact with a health worker in the month preceding the survey.

Key informant interview findings

Key informants were asked to comment on IHP's effect on the availability and access of MPA-plus and CPA-plus at service delivery points and in the target communities. Respondents were asked to provide information that relate to the situation before IHP started and during the last four years of IHP's implementation.

With regard to the availability of health services since the beginning of IHP, 90% of KII respondents said that the project's support had increased the availability of family health services to the target population. According to 72% of KII respondents, IHP's training in various technical areas to most of the health service providers in the targeted HZs increased the availability of a wider range of preventive and curative health services. Some 75% of respondents said that IHP's support for community-based activities had resulted in increased coverage in the zones and related facilities of essential curative and preventive services, including community-based IMCI (C-IMCI) and vaccination. The establishment of the community outreach

sites was mentioned by 54% of KII respondents. On probing the new activities which were IHP-implemented, some 21.6% of respondents said that IHP's training of CODESAs in IEC activities related to TB had improved the TB services in the target areas. Also, some 21.6% of respondents said that IHP's focus on WASH activities in target communities had resulted in better sanitation and increased drinking water sources in communities and households. In addition, the same percentage mentioned IHP's distribution of LLITNs and encouragement for mothers, pregnant women, and children under 5 to sleep under mosquito nets.

With regard to services that IHP added to service providers' health portfolios, 82.8% of KII respondents mentioned provision of iron and folic acid (for anemia prevention) and sulfadoxine-pyrimethamine (SP) (for malaria prevention) during the antenatal consultations in the targeted facilities. Some 46.8% of the respondents felt that IHP's renovation of HCs and hospitals resulted in an increase in the availability of health services in the surrounding communities.

All KII respondents said that IHP had improved access of the target population to the available health services and products substantially over the five years of the project's lifespan. Some 82.8% of KII respondents said that access to health services also had increased because the IHP had trained the service providers to deliver health services, improving both the range of services and availability of trained personnel. In addition, some 61.2% of KII respondents said that IHP had established community outreach sites, which had increased the access of the target population with quality curative and preventive services. Some 39.6% of KII respondents felt that IHP's support for CODESAs had increased access to health services at the community level and fomented support for health service delivery. Furthermore, a small percentage of respondents, 7.2%, said that IHP's support of results-based financing (RBF) of health activities in specific HZs had progressed well, improving community access to health services. (The RBF initiative was established in a limited number of specific HZs. Hence, a small number of KII respondents were knowledgeable about this initiative.)

With regard to health services-related products, some 93.6% of KII respondents said that the procurement and delivery of medicines and medical supplies by IHP and its partners resulted in a considerable reduction in stockouts of medicines and medical supplies in comparison to the situation before the project began. On probing, the main contribution highlighted was the provision of medicines and medical supplies. In regard to the medicines and commodities mentioned specifically by KII respondents (although this is not an exhaustive list), 93.6% of respondents mentioned: artemisinin-based combination therapy (ACT), rapid diagnostic tests (RDT), sulfadoxine-pyrimethamine (SP), iron/folic acid tablets, amoxicillin, and zinc. Some 82.8% of respondents mentioned IHP's collaboration with Population Services International and *Association de Santé Familiale* (PSI/ASF) for improving the availability of contraceptives. Some 61.2% of respondents mentioned oral rehydration salts (ORS) and paracetamol tablets. Furthermore, 39.6% of respondents mentioned LLITNs. Some 32.4% of respondents also mentioned mebendazole tablets used for deworming. Some 27.8% of respondents said that IHP's provision of RDTs to service delivery points had facilitated the rapid diagnosis of malaria in both adults and children.

EVALUATION QUESTION 2:

Has the project improved the quality of key family health care services in targeted health zones?

Overview

This second evaluation question relates to IHP's IR 2: Increase quality of MPA/CPA-plus services in target HZs. The findings for this question stem from analysis of: 1) quantitative data from facility surveys; 2) perceived quality of care indicators from client exit survey at the health centers; 3) comparison of household survey indicators related to treatment outcomes of children less than 23 months who reportedly suffered from fever/diarrhea/PP; 4) maternal health care indicators; and 5) qualitative data collected through interviews with KIIs.

Quality of Care Measurement Index: We used iterative searches to identify literature describing the measurement of quality of healthcare services. Based on the review, we developed a quality-of-care index for the data analysis. The model identifies three proximate determinants that lead to the appropriate care and treatment of illness, and in this case, the treatment of childhood illnesses (i.e. PP, diarrhea, and malaria). As it is not feasible in large surveys to utilize nurses and doctors to directly observe client care, nor to use "mystery clients," the appropriate treatment of these three illnesses was used as the best proxy for quality of care. Figure 2 on the next page illustrates the relationship between appropriate care of illness (as described by mothers who had a sick child in the two weeks prior to the

household interview) and the three proximate determinants which could potentially influence the results of the treatment.

The first proximate determinate, structural inputs of the health facility, are defined as availability of *commodities* that include medications, supplies, equipment, a communication system, transport and electricity; and *infection control* measures *in situ* such as continuous water source, basic sanitation (latrines), equipment needed for proper sterilization, and the removal of bio-hazardous waste.

The second proximate determinate in this quality-of-care index is personnel. The variables selected to measure the capacity and availability of personnel include those directly related to the staff, such as their level of pre-service training and the provider-to-client ratio, and more specifically client-to-nurse ratio, as it is quite rare to encounter a doctor working in an HC. Another category of variables under personnel include the tools of supportive supervision, such as available quality data (e.g., health management information system or other data source) and access to motivated staff (health workers in the DRC are not typically paid salaries).

The third proximate determinant, health-seeking behaviors, rely on the health information received by the community or clients that relate to changes in their cognitive and psycho-social attributes such as knowledge, attitude and practices. There is a body of evidence indicating that clients' perception of care leads to increased utilization of services (Baltussen, R. et al, 2002; Larson, E. et al, 2014; Manzi A. et al, 2014; Nanyonjo A. et al, 2013). Thus, this Index takes note of the myriad variables that influence the *perception of quality of care* received by facility clients such as the interpersonal communication skills of providers, interpretation of whether prices for services are reasonable, wait times, whether staff are adequate to meet the volume of patients in a facility, overall satisfaction with the care received, and recent contact or exposure to a health provider. This cluster of factors influences a client's overall viewpoint as to whether she will receive quality care and therefore, influence their health-seeking behaviors.

Facility survey findings

Facility infrastructure and operations

Information was collected using the facility survey on the availability of basic infrastructure and facility operations, including staff, supervision, commodities such as drugs and supplies, and infection control, including waste management. Health facility surveys (n=96) show comparative results related to the facility infrastructure and operations at baseline and endline (Table 9). The analysis of facility infrastructure variables show no changes in basic infrastructure. However, there are major declines in the availability of continuous water (i.e., piped water supply is the definition, therefore a water container with a spigot is not included) in the facility building and consistent access to transportation. Only 34% of HCs reportedly had access to a means of transportation at all times, and the most common method was a bicycle (70%), followed by a 4-wheel

Figure 2. Quality of Care Measurement Index

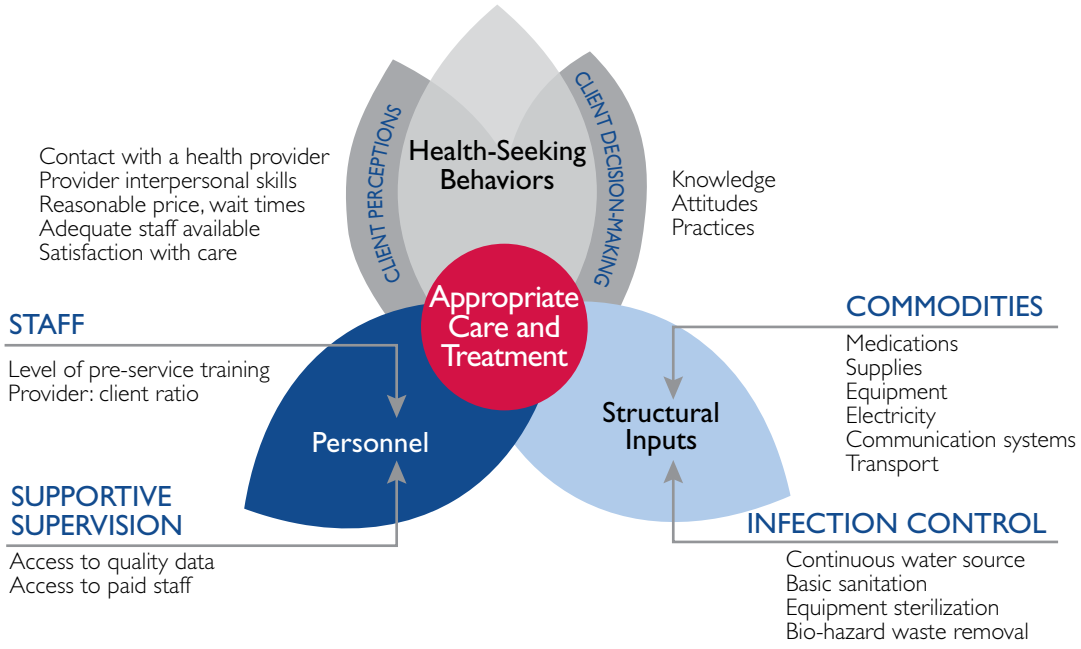


Table 9. Health facility operations and infrastructure (2013, 2015)				
Both HCs and GRHs	2013 n=96	2015 n=96	% Difference	*p-value*
Staff training, facility supervision, and stock management				
Staff received training in the past 3 years**	89%	100%	11%	0.00
Received MSP Supervisory visit at least once in past 3 months**	61%	90%	29%	0.00
Facility experience delivery delays for medications/supplies	85%	88%	3%	0.23
Facility experience delivery delays for contraceptive supplies	44%	52%	8%	0.62
Main Reason for medications/supplies delays:				
Regional Distribution Centers depleted**	54%	26%	-28%	0.00
Inadequate transportation**	30%	40%	10%	0.04
Administrative difficulties	15%	23%	8%	0.80
Financial difficulties	4%	11%	7%	0.80
Facility infrastructure				
Waiting room present	86%	81%	-5%	0.85
Continuous electricity supply present	31%	27%	-4%	0.80
Water supply inside the building present*	51%	35%	-16%	0.06
Has emergency communication system	18%	10%	-8%	0.62
Has access to transportation at all times*	49%	36%	-13%	0.08
Toilet present	92%	89%	-3%	0.91
Disinfection and infection control measures				
Has bio-medical waste disposal procedures	100%	99%	-1%	0.9
Has disinfectant currently in stock*	77%	86%	9%	0.10
Facility's method of sterilization of medical equipment (multiple methods availability)				
Boiling*	64%	53%	-11%	0.06
Autoclave	23%	23%	0	0.90
Dry/steam heat	13%	24%	11%	0.43
Facility's method of medical waste disposal (multiple methods availability):				
Burial**	47%	28%	-19%	0.00
Outdoor incineration	27%	33%	6%	0.40
Incineration in an indoor incinerator**	20%	34%	14%	0.00
Nothing/thrown outside	6%	5%	-1%	0.90

Source: *Health center surveys, 2013 and 2015*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10. Red font indicates significant result.

Table 10. Case management of childhood illnesses: Household survey results (2011, 2015)		
	2011	2015
Presumed pneumonia (PP); *n=208 (2011), n=595 (2015)*		
Child with PP and difficulty in breathing, treated with antibiotics in health facility**	61%	81%
Fever-suspected malaria; *n=208 (2011), n=647 (2015)*		
Child with fever treated with antimalarial in health facility	26%	34%
Childhood diarrhea; *n=208 (2011), n=528 (2015)*		
Child with diarrhea who sought treatment was treated with Zinc	NA	14%

Sources: *MSH Household Surveys IBTCI Household Surveys (2015)*
Key: **denotes p≤0.05. The percentages respond to the subset of children with PP and suspected malaria who were brought to the HC for treatment. Red font indicates significant result.

drive vehicle (25%), and a motorcycle (5%). Health facility staff who reported having received training over the past three years and facility supervision by MSP staff in the past three months improved significantly. The average number of outpatient attendance in the past 12 months to a health facility for any service was about 2,749 in 2015, compared with 2,250 in 2013. The average nurse-to-catchment-population ratio is 0.27 per 1000 in 2015, same as in 2013. The predominant sources of procurement for medications and supplies are central offices of HZs (53%), followed by international NGOs (24%), and private suppliers (23%). The delay in supply of drugs and medications, including contraceptives, continued at the similar rates (88% in 2015, 85% in 2013). change here. All facilities (100%) in Tshumbe reported delivery delays. The fewest delays were reported in Luiza (66%). However, there was a significant reduction in the predominant reason of delays reported due to "Regional Distribution Centers (CDRs) being depleted," while the reported reason of "inadequate transportation" increased significantly. The availability of disinfectant for infection control improved by 7%. The most effective method for medical equipment sterilization is the autoclave; its availability improved in surveyed health facilities. There was a significant decline in "boiling" as the predominant method for equipment sterilization and, at the same time, an improvement in "autoclave" and "dry or steam heat" as the predominant methods of sterilization. Similarly, there was a significant change in the type of medical waste management used in the health facilities. The predominant method of medical waste disposal method in 2015 was incineration (67%), an effective method compared to the burial method (28%).

Household survey findings

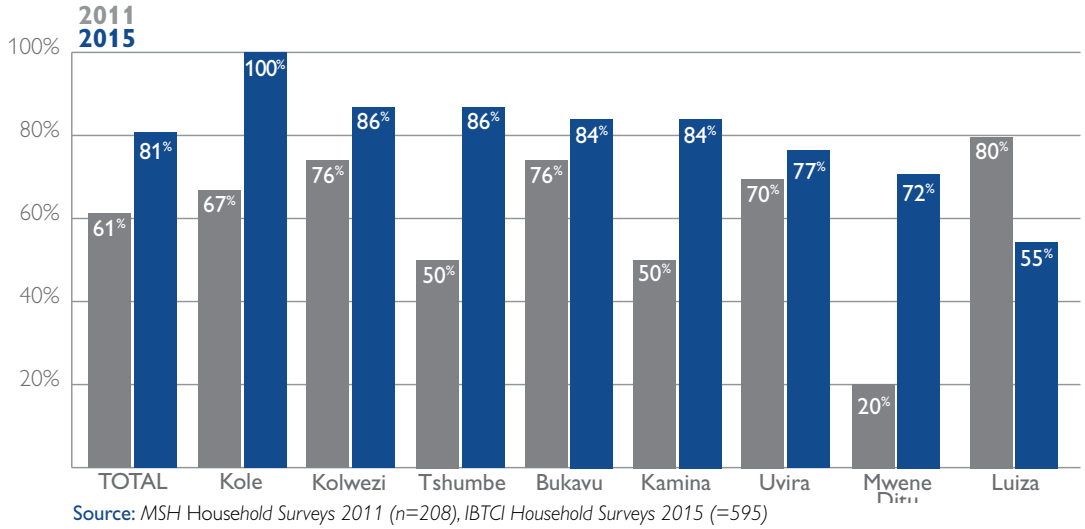
Quality of care received by households

Treatment outcome of childhood illnesses:[22] Malaria, diarrhea, and pneumonia are major morbidity and mortality factors in children under 5. One of IHP's activities is to support IMCI and improve the quality of care related to childhood illnesses. Table 10 presents the analysis of treatment received by children aged 0–23 months with suspected pneumonia, diarrhea, or malaria in the two weeks preceding the household survey.

Thirty-five percent (35%) of children under 23 months old reportedly suffered from a cough or PP in the two weeks preceding the survey. Twenty-six percent (26%) of mothers of children with PP with reported difficulty in breathing, sought treatment in a health facility. At the facility, 81% of children with PP were treated with antibiotics, significantly higher than the IHP baseline household survey results of 61%. Contact with a health care worker in the previous month was a key factor in bringing the child to the health facility for treatment. All other demographic factors such as mother's age, place of residence, and child's age were not found to play a key role. Children cared for with antibiotics were slightly higher among literate mothers[23] than among illiterate (13% vs. 9%). The percentage of children with PP receiving appropriate treatment was highest in Kole (100%) and lowest in Luiza (55%) (See Figure 3).

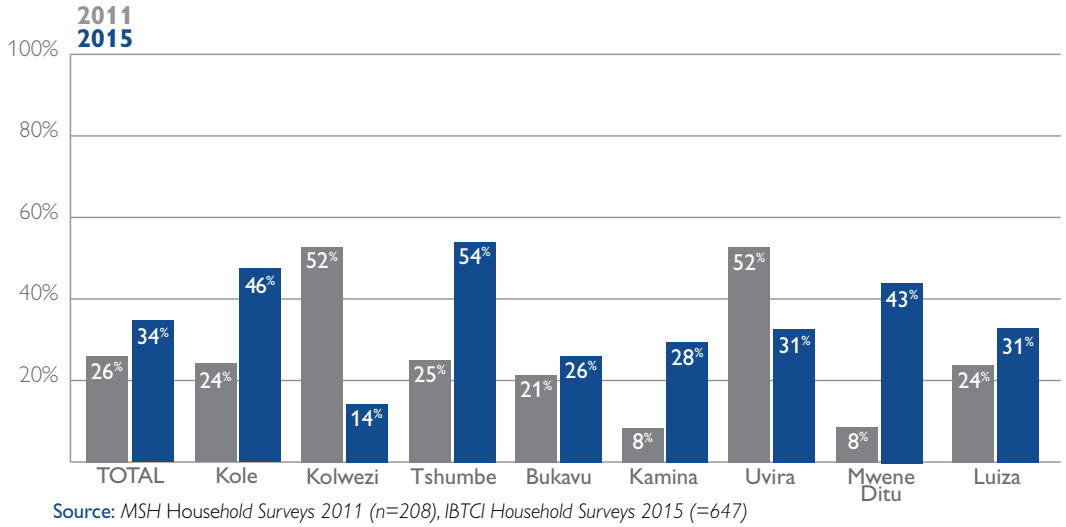
22. Logistic regression model used treatment outcomes (children with diarrhea received Zinc supplements in a HF, children with PP were treated with antibiotics, children with fever who presented to a health facility received antimalarial treatment) as dependent variables and mother's literacy, child's age, mother's age, urban/rural residence, contact with a health care worker in the past one month as independent variables.
23. Literate is defined as the respondent who reported that she can read and write; illiterate is defined as the respondent who reported that she can read only and cannot write, OR neither can read nor write.

Figure 3. Percentage of children under 23 months with PP in the two weeks preceding survey who were treated with antibiotics



Source: *MSH Household Surveys 2011 (n=208), IBTCI Household Surveys 2015 (=595)*

Figure 4. Percentage of children under 23 months with a fever in the two weeks preceding survey who were treated with antimalarial medication



Source: *MSH Household Surveys 2011 (n=208), IBTCI Household Surveys 2015 (=647)*

Thirty-eight percent (38%) of children under 23 months old reportedly suffered from fever or suspected malaria in the two weeks preceding the survey. The DRC MSP recommended guideline for children with a fever is to provide antimalarial medication. Thirty-nine percent (39%) of children with a fever were brought to the health facility for treatment. Only 34% of children with fever who went to a health facility received antimalarial treatment and 30% had their blood drawn for testing. Rural residence and contact with a health worker in the previous month was significantly associated with the child receiving antimalarial treatment. A mother's age, literacy, and child's age were not found to be associated with the child receiving appropriate care. As shown in Figure 4, the percentage of children with fever treated with antimalarial medications in a health facility was highest in Kole (46%) and lowest in Kolwezi (14%).

About 31% of children under 23 months old reportedly suffered from diarrhea in the two weeks preceding the survey. Fifty-six percent (56%) of mothers of children with diarrhea gave oral rehydration salts (ORS) in any form (liquid prepared using a special packet, prepackaged ORS liquid, or recommended homemade sugar-salt solution) to her child. Mothers who gave any form of ORS for diarrhea were found to have contact with a health worker in the previous month. A mother's literacy, age, urban/rural residence, and child's age were not associated with ORS. At endline, 14% of children with diarrhea received zinc supplements (includes both in a health facility and in community). The percentage of children with diarrhea who were treated with zinc supplements was highest in Kamina (44%) followed by Kole (35%) and lowest in Uvira and Luiza (less than 1%).

Table 11. Qualitiy of maternal and child health services: Household Survey results (2011, 2015)			
Health center	2011 (n=208)	2015 (n=1704)	*p-value*
Received at least 2 doses of Tetanus vaccine while pregnant with youngest child	47%	50%	0.24
Examined by a medical personnel 3 days after the child-birth**	18%	27%	0.00
Received vitamin A supplement within 2 months after giving birth**	18%	29%	0.00

Sources: *MSH Household Surveys IBTCI Household Surveys (2015)*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10.
Red font indicates significant result.

Maternal and newborn health services: Household survey results (n=1,704) show that 93% of women reported receiving antenatal care. About 78% of mothers received at least one dose of Tetanus Toxoid (TT) injection and 50% of mothers with children aged 0–23 months received at least two doses of TT vaccination while pregnant with their youngest child. Forty-five percent (45%) of mothers reported that the HC nurse assisted during childbirth. The nurse-midwife *(accoucheuse)* assisted 19% of women, 17% of births were assisted by a *sage-femme*, 5% by doctors, 8% by other family members, and only 6% were assisted by a TBA. The mothers and newborns examined within three days after childbirth improved significantly between baseline and endline (18% vs. 27%). Similarly, mothers receiving a vitamin A supplement within two months of childbirth significantly improved by 11%. (Table 11).

Quality of child vaccination services: About 73% of mothers with children aged 12–23 months reported that they either currently have a vaccination card or have had one in the past. A large proportion of women could not provide their child's vaccination card for observation during the endline household survey; only 12% provided vaccination cards with written records. According to the national immunization guidelines, children should receive DTP, HepB, and oral polio at the same vaccination visit on three separate contacts (recommended at two, three and four months of an infant's age). A review of Table 12 indicates similar coverage rates of polio, DTP and HepB vaccines for the visits on the first two occasions, and slightly lower rates for HepB vaccines at the third vaccination visit, compared with the other two vaccines. Similarly, the measles and yellow fever vaccination coverage rates, which are usually given at nine months of age, remained low between the two surveys.

Table 12. Vaccination status of children 12–23 months		
	2011	2015
Vaccination cards available for observation‡	67 (32%)	(188) 12%
Cards had written records of vaccines		
BCG	30%	61%
Polio at birth	25%	64%
Polio 1	30%	60%
DTP1	29%	61%
Hepatitis B1	28%	54%
Polio 2	27%	54%
DTP2	27%	55%
Hepatitis B2	26%	51%
Polio 3	25%	56%
DTP3	25%	49%
Hepatitis B3	25%	42%
Measles	25%	30%
Yellow fever	23%	28%

‡Statistical significance testing is not performed, since the number of observations are unequal. Therefore, meaningful comparisons cannot be made.
Source: *MSH Household Surveys 2011 and IBTCI Household Survey 2015*

Client exit survey findings

Perception of the quality of services among health center clients: Respondent mothers with children aged 0–56 months who received care on the day of the interview were asked to report their level of satisfaction for the services received on the day of their health center visit. Approximately 92% of mothers expressed satisfaction with the overall quality of services received. The perception of an appropriate waiting time to see a service provider decreased significantly—at endline, fewer women were satisfied with their waiting times compared to the baseline. Other perceptions of quality of care variables (level of privacy in the examination room, the amount of time the service provider spent and the service provider's attitude toward the client) remained at higher than 90% satisfaction levels. The findings of decreased satisfaction with the appropriate waiting time to see a service provider appears to be related to a low number of health workers at the HCs. (Table 13). The majority of HCs (>85%) are staffed with only one nurse and one other support staff.

Key informant interview findings

Ninety-three percent (93%) of KII respondents said that IHP had improved the quality of key family services in the targeted HZs since the project started. With regard to the quality of service delivery at the facility level, some 79.2% of

Table 13. Quantity of curative MPA services at health centers: Client statistics						
	2013 (n=293)			2015 (n=359)		
Client satisfaction indicators	Satisfied	Not sure	Not satisfied	Satisfied	Not sure	Not satisfied
Overall quality of services received	95%	1%	4%	92%	2%	6%
Wait time to see service provider*	90%	2%	8%	88%	1%	11%
Level of privacy in the examination room	95%	1%	4%	92%	2%	6%
The amount of time service provider spent with the client	91%	2%	7%	90%	2%	8%
The attitude of service provider towards the client	91%	2%	7%	93%	2%	5%
Source: *Client Exit Interviews, 2013, 2015* Key: Red font indicates significant result. *denotes p>0.05 and <=0.10						

KII respondents felt that it improved. During the performance evaluation conducted in 2013, 72% of key informants stated that the quality of key family services had improved since IHP started implementation, while 25% of informants said that service quality was about the same.

About 75.6% of respondents said the motorcycles and bicycles supplied by IHP to targeted HZs had facilitated transport to and from the project areas to conduct monthly and quarterly supervision visits and community health promotion outreach in some areas. Some 33% of respondents said that the subsidies for facility renovation provided by IHP at selected HCs and GRH maternity and pediatric wards resulted in higher quality services being delivered at those facilities. Some 50.4% of respondents said that the kerosene fuel, solar equipment, and fuel subsidies supplied by IHP maintained the cold chain system for routine vaccinations in the targeted HZs. Some 57.6% said that IHP had provided support for the health management information systems at facilities. However, about 32.4% of respondents said that stock status reporting did not take place regularly on a monthly or quarterly basis in their HZs. In the health facility surveys, 88% of facilities reported delayed delivery of medicines and supplies.

About 25.2% of respondents said that the FOSACOF training and implementation had made a real difference in the range and quality of the services provided at the related facilities. Respondents noted that the FOSACOF implementation had resulted in the establishment of functional HCs using good management practices. Some 21.6% of respondents were aware of IHP training in MNCH, including cardiopulmonary resuscitation. Respondents said that the refresher training for service providers in common diseases, such as malaria, diarrheal disease, pneumonia, STIs/HIV, WASH, and malnutrition, had resulted in a higher quality of service delivery at the related facilities.

EVALUATION QUESTION 3:

Have knowledge, attitudes, and practices to support health-seeking behaviors increased in the targeted health zones?

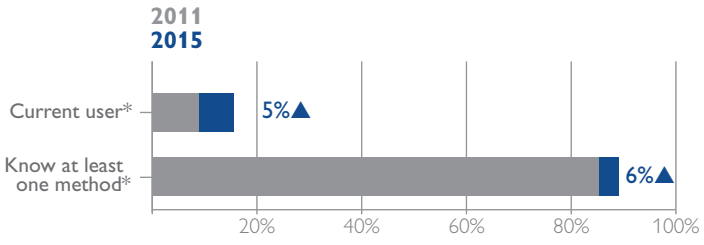
Overview

This question relates to IHP IR 3: Improved knowledge, attitudes, and practices (KAP) to support health-seeking behaviors. The findings for this question stem from analysis of the quantitative data from client exit survey at HCs, comparison of household survey indicators related to health-seeking behaviors, and qualitative data collected through interviews with KIIs. IHP's Behavior Change and Communication (BCC) activities were implemented in 34 health zones only. The analysis presented here represents all IHP health zones, including BCC nonintervention health zones.

Household survey findings: Knowledge, attitude, and practices of key family health services by households

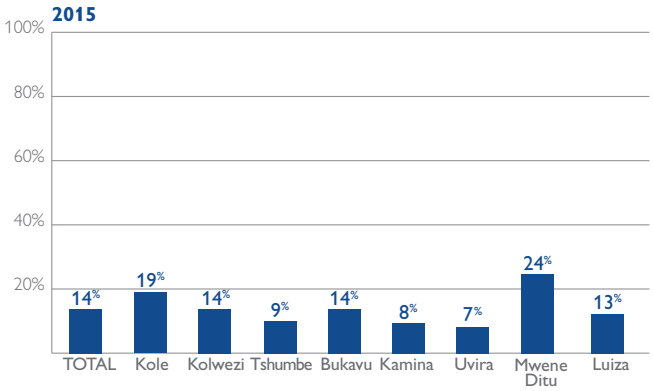
Family Planning: Modern contraceptive use by non-pregnant mothers whose youngest child was 0–23 months increased significantly from 8 to 13.5% (Figure 5, below). The most common method used was male condoms (61%), followed

Figure 5. Current users of modern contraceptive methods



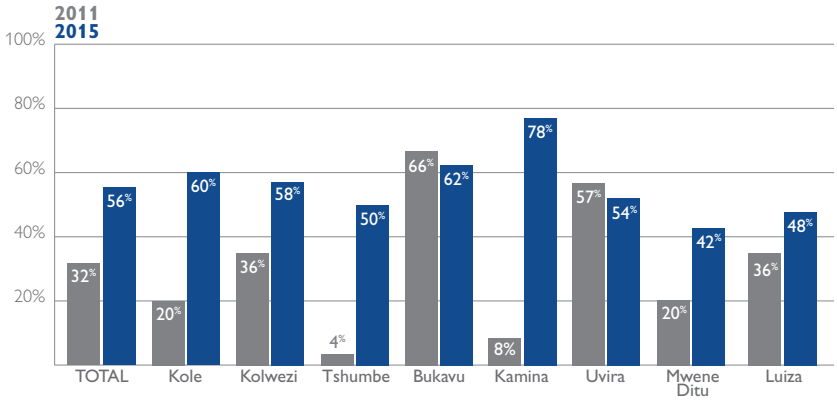
Key: * p<=0.05
Source: *MSH Household Surveys 2011 (n=208), IBTCI Household Surveys 2015 (=595)*

Figure 6. Current users of modern contraceptive methods by coordination office



Source: *IBTCI Household Surveys 2015 (n=1704)*

Figure 7. Percent of women ages 15–49 who were tested for HIV and received results during the past 12 months



Source: *MSH Household Surveys 2011*, n=208; *IBTCI Household Surveys 2015 (n=1704)*

by injections (16%) and pills (14%). The increase in modern contraceptive use is correlated with a significant increase in knowledge about at least one modern method of family planning (89% of mothers knew at least one method of modern contraceptive). Literate women were found more likely to use a modern method. The percentage of non-pregnant mothers currently using a modern contraceptive method was highest in the Mwene Ditu BC (24%) and lowest in the Uvira BC (7%) (see Figure 6, above).

Maternal, Newborn, and Child Health: Forty-nine percent (49%) of mothers reported that they had at least four antenatal consultations while pregnant with their youngest child, compared to 43% at baseline (Table 14). This indicator was highest in Tshumbe (60%), followed by Kolwezi (56%) and lowest in Uvira (30%). The prevalence of facility births[24] remained high at 86%. However, there was no change in the practice of early breastfeeding behavior, which remained at 58%. Ninety-six percent (96%) of mothers reported breastfeeding their child at 6–23 months. Breastfeeding initiation within the first hour after birth was 51% and exclusive breastfeeding for children 0–6 months was 54% at the endline; these rates are similar to the baseline (52%). About 88% still continue to breastfeed after 6 months of child's age and 81% of mothers gave other food or liquid to the child besides breast milk during the first six months at the endline; similar rates are seen at baseline. About 28% of women had heard about genital fistula at the endline compared to 37% at the baseline, which is significantly lower.

HIV and AIDS: Only 14% of surveyed mothers queried on the six HIV and AIDS knowledge questions had correct HIV knowledge; there was not a significant improvement from the baseline (18%). However, 56% of mothers reported receiving HIV test results in the past 12 months, which is a significant increase from the baseline (32%). Mother's literacy and urban residence was found to be significantly associated with the

24. Facility births indicator data provides self-reported information on whether the child birth occurred in a HC, it does not provide the information whether the childbirth was assisted by a skilled personnel.

Table 14. Knowledge, attitudes, and practices to support health-seeking behavior, Household Surveys

To support health-seeking behaviors Mothers of children 0–23 months	2011 *(n=208)*	2015 *(n=1704)*	*p-value*
Maternal, newborn, and child health			
Had at least 4 antenatal consultations when pregnant with the youngest child**	43%	49%	0.05
Gave birth in a health facility	79%	86%	0.8
Started breast-feeding during the first hour of birth	52%	58%	0.7
Heard about genital fistula**	37%	28%	0.00
WASH			
Soap is available in the household, observed by interviewer	51%	48%	0.9
Used improved source of drinking water*	48%	56%	0.08

Source: *MSH Household Surveys (2011) and IBTCI Household Surveys (2015)*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10. Red font indicates significant result.

practice of receiving HIV test results among mothers with children 0–23 months. The percentage of mothers receiving their HIV test results were highest in the Kamina BC (78%) and lowest in the Mwene Ditu BC (42%) (Figure 7).

Malaria: Sixty-five percent (65%) of households have at least one bed net; 65% of these homes had at least one insecticide-treated bed net (LLITN). This was an improvement over baseline, when 47% of households had at least on LLITN. Fifty-six percent (56%) of children under 23 months and 73% of pregnant women slept under an LLITN the previous night of survey, a significant increase from the baseline when only 47% of children and 32% of pregnant women used LLITNs. The percentages were highest in Bukavu and Uvira (90%), and lowest in Mwene Ditu and Kolwezi (50%) and Tshumbe (33%).

Water, sanitation, and hygiene (WASH): The presence of soap for hand washing in the household remained low, at about 50%. Forty-two percent (42%) of households used nothing at all and 8% used mud/ash for hand washing. Fifty-six percent (56%) of households reported using an improved water source;[25] 4% of households with an unprotected water source used a water purification method. Availability of improved water source in the household was highest in Mwene Ditu (87%), followed by Bukavu (84%), and least in Tshumbe (6%). The difference was significantly higher for urban versus rural households (90% versus 48%). Fourteen percent (14%) of households did not use any kind of toilet. Pit latrines without slabs were available for 76% of households, but only 8% of households had flushing toilets or pit latrines with covers, which are in accordance with WHO recommendations.

25. Covered water sources or tap water.

Client exit survey findings: Knowledge, attitude, and practices of key family health services by health center clients

Analysis of KAP indicators related to childhood pneumonia on client exit interviews did not show any improvements in PP knowledge among mothers of child 0–23 months (Table 15). However, the percentage of mothers reporting that they received pneumonia treatment from someone else (not a health care worker) before coming to the HC reduced significantly, from 64% to 37%. Nevertheless, healthy practices such as giving ORS to a child with diarrhea and continued feeding during diarrhea showed significant decline.

The knowledge of fever as a sign/symptom of malaria improved, but this was juxtaposed with the malaria prevention practices of using LLITNs, which remained unchanged. Other KAP indicators' results from the client exit interviews are presented in Annex J.

Key informant interview findings

Eighty-seven percent (87%) of KII respondents said that health-seeking behaviors in the target communities have improved. About 61.2% of respondents noted that the increased delivery of both facility- and community-based IEC/BCC activities,

Table 15. Knowledge, attitudes, and practices to support health-seeking behavior, Client Exit Surveys

Childhood illness Mothers of children 0–23 months	2013 *(n=117)*	2015 *(n=165)*	*p-value*
Childhood pneumonia			
Awareness of two danger signs of child pneumonia	49%	55%	0.3
Mother brought child to HC in last 2 weeks due to suspected child pneumonia	21%	21%	0.9
Mother thought child has pneumonia, treated with antibiotics before bringing the child to HC	96%	86%	0.6
Already have a child treated for pneumonia by someone else before coming to HC**	64%	37%	0.03
Childhood diarrhea			
Mother gave ORS for diarrhea to the child who had diarrhea in the past 2 weeks*	84%	72%	0.08
Continued feeding the child during diarrhea**	87%	68%	0.01
Suspected malaria			
Mother knows fever is a sign/symptoms of malaria**	68%	85%	0.00
Child received malaria treatment within 24 hours of fever	79%	83%	0.5
Child slept under LLITN during this year	64%	68%	0.5
Child slept under LLITN last night	79%	73%	0.3

Source: *Client exit interviews (2013, 2015)*
Key: **denotes p≤0.05; *denotes p>0.05 and ≤0.10. Red font indicates significant result.

including WASH, had improved health-seeking behaviors. Some 57.6% of respondents said that CODESAs had promoted the use of the available health services through health education sessions held in community and that the CODESAs referred complicated cases to HCs. Some 43.2% of respondents said the donation of bicycles by IHP to CODESAs facilitated home visits to provide health services.

According to 43.2% of respondents, counseling training provided by IHP for the increased delivery of FP/RH services had resulted in improved health-seeking behaviors. Some 32.4% of respondents noted that IHP's support for the promotion of malaria prevention and control activities at facilities and in communities had resulted in increased use of LLITNs.

Regarding the use of health services at the facilities chosen by community members, some 54% of the KII respondents said that most community members preferred to attend IHP-assisted facilities for care when they were ill. Also, 7.2% of respondents considered IHP's RBF initiative as a key intervention that improved health-seeking behaviors successfully in the zones where it was implemented. Some 43.2% of these respondents noted that most community members go to RBF facilities because the cost was affordable and the services provided at these facilities were of good quality. (It was noted that these facilities were subsidized by IHP, making the services provided more affordable for community members.)

The estimates made by KII respondents regarding the level of health service use by community members before IHP started compared to the present use of the services varied, ranging from 25.2% stating that service use by community members had doubled since IHP started; and 18% of respondents stating that service use had tripled since IHP started. A few respondents also noted that not only had the use of services doubled since IHP started, but community satisfaction with the quality of the services also had doubled. The main reasons of community satisfaction provided by the KII respondents were the increased availability of medicines and medical supplies (93%), increased capacity of service providers to deliver quality health services (73.6%), and better facility infrastructure than before (61.2%).

EVALUATION QUESTION 4:

Has health sector leadership and governance in the four targeted provinces improved?

The findings on whether leadership and governance has improved in the four targeted provinces are the results of an analysis of qualitative data collected through key informant interviews with national, provincial, district, and HZ and facility managers in the four IHP provinces. These qualitative results were triangulated with the available IHP annual and quarterly reports from 2010–2015 (Management Sciences for Health, 2010–2015).

Key informant interview findings

In regard to the effect of IHP's focus on leadership and governance, 72% of KII respondents said that, based on the leadership training and tools provided by IHP, health facility managers and staff members took more initiative with planning and implementing service delivery. Some 72% of respondents said that HZ and provincial managers had learned skills to solve operational problems and develop action plans using the available resources without needing much oversight from senior managers. The IHP yearly and quarterly reports review indicated that IHP provided technical and financial support to all 78 targeted HZs for AOP development. In year 2013, 99% of target HZs had developed AOPs. At end of 2014-Q3, it was 65% of HZs, and at the end of 2015-Q3, 56% of HZs had developed their AOPs, validated by their respective *Conseil d'Administration* (CA). The reports noted that the pace of development of AOPs is inconsistent among health zones. There were operational challenges between ECZ and DPS in planning advisory board meetings to validate draft AOPs in a timely manner.

A review of IHP annual reports indicated that IHP's LDP was designed specifically for health sector staff and managers who had major roles in HZ strengthening. Some 61.2% of KII respondents said that there was increased ownership of and accountability in targeted areas based on IHP's support in promoting the use of planning, reporting, and decision-making tools. Some 54% of respondents said the effect of the LDP training had been positive at all levels of the health system, despite the prevailing constraints on health service delivery. The staff trained in LDP carried out leadership projects in collaboration with stakeholders at various levels to improve key family health services delivery. In Project Year 4, a total of 189 LDP were implemented and 94% of the LDP projects had attained their expected results by the end of Year 4.

Regarding supervision and monitoring and evaluation (M&E) activities related to improvements in the health sector leadership and governance, 72% of KII respondents said that the HZ managers carried out most of the monthly and quarterly supervisory activities, while IHP provided technical support including fuel and funding subsidies to facilitate supervision at the targeted facilities and related communities. Some 68.4% of MSP respondents said they personally had been involved in HZ-level supervision and M&E activities to gauge the progress of IHP-supported health delivery. The same percentage of respondents said that IHP coordinators had joined HZ managers

> "CODESA has become more organized and active in promotional activities for the health center."
>
> —Chief nurse

in planned supervisory visits to service delivery points. In response to whether or not the KII respondents had been involved with IHP-facilitated training, including planning or conducting it, some 82.8% of respondents answered positively, while 14.4% responded negatively. (A few KII respondents were not directly involved with IHP's activities, and thus did not know about the training provided by IHP.) Some 43.2% of respondents said they were aware of IHP training for CODESAs in health promotion activities, that CODESA members implemented health promotion in facilities and in the communities, and that they received financial support from IHP to hold monthly reporting and information sharing meetings. Some 21.6% of KII respondents said the establishment of Community Champions by the IHP in some targeted HZs had strengthened CODESA participation and representation in planning of health services awareness generation activities, including vaccination campaigns in the target areas. The Community Champions strategy, initiated in Project Year 4, involved training a select number of motivated community members in management and leadership skills such as developing an action plan, defining targets, and incorporating sustainability strategies for health awareness and action. By the end of Year 4, fifteen Community Champion groups were established.

> "...within the context of partnership between the MSP, FEDECAME* and the related CDRs, FEDECAME is expected to work closely with CDR for the establishment of the country's pharmaceuticals and medical supply chain system through procurement, storage, and distribution of supplies to service delivery points. Therefore, it is not helpful for the development partners to establish a parallel system of procurement that cannot be integrated with the existing FEDECAME and CDR system."
>
> —National MSP official

*FEDECAME: *Fédération des Centrales d'Approvisionnements en Médicaments Essentiels* (Federation of Essential Medicine Procurement Agencies)

EVALUATION QUESTION 5:

What are the external factors that hamper IHP activities from delivering better results?

Overview

Qualitative data collected through KIIs provided a basis for the findings concerning the factors hampering IHP activities from delivering better results. As a result of a thematic analysis, only the external factors that were most common and mentioned in all four provinces are summarized below. These qualitative results were triangulated with the available IHP annual and quarterly reports from 2010–2015 (Management Sciences for Health, 2010–2015).

Key informant interview findings

Regarding major constraints to IHP's implementation, some 68.4% of KII respondents said that the lack of a functional LMIS in HZs and at facilities to order and track medicines and medical supplies had been the biggest constraint on the delivery of MPA and CPA services encountered over the five years of IHP. The poor infrastructure of targeted facilities, including the lack of durable, standard equipment based on MSP standards, was considered by 64.8% of respondents to have negatively affected service delivery. About a third of these respondents said that not all the IHP-renovated and equipped facilities had running water and continuous electricity, which also had a negative impact on the provision of health services. Because of a lack of LMIS, according to 61.2% of KII respondents, the delayed procurement and delivery of medicines, medical supplies, contraceptives, and medical equipment from CDRs had a negative impact on the delivery of MPA and CPA services at HCs, GRHs, and in the surrounding communities. Some 46.8% of respondents said the poor road conditions and the lack of appropriate vehicles for the difficult road trips in the targeted zones had decreased the ability to carry out regular quarterly/monthly supervision activities. In addition, 32.4% of respondents said the lack of the MSP-paid salaries and living allowances ("primes") for the majority of service providers had resulted in low staff morale at most facilities. In regard to whether KII respondents knew of any existing laws or regulations affecting MPA or CPA service delivery that limited IHP's efforts to support the increased availability of and access to these services, 93.6% said no. Some 3.6% of respondents said yes, but what they identified was the flouting of regulatory processes by a provincial medical inspector, enabling non-MSP-certified health professionals to open new HCs and provide health services illegally. Respondents said this had a negative impact on MPA service availability and access in the respective communities.

Regarding what IHP had done to address the constraints mentioned by respondents, 27.8% said that IHP had supported joint monthly and quarterly supervision visits using the most appropriate means of transportation, often making their own vehicle available for the joint supervisory visits. Some 18% of respondents said that IHP had facilitated support from the MSH activity SIAPS to improve the quantification of needs for medicines and medical supplies based on accurate information to ensure the increased availability of medicines, commodities, and medical supplies. The same percentage of respondents also

said that IHP had planned to carry out decentralized training in pharmaceutical logistics at all the targeted HZs with support from local trainers based on a new health facility survey that had been implemented. KII respondents were asked to reflect upon partnerships or collaboration with other USAID-funded projects in or near the IHP-supported HZs to improve availability and use of health services. Thirty-two percent (32%) of the KII respondents said that there were no formal agreements made, such as memoranda of understanding (MOUs). There was, however, collaboration taking place among partners. The collaborative efforts encompassed projects funded by donors other than USAID as well as USAID-funded programs, in the areas of FP/RH service delivery, HIV and AIDS, TB, and malaria prevention and control, to avoid duplication of efforts and wasted resources. Specifically in South Kivu province, coordination meetings were noted as regularly scheduled at the provincial level and included the USAID-funded implementing agencies.

The document review revealed that the IHP faced continued challenges in the implementation of its activities due to the chronic insecurity situation, particularly in South Kivu province. Frequent stockouts of essential medicines and supplies, as noted from the annual and quarterly reports, occurred throughout IHP implementation, due to operational delays from the Congolese government because of the lack of communication and coordination between various HZs and the provincial divisions in charge of commodity management. The government has recently converted the 11 administrative provinces into 26 new provinces and the number of HZs has increased to 516. The rationale for the increase in the number of HZs is primarily to improve geographic coverage for service delivery. In the MSP itself, a restructuring process is under way (there are now 26 DPS, 13 National Directorates of Health, and 52 National Health Programs). It is hoped that this will lead to better management and coordination in the delivery of health services, with greater involvement of DPS and the various health programs within them. Another major challenge described in the IHP program reports is the poor data quality reported from the health facilities. The routine data quality audits conducted by IHP identified major data inconsistencies between facility records and the SNIS. Major inaccuracies were noted in the basic health facility data records and data reporting forms. There is no system for routine data checks, monitoring, and data feedback on the reported SNIS data.

EVALUATION QUESTION 6:

How is IHP perceived and valued?

The following findings with respect to IHP is perceived and valued are derived from the key informant interviews conducted with district, zone, and facility managers, and CODESA members in the four provinces. The most frequent themes arising in the responses are described below. (See Figures 8–10, opposite).

Key informant interview findings

IHP strengths: Some 86.4% of KII respondents said that the subsidies for monthly and quarterly supervisory visits and meetings provided by IHP were given in a very timely way, including at the CODESA level, and had improved the quality of health services available and accessible in the targeted HZs. The respondents said that this support helped to verify the progress that was made by the project and promoted provider and community ownership of the integrated programmatic activities. Overall, the technical assistance and training provided by IHP was considered to be excellent by KII respondents. Some 50.4% of respondents said that IHP had provided LDP training at the HZ level and at targeted facilities and there were plans by IHP to expand the training at the community level for CODESA members. Some 43.2% of respondents were impressed with the quality and experience of IHP's technical advisors and managers at both the provincial and regional levels and their ability to facilitate planning for and management of service delivery. Some 27.8% of respondents said the training by IHP, including FOSACOF training, of chief medical officers and nurses in the targeted zones and at the related facilities in IMCI and C-IMCI was a real strength of the project. Some 18% of respondents felt that IHP's Community Champions strategy was remarkably successful, greatly appreciated in the targeted zones, and the initiative can be replicated elsewhere. Some 18% of respondents said that IHP's renovation of and provision of equipment at targeted HCs had strengthened their capacity to deliver quality health services. Finally, 18% of respondents said that the existence of IHP's policies and norms for the establishment of quality standards was one of the project's strengths. IHP's support under the RBF intervention was appreciated, and it was hoped that IHP will continue this intervention to ensure the sustainability of health services in the target communities. An example provided by a respondent regarding the impact of IHP's RBF on service use was that the bed occupancy rate in the local GRH had increased from an initial 10%, to 50% in 2015.

IHP weaknesses: All of the KII respondents—100%—said that the IHP had insufficient budgetary resources to address all the needs for facility renovations and procurement of medicines and medical supplies in the targeted HZs. Another weakness of the IHP identified by 39.6% of respondents was the lack of establishing a functional LMIS at all the targeted HCs and GRHs, which meant that monthly and quarterly stock quantification and status reporting did not occur on a regular basis. Some 18% of respondents said that IHP's work plan did not include all the priorities that were reflected in the annual work plans or annual operation plans of the HZs IHP had targeted. Some 14.4% of respondents said that IHP's lack of technical assistance and support for the implementation of WASH activities in all the targeted zones was a weakness. The

Figure 8. Perceived areas of strength, IHP

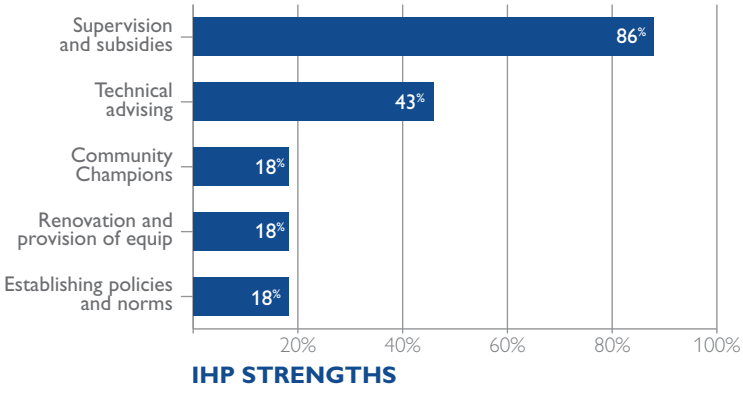
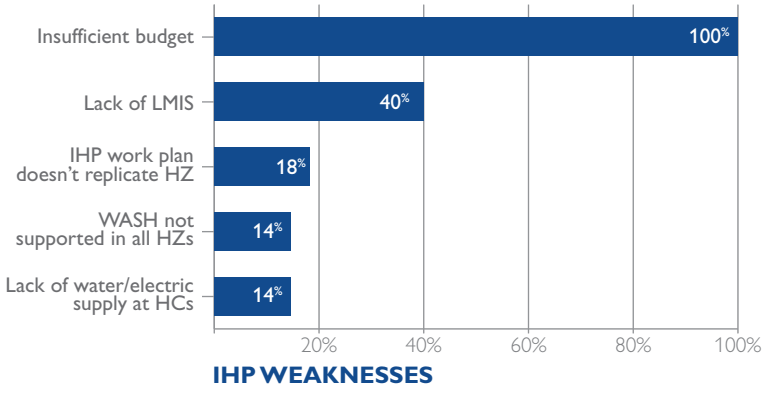


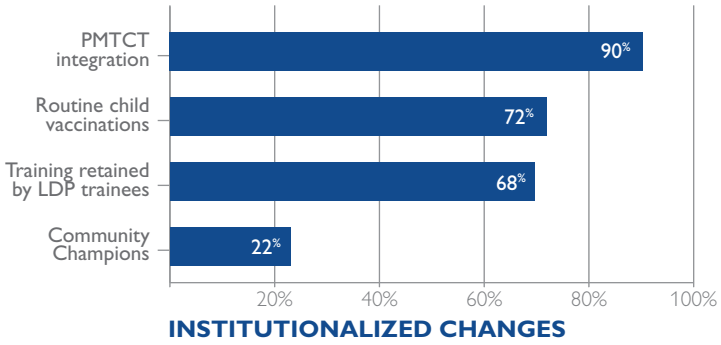
Figure 9. Perceived areas of weakness, IHP



Source (Figures 8–10): *IBTCI Key Informant Interviews 2015, n=123*

> "If IHP is able to staff its coordination offices with a large number of qualified technical assistants, why can't IHP do the same at the HZ level so that the transfer of the knowledge and skills can contribute to the development of the country's primary health care system?"
>
> —Health Zone manager

Figure 10. Perceived areas of sustainability, IHP



same percentage of respondents said the lack of running water and appropriate solar electrification equipment at the HCs renovated by the IHP was also a weakness.

The KII respondents said the interventions that had become integrated into and institutionalized at facilities and in communities based on IHP efforts were more likely to be sustained without too much financial support needed from donors. At the top of the list of sustainable interventions, according to 90% of the respondents, was the integration of PMTCT services that had been supported by IHP, including thorough specialized training in HIV screening and PMTCT and FP/RH services, and the referrals of HIV-positive women for treatment—with the caveat that the MSP would have to take over providing essential drugs/supplies in the future. The majority of respondents (72%) of respondents said the preschool consultations and routine child vaccination activities, along with reinforcement of the cold chain (all supported by IHP), would likely be sustainable beyond the IHP lifespan. Some 68.4% of respondents said the skills learned at LDP and clinical trainings provided by IHP would be retained by the trainees. A modest 21.6% of KII respondents said the establishment of Community Champions by the IHP in some targeted HZs had strengthened CODESA community-based activities and would most likely contribute to the sustainability of CODESAs and their related activities in the target areas.

DISCUSSION

The five-year USAID-funded IHP was designed to support the DRC PNDS's strategic components of service delivery and health system strengthening. The project's goal was to increase the availability and use of, and improve the enabling environment for, high-impact services, products, and practices for: (1) family planning; (2) maternal, newborn, and child health; (3) nutrition, (4) malaria and tuberculosis; (5) neglected tropical diseases; (6) HIV; and (7) water, sanitation, and hygiene in the target HZs. This section presents a discussion of which project strategies worked well, which did not work as well, and why. Also addressed herein are the constraints the project faced while working towards the project goal. The data from the health facility survey, household survey, client exit interviews, project document and literature review were used to triangulate findings.

IHP focused on four specific areas for improving availability and accessibility of services and products in the targeted HZs, namely:

1. IHP worked predominately with the public health facilities staff and HZ management teams to implement MPA-plus, CPA-plus, and to integrate new services
2. The technical skills of the service providers at HFs were improved through IHP training, resulting in an increased access of services by the target communities, particularly, in IMCI and FP/RH related services
3. The availability of medicines, contraceptives, and medical supplies increased at facilities through procurement and delivery, including via the coordination of procurement with other USAID and non-USAID partners
4. The project provided technical and logistics assistance to improve regular facility supervision by MSP.

IHP developed supervision tools and procedures, trained supervisors, and conducted joint supervision visits. Training on the FOSACOF service delivery assessment tool and its application with quarterly formative supervision activities at health facilities was utilized. Health facility survey results suggest that IHP supported improvements in the bio-hazard waste management and other infection control practices in the health facilities. Increases in the use of the most effective infection control methods, such as the use of autoclave/dry heat and incinerators, were realized. Health products have been made available since the project started, but frequent stockouts of essential medication and supplies occurred throughout IHP implementation. The main reason appears to be the lack of a functional LIMS. Provision of a wide range of medications and supplies to the health facilities in the absence of LIMS might have been a factor for poor quantification, delayed reporting of stockouts and hence, delayed delivery of stocks.

During the IHP implementation, the status of basic facility infrastructure did not change. Facilities have not been well maintained and lack basic amenities. The majority of the facilities—mainly HCs—still lack basic amenities such as water, electricity, toilets, modes of communication, and transportation. These conditions might dissuade clients from returning to the facility, especially new mothers who would understandably go home within few hours after delivery and might not return for newborn or postnatal consultations. IHP undertook some facility renovation activities and the effort was greatly appreciated. Facility renovations supported by IHP were also a factor in improving access to services. However, lack of running water supply and appropriate solar electrification equipment at the HCs renovated by the IHP was still considered as a weakness of IHP. Rehabilitation is a joint effort involving the health facilities, communities, and IHP. IHP had little to no control over timely contribution of input from health facilities and the community. Hence, there remains a need to improve the most basic facility amenities to improve access and quality of services.

The results from health-seeking behavior indicators obtained through the household survey, client exit interviews and key informants, reveal some evidence that IHP efforts have had a positive influence on increasing health-seeking behaviors in the targeted zones. Review of the 2007 and 2014 DRC DHS data indicate relatively high levels of knowledge, attitude, and practices in IHP target areas such as family planning, initiation of breastfeeding in the first hour of birth, exclusive breastfeeding until the age of six months, and child vaccinations. Baseline household surveys conducted by IHP in 2011 showed low levels of health practices for key family health interventions and the results of the endline household survey showed significant improvements in the knowledge, attitude, and practices for key family health interventions.

Improved availability of health services, products, and enhanced service provider skills appear to be factors in improving the health-seeking behaviors. IHP primarily utilized traditional BCC interventions, using community health workers and local partners, such as CODESAs, to actively engage with local populations. CODESAs carry out awareness-raising and community mobilization activities to promote services for vaccination, family planning, antenatal care, nutrition, child health, and disease prevention and treatment. Yet evidence on community activities related to gardening, fish-farming, livestock breeding, and support of orphans was negligible. Additionally, CODESAs role was mainly limited to awareness generation only. IHP has recently implemented innovative approaches, including Champion Communities focused on management and leadership skills for community action. The Community Champions activity started in Project Year 4 of IHP and its implementation was limited to a few communities. The Community Champions innovation appears to be an effective strategy in community mobilization—however, it needs to be evaluated in the local context.

Better leadership and management of the targeted HZs was a priority for IHP support. IHP support for leadership and governance was highly regarded by respondents. The main strategies that IHP had successfully used were the:

1. LDP which promoted the use of strategic planning, problem solving, management and decision-making tools;
2. integrated monthly and quarterly facility supervision activities with MSP; and
3. support for development of HZ annual operational plans. Several LDP projects were implemented and achieved expected results.

Several LDP projects were implemented and achieved expected results. KII data collected in 2013 noted that district and zone managers struggled to conduct monthly supervisory visits, because of the very low level of funding allocated for supervision activities. A lack of a means for transportation also had been a serious hurdle. To mitigate the effect of these external factors related to the logistical issues, IHP provided fuel subsidies to MSP officials for monthly and quarterly supervisory visits and meetings. IHP fostered supportive relationships with district and HZ managers and provided necessary support to improve facility supervision. IHP was seen to be able to provide better means of transportation than otherwise was available for supervisory visits and, presumably, IHP's presence enhanced the quality of the supervision provided. This finding is corroborated by the health facility survey results that show significant improvements in facility supervision rates. The supervision and training support was considered to be one of the factors in improving the ownership and accountability among HZ managers and health providers according to key informants.

All in all, the DRC is indeed one of the most challenging environments to implement any health project, much less a comprehensive one such as IHP, which covered the entire gamut of health services. Moreover, its goal to achieve 80% coverage of these services in a multitude of facilities across a wide geographic swath of land that is largely inaccessible makes any achievement, however small, impressive.

CONCLUSIONS

EVALUATION QUESTION 1:

To what extent has the project improved access to and availability of MPA-plus and CPA-plus services and products in targeted health zones?

- According to the vast majority of stakeholders interviewed, IHP improved access and availability of MPA-plus and CPA-plus services and products.
- Access to and availability of antenatal care, family planning, child vaccination services, and integrated management of childhood illnesses were sustained at high coverage levels in IHP-supported health facilities.
- IHP interventions supported the significant improvement of the care and treatment of worm infestation and the promotion of improved latrines.
- During the life of the project there was a marked and significant increase in the availability several health promotion materials.

IHP has sustained high levels of access to childhood prevention and curative services, including minor surgery, family planning, antenatal and postpartum care in the targeted health facilities since 2013. Since the baseline data were collected in the middle of the five-year project cycle, it is not possible to ascertain if the high level of available services were attained in the first couple years of the project, and therefore attributable to IHP. The services for normal childbirth, postpartum care, growth monitoring of children under 5, and STI care and treatment are improving; however, these services remain just below target coverage level. Marked improvements were noted in access to, and availability of, care and treatment services of worm infestation. IHP's integrated HIV activities were implemented in Katanga province and the availability of HIV treatment including PMTCT services improved in targeted HZs. Access to, and availability of, blood transfusion, tuberculosis, and referral services for obstetrics complications in the health centers are low. Marked improvements were seen in health promotion activities related to promotion of improved latrines, but the promotion of iodized salt use declined. Other health promotion related to condom use, general hygiene and sanitation, and oral rehydration in diarrhea. Community access to an improved water source and improved latrines remain low. Community activities related to gardening, fish-farming, livestock breeding, and support of orphans were negligible.

With regard to the availability of health promotion materials, there is an overall improvement since the project started. IEC materials on family planning, nutrition, child health, vaccination, safe motherhood, prevention of diarrhea, malaria, and HIV and AIDS were made more available as a result of IHP. The availability of antimalarial medications and supplies (ACT, SP, rapid diagnostic tests), iron folic acid for antenatal women, vitamin A for postnatal women and children, ORS, and condoms also improved. However, distribution of LLITNs and the availability of oral and injectable contraceptives fluctuated—and were significantly lower by time of the endline survey. The availability of vaccines remained unchanged. Facility characteristics related to access to services including time of facility operations, type and number of health workers, and cost of services remained unchanged. The curative care service use rates are stable. Community contact with a health worker, and particularly contact with a health center nurse, improved.

EVALUATION QUESTION 2:

Has the project improved the quality of key family services in targeted health zones?

- IHP has improved the quality of key family services by supporting facility personnel training and regular supervision.
- The coverage of nutrition, HIV, malaria, TB, and WASH services is low. However, the quality of these services where they are available is improving.
- IHP introduced effected infection control practices and improved the availability of medications. However, there is no change in the basic infrastructure of the health facilities and frequent stockout of medications and vaccines occurred during the life of the project.
- As the facility client volume has increased, the number of health facility staff has remained unchanged. The nurse-to-population ratio is far below the WHO recommendation of at least 2 nurses per 1000 people.
- Client perceptions of the overall quality of care received at IHP-supported health facilities remained high.

IHP support for staff training and facility supervision appears to be a factor in improving the quality of MPA-plus and CPA-plus services. Frequent stockouts of essential medication and supplies occurred throughout IHP implementation; the main reason appears to be due to the lack of a functional LMIS to report drug requirements and to order/reorder in a timely manner. The majority of the facilities, particularly HCs, still lack basic amenities such as water, electricity, toilets, modes of communication, and transportation. These basic amenities are necessary for providing quality care.

EVALUATION QUESTION 3:

Have knowledge, attitudes, and practices to support health-seeking behaviors increased in targeted health zones?

- Health seeking behaviors improved for an array of preventive services and seeking curative care at a health facility.
- Health practices for postnatal care and WASH were not improved.

IHP supported improvements in health-seeking behaviors in the following areas: family planning, maternal and child health, particularly in antenatal care and facility-based childbirth, malaria prevention, knowing one's HIV status, and seeking health care when a child is sick. Improvements in healthy practices included: women going to a health center for at least four antenatal visits, bed net use, modern contraceptive use, exclusive breastfeeding, and HIV testing. However, there was little evidence of healthy practices among households and facility clients in postnatal care, use of early initiation of breastfeeding, hand washing with soap, and drinking water treatment; the one exception was usage of improved water source by the households. Mothers' knowledge about major childhood illnesses improved, while knowledge about HIV and genital fistula remained unchanged.

EVALUATION QUESTION 4:

Has the health sector leadership and governance in the four targeted provinces improved?

- Health sector leadership and governance has improved in the four targeted provinces over the past 5 years.

Through technical trainings and LDP, IHP has improved the ownership and accountability among HZ managers and health workers. The IHP technical and financial support revitalized the roles and responsibilities of the CODESA. However, their involvement in planning and decision-making is still limited to awareness generation activities only. The Community Champions approach appears to be an effective strategy, but needs to be evaluated in the local context. The annual operating plans of the districts and zones were formulated jointly with IHP and other partners. Nevertheless, the lack of involvement and communications with provincial authorities led to delayed validation and finalization of annual plans.

EVALUATION QUESTION 5:

What are the external factors that hamper IHP activities from delivering better results?

- IHP faced a wide range of external factors that hamper IHP activities from delivering better results. The majority of these factors were outside the manageable control of IHP implementation partners.

IHP is operating in a resource-constrained environment where the health system lacks sufficient financial and material resources. Health care provision in the IHP-supported health facilities is hampered by the country's large geographic size, poor road conditions, lack of proper transportation system, poor health facility infrastructure, unavailability of regular electricity supply and running water, and insufficient or non-existent health worker compensation. The country's chronic insecurity compelled IHP to either halt or minimize field activities in affected areas.

IHP has encountered logistical problems in providing the consistent supply of essential medicine and medical equipment. These factors include the lack of a functional LMIS and a lack of coordination and communication between various Congolese government departments.

EVALUATION QUESTION 6:

How is IHP perceived and valued?

- IHP's support aligned with the PNDS components and its facilitation of activities was important to the MSP.
- IHP trainings, technical assistance, and leadership development support were highly valued.
- IHP weaknesses, while pertinent, were not a substantial nor were they an impediment to positive progress.

One of IHP's major benefits was the project's technical assistance and trainings, which were perceived as excellent. Other trainings appreciated were the FOSACOF training, specialized clinical trainings in HIV screening, PMTCT, FP/RH, and IMCI services. The establishment of Community Champions and strengthening of CODESA is highly appreciated. IHP's technical advisors and coordination office staff are generally valued. IHP's support for the supervisory visits and meetings in a very timely way is highly appreciated. Another main benefit was the supply of medications and medical supplies in the four provinces, despite irregular deliveries and the limited range. The LDP was highly regarded by HZ, district, and provincial managers.

The main weakness identified was the insufficient budgetary resources available to address the needs of health facilities, including facility renovations, procurement of medicines and medical supplies. Another weakness identified was the mismatch between IHP's work plan and the priorities reflected in the annual work plans of the target HZs. IHP's lack of technical assistance and support for the implementation of WASH activities in all targeted zones was considered a weakness.

RECOMMENDATIONS

The recommendations provided are both for immediate implementation by IHP and for long-term consideration for USAID to take into consideration for future strategies, plans, and programming.

EVALUATION QUESTION 1:

To what extent has the project improved access to and availability of MPA-plus and CPA-plus services and products in the targeted health zones?

- **Provide additional support to improve availability and access to MPA-plus and CPA-plus services and products.**

Additional technical support and financial support will be needed to support the expansion of MPA-plus and CPA-plus service delivery and related products in catchment areas of the target HZs. Efforts will be necessary to increase the percentage coverage of health services (such as growth monitoring, nutrition rehabilitation, TB, HIV/STIs, blood transfusion, and other neglected tropical diseases). Additional support should be mobilized based on the targeted HZs' need for the implementation of community activities related to WASH, support for orphans, nutrition, fish- farming, gardening, and livestock breeding.

EVALUATION QUESTION 2:

Has the project improved the quality of key family services in target health zones?

- **Continue competency-based trainings to service providers**

The project should provide training workshops, refresher training, and on-the-job training to service providers to increase their ability to consistently deliver quality family health services in the target areas. IHP should also provide training on data reporting and pharmaceutical logistics at all the targeted sites. This will improve quality of facility statistics and stock management, including drug/supply quantification based on the health facilities' needs.

- **Assume a more holistic and comprehensive approach to monitoring the quality of care, incorporating health-seeking behaviors as well as other proximate determinants such as personnel and structural inputs.**

Continued technical assistance is needed for the provincial and district health management teams to supervise the implementation of FOSACOF activities. The facility supervision should be intensified to include direct observation of provider/client interaction and on-the-job training in the target health facilities. Health zone managers should be able to contribute to on-the-job capacity building and briefings conducted during regular monthly or quarterly supportive facility supervision visits to HCs. This will strengthen the capacity of service providers to ensure continued delivery of quality family services and enhance compliance with national health standards and protocols. This will strengthen the capacity of service providers to ensure continued delivery of quality family services and enhance compliance with national health standards and protocols.

- **Support stock management in the IHP-supported health zones and facilities**

IHP should look at the root cause of stockouts and apply its comparative advantage and long experience in procurement to mitigate the ongoing problems of stockouts of MPA-plus and CPA-plus products. IHP should systematically improve upon the implementation of the LMIS at all functioning health facilities to ensure monthly and quarterly reporting of stock status to HZs and to CDRs. IHP should ensure the correct quantification of commodities by targeted HZs to avoid future shortages and stockouts of medicines and medical supplies. Delivery schedule for medicines and medical supplies to the regional distribution center should be semi-annual, to ensure that quarterly deliveries are made to the HZs and the related facilities.

- **Provide support for facility renovations to improve basic amenities**

Priority renovation and equipment of health facilities that are planned should conform to established norms and standards by the MSP to improve the delivery of key family services in target HZs. Solar electrification, continuous water supply, and slab covered pit latrines should be provided where basic amenities are lacking.

- **Considering IHP activities are increasing the quantity of services provided, forward planning by the MSP is warranted to meet this demand with an adequate supply of nurses deployed in the health facilities.**

Given that the MSP is currently operating with limited human resources for health, an immediate increase in the workforce volume to meet the existing demand is unrealistic without significant investment. USAID should work with the MSP to identify strategies that could be implemented alongside training and recruitment to help meet the increased demand for services. An assessment of the available supply of nurses graduating from health training institutions would be needed to determine the minimum workforce needs in the future. As human resources for health is outside the scope of the IHP mandate and scope, this recommendation applies to USAID and MSP for their consideration.

EVALUATION QUESTION 3:

Have knowledge, attitudes, and practices to support health-seeking behaviors increased in targeted health zones?

- **Promote innovative BCC approaches which motivate health behavior change**

Develop behavior change communication strategies and interventions that lead to behavior change among individuals—especially related to nutrition, newborn and postnatal care, early breastfeeding, treatment of childhood illnesses, infectious diseases, and WASH. These BCC interventions should build on the positive changes in community knowledge gains achieved by the project thus far. There is a need to promote innovative BCC approaches, in addition to standard BCC approaches, which motivate health behavior change and enhance the adoption of healthy practices among community members.

- **Improve awareness about importance of WASH services**

Organize sensitization sessions to enlist the support of village chiefs and CODESAs to build community/family covered latrines, improved water sources, and support campaigns for WASH interventions.

EVALUATION QUESTION 4:

Has the health sector leadership and governance in the four targeted provinces improved?

- **Expand leadership development program at all health system levels**

IHP should expand LDP training to all levels of the target HZs and their related communities. LDP, coupled with FOSACOF training and implementation, should be discussed and prioritized for inclusion in the development of HZs' annual work plans in consultation with HZ management teams.

- **Ensure involvement of the national and provincial level authorities in AOPs development**

IHP should involve national and provincial level authorities to coordinate AOPs' development, in order to reduce delays in organizing validation workshops and other operational issues. This could be accomplished through greater coordination and persistent communication efforts at the national and provincial levels. With the reorganization of provinces, districts, and HZs in the DRC, there are likely to be newly-organized ECZs with varying levels of technical expertise. IHP should continue to support these teams in the development of AOPs in accordance with the national health policies. IHP should promote the development of annual work plans by target HZs, which include other development partners active in the province, to promote increased coordination and prioritizing of development activities that can be supported by the MSP and donors.

- **Continue supporting community organization with a stronger emphasis on community leaders' trainings**

IHP should continue supporting community organizations with a stronger emphasis on community leaders' trainings and a focus on creating community demand for quality of services. This will therefore improve the service use of key family health services by the community. IHP should continue to build the capacity of community organizations, such as Champion Communities, particularly in effective governance, including their role and responsibilities as a community development organization and their skills in mobilizing and using available local resources.

- **Strengthen the capacities of provincial and health zone management teams to improve data quality**

Strengthen the ability of the ECZs to improve data quality reporting. IHP should encourage DPS and HZs to institutionalize annual data quality audits to complement supervision efforts. They should provide feedback to the health facilities for improved data collection and reporting. This will enhance data quality for decision making at national, provincial, and local levels for improved service delivery. This will also reduce the inconsistencies of the health information system between health facilities and the national health information system.

EVALUATION QUESTION 5:

What are the external factors that hamper IHP activities from delivering better results?

- **Support implementation of a functional logistic management information system**

IHP should work with MSP and other relevant government entities to implement a functional LMIS at central, provincial, and local levels. The LIMS should be able to quantify the needs and provide information on stock status of medicines

and medical supplies on a monthly and quarterly basis. The functional LIMS should ensure drug deliveries continue to be regular, that drug procurement problems are solved, and that its list of drugs is reviewed for possible changes to better meet drug supply needs in the targeted zones, taking into consideration the differing needs of HCs and hospitals. This will facilitate better quantification, timely drug procurement, and deliveries to service delivery points for improved drug management and use.

- Mobilize additional resources from other development partners and MSP

IHP should mobilize additional financial and material resources from other development partners, including UNFPA, DFID, etc., which might be able to cover the gaps in the resources that IHP was unable to provide at the targeted HZs. Review meetings and increased coordination involving all the development partners active in or around the targeted HZs should be established to support the increased delivery of quality health services in the relevant zones, including the coordination of procurement and delivery of medicines and medical supplies.

Support for carrying out quarterly review meetings should be institutionalized by DPS and HZs with the involvement of other donors and development partners that are active in the same provinces or HZs. This will support increased delivery of quality health services and avoid duplication and waste of resources. IHP should also encourage the provincial- and central-level MSP to release the budgeted monthly salaries and "primes" (bonuses) for services providers, in order to improve their morale and enhance productivity.

EVALUATION QUESTION 6:

How is IHP perceived and valued?

- USAID should build on the positive changes and improve on the weaknesses during the next phase of IHP

Based on the lessons learned from IHP's implementation, USAID should build on the positive changes and improve on the weaknesses that are within their manageable control during the next phase of IHP. Interventions that were integrated and institutionalized at facilities and in communities based on IHP's efforts, for example, counseling for family planning, are likely to be sustained without too much financial support from donors. Skills learned in leadership development and clinical trainings are likely to be sustained, provided they are supported by continuous staff supervision and on-the-job refresher trainings. The newly developed and acquired technical and management skills, gained through IHP, by health facility staff and management teams at provincial, district, and zonal levels will need to be monitored and evaluated for their performance.

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USAID
FROM THE AMERICAN PEOPLE

Final Performance Evaluation of the Integrated Health Project in the Democratic Republic of Congo

Annex Volume

March 2016
This publication was produced for review by the United States Agency for International Development. It was prepared independently by International Business & Technical Consultants, Inc. (IBTCI). It was authored by Swati Sadaphal, and Annette Bongiovanni.

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Annex Volume

March 2016

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ANNEX A. STATEMENT OF WORK

INTEGRATED HEALTH PROJECT: PERFORMANCE EVALUATION

Purpose

In September 2010, USAID/DRC awarded the five-year $139,767,129 Integrated Health Project (IHP), Cooperative Agreement #AID-OAA-A-10-00054, to Management Sciences for Health (MSH) and its partners—International Rescue Committee and Overseas Strategic Consulting Ltd. The purpose of this solicitation is to identify a contractor to carry out multiple external evaluations of IHP. USAID/DRC intends to conduct a performance evaluation of IHP. The performance evaluation will assess whether results of the project are being achieved as planned. The evaluation responds to USAID's new evaluation policy released in February 2011. The design and implementation of the evaluation will be closely coordinated with USAID/DRC and MSH.

Background and Context

Country Context

The Democratic Republic of Congo (DRC) currently has one of the lowest gross national incomes per capita in the world ($190).1 An estimated 80 percent of the population lives below the poverty line and half live in extreme poverty. The country has suffered a long decline from relative prosperity to complete free-fall that accelerated in the 1990s during the decade of conflict that accompanied the collapse of the former Zaire. DRC was ranked 187 out of 187 countries in the 2011 Human Development Index. Now, stakeholders are cautiously optimistic that the worst is over; recently, multiple donors have demonstrated renewed interest, particularly in supporting development of the health sector.

Until 1990, DRC's health system was well known in Africa for its network of health facilities, quality of physicians, and primary health care system. This was due, in part, to significant support from USAID and faith based entities (Protestant and Catholic missionaries). The U.S. Government invested heavily in the training of health workers, including the establishment of a School of Public Health in Kinshasa. However, war and mismanagement led to significant backsliding in the health sector. The health system now lacks financial and material resources and supply chain breakdowns are widespread, particularly in remote areas. This leaves a majority of the country with limited access to often poor quality health care services. Access to primary health care remains a challenge, with 70 to 80 percent of the population having difficult or no access to health care or who do not utilize the care available. Access varies widely by province and health zone, with urban areas generally better served than rural.

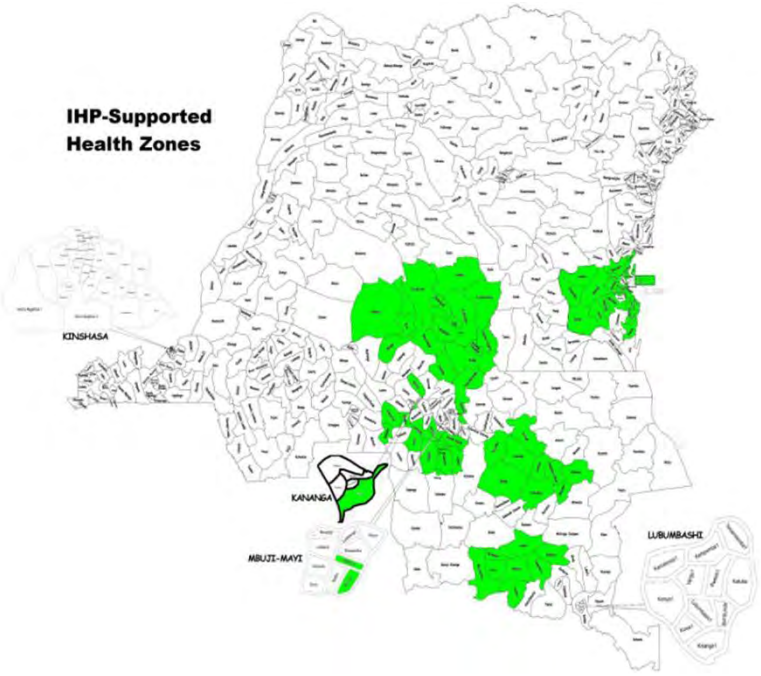
High population growth impedes economic growth, and threatens to undo future gains in the social services sector. Projections of population growth indicate that the DRC's population will more than double by the year 2050, from the current estimate of 68 million to nearly 147 million[2].

[1] World Development Indicators Database: World Bank, December 2011.

[2] This expanding population will exert increased pressure on the country's resources and communities and will present dramatic challenges to provide and deliver basic services. Before 1990, USAID-supported project areas experienced relatively high rates of family planning. The contraceptive prevalence rate (CPR) has fallen dramatically in the two decades since, and the country now has one of the highest total fertility rates (TFRs) and one of the lowest CPRs in the world. Against this background of pressing social needs, the Government of DRC (GDRC) will be challenged to demonstrate tangible progress in development and in rebuilding basic health services

INTEGRATED HEALTH PROJECT

Integrated Health Project Overview



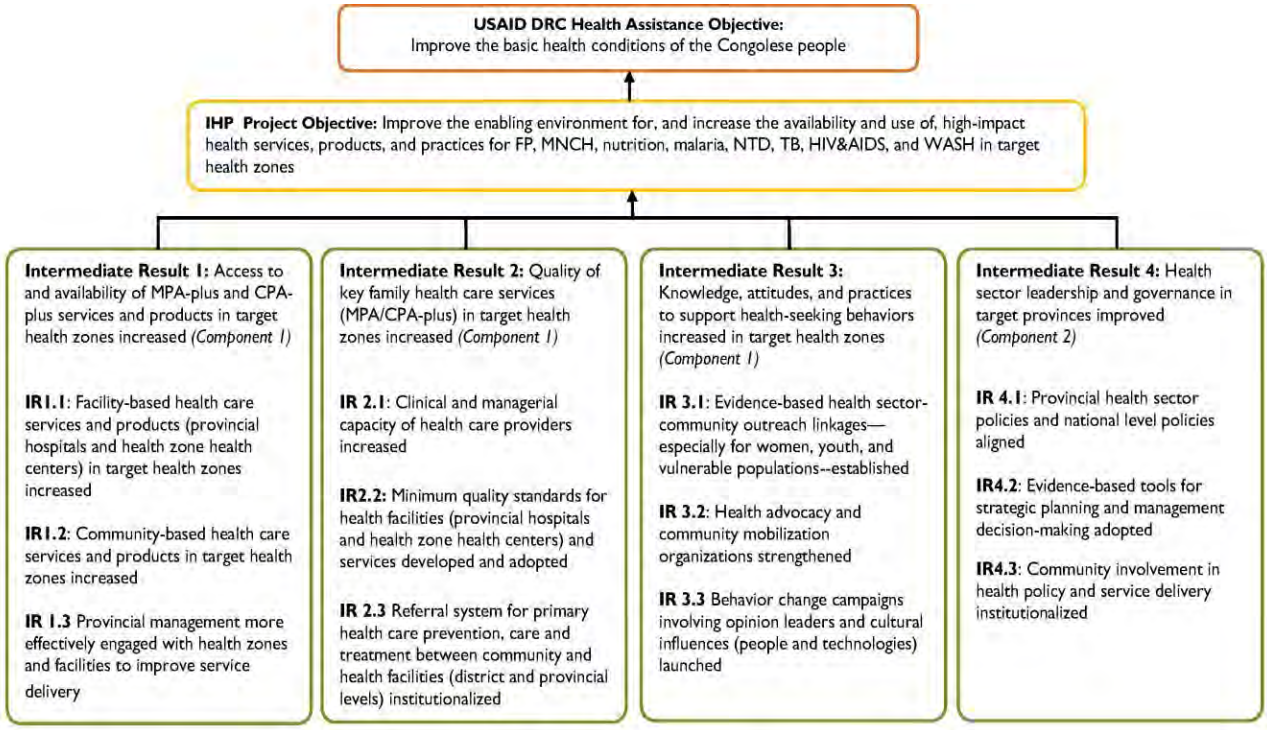
The five-year USAID-funded IHP supports the National Health Development Program (PNDS) of the DRC. The project's goal is to improve the enabling environment for, and increase the availability and use of, high-impact services, products, and practices for family planning; maternal, newborn, and child health; nutrition, malaria, and tuberculosis; neglected tropical diseases; HIV; and water/sanitation/hygiene in the target health zones. The project has two components. Through IHP Component 1, Services, IHP is supporting the first strategic focus of the PNDS: health zone strengthening. Component 2, Other Health Systems, corresponds to the second PNDS strategic pillar, support for health zone strengthening in six priority areas: human resource development; pharmaceutical management; health finance; construction/rehabilitation of infrastructure; equipment and new technologies; and improved health system management. Component 1 strengthens health zones' capacity to deliver services by addressing both the supply and demand sides of services. Under Component 2, Health Systems, IHP is focusing on activities that create the enabling environment for strong health zones, with particular emphasis on leadership and governance and the provision of resources tied to performance to eliminate health system bottlenecks stemming from unaligned or absent policies, particularly at the provincial level.

The project is designed to create better conditions for, and increase the availability and use of, high impact health services, products, and practices. The project works in 80 target health zones in four provinces (East Kasai, West Kasai, Katanga, and South Kivu).

At the end of the five-year IHP life of project it is anticipated that 80 percent of target health centers and general referral hospitals will offer the minimum package of health service activities-plus and complementary package of health service activities-plus (MPA-plus and CPA-plus). Many bilateral and multinational donors, as well as faith-based (FBOs) and non-governmental organizations (NGOs), are providing support to implement MPA/CPA-plus, as well as technical assistance for specialized health systems strengthening interventions at all levels. Under IHP, MSH builds on this investment through service

delivery contracts with providers and the Ministry of Health (MOH), ensuring they receive training, medical equipment and access to essential medicines and other health commodities.

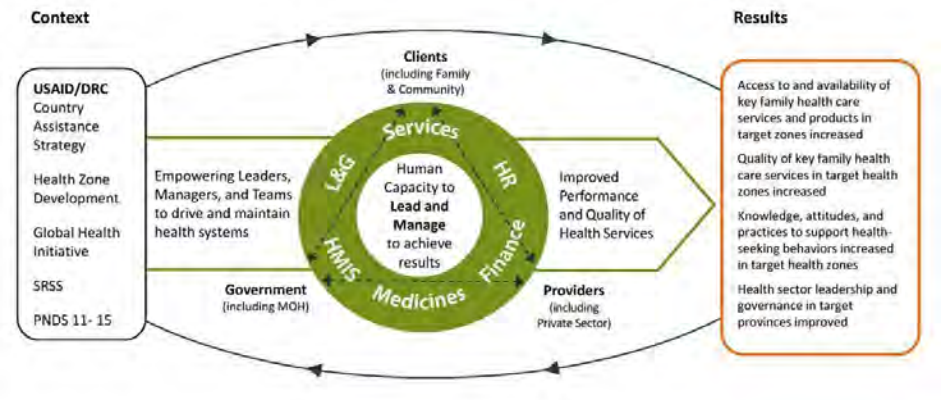
IHP Results Framework



Project Approach and Implementation

The overarching technical strategy used by IHP to integrate activities across health system sectors, levels, and geography is people-centered health systems strengthening, presented in Figure 1. At the heart of the strategy is outreach to providers, health authorities, community organizations, and families with evidence-based techniques they can use to impact the health system in ways they experience as meaningful and sustainable. IHP builds human capacity to lead and manage for health results, whether in the public, civil society, or private sector. Two of the evidence-based techniques scaled up under the strategy are: leadership and management training and the Fully Functional Service Delivery Point (FOSACOF) service delivery model.

Figure A-1: Building People-Centered Leadership and Management Capacity



As shown in Figure 1, interactions between and among health stakeholders—the government, personnel in health sector subsystems, clients, communities—play a critical role in overall system performance and the ultimate health status of citizens. IHP tailored a Leadership Development Program (LDP) for participants with major roles in HZ strengthening: provincial planning authorities, health zone management teams, facility management teams, community organizations, patient groups, and so on.

Existing Information

The following background documents are included in the SOW as annexes: Project health zone data (Annex A) Minimum package of health service activities-plus and complementary package (Annex B) USAID/DRC and IHP will provide the successful contractor with a package of briefing materials upon award, including: Detailed Project Description, Project quarterly and annual reports, Project Performance Monitoring Plan, Report on the first part of IHP's Performance baseline survey, a population-based study on Knowledge & Practices and Coverage of Key IHP performance indicators, conducted by MSH in May 2011 (IHP Part 1 baseline).

EVALUATION RATIONALE

Performance Evaluation Rationale

The performance evaluation will help USAID/DRC determine what components and project aspects are working well and why, and which constraints the project faces, and to make modifications and midcourse corrections, if necessary. As part of IHP's evaluation strategy, MSH and its partners conducted the first part of a baseline study (IHP Part I Baseline) on knowledge, practices, and coverage of key health areas in May 2011. The study used a cross- sectional population-based survey to assess the health conditions of young children, their mothers, and women of reproductive age living in IHP target areas. The survey used the Lot Quality Assurance Sampling (LQAS) methodology with a parallel sampling strategy. A second baseline study (IHP Part II Baseline) of targeted facilities is required to elicit and analyze information on the provision and quality of key health services. The study will provide quantitative and qualitative baseline data on access, availability, utilization, and quality of a minimum package of activities/complementary package of activities at the health centers and general referral hospitals.

USAID fully recognizes that the IHP Part II Baseline will have been collected well into project implementation and while this is not ideal, it will still offer data to compare to an end line survey. As part

of the performance evaluation the contractor will carry out a baseline (facilities), mid- term, and final evaluation according to the following schedule:

IHP PERFORMANCE EVALUTION SCHEDULE

IHP Part I Baseline (completed)	May 2011
IHP Part II Baseline	December 2013
IHP Mid-Term Evaluation	Dec 2014
IHP Final Performance Evaluation	March 2016

OBJECTIVES OF THE EVALUATION

Performance Evaluation Objectives

Final Evaluation Objective: To determine the extent to which project outcomes were achieved and to inform future USAID/DRC integrated health strategy and design.

Audience and Intended Uses

The audience of the performance evaluation will be the USAID/DRC Mission, specifically the health team and program office, and the implementing partner. An Executive Summary and recommendations will be provided to the MOH. USAID will use the report to make changes to its current integrated health strategy and to share lessons learned with other stakeholders.

The audience of the RBF impact evaluation will be the USAID/DRC Mission, specifically the health team and program office, the implementing partner, the Ministry of Health, donors involved in RBF piloting, and secondary users like NGOs and other stakeholders. USAID/DRC will use this evaluation to inform policy and learning on RBF.

Evaluation Questions

Evaluation questions will structure the evaluation process, and USAID intends that these be aligned with the evaluations purpose and expected use. It also intends that each question be answerable with the highest quality and most credible evidence possible, given time and budget constraints. To ensure this, the total numbers of questions included in the SOWs for each evaluation will be limited.

IHP PERFORMANCE EVALUATION QUESTIONS

The final performance evaluation will focus on verifying the theory of change underlying IHPs results framework. The following illustrative questions may lead the evaluation:

1. To what extent has the project improved access to and availability of MPA-plus and CPA-plus services and products in targeted health zones?
2. Has the project improved the quality of key family health care services in targeted health zones?
3. Have knowledge, attitudes, and practices to support health-seeking behaviors increased in targeted health zones?
4. Has the health sector leadership and governance in the four targeted provinces improved?
5. What are the external factors that hamper IHP activities from delivering better results?
6. How is IHP perceived and valued?

EVALUATION DESIGN AND METHODOLOGY

USAID/DRC will provide the contractor with a statement of work for each evaluation component (baseline, mid-term, and final) conducted under this contract but the contractor will design the methodology, sampling frames, and data collection instruments in consultation with USAID/DRC staff, implementing partners and country counterparts. Illustrative designs are set forth in Section J – Attachments. For the two baseline evaluations a SOW will be provided immediately after award of the contract and will require a collaborative effort between USAID and the contractor due to time sensitivities. The SOWs for all mid-term and final evaluations will be provided at least four months prior to the start of each evaluation component. The contractor will be responsible for managing the evaluation and data collection in the field, working directly with program implementers, verifying data quality, and preparing clean data sets, for analysis.

USAID/DRC will provide the contractor with a statement of work for each evaluation component (baseline, mid-term, and final) conducted under this contract but the contractor will design the methodology, sampling frames, and data collection instruments in consultation with USAID/DRC staff, implementing partners and country counterparts. Illustrative designs are set forth in Section J – Attachments. For the two baseline evaluations a SOW will be provided immediately after award of the contract and will require a collaborative effort between USAID and the contractor due to time sensitivities. The SOWs for all mid-term and final evaluations will be provided at least four months prior to the start of each evaluation component. The contractor will be responsible for managing the evaluation and data collection in the field, working directly with program implementers, verifying data quality, and preparing clean data sets, for analysis.

EVALUATION DESIGN

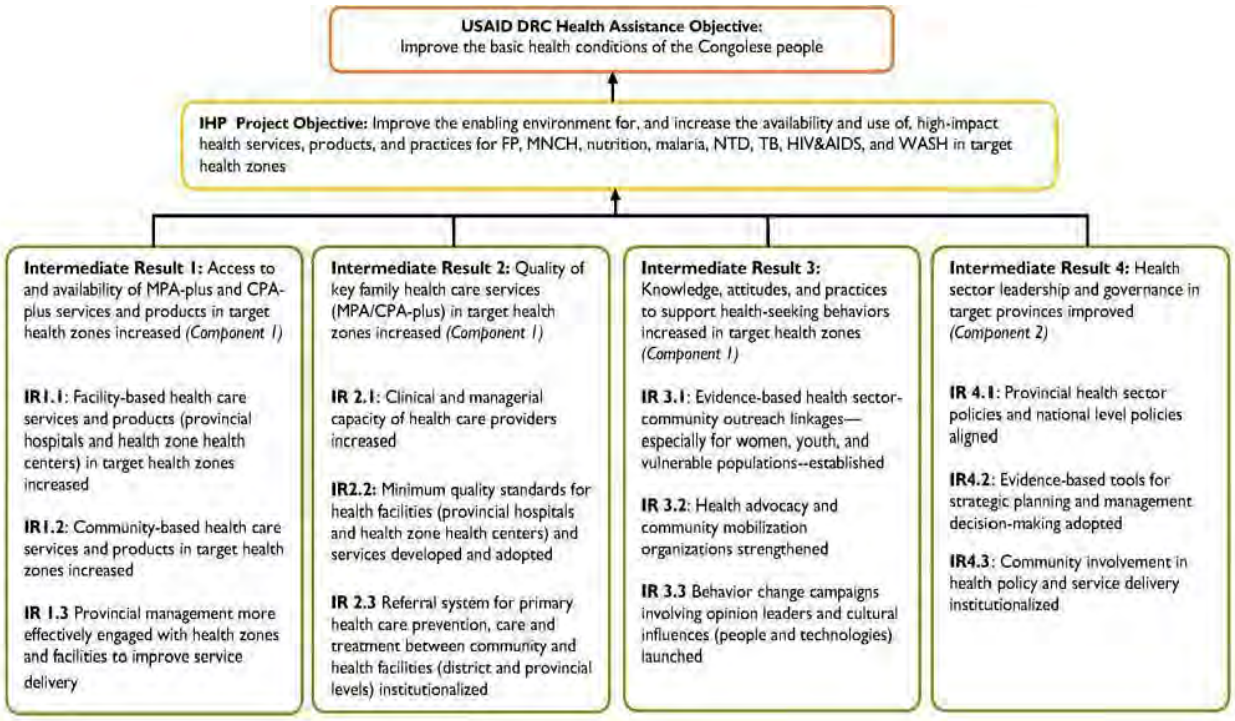
Performance Evaluation will include participatory methodologies to be built in at key stages for measuring potential behavior change, and for learning. Both quantitative and qualitative methods will be used. Questions will need to be answered around all key outcomes/results of IHP with particular focus on changes at the household level; why, how and under what circumstances/conditions change occurs. Case studies and targeted studies may also be considered to test the hypotheses and provide more in-depth understanding of the process of change, particularly at household level. USAID recognizes that the Baseline Part II (facilities baseline) is being collected well after implementation of the IHP project has begun. The final evaluation will note that the baseline for the facilities component was collected later in implementation.

Data Collection Methods

Data collection methods will neither completely be prescribed by USAID/DRC nor completely left up to the contractor to propose. USAID encourages a collaborative approach to their development. The following steps for developing the SOW for the evaluation are envisaged:

1. USAID will provide a first draft of the evaluation SOW to the contractor.
2. Within 15 working days, the contractor will provide comments to the SOW and propose the detailed methodology for data collection and data analysis.
3. USAID conducts an internal peer review of the SOW and methodology and provides final comments to the contractor (within five working days)
4. The contractor finalizes the SOW and methodology and submits to USAID for final approval (within five working days)
5. USAID provides final approval of the SOW (within three working days).

ANNEX B. IHP RESULTS FRAMEWORK



ANNEX C. DATA COLLECTION TOOLS

Enquête sur les structures de santé (ESS) DRC 2015

EVALUATION LIGNE BASE
PROJET INTEGRE DE SANTE (PROSANI) MSH

QUESTIONNAIRE DISPONIBILITE DES SERVICES ET EQUIPEMENT

N°	QUESTION		N°	QUESTION	
	GPS Location :			Code du « data collector »:	
	Nom de la structure sanitaire _____			Code de la structure : /_____/	
	Nom de l'Aire de Supervision			Code de l'Aire de Supervision	
	Nom de la Zone de santé			Code de la Zone de santé	
	Type de structure : Centre de santé Hôpital Général de Référence	 1 2		Nom et code de la Province Kasaï Occidental Kasaï Oriental Katanga Sud-Kivu	 1 2 3 4
	Nom et code du superviseur :			Urbain/Rural : Urbain Semi-urbain Rural	 1 2 3
	Catégorie professionnelle du répondant: Médecin Infirmier d'état Sage-femme d'état Technicien de santé Agent technique de santé Médecin stagiaire/bénévole Autre stagiaire/bénévole Autre (préciser) : _____	 1 2 3 4 5 6 7		Date et Heure de l'enquête Date : /____ /____/_____/ Heure : /_____H:_____/ Minutes	

Guide pour l'enquête sur la disponibilité des services et équipement
Trouver l'Infirmier Titulaire e Chef du centre de santé ou le Médecin Directeur du HGR et se présenter comme suit :

Bonjour. Je m'appelle _____. Je représente IBTCI une organisation de recherche qui travaille avec l'USAID en collaboration avec le Ministère de la Santé. Mous menons une enquête dans les établissements de santé appuyés par l'USAID à travers MSH/PROSANI dans le but d'identifier les moyens d'améliorer la prestation des services. Nous aimerions nous entretenir avec vous sur la situation de cet établissement et la disponibilité des services et équipement. Soyez assuré que notre conversation demeurera strictement confidentielle et qu'il sera impossible de vous identifier. Vous pouvez, à tout moment, choisir d'interrompre l'entrevue ou refuser de répondre à une question.
Puis-je continuer ? ***Oui….*** ***Non****…*

Si NON, aller à la fin du questionnaire

MODULE 1 : INFORMATIONS GENERALES SUR LA FORMATION SANITAIRE (IG)

N°	QUESTIONS	CODE
	Observer seulement et noter *voyez*-vous une pancarte ou une affiche indiquant la disponibilité des services suivants (encercler toutes les réponses appropriées) :	Oui, A L'EXTERIEUR / Oui, A L'INTERIEUR / Non
	A) Services de planification familiale	1 / 2 / 0 1
	B) Services de santé infantile	2 / 0
	C) Consultations prénatales	1 / 2 / 0 1
	D) Consultations pour les IST/SIDA	2 / 0
	E) Les tarifs pour les services	1 / 2 / 0
	Si tarif NON affiché? Allez à IG3	
	Si OUI, quel prix est marquée pour:	
	La fiche à la première visite	/_____/ FC
	Cas malaria	/_____/ FC
	Cas diarrhée	/_____/ FC
	Consultation prénatale	/_____/ FC
	Accouchement	/_____/ FC
	Planification familiale	/_____/ FC
	Petite chirurgie/Circoncision	/_____/ FC
	Laboratoire	/_____/ FC
	CPS	/_____/ FC
	Hospitalisation	/_____/ FC
	Autres (préciser) : _____	/_____/ FC
		/_____/ FC
		/_____/ FC
		/_____/ FC
	Y a-t-il une salle d'attente pour les patients ?	
	Oui	1
	Non	2
	Combien de jours cet établissement est-il ouvert aux patients externes ? (Les patients externes sont ceux qui reçoivent des soins préventifs ou curatifs qui rentrent chez eux le même jour.)	
	Nombre de jours	/_____/ jours
	Nombre de jour par mois	/_____/ jours
	Ne sait pas	98
	Est-ce que ce centre fournit des soins à toute heure? c.-à-d. 24 heures sur 24?	
	Oui	1
	Non	2
	À quelle heure de la journée commencez-vous les soins aux malades externes?	/_____ /
	À quelle heure prennent fin les soins aux malades externes?	/_____ /
	Avez-vous une source d'électricité en permanence dans l'établissement ?	
	Oui	1
	Non	2

N°	QUESTIONS	CODE
	Si non, allez à IG11	
	Si oui laquelle ? Groupe électrogène Panneau solaire SNEL Autre (spécifier) : _____	 1 2 3 4
	Avez-vous de l'électricité aujourd'hui ? Oui Non	 1 2
	Avez-vous de l'eau en permanence dans l'enceinte de l'établissement ? Oui Non***Si non, allez à IG14***	 1 2
	Si OUI, quelle en est la source ? Forage Puis aménagé REGIDESO Citerne d'eau de pluie Autre (spécifier) :_____	 1 2 3 4 5
	Avez-vous de l'eau courante aujourd'hui ? Oui Non	 1 2
	L'établissement dispose –t-il d'un moyen de communication pour les cas d'urgence ? Oui Non ***Si non, allez à IG17***	 1 2
	Si OUI, lequel ? Téléphone Phonie Motorola/radio VHF Internet Radio à onde courte Autre (spécifier) _____	 1 2 3 4 5 6
	Ces appareils sont-ils fonctionnels ? Oui Non	 1 2
	L'établissement a-t-il accès à un moyen de transport en tout temps ? Oui Non ***Si non, allez à IG19***	 1 2
	Quels types de moyen de transport dispose l'établissement actuellement ? Moto Véhicule Vélo Autre (spécifier) _____	 1 2 3 4
	Il ya t-il des toilettes dans cet établissement ? Oui Non	 1 2 si Non allé à IG21

N°	QUESTIONS	CODE
	Si oui, quel type de toilette/douche ? Latrines à fosse septique Fosse arabe Autre (spécifier) _____	 1 2 3
	Quel(s) désinfectant(s) sont utilisés dans la formation sanitaire? Cytéal (Chlorhexidine - gluconate) Dakin Eau de javel (Hypochlorite de Sodium/Chlorine solution/JIKsolution) Alcool dénaturé AUTRE A PRÉCISER : _____	 1 2 3 4 5
	Avez-vous des désinfectants actuellement en stock ? Oui Non	 1 2
	Quelle est la procédure utilisée pour décontaminer les équipements médicaux après l'utilisation initiale? Imbibés dans une solution désinfectante, puis brossés et frottés avec du savon + eau Brossés avec du savon et de l'eau, puis trempés dans une solution désinfectante Brossés uniquement avec du savon et de l'eau Trempé seulement dans une solution désinfectante Nettoyés avec de l'eau et du savon Equipements jamais décontaminés Equipements jamais réutilisés Autre (préciser) : _____	 1 2 3 4 5 6 7 8
	Quelle est la procédure utilisée pour la stérilisation de l'équipement médical avant réutilisation? Stérilisation en chaleur sèche (poupine) En autoclave Ebullition Stérilisation à la vapeur Méthode chimique Autre (préciser): _____	 1 2 3 4 5 6
	Y a-t-il des dispositions prévues pour l'élimination des déchets bio médicaux? Oui Non Ne sait pas	 1 2 98
	Comment se fait l'évacuation des déchets dans l'établissement ? Incinération dans l'incinérateur Incinération dans la nature Enfouissement Jetés dans la nature Autre (spécifier) : _____	 1 2 3 4 5
	Commentaires de data Collector	
	Commentaires du superviseur	

MODULE 2 : STATISTIQUES SUR LE PERSONNEL (SP)

CATÉGORIES PROFESSIONNELLES	**SP1** : Nombre disponible en fonction actuellement		
	Nombre;	Ne sait pas=98;	Non établi=99
a) Médecins			
b) Infirmiers A1			
c) Infirmiers A2			
d) Infirmiers A3			
e) Accoucheuse diplômée			
f) Matrones / accoucheuses villageoises			
g) Relais communautaire			
h) Technicien de laboratoire			
i) Nutritionniste			
j) Kinésithérapeute			
k) Autre (spécifier) : _____			
Autre (spécifier) : _____			
Autre (spécifier) : _____			

Catégorie	**SP2** : Sexe	Quels services sont assurés par (NOM) ?				**SP7** : Est-ce que (Catégorie) a reçu une formation durant les 3 dernières années ?
		SP3. Planning familial	**SP4**. Soins prénatals/ postnatals	**SP5**. Santé de l'enfant	**SP6**. IST/SIDA	
a) Médecins	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à b)]
b) Infirmiers A1	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à c)]
SUc) Infirmiers A2	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à d)]
d) Infirmiers A3	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à e)]
e) Accoucheuse diplômée	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à f)]
f) Matrones / accoucheuses villageoises	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à g)]
g) Relais communautaire	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à h)]
h) Technicien de laboratoire	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à i)]
i) Nutritionniste	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à j)]
j) Kinésithérapeute	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2 [à k)]
k) Autre (spécifier) : _____	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2
Autre (spécifier) : _____	M....1 F....2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2

Autre (spécifier) : _____	M....1 F….2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2	Oui....1 Non...2

MODULUE 3 : SOINS PREVENTIFS (PREV)

N°	QUESTIONS		CODES
	Combien de patients externes (au total) ont été reçus dans cet établissement les 12 derniers mois ? (Le nombre pour les 12 derniers mois pour lesquels les données sont disponibles.)	Nombre Ne sait pas	/_____ / 98
	CPN		
	Cet établissement offre-t-il des consultations prénatales (CPN) ?	Oui Non	1 2 [Passer à Prev20]
	Combien de jours par semaine les clientes CPN sont-elles reçues dans l'établissement ?	Nombre par semaine Nombre par mois Ne sait pas	/_____ / /_____ / 98
	Combien de consultations prénatales y'avait-il dans ce centre de santé en 2014 ?	Nombre Ne sait pas	/_____ / 98
	Pendant les 6 derniers mois, combien de réunions est ce que la formation sanitaire a tenu avec les accoucheurs (ses) traditionnel (les)?	Nombre Ne sait pas	/_____ / 98
	Durant toute l'année 2014, avez-vous prescrit du fer et de l'acide folique de façon systématique? ***Enquêteur : vérifier les registres. S'il n'y a pas de registres, demandez au responsable. Inscrire les réponses en tenant compte du fait que vous avez consulté les registres ou non.***	Oui Non Ne sait pas	1 2 98
	Les femmes enceintes en CPN reçoivent-elles le Vitamine A?	Oui Non	1 2
	Les femmes qui viennent à la formation sanitaire pour les soins prénataux reçoivent-elles des carnets de santé prénatale ou maternelle? **Si non, passez à PREV11**	Oui Non	1 2
	Où est gardée la carte de santé maternelle une fois qu'elle a été délivrée à la mère?	Remise à la mère afin qu'elle l'apporte à la prochaine visite	1
		Gardée au sein de la formation sanitaire	2
		Un exemplaire est remis à la mère et l'autre gardé à l'hôpital	3
		Autre, précisez: _____	4
	Pouvez-vous me montrer des cartes qui appartiennent à des patients précis?	Vu Pas vu	1 2
	PTME		
	Les femmes reçues en CPN sont-elles conseillées pour le test VIH en vue de la PTME?	Oui Non	1 2 **Si non, passez à PREV 20**
	Le centre propose-t-il de manière systématique le test VIH aux femmes enceintes pour la prévention du VIH de la mère à l'enfant?	Oui Non	1 2
	Le Centre dispose-t-il du personnel formé pour la PTME?	Oui	1

		Non	2
	Combien de femmes enceintes ont été dépistées pour le VIH en 2014?	Nombre Ne sait pas	/_____/ 98
	Quels services le Centre propose-t-il aux femmes enceintes dépistées séropositives au VIH et à leurs bébés?	Référées pour traitement à l'HGR	1
		Reçoivent du cotrimoxazole	2
		Conseils de planification familiale	3
		Cotrimoxazole pour les enfants nés de mères séropositives	4
		Conseils nutritionnels	5
		Traitement ARV	6
		Autres (préciser) _____	7
	Combien de femmes dépistées séropositives ont reçu les ARV pour la prévention de la transmission du VIH à leurs bébés?	Nombre Ne sait pas	/_____/ 98
	Combien de bébés nés de mères séropositives ont-t-ils reçu un traitement antirétroviral pour la prévention du VIH à la naissance?	Nombre Ne sait pas	/_____/ 98
	Les partenaires/maris des femmes enceintes dépistées sont-ils invités à se dépister?	Oui Non	1 2 [Passer à PREV 20]
	Combien de partenaires/maris des femmes dépistées ont-ils acceptés et ont fait également le dépistage?	Nombre Ne sait pas	/_____/ 98
ACCOUCHEMENT ET POSTPARTUM			
	Cet établissement dispose-t-il d'une maternité ?	Oui Non	1 2 [Passer à Prev33]
	Le service de maternité fonctionne –t-il 24 heures sur 24	Oui Non	1 2
	Le personnel de la formation sanitaire offre les services liés à l'accouchement au sein de la formation sanitaire, seulement dans la communauté ou bien dans les deux cas?	Exclusivement au sein de la formation sanitaire	1
		seulement dans la communauté	2
		A la fois dans la formation sanitaire et dans la communauté	3
	Combien d'accouchements ont été assistés par le personnel de cet établissement en 2014 ?	Nombre Ne sait pas	/_____/ 98
	Est-ce que cette formation sanitaire dispose des capacités de gérer des césariennes d'urgence?	Peut être géré aujourd'hui	1
		Habituellement, mais pas maintenant	2
		Doit être transféré	3
	Dans ce Centre de santé, disposez-vous des instructions écrites pour la référence des femmes enceintes en cas des complications obstétricales ?	Oui Non	1 2 [Passer à Prev27]
	Si oui, combien de femmes ont-elles été référées à l'HGR suites à des complications obstétricales en 2014?	Nombre Ne sait pas	/_____/ 98
	Cette formation sanitaire offre-t-elle des soins post-partum?	Oui Non	1 2 [Passer à Prev32]
	Les services liés aux soins post-partum sont-ils offerts exclusivement à des heures spécifiques, pendant les heures de consultations de malades externes, ou à la fois à des heures précises et pendant les heures de consultations externes?	Seulement à des heures précises	1
		Heures de consultations externes	2
		A la fois à des heures spécifiques et à des heures de consultations externes	3
	En 2014, pendant combien de jours les femmes ont-elles eu droit aux soins post-partum?	Nombre Ne sait pas	/_____/ 98
	Quels soins post partum sont-ils donnés aux femmes?		1

			2
			3
			4
			5
	En 2014, la formation sanitaire a tenu combien de sessions cliniques de sensibilisation aux clients en post-partum?	Nombre Ne sait pas	/_____/ 98
	En 2014, la formation sanitaire a enregistré combien de cas de décès maternels? ***Enquêteur : vérifier les registres***.	Nombre Ne sait pas	/_____/ 98
	PLANIFICATION FAMILIALE		
	Cet établissement offre-t-il des services de planification familiale ? (La planification familiale inclut les méthodes et conseils d'espacement ou de limitation des naissances.)	Oui Non	1 2 [Passer à Prev37]
	Combien de jours par semaine les services de planification familiale sont-ils disponibles ?	Nombre par semaine Nombre par mois Ne sait pas	/_____/ /_____/ 98
	Combien de consultations de planification familiale y'avait-il dans ce centre de santé durant les 12 derniers mois ?	Nombre Ne sait pas	/_____/ 98
	Quelles méthodes de planification familiale sont dispensées aux femmes dans le CS ? ***Multiple réponses.***	Pilules	1
		Préservatifs	2
		Depo/Injections	3
		DIU	4
		Méthode de collier du cycle	5
		Méthode naturelle de l'allaitement	6
		Autres (spécifier) : _____	7
	SOINS AUX ENFANTS		
	Cet établissement offre quels types de soins de santé aux enfants ? **(Les soins infantiles préventifs et curatifs, y compris.)** ***Notez tous les types de soins***	Soins curatifs	1
		Soins préventifs	2
		Soins promotionnels	3
	Quels types de soins préventifs votre établissement propose-t-il ?	Vaccination	1
		Suivi de la croissance et prise de poids	2
		Autre (spécifier) _____	3
	Combien de jours offrez-vous les soins préventifs aux enfants?	Nombre par semaine Nombre par mois Ne sait pas	/_____/ /_____/ 98
	Y a-t-il un plan de sensibilisation à la vaccination pour l'année en cours?	Oui Non	1 2
	Combien de méthodes de stockage parmi les suivantes que ce site possède pour stocker les vaccins? ***Multiple réponses***	Réfrigérateur avec partie réfrigérante	1
		Glacière	2 [Passer à Prev46]
		Congélateur	3
		Porte-vaccins	4 [Passer à Prev46]
		Accumulateur de froid	5
		Aucune	6 [Passer à Prev46]
	Est-ce que les variations de température sont enregistrées? ENQUÊTEUR : SI OUI, DEMANDEZ A VOIR	Oui et vu	1
		Oui et pas vu	2
		Non	3 [Passer à Prev46]

	Pendant les 7 derniers jours, pendant combien de jours la température a-t-elle été consignée?	Nombre Ne sait pas	/_____/ 98
	Au cours des 7 derniers jours, combien de fois au total est ce que la température a été consignée ?	Nombre Ne sait pas	/_____/ 98
	Au cours des 7 derniers jours, combien de jours avez-vous consigné des températures au-delà de 8^0C ou en dessous de 2^0C?	Nombre Ne sait pas	/_____/ 98
	Est-ce que chaque enfant qui commence son calendrier de vaccination reçoit une carte de vaccination?	Oui Non	1 2 [Passer à Prev49]
	Où sont gardées les cartes de vaccination après le début du calendrier de vaccination?	Remis au parent ou son substitut pour qu'il/elle l'apporte à la Prochaine visite	1
		Gardé à la formation sanitaire	2
		Un exemplaire est remis au parent et l'autre gardé à l'hôpital	3
		Autre (spécifier): _____	4
	Pouvez-vous me montrer des cartes qui appartiennent à des patients précis?	Vu Pas vu	1 2
	Cet établissement a-t-il un service de vaccination pour les enfants?	Oui Non	1 2 [Passer à **Prev55**]
	Combien de jours par semaine les services de vaccination sont-ils disponibles ?	Nombre par semaine Nombre par mois Ne sait pas	/_____/ /_____/ 98
	Combien d'enfants ont reçu une première vaccination contre la diphtérie / tétanos / coqueluche (DTCoq 1) dans ce centre de santé durant l'année 2014 ?	Nombre Ne sait pas	/_____/ 98
	En 2014, combien d'enfants ont-ils reçus la vaccination complète?	Nombre Ne sait pas	/_____/ 98
	Combien de consultations pour les enfants malades y'avait-il dans cet établissement durant les 12 derniers mois ?	Combien d'enfants de 0-11 mois	/_____/
		Combien d'enfants de 12-23 mois	/_____/
		Combien d'enfants de 24-59 mois	/_____/
		Combien d'enfants de 0-24mois	/_____/
		Combien d'enfants de 0-59 mois	/_____/
	Combien de consultations infantiles préventives y'avait-il dans cet établissement durant les 12 derniers mois ?	Combien d'enfants de 0-11 mois	/_____/
		Combien d'enfants de 12-23 mois	/_____/
		Combien d'enfants de 24-59 mois	/_____/
		Combien d'enfants de 0-24mois	/_____/
		Combien d'enfants de 0-59 mois	/_____/
	IST		
	Cet établissement offre-t-il des services de consultation sur les infections sexuellement transmissibles (IST) ? **Si non, passez à PREV 61**	Oui Non	1 2
	Combien de jours les services de consultation sur les IST sont-ils disponibles ?	Nombre par semaine Nombre par mois Ne sait pas	/_____/ /_____/ 98
	Quel protocole le Centre utilise-t-il pour la prise en charge des IST	Méthode étiologique	1
		Approche syndromique	2
		Autre (spécifier) _____	3

			Ne sait pas	98
	Le Centre a-t-il connu une rupture de stock des médicaments IST au cours de l'année 2014?		Oui Non Ne sait pas	1 2 98
	Le Centre dispose-t-il actuellement des médicaments pour la prise en charge des ISTs?		Oui Non Ne sait pas	1 2 98
	Combien de consultations sur les IST y'avait-il dans ce centre de santé en 2014 ?		Nombre Ne sait pas.	/_____ / 98
	VIH SIDA			
	Cet établissement offre-t-il des services de consultation sur le VIH/SIDA ?		Oui Non	1 2 [Passer à **PREV67**]
	Combien de jours les services de consultation sur le VIH/SIDA sont-ils disponibles ?		Nombre par semaine Nombre par mois Ne sait pas	/_____ / /_____/ 98
	Combien de consultations sur le VIH/SIDA y'avait-il dans ce centre de santé durant les 12 derniers mois ?		Nombre Ne sait pas.	/_____ / 98
	Des informations sur la prévention du VIH/SIDA sont-ils données à la population ?		Oui Non Ne sait pas	1 2 [Passer à Prev67] 98
	Si OUI, quelles informations ? **Multiples réponses.**		Sur la prévention Sur la prise en charge Sur l'atténuation de l'impact	1 2 3
	Quels supports sont-ils utilisés ?		Affiches Dépliants Projection vidéo Messages audio Sensibilisation lors des séances CPN, CPS Activités de sensibilisation dans la communauté Autre (spécifier) : _____	1 2 3 4 5 6 7
	L'établissement dispose-t-il des instructions écrites pour la prise en charge des cas de viols ou autres violences basées sur le genre?		Oui Non Ne sait pas	1 2 98
	L'établissement dispose-t-il des kits PEP (prophylaxie post exposition) ?		Oui Non Ne sait pas	1 2 98
	PREVENTION DU PALUDISME			
	Un programme de prévention du paludisme par la distribution de moustiquaires imprégnées d'insecticide est-il mis en place dans la structure de santé ?		Oui Non	1 2 [Passer au module suivant/à SC1].
	Si OUI, les moustiquaires imprégnées d'insecticide sont distribués à qui ?		Femme enceinte Femme avec enfant de 0 à 23 mois Autre (spécifier) : _____	1 2 3
	Les moustiquaires imprégnées d'insecticide sont distribuées gratuitement ou vendues ?		Distribuées gratuitement Vendues	1 2
	Les moustiquaires imprégnées d'insecticide sont- ils actuellement en stock ?		Oui Non	1 2

MODULE 4 : SOINS CURATIFS (SC)

N°	QUESTIONS		CODES
	MALARIA, IRA ET VIH/SIDA		
	Cet établissement offre-t-il des soins/traitement aux enfants souffrant des maladies suivantes ?		
	Malaria	Oui Non Ne sait pas	1 2 98
	Infections respiratoires aigués	Oui Non Ne sait pas	1 2 98
	VIH/SIDA	Oui Non Ne sait pas	1 2 98
	Combien de jours les services de traitement des maladies de l'enfant sont-ils offerts ?	Nombre de par semaine Nombre par mois Ne sait pas	/_____/ /_____/ 98
	L'établissement dispose-t-il de protocole écrit sur le traitement des maladies de l'enfant ?	Oui Non Ne sait pas	1 2 [Passer à SC 5] 98
	Si OUI, vérifier que le document existe	Existe et Affiché Existe et Non affiché	1 2
	Le personnel affecté à ces soins ont-ils été formés en PCIME ?	Oui Non Ne sait pas	1 2 98
	L'établissement dispose-t-il des médicaments et intrants nécessaires en stock ?	Oui Non Ne sait pas	1 2 98
	Les médicaments pour le traitement de ces maladies sont-ils fournis aux enfants au sein même de l'établissement ou les parents doivent les chercher ailleurs dans les pharmacies externes ?	Dans la pharmacie de l'établissement obligatoirement Doivent se procurer en dehors du centre Cela dépend des parents Ne sait pas	1 2 3 98
	Le tarif pour le traitement de ces maladies inclut-il la consultation et les médicaments ?	Oui Non Ne sait pas	1 2 98
	Combien de consultations pour les enfants malades y'avait-il dans cet établissement durant les 12 derniers mois ?	Combien d'enfants de 0-11 mois	/_____/
		Combien d'enfants de 12-23 mois	/_____/
		Combien d'enfants de 24-59 mois	/_____/
		Combien d'enfants de 0-24 mois	/_____/
		Combien d'enfants de 0-59 mois	/_____/
	MALADIES CHRONIQUES		
	Quels sont les services liés à la tuberculose qu'offre cette formation sanitaire? ***ENQUÊTEUR : LE COIN TUBERCULOSE EST UN ENDROIT DANS LA FORMATION SANITAIRE OÙ LES MALADES ATTEINTS DE TUBERCULOSE SONT CONSULTÉS ET TRAITÉS.*** ***Si aucun, passez à SC 15***	Seulement des services relatifs au diagnostique	1
		Seulement des services liés au traitement	2
		A la fois des services de diagnostic et de traitement	3
		Aucun	4 [Passer à SC 15]

N°	QUESTIONS		CODES
	Y-a-t-il un coin réservé à la tuberculose dans la formation sanitaire? ***ENQUÊTEUR : ENQUÊTEUR : LE COIN TUBERCULOSE EST UN ENDROIT DANS LA FORMATION SANITAIRE OÙ LES MALADES ATTEINTS DE TUBERCULOSE SONT CONSULTÉS ET TRAITÉS.***	Oui Non	1 2
	Les personnes diagnostiquées de la tuberculose sont-ils suivies au niveau de la communauté	Oui Non	1 2
	Les contacts des personnes atteintes de tuberculose sont-ils invités à se faire dépistés?	Oui Non	1 2
	Existe-t-il un registre tuberculose? SI OUI, ***DEMANDEZ À VOIR.***	Oui Non	1 2
	Le centre dispose-t-il du document énonçant les *Normes et procédures de services en santé de la reproduction*, adopté en 1997 ?	Oui Non	1 2 [Passer à SC17]
	Puis-je voir un exemplaire de ce document ?	Vu Pas vu	1 2
	Comment se fait la prise en charge des personnes dépistées VIH positives ?	La prescription est faite par le médecin au niveau du HGR L'établissement ne fait que renouveler la prescription faite par le médecin Rien n'est fait pour les malades L'établissement ne fait pas de dépistage Autre (spécifier) : _____	1 2 3 4 5
	Existe-t-il au niveau de l'établissement des instructions écrites concernant le dépistage et la prise en charge des personnes vivant avec le VIH ?	Oui Non	1 2
	L'établissement dispose-t-il des instructions écrites sur la transfusion sanguine ? ***Si non passez à SC21***	Oui Non	1 2 [Passer à SC 21]
	La transfusion sanguine se fait-il au niveau de l'établissement ? **SI OUI PASSER A SC 22 INTEGRE LE SAUT**	Oui Non	1 [Passer à SC 22] 2
	Si NON, que fait l'établissement dans le cas où un enfant ou une femme enceinte avait besoin de transfusion sanguine ?	Transférer à l'HGR Transférer dans une autre formation médicale Ne sait pas	1 2 98
	L'établissement dispose-t-il des instructions écrites pour la prise en charge des cas des maladies suivantes ? : **Multiples réponses**	Lèpre Trypanosomiase Filariose lymphatique Onchocercose Schistosomiase Verminose	1 2 3 4 5 6
	L'établissement effectue-t-il la petite chirurgie ?	Oui Non	1 2 [Passer à SC 25]
	Combien de cas de petite chirurgie avez-vous effectués au cours de l'année 2014 ?	Nombre Ne sait pas.	/_____ / 98
	L'établissement effectue-t-il la réhabilitation nutritionnelle ?	Oui Non	1 2
	ACTIVITES PROMOTIONNELLES		
	L'établissement effectue-t-il les activités promotionnelles suivantes ?		
	A.	Promotion de l'utilisation du préservatif	Oui Non Ne sait pas
	B.	Hygiène et assainissement	Oui Non Ne sait pas
	C.	Allaitement maternel exclusif des	Oui

N°	QUESTIONS		CODES
		enfants au cours des 6 premiers mois après la naissance	Non Ne sait pas
	D.	Hygiène alimentaire	Oui Non Ne sait pas
	E.	Consommation du sel iodé	Oui Non Ne sait pas
	F.	Amélioration des latrines	Oui Non Ne sait pas
	G.	Promotion de la réhydratation oral pour les cas de diarrhée chez les enfants	Oui Non Ne sait pas
	H.	Information sur la prévention des fistules	Oui Non Ne sait pas

MODULUE 5 : SUPERVISION (SUP)

N°	QUESTIONS	REPONSES	CODE
	Une visite de supervision est une visite d'un représentant du ministère de la Santé venant observer ce qui se passe dans l'établissement afin d'aider son personnel à améliorer ses services. Quand a eu lieu la dernière visite de supervision de votre établissement ? **1 seule réponse.**	Le mois passé Durant les 3 derniers mois Durant les 6 derniers mois Il y a plus de 6 mois Aucune visite de contrôle **[Passer au module 6]** Ne sait pas **[Passer au module 6]** Le mois en cours	1 2 3 4 5 6 7
	Que s'est-il passé durant cette visite de supervision ? **ENTOURER TOUTES LES REPONSES + MENTIONNEES. SONDER** : D'autres choses ? **Multiples réponses.**	Examen des dossiers/rapports Réunions Contrôle/apport d'équipement Observation de consultations Discussion de problèmes Discussion sur le personnel Autre_____ Rien Ne sait pas	1 2 3 4 5 6 7 8 98

MODULUE 6 : ÉQUIPEMENT ET MATERIEL (EM)

J'aimerais vous poser quelques questions sur les équipements et matériels dans cet établissement.

N°	QUESTION	REPONSES	CODE
	Quelle est la méthode *la plus* souvent employée pour la désinfection de haut niveau ou la stérilisation de l'équipement et du matériel médical ? **1 seule réponse.**	Plaque chauffante Stérilisateur à vapeur (cocote à vapeur) Chlorhexidine Eau de javel Autre : _____ Aucune Ne sait pas	1 2 3 4 5 6 98
	Comment vous débarrassez-vous de vos seringues et objets tranchants contaminés ? (ENTOURER TOUTES LES REPONSES	Incinération A Ensevelissement Poubelle Réutilisation Fosse septique Fosse spéciale	1 2 3 4

	MENTIONNEES)	Autre_____ Ne sait pas	5 98
	Quand avez-vous procédé à votre dernier inventaire de médicaments, d'équipement ou de matériels ?	Mois. . . . . . Année . . . . . . Ne sait pas	/_____ / /_____/ 98
	Où votre établissement se procure-t-il généralement ses médicaments et matériels ? **Multiples réponses.**	Fournisseur d'état Fournisseur privé Fournisseur international/ONG Bureau Central ZS Autre_____ Ne sait pas Bureau Central ZS	1 2 3 4 5 98
	Souffrez-vous parfois de retards de livraison des médicaments et matériels ?	Oui Non	1 2 **[**Passer à **EM7]**
	Quelles sont les causes les plus courantes des retards de livraison des médicaments et matériels ? **Réponses multiples.**	Transports inadéquats Insuffisance de carburant Difficultés administratives Insuffisance de personnel Problèmes financiers Stocks centraux épuisés Autre_____ Ne sait pas	1 2 3 4 5 6 7 98
	Où votre établissement se procure-t-il ou reçoit-t-il généralement les contraceptifs ? **Réponses multiples.**	Fournisseur d'état Fournisseur privé Fournisseur international/ONG Bureau Central ZS Autre_____ Ne sait pas Bureau Central ZS	1 2 3 4 5 98
	Souffrez-vous parfois de retards de livraison des contraceptifs ?	Oui Non	1 2 **[Passer module 7]**
	Quelle est la cause la plus courante des retards de collecte ou livraison des contraceptifs ?	Transports inadéquats Insuffisance de carburant Difficultés administratives Insuffisance de personnel Problèmes financiers Stocks centraux épuisés Autre_____ Ne sait pas	1 2 3 4 5 6 7 98

MODULE 7 : INVENTAIRE DES MATERIELS ET MEDICAMENTS POUR LA SANTE REPRODUCTIVE

POSER LA QUESTION N° 530 POUR CHAQUE PRODUIT. S'IL N'EST PAS DISPONIBLE, PASSER AU PRODUIT SUIVANT

PRODUIT	530. Avez-vous une fiche d'inventaire de (PRODUIT) ?	531. Les (PRODUIT) sont-ils stockés en fonction de leur date limite d'utilisation ?	532. Les (PRODUIT) sont-ils stockés à l'abri de la pluie, du soleil, des températures néfastes, des rats et autres animaux et insectes nuisibles ?

a) Contraceptifs	Oui....1 Non...2 [Passer à b)]	Oui ....1 Non....2	Oui ....1 Non....2
b) Médicaments pour le traitement des IST	Oui....1 Non...2 [Passer à c)]	Oui ....1 Non....2	Oui ....1 Non....2
c) Vaccins	Oui....1 Non...2 [Passer à d)]	Oui ....1 Non....2	Oui ....1 Non....2
d) Autres médicaments	Oui....1 Non...2	Oui ....1 Non....2	Oui ....1 Non....2

MODULE 8 : DISPONIBILITE DES METHODES DE PF ET DES VACCINS

J'aimerais maintenant vous poser quelques questions sur les méthodes de planification familiale et les vaccins disponibles dans cet établissement. Après ces questions, il me faudra voir vos stocks des contraceptifs et vaccins.

POSER LA QUESTION N° 533 POUR CHAQUE METHODE DE PF OU VACCIN. S'IL N'EST PAS DISPONIBLE, PASSER A LA METHODE OU AU VACCIN SUIVANT.

METHODE/VACCIN	533. Est-ce que le (METHODE/VACCIN) est actuellement disponible dans l'établissement ?	534. Avez-vous souffert d'une rupture de stock de (METHODE/VACCIN) ou étiez-vous incapable de l'offrir durant les 6 derniers mois ?	535. VERIFIER PAR INSPECTION VISUELLE : DEUX UNITÉS DE (METHODE/VACCIN) NON PÉRIMÉES OBSERVÉES ?
a) Pilule combinée (Lo-femenal)	Oui....1 Non...2 [Passer à b)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
b) Pilule à la progestérone seulement (Ovrette)	Oui....1 Non...2 [Passer à c)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
c) Injection (Depo-provera)	Oui....1 Non...2 [Passer à d)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
d) Kit DIU	Oui....1 Non...2 [Passer à e)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
e) Spermicide	Oui....1 Non...2 [Passer à f)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
f) Préservatif	Oui....1 Non...2 [Passer à g)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
g) le Vaccin BCG	Oui....1 Non...2 [Passer à h)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
h) le Vaccin antipoliomyélitique (OPV)	Oui....1 Non...2 [Passer à i)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
i) le Vaccin DTCoq	Oui....1 Non...2 [Passer à j)]	Oui ....1 Non....2	Vu .....1 Pas vu....2
j) Vaccination contre la rougeole	Oui....1 Non...2	Oui ....1 Non....2	Vu .....1 Pas vu....2

MODULE 9 : DISPONIBILITE DES MATERIELS IEC

Disposez-vous actuellement des matériels éducatifs sur la planification familiale, la santé maternelle et infantile, et les IST/SIDA ?

SERVICE	601. Boite à images	602. Dépliants	603. Affiches murales
a) Planification familiale	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
b) Soins prénatals/postnatals	Oui.....1	Oui.....1	Oui.....1

	Non.....2	Non.....2	Non.....2
c) Maternité sans risque (accouchement)	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
d) Prévention/traitement du VIH/SIDA	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
e) Prévention/traitement des autres IST	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
f) Nutrition de la mère	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
g) Surveillance nutritionnelle et pondérale de l'enfant	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
h) Allaitement maternel	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
i) Lutte contre les maladies diarrhéiques	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
j) Infections respiratoires aiguës	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
k) Paludisme	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
l) Vaccination	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
m) Vitamine A	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
n) Santé reproductive des adolescents	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2
o) Santé reproductive des hommes	Oui.....1 Non.....2	Oui.....1 Non.....2	Oui.....1 Non.....2

Pendant l'interview, le répondant consultait les registres et rapports :	
Tout le temps	1
Parfois	2
Rarement ou jamais	3

	Résultat final de l'enquête sur la disponibilité des services et équipement : Complète Partiellement complète Refus Enquêté compétent non trouvé Structure non trouvée Autre (préciser) : _____	 **1** **2** **3** **4** **5** **6**
Commentaires de l'enquêteur :		
Commentaires du superviseur :		

Heure de la fin : /____/_____/

Enquête sur les structures de santé (ESS) DRC 2015
EVALUATION FINALE
PROJET INTEGRE DE SANTE (PROSANI) MSH

Pour clients de Sexe Féminin:
Module 1. Mère avec un Enfant de 0-23 Mois
Module 2. Mère avec un Enfant de 24-59 Mois
Module 3. Femme âgée de 15-49
Module 4. Femme enceinte

N°	QUESTION		N°	QUESTION	
	GPS Location :			Code de l'enquêteur: /_____/	
	Nom de la structure sanitaire _____			Code de la structure : /_____/	
	Nom de l'Aire de Supervision			Code de l'Aire de Supervision	
	Nom de la Zone de santé			Code de la Zone de santé	
	Nom de la femme : _____			Age de la femme : /_____/	
	Type de structure : Centre de santé Hôpital Général de Référence	 1 2		Nom et code de la Province Kasaï Occidental Kasaï Oriental Katanga Sud-Kivu	 1 2 3 4
	Nom et code du superviseur : /_____/			Urbain/Rural : Urbain Semi-urbain Rural	 1 2 3
	Date : /____ /_____/_____/			Heure : /_____H:_____/ Minutes	

Indication aux Enquêteurs: Si la femme a deux enfants âgés de 0-23 mois et si les deux enfants ont reçu des soins aujourd'hui, remplissez ce questionnaire pour le plus jeune des deux enfants de 0-23 mois ayant reçu des soins.

Indications à l'enquêteur : A toutes les femmes, présentez-vous et donnez le but de cette entrevue.

Bonjour, je m'appelle _____. Mes collègues et moi travaillons pour le projet qui appuie les services de soins de santé dans votre contré. Je voudrais m'entretenir avec à propos des services de santé que vous / ou votre enfant avez reçus aujourd'hui.

Questions de Dépistage:
Etes-vous venu au centre aujourd'hui pour obtenir des soins pour cet enfant ou pour vous-même ?
Pour cet enfant Oui /Non (Si oui éligible pour module 1 ou 2 alors poser la question 3)
Pour moi-même Oui / Non (Si oui éligible pour le module 3 et/ou4 alors posez la question 4)
Quel âge avait votre enfant avait à son dernier anniversaire? (Indication : complétez l'âge en mois) /____/___/
Si entre 0 et 23 mois => Administrer le module 1
Si entre 24 et 59 mois => Administrer le module 2
Si 60 mois et plus (Vérifier si non à la réponse 2 de la question 2 Arrêter l'interview)
Quel âge aviez-vous à votre dernier anniversaire? /___/____/
Si moins de 15 ans (Posez la question 5)
Si entre 15 et 49 ans => Administrer le module 3

Si 60 ans et plus (Arrêter l'interview)

Etes –vous actuellement enceinte ?

Oui => Administrer le module 4
Non

Consentement éclairé pour l'enquêteur :
Cette étude servira à déterminer la gamme de services de santé fournis dans les centres de santé communautaires et les hôpitaux. Elle va aussi servir à orienter les efforts du projet en vue de la fourniture des services de santé de haute qualité à l'avenir. Nous sommes très intéressés à écouter vos observations sur l'accession aux soins de santé que vous / votre enfant / vos enfants avez reçus aujourd'hui. Votre opinion est très importante, car il aidera à améliorer et à renforcer les services de santé et le bien-être de toute la population.

Nous aimerions mener avec vous maintenant une interview qui prendra environ 30 minutes. Nous demandons votre consentement pour discuter de votre expérience sur l'accession aux services de santé aujourd'hui à ce centre de santé. Les informations que vous allez nous fournir ne seront pas liées personnellement à votre nom, à vos réponses, ni dans notre rapport. Nous vous encourageons à partager vos points de vue et vos suggestions pour améliorer les trois prochaines années de la mise en œuvre du PROSANI. Cependant, votre participation à cette interview est entièrement volontaire. Si vous optez de ne pas participer, vous ne perdez absolument rien. Vous pouvez également refuser de répondre à des questions spécifiques, si vous n'avez pas suffisamment d'informations pour y répondre, ou si vous les trouvez trop sensibles. En outre, vous pouvez à tout moment, mettre fin à cette interview. Veuillez me dire dès maintenant si vous avez une quelconque objection à participer à cette interview et si vous avez des questions avant que nous ne puissions commencer? Vous pouvez également poser des questions ou demander des éclaircissements sur des questions au fur et à que nous avançons. Merci beaucoup d'avoir pris le temps de parler avec nous.

Indication pour l'enquêteur: si la femme refuse l'entrevue, veuillez-vous référer au superviseur. Si elle accepte, veuillez commencer avec les questions suivantes:

Module 1 : Enfant de 0 à 23 mois

Votre enfant est-il malade aujourd'hui? **OUI NON Si NON, allez à la question 7**
Quel type de soin votre enfant a-t-il reçu aujourd'hui ? (Cochez toutes les réponses qui s'appliquent)
Vaccination
Nutrition (par exemple, l'allaitement, l'introduction d'aliments)
La vitamine A (NB: Certaines mères pourraient supposer que la vitamine A est un vaccin, nous devons voir comment arriver à établir la différence sans les pousser vers une réponse quelconque)
Traitement des maladies respiratoires
Traitement de la diarrhée
Traitement de la malaria
Traitement de la fièvre
Autre: ……..
Est-ce que c'est un (e) infirmier(e) qui a administré des soins à votre enfant? **OUI NON** Si non, passez à la question 14
Est-ce que l'infirmier(e) vous a traitée avec respect et dignité ? **OUI NON**
Est-ce que l'infirmier(e) a traité votre enfant avec respect et dignité ? **OUI NON**
Est-ce que l'infirmière a répondu à toutes vos préoccupations? **OUI NON**

Avez-vous des questions que vous aimeriez poser à l'infirmier(e) ? **OUI NON**
Etes-vous satisfait de la qualité des soins que l'infirmier(e) vous a administré aujourd'hui?

(INSTRUCTION POUR L'ENQUETEUR : LISEZ LES REPONSES POSSIBLES A LA FEMME AVANT QU'ELLE NE REPONDE)

Très satisfaite **Plutôt insatisfaite**
Assez satisfaite **Très insatisfaite**
Neutre

Aimeriez-vous que cet(te) infirmier(e)puisse encore prendre soin de votre enfant? **OUI NON**
Est-ce que c'est un médecin qui a pris soins de votre enfant? **OUI NON** Sinon, allez à la question 21
Est-ce que le médecin vous a traité avec respect et dignité? **OUI NON**
Est-ce que le médecin a traité votre enfant avec respect et dignité ? **OUI NON**
Est-ce que le médecin a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser au médecin? **OUI NON**
Etes-vous satisfaite de la qualité des soins que le médecin a administré à votre enfant aujourd'hui?

(INSTRUCTION POUR L'ENQUETEUR : LISEZ LES REPONSES POSSIBLES A LA FEMME AVANT QU'ELLE NE REPONDE)

Très satisfaite **Plutôt insatisfaite**
Assez satisfaite **Très insatisfaite**
Neutre

Aimeriez-vous que ce médecin puisse soigner encore votre enfant? **OUI NON**
Pensez-vous qu'il y a d'autres centres de santé qui pourraient offrir à votre enfant une meilleure qualité des soins? **OUI NON** Sinon, allez à la question 1 du tableau ci-dessous
Si oui, quel est le nom de ce centre?

Question:	Réponse: Oui (1)	Réponse: Non (0)	Réponse: Je ne sais pas (99)	Fiche de soin de l'enfant (Carnet)
Nutrition du nourrisson:				
Est-ce que l'infirmière ou docteur vous a dit (parlé) aujourd'hui sur la nutrition de votre enfant? (**Si non, allez à la Q3**)	*1*	0	99	n/a
Qu'est-ce qu'elle/ il vous a dit sur l'alimentation de l'enfant? **Indication pour l'Enquêteur**: Ne rien souffler à la mère et cochez toutes les réponses qui s'appliquent. Allaiter exclusivement mon bébé jusqu'à 6 mois d'âge Mon enfant doit prendre des aliments solides, semi-solides ou de bouillie 3 fois par jour Autre ……. Autre……..	 *1* *1*	 0 0	 99 99	

Question:	Réponse: Oui (1)	Réponse: Non (0)	Réponse: Je ne sais pas (99)	Fiche de soin de l'enfant (Carnet)
Avez-vous commencé à allaiter votre bébé durant la première heure après sa naissance? (**Si NON, allez à la question 5)**				
Si oui à la Q ° 3, qui vous aurait dit qu'il était important d'allaiter votre bébé durant la première heure après sa naissance? **Indication pour Enquêteur** Ne rien souffler au répondant et cochez toutes les catégories indiquées par le répondant : • Infirmière du centre de Santé • Infirmière à l'hôpital • Médecin à l'hôpital • Accoucheuse traditionnelle • Mère • Belle-mère • Mari • Autre membre de la famille • Ami • Autre				
Vous ne nourrissez exclusivement votre bébé qu'avec le lait maternel? (**Si oui, passez à la question 8)**				
Est- ce que vous lui donnez aussi des aliments mélanges?				
Votre enfant a-t-il mangé des aliments solides, semi-solides, des aliments ou bouillie, au moins 3 repas hier?				
Votre enfant a reçu une dose de vitamine A durant les 6 derniers mois?				
Est-ce le poids e de votre enfant a été mesurée?				
Est-ce la taille de votre enfant a été mesurée?				
Avez-vous été informé de l'état de croissance de votre bébé?				
Couverture vaccinale des enfants de 0-23 mois				
Indication pour Enquêteur: Demandez à l'enquêtée de vous montrer la fiche des soins de son enfant (carnet) et examinez le statut vaccinal indiquant les vaccinations enregistrées. Ne cochez la case dans la dernière colonne que si le vaccin a été enregistré dans la fiche des soins (carnet) de l'enfant.				
Avez –vous la carte de vaccination de votre enfant sur vous? **Si oui allez à la question 11 et remplissez la colonne (Carte vaccination)**				
Est-ce que votre enfant a reçu le vaccin BCG (TB) avant son 1er anniversaire?				
Est-ce que votre enfant a reçu toutes les 3 doses du vaccin VPO (poliomyélite) avant son 1er anniversaire?				
Est-ce que votre enfant a reçu toutes les 3 doses du vaccin DTC (diphtérie / tétanos / coqueluche) avant son 1er anniversaire?				

Question:	Réponse: Oui (1)	Réponse: Non (0)	Réponse: Je ne sais pas (99)	Fiche de soin de l'enfant (Carnet)
Est-ce que votre enfant était vacciné contre la rougeole avant son 1er anniversaire?				
Est-ce que votre enfant a reçu toutes les 3 doses du vaccin contre l'hépatite B avant son 1er anniversaire?				
Est-ce que votre enfant était vacciné contre la contre la fièvre jaune avant son 1er anniversaire?				
Connaissez-vous les 2 signes de danger indiquant que votre enfant a la pneumonie?				
Avez-vous amené votre enfant au centre de santé parce qu'au cours des 2 dernières semaines pensant qu'il pourrait avoir la pneumonie (respiration rapide et difficile)? (**Si NON, passez à la question 22)**				
Si au cours des 2 dernières semaines, vous avez amené votre enfant au centre de santé, pensant qu'il pourrait avoir la pneumonie, était-il traité avec un antibiotique?				
Aviez-vous déjà fait soigner votre enfant pour un cas de pneumonie par quelqu'un d'autre avant de venir au centre de santé aujourd'hui**? Si non allez à q24**				
Si oui à q20: Qui avez-vous consulté pour les soins? **Indication pour enquêteur:** Ne rien suggérer au répondant et cochez tous les fournisseurs de soins (le personnel soignant) qu'elle indique : Membre de famille Ami / voisin Guérisseur traditionnel Accoucheuse traditionnelle Relais communautaire Relais prestataires Autre, spécifier:	n/a	n/a	n/a	
Est-ce votre enfant avait la diarrhée au cours des 2 dernières semaines? Si non, allez à la question 28				
Est-ce que vous lui aviez donné le SRO ou les liquides recommandés?				
Est-ce que vous avez continué à le nourrir pendant qu'il avait la diarrhée?				
Est-ce que vous avez amené votre enfant au centre de santé aujourd'hui pour le faire traiter contre la diarrhée?				
Est-ce que votre enfant a fait de la fièvre au cours des deux dernières semaines?, Si non allez à question 30				
Si Oui, a-t-il reçu un traitement contre la malaria dans les 24 heures après la constatation des symptômes?				
Est-ce que votre enfant a dormi sous une moustiquaire imprégnée d'insecticide, ou une moustiquaire traitée à l'insecticide, au cours de l'année 2012?				
Est-ce que votre enfant a dormi sous une moustiquaire imprégnée d'insecticide la nuit dernière?				

Question:	Réponse: Oui (1)	Réponse: Non (0)	Réponse: Je ne sais pas (99)	Fiche de soin de l'enfant (Carnet)
Connaissez-vous les signes / symptômes de la malaria indiquant que vous devez rapidement faire soigner votre enfant? Si non, allez à la question 31.				
Quels sont ces signes ou symptômes? fièvre maux de tête Autre……				
Combien des visites prénatales avez-vous effectuées pendant que vous étiez enceinte de votre dernier né?	/____/			
Avez-vous reçu au moins 2 vaccins contre le tétanos pendant que vous étiez enceinte de votre dernier né?				
Avez-vous reçu une dose de vitamine A dans les 2 mois qui suivaient la naissance de votre dernier né?				
Avez-vous été assistée par un personnel médical qualifié pendant l'accouchement de votre dernier né?				
Avez-vous donné naissance à votre dernier né dans un établissement médical?				
Avez-vous été examinée par un personnel médical qualifié dans les 3 jours qui suivaient la naissance de votre dernier né?				
Avez-vous déjà entendu parler de la fistule?				
Avez-vous accès à une source d'eau potable?				
Est-ce que votre ménage utilise des méthodes appropriées de traitement d'eau potable?				
Votre ménage utilise-t-il des installations sanitaires améliorées autres que les installations communes?				
Il y a-t-il chez vous à la maison de l'eau et du savon dans un emplacement spécifique de lavage des mains?				
Il y a-t-il quelque part chez vous à la maison du savon pour les membres de votre ménage?				

Rentrer au contrôle pour vérifier la question 2 (Vérifier si la mère est éligible)

Module 2 : Mère avec un enfant de 24-59 mois

Cet enfant a quel âge ? /_____/ **(tranche d'âge de 24-59 mois)**
Votre enfant-il était soigné aujourd'hui ? **Si non, passez à la question 4**
Quel type de soins votre enfant a-t-il reçu aujourd'hui? **(Cochez tout ce qui s'applique)**
Vaccination
Vitamine A (NB: Certaines mères pourraient supposer que la vitamine A est un vaccin, nous devons savoir comment différencier ceci sans souffler des réponses)
Traitement d'un cas présumé de pneumonie les ou d'une maladie respiratoire
Traitement de la diarrhée
Traitement de la malaria
Traitement de la tuberculose (TB)
Traitement de la fièvre

Autre
Est-ce qu'un(e) infirmier(e) a administré des soins à votre enfant? **OUI NON Si non, allez à la question 11**
Est-ce que l'infirmière vous a traitée avec respect et dignité ? **OUI NON**
Est-ce que l'infirmière a traité votre enfant avec respect et dignité ? **OUI NON**
Est-ce que l'infirmière a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser à l'infirmière? **OUI NON**
Etes-vous satisfaite de la qualité des soins que l'infirmière a administré à votre enfant aujourd'hui?

(Instruction pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que cette infirmière puisse encore prendre soin de votre enfant? OUI NON
Est-ce que c'est un médecin qui a pris soins de votre enfant? OUI NON
Est-ce que le médecin vous a traitée avec respect? OUI NON
Est-ce que le médecin a traité votre enfant avec respect? OUI NON
Est-ce que le médecin a répondu à toutes vos préoccupations? OUI NON
Avez-vous des questions que vous aimeriez poser au médecin? OUI NON
Etes-vous satisfaite de la qualité des soins que l'infirmière a administre à votre enfant aujourd'hui?

(Instruction pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que ce médecin puisse soigner votre enfant? **OUI NON**
Pensez-vous qu'il y a d'autres centres de santé qui pourraient offrir à votre enfant une meilleure qualité des soins? **OUI NON**
Si oui, quel est le nom de ce centre?
_____
Rentrer au contrôle pour vérifier la question 2 (Vérifier si la mère est éligible)

Module 3 : Femme Agée de 15-4

Etes-vous venu vous faire soigner? **OUI NON**
Quel âge avez-vous? (tranche d'âge 15-49)

Question:	Réponse: Oui (1)	Réponse: Non (0)	Réponse: Je ne sais pas (99)
Avez-vous reçu des conseils sur la planification familiale aujourd'hui?			
Est-ce que vous pratiquez la planification familiale?			
Avez-vous été soumise à un dépistage de la tuberculose l'an dernier?			
Avez-vous reçu le counseling et le dépistage du VIH à ce centre de santé ? **si non, passez à la question 8**			
Avez-vous reçu les résultats de votre test de VIH?			
Quelqu'un dans ce centre vous-t-il transféré vers une autre formation médicale pour les services de santé			
Avez-vous participé à des réunions de coordination de la santé dans votre communauté?			
Avez-vous reçu de la part de quelqu'un dans votre communauté des informations spécifiques de santé, adressées à vous en tant que femme/jeune fille?			
Avez-vous reçu des messages de santé par SMS sur votre téléphone portable?			
Avez-vous accès à une source d'eau potable?			
Avez-vous des installations sanitaires améliorées chez vous à la maison?			

Est-ce que c'est une infirmière qui vous a administré des soins? **OUI NON** Si non, allez à la question 20
Est-ce que l'infirmière vous a traitée avec respect? **OUI NON**
Est-que l'infirmière a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser à l'infirmière? **OUI NON**
Etes-vous satisfaite de la qualité des soins que l'infirmière vous a administré aujourd'hui? **OUI NON**
(Instruction pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que cette infirmière puisse encore prendre soin de vous? **OUI NON**
Est-ce que c'est un médecin qui a pris soins de vous? **OUI NON**
Est-ce que le médecin vous a traité avec respect? **OUI NON**
Est-ce que le médecin a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser au médecin? **OUI NON**
Etes-vous satisfaite de la qualité des soins que le médecin vous a administrés aujourd'hui? **OUI NON**

(Instruction pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que ce médecin puisse encore vous soigner? **OUI NON**
Pensez-vous qu'il y a d'autres centres de santé qui pourraient vous offrir une meilleure qualité des soins? **OUI NON**

Module 4: Femme enceinte

Etes-vous venu aujourd'hui pour vous faire soigner vous-même?
Quel âge avez-vous? /_____/ (Tranche d'âge 15-49)

Question:	Oui (1)	Non (0)	Ne sait pas (99)
Avez-vous reçu des soins prénatals aujourd'hui au centre de santé?			
4. Avez-vous reçu un complément de fer et d'acide folique?			
Avez-vous fait le dépistage de la tuberculose l'an dernier?			
Avez-vous reçu le counseling et le dépistage du VIH à ce centre de santé?			
Avez-vous reçu les résultats de votre test du VIH?			
Votre partenaire ou votre mari a-t-il été soumis au dépistage de VIH et a-t-il reçu le résultat?			
Avez-vous suivi, votre partenaire et vous, le counseling pour couples et avez-vous été soumis au dépistage de VIH?			
Est-ce que vous recevez le traitement par le cotrimoxazole (CTX)?			
Avez-vous reçu au moins deux doses de traitement préventif contre la malaria au centre de santé pendant votre grossesse?			
Est-ce que vous utilisez une moustiquaire imprégnée d'insecticide?			
Indication pour l'enquêteur : Si elle répond oui, demandez si elle a utilisé une moustiquaire imprégnée la nuit dernière?			
Avez-vous participé à des réunions de coordination de la santé dans votre communauté?			
Avez-vous reçu de la part de quelqu'un dans votre communauté, des informations spécifiques de santé spécialement adressée à vous en tant que femme / jeune fille?			
Avez-vous reçu des messages de santé par SMS sur votre téléphone portable?			
16. Avez-vous accès à une source d'eau potable?			
Avez-vous des installations sanitaires améliorées dans votre maison?			
Avez-vous été informé des fournisseurs des services et avez-vous discuté avec eux les signes de danger qui peuvent survenir pendant la grossesse. Par exemple, des saignements, des maux de tête sévères, des vertiges, des douleurs abdominales, des contractions, diminution des mouvements fœtaux, etc.			
Etiez-vous informé des complications qui nécessitent une consultation médicale?			

Est-ce que c'est une infirmière qui vous a administré des soins? **OUI NON (Si non, passez à la question 33)**
Est-ce que l'infirmière vous a traitée avec respect? **OUI NON**

Est-que l'infirmière a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser à l'infirmière? **OUI NON**
Etes-vous satisfaite de la qualité des soins que l'infirmière vous a administrée aujourd'hui?

(**Indication pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde**)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que cette infirmière puisse encore prendre soin de vous? **OUI NON**
Est-ce que c'est un médecin qui a pris soins de vous? **OUI NON**
Est-ce que le médecin vous a traité avec respect? **OUI NON**
Est-ce que le médecin a répondu à toutes vos préoccupations? **OUI NON**
Avez-vous des questions que vous aimeriez poser au médecin? **OUI NON**
Etes-vous satisfaite de la qualité des soins que l'infirmière ou le médecin vous a administré aujourd'hui?

(**Indication pour l'enquêteur : Lisez les réponses possibles à la femme avant qu'elle ne réponde**)

Très satisfaite
Assez satisfaite
Neutre
Plutôt insatisfaite
Très insatisfaite

Aimeriez-vous que ce médecin puisse encore vous soigner? **OUI NON**
Aimeriez-vous que ce médecin puisse encore vous soigner? **OUI NON**
Pensez-vous qu'il y a d'autres centres de santé qui pourraient vous offrir une meilleure qualité des soins? **OUI NON**

Aimeriez-vous que ce médecin puisse encore vous soigner? **OUI NON**
Pensez-vous qu'il y a d'autres centres de santé qui pourraient vous offrir une meilleure qualité des soins? **OUI NON**
Je pense à des questions d'ordre général pour évaluer la qualité des services (soins de santé) offerts à la population cible. Ces questions, sont à posées à tous les répondants:

#	Questions	*Satisfaite*	*Pas Satisfaite*	*Incertaine*
	Veuillez évaluer votre satisfaction globale à l'égard du service que vous avez reçu?			
	Etes-vous satisfaite du temps d'attente avant de voir le fournisseur de services de santé?			
	Etes-vous satisfaite des conditions d'intimité dans la salle de consultation ?			

	Etes-vous satisfaite du temps que vous réserve le fournisseur des soins de santé?			
	Etes-vous satisfaite de l'attitude du fournisseur des services de santé à votre égard ?			

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES

QUESTIONNAIRE MERES D'ENFANTS DE 0-23 MOIS

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-23 MOIS **Information sheet for mother with child age 0-23 months**	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-23 mois *This questionnaire must be administered to a mother who's youngest child is age 0-23 months.*	
Nom et Numéro du village *Name and number of the village* Nom _____ *Name*	**Numéro de ménage dans le village** *Number of the household in the village*
03. Nom et numéro de l'Aire de Santé *Name and number of the health area* Nom _____	**04. Nom et numéro de la Zone de Santé** *Name and number of the health zone* Nom _____
05. Nom et numéro de l'Aire de Supervision (A.S.) Nom _____	
06. Nom et code de la Province *Name and code of the province* Kasaï Occidental ..... 1 Kasaï Oriental ..... 2 Katanga ..... 3 Sud-Kivu 4	**07. Milieu de résidence** *Residential setting* Urbain ..... 1 Rural 2
08. Nom et Numéro de la mère dans l'A.S. *Name and number of the mother in the health area* Nom _____	**09. Nom de l'enfant** *Name of the child*
10. Date de naissance de l'enfant *Child's date of birth* Jour Mois Année _____/_____/_____/	**11. Age de l'enfant (en mois)** *Age of child (in months)*
12. Nom et code de l'enquêteur/enquêtrice *Name and code of the interviewer* Nom_____	**13. Jour / Mois / Année de l'interview** *Day/Month/Year of the Interview* _____/_____/ _____

CONSENTEMENT INFORMÉ

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne.

Hello. My name is _____, and I work for IBTCI/USAID. We are conducting an interview in which we would like you to participate. I would like to ask you some questions about your health and the health of your youngest child under the age of 2 years old. This information will be used by PROSANI to plan health services and to evaluate if they conform with the objective of improved child health. The interview usually takes _____ minutes. Whatever information you give us will stay strictly confidential and will not be divulged to anyone.

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Participation in this interview is voluntary and you can decide to not respond to any personal question or to all of the questions. However, we hope that you will participate in this interview because your thoughts are of great interest to us.

Avez-vous maintenant des questions à me poser concernant l'enquête?
Do you have any questions concerning the interview for me now?

Signature de l'enquêteur: _____ Date: _____
Signature of the interviewer: *Date:*

PUIS-JE COMMENCER MAINTENANT ?

Can I start now ?

/__/ **OUI**, *permission accordée* c:: *Allez au module « Composition du ménage » pour commencer l'interview.*
/__/ **Yes**, *permission granted :: Go to the moduel « Household composition » to start the interivew.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*
/__/ **No**, *permission not granted ⇒ Discuss this with your supervisor.*

14. Contrôlé sur le terrain par (Nom et code):	**15. Agent de saisie (Nom et code):**
Administered by (Name and code) :	*Entry clerk (Name and code) :*
Nom _____ /___/___/	Nom _____ /___/___/

MODULE 1.1: COMPOSITION DU MENAGE										**CM**
Pour toutes les personnes du ménage *For all the people in the household*						Pour tous les enfants de 5 à 24 ans *For all children from 5-24 years old*		Pour toutes les personnes âgées de 15 ans ou plus *For all people 15 years and older*		
CM1	CM2	CM3	CM4	CM5	CM6	CM7	CM8	CM9	CM10	CM11
N° Ordre	**NOM** *Name*	**Lien de parenté** *Connection to Parent* 1= C.M. 2= Epouse *Spouse* 3= Fils/Fille *Son/Daughter* 4= Autre Parent *Other Parent* 5= Non Parent *Not parent*	**Sexe** *Sex* 1= Masc *Male* 2= Fém *Female*	**Age (en mois révolues)**	**Situation d'activité** *Activity Status* 1= Enfant Bas âge *Child under age 2* 2= Enfant non scol. *Child not in school* 3= Elève / Etudiant *Student* 4= Travailleur salarié *Employee* 5= Travailleur indép. *Self-employed* 6= Retraité	***Fréquentation scolaire actuelle*** *Currently attending school* (Nom) fréquente-t- il un établissement scolaire au cours de l'année scolaire 2010-2011 ? *Did (name) attend an academic institution during the 2010-2011 school year?*	**Niveau d'instruction** *Level of instruction* A quel niveau est-il ? *At what level of instruction is he?* 0 = Maternel *Nursery* 1= Primaire *Elementary* 2= Secondaire ou *Highschool* 3= Programme non formel *Informal program* 9 = NSP	**Degré d'alphabétisation** *Literacy* 1= Ne sait ni lire ni écrire *Cannot read or write* 2= Sait lire seulement *Can read only* 3= Sait lire et écrire *Can read and write*	**Plus haut niveau d'instruction atteint** *Highest level of education attained* 0 = Maternel *Nursery* 1= Primaire *Elementary* 2= Secondaire ou *Highschool* 3= Programme non formel *Informal program* 9 = NSP	**Etat matrimonial** *Marital Status* 1= Célibataire *Single* 2= Marié *Maried* 3= Uni de fait *Coupled* 4= Divorcé /Séparé. *Divorced/Separated* 5= Veuf /Veuve *Widow/Widower*
01		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
02		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
03		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
04		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
05		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
06		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
07		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
08		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
09		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
10		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
11		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5
12		1 2 3 4 5	1 2	/ / /	1 2 3 4 5 6 7 8 9	1 2	0 1 2 3 9	1 2 3	0 1 2 3 9	1 2 3 4 5

MODULE 1.2: EAU ET ASAINISSEMENT			EA
EA1.	D'OU PROVIENT **PRINCIPALEMENT** L'EAU QUE BOIVENT LES MEMBRES DE VOTRE MENAGE ? *What is the main source of the water the members of your household drink?*	Robinet Dans le logement.....11 Dans concession, cour ou parcelle.....12 Robinet du voisin.....13 Robinet public / Borne fontaine.....14 Puits à pompe, Forage.....21 Puits creusé Puits protégé.....31 Puits non protégé.....32 Eau de source Source protégée.....41 Source non protégée Eau de surface (rivière, fleuve, barrage, lac, mare, canal, canal d'irrigation) .....81 Autre (*précisez*)_____96	11 **Passer à** EA3 12 **Passer à** EA3 13 **Passer à** EA3
EA2.	OU CETTE SOURCE D'APPROVISIONNEMENT EN EAU EST- ELLE SITUEE ? *Where is this water source located?*	Dans logement.....1 Dans cour / parcelle.....2 Ailleurs.....3	
EA3.	FAITES-VOUS QUELQUE CHOSE POUR RENDRE L'EAU PLUS SAINE AVANT DE LA BOIRE ? *Do you do anything to clean the water before drinking it?*	Oui.....1 Non.....2 NSP.....8	2 **Passer à** EA5 8 **Passer à** EA5
EA4.	HABITUELLEMENT, QUE FAITES-VOUS POUR RENDRE L'EAU QUE VOUS BUVEZ PLUS SAINE ? *Typically, what do you do to clean your drinking water?* *Insistez:* AUTRE CHOSE? *Anything else?* *Enregistrez tout ce qui est mentionné.*	La faire bouillir.....A Y ajouter de l'eau de Javel / chlore.....B La filtrer à travers un linge .....C Utiliser un filtre (céramique, sable, composite, etc.) ...D Désinfection solaire.....E La laisser	

MODULE 1.2: EAU ET ASAINISSEMENT			EA
EA5	HABITUELLEMENT, QUEL TYPE DE TOILETTES LES MEMBRES DE VOTRE MENAGE UTILISENT-ILS? *Typically, what type of toilets do the members of your household use?* *Si "chasse d'eau" ou "chasse d'eau manuelle", insistez:* *If 'flush' or 'manual flush', ask:* OU VONT LES EAUX USEES? *Where does the wastewater go?* *Si nécessaire, demandez la permission de voir les toilettes.*	Toilettes avec chasse d'eau avec ou sans réservoir d'eau Connectée à système d'égouts.....11 Connectée à une fosse septique.....12 Reliée à des latrines.....13 Reliée à autre chose.....14 Reliée à endroit inconnu/pas sûr/NSP où.....15 Fosses/latrines Latrines améliorées ventilées (LAV) .....21 Latrines à fosses avec dalle.....22 Latrines à fosses sans dalle/trou ouvert.....23 Toilettes à compostage.....31 Seaux.....41 Toilettes/latrines suspendues.....51 Pas de toilettes, nature .....95 Autre (précisez) _____96	95 **Passer à** EA9
EA6.	PARTAGEZ-VOUS CES TOILETTES AVEC D'AUTRES PERSONNES QUI NE SONT PAS MEMBRES DE VOTRE MENAGE? *Do you share toilets with other people who are not members of your household?*	Oui.....1 Non.....2	2 **Passer à** EA9
EA7.	PARTAGEZ-VOUS CES TOILETTES SEULEMENT AVEC DES MEMBRES D'AUTRES MENAGES QUE VOUS CONNAISSEZ, OU EST-CE QUE N'IMPORTE QUI PEUT UTILISER CES TOILETTES ? *Do you share these toilets only with members of other households that you know or can anyone use these toilets?*	Autres ménages seulement (pas publiques) .....1 Toilettes publiques.....2	2 **Passer à** EA9
EA8.	AU TOTAL, COMBIEN DE MENAGES, Y COMPRIS VOTRE MENAGE, UTILISENT CES TOILETTES ? *In total, how many households, in addition to yours, use these toilets?*	Nombre de ménages (si moins de 10) .....0 Dix ménages ou plus.....10 NSP.....98	

MODULE 1.2: EAU ET ASAINISSEMENT			EA
EA9.	MONTREZ-MOI, S'IL VOUS PLAIT, LA OU LES MEMBRES DE VOTRE MENAGE SE LAVENT LES MAINS LA PLUPART DU TEMPS. *Show me, if you don't mind, where the members of your family most commonly wash their hands.*	Observé.....1 Pas observé.....2	2 **Passer à** EA12
EA10.	*Observer s'il y a de l'eau au lieu spécifique de lavage des mains* *Observe if they have water at the location where they wash their hands.* *Contrôler en vérifiant s'il y a de l'eau au robinet/pompe/ou bassin, dans le seau, container d'eau ou objet similaire.* *Check whether there is water at the tap / pump / or basin, in the bucket, water container or similar object.*	Eau disponible.....1 Eau non disponible 2	
EA11	*Enregistrez si du savon ou d'autres produits nettoyants sont présents dans l'endroit spécial prévu pour se laver les mains.* *Record if soap or other sanitizing products are present in the place designated for hand washing.* *Encerclez tout ce qui est mentionné.* *Circle everything that is mentioned.*	Morceau de savon.....A Nettoyant (Poudre / Liquide / Pâte) .....B Savon liquide.....C Cendre / Boue / Sable.....D Rien .....Y	C **Passer au** Module suivant
EA12.	AVEZ-VOUS DU SAVON OU D'AUTRES PRODUITS NETTOYANTS (***ou d'autres produits locaux utilisés comme produits nettoyants)*** DANS VOTRE MENAGE POUR LE LAVAGE DES MAINS? *Do you have soap or other sanitizing products (or other local products used like sanitizing products) in your house for hand washing?*	Oui.....1 Non.....2	2 **Passer** au Module suivant

MODULE 1.2: EAU ET ASAINISSEMENT			EA
EA13.	POUVEZ-VOUS, S'IL VOUS PLAIT, ME LE MONTRER? *Would you, if you don't mind, show it to me?* *Enregistrez l'observation. Encerclez tout ce qui est mentionné*	Morceau de savon.....A Nettoyant (Poudre / Liquide / Pâte) .....B Savon liquide.....C Cendre / Boue / Sable.....D N'a pas pu montrer/A refusé de montrer.....Y Autre (précisez) X	

MODULE 1.3: CONTRACEPTION			CO
Ce module concerne toutes les femmes âgées de 15-49 ans non enceintes. *This module is for all women age 15-49 who are not pregnant.* *Maintenant, je voudrais vous poser des questions sur la planification familiale – les différents moyens ou méthodes qu'un couple peut utiliser pour retarder ou éviter une grossesse.* *Now, I would like to ask you some questions regarding family planning- the different ways and methods that a couple can use to delay or avoid a pregnancy.* ENCERCLEZ LE CODE 1 A CO1 POUR CHAQUE METHODE CITEE DE FAÇON SPONTANEE. PUIS, LISEZ LE NOM ET LA DESCRIPTION DE CHAQUE METHODE NON CITEE SPONTANEMENT. ENCERCLEZ LE CODE 1 SI LA METHODE EST RECONNUE ET LE CODE 2 SI ELLE N'EST PAS RECONNUE. *Circle the code 1 or 2 for each method given unprompted. Then, list the name and the description of each method given after prompting. Circle code 1 if the method is recognized and code 2 if it is not recognized.*			
CO1.	DE QUELS MOYENS OU METHODES AVEZ-VOUS ENTENDU PARLER? *Of what ways and methods have you heard?* Pour les méthodes non citées spontanément, demandez Avez-VOUS DEJA ENTENDU PARLER DE (METHODE)? *For the methods not given unprompted, ask have you ever heard of the following methods?*		
CO1 a	STÉRILISATION FÉMININE Les femmes peuvent subir une opération pour éviter d'avoir d'autres enfants. *Women can have an operation to avoid having anymore children.*	Oui ..... 1 Non..... 2	
CO1b	STÉRILISATION MASCULINE *Male Sterilization* Les hommes peuvent subir une opération pour Eviter d'avoir d'autres enfants. *Men can have an operation to avoid having anymore children.*	Oui ..... 1 Non 2	
CO1c	PILULE *Pill* Les femmes peuvent prendre une pilule chaque jour pour éviter de tomber enceinte. *Women can take a pill each day to avoid becoming pregnant.*	Oui ..... 1 Non 2	

MODULE 1.3: CONTRACEPTION		CO	
CO1d	DIU Les femmes peuvent avoir un stérilet que le médecin ou l'infirmière leur place à l'intérieur. *Women can have an IUD that a doctor or nurse can install.*	Oui ..... 1 Non 2	
CO1e	INJECTIONS Les femmes peuvent avoir une injection faite par du personnel de santé pour éviter de tomber enceinte pendant un mois ou plus. *Women can have an injection administered by a healthcare profesesional to avoid becoming pregnant for a month or more.*	Oui ..... 1 Non 2	
CO1f	IMPLANTS Les femmes peuvent se faire insérer sous la peau de La partie supérieure du bras plusieurs petits bâtonnets qui les empêchent de tomber enceinte pendant une année ou plus. *Women can have several small sticks inserted under the skin of their upper arm that will prevent pregnancy for a year or more.*	Oui ..... 1 Non 2	
CO1g	CONDOM Les hommes peuvent se mettre une capote en caoutchouc au pénis pendant les rapports sexuels. *Men can put a rubber hood on their penis during sexual encounters.*	Oui ..... 1 Non 2	
CO1h	CONDOM FÉMININ Les femmes peuvent se placer un étui dans leur vagin avant les rapports sexuels. *Women can place a case in their vagina before sexual encounters.*	Oui ..... 1 Non 2	
CO1b	DIAPHRAGME Les femmes peuvent se placer un diaphragme dans leur vagin avant les rapports sexuels. *Women can place a diaphram in their vagina before sexual encounters.*	Oui ..... 1 Non 2	
CO1i	COMPRIME, MOUSSE OU GELÉE Les femmes peuvent s'insérer un comprimé, se mettre de la gelée ou de la crème dans leur vagin avant les rapports sexuels. *Women can insert a tablet, to put a gel or creme in their vagina before sexual encounters.*	Oui ..... 1 Non 2	
CO1j	ABSTINENCE PERIODIQUE/RYTHME/CALENDRIER Periodical abstinence, Une femme sexuellement active peut éviter une grossesse en évitant les rapports sexuels les jours du mois où elle a plus de chances de tomber enceinte. *A sexually active woman can avoid becoming pregnant by avoiding sexual interactions on the days of the month when she has the highest chance of becoming pregnant.*	Oui ..... 1 Non 2	

MODULE 1.3: CONTRACEPTION		CO	
CO1k	RETRAIT- *Withdrawal* Les hommes peuvent faire attention et se retirer avant l'éjaculation. *Men can be careful and withdraw before ejaculation.*	Oui ..... 1 Non 2	
CO1l	PILULE DU LENDEMAIN- *Morning after pill* Les femmes peuvent prendre des pilules les jours après les rapports sexuels, jusqu'au troisième jour après, pour éviter de tomber enceinte. *Women can take pills in the days following the sexual encounter, up to three days after, to avoid becoming pregnant.*	Oui ..... 1 Non 2	
CO1m	Avez-vous entendu parler d'autres moyens ou méthodes que les femmes ou les hommes peuvent utiliser pour éviter une grossesse? *Have you heard of other ways and methods that women or men can avoid a pregnancy?*	Oui ..... 1 (Préciser) : Non 2	
CO2.	CERTAINS COUPLES UTILISENT DIFFERENTS MOYENS OU METHODES POUR RETARDER OU EVITER UNE GROSSESSE EN CE MOMENT, FAITES-VOUS QUELQUECHOSE OU UTILISEZ-VOUS UNE METHODE POUR RETARDER OU EVITER UNE GROSSESSE? *Some couples use various ways and methods to delay or avoid a pregnancy now, do you do something or have a method for delaying or avoiding a pregnancy?*	Oui ..... 1 Non 2	2 **Passer à** CO4
C03.	QUE FAITES-VOUS ACTUELLEMENT POUR RETARDER OU EVITER UNE GROSSESSE? *What do you do now to delay or avoid a pregnancy?* *Ne suggérez pas de réponse.* *Si plus d'une méthode est mentionnée, encerclez* *chaque méthode.* *Do not suggest a response. If more than one method is mentioned, circle each method.*	Stérilisation féminine ..... A Stérilisation masculine..... B DIU ..... C Injections ..... D Implants..... E Pilules..... F Condom masculin..... G Condom féminin ..... H Diaphragme..... I Mousse/gelée ..... J Méthode de l'Allaitement Maternel et de l'Aménorrhée (MAMA)..... K Abstinence périodique/Rythme/Calendrier ... L Retrait..... M Pilule du lendemain..... N Autre (*précisez*) _____ X	
C04.	AU COURS DES DERNIERS MOIS, AVEZ-VOUS DISCUTE DE LA PRATIQUE DE LA PLANIFICATION FAMILIALE AVEC VOS AMIS OU AMIES, VOS VOISINS	Oui..... 1 Non..... 2	2 **Passer au** MODULE SUIVANT

MODULE 1.3: CONTRACEPTION			CO
	OU VOISINES OU VOS PARENTS OU PARENTES? *During the last month, have you discussed the practice of family planning with your male or female freinds, neighbors, neighbors of your parents, or parents?*		
C05.	AVEC QUI EN AVEZ-VOUS DISCUTE? *With whom have you discussed family planning?* QUELQU'UN D'AUTRE? *Anyone else?* Enregistrez tout ce qui est mentionné.	Mari/Partenaire.....A Mère.....B Père.....C Sœurs.....D Frères.....E Fils.....F Filles.....G Belle-mère.....H Ami(e)s, Voisin(e)s.....I Autre (*précisez*)	

MODULE 1.4: VIH/SIDA			VS
VS1.	MAINTENANT, JE VOUDRAIS VOUS PARLER D'UN AUTRE SUJET. *Now, I would like to speak about another subject with you.* AVEZ-VOUS DEJA ENTENDU PARLER D'UNE MALADIE APPELEE SIDA? *Have you ever heard of a disease called AIDS?*	Oui.....1 Non.....2	2 **Passer à** VS12
VS2.	EST-CE QUE LES GENS PEUVENT REDUIRE LEUR RISQUE DE CONTRACTER LE VIRUS DU SIDA EN AYANT SEULEMENT UN PARTENAIRE SEXUEL QUI N'EST PAS INFECTE ET QUI N'A AUCUN AUTRE PARTENAIRE? *Is it possible to reduce one's risk of contracting the AIDS virus by having only one sexual partner who is not infected and who does not have any other partners?*	Oui.....1 Non.....2 NSP.....8	
VS3.	EST-CE QUE LES GENS PEUVENT ATTRAPER LE VIRUS DU SIDA PAR SORCELLERIE OU AUTRES MOYENS SURNATURELS? *Is it possible to catch the AIDS virus by sorcery or other supernatural methods?*	Oui.....1 Non.....2 NSP.....8	
VS4.	EST-CE QUE LES GENS PEUVENT REDUIRE LEUR RISQUE DE CONTRACTER LE VIRUS DU SIDA EN UTILISANT UN CONDOM CHAQUE FOIS QU'ILS ONT DES RAPPORTS SEXUELS? *Is it possible to reduce one's risk of contracting the AIDS virus by using a condom each time one has a sexual interaction?*	Oui.....1 Non.....2 NSP.....8	

	MODULE 1.4: VIH/SIDA	VS	
VS5.	EST-CE QUE LES GENS PEUVENT CONTRACTER LE VIRUS DU SIDA PAR DES PIQURES DE MOUSTIQUES? *Is it possible to contract the AIDS virus through mosquito bites?*	Oui.....1 Non.....2 NSP.....8	
VS6.	EST-CE QUE LES GENS PEUVENT CONTRACTER LE VIRUS DU SIDA EN PARTAGEANT LA NOURRITURE AVEC UNE PERSONNE ATTEINTE DU SIDA? *Is it possible to contract the AIDS virus by sharing food with a person who has the virus?*	Oui.....1 Non.....2 NSP.....8	
VS7.	EST-IL POSSIBLE QU'UNE PERSONNE PARAISSANT EN BONNE SANTE AIT, EN FAIT, LE VIRUS DU SIDA? *Is it possible that a person who appears healthy in fact has the AIDS virus?*	Oui.....1 Non.....2 NSP.....8	
VS8.	EST-CE QUE LE VIRUS QUI CAUSE LE SIDA PEUT ETRE TRANSMIS DE LA MERE A SON BEBE? *Is it possible for the virus that causes AIDS to be transmitted from mother to child?* [A] AU COURS DE LA GROSSESSE? *During pregnancy?* [B] PENDANT L'ACCOUCHEMENT? *During childbirth?* [C] EN ALLAITANT? *During breastfeeding?*	Oui Non NSP Au cours de la grossesse .....1 2 8 *During pregnancy* Pendant l'accouchement .....1 2 8 *During childbirth* En allaitant.....1 2 8 *During breastfeeding*	
VS9.	JE NE VEUX PAS CONNAITRE LES RESULTATS MAIS AVEZ-VOUS DEJA EFFECTUE UN TEST POUR SAVOIR SI VOUS AVIEZ LE VIRUS DU SIDA? *I do not want to know the results but have you ever taken a test to know if you have the AIDS virus?*	Oui.....1 Non.....2	2 **Passer à** VS12
VS10.	QUAND AVEZ-VOUS EFFECTUE LE TEST DU VIH/SIDA POUR LA DERNIERE FOIS? *When was the last time you took an HIV/AIDS test?*	Il y a moins de 12 mois.....1 *It has been less than 12 months.* Il y a 12-23 mois.....2 *It has been between 12-23 months.* Il y a 2 ans ou plus.....3 *It has been more than 2 years.*	
VS11.	JE NE VEUX PAS CONNAITRE LES RESULTATS, MAIS, AVEZ-VOUS OBTENU LES RESULTATS DU TEST? *I do not want to know the results, but, have you received the results of the test?*	Oui.....1 Non.....2 NSP.....8	

MODULE 1.4: VIH/SIDA		VS	
Maintenant, je voudrais vous poser quelques questions sur votre activité sexuelle afin de mieux comprendre certains problèmes de la vie. Les informations que vous nous fournirez resteront strictement confidentielles. ***Vérifiez la présence d'autres personnes, avant de continuer l'interview. Faites tout votre possible pour vous trouver en privé avec l'enquêtée.***			
VS12.	ÊTES-VOUS ACTUELLEMENT MARIEE OU VIVEZ-VOUS ACTUELLEMENT AVEC UN HOMME, COMME SI VOUS ETIEZ MARIEE ? *Are you currently married or do you currently live with a man as if he were your husband?*	Oui, actuellement mariée..... 1 *Yes, my husband* Oui, vit avec un homme ..... 2 *Yes, I live with a man* Non, pas en union..... 3 *No, not in a relationship*	
VS13.	QUAND AVEZ-VOUS EU DES RAPPORTS SEXUELS POUR LA DERNIERE FOIS? *When was the last time you had a sexual interaction with him?* Enregistrer en 'nombre d'années' seulement si les derniers rapports sexuels ont eu lieu il y a un an ou plus. Si 12 mois ou plus, la réponse doit être enregistrée en années.	Il y a … jours..... 1 __ _____ *It has been … days* Il y a … semaines ..... 2 __ _____ *It has been …weeks* Il y a … mois ..... 3 __ _____ *It has been … months* Il y a …ans..... 4 __ _____ *It has been … years*	4 **Passer au Module suivant**
VS14.	LA DERNIERE FOIS QUE VOUS AVEZ EU DES RAPPORTS SEXUELS, EST-CE QU'UN CONDOM A ETE UTILISE? *Did you use a condom the last time you had a sexual interaction?*	Oui..... 1 Non 2	
VS15.	QUELLE ETAIT VOTRE RELATION AVEC LA PERSONNE AVEC QUI VOUS AVEZ EU VOS DERNIERS RAPPORTS SEXUELS? *What is your relation to the person with whom you had your last sexual interaction?* Si la personne est un 'petit ami' ou 'fiancé', demandez: *If the person is a boyfriend or fiance ask:* VIVIEZ-VOUS ENSEMBLE COMME SI VOUS ETIEZ MARIE? *Do you live together as if you were married?* Si 'Oui', encerclez '01' ou'02'ou '03''04'. Si 'Non', encerclez '05'. *If 'Yes', circle '01' or '02' or '03''04'. If 'no' cirlce '05'.*	Epoux..... 01 *Husband* Partenaire cohabitant..... 02 *Domestic partner* Ex-époux..... 03 *Ex-husband* Ex- partenaire cohabitant..... 04 *Ex-domestic partner* Petit ami / fiancé..... 05 *Boyfriend/Fiance* Rencontre occasionnelle..... 06 *Casual encounter* Travailleur (se) du sexe..... 07 *Sex Worker* Autre (*précisez*)_____ 96 *Other*	

MODULE 1.5: SANTÉ MATERNELLE — SM

Ce module concerne toutes les femmes qui ont un enfant âgé de 0-23 mois. Enregistrez ici le nom de l'enfant
This model concerns all women with a child between 0-23 months. Write the name of the child here.
Quand vous posez les questions suivantes, utilisez le nom de l'enfant, là où c'est indiqué.
When you ask the following questions, use the name of the child where indicated.

SM1.	AVEZ-VOUS REÇU DES SOINS PRENATALS AU COURS DE LA GROSSESSE DE (*nom*)? *Have you received prenatal care during your pregnancy with (name)?*	Oui.....1 Non.....2	2 **Passer à** SM4
SM2.	QUI AVEZ-VOUS VU? *Who have you seen?* Insistez: *Ask again:* QUELQU'UN D'AUTRE? *Anyone else* Insistez pour obtenir le type de personne vue et encerclez toutes les réponses données. *Ask to know the type of person seen and circle all the responses given.*	Professionnel de la santé: Médecin.....A Infirmier/Infirmière.....B Accoucheuse .....D Sage-femme.....E Autre personne Accoucheuse traditionnelle.....F Agent de santé communautaire.....G Autre (précisez) X	
SM3.	COMBIEN DE FOIS AVEZ-VOUS REÇU DES SOINS PRENATALS AU COURS DE CETTE GROSSESSE? *How many times have you received prenatal care during this pregnancy?*	Nombre de fois ..... NSP.....98	
SM4.	AVEZ-VOUS UN CARNET OU AUTRE DOCUMENT DANS LEQUEL SONT INSCRITES TOUTES VOS VACCINATIONS? PUIS-JE LE VOIR, S'IL VOUS PLAIT? *Do you have a notebook or other document in which to write all of your vaccinations? May I see it, please?* Si un carnet vous est présenté, utilisez-le pour les réponses aux questions suivantes. *If a notebook is shown to you, use it for the responses to the following questions.*	Oui (carnet vu).....1 Oui (carnet non vu).....2 Non.....3 NSP.....8	
SM5.	QUAND VOUS ETIEZ ENCEINTE DE (nom), VOUS A-T-ON FAIT UNE INJECTION DANS LE BRAS OU A L'EPAULE POUR EVITER AU BEBE DE CONTRACTER LE TETANOS, C'EST-A-DIRE DES CONVULSIONS APRES LA NAISSANCE? *When you were pregnant with (name), did you receive an injection in the arm or the shoulder to prevent the baby from contracting tetanus, meaning convulsions after birth?*	Oui.....1 Non.....2 NSP.....8	2 **Passer à** SM7 8 **Passer à** SM7

MODULE 1.5: SANTÉ MATERNELLE		SM	
SM6.	COMBIEN DE FOIS AVEZ-VOUS REÇU CETTE INJECTION CONTRE LE TETANOS AU COURS DE LA GROSSESSE DE (nom)? Si 7 fois ou plus, enregistrez '7'. *How many times did you receive this anti-tetanus injection during your pregnancy with*	Nombre de fois ..... NSP.....8	
SM7.	QUI VOUS A ASSISTE PENDANT L'ACCOUCHEMENT DE (*nom*)? *Who helped you during the delivery of (Name)* *Insistez:* QUELQU'UN D'AUTRE? *Anyone else* Insistez pour le type de personne qui a assisté l'accouchement et encerclez toutes les réponses mentionnées. Si l'enquêtée déclare que personne ne l'a assistée, insistez pour déterminer si aucun adulte n'était présent lors de l'accouchement. *Ask for the type of person who assisted in the delivery and circle all the responses mentioned.* *If the interviewee says no one helped, ask to know if another adult was present during the delivery.*	Professionnel de la santé: Médecin ..... A Infirmier/Infirmière..... B Accoucheuse ..... D Sage-femme ..... E Autre personne Accoucheuse traditionnelle..... F Agent de santé communautaire.....G Parent(e) / Ami(e) ..... H Autre (précisez) X Personne .....Y	
SM8.	OU AVEZ-VOUS ACCOUCHE DE (nom)? *Where did you deliver (name)?* Insistez pour obtenir le type d'endroit. *Ask for the type of location.* Si vous ne pouvez déterminer si l'endroit est un établissement public ou privé, inscrivez le nom de l'endroit. *If you cannot determine if the location is in the public or private sector, record the name of the place.* _____ (Nom de l'endroit)	Domicile Votre domicile.....11 Autre domicile.....12 Secteur médical public Hôpital du Gouvernement.....21 Clinique / Centre de santé du Gouv. .....22 Poste de santé du Gouv.....23 Autre public (précisez) 26 Secteur médical privé Hôpital privé .....31 Clinique privée .....32 Maternité privée .....33 Autre privé médical (précisez) 36 Autre (précisez) 96	
SM9.	APRES LA NAISSANCE DE (nom), EST-CE QU'UN PROFESSIONNEL DE LA SANTE OU UNE AUTRE PERSONNE VOUS A EXAMINEE? *After the birth of (name) did a health professional or anyone else examine you?*	Oui 1 Non 2	2 **Passer à** SM12

MODULE 1.5: SANTÉ MATERNELLE		SM	
SM10.	APRES COMBIEN DE JOURS OU DE SEMAINES APRES L'ACCOUCHEMENT AVEZ-VOUS EU VOTRE PREMIER EXAMEN DE SANTE? *How many days or weeks after delivery did you have your first health examination?* Encerclez '1' et inscrivez "00" jour si même jour. *Circle '1' and write '00' days if the same day.*	Nombre de jours après ACC .....1 Nombre de semaines après ACC.....2 NSP 998	
SM11.	QUI VOUS A EXAMINEE? *Who examined you?* Insistez: QUELQU'UN D'AUTRE? *Anyone else?* Insistez pour obtenir le type de personne vue et encerclez toutes les réponses données. *Ask for the type of person seen and circle all the responses given.*	Professionnel de la santé: Médecin ..... A Infirmier/Infirmière..... B Accoucheuse ..... D Sage-femme ..... E Autre personne Accoucheuse traditionnelle .....F Agent de santé communautaire ..... G Guérisseur traditionnel.....H Maman du quartier/village.....I Autre (précisez) X	
SM12.	DANS LES MOIS QUI ONT SUIVI L'ACCOUCHEMENT, AVEZ-VOUS RECU UNE DOSE DE VITAMINE A COMME CELLE-CI ?Montrez la capsule. *In the months that followed the delivery, did you recieve a dose of vitamin A like this one? Show the capsule.*	Oui 1 Non 2	2 **Passer à** SM14
SM13.	COMBIEN DE TEMPS APRES LA NAISSANCE DE (nom) AVEZ-VOUS REÇU LA PREMIERE DOSE DE VITAMINE A? *How much time after the birth of (name) did*	Avant 1 mois .....1 Entre 1 et 2 mois .....2 Entre 2 et 6 mois .....3 Après 6 mois .....4 NSP 8	
SM14.	MAINTENANT, JE VOUDRAIS VOUS PARLER D'UN AUTRE SUJET. AVEZ-VOUS DEJA ENTENDU PARLER D'UNE MALADIE APPELEE FISTULE, c'est-à-dire la maladie qui fait que la femme perd de l'urine et/ou défèque continuellement. *Now I would like to talk to you about another subject. Have you ever heard of an illness called fistula, it is an illness that causes the woman to expel urine and/or feces continuously.*	Oui.....1 Non.....2	2 Passer au MODULE SUIVANT
SM15.	SELON VOUS, QUELLE EST LA PRINCIPALE CAUSE DE CETTE MALADIE? *In your opinion, what is the main cause of this*	Accouchement.....1 Intervention chirurgicale.....2 Traumatisme.....3 NSP.....8	

MODULE 1.5: SANTÉ MATERNELLE			SM
SM16.	JE NE VEUX PAS CONNAITRE LE NOM, MAIS, Y A-T-IL, DANS VOTRE COMMUNAUTE, UNE FEMME QUI SOUFFRE DE CETTE MALADIE? *I do not want to know their name, but, is there, in your community, a woman who suffers from this condition.*	Oui.....1 Non .....2 NSP 8	

MODULE 1.6: SYMPTOMES DE MALADIES			SY
SY1.	IL ARRIVE PARFOIS QUE LES ENFANTS SOIENT GRAVEMENT MALADES ET DOIVENT ETRE CONDUITS IMMEDIATEMENT DANS UN ETABLISSEMENT DE SANTE. QUELS SONT LES TYPES DE SYMPTOMES QUI VOUS INCITERAIENT A EMMENER IMMEDIATEMENT VOTRE ENFANT DANS UN ETABLISSEMENT DE SANTE? *Sometimes a child is seriously ill and needs to be seen immediately in a health facility. What are the types of symptoms that make you bring your child to a health center immediately?* AUCUN AUTRE SYMPTOME? *Any other symptoms?* Insistez pour autres signes ou symptômes jusqu'à ce que la mère ne se souvienne plus d'autre signes ou symptômes. *Ask for more signs and symptoms until the mother cannot think of anymore.*	Enfant incapable de boire ou de téter ..... A État de l'enfant s'aggrave..... B Enfant devient fiévreux..... C Enfant respire rapidement ..... D Enfant a des difficultés pour respirer..... E Enfant a du sang dans les selles ..... F Enfant boit difficilement ..... G Enfant fait la diarrhée ..... H Enfant fait des vomissements..... I Autre (précisez) ..... X Autre (précisez) ..... Y Autre (précisez) ..... Z	

MODULE 1.7: CONTACTS AVEC LES SERVICES DE SANTE					CS-SIS
CS1.	AU COURS DU DERNIER MOIS, COMBIEN DE FOIS ETES-VOUS ENTREE EN CONTACT AVEC LES PROFESSIONNELS DE SANTE SUIVANTS: *During this last month, how many times did you get in contact with the following health professionals:*	Catégories de codage Fréquemment (4 fois ou plus)	Parfois (1-3 fois)	Ne jamais (0 fois)	
	Médecin	1	2	3	
	Infirmière/Sage-femme	1	2	3	
	Relais communautaire	1	2	3	
	Personne chargée du contrôle de croissance	1	2	3	
	Accoucheuse qualifiée	1	2	3	
	Guérisseur traditionnel	1	2	3	
	Autre (précisez):	1	2	3	

	MODULE 1.7: CONTACTS AVEC LES SERVICES DE SANTE	CS-SIS
	S'IL Y AVAIT AU MOINS UN CONTACT DE SANTE MENTIONNE CI-DESSUS, PASSEZ A LA QUESTION SUIVANTE. **SINON, PASSEZ À LA QUESTION RC4.**	
CS2.	A quelle occasion êtes-vous entrée en contact avec cette (ces) personne (s) ? *For what reason did you get in contact with this person?*	Visites de routine ..... A Visites de sensibilisation sur un sujet de santé..... B Visites pour annoncer une activité future ..... C Autre (précisez) X
CS3	QUELLES PRATIQUES DE SANTE AVEZ-VOUS APPRISES AU CONTACT DE CES PROFESSIONNELS DE SANTE ? *What health practices have you learned from contacting these health professionals?* INSISTEZ: AUTRE PRATIQUE ? ENREGISTREZ TOUT CE QUI EST MENTIONNE.	L'allaitement maternel exclusif ..... A Une bonne nutrition..... B Les Vaccinations..... C La prévention et traitement de la diarrhée..... D La prévention et traitement des infections respiratoires aiguës ..... E La prévention et traitement du paludisme..... F L'éducation et l'utilisation de méthodes de planification familiale..... G La prévention et le traitement du VIH / SIDA..... H Autre (précisez):_____X
CS4.	auprès de qui avez-vous l'habitude d'obtenir des informations générales ou des conseils en matière de santé ou de nutrition ? Enregistrez tout ce qui est mentionné. *Besides them, do you regularly get general information or counseling on health issues or nutrition from someone else?*	Réseau formel Médecin .....A Infirmier/Sage-femme .....B Sage-femme auxiliaire .....C Relais communautaire .....D Personne contrôle de la croissance .....E Accoucheuse qualifiée .....F Réseau informel L'époux / partenaire ..... G Mère / Mère adoptive ..... H Sœur..... I Grand-parent ..... J Tante ..... K Ami/voisin ..... L Guérisseur traditionnel ..... M Anciens du Village ..... N Autre (précisez) X
CS5.	AU COURS DU DERNIER MOIS, AVEZ-VOUS REÇU DES MESSAGES DE SANTE A TRAVERS LES CANAUX SUIVANTS? *Over the last month have you received health messages from the following sources?*	Oui Non Relais communautaires? ..... 1 2 Médecin ou infirmière? ..... 1 2 Membre de famille? ..... 1 2 Radio? ..... 1 2 Journal/revue? …..... 1 2 Télévision? ..... 1 2 Ecole ..... 1 2 Autre: (précisez): _____

MODULE 1.7: CONTACTS AVEC LES SERVICES DE SANTE	CS-SIS
Observations du Superviseur	
Observations de l'enquêteur/enquêtrice	

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
QUESTIONNAIRE ENFANTS DE 0-5 MOIS

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-5 MOIS	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-5 mois	
08. Nom et Numéro de la mère dans l'A.S. Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?
/__/ **OUI**, *permission accordée ⇒Commencer l'interview.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 2.1: ALLAITEMENT			AL
AL1.	EST-CE QUE (*nom*) A ETE ALLAITE ? *Was (name) breastfed?*	Oui .....1 Non.....2 NSP.....8	2 **Passer à** AL3 8 **Passer à** AL3
AL2.	EST-CE QUE (nom) EST ENCORE ALLAITE? *Is (name) still breastfed?*	Oui .....1 Non.....2 NSP.....8	
AL3.	JE VOUDRAIS MAINTENANT VOUS DEMANDER QUELS LIQUIDES (nom) A RECU HIER PENDANT LE JOUR OU LA NUIT. JE CHERCHE A SAVOIR SI (nom) A REÇU CE LIQUIDE MEME S'IL ETAIT MELANGE AVEC D'AUTRES ALIMENTS. EST-CE QUE (nom) A BU DE L'EAU HIER, PENDANT LE JOUR OU LA NUIT ?	Oui .....1 Non.....2 NSP.....8	

	MODULE 2.1: ALLAITEMENT		AL
	I would now like to ask you what liquids (name) received yesterday during the day and night. I am looking to know if (name) received this liquid even if it were mixed with other foods. Did (name) drink water yesterday, during the day or night?		
AL4.	EST-CE QUE (nom) A BU UNE PREPARATION POUR BEBE VENDUE EN COMMERCE (lait maternisé) PRECISER) HIER, PENDANT LE JOUR OU LA NUIT ? *Did (name) drink baby formula sold in stores (mother's milk)? Specifically, was it yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	2 **Passer à** AL6 8 **Passer à** AL6
AL5.	COMBIEN DE FOIS (nom) A T-IL BU UNE PREPARATION POUR BEBE VENDUE EN COMMERCE ? *How many times did (name) drink baby formula?*	Nombre de fois	
AL6.	EST-CE QUE (nom) A BU DU LAIT TEL QUE DU LAIT EN BOITE, EN POUDRE OU DU LAIT FRAIS D'ANIMAL, HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink bottled milk, powder, or fresh animal milk, yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	2 **Passer à** AL8 8 **Passer à** AL8
AL7.	COMBIEN DE FOIS (nom) A T-IL BU DU LAIT EN BOITE, EN POUDRE OU DU LAIT FRAIS D'ANIMAL ? *How many times did (name) drink bottled milk, powdered milk, or fresh animal milk?*	Nombre de fois	
AL8.	EST-CE QUE (nom) A BU DES JUS DE FRUITS OU DES BOISSONS A BASE DE JUS, HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink fruit juice or fruit based juice, yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL9.	EST-CE QUE (nom) A BU DE LA SOUPE (POTAGE) HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink soup yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL10.	EST-CE QUE (nom) A BU DES SUPPLEMENTS VITAMINIQUES OU MINERAUX OU DES MEDICAMENTS, HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink vitamin or mineral supplements or other medications, yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL11.	EST-CE QUE (nom) A BU UNE SRO (SOLUTION DE REHYDRATATION ORALE) HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink an SRO yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	

	MODULE 2.1: ALLAITEMENT		AL
AL12.	EST-CE QUE (nom) A BU DU THE /INFUSION, HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink herbal tea yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL13.	EST-CE QUE (nom) A BU D'AUTRES LIQUIDES HIER PENDANT LE JOUR OU LA NUIT ? *Did (name) drink any other liquids yesterday during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL14.	EST-CE QUE (nom) A BU OU MANGE DES YAOURTS HIER, PENDANT LE JOUR OU LA NUIT ? *Did (name) drink or eat yogurt yesterday, during the day or night?*	Oui .....1 Non.....2 NSP.....8	2 **Passer à** AL16 8 **Passer à** AL16
AL15.	COMBIEN DE FOIS (nom) A T-IL BU OU MANGE DES YAOURTS HIER, PENDANT LE JOUR OU LA NUIT ? *How many times did (name) drink or eat yogurt yesterday, during the day or night?*	Nombre de fois	
AL16.	EST-CE QUE (nom) A MANGE DE LA BOUILLIE LEGERE HIER, PENDANT LE JOUR OU LA NUIT ? *Did (name) eat a light soup yesterday, during the day or night?*	Oui .....1 Non.....2 NSP.....8	
AL17.	EST-CE QUE (nom) A MANGE DES ALIMENTS SOLIDES OU SEMI SOLIDES (EN BOUILLIE, PUREE) HIER, PENDANT LE JOUR OU LA NUIT ? *Did (name) eat solid food or semi solid food (porridge, mash) yesterday, during the day or night?*	Oui .....1 Non.....2 NSP.....8	2 **Passer à** FIN 8 **Passer à** FIN
AL18.	COMBIEN DE FOIS (nom) A T-IL MANGE DES ALIMENTS SOLIDES OU SEMI SOLIDES (EN BOUILLIE, PUREE) HIER, PENDANT LE JOUR OU LA NUIT ? *How many times did (name) eat solid food or semi solid food (porridge, mash) yesterday, during the day or night?*	Nombre de fois	
Observations de l'enquêteur/enquêtrice			
Observations du Superviseur			

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
ENQUETE DANS LES MENAGES QUESTIONNAIRE ENFANT DE 12-23 MOIS

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 12-23 MOIS	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 12-23 mois	
08. Nom et Numéro de la mère dans l'A.S. Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?
/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 4.1: VACCINATIONS	VA
Si un carnet (une carte) de vaccination (ou une fiche de consultation préscolaire) est disponible, recopiez les dates à VA3 pour chaque vaccination enregistrée sur le carnet (la carte ou la fiche de consultation préscolaire). Les questions VA6-VA17 servent à enregistrer les vaccinations qui ne sont pas inscrites sur le carnet (la carte ou la fiche de consultation préscolaire). Vous ne poserez les questions VA6 à VA17 que si le carnet (carte ou fiche de consultation préscolaire) n'est pas disponible.	

MODULE 4.1: VACCINATIONS			VA
VA1.	AVEZ-VOUS UN CARNET (UNE CARTE/FICHE DE CONSULTATION PRESCOLAIRE) OU LES VACCINATIONS DE (nom) SONT ENREGISTREES? *Do you have a notebook (a card/preschool consultation sheet) where (name's) vaccinations are recorded?* (SI Oui) PUIS-JE LE VOIR, S'IL VOUS PLAIT ? *(If yes) can I see it, please?*	Oui, vu ..... 1 Oui, non vu ..... 2 Pas de carnet 3	1 **Passer à** VA3 2 **Passer à** VA6
VA2.	AVEZ-VOUS DEJA EU UN CARNET (UNE CARTE/ FICHE DE CONSULTATION PRESCOLAIRE) DE VACCINATION POUR (nom) ? *Did you ever have a notebook (a card/preschool consultation sheet) of vaccinations for (name)?*	Oui ..... 1 Non 2	1 **Passer à** VA6 2 **Passer à** VA6

VA3.	*Recopiez les dates de chaque vaccination à partir du carnet (de la carte/fiche de consultation préscolaire).* *Inscrivez '44'dans la colonne jour si le carnet (la carte/fiche de consultation préscolaire) montre que le vaccin a été donné mais que la date n'a pas été enregistrée.*	Date des vaccinations								
		Jour		Mois		Année				
	BCG BCG									
	POLIO À LA NAISSANCE VPO0									
	POLIO1 VPO 1									
	POLIO 2 VPO 2									
	POLIO 3 VPO 3									
	DTCOQ 1 DTCOQ1									
	DTCOQ 2 DTCOQ2									
	DTCOQ 3 DTCOQ 3									
	HEPB1 H1									
	HEPB2 H2									

MODULE 4.1: VACCINATIONS											VA
	HEPB3 H3										
	ROUGEOLE (VAR) VAR										
	FIÈVRE JAUNE VAA										
VA4.	*Vérifiez VA3. Est-ce que toutes les vaccinations (du BCG à la Fièvre Jaune) sont enregistrées?* Si *Oui* *Fin de l'interview* D *Non Continuez avec VA5*										
VA5.	EN PLUS DE CE QUI EST ENREGISTRE SUR CE CARNET (CETTE CARTE/FICHE DE CONSULTATION PRESCOLAIRE), EST-CE QUE (*nom*) A REÇU D'AUTRES VACCINS – Y COMPRIS DES VACCINS REÇUS AU COURS DES CAMPAGNES OU DES JOURNEES DE VACCINATIONS? *In addition to what is recorded in the notebook (this card/preschool consultation sheet), did (name) receive other vaccinations including vaccinations received during campaigns or vaccination days?* *Enregistrez 'Oui' seulement si l'enquêtée mentionne des vaccins qui figurent dans le tableau ci-dessus.*										Oui ..... 1 *(Insistez pour les vaccins et inscrivez '66' à la colonne jour correspondante pour chaque vaccin mentionné. Ensuite, terminez l'interview* Non ..... 2 2 **Passer à** Fin NSP ..... 8 8 **Passer à** Fin
VA6.	EST-CE QUE (*nom*) A DEJA REÇU DES VACCINS POUR LUI EVITER DE CONTRACTER DES MALADIES, Y COMPRIS DES VACCINS REÇUS AU COURS DES CAMPAGNES OU DE JOURNEES DE VACCINATIONS? *Did (name) ever receive vaccinations to prevent contracting illnesses, including vaccinations received during campaigns or immunization days?*										Oui ..... 1 Non ..... 2 2 **Passer à** Fin NSP ..... 8 8 **Passer à** Fin
VA7.	EST-CE QUE (*nom*) A DEJA REÇU LE VACCIN DU BCG CONTRE LA TUBERCULOSE – C'EST-A-DIRE UNE INJECTION FAITE A L'AVANT BRAS GAUCHE ET QUI LAISSE HABITUELLEMENT UNE CICATRICE? *Did (name) ever receive the anti-tuberculosis BCG vaccine, this is a vaccine administered above the left arm and usually leaves a scar?*										Oui ..... 1 Non ..... 2 NSP 8
VA8.	EST-CE QUE (*nom*) A REÇU UN « VACCIN SOUS FORME DE GOUTTES DANS LA BOUCHE » POUR LE/LA PROTEGER CONTRE DES MALADIES - C'EST-A-DIRE LA POLIO? *Has (name) received a vaccine in the form of mouth drops for protection against illnesses such as polio?*										Oui ..... 1 Non ..... 2 2 **Passer à** VA11 NSP ..... 8 8 **Passer à** VA11

MODULE 4.1: VACCINATIONS			VA
W	EST-CE QUE LA PREMIERE DOSE DU VACCIN CONTRE LA POLIO A ETE DONNEE DANS LES DEUX SEMAINES QUI ONT SUIVI LA NAISSANCE OU PLUS TARD? *Was the first dose of the anti-polio vaccine given within the first two weeks after birth or later?*	Dans les 2 premières semaines..... 1 Plus tard..... 2	
VA10.	COMBIEN DE FOIS LE VACCIN CONTRE LA POLIO A-T-IL ETE DONNE? *How many times was the anti-polio vaccine given?*	Nombre de fois ..... /___/	
VA11.	EST-CE QUE (*nom*) A DEJA REÇU « LE VACCIN DTCOQ » – C'EST-A-DIRE UNE INJECTION A LA CUISSE OU A LA FESSE – POUR LUI EVITER DE CONTRACTER LE TETANOS, LA COQUELUCHE ET LA DIPHTERIE? *Did (name) ever receive the DTCOQ vaccine, which is given in the thigh or in the leg to prevent contracting tetanus, whooping cough, or diphtheria?* Insistez en précisant que le vaccin du DTCoq est parfois donné en même temps que la polio	Oui..... 1 Non..... 2 2 **Passer à** VA13 NSP..... 8 8 **Passer à** VA13	
VA12.	COMBIEN DE FOIS A-T-ON DONNE A (*nom*) LE VACCIN DTCOQ? *How many times was he/she given the DTCOQ vaccine?*	Nombre de fois ..... /___/	
VA13.	EST-CE QUE (*nom*) A DEJA REÇU LE VACCIN CONTRE L'HEPATITE B – C'EST-A-DIRE UNE INJECTION A LA CUISSE OU A LA FESSE – POUR LUI EVITER DE CONTRACTER L'HEPATITE B *Did (name) ever receive an anti-Hepatitis B vaccine, it is an injection in the thigh or leg, to prevent contracting Hepatitis B?* Insistez en précisant que le vaccin contre l'hépatite B est parfois donné en même temps que les vaccins de la polio et du DTCoq	Oui..... 1 Non..... 2 2 **Passer à** VA16 NSP..... 8 8 **Passer à** VA16	
VA14.	EST-CE QUE LA PREMIERE DOSE D'HEPATITE B A ETE DONNEE DANS LES 24 H APRES LA NAISSANCE OU PLUS TARD ? *Was the first dose of hepatitis B given within 24 hours of birth or later?*	Dans les 24 h après naissance..... 1 Plus tard..... 2	

MODULE 4.1: VACCINATIONS			VA
VA15.	COMBIEN DE FOIS LE VACCIN CONTRE L'HEPATITE B A-T-IL ETE DONNE? *How many times was the anti-hepatitis B vaccine given?*	Nombre de fois ..... /____/	
VA16.	EST-CE QUE (*nom*) A DEJA REÇU LE « VACCIN CONTRE LA ROUGEOLE » OU VAR - C'EST-A-DIRE UNE INJECTION FAITE AU BRAS GAUCHE A L'AGE DE **9** MOIS OU PLUS – POUR LUI EVITER DE CONTRACTER LA ROUGEOLE? *Did (name) ever receive the anti-measles vaccine, which is an injection in the left arm given at 9 months or older, to avoid contracting measles?*	Oui..... 1 Non..... 2 NSP..... 8	
VA17.	EST-CE QUE (*nom*) A DEJA REÇU UNE INJECTION CONTRE LA FIEVRE JAUNE - C'EST-A-DIRE UNE INJECTION FAITE AU BRAS DROIT A L'AGE DE **9** MOIS OU PLUS - POUR LUI EVITER DE CONTRACTER LA FIEVRE JAUNE? *Did (name) ever receive a yellow fever immunization, which is an injection in the right arm given at 9 months or older, to avoid contracting yellow fever?* *Insistez en précisant que le vaccin de la fièvre jaune est parfois donné en même temps que le vaccin de la rougeole.*	Oui..... 1 Non..... 2 NSP..... 8	
Observations de l'enquêteur/enquêtrice			
Observations du Superviseur			

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
QUESTIONNAIRE ENFANTS DE 0-23 MOIS

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-23 MOIS	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-23 mois	
08. Nom et Numéro de la mère dans l'A.S. Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?

/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*

/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 5.1: ALLAITEMENT INITIAL — AP

Ce module concerne toutes les femmes qui ont un enfant âgé de 0-23 mois. Enregistrez ici le nom de l'enfant

Quand vous posez les questions suivantes, utilisez le nom de l'enfant, là où c'est indiqué.

AP1.	AVEZ-VOUS ALLAITE (*NOM*)? *Did you breastfeed (name)?*	Oui ..... 1 Non 2	2 **Passer au** Module suivant
AP2.	COMBIEN DE TEMPS APRES LA NAISSANCE AVEZ-VOUS MIS (NOM) AU SEIN POUR LA PREMIERE FOIS? *How much time passed after birth before you breastfed for the first time?* SI MOINS D'1 HEURE, NOTEZ '00' HEURE. SI MOINS DE 24 HEURES, NOTEZ EN HEURES. AUTREMENT, NOTEZ EN JOURS	Immédiatement .....000 Heures ..... 1 Jours .....2 Ne sait pas/ Ne se rappelle pas 998	

MODULE 5.2: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE — MI

MI1.	EST-CE QUE VOTRE MENAGE POSSEDE DES MOUSTIQUAIRES QUI PEUVENT ETRE UTILISEES POUR DORMIR? *Does your household have a mosquito net that can be used to protect you while you sleep?*	Oui ..... 1 Non..... 2	2 **Passer au** Module suivant

	MODULE 5.2: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE		MI
MI2.	COMBIEN DE MOUSTIQUAIRES VOTRE MENAGE POSSEDE T-IL ? *How many mosquito nets does your household have?* Si le ménage possède 7 moustiquaires ou plus, inscrivez '7'	Nombre de moustiquaires..... /_____/	
MI3.	(Nom de l'enfant) A-T-IL (ELLE) DORMI SOUS UNE MOUSTIQUAIRE LA NUIT DERNIERE *Did (name of child) sleep under a mosquito net last night?*	Oui .....1 Non 2	2 **Passer à** Module suivant
Demandez à l'enquêté de vous montrer la moustiquaire sous laquelle l'enfant a dormi la nuit précédant l'enquête. *Ask the interviewee to show you the mosquito net under which the child slept the night before the interview.*			
MI4.	Moustiquaire observée? *(To interviewer): Did you see the mosquito net?*	Observée .....1 Non observée.....2	2 **Passer à** MI6
MI5.	Observez ou demandez la marque/type de moustiquaire *Find or ask for the brand/type of mosquito net*	Moustiquaire imprégnée de longue durée Permanet (Serena).....11 Olyset ..... 12 Net Protect.....13 Duranet.....14 Interceptor.....15 Autre (*précisez)* 16 NSP marque.....18 Autre moustiquaire *(précisez)*_____ 31 NSP marque / type.....98	
MI6.	OU AVEZ-VOUS OBTENU CETTE MOUSTIQUAIRE ? *Where did you get this mosquito net?*	Lors d'une campagne .....1 Dans un centre de santé.....2 Autre *(précisez)*_____6	
MI7.	DEPUIS COMBIEN DE MOIS VOTRE MENAGE A-T-IL CETTE MOUSTIQUAIRE? *For how many months has your household had this mosquito net?* *Si moins d'un mois, enregistrez '00'*	Nombre de Mois....._/____/_____/ Plus de 36 mois .....95 NSP / Pas sûr 98	
MI8.	Vérifiez MI5 pour le type de moustiquaire *Check MI5 for the type of mosquito net*	/___/ *Longue durée (11-18)* /___/ *Autre*	**Passer au** *Module suivant*

	MODULE 5.2: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE		MI
MI9.	QUAND VOUS AVEZ OBTENU CETTE MOUSTIQUAIRE, ETAIT-ELLE DEJA TRAITEE AVEC UN INSECTICIDE QUI TUE OU ELOIGNE LES MOUSTIQUES? *When you got this mosquito net, was it already treated with an insecticide that kills or keeps mosquitos away?*	Oui ..... 1 Non ..... 2 NSP / Pas sûr 8	
MI10.	DEPUIS QUE VOUS AVEZ CETTE MOUSTIQUAIRE, A-T- ELLE ETE TREMPEE OU PLONGEE DANS UN LIQUIDE QUI TUE OU ELOIGNE LES MOUSTIQUES? *Since you have had this mosquito net, has it been dipped or soaked in a liquid that kills or keeps mosquitos away?*	Oui ..... 1 Non ..... 2 Passez au Module suivant NSP / Pas sûr ..... 8 Passez au Module suivant	
MI11.	COMBIEN DE MOIS SE SONT ECOULES DEPUIS QUE LA MOUSTIQUAIRE A ETE TREMPEE OU PLONGEE POUR LA DERNIERE FOIS ? *How many months have passed since the last time the mosquito net was dipped or soaked?* *i moins d'un mois, enregistrez '00'*	Nombre de Mois ..... _____ Plus de 24 mois ..... 95 NSP / Pas sûr 98	

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
QUESTIONNAIRE ENFANTS DE 0-23 MOIS AVEC DIARRHEE

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-23 MOIS AVEC DIARRHEE	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-23 mois avec diarrhée	
08. Nom et Numéro de la mère dans l'A.S. Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne.

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?

/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 6.1: TRAITEMENT DE LA DIARRHEE			TD
TD1.	EST-CE QUE (*nom*) A EU LA DIARRHEE AU COURS DES DEUX DERNIERES SEMAINES ? *Has (name) had diarrhea during the last two weeks?*	Oui.....1 Non .....2 NSP.....8	2 **Passer à** FIN 8 **Passer à** FIN

	MODULE 6.1: TRAITEMENT DE LA DIARRHEE		TD
TD2.	JE VOUDRAIS SAVOIR QUELLE QUANTITE DE LIQUIDES A ETE DONNEE A (nom) DURANT SA DIARRHEE (Y COMPRIS LE LAIT MATERNEL). PENDANT QUE (nom) AVAIT LA DIARRHEE, A T-IL/ELLE RECU A BOIRE MOINS QUE D'HABITUDE, ENVIRON LA MEME QUANTITE OU PLUS QUE D'HABITUDE? *I would like to know what quantity of liquids were given to (name) when they had diarrhea (including breast milk). When (name) had diarrhea did he/she receive less than usual to drink, approximately the same quantity, or more than usual to drink?* *Si moins, insistez: If less, ask* EST-CE QU'IL/ELLE A RECU BEAUCOUP MOINS A BOIRE QUE D'HABITUDE, OU UN PEU MOINS A BOIRE QUE D'HABITUDE? *Was he/she given a lot less to drink than usual or a little less than usual?*	Beaucoup moins ..... 1 Un peu moins ..... 2 Environ la même quantité ..... 3 Plus ..... 4 Rien à boire ..... 5 NSP 8	
TD3.	PENDANT QUE (*nom*) AVAIT LA DIARRHEE, A-T-IL/ELLE RECU A MANGER MOINS QUE D'HABITUDE, ENVIRON LA MEME QUANTITE, PLUS QUE D'HABITUDE OU N'A-T-IL/ELLE RIEN MANGE ? *When (name) had diarrhea, did he/she receive less than usual to eat, approximately the same amount, more than usual, or nothing at all?* *Si moins, insistez: If less, ask* EST-CE QU'IL/ELLE A RECU BEAUCOUP MOINS A MANGER QUE D'HABITUDE, OU UN PEU MOINS A MANGER QUE D'HABITUDE? *Did he/she receive a lot less to eat than usual, or a little less than usual?*	Beaucoup moins ..... 1 Un peu moins ..... 2 Environ la même quantité ..... 3 Plus ..... 4 A stoppé nourriture ..... 5 N'a jamais donné à manger ..... 6 NSP 8	

	MODULE 6.1: TRAITEMENT DE LA DIARRHEE		TD
TD4.	AU COURS DE SA DIARRHEE, AVEZ-VOUS DONNE A BOIRE A (*nom*) L'UN DES PRODUITS SUIVANTS: *When he/she had diarrhea, did you give them any of the following products to drink:* *Lisez à haute voix le nom de chaque produit et enregistrez la réponse avant de passer au produit suivant.* [A] UN LIQUIDE PREPARE A PARTIR D'UN SACHET SPECIAL APPELE (*nom local du sachet de solution SRO*)? *A liquid prepared using a special packet called (local name for the ORS solution packet)?* [B] UN LIQUIDE SRO PRECONDITIONNE POUR LA DIARRHEE? *A prepackaged ORS liquid for diarrhea?* [C] UN LIQUIDE MAISON (SOLUTION SALEE SUCREE-SSS =*recommandé par le gouvernement*)? *A homemade solution (salty-sweet solution (SSS) recommended by the government)?*	O N NSP Liquide sachet SRO .....1 2 8 Liquide SRO préconditionné .....1 2 8 Liquide maison recommandé 1 2 8	
TD5.	EST-CE QUE QUELQUE CHOSE (D'AUTRE) A ETE DONNE POUR TRAITER LA DIARRHEE? *Was he/she given anything else to treat the diarrhea?*	Oui.....1 Non .....2 NSP.....8	2 **Passer à** FIN 8 **Passer à** FIN

	MODULE 6.1: TRAITEMENT DE LA DIARRHEE		TD
TD6.	QU'A-T-ON DONNE (D'AUTRE) POUR TRAITER LA DIARRHEE? *What (else) was he/she given to treat the diarrhea?* *Insistez:* RIEN D'AUTRE ? *Anything else?* *Enregistrez tous les traitements donnés. Inscrivez les noms de tous les médicaments mentionnés.* *Write all of the treatments given. Write the names of all of the medications mentioned.* _____ *(Noms des médicaments)*	Comprimé ou Sirop Antibiotique..... A Antimotilité..... B Zinc..... C Autre (pas antibiotique, antimotilité ou zinc) ..... G Comprimé ou sirop inconnu ..... H Injection Antibiotique..... L Non-antibiotique ..... M Injection inconnue ..... N Intraveineuse..... O Remède maison/ herbes médicinales..... Q Autre (*précisez*)_____ X	
Observations de l'enquêteur/enquêtrice			
Observations du Superviseur			

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES QUESTIONNAIRE ENFANTS DE 0-23 MOIS AVEC PNEUMONIE PRESUMEE

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-23 MOIS AVEC PNEUMONIE PRESUMEE	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-23 mois avec a eu une pneumonie présumée au cours des deux semaines précédant l'enquête.	
08. Nom et Numéro de la mère dans l'A.S. Nom _____ ___ ___ ___	**09. Nom de l'enfant** ___ ___
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?

/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*

/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 7.1: TRAITEMENT DE LA PNEUMONIE PRESUMEE		PP	
PP1.	EST-CE QU'AU COURS DES DEUX DERNIERES SEMAINES, (*nom*) A ETE MALADE AVEC DE LA TOUX ? *In the last 2 weeks, did (name) have a cough?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** Fin 8 **Passer à** Fin
PP2.	QUAND (*nom*) ETAIT MALADE AVEC DE LA TOUX, EST-CE QU'IL/ELLE RESPIRAIT PLUS VITE QUE D'HABITUDE AVEC UN SOUFFLE COURT ET RAPIDE OU EST-CE QU'IL/ELLE AVAIT DES DIFFICULTES POUR RESPIRER ? *When (name) was sick, did he/she breathe faster than usual, with short and rapid breaths, or did he/she have trouble breathing?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** Fin 8 **Passer à** Fin

MODULE 7.1: TRAITEMENT DE LA PNEUMONIE PRESUMEE		PP	
PP3.	AVEZ-VOUS RECHERCHE DES CONSEILS OU UN TRAITEMENT POUR LA MALADIE A L'EXTERIEUR DE LA MAISON ? *Did you receive advice or treatment for the disease outside of your home?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** PP5 8 **Passer à** PP5
PP4.	OU AVEZ-VOUS RECHERCHE DES CONSEILS OU UN TRAITEMENT ? *Where did you seek advice or treatment?* *Insistez: Ask again* NULLE PART AILLEURS ? *Anywhere else?* Encerclez tous les endroits mentionnés, Mais ne suggérez PAS de réponse. *Circle all locations mentioned, but do NOT suggest responses.* Insistez pour identifier chaque type d'endroit. *Ask again, to find out the type of location.* Si vous ne pouvez déterminer si l'endroit appartient au secteur public ou privé, inscrivez le nom de l'endroit. *If you cannot determine whether the location is in the public or private sector, write the name of the location.* *(Nom de l'endroit)*	Secteur public Hôpital de l'Etat ..... A Centre de santé de l'Etat ..... B Poste de santé de l'Etat ..... C Agent de santé communautaire ..... D Clinique mobile/communautaire ..... E Autre public (*précisez*)_____H Secteur médical privé Hôpital/clinique privé ..... I Médecin privé ..... J Pharmacie privée ..... K Clinique mobile ..... L Autre médical privé (*précisez*)_____O Autre source Parent (e)/ Ami (e ..... P Boutique ..... Q Praticien traditionnel ..... R Eglises ..... S Autre (*précisez*)_____X	
PP5.	EST-CE QU'ON A DONNE A (*nom*) UN MEDICAMENT POUR TRAITER CETTE MALADIE ? *Was (name) given a medication to treat this illness?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** Fin 8 **Passer à** Fin
PP6.	QUEL MEDICAMENT A-T-ON DONNE A (*nom*) ? *What medication was (name) given?* *Insistez: Ask again* AUCUN AUTRE MEDICAMENT ? *Any other medications?* Encerclez tous les médicaments donnés. Inscrivez le nom des marques de tous les médicaments mentionnés. *Circle all the medications given. Write the brand name of all the medications mentioned.* *(Nom des médicaments)*	Antibiotique Comprimé / Sirop ..... A Injection ..... B Antipaludéens ..... M Paracétamol/Panadol/Acétaminophène ..... P Aspirine ..... Q Ibuprofen ..... R Autre (*précisez*)_____X NSP ..... Z	

MODULE 7.1: TRAITEMENT DE LA PNEUMONIE PRESUMEE	PP
Observations de l'enquêteur/enquêtrice	
Observations du Superviseur	

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
QUESTIONNAIRE ENFANTS DE 0-23 MOIS AVEC FIEVRE

CADRE D'INFORMATION SUR LA MERE D'ENFANT DE 0-23 MOIS AVEC FIEVRE	
Ce questionnaire doit être administré à la mère dont le plus jeune enfant est âgé de 0-23 mois a eu de la fièvre au cours des deux semaines précédant l'enquête.	
08. Nom et Numéro de la mère dans l'A.S. Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant ___ ___ ___ Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)** ___ ___

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?

/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 8.1: TRAITEMENT DU PALUDISME		TP	
TP1.	AU COURS DES DEUX DERNIERES SEMAINES, EST-CE QUE (*nom*) A ETE MALADE AVEC DE LA FIEVRE?	Oui ..... 1 Non ..... 2 NSP 8	

MODULE 8.1: TRAITEMENT DU PALUDISME		TP	
	In the past 2 weeks, has (name) had a fever?		
TP2.	À N'IMPORTE QUEL MOMENT DURANT SA MALADIE, EST-CE QUE (*nom*) A EU DU SANG PRELEVE AU BOUT DE SON DOIGT OU AU TALON POUR EFFECTUER UN TEST? *At any time when (name) was sick, was blood drawn from his/her fingertip or heel to perform a test?*	Oui ..... 1 Non ..... 2 NSP 8	
TP3.	AVEZ-VOUS RECHERCHE DES CONSEILS OU UN TRAITEMENT QUELQUE PART OU AUPRES DE QUELQU'UN POUR LA MALADIE? *Did you receive advice or treatment anywhere or from anyone for this illness?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** TP8 8 **Passer à** TP8
TP4.	EST-CE QUE (*nom*) A ETE EMMENE DANS UN ETABLISSEMENT DE SANTE DURANT SA MALADIE? *Was (name) taken to a health facility during his/her illness?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** TP8 8 **Passer à** TP8
TP5.	EST-CE QUE L'ON A DONNE A (*nom*) UN MEDICAMENT POUR LA FIEVRE OU LE PALUDISME DANS CET ETABLISSEMENT DE SANTE? *Was (name) given a medication for fever or malaria at this health facility?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** TP7 8 **Passer à** TP7
TP6.	QUEL MEDICAMENT A-T- ON DONNE A (*nom*) ? *What medication was (name) given?* *Insistez: Ask again* AUCUN AUTRE MEDICAMENT ? *Any other medication?* *Encerclez tous les médicaments mentionnés. Si des médicaments ont été donnés, inscrivez les noms de tous les médicaments.* *Circle all the medications mentioned. If medications were given, write the names of all of the medications.* _____ *(Nom des médicaments)*	*Antipaludéens:* SP (*) ..... A Chloroquine ..... B Amodiaquine/Camoquin/ Flavoquine ..... C Quinine ..... D Combinaison avec Artémisinine(**) ..... E Antipaludique/site de soins à base communautaire ..... F Autre antipaludique (*précisez*) _____ H *Antibiotiques* Comprimés / Sirop ..... I Injection ..... J *Autres médicaments:* Paracétamol/ Panadol /Acétaminophen P Aspirine ..... Q Ibuprofen ..... R Autre (*précisez*) _____ X NSP ..... Z	

(*) SP = Falcidox, Malariadexin, Fansidar, Paludose, etc.

(**)Combinaison avec Artémisinine = Serenadose, Luther, Coartem, Co-arinate, Co-arsucam, Artemod, Arsumoon, etc.

MODULE 8.1: TRAITEMENT DU PALUDISME		TP	
TP7.	EST-CE QU'ON A DONNE A (*nom*) UN MEDICAMENT POUR LA FIEVRE OU LE PALUDISME AVANT D'ETRE CONDUIT DANS UN ETABLISSEMENT DE SANTE? *Was (name) given a medication for fever or malaria before being taken to a health facility?*	Oui ..... 1 Non ..... 2 NSP 8	1 **Passer à** TP9 2 **Passer à** TP10 8 **Passer à** TP10
TP8.	EST-CE QU'ON A DONNE A (*nom*) UN MEDICAMENT POUR LA FIEVRE OU LE PALUDISME AU COURS DE CETTE MALADIE? *Was (name) given a medication for fever or malaria during this illness?*	Oui ..... 1 Non ..... 2 NSP 8	2 **Passer à** TP10 8 **Passer à** TP10
TP9.	QUEL MEDICAMENT A-T-ON DONNE A (*nom*)? *What medication was (name) given?* *Insistez:* AUCUN AUTRE MEDICAMENT? *Ask again: any other medication?* *Encerclez tous les médicaments mentionnés. Si des médicaments ont été donnés, inscrivez les noms de tous les médicaments.* *Circle all medications mentioned. If medications were given, write the names of all of the medications.* _____ *(Nom des médicaments)*	*Antipaludéens:* SP (*) ..... A Chloroquine ..... B Amodiaquine/Camoquin/Flavoquine .. C Quinine ..... D Combinaison avec artémisinine(**.... E Antipaludique/site de soins à base communautaire.....F Autre antipaludique (*précisez*) _____H *Antibiotiques* Comprimés / Sirop .....I Injection .....J *Autres médicaments:* Paracétamol/ Panadol /Acétaminophen ...P Aspirine..... Q Ibuprofen ..... R Autre (*précisez*) _____X NSP .....Z	

(*) SP = Falcidox, Malariadexin, Fansidar, Paludose, etc.
(**)Combinaison avec Artémisinine = Serenadose, Luther, Coartem, Co-arinate, Co-arsucam, Artemod, Arsumoon, etc.

TP10. *Vérifiez TP6 et TP9: Antipaludéens mentionnés (codes A - H)? Check TP6 and TP9 : Antimalarials mentioned (codes A-H)?*
/___/ *Oui. Continuez avec TP11*
/___/ *Non. Fin de l'interview*

TP11.	COMBIEN DE TEMPS APRES QUE LA FIEVRE AIT COMMENCE, (*nom*) A-T-IL/ELLE PRIS POUR LA PREMIERE FOIS (*nom de l'antipaludéen déclaré à TP6 ou TP9*)? *How long after (name)'s fever began did he/she take (name of antimalarial mentioned in TP6 or TP9) for the first time?* *Si plusieurs antipaludéens ont été déclarés à TP6 ou TP9, donnez le nom de tous les antipaludéens mentionnés* *If more than one antimalarial was mentioned in TP6 or TP9, list all antimalarials mentioned.* *Enregistrez combien de temps après le début de la fièvre le premier antipaludéen a été donné.* *Write how long after the fever began the first antimalarial was given.*	Même jour ..... 0 Jour suivant..... 1 2 jours après début de la fièvre..... 2 3 jours après début de la fièvre..... 3 4 jours ou plus après début de la fièvre ..... 4 NSP..... 8	

MODULE 8.1: TRAITEMENT DU PALUDISME	TP
Observations de l'enquêteur/enquêtrice	
Observations du Superviseur	

EVALUATION DE FINALE DU PROJET INTEGRE DE SANTE (PROSANI)
ENQUETE DANS LES MENAGES
QUESTIONNAIRE FEMMES ENCEINTES

CADRE D'INFORMATION SUR LA FEMME ENCEINTE	
Ce questionnaire doit être administré à la femme enceinte.	
08. Nom et Numéro de la mère dans l'A.S. ___ Nom _____	**09. Nom de l'enfant**
10. Date de naissance de l'enfant Jour Mois Année _____/_____/ _____	**11. Age de l'enfant (en mois)**

CONSENTEMENT INFORMÉ A LIRE SI LA MERE EST DIFFERENTE DE LA PRECEDENTE

Bonjour. Je m'appelle _____, et je travaille avec IBTCI/USAID. Nous effectuons une enquête à laquelle nous souhaiterions que vous participiez. Je voudrais vous poser des questions sur votre santé et sur la santé de votre plus jeune enfant de moins de deux ans. Ces informations seront utiles à PROSANI pour planifier des services de santé et pour évaluer s'ils sont conformes avec les objectifs d'amélioration de la santé de l'enfant. L'enquête prend habituellement _____ minutes. Quelles que soient les informations que vous nous fournirez, elles resteront strictement confidentielles et ne seront divulguées à personne..

La participation à cette enquête est volontaire et vous pouvez décider de ne pas répondre à des questions personnelles ou à toutes les questions. Cependant, nous espérons que vous allez participer à cette enquête car ce que vous pensez est d'un grand intérêt.

Avez-vous maintenant des questions à me poser concernant l'enquête ?

Signature de l'enquêteur: _____ Date: _____

PUIS-JE COMMENCER MAINTENANT ?
/__/ **OUI**, *permission accordée ⇒ commencer l'interview.*
/__/ **NON**, *permission non accordée ⇒ Discutez ce résultat avec votre Superviseur.*

MODULE 9.1: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE			
MI1.	EST-CE QUE VOTRE MENAGE POSSEDE DES MOUSTIQUAIRES QUI PEUVENT ETRE UTILISEES POUR DORMIR? *Does your household have mosquito nets that can be used to protect you while you sleep?*	Oui ..... 1 Non 2	2 **Passer au** Module suivant
MI2.	COMBIEN DE MOUSTIQUAIRES VOTRE MENAGE POSSEDE T-IL? *How many mosquito nets does your household have?* *Si le ménage possède 7 moustiquaires ou plus, inscrire '7'*	Nombre de moustiquaires…… /___/___/	

MODULE 9.1: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE

MI3.	AVEZ-VOUS DORMI SOUS UNE MOUSTIQUAIRE LA NUIT DERNIERE ? *Did you sleep under a mosquito net last night?*	Oui ..... 1 Non 2	2 **Passer au** Module suivant
Demandez à l'enquêté de vous montrer la moustiquaire sous laquelle la femme a dormi la nuit précédant l'enquête.			
MI4.	*Moustiquaire observée?* *Did you (interviewer) see the mosquito net?*	Observée ..... 1 Non observée 2	2 **Passer à** MI6
MI5.	*Observez ou demandez la marque/type de moustiquaire* *Observe or ask for the brand/type of mosquito net.*	Moustiquaire imprégnée de longue durée Permanet (Serena) ..... 11 Olyset ..... 12 Net Protect ..... 13 Duranet ..... 14 Interceptor ..... 15 Autre (*précisez*) ..... 16 NSP marque ..... 18 Autre moustiquaire *(précisez)*_____ 31 NSP marque / type 98	
MI6.	OU AVEZ-VOUS OBTENU CETTE MOUSTIQUAIRE? *Where did you get this mosquito net?*	Lors d'une campagne ..... 1 Dans un centre de santé ..... 2 Autre *(précisez)*_____ 6	
MI7.	DEPUIS COMBIEN DE MOIS VOTRE MENAGE A-T-IL CETTE MOUSTIQUAIRE? *For how many months has your household had this mosquito net?* *Si moins d'un mois, enregistrez '00'*	Nombre de Mois ..... /___/___/ Plus de 36 mois ..... 95 NSP / Pas sûr 98	
MI8.	*Vérifiez MI5 pour le type de moustiquaire* *Check MI5 for the type of mosquito net*	/___/ *Longue durée (11-18)* /__/ *Autre*	**Passer au** *Module suivant*
MI9.	QUAND VOUS AVEZ OBTENU CETTE MOUSTIQUAIRE, ETAIT-ELLE DEJA TRAITEE AVEC UN INSECTICIDE QUI TUE OU ELOIGNE LES MOUSTIQUES? *When you got this mosquito net, had it already been treated with an insecticide that kills or keeps mosquitos away?*	Oui ..... 1 Non ..... 2 NSP / Pas sûr 8	
MI10.	DEPUIS QUE VOUS AVEZ CETTE MOUSTIQUAIRE, A-T- ELLE ETE TREMPEE OU PLONGEE DANS UN LIQUIDE QUI TUE OU ELOIGNE LES MOUSTIQUES? *Since you have had this mosquito net, has it been dipped or soaked in a liquid that kills or keeps mosquitos away?*	Oui ..... 1 Non ..... 2 Passez Module suivant NSP / Pas sûr ..... 8 Passez Module suivant	
MI11.	COMBIEN DE MOIS SE SONT ECOULES DEPUIS QUE LA MOUSTIQUAIRE A ETE TREMPEE OU PLONGEE POUR LA DERNIERE FOIS ? *How many months have passed since the last time the mosquito net was dipped or soaked?* *Si moins d'un mois, enregistrez '00'*	Nombre de Mois ..... /___/___/ Plus de 36 mois ..... 95 NSP / Pas sûr 98	

MODULE 9.1: MOUSTIQUAIRE IMPREGNEE D'INSECTICIDE
Observations de l'enquêteur/enquêtrice
Observations du Superviseur

A. KII SAMPLING PLAN

Integrated Health Program (IHP) worked in a large geographic area that includes 80 target health zones in four provinces (East Kasai, West Kasai, Katanga, and South Kivu). Based on the complexity of the logistics of transport to and from most of the project remote areas in the target provinces, the sampling methodology for the final KII is described as follows:

At national level, key informants included officials from national health programs and services (i.e., Programme National de Santé de la Reproduction (PNSR), Primary Health Care, Director for Malaria & TB Control and Prevention Programs, Director of PNLS, Director of Expanded Program of Immunization, and the Directorate of Pharmacy Services or Director of Federation of Essential Medicine Procurement Agencies (FEDECAM);

The national level informants included: (a) IHP Director; (b) Focal Points for MNCH & FP/RH at USAID/DRC; (c) Focal point for PF/RH at UNFPA/DRC; and a select number of key local and international NGOs (e.g., SANRU, ABEF-ND, PSI, and EGPAF);

At provincial, regional and district levels, informants included Provincial Medical Inspector, Provincial Pharmacy Inspector, Director of Regional Distribution Center, and IHP Coordinator and Managers.

At health zone level, informants included Chief Medical Officer, Health Zone Management Teams.

At health facilities level, informants included the Director for GRH and Chief Nurse for Health Centers.

In catchment areas of the IHP-assisted facilities, KII with CODESA leaders.

Table 1 below provides a summary detail of selected sites for Key informants.

TABLE 1: SUPERVISION AREAS, HEALTH ZONES & HEALTH FACILITIES TARGETED FOR KII PER PROVINCE

Order No	Target Provinces	Supervision Areas (BCs)	Selected HZs for KII	Selected HC for KII	Selected GRH for KII	# of Health Facilities for KII
1	E. Kasai	Tshumbe	1	2	1	3
2	E. Kasai	Lodja (Kole)	0	0	0	0
3	E. Kasai	Mwene-Ditu	1	2	1	3
4	W. Kasai	Lwiza	2	4	2	6
5	Katanga	Kamina	1	2	1	3
6	Katanga	Kolwezi	1	2	1	3
7	South Kivu	Bukavu	2	4	2	4
8	South Kivu	Uvira	0	0	0	0
Total	**4**	**8**	**8**	**16**	**8**	**24**

B: QUESTIONNAIRE

Date: _____ Location: _____

Names of the respondents:

Name (s)	Title (s)

GREETING: (Introduction & Oral Informed Consent)

Good morning/Good afternoon:

My name is _____, and my colleague (s) is (are) _____.

We are part of the endline evaluation team that is examining the performance of the USAID-funded IHP/PROSANI Project that has been facilitating the implementation of the MOH's National Health Development Plan (PNDS). The Integrated Health Project (IHP) goal is to improve the enabling environment for, and increase the availability and use of high-impact services, products, and practices for family planning; maternal, newborn, and child health (MNCH); nutrition, malaria, and tuberculosis; neglected tropical diseases (NDT); support for integrated delivery of HIV/AIDS services; and water/sanitation/hygiene in the target health zones. The project has been working in 78 target health zones in four provinces (East Kasai, West Kasai, Katanga, and South Kivu). The IHP project was begun in October 2010 and it will end on September 30, 2015.

We are currently evaluating the project's progress toward the achievement of the objectives with the implementation of MPA-Plus, and CPA-Plus at service delivery points. We also would like to learn about the outcomes of the project activities in the target areas with regards to: (a) Increased mothers/care takers knowledge of disease prevention, improved nutrition practices, and case management of childhood illnesses at household level; (b) increased availability of essential medicines, contraceptives, and medical supplies to facilitate service delivery; and (c) improved delivery of Maternal Newborn, and Child Health (MNCH) services.

We would welcome the opportunity to ask you a few questions that relate to the IHP performance during the last five years, and this interview will take approximately one hour depending upon your availability and interest. We also would like to learn about some of the problems and constraints encountered during the implementation process and your recommendations to address those problems. The information you will provide will also help the USAID and the MOH to improve future programs so they can better provide quality MNCH services to the target population in rural provinces.

The information you will provide will remain confidential, the information you provide will not be linked to you personally in the report. You may choose to refuse to participate or not answer all the questions or stop the interview any time. Therefore, we request that you feel comfortable telling us what you know or have observed about the project performance, including the support the project has provided to the project areas in the target provinces and the related facilities.

Please let us know if you have any objection to participating in this interview and also if you have any questions before we start.

Thank you very much.

KII QUESTIONNAIRE

Evaluation Question 1: Improved availability and access to MPA and CPA Plus services
What do you think about the IHP/PROSANI project's effect on the availability of MPA-Plus and CPA-Plus at service delivery points and in the target communities?

Probe: before (**5 years ago**) and now (**after 5 years of IHP implementation**)?
Similarly, what do you think about the IHP's effect on the **access** of the target population to available health services (including MPA-Plus and CPA-Plus) at service delivery points?
Probe: before (**5 years ago**) and now (**after 5 years of IHP**)

Evaluation Question 2: Improved quality of key family health services (FHS)
What do you think about the IHP/PROSANI project's effect on the **quality of key family health services** at service delivery points and in the target communities?

Probe: before (**5 years ago**) and now (**after 5 years of IHP**)

1. System level capacity strengthening: What are the major program interventions that IHP has carried out at system level (health zones and the related facilities levels) to increase the capacity to deliver MPA-Plus and CPA-Plus:
2. Quality of service delivery (delivery of quality MPA+, and CPA+):

During the last four years that IHP has been working with target health facilities, have you noticed any changes in the Health Centers & Hospitals capacity to delivery services?

If so, how would you characterize the effects, if any, of the process of added interventions by IHP to increase the delivery of MPA + and CPA+ in terms of:

(a) Cost for service delivery,
(b) Wait-time of patient at the clinic,
(c) Service providers technical & communication skills, and
(d) Availability of medicines, contraceptives and medical supplies

3. Please describe any other services that have been added with support from IHP and your opinion on the quality of those service provisions by providers. Please describe any health products that IHP has financed and delivered to project areas?

4. Do all the IHP-assisted health facilities have functional Logistics Management Information Systems (LMIS) that provide information on stock status on monthly/quarterly basis? (Yes/NO)

If not, what has IHP done to ensure the establishment of the LMIS at the project-assisted health zones and the related facilities?

5. Quality of service delivery by service providers:

Are you aware of or have you been involved in the planning and implementation of training/capacity building activities by IHP to improve the quality, efficiency and the consistency of service delivery by providers? (Yes/No)

If so, please list some key training activities IHP supported in the target health zones during the last five years and discuss the effect of those training have had on the delivery of services in the target areas.

Probe: In addition to training/capacity building of service providers, what else has IHP provided as inputs to ensure the delivery of quality services in the target areas?

Evaluation Question 3: improvement in the knowledge, attitudes, practices, and positive behaviors related to health in the target health zones

Health seeking behavior by the target population: What do you think about the IHP/PROSANI project's effect on the **health seeking behavior** in the target communities?

Probe: before (**5 years ago**) and now (**after 5 years of IHP**)

What are the key interventions that IHP has carried out in target areas to improve health seeking behavior of the target population?

Service utilization by the community (target population):

Based on your knowledge of the target population in the target areas, when community members get sick, where do they normally go for health services?

Probe: What is your estimate of service utilization by the community **now** as compared to **previous years before IHP started?**

Probe: Please describe some of the factors that have contributed to increased use or decreased use of available services at Health Center/Hospital.

Probe: If there has been a decrease in the utilization of services, what has IHP done to address the problem?

Evaluation Question 4: Improved Leadership and Governance

Based on your knowledge of progress to date with PROSANI project implementation in target areas, **what is the effect on health sector leadership and governance** at: (a) provincial level, (b) health zone level, and (c) health facilities level?

If so, please describe progress in this area of leadership and governance at each level that has been described above:

6. Monitoring and supervision activities in IHP-assisted HZs:

Have you been involved in health zone level M&E and supervision activities to monitor progress with IHP activities?

If so, how often have the **national level** managers carried out field visits to verify progress with planned activities under IHP and the related health zones?

7. Program sustainability:

Which of the IHP interventions have a chance for sustainability beyond the life of the IHP and why?

Evaluation Question 5: Major constraints/problems encountered during IHP implementation:

8. Based on your knowledge of IHP interventions in the target areas, please provide a list of major constraints/problems encountered that impacted on the delivery of MPA-Plus and CPA-Plus at Health Centers, Hospitals and the related communities.

A. **Constraints:**

B. **Proposed resolutions** (What IHP has done to address the constraints):

9. Similarly, are there laws and regulations that have impacted negatively on the IHP efforts for increased **availability** and **access** to available MPA-Plus and CPA-Plus services?

If so, please provide some examples and describe what IHP has done to increase and expand those services:

Evaluation Question 6: IHP perception and value added:

10. Based on your knowledge of IHP activities to date in the target areas, what are the strengths and weaknesses of the IHP interventions at provincial, health zones, GRHs, HCs, and community levels, and what are the recommendations to improve the weaknesses?

A. **Strengths:**

B. **Weaknesses:**

C. **Recommendations:**

11. Lessons learned from the implementation of IHP interventions in the target areas:

Based on your experience working under the IHP-assisted program activities, please provide some lessons learned that can be shared with other providers and managers.

ANNEX D. FIELD IMPLEMENTATION PLAN

Week	Day/Date	Place	Activities
	Mweneditu		
1	Sunday, May 10, 2015	Mbujimayi	Travel from Kinshasa to Mbuji Mayi. Meetings with Provincial authorities
	Monday, May 11, 2015	Mweneditu	Travel from Mbujimayi to Mweneditu, meetings with District auhorities
	Tuesday, May 12, 2015	Mweneditu	Interviewers and data collection selection
	Wednesday, May 13, 2015	Mweneditu	Training
	Thursday, May 14, 2015	Mweneditu	Training
	Friday, May 15, 2015	Mweneditu	Training
	Saturday, May 16, 2015	Mweneditu	Training
2	Sunday, May 17, 2015	Mweneditu	Training
	Monday, May 18, 2015	Mweneditu	Travel from Mweneditu to Luputa HZ
	Tuesday, May 19, 2015	Luputa HZ	Data collection
	Wednesday, May 20, 2015	Luputa HZ	Data collection
	Thursday, May 21, 2015	Luputa HZ	Data collection
	Sunday, May 24, 2015	Mweneditu HZ	Travel from Luputa HZ to Mweneditu HZ
	Monday, May 18, 2015	Kandakanda	Data collection
	Tuesday, May 19, 2015	Kandakanda	Data collection
	Wednesday, May 20, 2015	Kandakanda	Data collection
	Thursday, May 21, 2015	Kandakanda	Data collection
	Friday, May 22, 2015	Mweneditu HZ	Travel from Kandakanda HZ to Mweneditu HZ
	Saturday, May 23, 2015	Mweneditu HZ	Data collection
3	Sunday, May 24, 2015	Mweneditu HZ	Data collection
	Monday, May 25, 2015	Mweneditu HZ	Data collection
	Tuesday, May 26, 2015	Mbujimayi	Travel from Mweneditu to Mbujimayi
	Wednesday, May 27, 2015	Mbujimayi	Travel from Mweneditu to Mbujimayi
	Thursday, May 28, 2015	Kananga	Travel from Mbujimayi to Kananga

Week	Day/Date	Place	Activities
	Mweneditu		
	Friday, May 29, 2015	Kananga	Training/Contacts with provincial authorities & interviewers and data collection selection
	Saturday, May 30, 2015	Kananga	Training
4	Sunday, May 31, 2015	Kananga	Training
	Luiza		
	Monday, June 01, 2015	Kananga	Travel from Kananga to Dibaya HZ
	Tuesday, June 02, 2015	Dibaya HZ	Data collection
	Wednesday, June 03, 2015	Dibaya HZ	Data collection
	Thursday, June 04, 2015	Dibaya HZ	Data collection
	Friday, June 05, 2015	Kananga	Travel from Dibaya HZ to Kananga
	Saturday, June 06, 2015	Bilomba HZ	Travel from Kananga to Bilomba HZ
	Sunday, June 07, 2015	Bilomba HZ	Data collection
	Monday, June 08, 2015	Bilomba HZ	Data collection
	Tuesday, June 09, 2015	Bilomba HZ	Data collection
	Wednesday, June 03, 2015	Kananga	Travel from Bilomba HZ to Kananga
	Saturday, May 30, 2015	Mweka	Travel from Kananga to Mweka HZ
	Sunday, May 31, 2015	Mweka	Travel from Mweka HZ to Dekese
	Monday, June 01, 2015	Mweka	Travel from Mweka HZ to Dekese
	Tuesday, June 02, 2015	Dekese HZ	Travel from Mweka HZ to Dekese
	Wednesday, June 03, 2015	Dekese HZ	Data collection
	Thursday, June 04, 2015	Dekese HZ	Data collection
	Friday, June 05, 2015	Dekese HZ	Data collection
	Saturday, June 06, 2015	Dekese HZ	Data collection
5	Sunday, June 07, 2015	Dekese HZ	Data collection
	Monday, June 08, 2015	Dekese HZ	Data collection
	Tuesday, June 09, 2015	Dekese HZ	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Luiza		

Week	Day/Date	Place	Activities
	Wednesday, June 10, 2015	Dekese HZ	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Thursday, June 11, 2015	Dekese HZ	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Wednesday, June 10, 2015	Dekese HZ	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Thursday, June 11, 2015	Mweka	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Friday, June 12, 2015	Mweka	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Saturday, June 13, 2015	Kananga	Travel from Dekese HZ to Kananga via Mweka and Mutoto
6	Sunday, June 14, 2015	Kananga	Travel from Dekese HZ to Kananga via Mweka and Mutoto
	Monday, June 15, 2015	Kinshasa	Travel Kananga to Kinshasa
	Monday, June 15, 2015		BREAK, NO FLIGHT
	Tuesday, June 16, 2015	Kinshasa	BREAK, NO FLIGHT
	Kole		
	Saturday, June 20, 2015	Lodja	Arrival from Kinshasa to Lodja, contact with local authorities
7	Sunday, June 21, 2015	Lodja	Interviewers and data collection selection
	Monday, June 22, 2015	Lodja	Training
	Tuesday, June 23, 2015	Lodja	Training
	Wednesday, June 24, 2015	Lodja	Training
	Thursday, June 25, 2015	Lodja	Training
	Friday, June 26, 2015	Lodja	Training
	Saturday, June 27, 2015	Benadibele HZ	Travel from Lodja to Bena Dibele HZ and contacts with local authorities
8	Sunday, June 28, 2015	Benadibele HZ	Data collection
	Monday, June 29, 2015	Benadibele HZ	Data collection
	Tuesday, June 30, 2015	Benadibele HZ	Data collection
	Wednesday, July 01, 2015	Benadibele HZ	Data collection
	Thursday, July 02, 2015	Benadibele HZ	Data collection
	Friday, July 03, 2015	Lodja	Travel from Bena Dibele HZ to Lodja
	Saturday, June 27, 2015	Kole HZ	Travel from Lodja to Kole HZ and contacts with local authorities
	Kole		
	Sunday, June 28, 2015	Kole HZ	Data collection

Week	Day/Date	Place	Activities
	Monday, June 29, 2015	Kole HZ	Data collection
	Tuesday, June 30, 2015	Kole HZ	Data collection
	Wednesday, July 01, 2015	Kole HZ	Data collection
	Thursday, July 02, 2015	Kole HZ	Data collection
	Friday, July 03, 2015	Lodja	Travel from Kole HZ to Lodja
	Saturday, June 27, 2015	Tshudiloto HZ	Travel from Lodja HZ to Tshudiloto HZ and contacts with local authorities
	Sunday, June 28, 2015	Tshudiloto HZ	Data collection
	Monday, June 29, 2015	Tshudiloto HZ	Data collection
	Tuesday, June 30, 2015	Tshudiloto HZ	Data collection
	Wednesday, July 01, 2015	Tshudiloto HZ	Data collection
	Thursday, July 02, 2015	Tshudiloto HZ	Data collection
	Friday, July 03, 2015	Tshudiloto HZ	Travel from Tshudiloto HZ to Lodja
	Saturday, July 04, 2015	Lodja	Travel from Tshudiloto HZ to Lodja
9	Sunday, July 05, 2015	Lodja	Break
	Tshumbe		
	Monday, July 06, 2015	Ototo HZ	Travel from Lodja to Ototo HZ and contacts with local authorities
	Tuesday, July 07, 2015	Ototo HZ	Data collection
	Wednesday, July 08, 2015	Lodja	Debriefing for all Supervisors
	Thursday, July 09, 2015	Annette returne to Kinshasa	
	Thursday, July 09, 2015	Lodja	Debriefing for all Supervisors
	Friday, July 10, 2015	Ototo HZ	Data collection
	Saturday, July 11, 2015	Ototo HZ	Data collection
	Sunday, July 12, 2015	Ototo HZ	Data collection
	Monday, July 13, 2015	Ototo HZ	Data collection
	Tuesday, July 14, 2015	Lodja	Travel from Ototo to Lodja
	Tshumbe		
	Monday, July 06, 2015	Katakokombe HZ	Travel from Lodja to Katakokombe HZ and contacts with local authorities
	Tuesday, July 07, 2015	Katakokombe HZ	Data collection
	Wednesday, July 08, 2015	Lodja	Debriefing for all Supervisors

Week	Day/Date	Place	Activities
	Thursday, July 09, 2015	Annette returne to Kinshasa	
	Thursday, July 09, 2015	Lodja	Debriefing for all Supervisors
	Friday, July 10, 2015	Katakokombe HZ	Data collection
	Saturday, July 11, 2015	Katakokombe HZ	Data collection
	Sunday, July 12, 2015	Katakokombe HZ	Data collection
	Monday, July 13, 2015	Katakokombe HZ	Data collection
	Tuesday, July 14, 2015	Lodja	Travel from Katakokombe to Lodja
	Monday, July 06, 2015	DjaloDjeka HZ	Travel from Lodja to DjaloNdjeka HZ and contacts with local authorities
	Tuesday, July 07, 2015	DjaloDjeka H	Data collection
	Wednesday, July 08, 2015	Lodja	Debriefing for all Supervisors
	Thursday, July 09, 2015	Annette returne to Kinshasa	
	Thursday, July 09, 2015	Lodja	Debriefing for all Supervisors
	Friday, July 10, 2015	DjaloDjeka H	Data collection
	Saturday, July 11, 2015	DjaloDjeka H	Data collection
10	Sunday, July 12, 2015	DjaloDjeka H	Data collection
	Monday, July 13, 2015	DjaloDjeka H	Data collection
	Tuesday, July 14, 2015	Lodja	Travel from DjaloNdjeka to Lodja
	Wednesday, July 15, 2015	Lodja	Checking questionnaires
	Thursday, July 16, 2015	Bena Tshadi	Travel from Lodja to Kananga
	Friday, July 17, 2015	Kananga	Travel from Lodja to Kananga
	Saturday, July 18, 2015	Kinshasa	Travel Kananga to Kinshasa
11	Sunday, July 19, 2015	Kinshasa	Break
	Monday, July 20, 2015	Kinshasa	Working on Expenses report
	Tshumbe		
	Tuesday, July 21, 2015	Kinshasa	Working on Expenses report and with Susan and Robert on LRA evaluation
	Wednesday, July 22, 2015	Kinshasa	Working on Expenses report
	Thursday, July 23, 2015	Kinshasa	Working on Expenses report
	Bukavu		

Week	Day/Date	Place	Activities
	Friday, July 24, 2015	Goma	Travel Kinshasa to Goma
	Saturday, July 25, 2015	Bukavu	Travel from Goma to Bukavu, selection of candidates interviewers
12	Sunday, July 26, 2015	Bukavu	Selection of candidates interviewers
	Monday, July 27, 2015	Bukavu	Training/Visit of Antoine USAID Kin
	Tuesday, July 28, 2015	Bukavu	Training/Visit of Antoine USAID Kin
	Wednesday, July 29, 2015	Bukavu	Training/Visit of Antoine USAID Kin
	Thursday, July 30, 2015	Bukavu	Training/Visit of Antoine USAID Kin
	Friday, July 31, 2015	Bukavu	Training/Visit of Antoine USAID Kin
	Saturday, August 01, 2015	Bukavu	Logistic preparation for the field
13	Sunday, August 02, 2015	Mwenga HZ	Travel from Bukavu to Mwenga HZ
	Monday, August 03, 2015	Mwenga HZ	Data collection
	Tuesday, August 04, 2015	Mwenga HZ	Data collection
	Wednesday, August 05, 2015	Mwenga HZ	Data collection
	Thursday, August 06, 2015	Mwenga HZ	Data collection
	Friday, August 07, 2015	Mwenga HZ	Data collection
	Saturday, August 08, 2015	Bukavu	Travel from Mwenga HZ to Bagira HZ/Bukavu
	Sunday, August 02, 2015	Kaniola HZ	Travel from Bukavu to Kaniola HZ
	Monday, August 03, 2015	Kaniola HZ	Data collection
	Tuesday, August 04, 2015	Kaniola HZ	Data collection
	Wednesday, August 05, 2015	Kaniola HZ	Data collection
	Thursday, August 06, 2015	Kaniola HZ	Data collection
	Friday, August 07, 2015	Kaniola HZ	Data collection
	Bukavu		
	Saturday, August 08, 2015	Bukavu	Travel from Kaniola HZ to Bagira HZ/Bukavu
14	Sunday, August 09, 2015	Bukavu	Checking questionnaires
	Monday, August 10, 2015	Bagira HZ/Bukavu	Data collection
	Tuesday, August 11, 2015	Bagira HZ/Bukavu	Data collection
	Uvira		

Week	Day/Date	Place	Activities
	Wednesday, August 12, 2015	Uvira	Travel from Bukavu to Uvira, contacts with local authorities
	Thursday, August 13, 2015	Uvira	Selection of interviewers and data collectors
	Friday, August 14, 2015	Uvira	Training
	Saturday, August 15, 2015	Uvira	Training
15	Sunday, August 16, 2015	Uvira	Training
	Monday, August 17, 2015	Uvira	Training
	Tuesday, August 18, 2015	Uvira	Training
	Wednesday, August 19, 2015	Lemera HZ	Travel from Uvira to Lemera HZ
	Thursday, August 20, 2015	Lemera HZ	Data collection
	Friday, August 21, 2015	Lemera HZ	Data collection
	Saturday, August 22, 2015	Lemera HZ	Data collection
	Sunday, August 23, 2015	Lemera HZ	Data collection
	Monday, August 24, 2015	Lemera HZ	Data collection
	Tuesday, August 25, 2015	Lemera HZ	Data collection
	Wednesday, August 26, 2015	Uvira	Travel from Lemera HZ to Uvira
	Wednesday, August 19, 2015	Ruzizi HZ	Travel from Lemera HZ to Uvira HZ
	Thursday, August 20, 2015	Ruzizi HZ	Data collection
	Friday, August 21, 2015	Ruzizi HZ	Data collection
	Saturday, August 22, 2015	Ruzizi HZ	Data collection
16	Sunday, August 23, 2015	Ruzizi HZ	Data collection
	Monday, August 24, 2015	Ruzizi HZ	Data collection
	Uvira		
	Tuesday, August 25, 2015	Ruzizi HZ	Data collection
	Wednesday, August 26, 2015	Uvira	Travel from Ruzizi HZ to Uvira
	Thursday, August 27, 2015	Bukavu	Travel from Uvira to Bukavu
	Friday, August 28, 2015	Bukavu	Checking questionnaires and Expenses report
	Saturday, August 29, 2015	Lubumbashi	Travel from Bukavu to Lubumbashi via Kamemie
17	Sunday, August 30, 2015	Lubumbashi	Logistical preparation
	Kolwezi		

Week	Day/Date	Place	Activities
	Monday, August 31, 2015	Kolwezi	Travel from Lubumbashi to Kolwezi
	Tuesday, September 01, 2015	Kolwezi	Contacts with provincial authorities & selection of interviewers and data collectors
	Wednesday, September 02, 2015	Kolwezi	Training
	Thursday, September 03, 2015	Kolwezi	Training
	Friday, September 04, 2015	Kolwezi	Training
	Saturday, September 05, 2015	Kolwezi	Training
18	Sunday, September 06, 2015	Lubudi HZ	Travel from Kolwezi to Lubudi HZ
	Monday, September 07, 2015	Lubudi HZ	Data collection
	Tuesday, September 08, 2015	Lubudi HZ	Data collection
	Wednesday, September 09, 2015	Lubudi HZ	Data collection
	Thursday, September 10, 2015	Lubudi HZ	Data collection
	Friday, September 11, 2015	Lubudi HZ	Data collection
	Saturday, September 12, 2015	Lubudi HZ	Travel from Lubudi HZ to Kamina
	Sunday, September 06, 2015	Kolwezi/Dilala HZ	Data collection
	Monday, September 07, 2015	Kolwezi/Dilala HZ	Data collection
	Tuesday, September 08, 2015	Kolwezi/Dilala HZ	Data collection
	Wednesday, September 09, 2015	Kolwezi/Dilala HZ	Data collection
	Sunday, September 06, 2015	Kolwezi/Manika HZ	Data collection
	Monday, September 07, 2015	Kolwezi/Manika HZ	Data collection
	Kolwezi		
	Tuesday, September 08, 2015	Kolwezi/Manika HZ	Data collection
	Wednesday, September 09, 2015	Kolwezi/Manika HZ	Data collection
	Thursday, September 10, 2015	Kolwezi	Logistic preparation and checking of questionnaires
	Thursday, September 10, 2015	Luena	Travel from Kolwezi to Kamina by road via Luena
	Kamina		
	Friday, September 11, 2015	Kamina	Travel from Kolwezi to Kamina by road via Luena
	Saturday, September 12, 2015	Kamina	Contacts with provincial authorities & Selection of interviewers and data collectors
19	Sunday, September 13, 2015	Kamina	Selection of candidates interviewers
	Monday, September 14, 2015	Kamina	Training

Week	Day/Date	Place	Activities
	Tuesday, September 15, 2015	Kamina	Training
	Wednesday, September 16, 2015	Kamina	Training
	Thursday, September 17, 2015	Kamina	Training
	Friday, September 18, 2015	Kitenge HZ	Travel from Kamina to Kitenge HZ
	Friday, September 18, 2015	Kitenge HZ	Data collection
	Saturday, September 19, 2015	Kitenge HZ	Data collection
	Sunday, September 20, 2015	Kitenge HZ	Data collection
	Monday, September 21, 2015	Kitenge HZ	Data collection
	Tuesday, September 22, 2015	Kitenge HZ	Data collection
	Wednesday, September 23, 2015	Kamina HZ	Data collection
	Thursday, September 24, 2015	Kamina	Travel from Kitenge HZ to Kamina
	Friday, September 18, 2015	Kayamba HZ	Travel from Kamina to Kayamba HZ
	Friday, September 18, 2015	Kayamba HZ	Data collection
	Saturday, September 19, 2015	Kayamba HZ	Data collection
	Sunday, September 20, 2015	Kayamba HZ	Data collection
	Monday, September 21, 2015	Kayamba HZ	Data collection
	Tuesday, September 22, 2015	Kayamba HZ	Data collection
	Kamina		
	Wednesday, September 23, 2015	Kayamba HZ	Data collection
	Thursday, September 24, 2015	Kamina	Travel from Kayamba HZ Kamina
	Friday, September 18, 2015	Kinkondja HZ	Travel from Kamina to Kinkondja HZ
	Friday, September 18, 2015	Kinkondja HZ	Data collection
	Saturday, September 19, 2015	Kinkondja HZ	Data collection
	Sunday, September 20, 2015	Kinkondja HZ	Data collection
20	Monday, September 21, 2015	Kinkondja HZ	Data collection
	Kamina		
	Tuesday, September 22, 2015	Kinkondja HZ	Data collection
	Wednesday, September 23, 2015	Kinkondja HZ	Data collection
	Thursday, September 24, 2015	Kamina	Travel from Kinkondja HZ Kamina

Week	Day/Date	Place	Activities
	Friday, September 25, 2015	Kamina	Checking of questionnaires/Expenses report
	Saturday, September 26, 2015	Lubumbashi	Travel from Kamina to Lubumbashi
	Sunday, September 27, 2015	Kinshasa	Travel Lubumbashi to Kinshasa

ANNEX E: LIST OF PERSONS INTERVIEWED

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West Kasai Province			
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Ilunga Nday	Community Health Worker (RECO)		
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ANNEX F. REFERENCE LIST

From USAID

- DRC/ Integrated Health Project – Performance Monitoring Plan November 15, 2011
- DRC-IHP Quarterly/Annual Report: Year 2, Quarter 4 (July- September 2012)
- BASELINE SURVEY May 2011
- DRC-IHP Quarterly/Annual Report: Year 1, Quarter 4 (July-September 2011)
- DRC-IHP Quarterly/Annual Report: Year 4, Quarter 4 (October 2013-September 2014)

From MSH

- Cooperative Agreement No. AID-OAA-A-10-00054
- Approval of contracts to Local Government Entities under MSH Cooperative Agreement No. AID-OAA-A-10-00054
- IHP PBF Health facilities and centers list
- IHP PBF program summary
- IHP-DRC Fixed-Price Contract Template
- DRC/Integrated Health Project – Performance Monitoring Plan Approved by USAID March 1, 2012
- Revised Quarterly Report October – December 2010
- DRC-IHP Quarterly Report: Year 1, Quarter 2 (January-March 2011)
- DRC-IHP Quarterly Report: Year 1, Quarter 3 (April-June 2011)
- DRC-IHP Quarterly/Annual Report: Year 1, Quarter 4 (July-September 2011)
- DRC-IHP Quarterly/Annual Report: Year 2, Quarter 1 (October - December 2011)
- DRC-IHP Quarterly/Annual Report: Year 2, Quarter 2 (January - March 2012)
- DRC-IHP Quarterly/Annual Report: Year 2, Quarter 3 (April - June 2012)
- DRC-IHP Quarterly/Annual Report: Year 2, Quarter 4 (July- September 2012)
- USAID/DRC/IHP Year 2 Workplan
- DRC/IHP - Cooperative Agreement AID-OAA-A-10-00054 -- Year 2 Workplan (October 1, 2011-September 30, 2012)
- IHP Cooperative Agreement AID-OAA-A-10-00054 Year 3 Workplan (October 1, 2012-September 30, 2013) (Approved December 14, 2012)
- USAID/DRC/IHP Annual Workplan PY3 October 2012 - September 2013 USAID APPROVED DECEMBER 14, 2012
- USAID/DRC/PROSANI - Year 1 Workplan March-May 2011 Quarterly Prioritized Activities
- USAID/DRC/PROSANI - DRAFT Year 1 Workplan October 2010 - September 2011
- IHP WorkPlan For June 1 – September 30, 2011
- DRC-IHP Quarterly Report: Year 5, Quarter 1 (October 2014-December 2014)
- DRC-IHP Quarterly/Annual Report: Year 4, Quarter 2 (January-March 2014)
- DRC-IHP Quarterly Report: Year 5, Quarter 3 (April-June 2015)
- DRC-IHP Quarterly Report: Year 5, Quarter 2 (January-March 2015)
- DRC-IHP Quarterly Report: Year 3, Quarter 3 (April-June 2015)

- DRC-IHP Quarterly Report: Year 4, Quarter 3 (April-June 2014)
- DRC-IHP Quarterly Report: Year 5, Quarter 2 (January-March 2015)
- DRC-IHP Quarterly Report: Year 3, Quarter 1 (October-December 2014)
- DRC-IHP Project Year 5 (PY5) Workplan
- DRC Update on Diarrhea and Pneumonia Situation
- Supporting Local Health Care in a Chronic Crisis: Management and Financing Approaches in the Eastern Democratic Republic of the Congo
- Pay-for-Performance, Motivation and Final Output in the Health Sector: Experimental Evidence from the Democratic Republic of Congo
- IHP RBF Manual August 2014
- Paying for Performance in Health: A Guide to Developing the Blueprint (2011)
- The PBF Handbook: Designing and Implementing Effective Performance-Based Financing Programs (2011)
- Dealing with difficult design decisions: The experience of an RBF pilot program in Haut-Katanga District of Democratic Republic of Congo (DRC)
- Nigeria State Health Investment Project (NSHIP) Performance-Based Financing User Manual (2013)

ANNEX G. DEFINITIONS OF MPA AND CPA

2015 LIST OF MPA AND CPA

HEALTH CENTER: MINIMUM PACKAGE OF ACTIVITIES (MPA)

CONTINUATION OF MPA

MPA includes curative, preventative, promotional, and support and other activities, whose tasks are delegated to a versatile team of health center nurses by the health zone team, and are under supervision by the latter. Those tasks are in standardized form of instructions or flowcharts.

PREVENTATIVE ACTIVITIES

- Monitoring growth and development of children under five years
- Prenatal consultations
- Family planning consultations
- Postnatal consultations
- Extended vaccination program

CURATIVE ACTIVITIES

- Curative care
- Screening and treatment of chronic illnesses (TB, leprosy, diabetes, AIDS, etc.)
- Nutritional rehabilitation
- Small medical and surgery interventions (minor surgeries)
- Natural deliveries

PROMOTIONAL ACTIVITIES

- Activities for the promotion of healthy behaviors:
- Promotion of use of condoms
- Promotion of sanitation
- Promotion of exclusive breastfeeding
- Promotion of healthy eating, nutritional, and cooking habits
- Promotion of the use of iodized salt
- Promotion of social marketing and distribution of ITNs
- Promotion of hygienic latrines
- Oral hydration therapy, etc…

MANAGEMENT AND OTHER ACTIVITIES

- Resource management (human, material, financial, etc.)
- Continuing education/training of personnel
- Supervision of health leaders (meetings, field visits, etc.)
- Management of health information
- Certain health center activities such as ivermectin administration, oral re-hydration therapy, fever treatment, Vitamin A administration, etc., may be extended in the community but remain the responsibility of the health team. These activities are not to be confused with community activities.

COMMUNITY ACTIVITIES

This category includes all community activities beneficial to its health that do not necessarily require the intervention of the health center team to ensure quality. This is not a level of care, but rather a set of knowledge and practices, modern and traditional, used by community members to prevent or alleviate suffering related to disease.

COMMUNITY-LEVEL ACTIVITIES INCLUDE:

- Measures for food sanitation
- Capture and management of springs, wells, supply of drinking water, community water treatment
- Vector control: use of ITNs, trapping of flies and mosquitoes
- Exclusive breastfeeding
- Support for orphans
- Gardening, fish farming, livestock breeding

GENERAL REFERENCE HOSPITAL (GRH): COMPLEMENTARY PACKAGE OF ACTIVITIES (CPA)

CONTINUATION OF CPA

CPA includes preventative, curative, and promotional activities that are organized within the framework of internal medical services, surgery, gynecology, obstetrics, and pediatrics. Along with those activities, are those related to management (management of hospital health information; human, material, and financial resources; action research and supervision of health zone personnel).
The PCA is created with varied support among which one retains:
The various reviews of a reference laboratory
Medical imaging
Equipment sterilization
Rehabilitation activities

2013 LIST OF MPA AND CPA

IHP MPA-PLUS (THE MPA-PLUS IS TO BE PROVIDED AT ALL HEALTH CENTERS IN THE 80 TARGETED HEALTH ZONES)

PREVENTIVE ACTIVITIES

- Growth & Development monitoring for under 5 year olds
- Prenatal counseling
- PMTCT, including counseling, HIV testing, antiretroviral prophylaxis, FP counseling, and Cotrimoxazole, nutrition counseling, and referrals for treatment, if indicated
- Cotrimoxazole for exposed infants:
- FP counseling and services (condoms, orals, injectables, intrauterine devices (IUD), standard day method cycle beads, lactational amenorrhea method (LAM) and referrals for long-acting and permanent methods)
- Postnatal counseling
- Immunizations: BCG (tuberculosis), OPV (Polio), DPTHepB-Hib (Diphteria, Pertussis, Tetanos, Hepatitis B, Haemophilus Influenza type B), VAR (Measles)
- Universal precautions for infection prevention & blood safety
- Distribution of IPTp and LLINs
- HIV information
- Vitamin A, other micronutrient supplementation

CURATIVE ACTIVITIES

- Clinic-based IMCI including treatment of malaria and acute respiratory infection (ARI), diarrhea
- Testing and treatment of chronic diseases, including NTDs
- HIV/AIDS: PMTCT and blood transfusion testing, monitoring patients on antiretroviral therapy who have been diagnosed at GHR, management of opportunistic infections (Cotrimoxazole) and related nutritional support devices.
- TB: sputum collection and forwarding to diagnostic and treatment centers; TB treatment
- Diagnosis and treatment (referrals as indicated) for other NTDs; Leprosy, Trypanosomiasis, Lymphatic Filariasis, Hookworm, Roundworm, Whipworm, Shistosomiasis, Onchocerciasis)
- Other curative care not elsewhere cited
- Nutritional rehabilitation
- Minor surgery
- Normal labor & delivery services including practice of active management of third stage labor (AMTSL), availability of oxycontin, and newborn care kits
- IPTp for pregnant women and children under 5 years of age
- STI syndromic treatment and referrals
- Post-exposure prophylaxis (PEP) and appropriate counseling for victims of S/GBV
- Acute respiratory infection treatment

PROMOTIONAL ACTIVITIES

- Condom use for dual protection
- Environmental sanitation
- Exclusive breast feeding
- Healthy eating & food handling
- Use of iodized salt
- Improved latrines
- Oral rehydration therapy and diarrheal disease control
- Fistula awareness and prevention

MANAGEMENT/ADMINISTRATIVE ACTIVITIES

- Increase availability of essential services to underserved populations (e.g. increase coverage)
- Management of resources (human, material, financial)
- Continuous health personnel training
- Training & mentoring of (community) outreach workers (meetings, site visits)
- Linkages with & referrals from private health providers in the Health Zones (if such exist)
- Management of health information
- Management of pharmaceutical information

COMMUNITY ACTIVITIES

- Community-based IMCI (c-IMCI) including early recognition and referral for danger signs
- Disease surveillance: TB, NTDs, etc.
- Food safety and food handling
- Potable water improvements: spring and well capping, improved water distribution systems, community water treatment
- Disease control: use of LLITNs, tsetse control, environmental sanitation, etc.
- Community based information-education-communication and distribution of FP commodities-standard day method cycle beads, orals, condoms, and referrals for other methods

- Community awareness and prevention S/GBV
- Vegetable gardens, fish farming, livestock production

IHP CPA-PLUS (THE CPA-PLUS IS TO BE PROVIDED AT ALL GENERAL REFERENCE HOSPITALS IN THE 80 TARGETED HZ)

The CPA includes the full MPA-plus as well as standard preventative, curative, and promotional activities associated with internal medicine, surgery, obstetrics and gynecology, and pediatrics. In addition, the CPA includes management activities (hospital health information management, management of resources, applied research and training/mentoring health zone personnel

SPECIALIZED SERVICES IN THE CPA-PLUS WOULD INCLUDE:

- Long Acting and Permanent Methods of contraception (implants, tubal ligation, vasectomy)
- Fistula repair
- Post-abortion care (PAC)
- Blood screening, storage & collection at selected hospitals, and maintenance of a "living blood bank" at others
- Multi-drug resistance (MDR) TB sputum collection and forwarding to Kinshasa or Lubumbashi labs; treatment and follow-up
- PMTCT-plus, to include provision and monitoring of ARV prophylaxis to HIV-infected women and exposed infants
- TB-HIV co-infection screening and treatment (entry point is PMTCT)

LABORATORY TESTING & ANALYSES

- Parasites (including Rapid Diagnostic Tests and microscopy for malaria)
- HIV (with PMTCT as point of entry)
- TB microscopy
- Blood (hematology)
- Bacterial
- Biochemical

MEDICAL IMAGING

- Radiography
- Echography

EQUIPMENT STERILIZATION

Cleansing followed by disinfection, sterilization with autoclave or hot water

REHABILITATION

Physiotherapy

ANNEX H. EVALUATION SAMPLE SIZE DISTRIBUTION

SAMPLE DISTRIBUTION: HEALTH FACILITY SURVEY

Table: Health Facility Sample Size by SA/BC, HZ

No.	BC	HZs	GRHs	HCs	Total HFs
1	Luiza	3	3	9	12
2	Mwene Ditu	3	3	9	12
3	Kole	3	3	9	12
4	Tshumbe	3	3	9	12
5	Kolwezi	3	3	9	12
6	Kamina	3	3	9	12
7	Bukavu	3	3	9	12
8	Uvira	2	2	10	12
Total		23	23	73	96

SAMPLE DISTRIBUTION: CLIENT EXIT INTERVIEWS

No.	Name of BC	HC Surveyed	2013		2015	
			Total No. Respondents	%	Total No. Respondents	%
1	Bukavu	9	44	15%	57	16%
2	Kamina	9	23	8%	35	10%
3	Kole	9	26	9%	24	7%
4	Kolwezi	9	38	13%	75	20%
5	Lwiza	9	39	13%	38	10%
6	Mwene-ditu	9	56	19%	49	13%
7	Tshumbe	9	32	11%	44	12%
8	Uvira	10	35	12%	44	12%
Total		73	293		366	

ANNEX I: QUANTITATIVE DATA ANALYSIS PLAN

IHP EVALUATION DATA ANALYSIS PLAN

END LINE EVALUATION

DESCRIPTIVE DATA ANALYSIS:

Availability of key family health care services

Accessibility to key family health care services

Derive quality of care indicators for Health facility by combining quality assessment variables

Service utilization of key family health care services

Client health seeking and utilization practices

Derive client knowledge, household health seeking practices and perceptions (client satisfaction) index by combining relevant variables

MULTIVARIATE ANALYSIS:

Disaggregate by Supervision Area; Multivariate analysis by mother's age, child's age, literacy level, location of residence (Urban/rural)

FINAL EVALUATION DATA ANALYSIS

Change in Availability of services: % change between baseline and final

Change in Accessibility of services: % change between baseline and final

Test of significance for HF indicators: change from baseline vs final: paired t test

% Change in service utilization score: baseline vs final

% change in IHP outcome indicators: baseline vs final

% changes in client or household health seeking and utilization practices current and past

Test of significance for household knowledge and client perceptions (client satisfaction) scores: change from baseline vs final.

Evaluation Questions	Assessment Domains	Source of Data (Quantitative)	Survey Questions	Descriptive Data Analysis
Availability of key family health care services minimum package of Activities/Complementary Package of Activities plus (MPA/CPA-plus)	Assess range and type of services provision including Preventive care, Curative, Water/Sanitation/Hygiene (WASH) services and products MPA+ services: supposed to be provided at all HCs CPA+ services: supposed to provided by all GRHs See annex for list of interventions	Facility survey: HCs and GRHs	Survey questions Module 2 questions Module 3 questions Module 4 questions	Percentage of facilities (HC and GRH) offering full range of MPA+), by health HZ, Province Percentage of GRH offering full range of CPA+), by health HZ, Province:
Accessibility to key family health care services	Assess community-based support and outreach with respect to information, communication, and delivery of key family health care services Assess referral system: community-facility-community Facility-facility	Facility survey: HCs and GRHs	Module 2 questions Module 3 questions Module 4 questions Module 10 questions	percentage of the health centers surveyed provide health promotion/information on: condom use; hygiene and sanitation; exclusive breastfeeding; food hygiene/food safety; oral rehydration for diarrhea; and, fistula
Quality of key family health care services provision	Health facility infrastructure, equipments, communication, transport, waste management	Facility survey: HCs and GRHs Facility Survey: (possibly? SP first section: a-k;) SU1, 2; Client Exit Survey: Module 3: 8. Facility Survey: EM5, 6, 7, 8, 9; Client Exit Survey: Module 3: 12; Module 4: 16.	Module 1 questions	Derive quality score on health facility infrastructure Compare by type of facility, location of HF, HZ, SA, Province
	Compliance with established service protocols or standards		Module 2 questions Module 3 questions Module 4 questions	% of facilities with written protocols or standards for range of services
	Staff Characteristics		Module 2 questions	Characteristics of staff: type of staff, number (%), gender, training status: by type of health facility, HZ, SA, Province
	Staff training and skills		Module 2 questions	Characteristics of staff: type of staff, number (%), gender, training status: by

Evaluation Questions	Assessment Domains	Source of Data (Quantitative)	Survey Questions	Descriptive Data Analysis
				type of health facility, HZ, SA, Province Percentage health workers with specific skills (FP, HIV, STI, IMCI, PMTCT) by type of facility, HZ, SA
	Facility Supervision		Module 5	Facility supervision rate: number and % of facilities with at least once in past 3 months supervision visit, by type, location, HZ, Province
	Essential Drugs, supplies management and monitoring systems		Module 6 Module 7 Module 8	Percent of health facilities experienced shortage of drugs, vaccine, FP products in past 6 months, by type, location, HZ, SA, Province The top three reasons why medications and supplies are delivered delayed % of facilities with available of IEC materials for each range of services, by type of health facility, HZ
Service utilization of key family health care services minimum package of Activities/Complementary Package of Activities plus (MPA/CPA-plus)	Review utilization of maternal, newborn, and child health (including pre and post-natal and child care and care of infants) Immunization malaria, diarrhea, pneumonia, tuberculosis family planning nutrition HIV/AIDS and PMTCT services	Facility survey: HCs and GRHs		Calculate service utilization rates: % of children received DTP last 12 month/population of under 12 month in catchment area for 2012 IHP PMP outcome indicators review baseline vs. 2012 (if available) Percent of clients receiving a given procedure or intervention (including frequency of visits, consultations, referrals, treatments) and demographic characteristics (i.e., age and place of residence) for the following health services: for women of reproductive age (15-49), pregnant

Evaluation Questions	Assessment Domains	Source of Data (Quantitative)	Survey Questions	Descriptive Data Analysis
				women, mothers and their children aged 0-23 months percentage of children aged 0-23 months slept under an insecticide-treated net the night before the child's mother brought him/her to a health center

Evaluation Questions	Assessment Domains	Source of Data (Quantitative)	Survey Questions	Descriptive Data Analysis

Access to health facility and available MPA and CPA –plus services and resources and service health seeking practices	Assess client's health seeking reason for current visit and practices in the past Assess services available to clients by health facility/providers in current visit	Client Exit Survey: Household Survey	Module 1, 2, 3, 4: Q on current reason for clinic visit, services received this visit and in the past Module 1: Q on access to qualified health providers, child, maternal health services, , infant nutrition education, immunization Module 1, 3, 4: Q on access and utilization of available services child immunization, breast feeding, malaria, fever, danger signs, pneumonia, diarrhoea, pre-natal , antenatal, alternate health providers Module 1, 3, 4: Q on access and utilization of availability of resource: ITN, Soap, sanitary facilities, safe water	N and % of client (infants, child, women 15-49, pregnant) received various types of care/services- current and past: by type of facility, location of facility, age of respondent, HZ, SA, Province Client health seeking and utilization practices: by age, location of facility, HZ, SA, age of respondent Percentage of the health center clients surveyed have access to a source of potable water
Evaluation Questions	**Assessment Domains**	**Source of Data (Quantitative)**	**Survey Questions**	**Descriptive Data Analysis**

Perceptions of services provided by health facility	Assess client satisfaction with key family health care services Client perceptions of staff skills and knowledge with interpersonal counseling skills of providers, perceived provider-client quality of interaction Client perceptions of tests and treatment for their children (0-23, 24-59 months); on current visit and past Client perceptions of treatment they received by staff (in all areas, including family planning clients) Client perceptions of waiting time, appointment schedules, privacy	Client Exit Survey: Household Survey	Module 1, 2: Q 9-14 Module 1, 2: Q 16-21 (Client satisfaction questions : Likert Scale, interpersonal skills of providers, quality and availability of provider) Module 1, 3, 4(Questions of services- child health, family planning, WASH, maternal health, TB, HIV- received in current visit and in the past i.e.; having their weight checked, testing for presence of cough, diarrhoea and fever	Calculate Overall satisfaction with the services received on current visit % of the mothers visiting a health facility to have her child ages 0-56 months treated who were surveyed were very satisfied/ somewhat satisfied/ neutral/ somewhat unsatisfied/ very unsatisfied
Knowledge on key health topics and availability of services	Assess client's source of information on key family health care services Assess client's participation in community interventions and resources on key family health care services	Client Exit Survey: Household Survey	Module 1: Q on knowledge on health topics and source of information: child immunization, breast feeding, danger signs, malaria, fever, pneumonia, diarrhoea, fistula, maternal health, WASH Module 1: Q on knowledge on availability of services child immunization, breast feeding, malaria, fever, danger signs, pneumonia, diarrhoea, pre-natal , antenatal	Calculate Overall knowledge on key health topics and availability of services Client knowledge: by type of information, source of information, HZ, SA, age of respondent

ANNEX J: QUANTITATIVE ANALYSIS

QUANTITATIVE ANALYSIS RESULTS FROM FACILITY SURVEY: AVAILABILITY OF MPA-PLUS SERVICES

Table 1. Availability of MPA-Plus Services: Preventative and Curative Services

		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Facility offers prenatal care	2013	91	95%	11	92%	12	100%	12	100%	12	100%	11	92%	11	92%	12	100%	10	83%
	2015	90	94%	10	83%	12	100%	12	100%	12	100%	10	83%	10	83%	12	100%	12	100%
	Diff.	-1	-1%	-1	-9%	0	0%	0	0%	0	0%	-1	-9%	-1	-9%	0	0%	2	17%
Women receive Vit. A during PNC	2013	21	23%	4	36%	2	17%	0	0%	4	33%	4	36%	2	18%	0	0%	5	50%
	2015	21	22%	4	33%	4	33%	3	25%	2	17%	2	17%	2	17%	1	8%	3	25%
	Diff.	0	-1%	0	-3%	2	16%	3	25%	-2	-16%	-2	-19%	0	-1%	1	8%	-2	-25%
Pregnant advised HIV test	2013	63	69%	11	100%	7	58%	9	75%	12	100%	7	64%	6	55%	4	33%	7	70%
	2015	45	50%	7	70%	8	67%	7	58%	9	75%	4	40%	4	33%	2	25%	3	25%
Routinely offers HIV test for PMTCT	2013	39	62%	9	82%	1	14%	6	67%	9	75%	4	57%	4	67%	2	50%	4	57%
	2015	36	80%	5	71%	6	75%	6	86%	7	78%	4	100%	3	75%	2	67%	3	100%
	Diff.	-3	18%	-4	-11%	5	61%	0	19%	-2	3%	0	43%	-1	8%	0	17%	-1	43%
Gives ARV for PMTCT prevention	2013	23	59%	5	56%	1	100%	2	33%	7	78%	0	0%	4	100%	1	50%	3	75%
	2015	29	81%	5	100%	2	33%	5	83%	7	100%	2	50%	3	100%	2	100%	3	100%
	Diff.	6	22%	0	44%	1	-67%	3	50%	0	22%	2	50%	-1	0%	1	50%	0	25%
offers normal labor services	2013	76	79%	10	100%	12	100%	6	50%	11	92%	10	83%	11	92%	7	58%	9	75%
	2015	79	82%	10	83%	12	100%	6	50%	11	92%	11	92%	11	92%	10	83%	8	67%
	Diff.	3	3%	0	-17%	0	0%	0	0%	0	0%	1	9%	0	0%	3	25%	-1	-8%
Facility offers postpartum care	2013	76	100%	10	100%	12	100%	6	100%	11	100%	10	100%	11	100%	7	100%	9	100%
	2015	77	80%	10	83%	12	100%	6	50%	11	92%	11	92%	10	83%	10	83%	7	58%
	Diff.	1	-20%	0	-17%	0	0%	0	-50%	0	-8%	1	-8%	-1	-17%	3	-17%	-2	-42%
Referrals for emergency obstetrics	2013	34	45%	5	50%	5	42%	0	0%	4	36%	4	40%	4	36%	5	71%	7	78%
	2015	44	46%	3	25%	7	58%	5	42%	3	25%	7	58%	8	67%	6	50%	5	42%
	Diff.	10	1%	-2	-25%	2	16%	5	42%	-1	-11%	3	18%	4	31%	1	-21%	-2	-36%
Facility offers FPg services	2013	94	98%	10	83%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%
	2015	95	99%	11	92%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%
	Diff.	1	1%	1	9%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	2013	84	88%	11	92%	10	83%	11	92%	10	100%	10	83%	11	92%	10	83%	9	75%

Table 1. Availability of MPA-Plus Services: Preventative and Curative Services																			
		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Immunization for children	2015	84	88%	11	92%	10	83%	11	92%	10	100%	10	83%	10	83%	10	83%	10	83%
	Diff.	0	0%	0	0%	0	0%	0	05	0	0%	0	0%	-1	-9%	0	0%	1	8%
Growth monitoring of children < 5	2013	58	60%	11	92%	8	67%	7	58%	5	42%	6	50%	6	50%	9	75%	6	50%
	2015	66	69%	8	67%	7	58%	5	42%	10	83%	9	75%	9	75%	8	67%	10	83%
	Diff.	8	9%	-3	-25%	-1	-9%	-2	-16%	5	41%	3	25%	3	25%	-1	-8%	4	33%
offers clinic-based IMCI	2013	96	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%
	2015	96	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%
	Diff.	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
distributes ITNs	2013	89	93%	11	92%	10	83%	12	100%	11	92%	11	92%	11	92%	11	92%	12	100%
	2015	77	80%	7	58%	9	75%	12	100%	12	100%	8	67%	10	83%	8	67%	11	92%
	Diff.	-12	-13%	-4	-34%	-1	-8%	0	0%	1	8%	-3	-25%	-1	-9%	-3	-25%	-1	-8%
ITNs for pregnant women	2013	87	98%	11	100%	10	100%	12	100%	10	91%	11	100%	11	100%	10	91%	12	100%
	2015	76	99%	7	100%	9	100%	12	100%	12	100%	8	100%	10	100%	7	88%	11	100%
	Diff.	-11	1%	-4	0%	-1	0%	0	0%	2	9%	-3	0%	-1	0%	-3	-4%	-1	0%
ITNs for children under 2 years	2013	51	57%	7	64%	4	40%	7	58%	4	36%	10	91%	7	64%	8	73%	4	33%
	2015	46	60%	2	29%	3	33%	6	50%	12	100%	5	63%	6	60%	3	38%	9	82%
	Diff.	-5	2%	-5	-35%	-1	-7%	-1	-8%	8	64%	-5	-29%	-1	-4%	-5	-36%	5	49%
offers nutritional rehabilitations	2013	38	40%	8	67%	0	0%	1	8%	7	58%	4	33%	7	58%	5	42%	6	50%
	2015	47	49%	8	67%	1	8%	3	25%	9	75%	2	17%	9	75%	9	75%	6	50%
	Diff.	9	9%	0	0%	1	8%	2	17%	2	17%	-2	-16%	2	17%	4	33%	0	0%
Care and treatment of HIV	2013	26	27%	6	50%	2	17%	2	17%	4	33%	4	33%	2	17%	2	17%	4	33%
	2015	31	32%	3	25%	5	42%	2	17%	7	58%	5	42%	3	25%	2	17%	4	33%
	Diff.	5	5%	-3	-25%	3	25%	0	0%	3	25%	1	9%	1	8%	0	0%	0	0%
Care and treatment of NTDs*	2013	68	71%	10	83%	9	75%	8	67%	6	50%	11	92%	4	33%	9	75%	11	92%
	2015	83	86%	7	56%	12	100%	12	100%	9	75%	11	92%	11	92%	12	100%	9	75%
	Diff.	15	15%	-3	-25%	3	25%	4	33%	3	25%	0	0%	7	58%	3	25%	-2	-17%
Care and treatment for TB	2013	55	57%	7	58%	9	75%	7	58%	7	58%	10	83%	6	50%	5	42%	4	33%
	2015	58	60%	6	50%	10	83%	8	67%	8	67%	8	67%	8	67%	4	33%	6	50%
	Diff.	3	3%	-1	-8%	1	8%	1	8%	1	8%	-2	-17%	2	17%	-1	-8%	2	17%
Facility offers blood transfusions	2013	31	32%	2	17%	4	33%	3	25%	6	50%	5	42%	4	33%	4	33%	3	25%
	2015	32	33%	3	25%	7	58%	3	25%	6	50%	4	33%	4	33%	3	25%	2	17%
	Diff.	1	1%	1	8%	3	25%	0	0%	0	0%	-1	-9%	0	0%	-1	-8%	-1	-8%

Table 1. Availability of MPA-Plus Services: Preventative and Curative Services		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Facility offers minor surgery	2013	87	91%	11	92%	11	92%	11	92%	10	83%	12	100%	11	92%	11	92%	10	83%
	2015	92	96%	12	100%	12	100%	12	100%	10	83%	12	100%	11	92%	11	92%	12	100%
	Diff.	5	5%	1	8%	1	8%	1	8%	0	0%	0	0%	0	0%	0	0%	2	17%
Facility offers STI treatment and referrals	2013	68	71%	12	100%	5	42%	10	83%	10	83%	8	67%	8	67%	8	67%	7	58%
	2015	75	78%	9	75%	6	50%	10	83%	9	75%	10	83%	12	100%	12	100%	7	58%
	Diff.	7	7%	-3	-25%	1	8%	0	0%	-1	-8%	2	16%	4	33%	4	33%	0	0%
Facility offers PEP	2013	23	34%	8	67%	0	0%	2	20%	2	20%	0	0%	1	13%	1	13%	7	100%
	2015	29	39%	7	78%	4	67%	1	10%	5	56%	3	30%	2	17%	0	0%	7	100%
	Diff.	3	5%	-1	11%	4	67%	-1	-10%	3	36%	3	30%	1	4%	-1	-13%	0	0%
Facility handles GBV/rape cases	2013	31	46%	10	83%	2	17%	1	10%	2	20%	3	38%	1	13%	4	50%	7	100%
	2015	40	53%	7	78%	6	50%	4	40%	5	56%	3	30%	5	42%	3	25%	7	100%
	Diff.	9	8%	-3	-6%	4	33%	3	30%	3	36%	0	-8%	4	29%	-1	-25%	0	0%
Facility gives HIV/AIDS information to public	2013	38	56%	8	67%	2	17%	6	50%	8	67%	5	42%	4	50%	1	13%	4	57%
	2015	40	53%	8	89%	6	100%	5	50%	7	78%	5	50%	4	33%	1	8%	4	57%
	Diff.	2	-3%	0	22%	4	83%	-1	0%	-1	11%	0	8%	0	-17%	0	-4%	0	0%

Coverage 0-49% Coverage 50-79% Coverage 80-100%

*=p≤0.05

Table 2. Availability of Community or Health Promotion Services		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Condom promotion	2013	92	96%	11	92%	12	100%	12	100%	12	100%	10	83%	12	100%	12	100%	11	92%
	2015	92	96%	10	83%	11	92%	12	100%	12	100%	12	100%	11	92%	12	100%	12	100%
	Diff.	0	0%	-1	-9%	-1	-8%	0	0%	0	0%	2	17%	-1	-8%	0	0%	1	8%
Hygiene and sanitation promotion	2013	90	94%	11	92%	11	92%	12	100%	12	100%	12	100%	11	92%	9	75%	12	100%
	2015	86	90%	12	100%	12	92%	10	83%	12	100%	11	92%	9	75%	10	83%	11	92%
	Diff.	-4	-4%	1	8%	1	0%	-2	-17%	0	0%	-1	-8%	-2	-17%	1	8%	-1	-8%
Exclusive breastfeeding promotion	2013	94	98%	12	100%	12	92%	11	92%	12	100%	12	100%	12	100%	12	100%	12	100%
	2015	91	95%	12	100%	12	92%	11	92%	12	100%	12	100%	190	83%	11	92%	12	100%
	Diff.	-3	-3%	0	0%	0	0%	0	0%	0	0%	0	0%	-2	-17%	-1	-8%	0	0%
	2013	89	93%	12	100%	12	92%	11	92%	11	92%	10	83%	12	100%	10	83%	12	100%

Table 2. Availability of Community or Health Promotion Services		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Food hygiene and safety promotion	2015	82	85%	10	83%	10	75%	11	92%	11	92%	9	75%	11	92%	10	83%	11	92%
	Diff.	-7	-8%	-2	-17%	-2	-17%	0	0%	0	0%	-1	-8%	-1	-8%	0	0%	-1	-8%
Iodized salt consumption promotion*	2013	41	43%	8	67%	8	42%	1	8%	8	67%	3	25%	4	33%	5	42%	7	58%
	2015	30	31%	3	25%	3	33%	3	25%	4	33%	0	0%	5	42%	2	17%	9	75%
	Diff.	-11	-12%	-5	-42%	-5	-9%	2	17%	-4	-34%	-3	-25%	1	9%	-3	-25%	2	17%
Improvement of latrines promotion	2013	78	81%	9	75%	9	92%	9	75%	11	92%	10	83%	10	83%	9	75%	9	75%
	2015	82	85%	11	92%	11	83%	8	67%	11	92%	10	83%	9	75%	12	100%	11	92%
	Diff.	4	4%	2	17%	2	-9%	-1	-8%	0	0%	0	0%	-1	-8%	3	25%	2	17%
ORS in diarrhea promotion	2013	92	96%	12	100%	12	100%	12	100%	11	92%	11	92%	12	100%	11	92%	11	92%
	2015	85	89%	11	92%	11	75%	10	83%	12	100%	10	83%	10	83%	11	92%	12	100%
	Diff.	-7	-7%	-1	-8%	-1	-25%	-2	-17%	1	8%	-1	-9%	-2	-17%	0	0%	1	8%
Fistula prevention promotion	2013	39	41%	8	67%	8	50%	3	25%	4	33%	3	25%	6	50%	4	33%	5	42%
	2015	40	42%	3	25%	3	50%	5	42%	6	50%	3	25%	5	42%	5	42%	7	58%
	Diff.	1	1%	-5	-42%	-5	0%	2	17%	2	17%	0	0%	-1	-8%	1	9%	2	16%
Facility distributes ITNs free of cost*	2013	89	93%	11	92%	11	83%	12	100%	11	92%	11	92%	11	92%	11	92%	12	100%
	2015	77	80%	7	58%	7	75%	12	100%	12	100%	8	67%	10	83%	8	67%	11	92%
	Diff.	-12	-13%	-4	-33%	-4	-8%	0	0%	1	8%	-3	-25%	-1	-8%	-3	-25%	-1	-8%

Coverage 0-49% Coverage 50-79% Coverage 80-100%

*=p≤0.05

Table 3. Accessibility of Health Services		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Facilities open 7 days per week	2013	83	86%	11	92%	9	75%	10	83%	10	83%	10	83%	11	100%	12	100%	10	83%
	2015	84	88%	12	100%	10	83%	9	75%	11	92%	10	83%	11	100%	12	100%	9	75%
	Diff.	1	2%	1	8%	1	8%	-1	-8%	1	9%	0	0%	0	0%	0	0%	-1	-8%
Facilities open 24 hours and 7 days per week	2013	80	83%	10	83%	9	75%	10	83%	9	75%	10	83%	11	100%	12	100%	10	83%
	2015	81	84%	10	83%	10	83%	10	83%	10	83%	10	83%	10	92%	11	92%	9	75%
	Diff.	1	1%	0	0%	1	8%	0	0%	1	8%	0	0%	-1	-8%	-1	-8%	-1	-8%

Coverage 0-49% Coverage 50-79% Coverage 80-100%

QUANTITATIVE ANALYSIS: QUALITY OF CARE

Table 1. Quality of Care Provision: Facility Infrastructure

		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Waiting room present	2013	83	86%	12	100%	10	83%	9	75%	11	92%	10	83%	11	92%	8	67%	12	100%
	2015	78	81%	10	83%	10	83%	9	75%	10	83%	10	83%	9	75%	11	92%	9	75%
	Diff.	-5	-5%	-2	-17%	0	0%	0	0%	-1	-9%	0	0%	-2	-17%	3	25%	-3	-25%
Continuous supply of electricity present	2013	30	31%	5	42%	3	25%	3	25%	6	50%	4	33%	4	33%	1	8%	4	33%
	2015	26	27%	8	67%	2	17%	2	17%	7	58%	1	8%	2	17%	1	8%	3	25%
	Diff.	-4	-4%	3	25%	-1	-8%	-1	-8%	1	8%	-3	-25%	-2	-16%	0	0%	-1	-8%
Continuous water inside building present*	2013	49	51%	9	75%	5	42%	3	25%	7	58%	4	33%	10	83%	2	17%	9	75%
	2015	34	35%	9	75%	4	8%	2	17%	5	42%	6	50%	5	42%	0	0%	6	50%
	Diff.	-15	-16%	0	0%	-1	-34%	-1	-8%	-2	-16%	2	17%	-5	-41%	-2	-17%	-3	-25%
Has emergency communication system	2013	17	18%	3	25%	0	0%	0	0%	4	33%	5	42%	2	17%	0	0%	3	25%
	2015	8	8%	2	17%	0	0%	0	0%	2	17%	1	8%	2	17%	0	0%	1	8%
	Diff.	-9	-10%	-1	-8%	0	0%	0	0%	-2	-16%	-4	-34%	0	0%	0	0%	-2	-17%
Has access to transportation at all times	2013	47	49%	6	50%	4	33%	6	50%	4	33%	6	50%	9	75%	6	50%	6	50%
	2015	35	36%	3	25%	8	67%	4	33%	4	33%	5	42%	6	50%	3	25%	2	17%
	Diff.	-12	-13%	-3	-25%	4	34%	-2	-17%	0	0%	-1	-8%	-3	-25%	-3	-25%	-4	-33%
Toilets present	2013	88	92%	11	92%	9	75%	11	92%	11	92%	12	100%	11	92%	11	92%	12	100%
	2015	85	89%	11	92%	11	92%	8	67%	12	100%	10	83%	12	100%	11	92%	10	83%
	Diff.	-3	-3%	0	0%	2	17%	-3	-25%	1	8%	-2	-17%	1	8%	0	0%	-2	-17%
Disinfectant currently in stock*	2013	76	79%	11	92%	11	92%	3	25%	10	83%	10	83%	12	100%	8	67%	11	92%
	2015	83	86%	11	92%	11	92%	8	67%	12	100%	9	75%	11	92%	10	83%	11	92%
	Diff.	7	7%	0	0%	0	0%	5	42%	2	17%	-1	-8%	-1	-8%	2	16%	0	0%
Bio-medical waste disposal present	2013	96	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%	12	100%
	2015	95	99%	12	100%	12	100%	12	100%	12	100%	12	100%	11	92%	12	100%	12	100%
	Diff.	-1	-1%	0	0%	0	0%	0	0%	0	0%	0	0%	-1	-8%	0	0%	0	0%

Coverage 0-49% Coverage 50-79% Coverage 80-100%

*=p≤0.05

Table 2. Quality of Care Provision: Staff Characteristics							
Staff Characteristics (all SA)		**N=96**	**%**	**% Male**	**% Female**	**Range**	**Received Training in Past 3 Years**
Has at least one doctor	2013	33	34%	94%	6%	1 to 15	73%
	2015	29	30%	90%	10%	1 to 30	89%
	Diff.	-4	-4%	-4%	4%		16%
Has at least one Nurse A1	2013	69	72%	87%	13%	1 to 30	72%
	2015	76	79%	84%	16%	1 to 28	81%
	Diff.	7	7%	-3%	3%		9%
Has at least one Nurse A2	2013	84	88%	77%	23%	1 to 36	74%
	2015	79	82%	66%	34%	1 to 48	82%
	Diff.	-5	-6%	-11%	11%		8%
Has at least one Nurse A3	2013	55	57%	65%	35%	1 to 11	51%
	2015	46	48%	53%	47%	1 to 17	53%
	Diff.	-9	-9%	-12%	12%		2%
Has at least one Certified Birth Assistant	2013	30	31%	0%	100%	1 to 4	77%
	2015	23	24%	5%	95%	1 to 3	79%
	Diff.	-7	-7%	5%	-5%		2%
Has at least one Lay/Village Birth Assistant	2013	61	64%	0%	100%	1 to 8	26%
	2015	64	67%	4%	96%	1 to 11	36%
	Diff.	3	3%	4%	-4%		10%
Has at least one Community Liaison	2013	77	80%	95%	5%	1 to 112	66%
	2015	74	77%	92%	8%	4 to 100	86%
	Diff.	-3	-3%	-3%	3%		20%

Table 3. Quality of Care Provision: Facility Supervision and Management																			
		Total (N=96)		Bukavu (N=12)		Kamina (N=12)		Kole (N=12)		Kolwezi (N=12)		Lwiza (N=12)		Mwene-ditu (N=12)		Tshumbe (N=12)		Uvira (N=12)	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
MOH representative visits facilities at least once in a month*	2013	59	61%	12	100%	0	0%	10	83%	1	8%	12	100%	1	8%	11	92%	12	100%
	2015	86	90%	12	100%	12	100%	11	92%	8	67%	9	75%	12	100%	12	100%	10	83%
	Diff.	27	28%	0	0%	12	100%	1	8%	7	58%	-3	-25%	11	92%	1	8%	-2	-17%
Drugs and Supplies Management																			
Source of Procurement																			
Central Office of Health Zone	2013	58	60%	12	100%	0	0%	11	92%	0	0%	12	100%	0	0%	11	92%	12	100%
	2015	50	52%	2	17%	9	75%	4	33%	6	50%	12	100%	7	58%	4	33%	6	50%
	Diff.	-8	-8%	-10	-83%	9	75%	-7	-58%	6	50%	0	0%	7	58%	-7	-58%	-6	-50%
International supplier/NGO	2013	34	35%	5	42%	12	100%	0	0%	11	92%	2	17%	2	17%	1	8%	1	8%
	2015	21	22%	4	33%	1	8%	6	50%	3	25%	0	0%	0	0%	6	50%	1	8%
	Diff.	-13	-14%	-1	-9%	-11	-92%	6	50%	-8	-67%	-2	-17%	-2	-17%	5	42%	0	0%
Private supplier	2013	28	29%	3	25%	2	17%	0	0%	7	58%	2	17%	10	83%	0	0%	4	33%
	2015	23	24%	5	42%	2	17%	1	8%	6	50%	0	0%	2	17%	2	17%	5	42%
	Diff.	-5	-5%	2	17%	0	0%	1	8%	-1	-8%	-2	-17%	-8	-67%	2	17%	-1	8%
Facility experiences delivery delays for medications & supplies	2013	82	85%	8	58%	9	75%	10	75%	8	75%	12	75%	11	75%	12	75%	12	75%
	2015	84	88%	12	100%	10	83%	11	92%	9	75%	8	67%	11	92%	12	100%	11	92%
	Diff.	2	2%	4	42%	1	8%	1	17%	1	0%	-4	-8%	0	17%	0	25%	-1	17%
Central storage depleted*	2013	43	54%	4	57%	3	33%	8	80%	3	38%	4	33%	10	91%	8	67%	3	25%
	2015	22	26%	2	17%	1	10%	4	36%	4	44%	0	0%	4	36%	3	25%	4	36%
	Diff.	-21	-28%	-2	-40%	-2	-23%	-4	-44%	1	7%	-4	-33%	-6	-55%	-5	333%	1	-25%
Inadequate transportation	2013	24	30%	1	14%	4	44%	2	20%	3	38%	6	50%	0	0%	3	25%	5	42%
	2015	34	40%	1	8%	5	50%	6	55%	3	33%	7	88%	2	18%	7	58%	3	27%
	Diff.	10	10%	0	-6%	1	6%	4	35%	0	-4%	1	38%	2	18%	4	275%	-2	-42%
Administrative difficulties	2013	12	15%	2	29%	2	22%	0	0%	2	25%	1	8%	1	9%	0	0%	4	33%
	2015	19	23%	6	50%	3	30%	1	9%	2	22%	1	13%	2	18%	1	8%	3	27%
	Diff.	7	7%	4	21%	1	8%	1	9%	0	-3%	0	4%	1	9%	1	8%	-1	-6%
Financial Problems	2013	3	4%	0	0%	1	11%	0	0%	0	0%	1	8%	0	9%	0	0%	1	8%
	2015	9	11%	3	25%	1	10%	0	0%	0	0%	0	0%	3	27%	1	8%	1	9%
	Diff.	6	7%	3	25%	0	-1%	0	0%	0	0%	-1	-8%	3	18%	1	8%	0	1%
Facility experiences delivery delays for contraceptives	2013	42	44%	3	25%	6	50	6	50%	6	50%	7	58%	9	82%	3	25%	2	17%
	2015	50	52%	4	33%	8	67	10	83%	3	25%	8	67%	8	67%	4	33%	5	
	Diff.	8	8%	1	8%	2	17%	4	33%	-3	-25%	1	9%	-1	-15%	1	8%	3	-17%
Infection Control and Waste Management																			
Facility's method for sharps and contaminated syringes disposal																			
By incineration	2013	77	80%	11	92%	8	67%	10	83%	10	83%	10	83%	11	92%	6	50%	11	92%
	2015	70	73%	11	92%	10	83%	11	92%	7	58%	5	42%	10	33%	6	42%	10	58%
	Diff.	-7	-7%	0	0%	2	16%	1	9%	-3	-25%	-5	-41%	-1	-59%	0	-8%	-1	-33%

By septic pit	2013	19	20%	1	25%	4	25%	2	17%	2	17%	2	17%	1	8%	6	50%	1	8%
	2015	26	27%	1	8%	2	17%	1	8%	5	42%	7	58%	2	17%	6	50%	2	17%
	Diff.	7	7%	0	-17%	-2	-8%	-1	-9%	3	25%	5	42%	1	8%	0	0%	1	8%
Reuse	2013	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	2015	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	Diff.	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Facility's method for sterilization of medical equipment																			
Boiling*	2013	64	67%	7	58%	7	58%	10	83%	4	33%	11	92%	8	67%	6	50%	11	92%
	2015	51	53%	9	75%	6	50%	5	42%	3	25%	4	33%	8	67%	6	50%	10	83%
	Diff.	-13	-14%	2	17%	-1	-8%	-5	-42%	-1	-8%	-7	-58%	0	0%	0	0%	-1	-8%
Autoclave	2013	20	21%	1	8%	4	33%	1	8%	3	25%	1	8%	3	25%	6	50%	1	8%
	2015	21	22%	0	0%	2	17%	3	25%	4	33%	2	17%	3	25%	4	33%	2	17%
	Diff.	1	1%	-1	-8%	-2	-16%	2	17%	1	8%	1	9%	0	0%	-2	-17%	1	8%
Dry heat	2013	12	13%	4	33%	1	8%	1	8%	5	42%	0	0%	1	0%	0	0%	0	0%
	2015	16	17%	3	25%	4	33%	3	25%	5	42%	0	0%	1	0%	2	17%	0	0%
	Diff.	4	4%	-1	-8%	3	25%	2	17%	0	0%	0	0%	0	0%	2	17%	0	0%
Facility's method for waste disposal																			
Burial*	2013	53	55%	5	42%	5	42%	5	42%	6	50%	8	67%	7	58%	6	50%	11	92%
	2015	27	28%	1	8%	5	42%	6	50%	2	17%	5	42%	3	25%	5	42%	0	0%
	Diff.	-26	-27%	-4	-33%	0	0%	1	8%	-4	-33%	-3	-25%	-4	-33%	-1	-8%	-11	-92%
Outdoor incineration	2013	26	27%	2	17%	5	42%	4	33%	0	0%	0	0%	8	67%	6	50%	1	8%
	2015	23	24%	0	0%	6	50%	2	17%	3	25%	1	8%	5	42%	4	33%	2	17%
	Diff.	-3	-3%	-2	-17%	1	8%	-2	-17%	3	25%	1	8%	-3	-25%	-2	-17%	1	8%
Incineration in an incinerator	2013	17	18%	5	42%	1	8%	1	8%	5	42%	3	25%	2	17%	0	0%	0	0%
	2015	33	34%	11	58%	1	8%	2	17%	6	50%	6	50%	4	33%	3	25%	0	0%
	Diff.	16	17%	6	17%	0	0%	1	8%	1	8%	3	25%	2	17%	2	25%	11	0%
Thrown outside	2013	5	5%	0	0%	1	8%	2	17%	1	8%	1	8%	0	0%	0	0%	0	0%
	2015	5	5%	0	0%	0	0%	2	17%	2	17%	0	0%	0	0%	1	8%	0	0%
	Diff.	0	0%	0	0%	-1	-8%	0	0%	1	8%	-1	-8%	0	0%	1	8%	0	0%

*=p≤0.05

QUANTITATIVE ANALYSIS: CLIENT PROFILE

Characteristics		2013		2015	
		Number	%	Number	%
Type of facility	Health Center	293	100%	366	100%
	GRH	0		0	
Gender of respondents	Female	293	100%	366	100%
Age of respondents	Mean age of respondent	27.3	14-47 years	27.5	15-49 years
	Women 15-49 years	181	62%	59	16%

Profile of women	Pregnant women	96	33%	113	31%
Profile of children	Child 0-23 months	117	40%	165	45%
	Child 24-59 months	39	13%	45	12%

RESULTS FROM CLIENT EXIT INTERVIEW

Table 1. Client Profile: Child 0-23 months (response per mother)				
		2013 (N=117)	2015 (N=165)	Diff.
Child Sick today?	Yes	98%	92%	-7%
	No	2%	8%	7%
Type of care received today	Vaccination	11%	11%	0%
	Nutrition	2%	1%	-1%
	Vit A	0%	2%	2%
	ARI treatment	19%	17%	-2%
	Diarrhea treatment	38%	39%	0%
	Malaria*	0%	32%	32%
	Fever	46%	53%	7%
	Other	38%	42%	4%
Health education/information received from health provider today	Education about child nutrition	40%	26%	-14%
	Education about exclusive breastfeeding*	77%	33%	-44%
	Feeding solid food/semi-solid/broth 3 times per day	64%	70%	6%
	Received other nutrition information	34%	16%	-18%
Mother started breast-feeding during first hour of birth	Yes	82%	78%	-4%
Source of early breast feeding information (multiple responses apply)	Nurse*	7%	61%	54%
	Doctor	1%	5%	4%
	TBA	9%	1%	-7%
	Mother	16%	19%	3%
	Mother-in-law	4%	4%	0%
	Husband	0%	2%	2%
	Other family member	5%	5%	0%
	Friend	4%	6%	2%
	Other sources	18%	7%	-11%
Child Nutrition practices	Mother exclusively breast-fed baby	42%	28%	-14%
	Mother also gave the child mixed food	51%	69%	18%
	Child ate solid food/semi-solid food/broth at least 3 meals yesterday	35%	41%	6%

Table 1. Client Profile: Child 0-23 months (response per mother)				
		2013 (N=117)	2015 (N=165)	Diff.
Services and health education received by child at health facility	Child received a dose of Vit A in past 6 months	67%	70%	4%
	Child was weighed	61%	56%	-5%
	Child height or length measured	13%	12%	-1%
	Mother informed about child's growth	26%	22%	-3%
	Mother has child's vaccination card with her	20%	13%	-7%
	Child received BCG before first birthday	84%	75%	-9%
	Child received OPV before first birthday	65%	69%	4%
	Child received 3 doses of DPT before first birthday	56%	61%	5%
	Child received Measles vaccine before first birthday	44%	48%	4%
	Child received 3 doses of Hep B vaccine before first birthday	43%	56%	14%
	Child received Yellow fever vaccine before first birthday	37%	40%	3%
Mother's knowledge and practice for child pneumonia	Mother knows two danger signs of child pneumonia	49%	55%	6%
	Mother bought child to HC in last 2 weeks due to suspected child pneumonia	21%	21%	0%
	Mother thought child has pneumonia, treated with antibiotics	96%	86%	-10%
	Mother already have child treated for pneumonia by someone else before coming to HC*	64%	37%	-27%
Source of consultation for pneumonia prior to coming at the health facility	Family member	20%	17%	-3%
	Friend/neighbor	8%	14%	6%
	Traditional healer	4%	0%	-4%
	Traditional midwife	4%	0%	-4%
	CHW	8%	3%	-5%
	Informal health worker	8%	0%	-8%
	Other	12%	3%	-9%
Mother's knowledge and practice for child diarrhea	Child had diarrhea in the past 2 weeks	52%	53%	1%
	Mother gave ORS for diarrhea	84%	72%	-12%
	Mother continued feeding the child during diarrhea	87%	68%	-19%
	Mother bought child today for diarrhea treatment*	70%	92%	22%
Mother's knowledge and practice for child fever or malaria	Child had fever in past 2 weeks	67%	77%	10%
	Child received malaria treatment within 24 hours of fever	79%	83%	3%
	Child slept under ITN during this year	64%	68%	4%
	Child slept under ITN last night	79%	73%	-5%
	Mother knows sign/symptoms of malaria requiring treatment right away	75%	77%	2%
	Mother knows sign/symptoms of malaria: Fever	68%	85%	17%
	Mother knows sign/symptoms of malaria : Headache	18%	12%	-6%
	Mother knows sign/symptoms of malaria : Other	41%	50%	9%

Table 1. Client Profile: Child 0-23 months (response per mother)				
		2013 (N=117)	2015 (N=165)	Diff.
Prenatal and delivery services received by mother while pregnant with youngest child	Number of prenatal visit : None	7%	2%	-4%
	Number of prenatal visit : Between 1 to 3	43%	42%	0%
	Number of prenatal visit : At least 4	50%	55%	6%
	Mother received 2 shots of Tetanus vaccine	72%	74%	2%
	Received Vit A within 2 months of childbirth	51%	54%	3%
	Assisted by a qualified medical professional during childbirth	79%	75%	-5%
	Mother delivered child in a health facility	82%	84%	2%
	Mother examined by a qualified medical professional within 3 days of childbirth	58%	71%	13%
	Women heard of fistula	28%	21%	-8%
WASH intervention access and use	Has access to potable water source	53%	55%	2%
	Use appropriate method to treat potable	20%	14%	-6%
	Use improved sanitary facility other than public facilities	38%	25%	-13%
	Has soap and water for washing hands	31%	25%	-6%
	Soap available at household	57%	64%	7%

Table 2. Client Profile: Pregnant Women				
		2013 (N=96)	2015 (N=112)	Diff.
Seeking care today?	Yes	94%	99%	5%
	No	6%	0%	-6%
Type of care received today	Prenatal care	81%	82%	1%
Type of care received in past	Iron/folic acid received at health center*	61%	29%	-32%
	TB screening last year	16%	12%	-4%
	HIV counselling	33%	32%	-1%
	Received HIV test results*	69%	89%	20%
	Received HIV test results among those tested at the HC	77%	69%	-9%
	Partner screen and received results*	82%	53%	-29%
	Couples counselling*	82%	53%	-29%
	Received 2 doses of malaria prevention drugs	51%	44%	-7%
Have access to health information	Received health info specific for women/girl	49%	42%	-6%
	Received SMS text health messages	2%	7%	5%
	Informed of danger signs	70%	71%	1%
	Informed about complication requiring immediate attention	72%	69%	-3%
WASH intervention access and use	Have access to source of potable water	44%	58%	15%
	Have access to Improved sanitary facilities	33%	21%	-12%
Behavior: usage of ITN	Currently Use ITN*	81%	61%	-20%
	Used last night among those who use ITNs	88%	87%	-2%

ANNEX K: BIBLIOGRAPHY

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