DRC-IHPplus
Integrated Health Project Plus
in the Democratic Republic of the Congo

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Revised Final
DRC-IHPplus Quarterly Report: Year 1, Quarter Three (January 1-March 31, 2016)
Subagreement Number OAA-A-11-00024-01-MSH under
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Cover photo: Albertine Tshibuabua cradles her new twins as she receives instructions on breastfeeding from a provider at the Bilomba General Referral Hospital. Lessons learned from IHPplus-supported trainings helped hospital staff to safely deliver the twins when Albertine went into convulsions during labor.

Project Name: Integrated Health Project Plus (IHPplus) in the Democratic Republic of Congo, Subagreement No. OAA-A-11-00024-01-MSH, Under Cooperative Agreement Number: AID-OAA-A-11-00024

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ACRONYMS

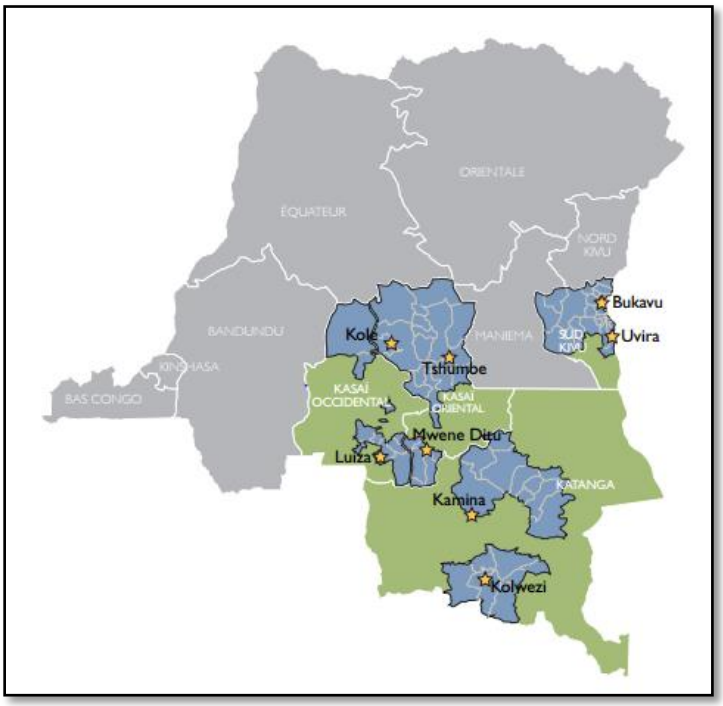
ACT	Artemisinin-based Combination Therapy
AFP	Acute flaccid paralysis
AMTSL	Active Management of Third Stage Labor
ANC	Antenatal care
AOP	Annual operational plan
ART	Antiretroviral therapy
BBF	Brother's Brother Foundation
BCC	Behavior Change Communication
CBD	Community-based distribution or community-based distributor
CBO	Community-based organization
CPLT	Coordination Unit for Leprosy and TB
i-CCM	Integrated Community Case Management
CHW	Community health worker
CODESA	*Comité de Développement Sanitaire* (health development committee)
CDR	*Centrale de Distribution Régionale* (regional distribution center)
CEPAC	*Communauté Eglises Pentecôtistes en Afrique Centrale*
CPA	Complementary Package of Activities
CLTS	Community-led total sanitation
CSDT	*Centre de Santé de Diagnostic et Traitement*
CYP	Couple Years of Protection
DEP	*Direction Etudes et Planification* (Direction of Studies and Planning)
DPS	*Division Provinciale de la Santé*
DRC	Democratic Republic of the Congo
E2A	Evidence to Action
EGM	Essential generic medicines
EPI	Expanded Program on Immunization
ETL	Education through listening
FOSACOF	*Formation Sanitaire Complètement Fonctionnelle* (Fully Functional Service Delivery Point)
GBV	Gender-based violence
GRH	General referral hospital
HIV	Human Immunodeficiency Virus
IHP	Integrated Health Project
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent preventive treatment (of malaria) in pregnancy
IRC	International Rescue Committee
IYCF	Infant and young child feeding
LDP	Leadership Development Program
LLIN	Long-lasting insecticide-treated net
MDR-TB	Multidrug-resistant tuberculosis
MOH	Ministry of Health
MNCH	Maternal, newborn, and child health
MPA	Minimum Package of Activities
MSH	Management Sciences for Health
NACP	National Aids Control Program
NGO	Nongovernmental organization
ORS	Oral rehydration solution
OSC	Overseas Strategic Consulting, Ltd.
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
PNAM	*Programme National d'Approvisionnement en Médicaments* (National Drug Supply Program)
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
PNLT	*Plan National de Lutte contre la Tuberculose* (National Tuberculosis Control program)

PNLP	*Programme National de Lutte Contre le Paludisme* (National Malaria Control Program)
ProVIC	Integrated HIV Program
PRONANUT	*Programme National de Nutrition*
RBF	Results-Based Financing
RDQA	Routine Data Quality Assessment
RDT	Rapid diagnostic test
SBA	Skilled birth attendant
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SP	Sulfadoxine Pyrimethamine
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

PROJECT BACKGROUND

This report covers the third quarter reporting period (January 1 – March 31, 2016) of Year 1 of the USAID-funded Integrated Health Project Plus (IHPplus) in the Democratic Republic of Congo (DRC). Implemented by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd (OSC) under a subcontract via Pathfinder/Evidence to Action (E2A), IHPplus is a two-year "bridge" to avoid a gap in services in USAID-supported health zones upon completion of the USAID Health Office's current five-year flagship Integrated Health Project (IHP).

DRC-IHP worked closely with the Government of the DRC to strengthen the country's health system at every level and achieve the Ministry of Health (MOH) targets of saving 437,000 lives of children and mothers over five years. Data modeling using the Lives Saved Tool (LiST) shows that DRC-IHP interventions saved the lives of more than 150,000 children over just three years. The project improved health services for more than 12 million people—17 percent of the Congolese population.



Continuing the work of DRC-IHP, IHPplus addresses "Services" and "Other Health Systems" to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in 83 health zones (the IHP 78 plus 5 additional President's Malaria Initiative [PMI]-focused zones), all within the same eight *Divisions Provinciales de Santé (DPS)*: 1) Kasaï; 2) Kasaï Central; 3) Lomami; 4) Kasaï Oriental; 5) Sankuru; 6) Haut Lomami; 7) Lualaba; and 8) Sud Kivu (formerly the four provinces of Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu).

The project provides varying levels of effort and support to 1,562 health facilities: 1,479 health centers and 83 general referral hospitals (GRHs) in 83 health zones. In addition to maintaining its project office in Kinshasa to facilitate communication with the DRC MOH, other host government authorities, and USAID, IHPplus has eight coordination offices to facilitate activity implementation at the field level (see box below). To ensure the continuity of reporting by coordination offices set up during IHP, IHPplus reports its achievements based on the coordination "clusters" of Bukavu, Kamina, Kolwezi, Lodja, Luiza, Mwene Ditu, Tshumbe, and Uvira.

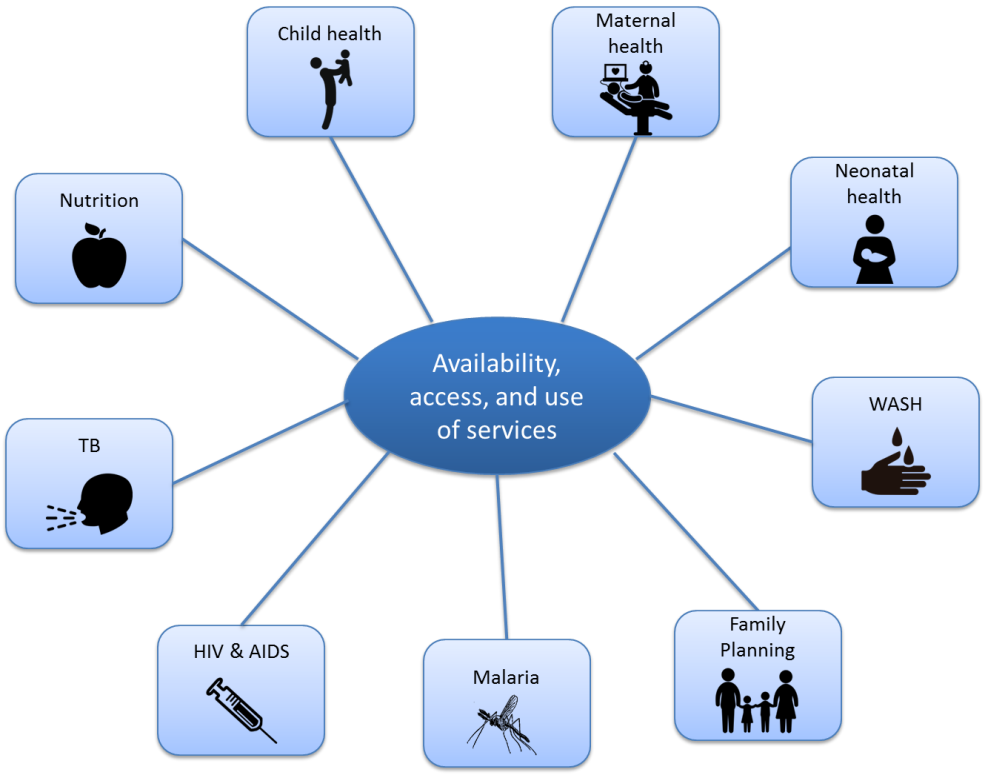
Bukavu Representation and Coordination Office – 27 health zones
Kamina Coordination Office – 9 health zones
Kananga Representation and Coordination Office – 10 health zones
Mwene Ditu Coordination Office – 13 health zones
Lodja Coordination Office – 16 health zones
Kolwezi Coordination Office – 8 health zones
Lubumbashi Representation office
Mbuji Mayi Representation office
Total population served: 13,882,943

The project's **vision** is that:

- People in the 83 project health zones will continue to participate more fully in determining their health outcomes by virtue of greater access to higher-quality comprehensive care
- Service delivery systems will be accountably and effectively managed in their interests
- Family-centered communication will reflect healthy behaviors that people understand and can act on in their daily lives.

The overarching objective of the project is 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 AIDS, and water/sanitation/hygiene (WASH) in target health zones (see Figure 1).

Figure 1: IHPplus objective and focus areas



The project reinforces a people- and team-centered approach to strengthening the health system in DRC, with a focus on four intermediate results detailed in Table 1 below.

The USAID/DRC Health Office is designing a new portfolio of programs to continue the investments begun by its two flagship service delivery programs: the Integrated HIV Program (ProVIC) and IHP. These two programs ended before the new programs could be launched; therefore, to avoid major disruptions in services, among other negative possibilities, the mission continued key activities from both of these programs through the USAID/Washington-managed mechanism, Evidence to Action (E2A). E2A serves as a crucial "bridge mechanism." The prime implementing agencies for IHP and ProVIC, MSH and PATH, respectively, are both members of the E2A consortium.

Table 1: DRC-IHPplus Results Framework

Component 1: Services	Strategies by Sub-IR
Intermediate Result 1: Access to and availability of Minimum Package of Activities (MPA)-plus and Complementary Package of Activities (CPA)-plus services and products in target health zones increased	**IR 1.1:** Increased facility-based health care services/products • Provide materials and equipment • Provide essential medicines, commodities, and materials
	IR 1.2: Increased community-based health care services/ products • Integrated Community Case Management (i-CCM) at community treatment sites • *Comité de Développement Sanitaire* or health development committee (CODESA) - collaborative strategy at the community level
	IR 1.3 Effectively engaged provincial management • Leadership Development Program
Intermediate Result 2: Quality of key family health care services (MPA/CPA-plus) in target health zones increased	**IR 2.1:** Clinical and managerial capacity of health care providers • Training, supportive supervision
	IR 2.2: Minimum quality standards • Fully Functional Service Delivery Point (FOSACOF) • Results-based financing (RBF)
	IR 2.3: PHC referral system for prevention, care and treatment
Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones	**IR 3.1:** Health sector-community outreach linkages • CODESA • Youth outreach groups
	IR 3.2: Health advocacy/community mobilization organizations • Education Through Listening • CODESA
	IR 3.3 Behavior change campaigns • Behavior change communication (BCC) messaging • Mini-campaigns • Champion Communities
Component 2: Other Health Systems	
Intermediate Result 4: Health sector leadership and governance in target provinces improved	**IR 4.1:** Health sector policy alignment
	IR 4.2: Evidence-based strategic planning and decision-making
	IR 4.3: Community involvement in health policy/service delivery

EXECUTIVE SUMMARY

PROJECT PERFORMANCE

IHPplus continues to track results for 15 groups of technical area indicators according to the project's Performance Monitoring Plan (PMP). These areas include the following:

- Family planning
- Maternal, newborn and child health (MNCH)

- Nutrition
- Tuberculosis (TB)
- HIV and AIDS
- Malaria
- Water and sanitation (WASH)
- Leadership, management, and governance (LMG)
- Gender and gender-based violence (GBV)
- Referral systems
- Stock-outs of pharmaceuticals
- Health service quality and availability
- Community mobilization
- Behavior change communication (BCC)
- Project management

Of the 81 IHPplus indicators, 47 were achieved at the 75% or greater level; of these, 31 surpassed their targets at the 100% level. Five of the new HIV indicators were not applicable this quarter. IHPplus made notable improvements in **increasing facility-based health care services and products** in target health zones. All health centers targeted during the quarter are providing the MPA, and the project exceeded the target number of GRHs providing CPA. Also, the health services utilization rate for each of the eight coordination zones surpassed the national average of 35% during the quarter.

Working in close collaboration with IHPplus, the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) program helps ensure the **availability of essential generic medicines** (EGM) at all IHPplus-supported sites. SIAPS continued to monitor the IHPplus PY1 order with suppliers IDA, IMRES, MEG, and ASRAMES, and to date, the regional distribution centers (CDRs) and warehouses have received 28% of the total expected delivery from these four suppliers. Moreover, 93% of the first IHP PY5 order has reached the health zones, and the second IHP PY5 order is still being delivered to all CDRs, concurrent with the remaining IHPplus PY1 deliveries. Finally, for IHPplus PY1 order #2, the first shipment arrived in DRC on April 28, 2016, and amounts to 17% of the order's total expected value. Reducing stock-outs of tracer medicines remains challenging, although several gains were achieved during the quarter. Strong performance was noted in reducing the number of stock-outs for folic acid and oral rehydration solution (ORS). The project exceeded the target for folic acid and almost achieved its target related to stock-outs of ORS, whereas the number of stock-outs for ACT and Depo-Provera were higher than last quarter and did not achieve their respective targets.

The **i-CCM strategy** remains effective for increasing community-based health care services. In total, 50,896 cases of malaria (21,364), pneumonia (10,994), and diarrhea (18,538) were treated at i-CCM sites during the quarter. IHPplus continued to treat cases of **childhood pneumonia, diarrhea, and malaria** in all United States Government (USG)-supported facilities. A total of 115,009 children with pneumonia were treated with antibiotics (95% of the target); 164,316 new cases of childhood diarrhea were treated with packs of combined ORS and zinc supplements (108% of the target); and 304,155 children with malaria were treated during the quarter.

Health Development Committees (CODESAs) continue to play an important role in increasing the use of community health care services. The number of identified CODESA for this quarter was 1,398, and out of these, 1,295 were reported as active. In addition, 94% of these active CODESAs have communication action plans for addressing health problems through locally-proposed solutions.

Project performance in increasing **community-based WASH** services improved compared to the last quarter, as IHPplus achieved its target for bringing access to improved drinking water supply (162,741, or 103% of the targeted population) and almost achieved the target for sanitation facilities (89,149 people, or 84% of the targeted population). Strong performance was also recorded in increasing nutritional counseling services for mothers, as 104% (177,885 of 170,478) of targeted mothers received these services.

Results from the provincial teams participating in the **Leadership Development Program** (LDP) are promising. During the quarter, the project evaluated 59 of 78 (80%) health zone management teams that started their LDPs in August 2015; 47 of the 59 teams (80%) achieved at least 80% of the targets for improving service delivery in their action plans between October and December 2015.

IHPplus continues to make great strides towards **improving quality health care services**. Results were particularly strong in the areas of MNCH, nutrition, HIV, malaria, and LDP. The project exceeded targets for several **HIV** indicators, including the percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women and the number of HIV-positive adults and children receiving a minimum of one clinical service, among others.

The project met its target for **MNCH** indicators related to pregnant women attending antenatal care (ANC), receiving active management of the third stage of labor, and newborns receiving newborn care. The project fell slightly below the PMP targets for other indicators related to deliveries with a skilled birth attendant (SBA), the number of newborns receiving antibiotic treatment for infection from appropriate health workers, and the number of postpartum/newborn visits within three days of birth that occurred during this quarter. **Vaccination** coverage rates remain high, as four out of seven vaccines had a coverage rate of 99% or greater (DTP HepB-Hib1 and Hib3, Tetanus vaccine 2+, and measles). These results contribute to improved child health in IHPplus-supported health zones. The project performed relatively well in improving **malaria prevention** among pregnant women with intermittent preventive treatment (IPTp), as it was very shy of meeting its targets in this area with 99% achievement rate. With regards to the purchase and delivery of malaria commodities, IHPplus' performance was strong, as all results almost met (one indicator) or exceeded targets (three indicators) for the provision of long-lasting insecticide-treated nets (LLINs), Sulfadoxine-Pyrimethamine (SP), Artemisinin-based Combination Therapy (ACT), and rapid diagnostic tests (RDTs) at health facilities. However, the project malaria indicators who faced challenges during this quarter were the ones related to ACT stock outs and number of health workers trained in malaria case management, including prevention and diagnosis.

In **family planning**, the project achieved a couple-year of protection (CYP) of 140,143, compared to the target of 144,873 (97% achievement rate). Moreover, IHPplus almost met its target on the number of counseling visits for family planning and reproductive health (96% achievement rate) the number of new acceptors of modern contraceptive methods (88%). However, the project was well below its target on the number of Depo-Provera stock outs reported this quarter.

In **nutrition**, 177,885 expected mothers with children two years of age or younger received counseling, against a target of 170,478 (104% achievement). Moreover, 132% (176,801 out of 134,107 expected) of pregnant women received iron-folate supplements (against a target of 89%,which represents a 149% achievement rate). Finally, only 167 facilities of the 200 expected experienced stock-outs in folic acid. Performance against **TB and GBV** indicators was weaker. While the case detection rate reached its target, other TB indicators (case notification rate, percent of all registered TB patients who are tested

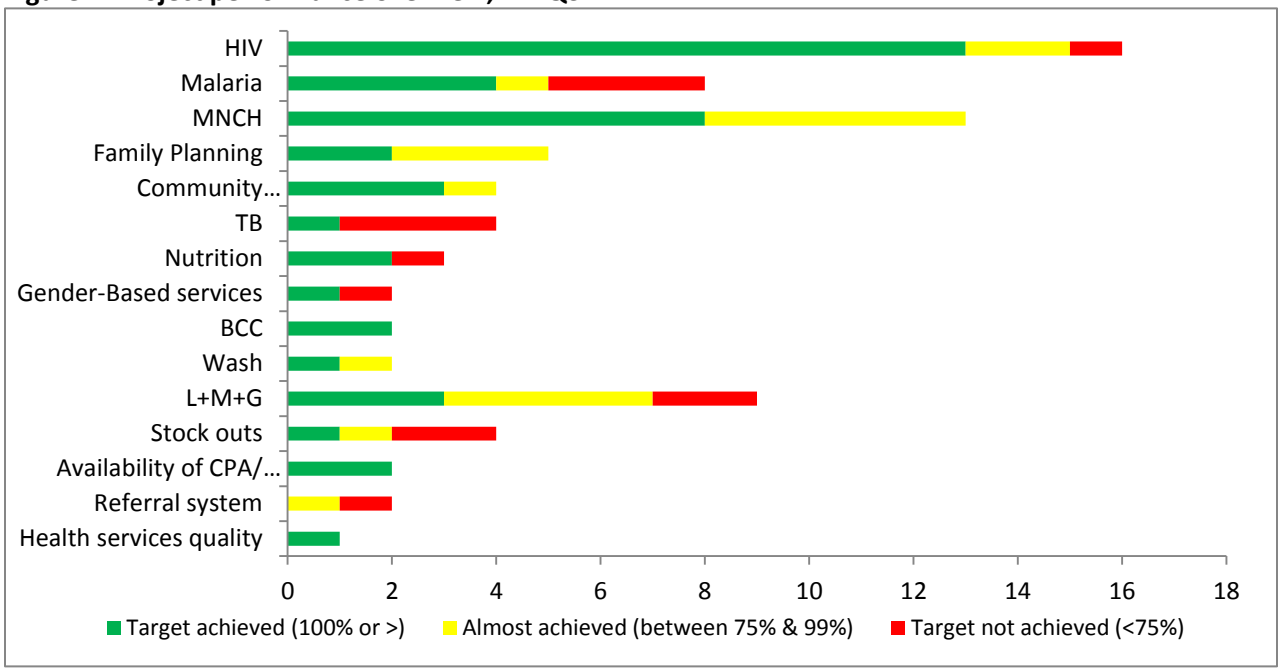
for HIV and number of multi-resistant drugs TB cases) fell below targets. One **GBV** indicator exceeded its target (number of people reached by a USG-supported intervention providing GBV services).

IHPplus continues to implement the ***Formation Sanitaire Complètement Fonctionnelle*** **(Fully Functional Service Delivery Point, or FOSACOF) and Results-based Financing (RBF)** approaches to promote the adoption of minimum quality standards at health facilities and improve the quality of care. IHPplus evaluated 55% of the total health facilities implementing FOSACOF. Results from these evaluations indicate that most facilities (79%) meet 50-80% of the criteria, and additional support is needed to increase performance. RBF evaluations demonstrate that the RBF approach contributed to significant increases in the utilization rate of curative services and the quality of health center and GRH services.

Increasing the number of **patient referrals** to health facilities is an important aspect of improving the quality of health services provided to the community. During the quarter, the percentage of patients referred to GRHs and health centers after being seen by a community health worker (CHW) or health care provider was 4% (77% achievement rate) and 8% (54% achievement rate), respectively.

Project performance in **increasing knowledge, attitudes, and practices to support health-seeking behaviors** was strong, as the project met or exceeded all targets for indicators in this area, including the percent of youth organizations that are actively completing awareness-raising activities, number of fully functional CODESAs, and the number of educational messages disseminated through mini-campaigns and mHealth technology. IHPplus currently supports 34 Champion Communities in all supported health zones, of which 32 are active.

Figure 2: Project performance overview, PY1Q3



KEY ACHIEVEMENTS

Figure 3 below presents key achievements from the quarter.

Figure 3: In PY1Q3, USG-supported health facilities and community care sites in IHP-targeted areas provided the following:

Child health

- 115,009 child pneumonia cases were treated with antibiotics
- 164,316 child diarrhea cases were treated with ORS/ORS zinc
- 304,155 child malaria cases treated with ACT
- 113,113 children less than 12 months of age received DPT-HepB-HIB3 (97% coverage)
- 110,062 children less than 12 months of age received measles vaccine (94%

Maternal health

- 140,516 pregnant women attended at least one ANC visit
- 73,857 pregnant women attended at least four ANC visits
- 116,603 deliveries occurred with a SBA

Neonatal health

- 112,285 newborns received essential newborn care
- 8,019 newborns received antibiotic treatment for infection

WASH

- 162,741 people in target areas had first-time access to improved drinking water supply
- 89,149 people in target areas had first-time access to improved sanitation facilities

Family planning

- 140,143 Couple Years of Protection (CYP)
- 133,788 patients accepted for the first time a modern contraceptive method
- 197,178 family planning (FP)/ reproductive health (RH) counseling visits occurred

HIV & AIDS

- 15,280 individuals received testing and counseling (T&C) for HIV and received results
- 4,573 HIV-positive adults and children received a minimum of one clinical HIV service
- 3,490 adults and children received ART
- 96 HIV-positive pregnant women received antiretroviral therapy (ART)

TB

- 1,731 of all registered tuberculosis (TB) patients were tested for HIV
- 70% TB case detection rate (2,267 new smear positive TB cases detected out of 3,219 expected)
- 678 HIV-positive patients were screened for TB

Nutrition

- 176,801 pregnant women received iron-folate tablets to prevent anemia during the last five months of pregnancy
- 177,885 mothers of children 2 years of age or less received nutritional counseling

Malaria

- 99,565 pregnant women received two doses of SP for IPTp
- 140,750 LLINs were distributed at the first ANC visit and preschool consultations
- 526,200 RDTs and 1,184,139 ACT treatment purchased with USG funds were distributed to health facilities

Ye

Key challenges and way forward:

1. **Challenge:** Health facilities continue to report stock-outs of tracer medicines. During PY1Q3, ACT and Depo-Provera stock-outs exceeded the target number of stock-outs (146 stock-outs against a target of 100, and 243 stock-outs against a target of 100, respectively).
   Way forward: IHPplus and SIAPS will continue to address bottlenecks that contribute to high stock-out levels at the facility level. Consolidating the supply chain, streamlining procedures for ordering essential medicines, and building capacity to manage inventories and quantify essential medicine orders will help ensure adequate supplies of medicines and commodities throughout the system.

2. **Challenges:** There is inconsistency between the number of deliveries by skilled birth attendants and other indicators related to childbirth, such as the number of women receiving Active Management of Third Stage Labor (AMTSL) and the number of newborns receiving essential care. The norms and standards for assisted deliveries include AMTSL and essential care for newborns; therefore, the data should be similar.
   Way forward: IHPplus will conduct additional trainings (using the new MNCH competency-based training methodology) for health facilities to reinforce their knowledge and application of the skilled birth norms, and increase the number of supervision visits to health facilities to strengthen monitoring practices for deliveries.

3. **Challenge:** TB screening for HIV-positive patients remains low. In PY1Q3, 678 of the targeted 3,600 (19%) HIV-positive patients were screened for tuberculosis in an HIV care or treatment setting. The project result fell below the target of 70%, with an achievement rate of 27%.
   Way forward: IHPplus will continue to provide TB screening equipment in two coordination areas to improve performance and will continue to conduct post-training follow-up and provide on-site technical assistance to health care providers and health zone management teams.

4. **Challenge:** Project performance on the referral system was low during PY1Q3 as one indicator almost met the target (80%) and the other achieved only a little over half (54%). During this quarter, the percentage of patients referred to GRHs after being seen by a CHW or health care provider was 4%, against a PMP target of 5% (80% achievement rate) and the percentage of patients referred to health centers after being seen by a CHW is 8%, against a PMP target of 15% (54% achievement rate). For the first indicator, one of the factors for the moderate performance reported is the location of GRHs in remote areas (Kamina and Luiza coordination). However, since Kolwezi is 80% urban and still report lower referral rate, the project is still looking into the underlying reasons for the poor results reported by this coordination. For the second indicator, the project's overall performance was negatively impacted by the low level of community involvement in some coordinations (Luiza and Mwene Ditu) while other were more impacted by the lack of health zone management team supervision visits to health centers (Luiza). The Ministry of Health mobilized the CHWs during this period to contribute to a number of activities, in particular the vaccination campaign, planning process, and other activities.
   Way Forward: During the next quarter, IHPplus will procure EGM for GRHs and health centers, including community care sites, working with health zone management teams during supervision visits to health facilities to help with flow chart use and meeting planning and organization between head nurses, CHWs, and nurses working in community care sites; brief head nurses who work for health centers connected to community care sites on how to properly use the coaching checklist with CHWs; and expand the integrated community case management

approach by implementing more community care sites. The project will also expand the i-CCM approach by implementing more community care sites in Mwene Ditu and Luiza.

PROJECT PERFORMANCE

COMPONENT 1: HEALTH SERVICES

DRC's health sector faces significant challenges, with a high burden of infectious disease, insecurity in many areas, and poor infrastructure. While maternal and infant mortality rates are dropping, they remain a project priority, along with the related challenges of high rates of fertility, domestic violence, malnutrition, and poor access to services. IHPplus is helping to increase low-cost, high-impact health services, and access to them, in 83 targeted health zones. Based on innovative, evidence-based strategies, our assistance to the service delivery sector focuses on the primary health care and community levels. Activities for the quarter are summarized in Table 2 below.

Table 2: PY1Q2 health service key activities at a glance

IR	Strategy	Key activities	Targeted zones
1	**Provision of drugs, commodities, products**	• Monitored pharmaceutical management	All coordination offices
		• Conducted health zone inventory data checks	All coordination offices
		• Ordered and delivered EGM	*Centrale de Distribution Régionale* (CDRs): CEDIMEK, CADIMEK, CADMEKO, FODESA, *Communauté Eglises Pentecôtistes en Afrique Centrale* (CEPAC)
		• Procured EGM, family planning, and PMI commodities	All coordination offices
		• Procured digital hygrometers	Kinshasa and Kamina pharmaceutical warehouses
	Rehabilitation infrastructure and equipment	• Provided medical materials to RBF health centers GRH	All 7 RBF health zones
	Reinforce community care sites/ collaborative approach	• Provided EGM drugs (Ora-zinc, artemisinin combination therapy [ACT], paracetamol, amoxicillin) and management tools to community care sites	All supported health zones
		• Supervised community care sites	Health zones supported by Mwene Ditu, Kole, and Kamina coordination offices
	Community-led Total Sanitation (CLTS)- WASH	• Renovated 147 new water sources	All four health zones with WASH program
		• Constructed 12,902 new latrines	All four health zones with WASH program

		• Conducted joint supervision and monitoring	All health zones
	LDP	• Implemented Leadership Development Program (LDP) projects	All health zones
	Results-based financing	• Implemented RBF	All seven health zones with RBF programs
		• Identified new community-based organization (CBO) for community verification	Kanzenze health zone
3	**BCC**	• Launched a mini-campaign	Seven coordination offices
	Community Mobilization	• Sent 147,607 awareness-raising text messages through FrontLine SMS	All health zones with cell network (46)
4	**Routine Data Quality Assessment (RDQA)**	• Facilitated RDQA training	*Division Provinciale de Santé* (DPS) of Sud Kivu

Intermediate Result 1 (IR1): Access to and availability of Minimum Package of Activities (MPA) and Complementary Package of Activities (CPA) services and products in target health zones increased

Key IHPplus performance results, compared to targets set in the PMP, for IR1 during PY1Q2, are summarized in Table 3 below and discussed in detail in the following section.

Table 3: Summary of IR 1 key results for PY1Q3 IHP Plus by Sub-IR

Sub-IR	Key Indicators	Results
1.1 Facility-based services and products	Utilization of health care services	
	Availability of CPA/MPA	
	Availability of medicines and equipment (stock-outs)	
1.2 Community-based services and products	i-CCM – Pneumonia	
	i-CCM—Diarrhea	
	CLTS-WASH	
1.3 Leadership practices	LDP desired measureable results achieved	

***** **Green = achievement rate against the PMP target of 100% and above; Yellow = achievement rate against the PMP target between 75% and 99%; Red = achievement rate against the PMP target under 75%*

IR 1.1: Facility-based health care services and products (provincial hospitals and health zone health centers) in target health zones increased

Utilization of health care services: During PY1Q3, the health services utilization rate for all eight coordination offices surpassed the national target of 35% (see Figure 4). Seven offices increased or maintained their performance compared to PY1Q2 performance: Kole (from 47% to 48%), Kolwezi (65% for both quarters), Tshumbe (from 38 to 39%), Bukavu (from 49% to 50%), Kamina (from 39% to 43%), Mwene Ditu (from 42% to 45%) and Uvira (from 43% to 46%). Only Luiza reported a slightly lower performance (from 38% to 36%).

Figure 4: Percentage of health service utilization rate by coordination office for PY1Q3

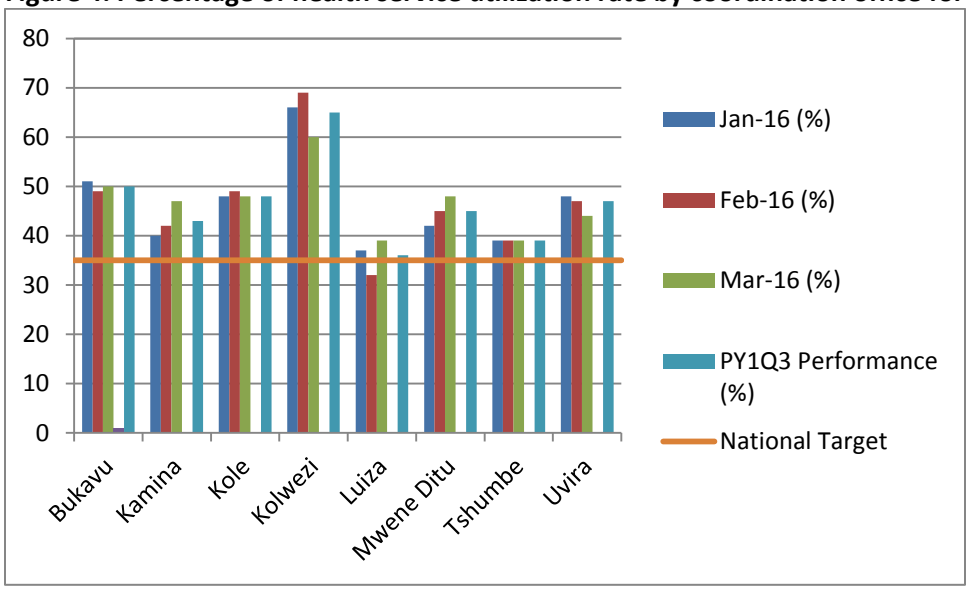


Table 4: Curative services utilization by coordination during PY1Q3

Coordination	Jan-16 (%)	Feb-16 (%)	Mar-16 (%)	PY1Q3 performance (%)	National target (%)
Bukavu	51	49	50	50	35
Kamina	40	42	47	43	35
Kole	48	49	48	48	35
Kolwezi	66	69	60	65	35
Luiza	37	32	39	36	35
Mwene Ditu	42	45	48	45	35
Tshumbe	39	39	39	39	35
Uvira	48	47	44	46	35

Availability of Health Services - Facility-based Minimum Package of Activities (MPA)/Complementary Package of Activities (CPA)*:* Building the capacity of health centers and hospitals to offer the full spectrum of health services is a key priority for IHPplus. During PY1Q3, the project reported that 90% (70/78) of GRHs were implementing CPA, against a target of 88%, representing a 102% achievement rate (see Table 5 below). During this quarter, the project also reported that 99% of the supported health centers (1,382/1,398) were offering MPA against the target of 99%, representing a 100% achievement rate (see Table 6 below). IHPplus maintained consistent performance from PY1Q2 when the same number of GRHs and health centers implemented CPA and MPA, respectively.

Table 5: Number and percent of GRH implementing a complementary package of activities CPA by coordination

Coordination	# of GRHs implementing CPA				Total # of GRHs	% of GRHs implementing CPA	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	PY1Q3 result				
Bukavu	21	21	21	21	22	95	88	108
Kamina	6	6	6	6	9	67	88	76
Kole	7	7	7	7	8	88	88	99
Kolwezi	7	7	7	7	8	88	88	99
Luiza	9	9	9	9	9	100	88	114
Mwene Ditu	8	8	8	8	9	89	88	101
Tshumbe	8	8	8	8	8	100	88	114
Uvira	4	4	4	4	5	80	88	91
Total	70	70	70	70	**78**	**90**	88	**102**

Table 6: Number and percentage of health centers implementing MPA by coordination

Coordination	# of health centers implementing MPA				Total # of health centers	% of health centers implementing MPA	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	PY1Q3 result				
Bukavu	399	399	399	399	399	100	99	101
Kamina	201	201	201	201	202	100	99	101
Kole	129	129	129	129	129	100	99	101
Kolwezi	105	105	105	105	106	99	99	100
Luiza	170	170	170	170	170	100	99	101
Mwene Ditu	168	168	168	168	171	98	99	99
Tshumbe	118	118	118	118	119	99	99	100
Uvira	92	92	92	92	102	90	99	91
Total	**1,382**	**1,382**	**1,382**	**1,382**	**1,398**	**99**	**99**	**100**

Availability of medicines, commodities, and equipment: SIAPS works with IHPplus to ensure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. SIAPS helps ensure the availability of EGM at all IHPplus-supported sites. As part of its support for IHPplus, SIAPS implemented the following activities during PY1Q3.

Ensure the availability of medications in IHP-supported health facilities: SIAPS continued to monitor the IHPplus order for PY1 with suppliers IDA, Imres, MEG, and ASRAMES, as well as the IHPplus PY1 order. SIAPS monitored both the process of obtaining all documents to facilitate the customs clearance process, and the process of transporting the goods to IHPplus-supported CDRs. To date, the CDRs and warehouses have received 28% of the total expected delivery from these four suppliers. For further details, please refer to Table 7 below:

Table 7: Commodities expected for IHPplus PY1 (from suppliers ASRAMES, IDA, Imres, and MEG)

Province	Warehouse (DRC)	Total order value (USD)	Order delivered as of April 2016	Order delivered (%)	Order remaining to deliver as of April 2016	Order remaining to deliver (%)
Sud Kivu	APAMESK, DCMP 8eCEPAC, and BDOM	$1,007,064.46	$466,328.06	46%	$540,736.40	54%
Katanga	CEDIMEK	$396,855.51	$101,891.83	26%	$294,963.68	74%
	Kolwezi	$212,883.47	$68,719.19	32%	$144,164.28	68%
Kasaï Occidental	CADIMEK	$368,982.50	$80,159.82	22%	$288,822.68	78%
Kasaï Oriental	CADMEKO	$545,197.11	$154,051.61	28%	$391,145.50	72%
	FODESA	$429,686.31	$66,804.37	16%	$362,881.94	84%
Order/Delivery Total		**$2,960,669.37**	**$937,954.88**	**28%**	**$2,022,714.48**	**72%**

For a more detailed breakdown by supplier and CDR, please refer to Appendix 4, "IHPplus Pharmaceutical Monitoring." Additional information on all deliveries received in the CDRs, including those not yet unpacked, is available in "DRC-IHPplus MSH Cargo Tracking" (Appendix 5).

To date, 93% of the first IHP PY5 order has reached the health zones (see Table 8 below). Other than Sud Kivu, all other provinces received the entirety of deliveries expected from this order. The small amount of goods remaining in the other provinces represents goods that the MOH control office (at the border) has removed for analysis (quality control). The last delivery, intended for Bukavu, was delayed at customs due to confusion with the documentation. The order has now been received and is currently being unpacked. The second IHP PY5 order is still being delivered to all CDRs, concurrently with the remaining IHPplus PY1 deliveries.

Table 8. Commodities expected for IHP PY5, emergency order #1 (supplier IDA):

Province	Warehouse (DRC)	Total order value (USD)	Order delivered as of April 2016	Order delivered (%)	Order remaining to deliver as of April 2016	Order remaining to deliver (%)
Sud Kivu	APAMESK, DCMP 8eCEPAC, and BDOM	$100,118.11	$61,405.33	61.3%	$38,712.78	38.7%
Katanga	CEDIMEK	$43,949.39	$43,928.87	100.0%	$20.52	0.0%
	Kolwezi	$37,964.25	$37,991.73	100.1%	$-27.48*	-0.1%
Kasaï Occidental	CADIMEK	$42,261.45	$42,133.18	99.7%	$128.27	0.3%
Kasaï Oriental	CADMEKO	$57,790.69	$57,743.13	99.9%	$47.56	0.1%
	FODESA	$40,249.48	$39,357.46	97.8%	$892.02	2.2%
Order/delivery total		**$322,333.37**	**$282,559.70**	**93.1%**	**$39,773.67**	**6.9%**

**The vendor delivered slightly more goods than requested.*

For IHPplus PY1 order #2, the first shipment arrived in DRC on April 28, 2016. This shipment amounts to 17% of the order's total expected value, and 27% of its total weight. ASRAMES has stored it in its warehouses in Goma and will distribute it to the CDRs. SIAPS is waiting for *notes verbales* to be issued by USAID to complete the customs clearance for this first shipment.

SIAPS also continued to support the distribution of the rest of the IHP PY4 drugs from the CDRs to the health zones by analyzing requisitions and the distribution plan and monitoring CDR deliveries to the health zones. To date, nearly all IHP PY4 deliveries have reached the health zones. Distribution is ongoing, including specific commodities for malaria and family planning.

Strengthen the management of essential medicines and medical consumables: From January 18-21, 2016, SIAPS and IHPplus conducted a drug-management training for 11 health zone management teams in Kolwezi in the Lualaba Province, in collaboration with the *Programme National d'Approvisionnement en Médicaments* (National Drug Supply Program, or PNAM). This training aimed to reinforce the technical capacity of DPS, CDRs, and health zone management teams, to manage medicines and other health commodities (see Appendix 6). In total, 40 participants took part in the training, including 32 men and 8 women. At the end of the training, participants developed a post-training action plan and had it approved by the DPS (see Appendix 7). These newly-trained staff will disseminate their knowledge by training health center service providers during PY1Q4.

In September 2015, SIAPS produced a situational analysis of the MSH warehouse in Kamina, resulting in two recommendations: equip the warehouse with office furniture and supplies, security/compliance and reporting tools, and storage equipment; and hire an additional full-time warehouse employee to manage drug stocks daily. At the beginning of March 2016, more than 50% of the total expected shipment of medical equipment was delivered to the warehouse. The shipment mainly included IT kits, office furniture, a power generator, fire extinguishers, refrigerators, and forklifts. A new drug stock manager was hired and began working in Kamina's warehouse in March 2016.

From March 27 to April 3, 2016, a joint SIAPS-IHPplus-PNAM team visited Kamina with the following objectives:

- Provide a technical orientation to the new drug stock manager
- Produce a procedures manual to improve management of the warehouse
- Monitor the response to recommendations from the evaluation that PNAM conducted at the CEDIMEK RDC in September 2015.

At the end of this visit, the team produced a procedures manual and a job description for the stock manager. They submitted both documents to the Project Directors of SIAPS and IHPplus for their approval (see Appendix 8).

Following up on the PNAM evaluation, the two PNAM delegates from the joint team reported that the CEDIMEK CDR had not yet reached the standard required to store medicines (see Appendix 9). To date, it has only met 4 of the 14 recommendations (28.6%) made by PNAM in September 2015.

As mentioned in the PY1Q2 report, alerts raised by SIAPS and involvement from the local USAID mission saved a supply of 13,665,006 male condoms that were at risk of expiring. In IHP PY5Q2 (February 2015), as a result of using the expiration-warning system that SIAPS set up as part of MSH's warehouse monitoring system, IHP identified 19,244,157 condoms that were at risk of expiring. The total estimated value of this supply was $769,766 USD. USAID was officially alerted and called an urgent meeting to

develop a redeployment plan in order to save the supply. After a year of consumption, thanks to the involvement of USAID partners, 13,665,006 of the 19,244,157 condoms (71%) were successfully distributed. Despite these joint efforts and support from USAID, the remaining 5,579,151 condoms expired in April 2016 before they could be distributed. During PY1Q2 of IHPplus, SIAPS alerted USAID that a stock of 173,571 oral contraceptives (Microgynon) in the Kinshasa warehouse was at risk of expiring as well. Unfortunately, this supply of Microgynon also expired in April 2016 before it could be distributed. The expired condoms were valued at $223,166 USD and the Microgynon was valued at $46,864 USD. These expired supplies will be destroyed during PY1Q4.

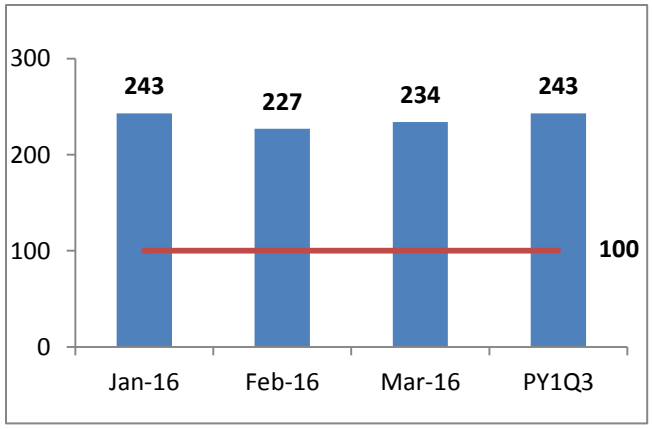
Support quarterly visits to supervise medicines management in the health zones, health facilities, and CDRs supported by IHPplus: SIAPS did not support medicines management supervision during PY1Q3. During the quarter staff time was focused on participating in trainings, conducting end-user verification surveys, and receiving goods delivered to CDRs.

Minimize tracer medicine stock-outs: Long-standing supply chain issues, which include insufficient quantity of pharmaceuticals ordered and delayed or extended delivery periods, continued to contribute to stock-outs of tracer medicines (Depo-Provera, folic acid, ACT, and oral rehydration solution [ORS]) as illustrated in Figure 5 below. The project reported a reduction in the number of facilities experiencing folic acid stock-outs (167 facilities as compared to a target of 200). The number of ORS stock-outs was very close to the target (101 stock-outs compared to the target of 100). However, facilities reporting ACT and Depo-Provera stock-out continued to exceed the target number of stock-outs (146 stock-outs against a target of 100, and 243 stock-outs against a target of 100, respectively).

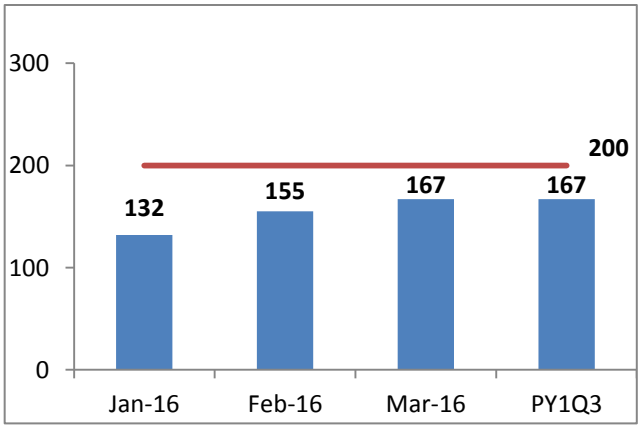
Compared to PY1Q2, IHPplus improved its performance for two stock-out indicators: the number of folic acid stocks-outs decreased from 244 to 132, and the number of ORS stock-outs decreased from 140 to 101. Project performance for the Depo-Provera and ACT stock-out indicators was lower: Depo-Provera stock-outs increased from 188 to 243, and the number of ACT stock-outs increased from 79 to 146.

Figure 5: Stock-outs of tracer medicines during PY1Q3

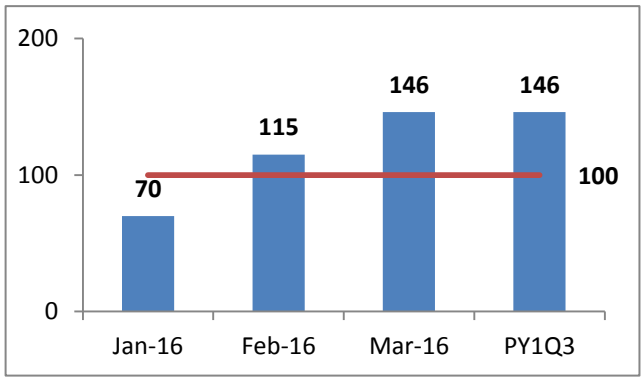
Stock-out Depo-Provera



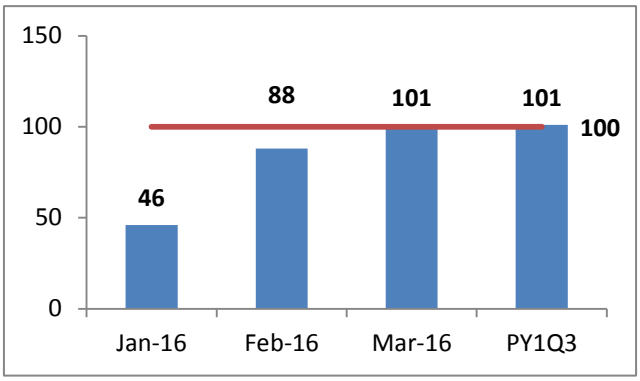
Stock-out folic acid



Stock-out ACT 1- 5 years



Stock-out ORS



As shown in Table 9 below, the Kamina coordination office reported the highest number of stock-outs for the four tracer medicines during this quarter. Kolwezi recorded the lowest number of stock-outs.

Table 9: Stock-outs of tracer medicines by coordination office

	Depo-Provera			Folic acid			ORS			ACT 1-5		
Coordination	**Jan-16**	**Feb-16**	**Mar-16**	**Jan-16**	**Feb-16**	**Mar-16**	**Jan-16**	**Feb-16**	**Mar-16**	**Jan-16**	**Feb-16**	**Mar-16**
Bukavu	21	27	14	40	57	49	9	39	36	10	30	24
Kamina	96	80	66	50	26	30	15	7	29	52	63	80
Kole	1	1	1	5	6	7	3	6	6	7	7	11
Kolwezi	0	0	1	0	15	6	0	0	0	0	13	8
Luiza	64	38	21	0	0	0	0	0	0	0	0	0
Mwene Ditu	46	64	116	23	39	46	2	18	17	0	0	0
Tshumbe	13	9	3	14	11	13	17	18	11	1	2	22
Uvira	2	8	12	0	1	16	0	0	2	0	0	1
Total	**243**	**227**	**234**	**132**	**155**	**167**	**46**	**88**	**101**	**70**	**115**	**146**

Coordination offices reported the highest number of ORS stock-outs during the month of March. Bukavu and Kamina reported the lowest performance, with 39 and 29 stock-outs, respectively, which represents two-thirds of the total number reported during PY1Q3. Delays in drug procurement and delivery to health facilities located in Shabunda and Malemba-Nkulu health zones contributed to the project's decreased performance this quarter. However, as explained earlier, the project reported an overall better performance than during PY1Q2, as Kole and Tshumbe improved their respective performance. While health facilities in both coordination areas reported extended drug delivery delays during PY1Q2, IHPplus provided adequate stock during PY1Q3 and the health facilities properly managed their stock, allowing them to report less stock-outs.

With regard to ACT stock-outs, Kamina, Bukavu, and Tshumbe contributed to lower project performance with the following stock-out rates: 80 stock-outs (up from 47 during PY1Q2), 24 stock-outs (up from 12 during PY1Q2), and 22 stock-outs (up from 2 during PY1Q2), respectively. Kamina's poor performance can be explained by flooding which affected five health zones, making them inaccessible and preventing the drugs from reaching their destination by road. Since these health zones were located near the river, the project turned to an alternative supply route (river freight), which delayed the drug supply delivery.

To prevent future stock-outs, especially during the rainy season, the project delivered more than six months of ACT supply to these health zones. Delays in ordering ACT supplies from the health zone management offices from the Mwana, Walungu, and Miti Murhesa health zones contributed to poor performance in Bukavu. During the next quarter, IHPplus is planning on working closely with the DPS to develop a circular to be distributed to health zone management offices and health facilities reminding them to order their drug supplies on time, deliver six-month's worth of procurement at a time to inaccessible health zones, and reinforce monitoring and supervision visits related to supply chain management by health zone management team to health facilities.

The continuous folic-acid stock-outs within certain health zones are due to the lack of management/ knowledge regarding average consumption of EGMs (in Pania, Mutombo, Minga, Lusambo, Katakokombe, and Tshumbe health zones), the delay in the processing of drug orders by the health centers to the health zones and the health zones to the regional distribution center, and the delay in delivery of medicines by the CDR (in Minova, Mulungu, Kalole, Kalonge, Mwana, and Mwenga health zones). Some facilities await the monthly review meetings to request and re-stock necessary medicines (Lubudi, Bunkeya, Dilala, Kanzenze, and Lubudi health zones).

Kamina and Mwene Ditu had by far the highest number of health facilities reporting Depo-Provera stock-outs, while Kole and Kolwezi had only one health facility reporting stock-out during PY1Q3. However, it should be noted that four coordination offices were able to improve their performance for this indicator during this quarter compared to the previous one: Uvira (7 down to 2), Tshumbe (28 down to 13), Kole (11 down to 1), and Kolwezi (3 down to 0).

As in previous quarters, the majority of stock-outs—such as the one for Depo-Provera reported by the health facilities—were "false" stock-outs, because the products were available in the CDRs and the central office stockrooms. Health centers did not place commodity orders on time because they had underestimated their needs, e.g., the Depo-Provera stock out was due to an incorrect calculation of the average monthly utilization of this commodity.

> **Lesson Learned:** Regular supervisions encourage the timely preparation and processing of medicine orders. If the delivery period in the health zones by the regional distribution centers is short, there will be fewer stock-outs.

Next Steps: IHPplus and SIAPS will continue to address bottlenecks that contribute to high stock-out levels at the facility level. Consolidating the supply chain, streamlining procedures for ordering essential medicines, and building capacity to manage inventories and quantify essential medicine orders will help ensure adequate supplies of medicines and commodities throughout the system.

IR 1.2: Community-based health care services and products in target health zones increased

Malaria, diarrhea, and pneumonia are the three main killers of children under five in DRC. For this reason, the MOH adopted the strategy for the Integrated Management of Childhood Illnesses (IMCI) as the main approach to reduce the child mortality rate. IHPplus supports the MOH to implement this strategy at both the clinic and community levels.

Integrated Community Case Management (i-CCM)*:* i-CCM is an equity-based strategy to increase access to effective case management for children suffering from malaria, pneumonia, and diarrhea, especially

in hard-to-reach areas and among vulnerable populations. Through i-CCM programs, community health workers (CHWs) are equipped, trained, supported, and supervised to deliver life-saving treatments, including IMCI kits, and assist with vaccination outreach strategies at community care sites. A total of 59 health zones have iCCM sites: Bukavu (11), Uvira (4), Kolwezi (7), Kamina (9), Luiza (10), Mwene Ditu (7), Tshumbe (5), and Kole (6).

During PY1Q3, IHPplus continued to support 776 community care sites where a total of 50,896 cases of malaria (21,364), pneumonia (10,994), and diarrhea (18,538) were treated (see Table 10 below). Compared to PY1Q2, when 49,547 cases were treated, the project improved its performance. This progression was driven by the increase in the number of pneumonia cases treated (from 10,428 to 10,994) and the number of diarrhea cases treated (from 17,074 to 18,538).

IHPplus staff monitored health center nurses to make sure they were providing monthly supervision visits to CHWs and ensured continuous availability of essential drugs to be distributed by CHWs, which positively impacted the project's performance. The project also planned to establish approximately 55 new community care sites in Miabi, Kasansa, and Kabinda health zones; however, it was not possible due to the DPS conflicting calendar of activities. IHPplus will continue to work to establish these new sites in the next quarter.

Kamina and Mwene Ditu coordination offices reported the highest number of cases treated, of all diseases combined. IHPplus provides stipends to health centers to supervise community care centers and research pre-referral treatment of the most severe cases of malaria, which is one of the contributing factors to the strong performance in these areas. The availability of malaria, diarrhea, and pneumonia commodities at community care sites also played an important role in improving the health service utilization rates for these specific diseases. While Uvira still reports the lowest number of cases treated for this quarter, its performance compared to PY1Q2 increased from 903 cases treated (all diseases combined) to 1,280.This improvement is related to the supervision stipends provided to health centers to supervise community care centers which was introduced to Uvira during this quarter, coupled with the briefings on community care site supervision visits organized by the project staff with nurses working in Uvira (which included training on the correct use of the supervision visit checklist).

Table 10: Pneumonia, diarrhea, and malaria cases treated through i-CCM sites during PY1Q3

	Diarrhea			Pneumonia			Malaria			Total PY1Q3		
Coordination	**Jan-16**	**Feb-16**	**Mar-16**	**Jan-16**	**Feb-16**	**Mar-16**	**Jan-16**	**Feb-16**	**Mar-16**	**Diarrhea**	**Pneumonia**	**Malaria**
Bukavu	327	609	397	71	771	207	732	236	522	1,333	1,049	1,490
Kamina	2,291	1,710	1,902	816	1,206	1,207	7,509	1,009	1,190	5,903	3,229	9,708
Kole	1,387	1,530	1,643	554	688	697	424	264	266	4,560	1,939	954
Kolwezi	87	180	608	52	99	106	83	545	453	875	257	1,081
Luiza	747	417	747	364	297	244	1,529	161	1,308	1,911	905	2,998
Mwene Ditu	660	642	632	679	629	621	2,032	950	334	1,934	1,929	3,316
Tshumbe	346	617	573	263	563	634	547	351	351	1,536	1,460	1,249
Uvira	206	170	110	105	52	69	249	135	184	486	226	568
Total	**6,051**	**5,875**	**6,612**	**2,904**	**4,305**	**3,785**	**13,105**	**3,651**	**4,608**	**18,538**	**10,994**	**21,364**

i-CCM and other health facilities supported by IHPplus

Pneumonia: For PY1Q3, IHPplus combined treatment sites reported 115,009 children presenting pneumonia symptoms and treated with antibiotics (such as amoxicillin), which represents 95% of the expected results (see Table 11 below). Compared to PY1Q2, when 104,711 cases were treated, the project improved performance during the quarter. Bukavu reported a little more than a quarter of the total number of pneumonia cases treated, and several factors played a positive role in this performance: the larger size of the population supported by the project in that coordination; the relatively high number of supervision visits led by the health zone management team focusing on monitoring of drug management and proper pneumonia health care; and the high availability of dispersible amoxicillin 250mg in the health facilities. Coverage rates remained low in Kolwezi (47% of achievement rate against target), mainly due to low data reporting from community care sites coupled with a delay in procurement of EGM in some health zones such as Lubudi.

Overall, community care sites treated nearly 10% of the total cases, indicating continued progress at that level. Ultimately, the project aims to see the number of pneumonia cases treated in both health facilities and i-CCM sites decrease over the quarters, as the PCV-13 coverage increases due to IHPplus support to the national Expanded Program on Immunization (EPI).

Table 11: Number of cases of childhood pneumonia treated with antibiotics in US Government (USG)-supported facilities and i-CCM sites

	Jan-16			Feb-16			Mar-16			Total PY1Q3			Target	Achievement (%)
Coordination	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total		
Bukavu	11,325	71	11,396	10,081	771	10,852	9,185	207	9,392	30,591	1,049	31,640	34,963	**72%**
Kamina	6,247	816	7,063	7,027	1,206	8,233	5,931	1,207	7,138	19,205	3,229	22,434	19,290	**92%**
Kole	2,650	554	3,204	2,895	688	3,583	2,726	697	3,423	8,271	1,939	10,210	8,439	**96%**
Kolwezi	1,296	52	1,348	1,569	99	1,668	1,838	106	1,944	4,703	257	4,960	8,439	**47%**
Luiza	3,526	364	3,890	3,234	297	3,531	3,404	244	3,648	10,164	905	11,069	13,262	**66%**
Mwene Ditu	5,275	679	5,954	5,496	629	6,125	5,140	621	5,761	15,911	1,929	17,840	19,290	**73%**
Tshumbe	2,136	263	2,399	2,141	563	2,704	1,932	634	2,566	6,209	1,460	7,669	8,439	**72%**
Uvira	2,524	105	2,629	3,234	52	3,286	3,203	69	3,272	8,961	226	9,187	8,439	**86%**
Total	**34,979**	**2,904**	**37,883**	**35,677**	**4,305**	**39,982**	**33,359**	**3,785**	**37,144**	**104,015**	**10,994**	**115,009**	**120,563**	**95%**

Diarrhea: As shown in Table 12 below, during PY1Q3, the project exceeded its target (108% achievement rate), with 164,316 new cases of diarrhea treated with packs of ORS and zinc supplements. Compared to PY1Q2, the number of diarrhea cases treated increased (155,695). In addition, the percentage of diarrhea cases treated in community care sites remained the same as during PY1Q2 (11%). Finally, Bukavu reported the best performance while Kolwezi performed the lowest in this indicator, for the same reasons listed above in the pneumonia section.

Ultimately, the project aims to see the number of diarrhea cases treated in both health facilities and i-CCM sites decrease over the quarters due to the positive impact of the project's WASH activities, which includes the construction or modification of hygienic latrines and safe drinking water systems.

Table 12: Number of children under five years old with diarrhea treated with ORS or ORS plus zinc supplements in USG-supported facilities

	Jan-16			Feb-16			Mar-16			Total PY1Q3			Target	Achievement (%)
Coordination	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total		
Bukavu	12,779	327	13,106	13,547	609	14,156	10,518	397	10,915	36,844	1,333	38,177	44,085	**47%**
Kamina	7,089	2,291	9,380	7,527	1,710	9,237	8,613	1,902	10,515	23,229	5,903	29,132	24,323	**120%**
Kole	4,861	1,387	6,248	4,649	1,530	6,179	5,401	1,643	7,044	14,911	4,560	19,471	10,641	**183%**
Kolwezi	1,316	87	1,403	1,944	180	2,124	2,440	608	3,048	5,700	875	6,575	10,641	**62%**
Luiza	5,218	747	5,965	5,099	417	5,516	5,746	747	6,493	16,063	1,911	17,974	16,722	**107%**
Mwene Ditu	7,024	660	7,684	8,469	642	9,111	7,487	632	8,119	22,980	1,934	24,914	24,323	**102%**
Tshumbe	3,295	346	3,641	3,487	617	4,104	3,327	573	3,900	10,109	1,536	11,645	10,641	**109%**
Uvira	6,541	206	6,747	6,528	170	6,698	2,873	110	2,983	15,942	486	16,428	10,641	**154%**
Total	**48,123**	**6,051**	**54,174**	**51,250**	**5,875**	**57,125**	**46,405**	**6,612**	**53,017**	**145,778**	**18,538**	**164,316**	**152,017**	**108%**

Malaria: As shown in Table 13 below, during PY1Q3, the total number of children under the age of five with malaria treated in USG-supported facilities reached 304,155, an increase from the 212,923 children treated in PY1Q2. The highest number of children treated was reported by Bukavu (67,951 cases treated), while the lowest performance by far was reported by Kolwezi (17,861 cases treated).

Table 13: Number of children under five years old with malaria treated in USG-supported facilities in PY1Q3 IHPplus

	Jan-16			Feb-15			Mar-15			PY1Q3		
Coordination	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total	Health facility	i-CCM site	Total PY1Q3
Bukavu	21,558	732	22,290	21,611	236	21,847	21,802	522	22,324	66,461	1,490	67,951
Kamina	17,366	7,509	24,875	13,241	1,009	14,250	14,889	1,190	16,079	55,204	9,708	64,912
Kole	6,580	424	7,004	8,215	264	8,479	8,026	266	8,292	23,775	954	24,729
Kolwezi	4,786	83	4,869	5,443	545	5,988	5,470	453	5,923	16,780	1,081	17,861
Luiza	9,722	1,529	11,251	8243	161	8,404	10,366	1,308	11,674	31,329	2,998	34,327
Mwene Ditu	13,569	2,032	15,601	16,229	950	17,179	17,795	334	18,129	50,909	3,316	54,225
Tshumbe	5,695	547	6,242	5,483	351	5,834	4,981	351	5,332	17,408	1,249	18,657
Uvira	6,708	249	6,957	6,897	135	7,032	6,752	184	6,936	20,925	568	21,493
Total	**85,984**	**13,105**	**99,089**	**85,362**	**3,651**	**89,013**	**90,081**	**4,608**	**94,689**	**282,791**	**21,364**	**304,155**

Challenge: Maintaining availability of medicines in health facilities and management tools.

Next steps:

- Maintain performance gains in the management of malaria, pneumonia, and diarrhea at the community and clinic levels
- Maintain regular procurement of health commodities and medicines at health center and i-CCM sites
- Revitalize 10 community care sites in Kalenda health zone and establish 40 new ones in the new IHPplus health zones: Miabi (7), Kabinda (21), and Kansasa (12)

- Train 64 CHWs in i-CCM case management
- Support the health zone management teams from Kole and Tshumbe health zones in monitoring proper management and use of EGM in health facilities and community care sites

CODESA (Health Development Committees): CODESA activities—such as leading awareness-raising and community mobilization activities and providing referrals to local health centers—are an important contribution to increasing the use of community health care services and products in target health zones. To facilitate these activities, IHPplus provides regular financial support to all CODESAs in its target regions in the form of fixed subsidies, as well as managerial support to assist CODESAs in monitoring their own activities and conducting monthly meetings. This support is essential to CODESA functionality in IHPplus target communities.

IHPplus assists CODESAs in developing and implementing self-designed solutions to community health problems they have identified. Locally proposed solutions to health problems are codified into action plans, and IHPplus assists the CODESs in tracking the development, implementation, and results of these plans. Examples of initiatives in CODESA action plans include partnering with local opinion leaders such as pastors to announce health messages in churches, group discussions on health topics, and public announcements of WASH; MNCH; and family planning messages with megaphones in village centers.

During the quarter, 1,295 IHPplus-supported communities had CODESAs that were actively involved in management of priority health services (see Table 14 below). This represents 93% of the total number of communities in IHP target areas (1,398), an increase from the PY1Q2 result of 91%. Compared to the target of 92%, this represents an achievement rate of 101%. Additional details related to CODESA activities and achievements during the quarter, challenges, and lessons learned are presented in IR 3.

Table 14: Number of CODESAs that are identified and active during PY1Q3

Coordination	Number of identified CODESAs	Number of active CODESAs, PY1Q3	% active CODESAs	Target (%)	Achievement rate (%)
Bukavu	399	399	100	92	109
Kamina	202	197	98	92	106
Kole	129	129	100	92	109
Kolwezi	106	91	86	92	93
Luiza	170	147	86	92	94
Mwene Ditu	171	156	91	92	99
Tshumbe	119	74	62	92	68
Uvira	102	102	100	92	108
Total	**1,398**	**1,295**	**93**	**92**	**101**

Evidence-based WASH activities: During PY1Q3, 162,741 of the targeted 158,583 people (103%) had access to an improved drinking water supply. This represents a significant increase from the 35,441 people that had access in PY1Q2.

Additionally, 89,149 of the targeted 105,772 (84%) people had access to an improved sanitation facility. While falling below the quarterly target, the result is an increase from the PY1Q2 result of 29,750

people. Table 15 presents the number of people that obtained access to improved drinking water and sanitation facilities during the quarter by coordination area, and the respective achievement rates.

Table 15: WASH indicators results per coordination for PY1Q3

Coordination	Number of people in target areas (drinking water)	First-time access to improved drinking water supply as a result of USG support in target area		Number of people in target areas (sanitation facilities)	First-time access to improved sanitation facilities as a result of USG support in target area	
		#	Achievement rate (%)		#	Achievement rate (%)
Luiza	71,360	44,695	**63%**	47,596	61,374	**129%**
Mwene Ditu	87,224	118,046	**135%**	58,176	27,775	**48%**
Total	**158,584**	**162,741**	**103%**	**105,772**	**89,149**	**84%**

Population targeted for improved access to water sources and sanitation facilities: IHPplus focused on the implementation of the CLTS approach in four health zones (Ndekesha and Luambo in the DPS of Kasaï Central and Kanda Kanda and Luputa in the DPS of Lomami), with a cumulative goal of reaching 12% of the population living in the health areas where the project is implementing WASH activities by the end of June 2016. The total population of these four health zones is estimated at 991,620, and annual targets for the number of people accessing improved water sources and sanitation facilities were fixed at 16% (277,522) and 8% (185,101), respectively. These targets were set taking into account the implementation capacities of the project partners and targeted households as well as logistical constraints related to bringing constructions materials to project sites. Quarterly targets were increased for PY1Q3 to reflect actual implementation experiences (28% for first time access to improved drinking water supply and 19% for increased access to improved sanitation facilities).

Improved water sources and sanitation facilities: IHPplus provided technical and financial support to the MOH and local communities to renovate 147 of the targeted 150 water sources (98%), which contributed to the strong performance in improving access to water sources during the quarter. The number of renovated water sources increased from PY1Q2, when only 34% of the targeted water sources were renovated (51 out of 150).

Considering performance in the previous quarters, the project reduced the target for the number of latrines during the quarter, from 15,719 to 6,856. Of the 6,856 IHPplus renovated 12,902 latrines (188%), compared to the 27% of targeted latrines that were removed in PY1Q2. Other factors contributing to this increase include strengthened capacity and skills of members of the WASH committee, as well as local artisans who were trained by the project on how to properly build hygienic family latrines. The work of CHWs, the WASH committee, and Community Champions increases the demand for improved latrines and water sources.

However, several challenges remain, such as the unavailability of sustainable construction materials in targeted areas and the lack of maintenance provided to the renovated water courses and newly-built latrines by the local population, which leads to their quick deterioration overtime. The project is looking for mechanisms to provide financial incentives to WASH committees and involving local chiefs in implementing the new water law and ensuring the sustainability of their water sources and latrines.

Other activities led this quarter by the project related to WASH were:

- Provided assistance to develop a national public water strategy following the government's enactment of the new water law on January 4, 2016. As the law describes the roles of user associations and local committees for water and sanitation, it is important to clarify their roles in relation to the health sector and compared to the heads of decentralized entities that are responsible for providing potable water.
- Within the context of support to the development of the new WASH national policy, IHPplus supported a WASH consortium made up of five nongovernmental organizations (NGOs) to develop a guide for WASH stakeholders involved in the implementation of the new water law.
- Per USAID/DRC request, IHPplus' WASH technical advisor attended the monthly meeting of the WASH inter-donor group, which discusses sector-wide issues, advocacy, and other common items.
- The project led a joint field visit with the USAID/Washington WASH Manager in the Lualaba province from February 13-21, 2016. During this mission, the team visited Kanzenze and Lubudi health zones as well as Lualaba Provincial Health Division in Kolwezi to evaluate WASH achievements accomplished with the project's continuous support. The main observations from this visit were:
    - Although the project recently renovated water sources in these supported health zones, they are not regularly maintained by the beneficiaries. This is probably due to the lack of: an ownership strategy, clear monitoring mechanism, and a maintenance fund that could be used to cover maintenance costs and fed through household contribution. Despite the unwritten rule that everyone should have free access to water, it should be noted that this maintenance fund strategy has already been implemented in Lubudi health zone where water hand pumps were installed and beneficiaries currently contribute to their maintenance by paying US$0.50 per household and per month. However, this strategy still needs to be improved as this amount was randomly determined, with no reference to the actual cost of maintenance and repair.
    - While households seem to have adopted several good hygiene practices, there is still a gap between knowledge and action, especially regarding latrine maintenance and coverage, establishing hand washing routines with soap or ashes, automatic hand washing after defecation, etc.
    - Sustainability of WASH installations (both water pumps and hygienic latrines) is at risk as they are often built with local construction materials, meaning they lack quality and durability. A solution could be to sub-contract these WASH activities to small local construction companies which will then be responsible for finding reliable and higher-quality procurement sources.

Next steps:

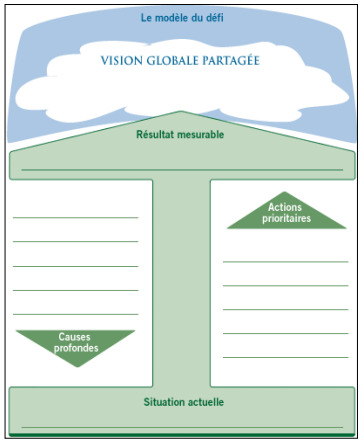
- Continue to renovate water and latrine sources in local communities
- Work with WASH committees and local leaders to create community ownership to ensure the sustainability of renovated water sources and newly built latrines
- Improve the engagement of local leadership and communities in the maintenance of water and sanitation sources by emphasizing the importance of monitoring the quality of the water, analysis of epidemiological data, and considering the impact of pollution
- Explore the possibility of introducing sanitation marketing to address the lack of adequate materials in certain health zones

Community-based nutrition activities

Number of mothers of children two years of age or younger who have received nutritional counseling for their children: During PY1Q3, 177,885 of the 170,478 expected mothers with children two years of age or younger received counseling (104% achievement). This represents a decrease from PY1Q2; however, results remain higher than expected targets. More details related to this indicator are presented in IR2.1.

IR 1.3 Provincial management more effectively engaged with health zones and facilities to improve service delivery

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



To demonstrate their commitment to improving health service delivery, DPS management teams carried out monitoring and supervision visits to health zone management teams supported by IHPplus as part of their routine activities. Teams that participated in the LDP implemented leadership projects lasting between six and eight months. They collaborated on these projects with other stakeholders involved in improving public health.

From January to March 2016

- 78 health zone management teams were trained on the LDP approach
- 59 of 78 (80%) health zone management teams completed an evaluation of their LDP action plans (these teams started the LDP in August 2015)
- 47 of 59 (80%) projects implemented by leadership teams achieved over 80% of desired performance according to indicators in their action plans within six months of completing the LDP projects (between October and December 2015)

Of the 78 teams supported by IHPplus, 59 implemented LDP projects between August and October 2015. Table 16 below shows the number and proportion of LDP teams that achieved at least 80% of their target six months after the LDP.

Table 16: Proportion of senior LDP teams that have achieved at least 80% of their desired performance

Coordination	Number of senior LDP teams trained teams that have developed a leadership project	Number teams that have achieved at least 80% of their desired performance	Proportion (%) of senior LDP teams that have achieved at least 80% of their desired performance	Target (%)	Achievement rate (%)
Bukavu	18	18	100	64	156
Kamina	6	5	83	64	130
Kole	5	2	40	64	63
Kolwezi	8	6	75	64	117
Luiza	5	4	80	64	125
Mwene Ditu	8	6	75	64	117
Tshumbe	5	2	40	64	63
Uvira	4	4	100	64	156
Total	**59**	**47**	**80**	**64**	**124**

The result of 80% exceeded the project target of 64%, for an achievement rate of 124%. This result is explained in part by the attempt of most teams to select realistic goals, with the exception of Sankuru (coordinations of Tshumbe and Kole). In addition, the DPS management teams have effectively monitored and supported six of the health coordination offices throughout the implementation of their projects.

Table 17 shows that the LDP teams predominantly chose projects linked to maternal and child health and tuberculosis (33 and 15 respectively of 63 projects), and also shows the distribution of LDP projects across technical areas.

Table 17: LDP projects per technical area

Focus Areas	Indicator areas	# of projects implemented	# of projects achieving expected results	Achievement rate (%)
MNCH	Immunization/VAT 2+	2	2	**100**
	Immunization/DTC-Heb-HiP-3	1	1	**100**
	Malaria/IPT 2+	5	4	**80**
	ANC 4	7	5	**71**
	More than 2 preschool consultations	6	5	**83**
	IMCI	6	6	**100**
	Assisted deliveries	4	4	**100**
	AMTSL	2	1	**50**
	Total MNCH	33	28	**85**

Family planning	Availability of contraceptives	4	4	**100**
L+M+G	Utilization of services	6	4	**67**
TB	SPPT*detection	15	10	**67**
HIV	TB patients tested for HIV	1	1	**100**
Total		**63**	**59**	**47**

*Sputum Positive Pulmonary Tuberculosis

Challenges:

1. Obtaining sufficient financing for implementing this approach: there are new members of the teams, and additional funding is needed to fully support them in implementing their LDP projects.
2. Ensuring that all health zone management teams using the LDP approach implement a realistic leadership project on a regular basis, as the project's past experience with the LDP has shown that teams tend to select over-ambitious objectives.
3. Ensuring that new coordination teams from the DRC MOH are informed about the LDP so they can efficiently engage to support their health zone management teams in improving health service delivery

Next steps: During the next quarter, IHPplus will continue to support LDP teams through supervision visits to ensure that they regularly implement leadership projects to progressively overcome the challenges they face. IHPplus will also continue providing technical and financial support to the new DPS teams from the DRC MOH to enable them to support LDP teams as they improve health service delivery.

Intermediate Result 2: Quality of key family health care services in target health zones increased

Increasing access to quality health services is a key objective of the IHPplus project. While the project continues to experience challenges with some indicators, particularly those related to TB, progress is being made in the areas of maternal and child health, HIV and AIDS, referral systems and quality of care, among others. Details are presented by sector in Table 18, below.

Table 18: Summary of Key IR 2 Results for PY1Q3

Sub-IR	Focus area	Key Indicators	Results
2.1 Clinical and Management Capacity	Maternal health	Service delivery (antenatal care [ANC] 1, ANC 4)	
		Service delivery (SBA)	
		Quality of care (AMTSL)	
	Neonatal health	Neonates receiving essential care	
		Newborns receiving antibiotics for infection	
	Child health	Vaccinations (under 12 months)	
		Pneumonia, diarrhea, malaria treatment	
	Family planning	Service delivery (counseling, new adopters)	
		Couple Years of Protection (CYP)	

		Service delivery points	
	Nutrition	Pregnant women receiving iron-folate	
		Nutritional counseling	
	Malaria	Service delivery (IPTp)	
		Commodities distributed	
		Health workers trained	
	HIV and AIDS	Service delivery (testing & counseling, HIV services, antiretroviral therapy [ART], new enrollees)	
		Service delivery and prevention (known status, key populations reached)	
		Service delivery (% ART, prevention of mother-to-child transmission (PMTCT), TB screen, TB ART, lab)	
	Tuberculosis	HIV testing of TB patients	
		New TB case detection rate	
		Multidrug-resistant TB (MDR TB) cases detected	
	GBV	GBV service delivery	
		GBV behavior change communication campaigns	
2.2 Minimum Quality	FOSACOF	Health center that completed an evaluation of the nine minimum FOSACOF standards	
		GRH that completed an evaluation of the nine minimum FOSACOF standards	
2.3 Referral Systems		Patients referred to health center	
		Patients referred to GRH	

***** **Green = achievement rate against the PMP target of 100% and above; Yellow = achievement rate against the PMP target between 75% and 99%; Red = achievement rate against the PMP target under 75%*

IR 2.1: Clinical and managerial capacity of health care providers increased

Maternal, newborn, and child health (MNCH): IHPplus results in the area of MNCH were strong during PY1Q3 compared to PMP targets, with many results showing an improvement from PY1Q2. IHPplus exceeded targets related to the percent of pregnant women attending at least one and at least four ANC visits by skilled providers. Three indicators had achievement rates greater than 90%, and only one indicator had an achievement rate of less than 80%. All 78 health zones reported data during the quarter.

Pregnant women attending ANC visits: ANC continues to be offered to pregnant women during their pregnancy in all IHPplus-supported health facilities to improve maternal and newborn health. During PY1Q3, 105% of pregnant women (140,516/134,107) attended at least one ANC visit (ANC1) and 55% of pregnant women (73,857/134,107) attended at least four ANC visits (ANC4). Compared to PY1Q2, the number of pregnant women attending at least one ANC increased from 132,062 to 140,516, and the

number of women attending at least four ANC visits increased from 71,741 to 73,857. The majority of coordination areas reported an increase in the number of pregnant women attending ANC1 and ANC4 visits compared to the previous quarter.

When compared to the quarterly targets, the project performed well for both indicators and exceeded the set targets for ANC1 and ANC4 visits of 95% and 53%, respectively. The achievement rate for ANC1 visits is 110% and the achievement rate for ANC4 visits is 104%. Tables 19 and 20 summarize the number and percent of pregnant women attending at ANC1 and ANC4 visits, compared to the targets.

Table 19: Number and percent of pregnant women attending ANC1 visit by skilled providers from USG-supported health facilities

Coordination	(ANC1)				Number of expected pregnancies (4% pop)	% women attending ANC1	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Tot. PY1Q3				
Bukavu	14,609	13,963	13,923	42,495	38,404	111	**95**	116
Kamina	7,135	7,315	7,299	21,749	21,138	103	**95**	108
Kole	3,704	3,824	3,790	11,318	9,915	114	**95**	120
Kolwezi	3,700	3,528	2,994	10,222	9,155	112	**95**	118
Luiza	4,875	4,803	4,546	14,224	14,824	96	**95**	101
Mwene Ditu	7,031	7,233	7,010	21,274	21,901	97	**95**	102
Tshumbe	2,911	2,996	2,871	8,778	9,110	96	**95**	101
Uvira	3,564	3,530	3,362	10,456	9,660	108	**95**	114
Total PY1Q3	**47,529**	**47,192**	**45,795**	**140,516**	**134,107**	**105**	**95**	**110**

Table 20: Number and percent of pregnant women attending ANC4 visit by skilled providers from USG-supported health facilities

Coordination	(ANC4)				Number of expected pregnancies (4% pop)	% women attending ANC4	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Tot. PY1Q3				
Bukavu	5,314	5,215	5,802	16,331	38,404	43	**53**	80
Kamina	3,588	3,580	3,490	10,658	21,138	50	**53**	95
Kole	2,511	2,608	2,578	7,697	9,915	78	**53**	146
Kolwezi	1,280	1,297	1,209	3,786	9,155	41	**53**	78
Luiza	3,535	3,508	3,701	10,744	14,824	72	**53**	137
Mwene Ditu	4,600	4,980	4,779	14,359	21,901	66	**53**	124
Tshumbe	1,871	1,954	1,847	5,672	9,110	62	**53**	117
Uvira	1,557	1,590	1,463	4,610	9,660	48	**53**	90
Total PY1Q3	**24,256**	**24,732**	**24,869**	**73,857**	**134,107**	**55**	**53**	**104**

Several factors contributed to the strong performance during the quarter including the information sessions on ANC outreach strategies in the Lubondaie and Bilomba health zones, trainings for health workers on MNCH in Luiza, joint supervision visits by health zone teams, distribution of LLINs, iron folate, and SP in health facilities, and the involvement of CODESAs in raising awareness in the community on the important of ANC visits that were conducted in Bukavu.

Factors contributing to underperformance in some coordination areas include the late start of ANC1 visits, poor record-keeping of ANC visits, and the movement of health workers in certain areas due to perceptions of higher salaries in certain health zones. The health zones with the weakest performance are Bilomba (49%), Dekese (67%), Kalomba (67%), and Tshudi-Loto (70%).

During the next quarter, IHPplus will involve community-based organizations and leaders and Champion Communities in identifying pregnant women (in all coordination areas), organize informational sessions on ANC outreach strategies (Bilomba, Dekese, Kalomba), and continue to provide technical support to health care workers to correctly complete ANC forms (Bukavu), and conduct additional awareness-raising initiatives among men on the importance of ANC visits (Kamina). The project will continue to purchase and distribute ANC commodities to all IHP-supported health facilities.

Deliveries by skilled birth attendant: During PY1Q3, 116,603 women delivered with an SBA, which represents 87% of the 134,107 expected deliveries. This result falls below the target of 90% (an achievement rate of 97%). This represents an increase from the previous quarter of 112,752 women. Table 21 below outlines the total number and percent of deliveries by coordination against the target, as well as the respective achievement rates by coordination.

Table 21: Number and percent of deliveries with a SBA in USG-supported facilities

Coordination	# deliveries with a SBA				Number of expected pregnancies (4% pop)	% of deliveries with a SBA	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	10,442	9,992	10,482	30,916	38,404	81	**90**	89
Kamina	6,099	6,029	5,745	17,873	21,138	85	**90**	94
Kole	3,219	3,286	3,255	9,760	9,915	98	**90**	109
Kolwezi	3,411	3,375	2,874	9,660	9,155	106	**90**	117
Luiza	4,676	4,520	4,676	13,872	14,824	94	**90**	104
Mwene Ditu	6,463	6,656	6,527	19,646	21,901	90	**90**	100
Tshumbe	2,541	2,562	2,479	7,582	9,110	83	**90**	92
Uvira	2,482	2,411	2,401	7,294	9,660	76	**90**	84
Total PY1Q3	**39,333**	**38,831**	**38,439**	**116,603**	**134,107**	**87**	**90**	**97**

IHPplus supported health care providers to raise awareness among pregnant women during ANC sessions on the importance of giving birth by skilled attendants at hospitals and clinics through SMS, education through listening (ETL) techniques, and the Champion Community model. The project also encouraged health facilities to include SBA deliveries as one of their performance indicators through the RBF program. These strategies contributed to the strong performance during the quarter.

Health facilities continue to face challenges in monitoring women in labor using the partograph (which must be used during deliveries) and administering oxytocin immediately following birth. IHPplus will continue to conduct supervision visits to improve data quality and completion.

Women receiving active management of the third stage of labor (AMTSL): During the quarter, 109,855 women received AMTSL, which represents 94% of the deliveries by SBAs (meeting the project target of 94%, an achievement rate of 100%). This represents an increase from the PY1Q2 result of 102,622 women. Table 22 outlines the number and percentage of women receiving AMTSL during PY1Q3 compared to the target.

Table 22: Number of women receiving AMTSL through USG-supported programs during PY1Q3

Coordination	Number of women receiving AMTSL				# woman giving birth in PY1Q3	% of woman women who received AMTSL	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	9,049	9,127	9,827	**28,003**	30,916	91	**94**	96
Kamina	6,025	5,919	5,262	**17,206**	17,873	96	**94**	102
Kole	2,896	3,134	2,818	**8,848**	9,760	91	**94**	96
Kolwezi	2,971	2,983	2,751	**8,705**	9,660	90	**94**	96
Luiza	4,653	4,427	4,578	**13,658**	13,872	98	**94**	105
Mwene Ditu	6,418	6,639	6,368	**19,425**	19,646	99	**94**	105
Tshumbe	2,419	2,514	2,368	**7,301**	7,582	96	**94**	102
Uvira	2,281	2,201	2,227	**6,709**	7,294	92	**94**	98
Total	**36,712**	**36,944**	**36,199**	**109,855**	**116,603**	**94**	**94**	**100**

AMTSL is not consistently applied in all health facilities. Not all facilities have providers trained in MNCH using the new competency-based training methodology (more practical and skills-based and less theoretical), which likely contributes to the inconsistent application. IHPplus will continue to train health care providers using the new methodology in subsequent quarters, and will conduct supervision visits in health zones where AMTSL application is poor to better identify the challenges.

All coordination areas reported improvements from PY1Q2, particularly in Bukavu (26,850 to 28,003), Kamina (15,687 to 12,206), and Kole (5,870 to 8,848). However, the gap between the number of deliveries by SBAs and the number of women receiving AMTSL remains large in many coordination areas, such as Bukavu, Kamina, and Kole, where the gap is greater than 10%.

Newborns receiving essential newborn care: During PY1Q3, a total of 112,285 newborns received essential newborn care, representing 96% of the total newborns delivered during the quarter in project-supported areas. This result exceeds the target of 89% (an achievement rate of 108%). Table 23 below summarizes the number and percentage of newborns receiving essential newborn care during the quarter, compared to the target by coordination.

Table 23: Number and percentage of newborns receiving essential newborn care through USG-supported programs

Coordination	Number of newborns receiving essential newborn care				Total live births PY1Q3	% newborns who received essential newborn care	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	10,296	9,746	9,957	29,999	30,445	99	89	111
Kamina	5,776	5,980	5,729	17,485	18,565	94	89	106
Kole	2,920	2,986	2,973	8,879	9,671	92	89	103
Kolwezi	3,028	2,902	2,023	7,953	9,251	86	89	97
Luiza	4,676	4,520	4,676	13,872	13,754	101	89	113
Mwene Ditu	6,453	6,687	6,175	19,315	19,670	98	89	110
Tshumbe	2,499	2,575	2,466	7,540	7,772	97	89	109
Uvira	2,455	2,397	2,390	7,242	7,242	100	89	112
Total	**38,103**	**37,793**	**36,389**	**112,285**	**116,370**	**96**	**89**	**108**

Project performance improved from the previous quarter, when 107,641 newborns received essential newborn care. The stronger performance during the quarter is linked to the increased number of deliveries at health facilities and monitoring visits to maternity wards. A significant improvement was reported in Uvira, where performance increased from 69% to 87%, due mostly to an increase in joint supervision visits.

As previously mentioned, the results for this indicator are still lower than the number of deliveries by SBAs. Data should be similar as essential newborn care is included in the norms for deliveries by SBAs. Data analysis at the health facility level is weak, and it is therefore challenging to assess the factors contributing to this gap. IHPplus will continue to provide technical assistance to the DPS to improve data analysis at health facilities.

Helping babies breathe: During PY1Q3, four out of eight coordination areas reported data on neonatal resuscitation. A total of 654 newborns suffered from neonatal asphyxia, and 92% (600) were resuscitated after neonatal intensive care. As outlined in Table 24 below, more than half of the newborn cases were reported in Bukavu coordination.

Table 24: Neonatal resuscitation success rate during PY1Q3

Coordination Office	Number of babies with neonatal asphyxia	Number of babies resuscitated after neonatal intensive care	% of babies resuscitated after neonatal intensive care
Bukavu	356	322	90
Kamina	20	19	95
Mwene Ditu	177	169	96
Uvira	101	90	89
Total	654	600	92

During the next quarter, the project will make sure that health facilities in the four remaining coordination are activity collecting data for this indicator.

Newborns receiving antibiotic treatment for infection from appropriate health workers: As presented in Table 25 below, a total of 8,019 of the targeted 10,321 newborns received antibiotics for minor and major infections, an achievement rate of 78%.

Table 25: Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs during PY1Q3

Coordination	Jan-16	Feb-16	Mar-16	Total PY1Q3	Target	Achievement rate (%)
Bukavu	487	520	595	1,602	2,993	54
Kamina	201	341	144	686	1,652	42
Kole	311	221	288	820	722	114
Kolwezi	1,041	561	372	1,974	722	273
Luiza	388	293	325	1,006	1,136	89
Mwene Ditu	302	378	402	1,082	1,652	65
Tshumbe	53	32	55	140	722	19
Uvira	188	302	219	709	722	98
Total	**2,971**	**2,648**	**2,400**	**8,019**	**10,321**	**78**

The results from this quarter represent a slight decrease from the PY1Q2 result of 9,907 newborns. The change can be explained in part by improved data collection in Kolwezi, which resulted in a lower, and more accurate, number of newborns reported that received antibiotic treatment. IHPplus increased supervision visits during the quarter after noting the high results in this coordination area during the previous quarter. Results from Tshumbe also remain low, and IHPplus will continue to provide support to verify and improve data quality in this area.

A significant increase was reported in Luiza (1,006 newborns treated during PY1Q3, compared to the 538 newborns treated in PY1Q2). Competency-based trainings for health workers on MNCH in this coordination area contributed to the increase of newborns treated for sepsis from 47% in the previous quarter to 89%. Additional support is needed to improve results related to this indicator, including increased awareness of the MNCH norms and guidelines, supervision visits, and routine data quality analysis of RDQA activities to improve data collection.

Challenges: There is inconsistency between the number of deliveries by skilled birth attendants and other indicators related to childbirth, such as the number of women receiving AMTSL and the number of newborns receiving essential care, for example. The norms and standards for assisted deliveries include AMTSL and essential care for newborns; therefore, the data should be similar. IHPplus will conduct additional trainings (using the new MNCH competency-based training methodology) for health facilities to reinforce their knowledge and application of the skilled birth norms, and increase the number of supervision visits to health facilities to strengthen monitoring practices for deliveries.

Next steps: Continuing to strengthen the capacity of health care providers in maternal and child health relies on the following:

- Strengthen community engagement in the early identification of pregnant women
- Increase the availability of oxytocin in all health facilities
- Improve communication among health care providers, community leaders, and clients
- Increase the availability of trained health care providers
- Distribute pediatric drugs to health facilities
- Improve commodity quantification and management
- Conduct accurate and comprehensive analysis of data by health zones
- Organize monitoring and supervision visits and RDQA to improve data quality

Expanded Program on Immunization (EPI): As in PY1Q2, the project continues to maintain overall good vaccination coverage, and performance for the majority of vaccination indicators is greater than 90% when compared to targets (see Table 26 below) during PY1Q3. Vaccines with coverage rates above 90% include tetanus vaccine 2+ (91%), DTP HepB-Hib1 (102%), DTP HepB-Hib3 (97%), and measles (94%). Coverage rates above 90% are mostly for vaccines that are included in DRC's vaccination calendar; however, some vaccines included in the vaccination schedules did not achieve coverage of 90% or higher. For example, BCG, PCV13-3, and OPV3 are included in the national vaccination calendar but had coverage rates of 71%, 70%, and 84%, respectively.

Table 26: Vaccination coverage per antigen and per coordination during PY1Q3

Coordination	Tetanus vaccine 2+ (%)	BCG (%)	DTP HepB-Hib1 (%)	DTP HepB-Hib3 (%)	PCV13_3 (%)	OPV3 (%)	Measles (%)
Bukavu	82	46	104	98	93	92	87
Kamina	97	84	100	96	35	90	100
Kole	92	80	106	97	38	98	103
Kolwezi	94	122	113	104	103	94	100
Luiza	96	88	97	94	66	93	98
Mwene Ditu	95	87	99	94	94	49	94
Tshumbe	99	57	101	96	0	84	95
Uvira	92	32	103	97	82	85	87
Total (%)	**91**	**71**	**102**	**97**	**70**	**84**	**94**
Target (%)	90	95	95	95	95	95	95
Achievement rate (%)	**101%**	**75%**	**107%**	**102%**	**74%**	**88%**	**99%**

IHPplus exceeded the coverage rate for the majority of vaccines, excluding BCG and PCV13_3 (achievement rates of 75% and 74%, respectively).

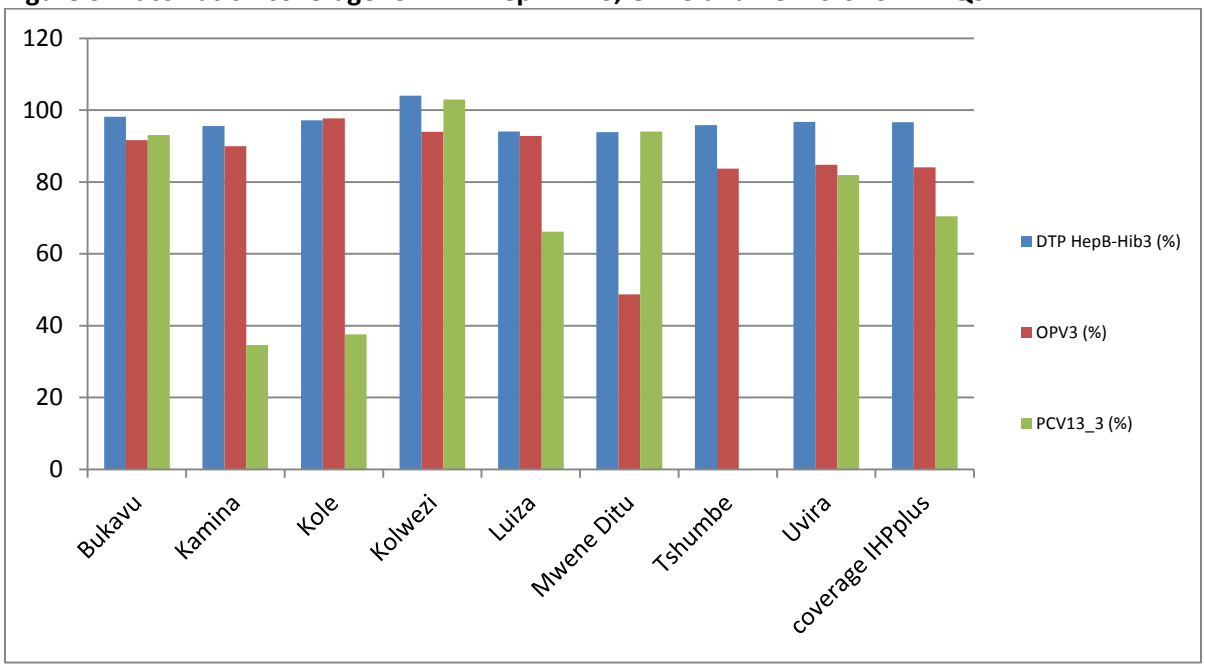
Several IHPplus initiatives contribute to the high coverage rates including the following:

- Provided fuel for all refrigerators in project-supported health zones and other products to improve the functioning of the cold supply chain
- Transported vaccines and syringes to EPI points of service in hard-to-reach health zones (Mulungu)
- Conducted supportive supervision and monthly monitoring to validate data

- Implemented the "*atteindre de chaque zone de santé*" strategy
- Provided leadership and management capacity-building to the MOH DPS and health zone levels
- Led community capacity-building activities (organization of awareness-raising activities and trainings for volunteers and focus groups [Tshumbe], active research of vaccination drop-outs and follow-up with communities to make sure that children are on track to receive all necessary vaccinations)
- Involved CODESAs in meetings to analyze and monitor vaccination data (Tshumbe, Mwene Ditu)
- Health facilities purchased vaccination indicators through the RBF program, leading to reductions in the number of drop-outs and number of non-vaccinated children and improvements in the quality of vaccination data (seven health zones)

Figure 6 below illustrates the vaccination coverage for DTP-HepB-HiB3, OPV3, and PCV13-3 for PY1Q3. DTP-HepB-HiB is the vaccine that is most available in health zones in all coordination areas. According to the national immunization calendar, children should receive the DTP-HepB-Hib3, OPV3, and PCV13-3 vaccines at the same time; therefore, performance data should be identical.

Figure 6: Vaccination coverage for DTP-HepB-HiB3, OPV3 and PCV13-3 for PY1Q3



The poor coverage rates for BCG and PCV13-3 are related to the low availability of vaccines at the central level and late deliveries of the vaccines, which results in logistical challenges in transporting and administering the vaccines in the provinces according to the schedule. Coverage rates for BCG were the lowest in Bukavu (46%) and Uvira (32%). PCV13_3 coverage rates were particularly low in Kamina (35%), Kole (38%), Luiza (66%), and Tshumbe (0%). Air transport challenges resulted in the insufficient distribution of syringes to Bukavu and Tshumbe, in particular. Often, airlines refuse to transport vaccines due to insufficient space. When compared to PY1Q2, the coverage rate for BCG decreased slightly from 72% to 71%; however, the coverage rate for PCV13-3 increased from 60% to 70%.

The low coverage rate of OPV3 (84%), a decrease from the PY1Q2 result of 98%, was due to insufficient availability of the OPV trivalent following the switch to OPV bivalent planned for the end of April 2016.

DRC, and the entire sub-region, must begin using OPV bivalent instead of OPV trivalent during vaccination campaigns during this period.

On January 13, 2016, DRC identified a case of vaccine-derived poliovirus, type 2 (with laboratory confirmation on March 1, 2016).[1] Following the identification, the country planned national vaccination days for children 0 to 59 months (a total of 18,266,268 children were targeted). The first vaccination campaign took place from March 24-26, 2016, and a total of 17,058,304 children were vaccinated against polio (approximately 95% of the target population). Partners conducted independent monitoring exercises in households that verified that 5% of children were not vaccinated (strong performance). Monitoring outside of the household in public places indicated that 6% of children were not vaccinated. The second vaccination campaign is planned for April 14-16, 2016, and results will be presented in the next quarter.

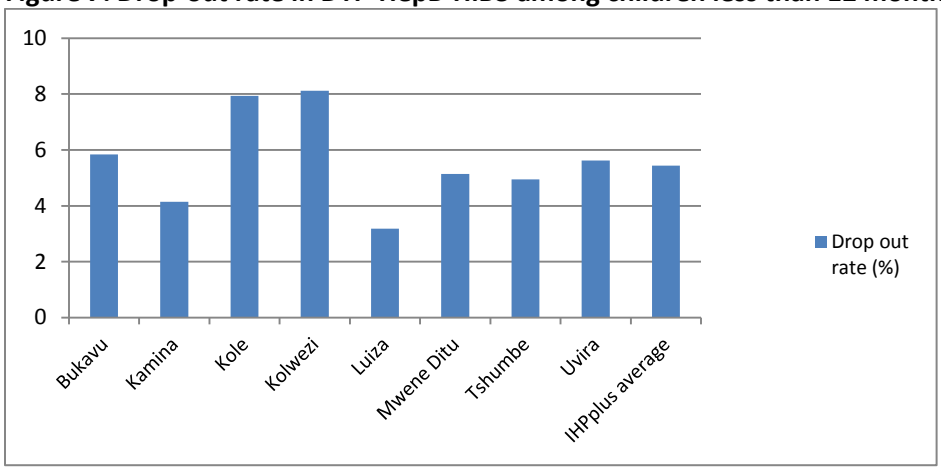
Rather than the 61 cases reported in the previous report, DRC had 66 polio-compatible cases at the end of 2015 (the five additional cases were confirmed after the original classification by the Intercounty Support Team [IST] Afrique Centrale, Libreville, Gabon, on April 25, 2016). DRC continued to conduct field visits to follow up on the identified cases, and a workshop was conducted in April 2016 to officially classify these polio-compatible cases.

With regards to the monitoring of acute flaccid paralysis (AFP) cases, 93 cases were reported from the 78 IHPplus supported sites, and stool samples were collected for laboratory confirmation. The majority of health zones that have not reported AFP cases are those with populations of fewer than 100,000 inhabitants (according to the norms, 2-3 cases of AFP are expected for every 100,000 inhabitants aged under 15). The probability of identifying cases in health zones with a population of less than 100,000 is lower; the population of those under 15 years old represents approximately 48% of the total population. For health zones that have fewer than 100,000 inhabitations, the population of those under 15 years of age is smaller (approximately 50,000 inhabitants), which reduces the probability of identifying AFP cases. Additional efforts are needed to strengthen monitoring and community surveillance in areas with a population of less than 100,000 inhabitants where no cases were reported.

As shown in Figure 7 below, the average drop-out rate for DTP-HepB-HiB3 among children less than 12 months of age is 5%, meeting the project target of 5% (achievement rate of 100%). This result was a slight increase from the 4% drop-out rate in PY1Q3. No drop-out rates were higher than 10% (the national performance standard is set between 0 and 10%).

[1] Please see the following documents in appendix 12 for additional information: *Mise à jour hebdomadaire sur l'Initiative d'Eradication de la Polio en Afrique Centrale, Mise à jour du 14 mars 2016, IST Afrique Centrale, Libreville-GABON,* slide 2, last bullet; and the *Activités d'éradication de la poliomyélite (IEP), République Démocratique du Congo, Mise à jour du 15 avril 2016*, slide 3.

Figure 7: Drop-out rate in DTP-HepB-HiB3 among children less than 12 months of age during PY1Q3



The major challenge remaining is the insufficient availability of vaccines and other vaccination commodities at the national and provincial levels.

To strengthen project performance, IHPplus will conduct the following activities:

- Support joint supervision visits to validate data through RDQA
- Conduct regular monitoring meetings to analyze and validate data
- Continue distribution of vaccines and other commodities in the provinces
- Continue providing support to maintain the cold supply chain
- Continue to administer vaccines in health zones
- Strengthen active surveillance of diseases that can be prevented by vaccines

Family planning

Couple Years of Protection: As shown in Table 27 below, the results obtained during this quarter (140,143) are slightly below those for PY1Q2 (142,321). The achievement rate has slightly decreased compared to PY1Q2 (from 98 to 97%). However, six out of eight coordination offices improved their respective performance this quarter compared to PY1Q2. Only Bukavu and Mwene Ditu reported a lower number of CYP for this quarter compared to the previous one due to the low availability of family planning commodities at the CDR level, which impacted the health zone level as well. IHPplus made a special request to the Lodja CDR in Kole to supply Mwene Ditu health facilities.

Table 27: CYP in USG-supported programs

Coordination	Jan-16	Feb-16	Mar-16	Total PY1Q3	Target	Achievement rate (%)
Bukavu	10,801	8,631	11,662	31,095	42,013	74%
Kamina	7,081	5,716	6,975	19,773	23,180	85%
Kole	3,525	3,572	3,416	10,512	10,141	104%
Kolwezi	6,993	7,711	5,578	20,283	10,141	200%
Luiza	5,659	5,945	6,822	18,426	15,936	116%
Mwene Ditu	8,543	8,289	7,500	24,333	23,180	105%
Tshumbe	3,423	3,392	3,335	10,150	10,141	100%
Uvira	2,005	1,794	1,773	5,573	10,141	55%
Total	**48,031**	**45,050**	**47,061**	**140,143**	**144,873**	**97%**

IHPplus successes in family planning are attributable to:

- Improved communication between providers and clients
- Strengthened communication between community volunteers and other community leaders
- The continuation of community-based distribution of commodities through the community-based distributors (CBDs) and community relays
- Routine RDQA of family planning data
- Regular monitoring of activities and data pertaining to family planning commodities
- Support for procurement of family planning commodities.

Next Steps: Uvira continues to report the lowest performance, with only 5,573 CYP achieved this quarter, likely due to insufficient community awareness of modern methods of contraception. For next quarter, the project is planning the following activities to improve its performance overall, especially in the underperforming health zones of Lemera, Nundu, Ruzizi, and Uvira:

- Support champion communities to organize SMS campaigns using FrontLine to raise community awareness on family planning and use of modern methods of contraception
- Support joint (MOH/IHPplus) monitoring visits to health zones management offices and health facilities
- Train health care providers, CBDs, and CHWs in family planning (particularly the new CBDs in Bibanga, Kanda Kanda, Nundu, Fungurume, and Katana)
- Train health care providers so they can improve interpersonal communication between their clients and themselves
- Train CHWs so they can strengthen interpersonal communication between community leaders and themselves

Modern contraception methods: As outlined in Table 28, the number of people who adopted a modern method of contraception deceased from 148,251 (PY1Q2) to 133,788 (PY1Q3). Consequently, the achievement rate this quarter (88%) decreased compared to PY1Q2 (97%). Five coordination offices out of eight reported an achievement rate higher than 100%. Uvira and Tshumbe reported the lowest performance due to family planning commodities stock-outs at the health facility level. Commodities were available at the CDR level; however, distribution to these two health zones was delayed due to inaccessibility challenges. Health zones in these areas are located farther from the CDRs, and it takes more time to reach these areas to distribute stock. In addition, Mwene Ditu's decreased performance

compared to the previous quarter can be explained by the shortage in family planning commodities at the CDR level, as explained earlier.

Table 28: Number of new acceptors of any modern contraceptive method in USG-supported family planning service delivery points

Coordination	Jan-16	Feb-16	Mar-16	Total PY1Q3	Target	Achievement rate (%)
Bukavu	7,525	6,424	7,195	21,144	44,154	48%
Kamina	6,857	6,640	8,607	22,104	24,361	91%
Kole	4,369	5,311	5,429	15,109	10,658	142%
Kolwezi	4,822	5,759	4,607	15,188	10,658	143%
Luiza	5,387	6,945	6,195	18,527	16,748	111%
Mwene Ditu	7,962	8,130	7,031	23,123	24,361	95%
Tshumbe	3,265	4,228	4,809	12,302	10,658	115%
Uvira	2,448	2,029	1,814	6,291	10,658	59%
Total	**42,635**	**45,466**	**45,687**	**133,788**	**152,256**	**88%**

The involvement of CBOs and community leaders in the planning and awareness-raising activities related to modern contraception methods and the increased availability of commodities for facilities contributed to the improvement in the use of services and to the demand for modern methods. Challenges remain regarding the availability of family planning commodities, the quality of care provided by skilled health providers, as well as the implication of political and administrative leaders in the advocacy efforts targeting women of reproductive age. The use of community-based distributors can increase the number of new acceptors of modern methods, especially in health zones with low performance.

Next steps: To improve and increase the number of new acceptors of modern contraceptive methods, IHPplus plans to:

- Provide continued technical support to the CBD activities in health zones with the poorest performance
- Work in synergy with peer educators and women leaders trained by other family planning implementing partners located in the same health zones supported by IHP
- Monitor and support CBDs and health providers trained in family planning
- Support the health zone management teams to regularly oversee the management of supplies in order to avoid stock-outs and expiration of products.

Depo-Provera stock-outs: To perform well on the two previous family planning indicators, health facilities need to be able to avoid stock-outs of key commodities, but managing them remains a challenge. As previously mentioned, 243 health facilities reported at least one stock-out in Depo-Provera during the reporting period, against a target of 100 (details by coordination are presented in IR 1.1).

Next steps: To avoid stock-outs in Depo-Provera, IHPplus will continue to work with the SIAPS project to implement the following steps:

- Organize training of target health zones on logistics and management of essential generic medicines, family planning, and malaria commodities

- Determine the contraceptives that are about to expire or that are overstocked in the health zones supported by E2A and IHPplus, return them to the provincial coordination offices, and redistribute them to other health zones where they are needed
- Return the overstock to the provincial coordination office for the National Reproductive Health Plan, once per quarter or as often as needed
- Perform monthly assessments of the supply management of contraceptives
- Perform monthly assessments of the provincial supply management of contraceptives
- Verify the contraceptive data reported by the health centers on a monthly basis

Nutrition: Performance on the three nutrition indicators reported and analyzed in this report (number of children under 5 years who received vitamin A supplements, number of pregnant women who received iron and folic acid supplements, and number of mothers of children 2 years or less receiving nutritional counseling for their children) is related to procurement of nutrition commodities, capacity building, monitoring, and community strengthening.

The integration of the nutrition support group approach—infant and young child feeding (IYCF)—and culinary demonstrations contributed to the improvement of the number of mothers and children under two years receiving nutritional support.

USAID Multi-Sectoral Nutrition Strategy Conference: Per USAID/DRC recommendation, the IHPplus Nutrition Senior Technical Advisor participated in a conference in Accra, Ghana, from January 17–23, 2016. The objectives of the conference were the following:

- Improve understanding of USAID's Multi-Sectoral Nutrition Strategy
- Utilize learnings from recent evidence and technical advice to guide multi-sectoral nutrition programs
- Share and learn from other participant's recent experiences
- Identify weaknesses and strengthen promising strategies within the multi-sectoral nutrition program

During the course of the conference, from the briefing on the multi-sectoral strategy for nutrition presented by the USAID Nutrition team in Washington, DC, and the sharing of experiences among experts present, it was acknowledged that nutrition is key in meeting the sustainable development objectives. Reducing chronic malnutrition cases by 20% requires a multi-sectoral strategy on nutrition, by supporting high-impact interventions such as the First 100 Days (which promotes that women and children get the right nutrition during the 1000 days between a woman's pregnancy and her child's second birthday) as well as strategies targeting adolescent girls. The adolescent nutrition interventions are explained in detail in the presentation "Adolescent Girls and Women's Nutrition: Moving the Agenda Forward" in Appendix 10. The key nutrition interventions in the First 1000 Days are:

- Improve nutrition before and during pregnancy: food and nutrition security, women's education, WASH
- Promote optimal breastfeeding
- Gradually introduce nutritious, affordable, and preferably local foods from 6 to 24 months old
- Provide early and effective treatment of Global Acute Malnutrition (GAM) with therapeutic methods
- Create an environment favorable to improving nutrition

IHPplus has been successful in the health zones and is an example of a program that integrates nutrition, WASH, and other health sectors. We are convinced that if IHP is expanded or integrated formally in other sectors, such as agriculture or education, that USAID's support will contribute substantially to the reduction of chronic malnutrition and the promotion of sustainable development in the DRC.

Joint USAID and IHPplus mission in the Kanzenze and Lubudi health zones: From February 13-21, 2016, USAID and IHPplus conducted a joint mission to the Kanzenze and Lubudi health zones, with approval from the health provincial division of Lualaba and Kolwezi, to evaluate progress made by IHPplus in the areas of nutrition and WASH. The follow-up and monitoring of the nutrition and WASH activities by USAID in the Kanzenze and Lubudi health zones was carried out successfully and as planned.

- IYCF was completed with the financial and technical support of IHP/USAID in the health zones visited
- The follow-up of the nutrition activities in the Kanzenze health zone is not carried out at all levels (provincial division, health zone central offices, and health centers)
- In the Lubudi health zone, the health zone management team oversees and supports the health care providers and CHWs in promoting IYCF (during this visit, the health zone presented its IYCF support group and success stories on breastfeeding).

Proportion of pregnant women who received iron-folate tablets to prevent anemia during the last five months of pregnancy: From January-March 2016, 176,801 pregnant women, or 132% of the expected pregnancies, received iron-folate supplements (see Table 29 below). Compared to the target of 89%, this represents an achievement rate of 149%.

Table 29: Number and percent of pregnant women who received iron-folate to prevent anemia during PY1Q3

Coordination	# pregnant women receiving iron-folate				Number of expected pregnancies (4% pop)	% pregnant women receiving iron-folate	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	16,384	14,075	17,019	47,478	38,404	124	**89**	139
Kamina	6,812	9,243	8,988	25,043	21,138	118	**89**	133
Kole	5,625	5,580	4,298	15,503	9,915	156	**89**	176
Kolwezi	5,896	5,293	2,758	13,947	9,155	152	**89**	171
Luiza	6,656	7,372	7,589	21,617	14,824	146	**89**	164
Mwene Ditu	11,629	11,783	11,009	34,421	21,901	157	**89**	177
Tshumbe	3,297	3,901	3,892	11,090	9,110	122	**89**	137
Uvira	2,066	2,159	3,477	7,702	9,660	80	**89**	90
Total PY1Q3	**58,365**	**59,406**	**59,030**	**176,801**	**134,107**	**132**	**89**	**149**

The result is an increase from the 159,855 pregnant women who received iron-folate in PY1Q2. The zones that reached or surpassed their quarterly objectives are Bukavu with 117%, Kolwezi with 152%, and Luiza with 115%. These results exceed the expected targets because, on one hand, in partnership with the CDRs, IHPplus provided an ongoing supply of EGMs--including iron-folate--based on the needs

of the zones. On the other hand, through prenatal consultations, pregnant women coming from surrounding areas, outside the funded health zones, also received supplements through Bukavu.

Despite the strong overall results compared to initial targets, some health zones did not reach their targets due to the late processing of EGMs at the regional CDR level, including Bagira, Kalole, Kitutu, Kamituga, Mulungu (Bukavu coordination), Songa (Kamina coordination), Dekese (Luiza coordination), and Ruzizi (Uvira coordination). The challenge is the delay in processing of medicine requests, including iron-folate in weak performing health zones. The lesson learned during PY1Q3 is that the availability of iron-folate positively influences the use of ANC services across health zones. In order to strengthen the weaker performance in some health zones, IHPplus will provide technical assistance, through field visits, to carry out a situational analysis and to develop a recovery plan that will standardize requisitions at the CDR level, the timeliness of the reporting system, and the management of EGMs.

Next steps: IHPplus will increase the number of pregnant women receiving these supplements in the next quarters by continuing distribution of iron and folic acid supplements in five health zones, supporting health zone management teams to better manage these commodities at health facilities, and encouraging the teams to put in place a distribution plan and assume responsibility for transport costs to health facilities.

Number of mothers of children two years of age or younger who have received nutritional counseling for their children: During PY1Q3, 177,885 of a target of 170,478 expected mothers with children two years of age or younger received counseling (104%). This result is lower than the second quarter when 144% performance was achieved. However, results still remain higher than expected targets.

IHPplus staff and *Programme National de Nutrition* (PRONANUT) provincial office teams conducted joint missions in February of 2016, to follow up on IYCF integration through the IYCF support groups and at the health facilities in the following health zones: Ndekesha and Kalomba (Luiza), Ruzizi, Nunu Uvira, and Lemera (Uvira).

During the missions, the teams observed that health zone management teams provided poor feedback and guidance to health care providers. CHWs continue to conduct home visits to provide household counseling on breastfeeding and on food fortification for children. IYCF support groups are still operational; and the topics linked to good nutrition practices are presented by the providers during the nutrition and health training sessions of the preschool consultation, ANC, etc. With regards to the weaknesses noted within each facility, IHPplus worked with stakeholders to develop immediate action and recovery plans. IHPplus also extended the integration of IYCF in March 2016 by funding a health care provider and CHW training in IYCF in all of the health zones of Mpokolo and Dibindi. PRONANUT experts from the Eastern Kasaï province facilitated this training.

IYCF support groups and active CODESA both contribute to the strengthening of information and the adaption of good practices regarding infant nutrition. The continuation of the IYCF within the health areas requires the guidance of the health zone management team, as well as the need for activities on areas of interest such as food security.

Planned actions for the next quarter include financial support for a visit to follow up on the revitalization of the IYCF support groups targeted by each IHPplus office in the province and to expand the integration of the IYCF training in the health areas.

Number of people trained in child health and nutrition through USG-supported : The project is reporting on this indicator for the first time this quarter. Only Mwene Ditu provided financial and technical support to train 74 health staff in child health and nutrition from Mpokolo and Dibindi health zones. In each health zone, a total of 37 people were trained: two members of the health zone management team, 10 nurses from the health centers, and 25 community health workers. The other coordinations were unable to organize any training during PY1Q3, due to conflicting activity calendars.

Planned actions for the next quarter: Each coordination office will determine its quarterly target for this indicator. In addition, IHPplus plans to conduct a child health and nutrition training in Bibanga health zone and one preschool consultation training in at least two health zones in every coordination office.

Malaria

Prevention: During PY1Q3, 99,565 of pregnant women, or 74% of the expected pregnancies, received at least two doses of IPTp. Compared to the target of 75%, this represents an achievement rate of 99%. Compared to PY1Q2 performance (89,134), the number of pregnant women who received at least two doses of IPTp increased by 12%. As shown in Table 30 below, five out of eight coordination offices either met or exceeded their target of 75%, with the exception of Kamina (70%), Kolwezi (68%), and Uvira (55%).

Table 30: Number and percentage of pregnant women who received at least two doses of SP during ANC visits during PY1Q3

Coordination	Number of pregnant women who received at least two doses of SP during ANC visits	Total number of expected pregnancies in USG-assisted health facilities	Percentage of pregnant women who received at least two doses of SP	Target (%)	Achievement rate (%)
Bukavu	27,880	38,404	**73%**	75	**97%**
Kamina	14,289	21,138	**68%**	75	**90%**
Kole	7,008	9,915	**71%**	75	**94%**
Kolwezi	6,011	9,155	**66%**	75	**88%**
Luiza	13,890	14,824	**94%**	75	**125%**
Mwene Ditu	18,271	21,901	**83%**	75	**111%**
Tshumbe	7,100	9,110	**78%**	75	**104%**
Uvira	5,116	9,660	**53%**	75	**71%**
Total	**99,565**	**134,107**	**74%**	75	**99%**

To achieve this performance, IHPplus has continuously worked to improve SP procurement for health facilities. A total of 618,000 doses of SP were distributed to pregnant woman during ANC visits (103% of target). In addition, by the beginning of PY1Q3, all CDRs had a combined stock of 4,549,000 tablets, which represents a 15-month supply. In addition to ensuring the availability of SP tablets in health facilities, IHPplus also supported CHW and Champion Communities in raising community awareness to encourage women to go to the doctor as soon as they miss their menstrual period.

Reasons for low performance in the Uvira coordination are unclear. The CDRs in Sud Kivu had more than two million units of SP in stock, and communities organized project-supported mini-awareness campaigns throughout the quarter to improve SP distribution to pregnant women. Despite these measures, the project underperformed on this indicator; therefore, next quarter the project will evaluate the factors affecting performance.

Number of LLINs purchased with USG funds that were distributed: As shown in Table 31 below, a total of 140,750 LLINs were distributed during the quarter, which represents 124% of the target. Compared to PY1Q2, this represents an increase from the 97,536 LLINs previously distributed. High performance was achieved across seven of the eight coordination areas (with the exception of Kole, which achieved an 89% rate). It is important to note that the figures in the below table refer to the LLINs distributed from the CDRs. Several CDRs in health zones did not distribute nets during the quarter. To achieve high performance on this indicator, the project continued to ensure availability of LLINs in the CDRs and supported quarterly transportation of LLINs from the CDRs to the health zone management offices.

Ensuring the availability of LLINs in health zones remains a challenge, as health zone management offices tend to store LLINs for an extended period of time instead of regularly distributing them to health facilities. Therefore, IHPplus focused on ensuring the transportation of EGM and commodities to health facilities by providing subsidies to health zone management offices as well as training health zone management teams in monitoring and managing commodity stocks. In addition, the project supported

the organization of awareness campaigns during ANC and preschool visits in order to encourage mothers to have their children sleep under an LLIN every night. Finally, the project also supported CHWs by providing them with outreach tools focusing on malaria, through which mothers and women of child-bearing age were encouraged to visit their doctor when they miss their period and to take their children to preschool visits to receive malaria-prevention counseling and an LLIN.

Table 31: Number of LLINs purchased with USG funds that were distributed during PY1Q3

Number of LLINs purchased with USG funds that were distributed					Target	Achievement rate (%)
Coordination	**Jan-16**	**Feb-16**	**Mar-16**	**Total PY1Q3**		
Bukavu	28,000	25,850	650	**54,500**	32,987	**165**
Kamina	0	0	0	**0**	18,200	**0**
Kole	0	0	0	**0**	7963	**0**
Kolwezi	26,600	11,100	0	**37,700**	7,963	**473**
Luiza	0	0	2,900	**2,900**	12,511	**23**
Mwene Ditu	0	0	14,200	**14,200**	18,200	**78**
Tshumbe	0	0	0	**0**	7,963	**0**
Uvira	4,050	24,100	3,300	**31,450**	7,963	**395**
Total	**58,650**	**61,050**	**21,050**	**140,750**	113,750	**124**

Correctly managing malaria cases in health facilities through training and distribution of medicine and commodities (ACTs, RDTs, and supervision): As shown in Table 32 below, IHPplus distributed 1,184,139 ACT treatments: 1,162,775 in health facilities and 21,364 through community care sites. Compared to the PMP target of 800,000, the achievement rate was 148%. Moreover, the project drastically improved its performance compared to PY1Q2 when 463,101 ACT treatments were distributed (440,850 through health facilities and 22,045 through community care sites).

Table 32: Number of ACT treatments purchased with USG funds that were distributed during PY1Q3

Number of ACT treatments purchased with USG funds that were distributed in health facilities and community				Target	Achievement rate (%)
Coordination	**Health facilities**	**Community**	**Total**		
Bukavu	278,585	1,490	**280,075**	232,000	**121**
Kamina	71,067	9,708	**80,775**	128,000	**63**
Kole	68,771	954	**69,725**	56,000	**125**
Kolwezi	310,048	1,081	**311,129**	56,000	**556**
Luiza	72,452	2,998	**75,450**	88,000	**86**
Mwene Ditu	143,059	3,316	**146,375**	128,000	**114**
Tshumbe	72,301	1,249	**73,550**	56,000	**131**
Uvira	146,492	568	**147,060**	56,000	**263**
Total	**1,162,775**	**21,364**	**1,184,139**	800,000	**148**

The majority of coordination areas reported achievement rates above 100%. Kamina and Luiza reported low achievement rates of 63% and 86%, respectively. The poor performance in Kamina is linked to the increase in stock-outs in the area (from 47 to 80, compared to the previous quarter). Distribution was delayed due to accessibility challenges during the rainy season.

The most notable improvements from the previous quarter were reported by Mwene Ditu (from 47% to 114%), Kole (from 66% to 125%), and Uvira (from 85% to 263%). This is largely due to the supervision visits and trainings led by the project on malaria commodities management, improved completion of data collection tools in the health zones, as well as linking the payment of subsidies to the receipt of completed data collection sheets. Additionally, the number of community care sites increased, and more malaria cases were treated with ACT.

To manage severe malaria cases in referral facilities, the project provided 47,000 vials of injectable artesunate and 29,006 vials of injectable quinine to treat patients. Health care providers used 1,762 artesunate suppositories at health centers and community care sites for pre-referral treatment of severe malaria.

Next steps: As previously mentioned, the project plans to revitalize 10 community care sites in Kalenda health zone and establish 40 new ones in the new IHPplus health zones: Miabi (7), Kabinda (21), and Kansasa (12). Revitalizing these community care sites will improve and increase malaria case management coverage in the next quarters. To improve coverage of malaria treatment, IHPplus will also advocate for the inclusion of the needs of satellite facilities in planning and reporting activities.

IHPplus has observed a notable improvement in the number of RDTs distributed at health facilities this quarter, with 526,200 used compared to the target of 625,000, an achievement rate of 84% (see Table 33 below). This represents an increase from the 366,533 reported in PY1Q2. Out of eight coordination offices, only Tshumbe and Kole did not improve their performance compared to the previous quarter. They placed their ACT orders with a CDR that reported a stock-out, which prevented them from being able to supply the health zones located in their area.

Table 33: Number of USG-funded malaria RDTs that were distributed during PY1Q3

	Coordination								
	Bukavu	**Kamina**	**Kole**	**Kolwezi**	**Luiza**	**Mwene Ditu**	**Tshumbe**	**Uvira**	**Total**
Total	170,370	116,436	23,940	34,594	52,666	48,346	22,987	56,861	**526,200**
Target	181,250	100,000	43,750	43,750	68,750	100,000	43,750	43,750	**625,000**
Achievement Rate (%)	**94**	**116**	**55**	**79**	**77**	**48**	**53**	**130**	**84**

During this quarter, the project team was able to notify a stock of RDT close to expiration date (May 25, 2016) during an MOH joint supervision visit to Kamiji health zone. The health zone management team calculated the quantity to be distributed within Kamiji based on the health facilities' current stock and needs and redeployed the rest (675) to Kanda Kanda health zone, which was out of stock. To avoid this type of situation, IHPplus also supported health facilities to organize open houses for malaria treatment and briefed CHWs on raising awareness within their communities. They encouraged patients to visit their closest health center to seek care within two days of fever symptoms, and if they presented a simple case of malaria, they were guaranteed treatment free of charge. This type of campaign proved to

be successful and improved both the health services utilization rate and avoided the expiration of the stock of malaria commodities.

Based on the project's results, the RDT/ACT ratio use is still below the expected *Programme National de Lutte Contre le Paludisme* (PNLP)/MOH norm of one ACT to two RDTs. In order to improve performance, IHPplus conducted joint supervision visits (IHPplus and MOH staff) to health facilities to ensure that the norms for malaria case management are respected.

During PY1Q3, the project trained a total of 115 staff—96 men and 19 women—from four health zones in the coordination of Tshumbe and Kole in malaria prevention and case management (IPTp, ACT case management, and RDT). Trainings on IPTp, ACT case management, and RDT are combined to maximize resources. Compared to the target number of individuals trained in IPTp (400), ACT case management (450), and RDT (450), the project fell below the expected results with achievement rates of 29%, 26%, and 26%, respectively[2]. Other MOH activities planned during the quarter--such as trainings in other health areas (family planning, nutrition, etc.) and the validation exercise for the operational health plans--were prioritized and contributed to underperformance during the quarter.

During PY1Q3, the implementation phase of the feasibility study on the use of rectal artesunate in community care sites was completed, with follow-up visits scheduled in seven health zones. Phase three will start in April 2016 and is scheduled to go over two months. Moreover, the malaria technical advisor for the project took part in two international conferences in Nairobi: one organized by the United Nations Children's Fund (UNICEF) on the scale up of the i-CCM approach and the other one by Medicine for Malaria Venture on the implementation of artesunate suppositories as primary treatment for severe cases of malaria.

The project also participated in the National Malaria Control Program partners meeting which focused on improving malaria commodities management. One of the recommendations was to extend redeployment/supply of malaria commodities to non-IHPplus supported health zones in case of overstock and when facing risk of expiration.

Many of the malaria indicators for this quarter are either equal to or more than 100% of the target due to a change in the data source for indicators 53, 55, 57, and 59. These data no longer come from the health facilities but from the CDRs to the health zone central offices where there is a higher level of completeness. This change was recommended by the USAID PMI team in order to harmonize data and improve data quality.

Next steps:

- Conduct follow-up supervision visits to the coordination areas of Tshumbe and Kole, which were trained during PY1Q2
- Train staff in the coordination areas of Kolwezi, Mwene Ditu, and Bukavu on malaria prevention and case management

HIV and AIDS: IHPplus continues to support 72 HIV health care sites--44 in Kolwezi and 28 in Kamina--an increase from the 68 sites supported under IHP. It should be noted that while all 72 sites reported HIV

[2] The target for IPTp is lower than the targets for ACT case management and RDT because the project trains CHWs in ACT case management and RDT but not IPTp.

data for this quarter, four sites in the Kabongo health zone submitted their March 2016 data late to the Kamina coordination; therefore these data were not included in this report.

In Kolwezi, the Mwangeji GRH, considered a hub, also reported data collected by two satellite health centers, Zikito and Mariopolis. In addition, the Manika health zone management team decided to shift its support from Bethsaida health center (deemed unproductive and non-collaborative) to Orthodoxe hospital, as agreed with Lualaba DPS. In addition, IHPplus completed data verification exercises in Kolwezi, particularly in Manika, and provided assistance to previously non-productive HIV sites (Nseke/Kanzenze, Kalwa, Kikobe/Lubudi, Mwanfwe, Kisanfu/Lualaba, and Mukabe/Lubudi) to test and treat new HIV-positive cases. This is an important success for the project, as these sites did not report any new HIV-positive cases in the previous quarters.

PEPFAR and the MOH have agreed to have one HIV implementing partner by health zone. Negotiations were completed in Kolwezi during the quarter to determine the implementing partner. There are also changes to the project's support in Kamina due to PEPFAR's rationalization process with the Global Fund[3]. IHPplus will no longer support HIV sites in Kamina, as they will be supported by the Global Fund.

Additionally, two teams from the PNLS national office and provincial one (ex-Katanga) led an evaluation in the HIV site laboratories, with the support of the project. No stock-outs of HIV testing or treatment commodities were recorded during this quarter.

Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women: During PY1Q3, 98% (39/40) of the PEPFAR-supported sites providing PMTCT services achieved 90% antiretroviral treatment coverage for seropositive pregnant women. This result exceeds the PMP target of 76%, an achievement rate of 129%. The PY1Q3 result is an increase from the coverage rate of 88% recorded in PY1Q2. Kamina achieved 100% coverage and Kolwezi achieved 97% coverage. The strong performance during the quarter is due to the availability of ARVs at health facilities and the implementation of option B+.

Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results): A total of 7,690 women out of the 8,054 women (95%) tested for HIV were aware of their HIV status and received their results during prenatal visits and in the labor and delivery ward, an increase from the 7,618 women reported in PY1Q2. This result exceeds the target of 85% and represents an achievement rate of 112%. In Kolwezi, 98% of pregnant women who were tested for HIV are aware of their status, and 95% of tested women in Kamina know their status.

Among the tested pregnant women in the 72 IHPplus-supported PMTCT sites, 109 tested positive for HIV (1%). Only 6 out of the 109 (6%) women were aware of their status upon admission and 103 (94%) new HIV cases were detected. The overall seropositivity rate increased from 1.3% to 1.41% in the 72 sites. In the coordination areas of Kolwezi/Lualaba and Kamina/Haut Lomami, 2.26% and 0.35% of pregnant women tested positive for HIV, respectively. During this quarter, the seropositivity rate among pregnant woman increased in Kamina (from 0.03% during PY1Q2) as more women were tested for HIV

[3] PEPFAR and Global Fund-financed programs are undergoing a rationalization process in DRC to improve program coordination, decrease costs, and create greater efficiencies between Global Fund and USG investments in order to increase the coverage of essential HIV services and save more lives. A USG-Government of DRC agreement specifies areas of implementation for each donor.

in the coordination. This is due to the increase in the monitoring and supervision of HIV care sites located in Kabongo and Malemba health zones by MOH/IHPplus joint teams.

DRC is making significant progress towards reaching the World Health Organization's 90-90-90 objective with the target of 90% of all people living with HIV who will know their HIV status by 2020. IHPplus support has contributed to this result by improving the quality of services provided and counseling by HIV health care providers, strengthening the testing circuit, and increasing the availability of testing materials at health facilities.

Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery: During PY1Q3, 97% (96/99) of HIV-positive pregnant women received antiretrovirals to reduce the risk of MTCT (100% in Kamina and 92% in Kolwezi). IHPplus exceeded the PMP target of 85% with an achievement rate of 114% (maintaining consistent performance from PY1Q2). Strong performance is linked to the increased availability of ARVs at health facilities and the implementation of option B+ by well trained and supervised medical staff.

Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required: The project reached a total number of 85 female sex workers, either individually or in small groups, through HIV prevention interventions based on evidence and/or minimum required standards. All sex workers reached were in Kamina: one from the Songa health zone (Samba site), 17 from the Kabongo health zone (Kamungu site), and 67 from the Malemba health zone (Butombe site). CHWs increased awareness of HIV in this key population group, and IHPplus supported health facilities in improving HIV testing and HIV health services for this targeted population.

Number of individuals who received testing and counseling (T&C) services for HIV and received their test results: A total of 15,280 individuals were counseled and tested for HIV and received their test results during PY1Q3, an increase from the PY1Q2 result of 14,421.This result exceeds the PMP target of 12,000, for an achievement rate of 122%. In Kamina, 6,891 individuals were tested and received T&C services, compared to 8,389 in Kolwezi. The results, disaggregated by sex, age, and HIV status are listed in table 34 below.

Table 34: Number of individuals who received T&C services for HIV and received their test results, disaggregated by sex, age and HIV status

Sex		Age		HIV status	
Women	**Men**	**Under 15 years**	**15 years+**	**HIV-positive**	**HIV-negative**
11,922 (78%)	3,358 (22%)	363 (3%)	14,058 (97%)	767 (5%)	14,513 (95%)

The seropositivity rate recorded at the 44 HIV health care sites in Kolwezi/Lualaba was 8%, and the seropositivity rate recorded at the 28 HIV health care sites in Kamina/Haut Lomami was 1%. Kolwezi reported a higher rate because of the mining activities in this region. IHPplus will allocate resources where the need is the greatest and prioritize support to focus on HIV in the Lualaba province. This focus is in line with PEPFAR's strategy of targeting support in the "right place."

The service delivery points for T&C services varied: 50% of tested clients came from ANC visits and maternity wards, 18% from out-patient consultations, 8% from sexually transmitted infection consultations, 5% from hospitalization, 4% of services were provided during TB consultations, and 15% from other services. The performance recorded during this period was mainly due to implementing the

provider-initiated testing and counseling strategy, the availability of screening tests, and the surge in mining--which generated an increased demand for testing.

Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (World Health Organization [WHO] staging) or CD4 count or viral load: During the quarter, 4,573 people living with HIV received at least one clinical assessment (WHO staging), CD4 count, or viral load of the infection's progress (4,411 in Kolwezi and 162 in Kamina). The project exceeded the PMP target of 3,600, for an achievement rate of 127%. The PY1Q3 result is a slight increase from the 4,525 people reported during PY1Q2. This performance is mainly due to the availability of PIMA equipment and CD4 tests provided by the IHPplus project. Health facilities were not able to identify patients' viral load in Kolwezi as the necessary equipment for this test is not available. This test is currently only available to people living with HIV in Lubumbashi and Kinshasa, where the analysis can be performed within six hours following the sampling time.

Number of HIV-positive adults and children receiving a minimum of one clinical service: A total of 4,573 HIV-positive adults and children received at least one clinical service at the HIV sites (162 in Kamina and 4,411 in Kolwezi). The project exceeded the PMP target of 3,600, an achievement rate of 127%. The PY1Q3 result is a slight increase from the 4,525 people reported during PY1Q2. The availability of cotrimoxazole and other HIV commodities provided to health facilities by partners such as IHPplus, the Global Fund, and mining companies working in these health zones contributed to this strong performance.

TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting: In PY1Q3, 678 of the targeted 3,600 (19%) HIV-positive patients were screened for tuberculosis in an HIV care or treatment setting. This represents an increase from the 415 patients reported in PY1Q2. The project result fell below the target of 70%, with an achievement rate of 27%. In Kamina, 100% of HIV-positive patients were screened (162/162), and 15% (516/3,338) were screened in Kolwezi. The project provided the TB screening equipment in the two coordination areas to improve performance. Due to the high volume of patients, Kolwezi health workers were unable to record all patients receiving TB screening. IHPplus will continue to conduct post-training follow-up and provide on-site technical assistance to health care providers and health zone management teams to improve performance in Kolwezi.

Number of adults and children receiving antiretroviral therapy (ART) (current): A total of 3,490 individuals are currently enrolled to receive ART (152 in Kamina and 3,338 in Kolwezi). This represents a slight increase from the 3,374 reported in PY1Q2. The project exceeded the PMP target of 2,900, for an achievement rate of 120%. Strong performance in this area is attributed to the availability of ART treatment commodities in all health facilities, the implementation of option B+ at all the PMTCT sites since the last quarter of IHP, and the technical support provided to health care providers by the health zone management teams and IHPplus staff. The mining boom in Lualaba also increased the demand for this service.

Several challenges exist in increasing the number of adults and children receiving ART, including:

- Availability of ART commodities within the context of reduced Global Fund support
- Determination patients viral load count with limited resources
- Retention of ART patients

IHPplus will continue to collaborate with the Supply Chain Management System (SCMS) project and the two agencies in charge of financing the purchase of ARVs and to calculate patient viral load. The project will also train social workers and mentor mothers on strategies for assisting with the retention of ART patients and improving the quality of life of people living with HIV.

Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging), or CD4 count or viral load: In PY1Q3, a total of 609 HIV-positive individuals that are newly enrolled in clinical care received at least one clinical assessment (WHO staging), CD4 count, or viral load (63 in Kamina and 546 in Kolwezi). This represents a slight decrease from the 653 individuals reported in PY1Q2; however, compared to the PMP target of 415, the project reported an achievement rate of 147%. Strong performance is a result of the mining boom of Lualaba and the availability of PIMA equipment at the two IHPplus-supported coordination areas.

Proportion of registered TB cases that are HIV-positive who are on ART: During this quarter, 280 out of the anticipated target of 285 (98%) TB patients registered that are also HIV positive were placed on ART. Kamina reported a 100% achievement (9/9), while Kolwezi reported a 99% achievement (271/276). The project achieved a rate of 109% against the PMP target of 90%. The demand generated from the mining boom in Lualaba and the availability of HIV testing contributed to the high performance in both coordination areas.

Percentage of laboratories and Point of Care (POC) testing sites performing HIV diagnostic testing that participate and successfully pass an analyte-specific proficiency testing (PT) program: A total of 47 of the 45 expected laboratories successfully completed the first step of the analyte-specific proficiency testing (PT) program (104%). However, all sites and POC laboratories ensure HIV testing. Laboratory quality control for the PEPFAR-supported HIV care sites is done biannually in partnership with the Lubumbashi provincial National AIDS program laboratory.

Number of PEPFAR-supported testing facilities (laboratories) that are recognized by national, regional or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation: Following an evaluation carried out by teams from both the PNLS national office and Lubumbashi provincial office, the Gecamines Hospital (*Hôpital Général du Personnel de Kolwezi*) in Dilala health zone, and Mwangeji GRH in Manika health zone have the potential to receive accreditation (exceeding the PMP target of one). Based the results of the PNLS evaluation, Mwangeji GRH still needs to make some improvements, at the infrastructure, human resources, and organizational levels to receive full accreditation.

Family planning and HIV integration: Number of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services: With IHPplus support, 72 functional PMTCT sites systematically integrated family planning and safe motherhood services. The project also ensured family planning commodities were available at all sites. Health providers were trained in long-term family planning methods. Post-training supervision by health zone management teams followed. Awareness-raising campaigns, including SMS messaging, were launched to inform the public about the availability of integrated HIV and family planning services at these sites.

Number of infants born to HIV-positive women who were started on CTX prophylaxis within two months of birth at USG-supported sites within the reporting period: During PY1Q3, a total of 96 HIV-exposed children (all in Kolwezi) received cotrimoxazole prophylaxis to reduce the risk of HIV

transmission, an increase from the 68 reported in PY1Q2. Compared to the target of 90, the project reported a 107% achievement rate. This strong performance reflects continuous efforts to make cotrimoxazole available in sites supported through PEPFAR and Global Fund funding.

Number of infants who had a virologic HIV test within 12 months of birth during the reporting period: During PY1Q3, 26 HIV-exposed children (all in Kolwezi) were tested for HIV before their first birthday. Compared to the PMP target of 32, the project attained an 81% achievement rate. This performance was made possible due to ongoing efforts to ensure the availability of dried blood spot (DBS) tests in PEPFAR-supported health facilities. Despite the fact that the project exceeded performance in this area, availability of this testing is not sufficient to meet the needs. Early infant diagnosis can only be done at the National AIDS Control Program (NACP) laboratories (the provincial-level lab in Lubumbashi or the national level in Kinshasa). As a consequence, the supported facilities receive analysis results with extensive delays or not at all. To overcome this challenge, the project is currently working with the management teams of the NACP laboratories to define an effective circuit to transport DBS samples from project-supported sites to the laboratories and to get the results back to sites in a timely manner.

Number of infants HIV exposed infants with a documented outcome by 18 months of age disaggregated by outcome type: During PY1Q3, the project was not able to collect data for this indicator because of the lack of activity from the psychosocial assistants working in supported sites. The PNLS postponed the training planned for the quarter to build the capacity of the psychosocial assistants to produce and collect data for this indicator to PY1Q4.

Number of adults and children newly enrolled on ART: During PY1Q3, 475 new PLWHA (60 in Kamina and 415 in Kolwezi) were placed on ARV treatment, an increase from the 318 reported in PY1Q2. The project exceeded the target of 358, reporting a 133% achievement rate. Several factors had a positive impact on project performance: high availability of ART in supported health facilities, introduction of option B+ in all PMTCT care sites during the last quarter of IHP, and continuous support of health facility staff by the project team. This strong performance was also due to the mining boom in Lualaba which also increased the demand for this service.

Number of adults and pediatric ART patients with a viral load result documented in the patient medical record within the past 12 months: In the geographical context of IHPplus project, this indicator is not applicable. The only laboratories equipped to perform this testing are the PNLS labs. Since the viral load protocol requires that samples not be transported for more than six hours, the project is unable to report data for this indicator due to the absence of nearby laboratory equipped to determine the viral load of HIV-positive patients receiving treatment in Lualaba province care sites.

Number of viral load tests from adult and pediatric ART patients conducted in the past 12 months with a viral load inferior to 1000 copies/ml: In the geographical context of IHPplus project, this indicator is not applicable, for the same reason as stated for the indicator above.

Number of adults and children who are still alive and treatment at 12 months after initiating ART: This indicator will be reported only on a yearly basis.

Number of HIV infected adults and children receiving care and support services outside of the health facility: During PY1Q3, the project was not able to collect data for this indicator. As explained above, the PNLS postponed the training that the project had planned this quarter to build the capacity of the psychosocial assistants to collect data for the indicator to PY1Q4.

Aggregated outcome of TB treatment among registered new and relapsed TB cases who are HIV-positive in the treatment cohort: During the quarter, 47 TB/HIV-positive co-infected patients in Kolwezi completed their TB treatment. Of these, 27 were declared cured from TB, 14 needed to start their TB treatment over again since they had relapsed, and six had passed away. In Kamina, the 13 TB/HIV-positive co-infected patients were still undergoing their TB treatment as they had only started it less than six months previously. Compared to the target of 48, the project's achievement rate is 98%.

Tuberculosis: IHPplus' support to the National TB Program (PNLT) aims to strengthen prevention of TB, HIV/TB co-infection, and multidrug-resistant tuberculosis (MDR-TB), and improve the quality of these services in 78 health zones supported by the project. With 67 of 78 health zones reporting for this quarter, a total of 3,135 new cases of TB were detected during PY1Q3. The MOH conducted several vaccination campaigns in February and March 2016; as a result, many health zones were not able to finalize and provide data this quarter.

Notification rate for new cases of smear-positive pulmonary tuberculosis in USAID-supported health zones: During the quarter, 2,267 new cases of TB were confirmed, for a notification rate of 85 cases for every 100,000 inhabitants (85/100,000). This rate is significantly lower than the rate of 104 cases for every 100,000 inhabitants reported in PY1Q2. It represents an achievement rate of 70% against the target (120/100,000 inhabitants). Table 35 below outlines the notification and achievement rates for each coordination area.

Table 35: New TB cases notification rates during PY1Q3

Coordination	Population covered	New TB+ cases detected	Expected number of new TB+ cases	Notification rate for every 100,000 inhabitants	Target for every 100,000 inhabitants	Achievement rate (%)
Kolwezi	747,819	-	224	-	120	**-**
Kamina	1,737,612	745	521	171	120	**143**
Kole	848,285	278	254	131	120	**109**
Tshumbe	749,578	183	225	98	120	**81**
Bukavu	3,040,236	253	912	33	120	**28**
Uvira	671,237	158	201	94	120	**78**
Mwene Ditu	1,800,258	329	540	73	120	**61**
Luiza	1,133,569	321	340	113	120	**94**
Total	**10,728,594**	**2,267**	**3,219**	**85**	**120**	**70**

The coordination areas of Kamina, Kole, and Luiza reported on-target rates of notification, with 171 (Kamina), 131 (Kole), and 113 (Luiza) cases confirmed for every 100,000 inhabitants. Tshumbe and Uvira also had strong performance, with reported rates of 98/100,000 and 94/100,000, respectively. Tshumbe's case notification rate improved compared to PY1Q2 (81/100,000) primarily due to door-to-door mini-campaigns to promote TB testing organized in three health areas (Tshumbe 1, Tshumbe 2, and Kalema) known to have low notification rates. Uvira's performance also significantly improved from PY1Q2 (50/100,000) as a result of a joint supervision visit from IHPplus staff and the *Coordinations provinciales lèpre et tuberculose* (Provincial Coordination Unit for Leprosy and TB, or CPLT) at the

beginning of PY1Q3. On the other hand, the coordination offices of Bukavu (33/100,000) and Mwene Ditu (73/100,000) both reported lower case notification rates during this quarter.

Four main factors contributed to poor performance during the quarter:

- Incomplete data for TB activities:
    - Only 67 health zones reported on this indicator, of a total of 78 health zones supported by IHPplus
    - The coordination office of Kolwezi did not report any TB notification data for PY1Q3. There were several challenges with data quality and completeness.
- Weak exposure of the population to key messages related to the fight against TB (lower community involvement)
- Insufficient number of supervision visits from CPLT provincial coordination teams to health zones and *Centre de Santé de Diagnostic et Traitement* (CSDTs)
- Challenges in accessing health zones in Bukavu due to poorly maintained roads and insecurity in the area.

Percentage of registered TB patients tested for HIV in USAID-supported health zones: As indicated in Table 36 below, with only 55% of registered TB patients tested for HIV (1,731 of 3,135), almost half of TB patients in 58 of 78 health zones did not receive HIV testing. This proportion corresponds to an achievement rate of 69% (55/80), relative to the PMP target of 80%.

Of the 1,731 TB patients who received HIV testing, a total of 201 patients (12%) tested positive for HIV. Only the coordination of Kolwezi, which receives PEPFAR-funded HIV tests and antiretrovirals (ARVs), exceeded the target percentage of TB patients tested for HIV, with an 89% testing rate (513/577). Moreover, all TB patients who received HIV counseling volunteered to take the test; among them, 29% (147/513) tested positive for HIV. This elevated rate of HIV results from the prevalence of mining activities in this province, which is a trend noted throughout the country in zones where there are mining activities. Outside of PEPFAR's support, the high percentage of TB patients receiving HIV testing in Kolwezi results from capacity building training for providers in case management of HIV/TB coinfection, which took place during the supportive supervision visit jointly organized with the CPLT during PY1Q3. The poor performance reported in other coordination offices, which receive HIV tests from the Global Fund, primarily results from an irregular supply and repeated stock-outs of HIV tests.

Table 36: Number and percentage of TB patients tested for HIV during PY1Q3

Coordination	Population covered	Number of registered TB patients	Number of registered TB patients that received HIV counseling	Number of registered TB patients tested for HIV	Number of registered TB patients that tested positive for HIV	Percentage of registered TB patients that tested positive for HIV (%)	Percentage of registered TB patients tested for HIV (%)	Target (%)	Achievement rate (%)
Kolwezi	747,819	577	513	513	147	29	89	80	111
Kamina	1,737,612	901	647	531	12	2	59	80	74
Kole	848,285	437	236	236	23	10	54	80	68
Tshumbe	749,578	213	83	80	1	1	38	80	47
Bukavu	3,040,236	404	77	137	11	8	34	80	42
Uvira	671,237	225	44	50	0	0	22	80	28
Mwene Ditu	1,800,258	-	-	86	-	0	-	80	-
Luiza	1,133,569	378	338	98	7	7	26	80	32
Total	10,728,594	3,135	1,938	1,731	201	12	55	80	69

Number of MDR-TB cases detected: The total number of MDR-TB cases detected in PY1Q3 was 6, an achievement rate of 40% compared to the PMP target of 15 cases per quarter (please refer to Table 37). The coordination of Bukavu reported 6 cases of MDR-TB confirmed by GeneXpert, compared to PY1Q2, when no cases of MDR-TB were detected. Bukavu's performance results from two factors:

- There are a higher number of health zones (8) with a GeneXpert machine, in contrast to the other coordination offices which only have one
- Funding from IHPplus to transport sputum tests from suspected MDR-TB patients from CSTs/CSDTs to GeneXpert sites

Table 37: Number of MDR-TB cases detected during PY1Q3

Coordination	Population covered	Number of MDR-TB cases detected	Target	Achievement rate (%)
Kolwezi	747,819	0	1	0
Kamina	1,737,612	0	2	0
Kole	848,285	0	1	0
Tshumbe	749,578	0	1	0
Bukavu	3,040,236	6	4	150
Uvira	671,237	0	1	0
Mwene Ditu	1,800,258	0	3	0
Luiza	1,133,569	0	2	0
Total	10,728,594	6	15	40

To further improve the quality of services for TB case management, MDR-TB, and HIV/TB coinfection, IHPplus will use several strategies in all supported health zones during the next quarter, including the following:

- Provide capacity building for service providers to incorporate the new directives for basic TB care outlined in the Integrated Anti-Tuberculosis Program (*Programme Antituberculeux Intégré,* or PATI V)
- Provide training for service providers in managing HIV/TB coinfection
- Expand coverage of HIV-TB coinfection management services by integrating HIV-TB activities in all CSDTs and CDVs
- Conduct joint supervision visits with the PNLT and the PNLS and ensure a reliable supply of HIV RDTs
- Further involve CBOs by organizing door-to-door mini-campaigns to raise awareness and promote TB testing in health zones with low detection rates
- Finance the transportation of anti-TB medicines and laboratory commodities from CPLTs to health zones

Sexual and gender-based violence*:* During PY1Q3, the total number of people reached by a USG-supported intervention providing GBV health services reached 775. Compared to the PMP target of 600, this represents an achievement rate of 129%. Sud Kivu remained the province with the highest prevalence of GBV, due to the ongoing conflict and insecurity. As shown in Table 38 below, the highest number of cases was reported from the Bukavu coordination office, with 655 GBV cases (649 women and 6 men). The Uvira coordination office, also in Sud Kivu, reported 91 GBV cases, followed by Mwene Ditu with 15 cases. Among the 775 GBV survivors reported this quarter, 358 (46%) sought care at a facility within 72 hours after the attack, and 417 (54%) between 72 and 120 hours. Compared to PY1Q2, the number of people reporting sexual violence to USG-supported health clinics has increased from 549 to 775. The gender of survivors reveals another decreasing trend; out of 775 cases reported this quarter, 10 males (1%) reported sexual violence compared to 21 out of 549 (4%) in PY1Q2. The project also supported the health zones by making post-exposure prophylaxis kits more available to complement the contributions of other partners.

Table 38: Number of people reached by GBV services funded by the USG, disaggregated by sex and period of arrival at a health facility

Coordination	Number of people reporting sexual violence in USG-supported health clinic		Number of people reporting sexual violence in USG-supported clinic within 72 hours	Number of people reporting sexual violence in USG-supported clinic between 72 and 120 hours	Number of people reporting sexual violence in USG-supported clinic given ARVs	Number of people reporting sexual violence in USG-supported clinic given emergency contraceptive
	# Female patients	# Male patients				
Bukavu	649	6	258	397	241	181
Kamina	3	0	3	0	1	1
Kole	11	0	10	1	6	6
Kolwezi	0	0	0	0	0	0
Luiza	0	0	0	0	0	0
Mwene Ditu	0	0	0	0	0	0
Tshumbe	14	1	13	2	7	7
Uvira	88	3	74	17	74	88
Total	**765**	**10**	**358**	**417**	**329**	**283**

Fistula: IHPplus supports Kaziba GRH in providing fistula repairs (vesico-vaginal and recto-vaginal) as well as uterine and rectal prolapse repair to women living in the Bukavu coordination. From January to March 2016, among the 80 female patients who visited the hospital to consult about urinary incontinence, 81% (65) were diagnosed with fistula. Kaziba GRH repaired 92% (60) of these 65 cases in a routine procedure. Among the 60 fistula patients on whom the Kaziba staff operated, the majority (66%) were between the ages of 20 and 34, and the primary causes were obstructed labor (45%) and home births (33%). By the end of PY1Q3, 53 patients (83%) who received operations had been released from the hospital with their fistula repair site fully closed and dry. The seven failed operations were relapses from previous fistulas.

Next steps:

- Conduct supportive supervision visits on partogram usage in Kaziba health zone to help service providers quickly decide whether to refer women with obstructed labor to the GRH
- Organize awareness-raising activities in the health zone and surrounding areas to encourage women to attend the fourth ANC visit and give birth at the hospital rather than at home.

IR 2.2: Minimum quality standards for health facilities (general referral hospitals and health zone health centers) and services developed and adopted

***FOSACOF approach**:* IHP and IHPplus have trained 611 teams (from the DPS and health zone coordination offices), 1,474 health service providers at health facilities, and 3,685 community leaders to implement the FOSACOF approach. Overall, 737 health centers and 38 GRHs are using FOSACOF across the 78 health zones supported by IHPplus.

During PY1Q3, 402 of the 737 health facilities (health centers and GRHs), or 55%, completed an evaluation of the nine FOSACOF criteria (see box at right). This result falls below the target of 76%, an achievement rate of 72%; however, it is an increase from the 378 health facilities that were evaluated on the FOSACOF criteria during PY1Q2. Of the 402 health facilities, 118 were evaluated as part of the RBF program during quarterly verification exercises. Table 39 below presents the results of the FOSACOF evaluations of health facilities during the quarter.

FOSACOF CRITERIA

1. Infrastructure
2. Equipment
3. Essential medicines and supplies
4. Personnel
5. In-service training
6. Community approach
7. Community support
8. Clinical quality
9. Management

Table 39: Results of FOSACOF evaluation of health facilities during PY1Q3

Coordination	# of health facilities with FOSACOF implemented	# of health facilities implementing FOSACOF that were evaluated during PY1Q3	Evaluation Results			
			Class D (0 <25%)	Class C (25< 50%)	Class B (50<80%)	Class A (≥ 80%)
Luiza	93	78	0	3	68	7
Kamina	77	35	0	12	20	3
Mwene Ditu	97	59	0	7	49	3
Bukavu	159	92	0	0	86	6
Uvira	52	46	0	0	42	4
Kolwezi	90	35	4	17	12	2
Tshumbe	93	38	0	0	21	17
Kole	76	19	0	0	19	0
Total	**737**	**402**	**4**	**39**	**317**	**42**
Percentage	**100%**	**55%**	**1%**	**10%**	**79%**	**10%**

The poor results from Kole, Kolwezi, Tshumbe, and Kamina contributed to the underperformance in evaluating health facilities. Conflicting activity calendars and high turnover of health facility staff are the two main reasons underlying the weak results reported. Also, Bukavu continues to experience unrest from armed groups, which limits the team's ability to work with health facilities in certain locations.

Of the health facilities evaluated, 79% met 50-80% of the criteria, 10% met 80% or greater of the criteria, 10% achieved 25-50% of the criteria, and 1% met only 0-25% of the criteria. Table 40 below presents the results from the evaluations of GRHs by coordination. A total of 27 of the 28 GRHs (71%) completed an evaluation. This lower performance can also be explained by conflicting activity calendars and staff turnover. The result falls slightly below the target of 76% of GRHs, representing an achievement rate of 93%. However, the result is an increase from the 17 GRHs that were evaluated during PY1Q2. Seven of these evaluations were conducted during the quarterly RBF data verification exercises. Of the 27 GRHs evaluated, 78% met 50-80% of the FOSACOF criteria, 19% met 80% or more of the criteria, 4% met 25-50% of the criteria, and no GRHs met less than 25% of the criteria.

Table 40: Results of FOSACOF evaluation of GRHs during PY1Q3

Coordination	# of GRHs with FOSACOF implemented	# of GRHs implementing FOSACOF that were evaluated	Evaluation Results			
			Class D (0 <25%)	Class C (25< 50%)	Class B (50<80%)	Class A (≥ 80%)
Luiza	5	1	0	0	1	0
Kamina	3	1	0	0	0	1
Mwene Ditu	5	3	0	0	1	2
Bukavu	10	13	0	0	13	0
Uvira	3	4	0	0	3	1
Kolwezi	3	3	0	1	1	1
Tshumbe	5	1	0	0	1	0
Kole	4	1	0	0	1	0
Total	**38**	**27**	**0**	**1**	**21**	**5**
Percentage	**100%**	**71%**	**0%**	**4%**	**78%**	**19%**

The FOSACOF approach offers an opportunity to promote hygienic practices in the supported health zones, through joint supervision visits by MOH and IHPplus staff to health centers and GRHs. If routine supervision visits do not allow for systematic collection of hospital hygiene information, the information can be collected during FOSACOF evaluations. Table 41 below presents a sample of hygiene data reporting from monitoring visits conducted by IHPplus and MOH staff in hospitals and health centers during FOSACOF evaluations at the 402 health centers and 27 hospitals.

Table 41: Percentage of health facilities with hygiene equipment

Equipment monitored for infection prevention practices	Incinerator	Garbage pit	Placenta pit	Sharps disposal containers	Latrines with hand-washing stations for patients	Latrines with hand-washing stations for staff
Total facilities visited, Jan-March 2016	489	489	489	489	489	489
Facilities with hygiene equipment	260	383	393	408	338	338
% of facilities with hygiene equipment	**53%**	**78%**	**80%**	**83%**	**69%**	**69%**
Facilities whose staff use hygiene equipment correctly	212	330	353	373	287	285
% of facilities whose staff use hygiene equipment correctly	**82%**	**86%**	**90%**	**91%**	**85%**	**84%**

Table 41 shows that the majority of health facilities have sufficient equipment for infection prevention and that personnel in health facilities correctly use hygiene equipment. A high percentage of health facilities have placenta pits and containers for disposing sharp items (80% and 83%, respectively) and a large number of staff at the facilities know how to use them correctly (90% and 91%, respectively). Incinerators were the least prevalent, with only 53% of facilities reporting having this equipment. Most facilities face difficulties paying for this equipment, and additional support is needed to fill this gap. On average, 85% of facility staff use all hygiene equipment correctly. Sud Kivu--particularly the coordination areas of Bukavu and Uvira--is the province with the most well-equipped health facilities.

Challenges: IHPplus staff encountered the following challenges during the quarter in implementing the FOSACOF approach:

- Financing the implementation of this approach
- Ensuring that health zone management teams conduct quarterly evaluations in at least 80% of health facilities, develop and implement quarterly improvement plans, organize evaluation meetings, and share successful experiences.

To improve health facility hygiene, additional support is needed from partners to procure the necessary equipment that is used to effectively prevent infections, as most health facilities lack sufficient funding.

Lessons learned:

- The FOSACOF approach continues to provide an effective strategy for improving hygiene practices in IHPplus supported health zones.
- The use of the FOSACOF approach for evaluating the quality of services offered by health facilities has improved in almost all health facilities visited due to improvements in health facility inventory systems, good environmental management practices (disposing of waste), and improved archiving systems.

Next steps: In the next quarter, IHPplus will continue to strengthen support to the coordination areas of Kole, Kolwezi, Tshumbe, and Kamina during routine supervision visits.

Results-based Financing: RBF provides incentives to health service providers to improve performance. Under RBF, facilities receive payments based on achievement of agreed-upon targets, rather than for inputs or processes as in traditional financing. During this quarter, the project implemented the following RBF activities:

- Entered validated IHP Quarter 4 performance data into the DRC RBF web portal by a joint IHPplus and MOH RBF unit team
- Supported the MOH to organize a review and presentation of the achievements and results after two years of implementing RBF
- Organized supervision visits to monitor RBF program progress throughout 7 RBF health zones (118 health centers, 7 GRHs, 7 health zone central offices, and 14 community organizations) by a joint IHPplus/RBF MOH unit/Provincial Health Division
- Organized a monitoring visit with joint RBF MOH unit/IHPplus team to ensure activity monitoring between verifications
- Organized technical data verification of Quarter 1 data in the seven health zones
- Organized the counter-verification of Quarter 1 verified data in seven health zones by 14 CBOs
- Paid each structure its Quarter 1 performance-related bonus

As shown in Figure 8 and Table 42 below, results from RBF implementation Q9's initial internal evaluation indicates excellent progress. Among the most significant results was the utilization of curative services, which tripled (200% increase) compared to the baseline (from 21% to 46%). Project performance decreased only slightly between Q7 and Q8 because performance in Bibanga, Lomela, and Kanzenze brought down the project average.

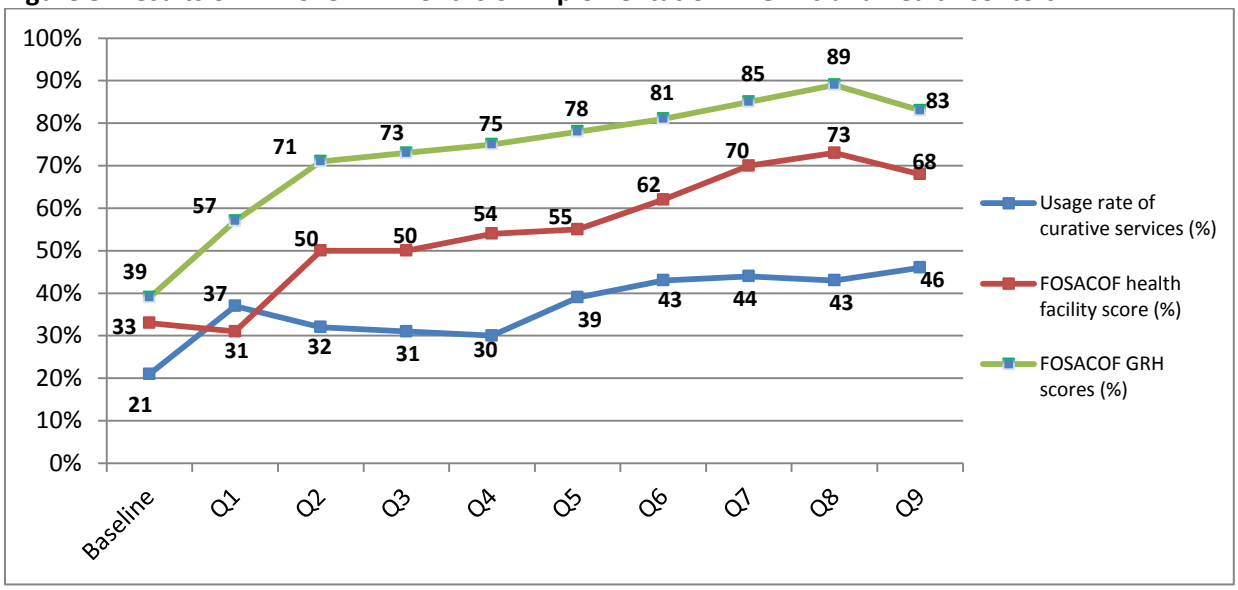
The quality score of health center services, according to the FOSACOF evaluation criteria, increased from 33% to 68%, as compared to 73% in Q8. The FOSACOF quality score for the GRHs increased from 39% to 83% to become fully functioning hospitals; a drop from the 89% in Q8. This decrease in performance from the previous quarter is mainly due to a lower score in health facilities and GRHs in Nundu GRH, due to a lack of monitoring from the intermediate level and insecurity in the region.

Table 42: Progress of RBF results over eight quarters of implementation*

	Baseline	Year 1				Year 2				Year 3
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Utilization rate of curative services (%)	21	37	32	31	30	39	43	44	43	46
FOSACOF health facility score (%)	33	31	50	50	54	55	62	70	73	68
FOSACOF GRH scores (%)	39	57	71	73	75	78	81	85	89	83

**Numbers may not add up exactly due to rounding*

Figure 8: Results of RBF over 27 months of implementation in GRHs and health centers



Luiza (86%) and Wembonyama (84%) were the highest performing health zones in terms of health center FOSACOF scores while Nundu (79%) and Lomela (74%) were the lowest performing. Nundu health zone increased slightly from 77% to 79% despite being one of the lower performing health zones. For the GRHs FOSACOF score, the best performing health zones are Lomela (85%) and Kanzenze (83%), while the lowest performing are Kayamba (66%) and Nundu (67%).

RBF has contributed to significant increases in the utilization rate of curative services and the quality of health center and GRH services. In fact, Target 7 of the National Health Development Plan (PNDS) 2011-2015, which stipulates that an additional 25% of the population should gain access to quality primary health care by 2015, has nearly been achieved in 24 months using few resources other than RBF (see Table 42 above). Other project activities also likely contributed to these results.

As we compare the change in results over the course of Q7 and Q8 to the last two quarters of Year 1 in the table, we observe very strong progress over the course of Year 2. Whereas previously the curves had flattened out or tended to descend, they have now begun to climb. This change is tied to decisions made at the Year 1 evaluation to encourage improvements in community participation by giving the CODESAs a 10% performance bonus and a framework developed by the health centers. As a result, the functioning of the CODESAs has improved, and they have raised more community awareness about consulting the health centers and giving birth at the health centers, as well as participated even more in bringing children lost to follow-up *(enfants perdus de vue)* back into the health centers. The RBF approach implemented by IHP and MOH, supported by national trainings and the leadership of the MOH's RBF Technical Support Unit, has significantly contributed to this progress.

It may not be possible to greatly increase the quality of services in future quarters, because most of the remaining areas needing improvement require interventions outside the scope of the project (such as repairs, equipment, and staff training). But even if not, the utilization of curative treatments may still continue to increase and surpass the PNDS target during the next reporting period.

IR 2.3: Referral system for primary health care prevention, care, and treatment between community and health facilities (district and provincial levels) institutionalized

During PY1Q3, 4% of patients were referred to GRHs after being seen by a CHW or health care provider, against a PMP target of 5%, which represents an 77% achievement rate (as shown in Table 43 below).

Table 43: Number and percentage of patients referred to GRHs

Coordination	# of patients (adults and children) referred to GRHs by a CHW or health care provider				Total number of patients seen by a CHW or health care provider	% patients referred to GRH	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	5,622	6,015	5,660	17,297	479,949	4	**5**	72
Kamina	1,337	1,263	1,001	3,601	479,949	1	**5**	15
Kole	2,717	2,700	2,778	8,195	228,062	4	**5**	72
Kolwezi	471	964	714	2,149	119,716	2	**5**	36
Luiza	932	914	867	2,713	148,877	2	**5**	36
Mwene Ditu	4,473	4,953	3,774	13,200	134,544	10	**5**	196
Tshumbe	2,275	2,402	2,539	7,216	247,100	3	**5**	58
Uvira	1,366	2,396	1,613	5,375	112,507	5	**5**	96
PY1Q3 Total	**19,193**	**21,607**	**18,946**	**59,746**	**1,559,511**	**4**	**5**	**77**

The project maintained its performance from PY1Q2. Five coordination areas (Bukavu, Tshumbe, Mwene Ditu, Kole, and Uvira) met or exceeded the PMP target; three out of the eight (Luiza , Kolwezi, and Kamina) reported a rate below the project average. The GRHs in Kamina and Luiza are located in remote areas; therefore, the project is still looking into the underlying reasons for the poor results in the Kolwezi coordination territory, 80% of which is urban.

Next Steps: During the next quarter, the project will lead the following corrective actions:

- Ensure procurement of EGM for GRHs
- Work with health zone management teams during supervision visits to health centers and GRHs to provide guidance to head nurses, CHWs, and nurses working in community care sites on the use of flow charts and meeting planning and coordination
- Brief head nurses working in health centers on how to properly use the coaching checklist with CHWs who work in community care sites

During PY1Q3, CHWs referred 8% of patients to health centers, indicating a slight decrease compared to PY1Q2 (12%). Compared to the PMP target of 15%, the project reached a 54% achievement rate this quarter (see table 44 below).

Table 44: Number and percentage of patients referred to health centers

Coordination	# of patients (adults and children) referred to health centers by a CHW				Total number of patients seen by a CHW or health care provider	% patients referred to health centers	Target (%)	Achievement rate (%)
	Jan-16	Feb-16	Mar-16	Total PY1Q3				
Bukavu	98	105	209	412	2,493	17	**15**	110
Kamina	476	431	645	1,552	2,493	62	**15**	415
Kole	405	470	284	1,159	15,117	8	**15**	51
Kolwezi	46	61	208	315	10,957	3	**15**	19
Luiza	206	147	246	599	1,699	35	**15**	235
Mwene Ditu	201	211	182	594	25,676	2	**15**	15
Tshumbe	361	338	322	1,021	11,314	9	**15**	60
Uvira	62	47	73	182	1,093	17	**15**	111
PY1Q3 Total	**1,855**	**1,810**	**2,169**	**5,834**	**72,514**	**8**	**15**	**54**

Luiza (2%) and Mwene Ditu (5%) brought down the project's overall performance for this indicator. Both coordination offices suffered from a low level of community involvement, while Luiza was also affected by the lack of health zone management team supervision visits to health centers.

Next Steps: To improve underperformance next quarter, the project plans to implement strategies that were successful in the five other coordination areas:

- Expand the i-CCM approach by implementing more community care sites in Mwene Ditu and Luiza (proved to be successful in Bukavu, Tshumbe, Uvira, and Kole)
- Ensure regular drug procurement to health centers, including community care sites

Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones

Community participation is one of nine principles of primary health care included in the PNDS. IHPplus is using approaches such as Champion Communities, ETL, and mHealth to encourage exchange of health knowledge, change attitudes harmful to health, and help communities support healthy behaviors and use of health care services. Through these approaches, IHP is helping maximize health sector–community outreach linkages, foster health advocacy and community mobilization, and facilitate BCC (see Table 45).

Table 45: Summary of IR 3 key results for PY1Q2 by Sub-IR

Sub-IR	Key Indicators	Results
3.1 Health sector-community outreach linkages	Youth and vulnerable group NGO participation	
	Active Champion Communities	
3.2 Health advocacy and community mobilization	Rehabilitated CODESAs	
3.3 Behavior Change Communication	Functional CODESAs with communication action plans	
	mHealth text messaging	

***** **Green = achievement rate against the PMP target of 100% and above; Yellow = achievement rate against the PMP target between 75% and 99%; Red = achievement rate against the PMP target under 75%*

IR 3.1: Evidence-based health sector-community outreach linkages—especially for women, youth, and vulnerable populations—established

Youth Associations: Youth associations continue to play a vital role in the promotion of healthy practices and behaviors. Of the 212 youth organizations identified by IHPplus, 148 are actively participating in awareness-raising activities (see Table 46 below), an increase from the PY1Q2 result of 143 organizations. The project exceeded the PMP target of 146, for an achievement rate of 101%.

Table 46: Number of youth organization completing youth awareness-raising activities

Coordination	Number of youth CBOs/NGOs	Number of youth CBOs/NGOs participating in awareness-raising activities
Bukavu	42	10
Kamina	7	5
Kole	36	35
Kolwezi	12	10
Luiza	18	15
Mwene Ditu	69	58
Tshumbe	3	2
Uvira	25	13
Total	**212**	**148**

The project continued to assist the health zone management teams, CODESAs, and Champion Communities to improve their collaboration with CBOs and youth NGOs by providing technical support in workplanning development and implementation. During the quarter, IHPplus held 15 knowledge-sharing meetings in 5 health zones (Luiza, Kolwezi, Kamina, Tshumbe, and Kole) with representatives from these various groups to discuss workplan implementation and activity monitoring. Additionally, IHPplus facilitated working meetings for 12 CBOs, youth organizations, Champion Communities, and health zone management teams to plan and discuss activities.

In Kolwezi, Kole, and Kamina, youth were incorporated into the Champion Communities. Parent committees organized 16 awareness-raising sessions in schools and churches on GBV, HIV and AIDS, hygiene, and the importance of education. Approximately 2,800 youths participated in the sessions. These sessions resulted in the reporting of six cases of GBV in Kole (Lodja) by community members to the appropriate authorities.

In the Kamina coordination, the health zone management teams of Kabongo and Songa educated five CBOs in group management and teamwork. IHPplus helped the territorial chief establish a steering committee for collaboration and discussion on youth issues, as well as youth participation in community development activities. These efforts led to communities identifying and vaccinating 204 children (134 in Kabongo health zone and 70 in Songa health zone) who were missed during the last measles vaccination campaigns.

In Mwene Ditu, the youth NGOs and CBOs, in conjunction with *Forum SIDA* (FOSI) and *Réseau des associations des jeunes contre le SIDA* (RACOJ), organized mini-campaigns on HIV and AIDS and family planning in schools. The project helped them brief management teams on the use of communications methods (advocacy, group interviews, community debates, and personal communication). The campaign targeted 24 secondary schools and 1,200 youth. After the campaigns, 43 sought testing for HIV. A large number of the youth that participated in the campaigns felt that it was important to learn about family planning.

Challenges: ETL activities have slowed, especially in Mwene Ditu, due to project-trained ETL personnel moving to other zones.

Lessons learned: Engaging youth groups and organizations is an effective way of raising awareness on sexually transmitted infections, sexual violence, and early marriage. Increased awareness on these subjects leads to greater youth participation in health-related discussions, testing for sexually transmitted infections, and reporting on suspected cases.

Next steps:

- Provide technical support to health zones and youth CBOs to reestablish the ETL teams and trainers
- Assist in the implementation of the CBO and NGO workplan activities
- Assist the health zones, Champion Communities, CBOs, and NGOs in documenting and archiving youth and adolescent activities

IR 3.2 Health advocacy and community mobilization organizations strengthened

As previously noted, 1,295 IHPplus-supported communities have CODESAs that are actively involved in management of priority health activities. Of these, 1,221 (94%) have a communication action plan (the same as the PY1Q2 result of 1,221). IHPplus exceeded the target of 1,200, an achievement rate of 102%.

Table 47: Number of CODESAs with communication action plans during PY1Q3

Coordination	Number of active CODESAs	Number of CODESAs with communication action plans	% of CODESAs with communication action plans
Bukavu	399	380	95
Kamina	197	180	91
Kole	129	129	100
Kolwezi	91	89	98
Luiza	147	142	97
Mwene Ditu	156	149	96
Tshumbe	74	70	95
Uvira	102	82	80
Total	**1,295**	**1,221**	**94**

The communication action plans include activities such as community activities (awareness-raising and education, community mobilization, and referrals to health structures). CODESAs contribute greatly to improving health services to the communities and populations of the health zones through the implementation of these action plans.

IHPplus continues to provide fixed monthly subsidies to the CODESAs ($15 per month) for monthly meetings and monitoring of the health areas. Furthermore, the project encourages collaboration among CODESA members, which further improves the efficiency and effectiveness of CODESA activities. The project is also successfully integrating CHWs into CODESA activities. Previously hesitant CHWs are now participating in CODESA meetings and Champion Community activities due to better funding opportunities for Champion Communities which are officially NGOs. The CHWs contribute to the CODESAs extensive experience raising awareness.

The following activities were achieved by the CODESAs during the quarter:

- Two CODESAs in the health zone of Mulongo (health areas of Ngoya and Kyabo) referred 280 cases of fever to health centers. Of the 280 referred cases, 198 were diagnosed and treated for malaria.
- As a result of the mobilization efforts of two CODESAs in the Kinkondja health zone (Kipamba I and Mangi II health areas), 12 suspected cases of cholera were transported by bike (donated by the project) to hospitals. All 12 patients recovered.
- In all health zones, the CODESA members actively participated in campaigns orchestrated by MOH officials in the health zones (such as the fight against polio, for example). In Bukavu and Uvira, members participated in campaigns against meningitis and initiatives to count the population for the distribution of insecticide-treated mosquito nets.

- IHPplus provided technical support to CODESAs to organize household visits to increase health awareness and promote related behaviors. The visits were used to collect data on households.

Challenges: Project staff experienced challenges accessing certain health areas and zones due to difficult terrain and security problems caused by armed groups and conflicts in Bukavu, Uvira, and Kole (health zones of Shabunda, Kalole, Mulungu, Haut Plateau, Lemera, and Pania Mutombo).

Lessons learned:

- Health zone involvement in CODESAs' work motivates CODESA members and fosters an environment conducive to collaborative work-planning and joint implementation of activities.
- The development of income-generating activities (livestock, stores, community farming) fosters greater member participation.
- Participation from the local population in CODESA activities enabled the rehabilitation and use of health centers, rural roads, potable water supplies, and latrines.
- Monitoring and supervising CODESAs in the development of their workplans reinforces CODESA leadership, strengthens the implementation of activities, and leads to greater achievement of goals and results.

Next steps:

- Continue to provide technical and financial support to CODESAs to implement their activities
- Provide technical support to health zones to evaluate achievement of CODESAs' communication action plans
- Continue to encourage the health zone management teams to perform regular visits to the CODESAs
- Strive for equal representation between men, women, and youth in CODESA membership
- Monitor the CODESAs in conjunction with the health zones and *Division Provinciale de la Santé*

IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched

Behavior Change Communication

Champion Communities: IHPplus currently supports 34 Champion Communities in the eight coordination areas, of which 32 are active. Neighboring communities, desiring to improve their own health standards, have adopted the Champion Community method on their own. Three operational autonomous Champion Communities (Tshumbe, Lodja, and Luiza) were created through community initiatives, with technical assistance from IHPplus supported Champion Communities. Another three autonomous Champion Communities in the health zones of Bilomba, Dibaya, and Ruzizi are in the initial phases of operation and receiving assistance from project Champion Communities (see Table 48 below).

Table 48: Champion Community creation

Coordination	Number of active Champion Communities implemented by IHPplus	Number of non-active Champion Communities implemented by IHPplus	Number of autonomous Champion Communities	Place or health zone benefiting from the autonomous Champion Communities
Bukavu	4	1	0	N/A
Kamina	3	0	0	N/A
Kole/Lodja	3	0	1	Lodja
Kolwezi	4	1	0	N/A
Luiza	6	0	3	Bilomba, Luiza, and Dibaya
Mwene Ditu	4	0	0	N/A
Tshumbe	3	0	1	Tshumbe
Uvira	5	0	1	Ruzizi
Total	**32**	**2**	**6**	**N/A**

In conjunction with provincial health authorities, the project trained 50 members from six of the Luiza Champion Communities in workplanning, project management, reporting writing, and governance, with the objective of improving grant management. IHPplus will extend this training program to the other health zones through the fourth quarter. The project's approach has proven to be sustainable, self-replicating, and acceptable in many different contexts. For example, communities not involved in IHPplus programs request mentorship from the project's Champion Communities on implementing the approach to achieve health results (see example from the Luiza coordination area below).

In Luiza, the Tudisange Champion Community, which has achieved NGO status, is developing income-generating activities through microloans and the support of local community leaders and administrative officials. Having witnessed this development, four neighboring health areas (Kanda Kanda, Kakala, Kazea, and Mukungu) decided to implement the Champion Community approach in their area. The Tudisange Champion Community steering committee mentored the four health areas to implement the approach and provided assistance during four informational and advocacy work sessions.

The new Champion Community, Diakaja, was founded on the free exchange of experiences and information through open sessions, direct assistance in workplanning, and the implementation of cooperative activities with the neighboring project Champion Community, Tudisange. Its steering committee is comprised of 33 members. The committee created a workplan with assistance from a head nurse. Furthermore, Tudisange provided the autonomous Diakaja Champion Community with two pigs (male and female). Local leaders monitored and discussed the creation of the new Champion Community during community meetings.

The development NGO Champion Communities in several health zones continue to show their creativity in managing and developing income-generating activities to strengthen their autonomy:

- **Luiza**: The Tudisange Champion Community earned $ 1,200 from the sales of their agricultural products (cowpeas and corn) and livestock (duck, rabbit, pork, and fowl).
- **Ndekesha**: The Koleshayi de Ndekesha Champion Community has 110 hens, 60 rabbits, and 50 kg of peanut seed.

- **Kalomba**: The Tuye Kumpala Kalomba Champion Community has 3 goats, 14 pigs, 2 hectares of planted peanut plants, and 40 kg of peanut seed.
- **Bilomba**: The Bobumue Bilomba Champion Community has saved $370 and has 2 pigs with 10 piglets, as well as 200 kg of rice.
- **Kabongo**: The Kabongo Champion Community has saved $345 and has 9 pigs, 7 goats, and 1.5 hectares of corn.

The implementation of Champion Community workplans resulted in the following:

- **Uvira**: Mwangaza Champion Community enabled 873 children to receive required infant immunizations, referred and brought 295 pregnant women to maternity clinics, raised awareness of family planning and contraception methods among 226 women of childbearing age, and taught over 10,611 people about WASH. These activities were achieved in schools, churches, house visits, and via SMS messaging.
- The International Rescue Committee (IRC) requested the assistance of the Champion Community in fighting cholera in the health zone of Uvira. A cooperative workplan is currently being developed.
- **Kamina**: The members of the Champion Community in Songa health zone referred 50 people with coughs to a CSDT. Eighteen of these people tested positive for TB and were provided with the appropriate treatment. These referrals and treatments were the result of house visits (130), ETL information sessions (43), and monitoring of suspected cases of TB.
- Using well-developed incentive schemes that allow financial independence, Champion Communities are able to develop, fund, and realize health projects that are identified by the community. Unlike previous Champion Community approaches in the DRC which did not continue after the cessation of funding, the IHPplus model has proven to be not only successful but sustainable and "naturally transitioning." The IHPplus Champion Community model adaption in DRC is now a gold standard.

Challenges:

- Implementation of a Champion Community, but with an alternate structure, by E2A in a health area already covered by IHPplus. This creates confusion on structure and activities.
- Weak leadership within some Champion Community steering committees.
- Insufficient supervision by community supervisors associated with the health zones.

Lessons Learned:

- The Champion Communities with NGO status are true partners to the health zones and are capable of improving living and health standards for the population.
- The Champion Communities are driven by the community in their development activities. The community is assuming responsibility for its own development.
- Other communities have begun to realize the benefits and are now starting their own autonomous Champion Communities and using IHPplus Champion Communities to mentor them in the process of development.

Next steps:

- Create regular meetings for the Champion Community steering committees to share their experiences.
- Continue to reinforce the Champion Community steering committees' knowledge of community project inception and management.

- Provide technical assistance to the NGO Champion Communities in the governance and management of grants.
- Continue to push for active partnerships that respect the principles of equality between communities and health structures.
- Encourage Champion Community members to organize meetings for sharing experiences with other community partners and youth associations.

Awareness-raising campaigns: During the quarter, 12 mini-campaigns were held in Bukavu, Kamina, Kole, Luiza, Mwene Ditu , Tshumbe, and Uvira. The campaigns discussed the following: TB, vaccinations, HIV and AIDS, and GBV (see Table 49 below).

Table 49: Number of awareness-raising campaigns organized during PY1Q3 by health topic

Health topic	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
TB	1	0	1	0	2	2	1	0	7
Vaccination	1	0	0	0	0	0	0	1	2
HIV and AIDS	0	0	0	0	0	1	0	0	1
GBV	0	1	0	0	1	0	0	0	2
Total	**2**	**1**	**1**	**0**	**3**	**3**	**1**	**1**	**12**

In Kamina, IHPplus held an awareness-raising mini-campaign on GBV in Malemba and Mulongo health zones. The women of Batwa Bemba de Malemba, a development NGO, created a workplan to raise awareness among young women on GBV. They began implementing the workplan in February 2016 in four health areas (Kabala, Mukomutombo, Nyoka, and Lwandwe).

In Luiza, IHPplus held two TB mini-campaigns from March 5-14, 2016, in the health zones of Lubondaie and Dibaya. During the mini-campaigns, 80 CHWs, *Club Amis de Damien* (NGO working in TB) members, and Champion Community members were briefed on the community role in the fight against TB. An additional 805 ETL sessions were held in households, schools, and churches, and 4,100 SMS with TB messaging were sent. As a result of the campaigns, 1,039 suspected cases were referred to CSDTs (430 in the health zone of Lubondaie and 609 in the health zone of Dibaya). Of the referred suspected cases, 32 patients tested positive for TB and were treated (15 in Lubondaie and 17 in Dibaya).

Challenges: The MOH prioritizes its own activities, with other activities being delayed or suspended.

Lessons learned: Mini-campaigns successfully raise awareness within target populations and increase health service demand within target populations.

Next steps:
- Organize mini-campaigns in each health zone based on community-identified needs
- Define goals for the CHWs during campaigns
- Organize mass awareness-raising activities and radio broadcasts in peripheral areas for greater impact
- Coordinate neighboring Champion Communities for campaigns
- Improve coordination between the MOH and IHPplus when conducting awareness-raising sessions

mHealth: The mHealth campaigns are effective at disseminating health-related information via SMS messages to targeted persons, their households, and surrounding communities. During the quarter, the project sent 147,607 SMS messages (see Table 50 below), exceeding the project target of 120,000 messages (an achievement rate of 123%). This result is a decrease from the previous quarter's result of 191,066 messages, due to the large number of mass campaigns organized by the MOH. Of the 147,607 messages sent, the health zones sent 130,000.

Table 50: Number of SMS messages sent by health area and by coordination during PY1Q3

	Bukavu	Kamina	Kole	Kolwezi	Luiza	Mwene Ditu	Tshumbe	Uvira	Total
Malaria	3,448	1,901	5,100	-	5,200	-	2,951	3,510	22,110
Family planning	748	3,400	5,420	3,040	14,000	-	3,100	-	29,708
WASH	1,364		2,877	-	6,000	576	2,156	-	12,973
Maternal and child health		3,200	1,773	-	13,000	-	1,847	-	19,820
TB	4,444	2,000	-	-	9,000	1,263	2,115	555	19,377
IYCF	1,364	-	-	-		-	3,027	-	4,391
Vaccination	-	-	7,491	-	12,200	2,301	3,050	7,392	32,434
Diarrhea/ cholera	-	-	-	-	-	-	1,594	1,500	3,094
GBV	-	3,700	-	-	-	-	-	-	3,700
Total	**11,368**	**14,201**	**22,661**	**3,040**	**59,400**	**4,140**	**19,840**	**12,957**	**147,607**

The target populations reacted positively to the mHealth campaigns by sharing and discussing the health messages. Knowledge-sharing took place in professional settings, as well as households and churches.

In **Mwene Ditu**, the CBOs organized listening groups to distribute and exchange the SMS health messages. The listening groups resulted in 10 TB and early marriage information sessions with 174 participants, 42 of whom were tested for TB.

In **Kamina**, the Songa health zone utilized family planning information obtained via SMS messaging during 21 information sessions. The information sessions were organized by the health zone's Champion Community and included nine couples. Of the attending couples, five visited health centers and began utilizing a contraceptive method.

In the Lemera health zone of **Uvira**, an estimated 65 people received SMS messages on malaria. The recipients shared the messaging with another 507 people. With the financial support of IRC, Uvira health zone sent 1,500 SMS messages to raise awareness on cholera. The messages included WASH information. During follow-up house visits, CHWs shared further information on cholera prevention.

The information spread in the Nundu health zone (Mboko and Nundu health areas) via discussions in schools. In the Uvira health zone, the information was shared with the Kasenga CEPAC, Kasenga Etat, Kavimvira, and Kilomoni. The project provided technical support on communication methods to the health zone management teams by facilitating 13 community health education sessions.

Challenges: Low commitment to SMS messaging by some health zones that perceive the method to be expensive and time consuming.

Lessons learned: Communities appreciate receiving health messaging via SMS and have expressed a desire for more information dissemination this way to the BCC specialists, CHWs, and health zone officials.

Next steps:

- Increase mobile phone database and consent for SMS messaging
- Discuss installing FrontLine software at the DPS to facilitate SMS messaging for the communication teams providing support to the health zones

COMPONENT 2: HEALTH SYSTEMS STRENGTHENING

Table 51: Summary of key IR 4 results for PY1Q3

Sub-IR	Key Indicators	Results
4.1 Provincial health sector policies aligned with national policy	Health zones with annual operational plans (AOPs) based on national policy	
	Health zone management teams with appropriate management system tools	

***** **Green = achievement rate against the PMP target of 100% and above; Yellow = achievement rate against the PMP target between 75% and 99%; Red = achievement rate against the PMP target under 75%*

Intermediate Result 4: Health sector leadership and governance in target provinces improved

IR 4.1: Provincial and national level health sector policies aligned

***Annual Operational Plans**:* The number and percentage of AOP drafts developed and validated during PY1Q3 remained the same compared to PY1Q2 (respectively 27 and 35%). During PY1Q2, there was a misunderstanding between the MOH Direction of Studies and Planning (DEP) and the DPS about the activities to prioritize. The DEP was focused on designing the new PNDS, while the DPS had received instructions to start with their local health development plans. The new PNDS was almost completed as of the end of March 2016. However, the insufficient financial support further delays the DPS work on finalizing their local health development plans and AOPs. Moreover, while health zones were able to get their AOPs consolidated at the DPS level, they were still waiting on their Boards to validate them by the end of PY1Q3. According to their schedule, their respective Boards will meet on May 2016, and the project already provided meeting organization subsidies to supported health zones to ensure that more AOPs are validated next quarter.

Finally, IHPplus will continue to offer its financial and technical support during PY1Q4 and will advocate that the DPS and health zones complete their respective AOPs.

Table 52: Number and percentage of AOP drafts developed and validated by province and field offices

Province	Coordination	Health zones	Health zones with AOP validated in 2015	Percentage (%)
Kasaï Occidental	**Luiza**	9	0	**0**
Kasaï Oriental and Lomami	**Mwene Ditu**	9	0	**0**
Sankuru	**Kole**	8	0	**0**
	Tshumbe	8	0	**0**
Haut Lomami	**Kamina**	9	0	**0**
Lualaba	**Kolwezi**	8	0	**0**
Sud Kivu	**Bukavu**	22	22	**100**
	Uvira	5	5	**100**
Total		78	27	**35**

IR 4.2: Evidence-based tools for strategic planning and management decision-making adopted

IHPplus continued to provide technical and financial support to the MOH to strengthen monitoring and evaluation systems and the national health information system. During the quarter IHPplus trained 12 staff from the DPS in Sud Kivu and 10 project staff in performing RDQA.

Data audits were conducted in six health zones (Kaziba, Miti Murhesa, Ruzizi, Kaniola, Mwana, and Mwenga). The DPS used information collected during these exercises to assess the quality of data during the annual provincial review and determine corrective actions to improve data quality. Involving the DPS in using the RDQA tool proved successful and enabled staff to identify additional challenges related to data collection, completing tools, and data analysis.

Several obstacles remain to improving data quality, including insecurity and instability in certain health zones (such as Mulungu and Kalole, for example). IHPplus will continue to conduct trainings on RDQA with new DPS in Kasaï and Tshikapa and will monitor the use of the RDQA tool in all trained DPS and coordination areas supported by the project.

IR 4.3: Community involvement in health policy and service delivery institutionalized

The project continued to assist health zone management teams, CODESAs, and Champion Communities to improve their collaboration with CBOs and youth NGOs by providing technical support in work-planning development and implementation. During the quarter, IHPplus held 15 knowledge-sharing meetings in five health zones (Luiza, Kolwezi, Kamina, Tshumbe, and Kole) with representatives from these various groups to discuss workplan implementation and activity monitoring. Additionally, IHPplus facilitated working meetings for 12 CBOs, youth organizations, Champion Communities, and health zone management teams to plan and discuss activities.

During this quarter, 1,295 IHPplus-supported health areas have CODESAs that are actively involved in management of health priorities, and 94% of them were implementing their communication action plan.

The NGO Champion Communities in several health zones continues to show their creativity in managing and developing income-generating activities to strengthen their autonomy while implementing their workplan activities to support service delivery, mainly in health centers through referrals: e.g., in Uvira, 873 children received required infant immunizations, 295 pregnant women were referred and brought to maternity clinics, and 226 women of childbearing age were sensitized on family planning.

PROJECT MANAGEMENT

Success stories: The project produced eight success stories to contribute toward the annual target of 24 stories. They are found in the last section of the report. During this quarter, the topics covered were RBF (two stories), TB (one story), MNCH (one story), nutrition (one story), WASH (one story), BCC (one story), and family planning (one story). During the next quarter, the project will develop more success stories on the LDP, malaria, i-CCM, FOSACOF, HIV, GBV, and access to care to ensure fair representation of each health topic across the project.

Cost share: Brother's Brother Foundation (BBF) is a nonprofit international humanitarian relief organization that equips the world's most resource-limited medical facilities with donated medical supplies and equipment. MSH started working with BBF under IHP and continues this collaboration under IHPplus. BBF recently donated 53 hospital beds as well as one bulk roll of vinyl material to cover mattresses. The estimated value of this cost share is $23,860 (fair market value of all donated goods). These items arrived in country on November 2, 2015, and were distributed to GRHs located in health zones prioritized by the MOH for support. Due to the sudden departure of BBF's Vice President (who was also the project's main point of contact), IHPplus has not yet received the signed cost share documentation, but is following up closely to remedy to this situation during the next quarter.

IHPplus also worked during the quarter to pursue two additional cost share opportunities with Project CURE and Vitamin Angels. Project CURE (a US-based gift-in-kind donation agency) shipped eight 40-foot containers of medical supplies for IHP, and additional donations are planned under IHPplus. To determine the type and quantity of medical supplies needed, a volunteer for Project CURE conducted a needs assessment in eight hospitals located in Sud Kivu from March 13–19 and submitted a report (including packing list requests) on April 22. IHPplus is working on reviewing the needs assessment report and drafting a scope of work (including number of containers, allocation, and sequencing strategy) to be shared with Project CURE during next quarter. The second cost-share opportunity is with Vitamin Angels, a California-based nonprofit helping to alleviate global micronutrient deficiency among at-risk populations—specifically pregnant women, new mothers, and children under five—and help them gain access to lifesaving vitamins and minerals. IHPplus is exploring a partnership with Vitamin Angels to secure donations for the project's ongoing vitamin A supplementation program. IHPplus will submit the needs assessment for this commodity in the next quarter.

Status of pharmaceutical procurement order #1: The first IHPplus pharmaceutical order was placed with IDA, ASRAMES, IMRES, and MEG in August 2015, for pickup in December 2015. A total of 23 shipments have been managed by global shipping and logistics experts and distributed in the country by GTM. The pharmaceutical shipments are well under way. At the time this report is being submitted, only one *note verbal*e is still pending for the last ocean shipment. The majority (95%) of the order has already reached its final destination and the remaining (5%) delivery should be completed before the end of May 2016.

Status of pharmaceutical procurement order #2: The second order of pharmaceuticals was placed with MissionPharma in December 2015 and is 50% delivered. All shipments from countries of origin to Goma, DRC, are managed by Bollore and will be stored and distributed in the country by ASRAMES. The first two deliveries are now in Goma and stored at ASRAMES warehouse.

Warehousing: In IHP PY5Q2, as a result of using the expiration-warning system that SIAPS set up within MSH's warehouse monitoring system, IHP identified 19,244,157 condoms that were at risk of expiring. The total estimated value of this supply was $769,766. The project officially alerted USAID and called an urgent meeting to develop a redeployment plan in order to distribute the supply. Following this meeting, it was agreed that MSH would redistribute 69% (13,183,000) of these condoms to partnering CDRs. By the end of PY1Q3, 71% of the total stock had been distributed (13,665,006 out of 19,244,157) which was a combined effort of all USAID partners. Unfortunately, the 5,579,151 condoms left (valued at $223,166) expired on April 2016. During PY1Q2, SIAPS also alerted USAID of a stock of 173,571 oral contraceptives (Microgynon) valued at $46,864 at risk of expiring in the Kinshasa warehouse. Regrettably, it was too late to develop a redeployment plan, as the contraceptives expired in April 2016. The destruction of both stocks of expired commodities is planned for PY1Q4.

In September 2015, SIAPS produced a situational analysis report of MSH's warehouse in Kamina. Two main recommendations were made: (1) better equip the warehouse with office furniture and supplies, security/compliance, reporting tools, storage equipment; and (2) hire an additional full-time employee (warehouse manager) to manage drug stocks daily. IHPplus purchased additional materials to equip the warehouse (estimated value of $37,558) and more than 50% of the order was delivered to Kamina at the beginning of March 2016. In addition, the warehouse wiring was completed by mid-February 2016.

Regarding recruitment, a warehouse manager was hired and started working on March 2016. Moreover, SIAPS also organized a joint supervision visit with the *Programme National d'Approvisionnement en Médicaments* (Drug Procurement National Program) to Kamina warehouse in order to: (1) provide a technical orientation training to the new warehouse manager; (2) draft a manual on optimal warehouse management procedures; and (3) monitor the implementation of the recommendations that were made by SIAPS in the situational analysis report. Upon completion of this mission, SIAPS technical advisor provided a draft of both the procedures manual and an updated version of the warehouse manager job description to IHPplus and SIAPS project directors for review and approval.

FAMILY PLANNING AND HIV AND AIDS STATUTORY REQUIREMENTS

During PY1Q3, IHPplus staff and service providers at IHPplus-supported health facilities provided family planning and HIV and AIDS services while ensuring that USAID's regulations concerning family planning and HIV and AIDS were followed.

1. **Family planning:** During this quarter, IHPplus led several family planning activities to ensure clients' willingness and informed consent. The project supplied a wide selection of contraceptive products (CycleBeads, male condoms, female condoms, Depo-Provera, ParaGard copper intrauterine devices, Implanon NXT, Microlut, and Microgynon) to service delivery points, which ensured that clients could make an educated selection from a range of methods after attending a family-planning counseling session.

   Over the course of PY1Q3, 68 IHPplus technical staff members and 10 partners from the MOH completed the online course on USG family planning regulations. IHPplus staff continued to monitor

adherence to the USG family planning regulations during family planning supervision visits to all coordination offices, post-training follow-up in Luiza and Mwene Ditu, and data verification activities in the seven health zones implementing the RBF program.

2. **HIV and AIDS:** All IHPplus staff involved in HIV care have previously received HIV and AIDS training, and IHPplus has trained and briefed providers at all HIV care sites. All HIV care sites continued to provide HIV pre-test and post-test counseling. They also provided counseling to people living with HIV/AIDS prior to initiating ART.

   Condoms distributed at IHPplus HIV care sites were accompanied by accurate and specific medical information, including the public health benefits of condom usage and the condom failure rate. Providers at IHPplus-supported HIV and AIDS care sites continued to observe and enforce infection-control regulations by taking universal personal precautions (washing hands, wearing masks and gloves, using condoms to prevent sexually transmitted infections/HIV) administrative precautions (properly ventilating workplaces, spacing out medical visits for TB patients and people living with HIV/AIDS), and environmental precautions (properly managing biomedical waste, specifically by sorting waste and using incinerators).

Next steps:

- Systematically apply statutory requirements to the areas of family planning and HIV and AIDS into the supervision program
- Request additional Tiahrt posters from USAID to replace old, unreadable, and damaged posters at health facilities
- Bring IHPplus technical staff from the Kolwezi and Kamina coordination offices who are involved in implementing the HIV package of services to take the online course on HIV and AIDS Legal and Policy Requirements.

ENVIRONMENTAL MONITORING AND MITIGATION PLAN

The MOH and IHPplus conducted field visits to 489 health facilities. The assessment of the proper disposal of biohazard wastes and appropriate individual hygiene practices were included in the field visit assessment.

In general, the majority of health facilities have sufficient equipment for infection prevention and personnel in health facilities correctly use hygiene equipment. A high percentage of health facilities have placenta pits and containers for disposing sharp items (80% and 83%, respectively) and a large number of staff at the facilities know how to use them correctly (90% and 91%, respectively). The availability of functional incinerators is lower—at only 53% of facilities visited; however, their proper utilization is at 82%.

IHPplus continued supporting the health zone management teams in implementing the following actions:

- Mobilize local resources to ensure that each health facility has a functional incinerator (on a case by case basis, IHPplus may contribute materials for health facilities that demonstrate their commitment)
- Continue to evaluate health facilities during the health zone management team monthly supervision visits

- Sensitize head nurses on the importance of compliance with recommended biohazard waste management and individual and facility hygiene practices during the monthly monitoring meetings and field visits

During this quarter, IHPplus focused on the implementation of the community-led total sanitation approach in four health zones (Ndekesha and Luambo in Kasaï Central and Kanda Kanda and Luputa located in Haut Lomami). The project provided access to improved drinking water supply to 162,741 people, against a targeted population of 158,584 by renovating 147 water sources. The project empowered the community to build 12,902 hygienic family latrines and to grant first-time access to improved sanitation facilities to 89,149 people, against a targeted population of 105,772. As mentioned from the joint USAID/IHPplus field visit in February 2016 in Kanzenze, additional investment is needed to further empower the communities for a sustained ownership of the WASH hardware including maintenance of water sources and adequate utilization of household latrines. IHPplus will support the DPS in revising and standardizing the training modules for WASH committees and local artisans, as well as intensifying the mini-campaigns for adoption of hygiene and sanitation practices.

CHALLENGES ENCOUNTERED

The main challenges that the project experienced during PY1Q3 included the following:

Delay in obligating IHPplus funds: IHPplus did not receive the additional obligation that was expected by end of January 2016 (expected $14,290,000). Partial funds were made available (i.e., $7,144,457) to the project on March 28, 2016. As a result, most of the training activities planned for January-March were postponed to the next quarter pending the availability of the information about the remaining obligation for IHPplus PY1.

Supply Chain Management System: The weak quality of the logistics management information system (LMIS) remains a great challenge. As a result, health facilities continue to report stock-outs of tracer medicines. During the quarter, ACT and Depo-Provera stock-out exceeded the target number of stock-outs (146 stock-outs against a target of 100, and 243 stock-outs against a target of 100, respectively). IHPplus and SIAPS will continue to address bottlenecks that contribute to high stock-out levels at the facility level. This includes but not limited to continuing to organize training activities for health zones management teams and health facility staff. On January 18-21, 2016, SIAPS and IHPplus conducted a drug-management training for 11 health zone management teams in Kolwezi, in collaboration with the National Drug Supply Program.

Data Quality: Ensuring the quality of data remains a challenge. For example, inconsistency in data was reported between the number of deliveries by skilled birth attendants and other indicators related to childbirth, such as the number of women receiving AMTSL and the number of newborns receiving essential care. IHPplus continued to work with the DPS and health zone management teams to identify and address data inaccuracies. IHPplus provided technical and financial support to the MOH's HMIS Office (DSNIS) to train two new provincial health division management teams of Sud Kivu to perform RDQAs.

Security: During this quarter, armed group activities continued in Sud Kivu. The health zones that were affected were mostly the same zones reported during the previous last quarter. IHPplus continues to work closely with the health zones and health authorities in the affected health zones to make sure that basic support is provided for health facilities, including timely delivery of essential medicines,

commodities to maintain the cold chain for vaccines, as well as the grants to health zone management teams and DPS. During next quarter the MSH Security Officer will travel to DRC to support IHPplus and other MSH projects in further improving the organization's security system.

WAY FORWARD: PLANNED ACTIVITIES FOR NEXT QUARTER

Please refer to Appendix 11: DRC-IHPplus PY1Q4 planned activities.

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*Appendices 4, 5, and 11 are attached separately as Excel files

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

A Father Takes his Girls to School: The Story of Jean Paul

The Champion Men initiative changes traditional attitudes toward women, offering two girls a second chance at their education

Photo: Overseas Strategic Consulting, Ltd.

Jean Paul Ntigingwa (far right) with members of the IHPplus Champion Men initiative.

"My husband has completely changed these last five months. He comes home with his pay, and we plan our finances together. On top of that, my daughters are back in school, and I've noticed that they are much happier, which makes me happy."

--Marthe, wife of Jean Paul and Katana health zone resident

In 2013, Jean Paul Ntingingwa believed, "It would be wasteful to spend money on school fees for my two girls as they will end up married and won't provide me with any value." These beliefs drove Jean Paul to pull his teenage daughters, Clarisse and Solange, out of school. Instead, he pushed them to help their mother work in the cassava field and perform household chores.

In partnership with the Democratic Republic of Congo (DRC) Ministry of Health, the USAID-funded Integrated Health Project Plus (IHPplus) works to promote sustainable behaviors that are beneficial to the health of individuals and the wider community through grassroots programs, including the Champion Men initiative.

In October 2015, 8 women and 17 men from Katana health zone – including Jean Paul – attended Champion Men training sessions, to discuss and change how couples address co-management of household finances, education for girls and boys, fidelity in relationships, family planning, and gender-based violence. From October 2015 to March 2016, an estimated 169 men received the Champion Men training. More than 80% of households with the training have made positive behavior changes.

Jean Paul recalled, "I felt ashamed during the Champion Men sessions and decided that I would start to act differently." Even though the school year had begun a month prior, Jean Paul managed to convince the school to register his two daughters. After three years of working with their mother in the cassava field, Clarisse and Solange returned to school.

Jean Paul's wife, Marthe, said, "My husband has completely changed these last five months. He comes home with his pay, and we plan our finances together. On top of that, my daughters are back in school, and I've noticed that they are much happier, which makes me happy."

His daughter Clarisse added, "My sister and I have our dignity again and are proud to be back in school after three years."

Implemented by Management Sciences for Health and Overseas Strategic Consulting, Ltd (OSC) in 83 health zones under a subcontract via Pathfinder/Evidence to Action (E2A), IHPplus is a two-year "bridge" to avoid a gap in services in USAID-supported health zones upon completion of the five-year flagship IHP.

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Clean water is a community affair in Kabuela, DRC

Community-led water and sanitation efforts create facilities that people are more likely to use and maintain.

Photo: Management Sciences for Health

With a clean, convenient source of water, Kabuela has seen diarrhea cases plummet.

"We know how the water points work and how to maintain them or fix them if necessary. There's no need for us to always depend on outsiders. This is really ours."

--Emmanuel Kabuela Ngoyi, local chief

Diarrheal disease, which can kill babies and small children, is largely preventable. People need clean water and good hygiene habits to avoid this and other "diseases of dirty hands." The village of Kabuela in the Democratic Republic of Congo (DRC) until recently faced high rates of diarrheal disease. While facilities for clean water had been installed at one point, they had fallen into disuse. Records show 84 cases of diarrhea in the first quarter of 2015, with a spike to 177 cases in May 2015, in this village of just 15,275 people.

To assist the Ministry of Health to bring these rates down, the USAID-funded Integrated Health Project Plus (DRC-IHPplus) implemented "community-led total sanitation" (CLTS)--a globally-recognized system of involving communities in their own water and sanitation issues. Between December 28 and January 15, 2016, IHPplus trained health zone officials and community leaders, and taught 18 local tradesmen--masons, plumbers, and technicians--how to build and refurbish water points. Local facilitators sparked awareness among families about the links between hygiene and health. The community then developed its own action plan for improving and maintaining the water points.

Meeting local workers who share the language and culture of the community helped inspire many residents to volunteer alongside the tradesmen. Within 12 days, workers and volunteers had organized 15 improved water sources. These facilities provided access to clean drinking water to 13,332 of the village's inhabitants for the first time.

"This is our achievement, and it's for our descendants," said local chief Emmanuel Kabuela Ngoyi. "We know how the water points work, and how to maintain them or fix them if necessary. There's no need for us to always depend on outsiders. This is really ours."

With residents' new access to clean water, diarrhea cases dropped by 36 percent – from 84 cases in the first quarter of 2015 to 54 cases in the first quarter of 2016. The community plans to build on this achievement by constructing household latrines, with help from IHPplus.

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Hands-on training empowers health providers to save the lives of mothers and newborns in the DRC

The hospital had lost nine women to this mother's condition two years before, but this time it was different.

Photo: Management Sciences for Health

Luckily, Albertine Tshibuabua delivered her twins after hospital staff had received training in difficult deliveries.

"As part of our training we learned more about eclampsia, and also… [practiced] handling obstructed labor….They also provided medicines and supplies for emergency obstetrics."

-- Kabemba Kapinga, Head of Maternity Unit, Bilomba General Referral Hospital

When the health team at Bilomba health center discovered that 26-year-old Albertine Tshibuabua had high blood pressure in her fourth pregnancy, they understood the gravity and immediately referred her to Bilomba's general referral hospital. Albertine had been attending her prenatal visits thanks in large part to the hospital's improved quality of care--the result of trainings conducted by the USAID-funded Integrated Health Project Plus (IHPplus).

IHPplus has been supporting the Democratic Republic of Congo (DRC) Ministry of Health (MOH) to reduce maternal, infant, and child mortality in 83 health zones in seven provinces through low-cost, high-impact interventions and intensive, effective training for health providers in how to use them.

For example, in 2015 the project trained 14 hospital nurses, 10 health center nurses, 6 midwives, and 3 health officials from Bilomba in a package of maternal and newborn interventions that included handling obstructed labor, prevention of hemorrhage and other problems, and vital newborn care. IHPplus provided technical and financial support for the MOH training, which features repeated practice of realistic, hands-on care to reinforce providers' new skills.

Albertine's hypertension alarmed the staff at the general hospital, since in 2013 they had lost nine mothers to this condition, and rumors of bad spells had spread in the community. It may have been unnerving to many when she went into convulsions during labor. But midwife Kabemba Kapinga, head of the maternity unit and trained by DRC-IHPplus, kept calm. She called for the medical director, who arrived quickly, reduced the convulsions, and helped deliver twins.

"As part of our training, we learned more about eclampsia, which is lethal if not treated properly, and also strengthened our expertise in handling obstructed labor," said Kapinga. "IHPplus trained us and provided medicines and supplies for emergency obstetrics."

Thanks to the training, Bilomba hospital saved eight women in 2015, with 93 percent of women attending at least one prenatal visit (CPN1) and 40 percent attending four prenatal visits (CPN4). By March 2016, the rate of prenatal visits had further increased to 97 percent (CPN1) and 48 percent (CPN4).

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

It takes a support group and good information: Healthier children in DRC thanks to IYCF support groups

From prenatal visits to preventing malaria, health education in a supportive atmosphere makes a lasting impact

Photo: Management Sciences for Health

Faïda brings Angela to the local health center for a check-up – as recommended by her IYCF support group.

"We don't need millions of dollars to keep our children healthy. IHPplus taught us how small actions can save lives."

-- Elysée Elumba, head nurse at Sange health center

Health education has a long way to go in many parts of the Democratic Republic of Congo (DRC), where hundreds of thousands of babies and small children die each year from preventable causes.

In the Ruzizi Health Zone of Sud Kivu, Baby Angela is lucky that her mother, Faïda, was able to join an Infant and Young Child Feeding (IYCF) support group. There Faïda learned the basics of nutrition, hygiene, and other vital family health topics.

"I practice the instructions I received in the IYCF group for the well-being of my baby, my family, and my own health," says Faïda. "They seem like small things, but they make a big difference."

She recites a menu of health topics discussed at IYCF support-group meetings: "We've learned about the importance of early and exclusive breastfeeding, how to make nutritious weaning foods and family meals from local ingredients, the importance of hand washing, how to correctly use a mosquito net, the schedule of vaccinations, preschool exams, how to make sure my children are growing properly, and why to attend four prenatal visits." The support group uses facilitated discussion, simple visual aids, and cooking demonstrations to get health messages across.

Faïda's quick learning and enthusiasm have made her a role model in her community, says Elysée Elumba, head nurse at the local health center.

"It's really encouraging--today a number of women have taken up these essential practices for nutrition and health because of her and the IYCF support group."

The USAID-funded Integrated Health Project Plus (DRC-IHPplus) has initiated IYCF support groups in 13 of the 18 local health areas of Ruzizi. Membership continues to grow: from 1,390 in January 2016, it grew to 1,500 members two months later. At the same time, the number of women who attended all four prenatal checkups rose from 155 to more than 200. "We don't need millions of dollars to keep our children healthy." says Elumba. "IHPplus taught us how small actions can save lives."

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Life will be radiant in this village: Health education at the hospital turns mother into hygiene activist

Hospital staff educate a typhoid patient. Then she holds leaders and villagers accountable to improve water and sanitation facilities for better health for all.

Photo: Management Sciences for Health

A patient at Luiza hospital washes her hands. Thanks to hygiene training and some citizen pressure, the hospital has cleaned up its act.

"From the information I received from the staff of Luiza hospital, I have become a real activist. And I'm sure that in the days ahead, life will be radiant in this village."

-- Marie Kaseu, farmer and mother of nine

Marie Kaseu's village was so plagued by illness that villagers blamed evil spells. It seemed that whenever a farmer made money, it was rapidly consumed by medical bills. Marie, a farmer and mother of nine, found herself in the Luiza General Referral Hospital with typhoid in November 2015.

As it turned out, this hospital had seen hard times of its own, as patients abandoned it in favor of private clinics, citing lack of hygiene, doctors' hours, and welcoming staff.

But in 2013, the USAID-funded Integrated Health Project (DRC-IHP) introduced results-based financing in the Luiza hospital, which meant that when it met agreed-on targets, the facility received a bonus to be spent on staff and the facility. The bonus could be as high as $12,000 every three months. The hospital staff had chosen to spend much of it on renovating latrines and toilets, general cleanliness, and educating patients on the importance of hygiene. Steadily, patient confidence returned and the bed occupation rate soared from 42 percent on average in 2013 to 69 percent in the first quarter of 2016.

Therefore, when Marie Kaseu showed up with typhoid, doctors and nurses were acutely aware of hygiene and its importance. They took time to educate her on "diseases of dirty hands"--the diarrhea, typhoid, and other maladies so prevalent in her village--and how they can be avoided through washing hands, drinking clean water, and other basic actions.

Back at home, Marie set about to educate her community on the real source of those "spells." She also lobbied village chiefs to lead public awareness raising and to organize water and sanitary facilities. Soon, without outside assistance, the village rehabilitated eight water sources and built over 80 latrines, with more in process.

Of the progress, Marie says, "My reaction is dampened since we have lost lives and also resources that we could have used for development. But from the information I received from the staff of Luiza hospital, I have become a real activist. And I'm sure that in the days ahead, life will be radiant in this village."

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Now I know my condition and I believe in a cure: Mama Bec's TB story

A well-coordinated week of outreach turns up many people with TB—and brings them treatment and hope

Photo: Management Sciences for Health

During the mini-campaign in Kamiji, people with suspected TB could get screened on the spot.

"Thanks to the campaign, I got screened and then immediately put on treatment. I call on everyone else not to hide but go get tested. Everything is free!"

--Mama Bec Kabamba, TB patient

Tuberculosis (TB) sparks stigma in the Democratic Republic of the Congo (DRC). Despite the fact that five percent of people in Kamiji health zone have it, many fear it as a curse, hide it, and avoid health facilities in favor of traditional treatments. People commonly believe it is incurable.

Nationally, only about 50 percent of estimated TB cases are actually found and treated, so this infectious disease continues to spread. The Ministry of Health's goal is to find and treat at least 85 percent of estimated cases.

To improve the detection rate in Kamiji, the USAID-funded Integrated Health Project Plus (DRC-IHPplus) supported the Ministry in a five-day "mini-campaign" at each center for TB detection and treatment in the health zone. Campaign staff organized six TB-education sessions for community leaders and the public, in churches, schools, and other public spaces. They screened films on TB and sent cell phone messages to 725 people thought to be at risk. They also trained 40 community health workers (CHWs) in how to talk with people about TB, and the CHWs practiced their skills walking door-to-door to search for people with a suspicious cough and urge them to be screened.

The Ministry's Department of Leprosy and TB provided laboratory diagnostic supplies, TB drugs, and a team of health workers. DRC-IHPplus staff and health zone officials supervised the activities. During the intense outreach, 422 people were found to have TB symptoms and were directed to TB centers. Of these, 20 tested positive for the disease. In the wake of the mini-campaign, then, the detection rate in the health zone soared to 77 percent in the first quarter of 2016, from a baseline of 5 percent during the first quarter of 2015.

Mama Bec Kabamba, one of those found positive for the disease, spoke for many: "I did not know I had TB. But thanks to the campaign I got screened and then immediately put on treatment. I want to thank the community health worker who convinced me to go to the center, during the door-to-door visits. Because of this service, I believe I will be cured. I call on everyone else not to hide but go get tested. Everything is free!"

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Results-based financing brings back the water--and patients

Results-based financing enables medical staff to address issues and attract patients back to a previously avoided hospital.

Photo: Management Sciences for Health

A group of women draw water from one of Bibanga Hospital's newly-rehabilitated wells.

"Thanks to the RBF approach, we now have a large reserve of water. This dream-become-reality is a praiseworthy solution for the institution and our patients."

-- Dr. Freud Ntambwe, Acting Medical Director, Bibanga General Referral Hospital

Bibanga General Referral Hospital was languishing, with only a 19 percent occupancy (31 beds filled out of 162) in July 2015. A satisfaction survey of patients and other community members indicated that the facility's lack of water was one of the things that kept people away. The hospital's wells hadn't operated for more than 15 years; not only was the hospital spending $140 a month on an inadequate supply of water, but everyone knew that patients and families had to walk close to two miles to collect water for their own use.

The USAID-funded Integrated Health Project Plus (DRC-IHPplus), partnering with the Ministry of Health of the Democratic Republic of the Congo (DRC) to improve the health system in 83 health zones, implemented results-based financing (RBF) in Bibanga. With RBF, health care providers agree on quarterly quality and performance targets, then receive a bonus if they achieve them (or a percentage of the bonus if they achieve a portion of the goals). Part of the bonus goes to the facility and part to staff members themselves. When Bibanga Hospital received its first bonus, the medical staff decided to dedicate a portion of it to renovating the hospital's two wells. The management team bought cement, tar, pipes, and other supplies, and paid local workers to install them and rehabilitate the water system. At a cost of $1,350--nearly half the hospital's monthly budget --this work would have been impossible before the new financing system.

After the wells were rebuilt, patients and staff reported a significant improvement in hospital cleanliness. In less than a year, occupancy of hospital beds nearly doubled, from 19 percent to 33 percent, between July 2015 and March 2016.

"This project has enabled us to save $1,680 a year--which has allowed us to buy new bed linens, and rehabilitate the showers and toilets," said Dr. Freud Ntambwe, Acting Medical Director. "Thanks to the RBF approach, we now have a large reserve of water. This dream-become-reality is a praiseworthy solution for the institution and our patients."

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FROM THE AMERICAN PEOPLE

SUCCESS STORY

Spacing births for healthier lives: Health support groups bring family planning to rural areas of DRC

Five babies in six years… Enough was enough for one couple, who enthusiastically embraced a simple method of birth spacing.

Photo: Management Sciences for Health

After five children, Anuarite learned about family planning from her local IHPplus-organized health support group.

"I've watched the children regain their health along with their mother. We thank the IYCF support group of Ciranga for their advice."

-- Pascal Cishi, father of five in Ciranga, Sud Kivu

In the isolated rural health area of Ciranga in Sud Kivu Province, Anuarite and Pascal Cishi had five babies in six years--enough to tire out any parent and make them receptive to new information about how a couple can control when to have children. "Four or five months after giving birth, I always got pregnant again," said Anuarite. "It was hard for me, but I didn't know what to do." This situation is common in rural areas in the Democratic Republic of Congo (DRC).

Family planning is a key area of primary health that the Integrated Health Project Plus (IHPplus) addresses, since spacing children well is important for both maternal and child health. As part of the project, which supports the Ministry of Health to bring health services closer to the people, IHPplus supports the formation of community Infant and Young Child Feeding (IYCF) support groups.

In 2015, members of the IYCF group of Ciranga were visiting families in the Cishi family's village and talked to Anuarite and Pascal about simple birth-spacing options. From that discussion and IYCF group meetings, they learned that the Lactational Amenorrhea Method, based on three conditions--exclusive breastfeeding, amenorrhea, and up to six months postpartum--could delay conception and decided to try it. They were advised to start another method if any of the three conditions changed.

"I had never experienced this before," said Anuarite, after six months of breastfeeding with no pregnancy. "I've really benefitted from this protection against pregnancy."

At six months, the support group treferred the couple to other FP methods, and they chose to use Depo-Provera. Said Pascal, "It's a miracle! I've also seen that the children have regained their health along with their mother. We thank the support group for their advice."

Launched in 2012, the IYCF group of Ciranga has reached an ever-growing number of women and families. Overall, the number of new adopters of family planning methods in Sud Kivu is only 9 percent of the target. But in Katana health zone, where the IYCF group operates, the number of new adopters rose from 17 percent to 23 percent of the target from December 2015 to March 2016.

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Appendix 1: DRC-IHPplus Performance Monitoring Plan, PY1Q3

PMP IHPplus			TOTAL_IHPplus							
Indicator		Definition	Jan-16	Feb-16	Mar-16	PY1Q3 Result	Target	Achievement (%)		Notes
USAID/DRC/IHP Objective: Increase use of high-impact health services, products, and practices for FP, MNCH, nutrition, malaria, NTDs, TB, HIV&AIDS, and WASH in target health zones										
1	**FP**: Couple years of protection (CYP) in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	48,031	45,050	47,061	140,143	144,873	97	97	
2	**FP:** Couple years of protection (CYP) after exclusion of LAM and self-observation methods (NFP) for FP in USG-supported programs	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives provided to clients in the IHP target areas during that period	22,717	22,406	23,039	68,163	57,718	118	118	
3	**FP:** Number of new acceptors for any modern contraceptive method in USG-supported family planning (FP) service delivery points	Number of new FP acceptors of a modern method will be calculated based upon records from USG-supported FP clinics in the IHP target areas	42,635	45,466	45,687	133,788	152,256	88	88	
4	**FP:** Number of counseling visits for FP/RH as result of USG support	Number of FP/RH counseling visits at USG-supported service delivery points	69,906	70,203	57,069	197,178	205,909	96	96	
5	**FP:** Number of USG-supported delivery points providing family planning (FP) counseling or services	Number of USG-supported service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated by type of service	2,093	2,090	2,095	2,095	735	285	285	
5.1	Disaggregated by type of service delivery:	(a) Health facility based	1,481	1,481	1,481	1,481	519			
5.2		(b) Community-level based	612	609	614	614	216			
6	**FP:** Number of USG-assisted health facilities experiencing stock-outs of Depo-Provera	Maximum number of USG-supported health facilities experiencing stock-outs of Depo-Provera	243	227	234	243	100	41	41	
7	**MNCH:** Percent of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least one antenatal care (ANC) visit by skilled providers from USG-supported health facilities	47,529	47,192	45,795	140,516	127,403			
		Denominator: # of expected pregnancies in USG-supported health facilities (4% of total population)	44,702	44,702	44,702	134,107	134,107			
		Numerator/ Denominator (in percentage)	**106**	106	102	105	95	110	110	
8	**MNCH:** Percent of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	Numerator: # of pregnant women attending at least four antenatal care (ANC) visits by skilled providers from USG-supported health facilities	24,256	24,732	24,869	73,857	71,077			
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	44,702	44,702	44,702	134,107	134,107			
		Numerator/Denominator (in percentage)	**54**	**55**	**56**	**55**	53	104	104	
9	**MNCH:** Percent of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	Numerator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	39,333	38,831	38,439	116,603	120,697			
		Denominator: # of expected deliveries in USG-supported health facilities (4% Tot Pop)	44,702	44,702	44,702	134,107	134,107			
		Numerator/ Denominator (in percentage)	**88**	**87**	**86**	**87**	90	97	97	
10	**MNCH:** Percent of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs	Numerator: Number of women giving birth who received AMSTL through USG-supported programs in IHP target area	36,712	36,944	36,199	109,855	113,455			
		Denominator: # of deliveries with a skilled birth attendant (SBA) in USG-supported facilities	39,333	38,831	38,439	116,603	120,697			
		Numerator/ Denominator (in percentage)	**93**	**95**	**94**	**94**	94	100	100	
11	**MNCH:** Number of postpartum/newborn visits within 3 days of birth in USG-supported programs	Number of postpartum/newborn visits within 3 days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery) (4% Tot Pop)	37,945	37,736	36,415	112,096	115,412	97	97	
12	**MNCH:** Percent of newborns receiving essential newborn care through USG-supported programs	Numerator: Number of newborn infants who received essential newborn care from trained facility, outreach or community health workers through USG-supported programs/IHP target area	38,103	37,793	36,389	112,285	119,356			
		Denominator: # of newborns delivered in the IHP target areas	39,269	38,629	38,472	116,370	134,107			
		Numerator/ Denominator (in percentage)	**97**	**98**	**95**	**96**	89	108	108	
13	**MNCH:** Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	Number of newborn infants identified as having possible infection who received antibiotic treatment from appropriately trained facility, outreach or community health workers through USG-supported programs/IHP target area (4% of Total Population *6% Infection rate-MICS 2010)	2,971	2,648	2,400	8,019	10,321	78	78	
14	**MNCH:** Number of child pneumonia cases treated with antibiotics by trained facility or community health workers in USG-supported programs	Number of children under five years old with pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs/IHP target area (20% Tot Pop*6% infection rate-MICS 2010)	37,883	39,982	37,144	115,009	120,563	95	95	
15	**MNCH:** Number of cases of child diarrhea treated in USG-supported programs	Number of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT) or ORT plus zinc supplements in USG-support programs/IHP target area (20% Tot Pop*18% infection rate-MICS 2010)	54,174	57,125	53,017	164,316	152,017	108	108	

16	**MNCH:** Percent of children less than 12 months of age who received DPT-HepB-Hib3 from USG-supported programs	Numerator: Number of children less than 12 months who received three doses of DPT, Hepatitis B, and Haemophilus Influenza (DPT-HepB-Hib1-3) vaccine from USG-supported programs/IHP target area	37,323	36,150	39,640	113,113	107,920			
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	39,003	39,003	39,003	117,009	113,600			
		Numerator/ Denominator (in percentage)	**96**	**93**	**102**	**97**	95	102	102	
17	**MNCH:** Drop-out rate in DPT-HepB-Hib3 among children less than 12 months of age	Numerator: Number of children less than 12 months who did not complete the full regimen of DPT-HepB-Hib1-3 vaccination	1,925	2,232	2,332	6,489	5,396			
		Denominator: All children less than 12 months who received DPT-HepB-Hib1	39,248	38,382	41,972	119,602	107,920			
		Numerator/ Denominator (in percentage)	**5**	**6**	**6**	**5**	5	100	100	
18	**MNCH:** Percent of children less than 12 months of age who received measles vaccine from USG-supported programs	Numerator: Number of children less than 12 months of age who received measles vaccine from USG-	36,262	35,389	38,411	110,062	109,539			
		Denominator: # of children less than 12 months of age in the IHP target areas (3.49% of Total Population ref EPI)	39,003	39,003	39,003	117,009	115,304			
		Numerator/ Denominator (in percentage)	**93**	**91**	**98**	**94**	95	99	99	
19	**MNCH:** Number of USG-assisted health facilities experiencing stock-outs of ORS	Number of USG-assisted health facilities experiencing stock-outs of ORS	46	88	101	101	100	99	99	
20	**NUTRITION:** Proportion of pregnant women who received iron-folate to prevent anemia	Numerator: Number of pregnant women who have received iron-folate tablets to prevent anemia during	58,365	59,406	59,030	176,801	118,939			
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% Tot Pop)	44,702	44,702	44,702	134,106	134,107			
		Numerator/ Denominator (in percentage)	**131**	**133**	**132**	**132**	89	149	149	
21	**NUTRITION:** Number of mothers of children 2 years of age or less who have received nutritional counseling for their children	Number of mothers of children 2 years of age or less who have received nutritional education within group support (8% of Total Population X 15% Malnutrition Prevalence Rate)	57,494	60,432	59,959	177,885	170,478	104	104	
22	**NUTRITION:** Number of people trained in child health and nutrition through USG-supported interventions		n/a	n/a	n/a	74	1,111	7	7	Quarterly target was identified (previously TBD).
23	**NUTRITION:** Number of USG-supported health facilities experiencing stock-outs of iron-folate	Number of USG-supported health facilities that experienced stock-outs of iron-folate tablets	132	155	167	167	200	120	120	
24	**TB:** Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year (150 cases for 100,000 people)	n/a	n/a	2,267	2,267	3,219			
		Denominator: Total population in the specified geographical area	10,728,594	10,728,594	10,728,594	10,728,594	10,728,594			
		Numerator/ Denominator (per 100,000 population)	n/a	n/a	85	85	120	70	70	Revised the target denominator to 10,728,594 correspond to the total targeted population. The total % targeted did not change.
25	**TB:** Percent of all registered TB patients who are tested for HIV through USG-supported programs	Numerator: Number of TB patients who are tested for HIV	n/a	n/a	1,731	1,731	2,508			
		Denominator: Number of registered TB patients in TB screening and treatment health facilities offering HIV testing	n/a	n/a	3,135	3,135	3,135			Revised the target denominator from 1,807 to 3,135 to correspond to the total targeted population.
		Numerator/ Denominator (in percentage)	n/a	n/a	**55**	**55**	80	69	69	
26	**TB:** Case detection rate	Numerator: Number of new smear positive TB cases detected	n/a	n/a	2,267	2,267	3,291			
		Denominator: Estimated number of TB cases expected	n/a	n/a	3,219	3,219	4,932			
		Numerator/ Denominator (in percentage)	**n/a**	**n/a**	**70**	**70**	67	106	106	
27	**TB:** Number of multi-drug resistant (MDR) TB cases detected	Number of TB cases with multi-drug resistance registered in USG-supported facilities	5	1	0	6	15	40	40	
28	Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	Numerator: Number of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women	n/a	n/a	39	39	34			
		Denominator: Total number of PEPFAR supported sites providing PMTCT services (HTC and ARV or ART services)	n/a	n/a	40	40	45			
		Percent =(Num/Den)x100	n/a	n/a	98	**98**	76	129	129	
29	Number and percentage of pregnant women with known status (includes women who were tested for HIV and received their results) (DSD)	Numerator: Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	n/a	7,690	7,690	3,570			
		Denominator: Number of new ANC and L&D clients	n/a	n/a	8,054	8,054	4,200			
		Percent =(Num/Den)x100	n/a	n/a	95	95	85	112	112	
30	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk for mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	Numerator: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	n/a	n/a	96	96	61			
		Denominator: Number of HIV- positive pregnant women identified in the reporting period (including known HIV-positive at entry)	n/a	n/a	99	99	72			
		Percent =(Num/Den)x100	n/a	n/a	97	97	85	114	114	
31	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (DSD)	Number of individuals who received T&C services for HIV and received their test results during the reporting period	n/a	n/a	15,280	15,280	12,500	122	122	Revised quarterly target from 6,000 to 12,5000 and annual target to 37,500. The decrease in the annual target is due to the face that we will no longer work in Kamina in Q3.

32	Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	Number of HIV positive adults and children (aggregated by age/sex : female, male , <15 and <15) who received at least one of the following in the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	n/a	n/a	4,573	4,573	3,600	127	127	Revised the quarterly target from 1,100 to 3,600 based on implementation trends.
33	Number of HIV-positive adults and children receiving a minimum of one clinical service (DSD)	Number of HIV-positive adults and children –aggregated by age/sex , female, male , <15 and > 15) in the reporting period receiving a minimum of one clinical service (DSD)	n/a	n/a	4,573	4,573	3,600	127	127	
34	TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	n/a	n/a	678	678	2,520	27		
		Denominator: Number of patient HIV-positive	n/a	n/a	3,600	3,600	3,600	100		
		Percent =(Num/Den)x100	n/a	n/a	19	19	70	27	27	Revised quarterly target to 70% based on national program standards.
35	Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD)	Number of adults and children receiving antiretroviral therapy (ART) [current] (DSD) (aggregated by age/sex , female, male , <15 and >15) in the reporting period	n/a	n/a	3,490	3,490	2,900	120	120	
36	Number of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV-infected adults and children newly enrolled in clinical care (aggregated by age/sex , female, male , <15 and >15) during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	n/a	n/a	609	609	415	147	147	
37	Proportion of registered TB cases who are HIV-positive who are on ART	Numerator: The number of registered TB cases with documented HIV-positive status who start or continue	n/a	n/a	280	280	189			
		Denominator: The number of registered TB cases with documented HIV-positive status during the reporting	n/a	n/a	285	285	210			
		Percent =(Num/Den)x100	n/a	n/a	98	98	90	109	109	
38	Percentage of laboratories and POC testing sites that perform HIV diagnostic testing that participate and successfully pass in an analyte-specific proficiency testing (PT) program	Number of PEPFAR-supported laboratories and testing sites that participate and perform analyte-specific testing on HIV serologic/diagnostic testing , CD4, EID and TB diagnostic	n/a	n/a	47	47	45			
		Denominator : Total number of laboratories and testing sites	n/a	n/a	45	45	45			
		Percent =(Num/Den)x100	n/a	n/a	104	104	100	104	104	Revised the target numerator and denominator based on a recent study that confirmed the number of POC sites that are eligible to participate in this program. The total % target did not change.
39	Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	**Numerator**: Number of service delivery points supported by PEPFAR for HIV services that are directly providing integrated voluntary family planning services	n/a	n/a	100	100	72	139	139	
40	**PMTCT_CTX** Number of infants born to HIV-positive women who were started on CTX prophylaxis within two months of birth at USG supported sites within the reporting period		n/a	n/a	96	96	90	107	107	Revised quarterly target from 64 to 90 to reflect implementation trends.
41	**PMTCT_EID** Number of infants who had a virologic HIV test within 12 months of birth during the reporting period		n/a	n/a	26	26	32	81	81	
42	**PMTCT_FO** Number of infants HIV exposed infants with a documented outcome by 18 months of age disaggregated by outcome type		n/a	n/a	n/a	n/a	28		n/a	During PY1Q3, the project was not able to collect data for this indicator because of the lack of activity of psychosocial assistants working in supported sites.
43	**Tx_NEW** Number of adults and children newly enrolled on ART		n/a	n/a	475	475	358	133	133	
44	**Tx_VIRAL** Number of adults and pediatric ART patients with a viral load result documented in the patient medical record within the past 12 months		n/a	n/a	n/a	n/a	978	n/a	n/a	In the geographical context of IHPplus project, this indicator is not applicable. The only laboratories equipped to perform this testing are the NACP labs.
45	**Tx_UNDETECT** Number of viral load tests from adult and pediatric ART patients conducted in the past 12 months with a viral load inferior to 1000 copies/ml.		n/a	n/a	n/a	n/a	787	n/a	n/a	Same as above.
46	**Tx_RET** Number of adults and children who are still alive and treatment at 12 months after initiating ART.		n/a	n/a	n/a	n/a	863	n/a	n/a	Since this indicator can only be reported on a yearly basis, the project is unable to report on it this quarter.
47	**CARE_COM** Number of HIV infected adults and children receiving care and support services outside of the health facility		n/a	n/a	n/a	n/a	78	n/a	n/a	Same as indicator 42.
48	**TB/HIV_ TB** outcome Aggregated outcome of TB treatment among registered new and relapsed TB cases who are HIV-positive in the treatment cohort		n/a	n/a	47	47	48	98	98	
Intermediate Result 1: Access to and availability of MPA and CPA services and products in target health zones increased (Component 1)										
IR 1.1: Facility-based health care services and products (provincial hospitals and district health centers) in target health zones increased										

49	***L+M+G:** % of general reference hospitals GRHs implementing complementary package of activities (CPA)	Numerator: # of GRHs implementing CPA	70	70	70	70	69			
		Denominator: Total # of GRHs	78	78	78	78	78			
		Numerator/ Denominator (in percentage)	**90**	**90**	**90**	90	88	**102**	**102**	
50	***L+M+G:** % of health centers implementing minimum package of activities (MPA)	Numerator: # of health centers implementing MPA	1,382	1,382	1,382	1,382	1,382			
		Denominator: Total # of health centers	1,398	1,398	1,398	1,398	1,398			
		Numerator/ Denominator (in percentage)	**99**	**99**	**99**	99	99	**100**	**100**	
51	**MALARIA:** Percent of pregnant women who received at least two doses of SP for Intermittent Preventive Treatment (IPT) during ANC visits	Numerator: Number of pregnant women who received at least two doses of SP for IPT during ANC visits/	32,175	32,727	34,663	99,565	100,580			Revised quarterly target numerator from 91,193 to 100,580 to reflect implementation trends.
		Denominator: # of expected pregnancies in USG-assisted health facilities (4% of total population)	44,702	44,702	44,702	134,106	134,107			
		Numerator/ Denominator (in percentage)	**72**	**73**	**78**	74	75	**99**	**99**	
52	**MALARIA:** Number of USG-supported service delivery points experiencing stock-outs of ACT for 1-5 year olds	Number of USG-assisted service delivery points (SDPs) experiencing stock-out of ACT for 1 – 5 years at any time during the defined reporting period	70	115	146	146	100	**68**	**68**	
53	**MALARIA:** Number of ITNs purchased with USG funds that were distributed	Number of ITNs purchased with USG funds that were distributed	58,650	61,050	21,050	140,750	113,750	**124**	**124**	Revised quarterly target from 95,000 to 113,750 to align with distribution trends from CDRs.
53.1		*(a) through campaigns*	0	0	0	0	0			
53.2		*(b) through health facilities*	58,650	61,050	21,050	140,750	113,750	**124**		
53.3		*(c) through the private/commercial sector*	0	0	0	0	0			
53.4		*(d) through other distribution channels*				0	0			
53.5		*(e) through voucher schemes*	0	0	0	0	0			
54	**MALARIA:** Number of health workers trained in IPTp with USG funds disaggregated by gender (male/female)	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds	115	0	0	115	400	**29**	**29**	
54.1		*Male*	96	0	0	96	260			
54.2		*Female*	19	0	0	19	140			
55	**MALARIA:** Number of SP tablets purchased with USG funds that were distributed to health facilities	Number of SP tablets purchased with USG funds that were distributed to health facilities (hospitals, health centers, health posts/stations, clinics)	164,000	369,000	85,000	618,000	600,000	**103**	**103**	Revised quarterly target from 300,000 to 600,000 to align with distribution trends from CDRs.
56	**MALARIA:** Number of health workers trained in case management with ACTs with USG funds	Number of health workers (doctor, nurse, nurse's assistant, clinical officer or community/village health worker) trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	115	0	0	115	450	**26**	**26**	
56.1	*(a) Number of health facility workers trained (male/female)*	*Male*	96	0	0	96	260			
		Female	19	0	0	19	140			
56.2	*(b) Number of community-level workers trained (male/female)*	*Male*	0	0	0	0	32			
		Female	0	0	0	0	18			
57	**MALARIA:** Number of ACT treatments purchased with USG funds that were distributed	Number of ACT treatments purchased with USG funds that were distributed	159,941	158,901	865,297	1,184,139	800,000	**148**	**148**	
57.1	Disaggregated in 3 sub-categories:	*(a) to health facilities*	146,836	155,250	860,689	1,162,775	784,000			
57.2		*(b) to community health workers (HBMF, CCM)*	13,105	3,651	4,608	21,364	16,000			
57.3		*(c) to the private/commercial sector*	0	0	0	0	0			
58	**MALARIA:** Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds Disaggregate in 3 sub-categories:	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	115	0	0	115	450	**26**	**26**	
58.1	*(a) Number of health facility workers trained (male/female)*	*Male*	96	0	0	96	260			
		Female	19	0	0	19	140			
58.2	*(b) Number of community health workers trained (males/females)*	*Male*	0	0	0	0	32			
		Female	0	0	0	0	18			
58.3	*(c) Number of laboratory technicians trained (males/females)*	*Male*	0	0	0	0	0			
		Female	0	0	0	0	0			
59	**MALARIA:** Number of RDTs purchased with USG funds that were distributed to health facilities	Number of RDTs purchased with USG funds that were distributed to health facilities	176,942	163,271	185,987	526,200	625,000	**84**	**84**	Revised quarterly target from 350,000 to 625,000 to align with distribution trends from CDRs.
IR 1.2: Community-based health care services and products in target health zones increased										
60	***L+M+G:** % of communities with CODESAs actively involved in management of priority health services	Numerator: # of communities with CODESAs with active involvement in management of priority health services for their communities	1,295	1,294	1,295	1,295	1,284			
		Denominator: Total # of communities in IHP target area	1,398	1,398	1,398	1,398	1,398			
		Numerator/Denominator (in percentage)	**93**	**93**	**93**	93	92	**101**	**101**	

61	**WASH:** Number of people gaining access to an improved drinking water source as a result of USG support	Number of people gaining access to an improved drinking water source (Improved drinking water technologies are those more likely to provide safe drinking water)	n/a	n/a	162,741	162,741	158,584	103	103	
62	**WASH:** Percent of the population using an improved drinking water source as a result of USG support	Numerator: Number of people using an improved drinking water source	n/a	n/a	n/a	n/a	TBD			
		Denominator: Total population targeted for the given period	n/a	n/a	n/a	n/a	330,537			
		Numerator/ Denominator (in percentage)	n/a	n/a	n/a	n/a	TBD		n/a	No activities were planned for the quarter.
63	**WASH:** Number of people gaining access to an improved sanitation facility as a result of USG support	Number of people gaining access to an improved sanitation facility (Improved sanitation facilities include those more likely to ensure privacy and hygienic use, e.g., connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine)			89,149	89,149	105,772	84	84	
64	**WASH:** Percent of the population using an improved sanitation facility as a result of USG support	Numerator: Number of people using an improved sanitation facility	n/a	n/a	n/a	n/a	TBD			
		Denominator: Total population targeted for the given period	n/a	n/a	n/a	n/a	330,537			
		Numerator/ Denominator (in percentage)	n/a	n/a	n/a	n/a	TBD		n/a	No activities were planned for the quarter.
IR 1.3: Engagement of provincial management with health zones and facilities to improve service delivery increased										
65	***L+M+G:** % of senior LDP teams that have achieved their desired performance according to indicators in their action plans within six months of completing the LDP	# of senior LDP teams that have achieved at least 80% of their desired performance according to indicators in their action plans within six months of completing the LDP	47	47	47	47	50			
		Denominator: Number of HZ with leadership that has undergone LDP training	59	59	59	59	78			In total, 78 health zones have teams that completed an LDP. However, only 59 conducted evaluations of their action plans.
		Numerator/ Denominator (in percentage)	**80**	**80**	**80**	80	64	124	124	
IR 2: Quality of key family health care services in target health zones increased (Component 1)										
IR 2.1: Clinical and management capacity of health care providers increased										
66	***L+M+G:** Percent of health zones (HZs) with validated action plans	Numerator: # HZ with validated actions plans	27	27	27	27	78			
		Denominator: Total # HZs in IHP target area	78	78	78	78	78			
		Numerator/ Denominator (in percentage)	**35**	**35**	**35**	35	100	35	35	
67	***L+M+G:** Percent of health centers with accurate and up-to-date inventory records	Numerator: Number of health centers with up-to-date and accurate record of inventory of essential drugs and supplies ("accurate" means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	1,224	1,254	1,229	1,236	1,069			
		Denominator: Total number of health centers in IHP areas	1,398	1,398	1,398	1,398	1,398			
		Numerator/ Denominator (in percentage)	**88**	**90**	**88**	88	76	116	116	
68	***L+M+G:** Percent of hospitals with accurate and up-to-date inventory records	Numerator: Number of hospitals with up-to-date and accurate record of inventory of essential drugs and supplies (Accurate means that the records correctly reflect the inventory of essential drugs and supplies that are currently in-stock)	67	70	68	68	70			
		Denominator: Total number of hospitals in IHP areas	78	78	78	78	78			
		Numerator/ Denominator (in percentage)	**86**	**90**	**87**	88	90	98	98	
69	**GENDER**: Number of people reached by a USG-supported intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Number of people reached by a USG-supported intervention providing GBV health services	278	239	258	775	600	129	129	
70	**GENDER:** # of BCC campaigns launched delivering key health messages targeting women and girls as primary audience	# of BCC campaigns developed and launched with key prevention priority messages for FP, nutrition, malaria, and WASH within the IHP target areas	0	0	1	1	5	20	20	Revised the annual target to 16.
IR 2.2: Minimum quality standards for health facilities (provincial hospitals and district health centers) and services developed and adopted										
71	***L+M+G**: % of health facilities that completed an evaluation of the nine FOSACOF minimum standards	Numerator: # of health centers and GRH meeting that completed an evaluation of the nine FOSACOF minimum standards	402	402	402	402	560			Revised the indicator definition.
		Denominator: Total # of health facilities implementing the FOSACOF approach	737	737	737	737	737			
		Numerator/ Denominator (in percentage)	55	55	55	55	76	72	72	
71.1	***L+M+G**: % of health centers meeting that completed an evaluation of the nine FOSACOF minimum standards	Numerator: # of health centers that completed an evaluation of the nine FOSACOF minimum standards	375	375	375	375	531			New sub-indicator for PY1Q3.
		Denominator: Total # of health centers implementing the FOSACOF approach	699	699	699	699	699			
		Numerator/ Denominator (in percentage)	54	54	54	54	76	71	71	
71.2	***L+M+G**: % of general reference hospital that completed an evaluation of the nine FOSACOF minimum standards	Numerator: # of GRH that completed an evaluation of the nine FOSACOF minimum standards	27	27	27	27	29			New sub-indicator for PY1Q3.
		Denominator: Total # of GRH integrating the FOSACOF approach	38	38	38	38	38			
		Numerator/ Denominator (in percentage)	71	71	71	71	76	93	93	
IR 2.3: Referral system for primary health care prevention, care and treatment between community structures and health facilities (district and provincial levels) institutionalized										
72	% of patients referred to HCs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to health centers by a CHW	1,855	1,810	2,169	5,834	5,800			
		Denominator: Total # of patients seen by a CHW	24,980	29,040	18,494	72,514	38,666			

		Numerator/ Denominator (in percentage)	7	6	12	8	15	54	54	
73	% of patients referred to GRHs, disaggregated by gender, and age groups (< 5 years; 5-14 years; >15 years)	Numerator: # of patients (adults and children) referred to GRHs by a CHW or health care provider	19,193	21,607	18,946	59,746	60,000			
		Denominator: Total number of patients seen by a CHW or health care provider	514,256	514,819	530,436	1,559,511	1,200,000			
		Numerator/ Denominator (in percentage)	4%	4	4	4	5	77	77	
IR 3: Knowledge, attitudes, and practices to support health-seeking behaviors in target health zones increased (Component 1)										
IR 3.1: Evidence-based health sector-community outreach linkages –especially for women, youth and vulnerable populations– established										
74	***L+M+G: % of NGOs representing women, youth and vulnerable groups participating in coordination meetings	Numerator: # of NGOs representing women, youth, and vulnerable groups attending NGO coordination meetings	182	182	182	182	155			
		Denominator: # of NGOs representing women, youth and vulnerable groups registered in DRC	212	212	212	212	212			
		Numerator/ Denominator (in percentage)	86	86	86	86	73	117	117	
75	***L+M+G: # Community Champion achieving the deliverables set in their signed fixed amount awards (FAAs)	# community Champion achieving the deliverables set in their signed fixed amount awards (FAAs)	34	34	34	32	34	94	94	
76	***L+M+G: # youth organizations participating in youth education outreach strategy	# youth organizations conducting member outreach and health education as part of IHP youth health education strategy	148	148	148	148	146	101	101	
IR 3.3: Behavior change campaigns involving opinion leaders and cultural influences (people and technologies) launched										
77	BCC: # of CODESAs supported by IHP and which have a "Communications action plan"	# of CODESAs supported by IHP within the IHP target area and which have a "Communications action plan" developed	1,221	1,221	1,221	1,221	1,200	102	102	
78	BCC: # of educational SMS messages during BCC campaigns or mini campaigns on malaria, nutrition and/or family planning	Key messages targeted to select groups (mothers, caretakers, partners, etc.) sent via SMS in FP, nutrition, malaria, WASH, etc., within the IHP target areas (annual targets will be based on pilot studies in PY2 as included in the workplan)	37,285	43,405	66,917	147,607	120,000	123	123	
IR 4: Health sector leadership and governance in target provinces improved (Component 2)										
IR 4.1: Provincial health sector policies and national level policies aligned										
79	***L+M+G: % of health zones with an annual operational plan based on National Development Plan ("PNDS")	Numerator: # of health zones with an annual operational plan based on National Development Plan ("PNDS")	27	27	27	27	78			
		Denominator: Total # of health zones	78	78	78	78	78			
		Numerator/ Denominator (in percentage)	35	35	35	35	100	35	35	
80	***L+M+G: % of health zone management teams with a performance management system that includes essential components	Numerator: # of health zone management teams with a performance management system that includes any of the three essential components: 1) up-to-date job descriptions and organigrams, 2) work plans (including supervision plan and guide), and 3) performance review reports	60	56	62	59	55			
		Denominator: Total # of health zones	78	78	78	78	78			
		Numerator/ Denominator (in percentage)	77	72	79	76	71	108	108	
Project Management										
81	PM: Number of success stories developed	Number of success stories developed disaggregated by technical components and sub-components where applicable (HIV/AIDS, TB, Malaria, NTD, MNCH, FP/RH, Nutrition, WASH, GBV, Gender, HSS, BCC, Commodities, Coordination, M&E, etc.)	3	5	7	8	8	100	100	

Appendix 2: DRC-IHPplus International Travel (STTA Plan)

DRC-IHPplus International Travel (STTA Plan) June 2015 - June 2016

	TECHNICAL AREA	SUGGESTED PERSON	ORG	Travel dates	INDICATIVE SCOPE OF WORK	Origin/destination to	Length of trips days	Airfare	Per Diem (at rate of $406/day)	Airport Transfr ($75/trip)	Visa	Misc ($15/day)	STATUS	Notes (optional: add any memory aids or details to ID or explain trip in any way)
STTA/PROJECT MANAGEMENT AND MONITORING														
Quarter 1 June-September 2015*														
PM	Program Management	Dan Nelson	MSH	July 15-September 15 2015	Provide technical and management support and visit project sites as acting Chief of Party until the permanent candidate is in place	Boston/Kinshasa	32	2,500.00	12,992.00	75.00	600.00		Completed (dates changed to 20 July-22 August)	
RBF	Results-Based Financing	Alfred Antoine Uzabakiliho	MSH	August 30-September 8, 2015	Provide IHP and its partners with short-term technical assistance in monitoring the function of the DRC Results Based Financing (RBF) web portal.	Boston/Kinshasa	9	2,500.00	3,654.00	75.00	250.00	-	Completed (replaced Jean Kagubare initial approved trip from July 15-30, 2015).	
							41	**5,000**	**16,646**	**150**	**850**	**-**		
Quarter 2 October-December 2015														
									-			-		
PM	Operations	Christele Joseph-Pressat	MSH	October 1-15, 2015	Provide operational support to Country Operations Management Unit (COMU) and project team	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Replaced by Monita Baba Djara. Moved to April 15-30, 2016. Cancelled.	
PM	Program Management	Kristin Cooney	MSH	October 1-15, 2015	Provide technical and management support and visit project sites	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Completed.	
RBF	Results-Based Financing	Jean Kagubare	MSH	October 15-30, 2015	Provide technical support for RBF activities	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Cancelled.	
Operations	Contracts	Kelley Scarmeas	MSH	October 15-30, 2015	Provide contractual technical and management support	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Cancelled.	
MNCH	MNCH	TBD	MSH	Nov 15-30, 2015	Provide technical support for MNCH	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Replaced with Stephanie York. SOW changed to: Perform needs assessment to determine cost share donation. Moved to March 13-19, 2016. Completed.	
FP/RH	FP/FRH	Kathryn Ramsey	MSH	Nov 15-30, 2015	Provide technical support for FP/RH	Boston/Kinshasa	15	1,867.00	5,063.00	75.00	250.00	-	SOW expanded to include Workplanning. Moved to June 4-17, 2016. Planned.	
PM	Program Management	Kristin Cooney	MSH	December 1-15, 2015	Provide technical and management support (including covering COP vacation) and visit project sites	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Cancelled.	
							105	17,500	41,603	525	1,750	**-**		
Quarter 3 January-March 2016														
Operations	Contracts	Kelley Scarmeas	MSH	January 15-30, 2016	Provide contractual technical and management support	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Moved to June 15-30, 2016. Planned.	
RBF	Results-Based Financing	Jean Kagubare	MSH	January 15-30, 2016	Provide technical support for RBF activities	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Moved to February 24-March 6, 2016. Completed.	
PM	Program Management	Kristin Cooney	MSH	February 1-15, 2016	Provide technical and management support and visit project sites	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00		Moved to March 19-April 1, 2016. Completed.	
Operations	Operations	John McKenney	MSH	February 1-15, 2016	Provide security management assistance and training or refresher training to staff	Boston/Kinshasa	15	1,502.00	5,469.00	75.00	250.00		Moved to May 18-27, 2016. Planned.	
M&E	HMIS	Ismail Yusuf Koleleni	MSH	February 8-28, 2016	Provide follow-up TA on DHIS 2 installation, customization, and training for IHP and IHPplus database to align with MOH/SNIS	Arusha/Kinshasa	20	1,500.00	8,120.00	76.00	250.00		Moved to July 1-15, 2016. Planned.	
PM	Communications	Carole Douglis	MSH	February 13-28, 2016	Develop materials that document and promote project results	DC/Kinshasa	15	2,500.00	6,090.00		250.00		Moved to June 15-30, 2016. Planned.	
Operations	Operations	TBD	MSH	February 13-28, 2016	Provide operational support to Country Operations Management Unit (COMU) and project team. (covering Fin. Dir. vacation)	Boston/Kinshasa	15	2,500.00	6,090.00		250.00	-	Moved to June 15-30, 2016. Planned.	
							125	**19,000**	**50,750**	**451**	**2,000**	**-**		

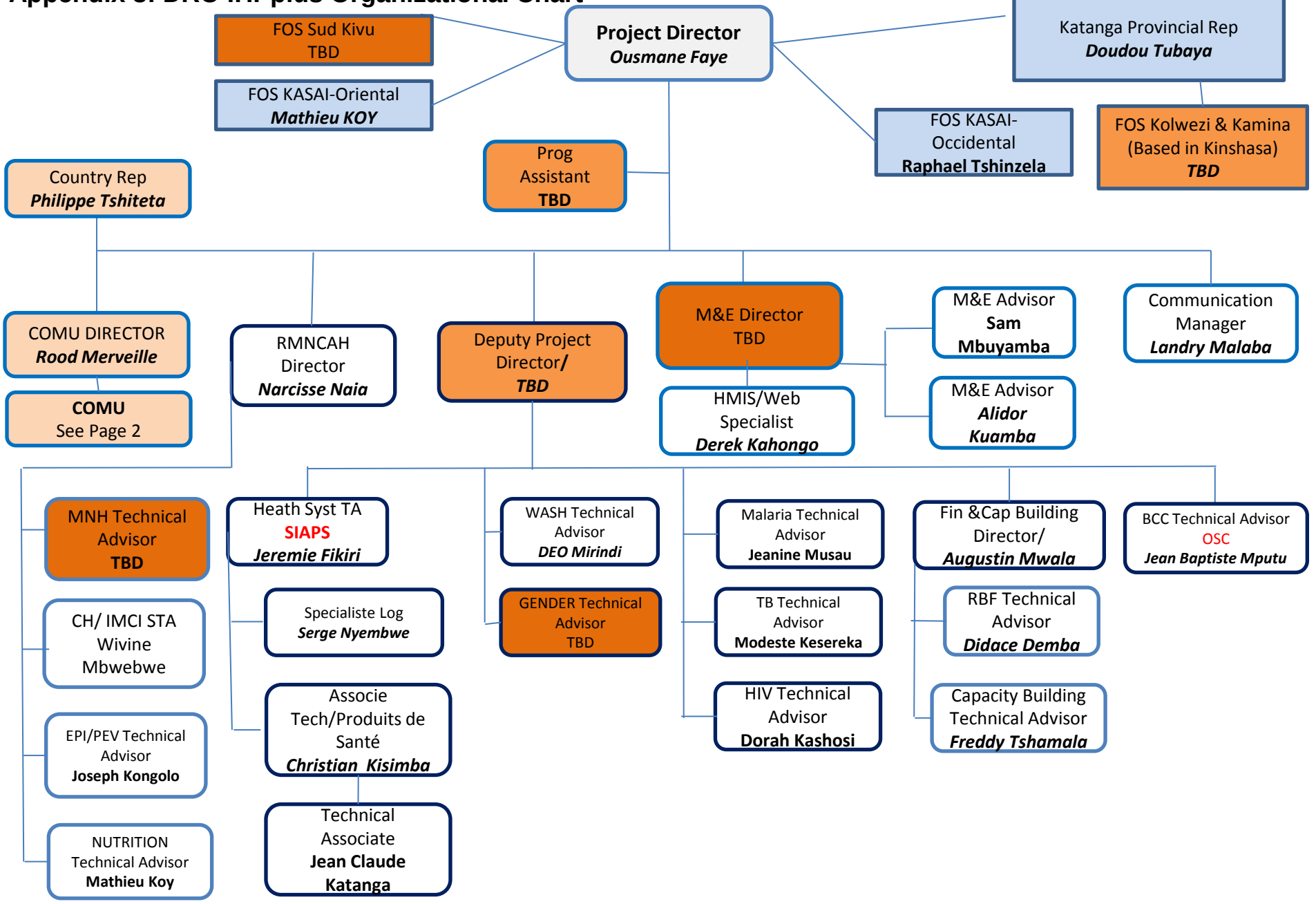
Appendix 2: DRC-IHPplus International Travel (STTA Plan)

		TECHNICAL AREA	SUGGESTED PERSON	ORG	Travel dates	INDICATIVE SCOPE OF WORK	Origin/destination	Length of trips	Airfare	Per Diem (at rate of $406/day)	Airport Transfr ($75/trip)	Visa	Misc ($15/day)	STATUS	Notes (optional: add any memory aids or details to ID or explain trip in any way)
							to	days							
Quarter 4 April-June 2016															
	PM	Communications	Carole Douglis	MSH	April 1-15, 2016	Develop materials that document and promote project results	Boston/Kinshasa	15	2,500.00	6,090.00	75.00	250.00	-	Cancelled.	
	PM	Monitoring and Evaluation	Monita Baba Djara	MSH	April 1-15, 2016	Provide M&E technical support in preparation for project close-out	Boston/Kinshasa	15	1,727.00	5,469.00	75.00	250.00	-	SOW changed to focus on workplanning. Moved to June 4-18, 2016. Planned.	
	PM	Program Management	Kristin Cooney	MSH	May 1-15, 2016	Provide technical and management support during close-out	Boston/Kinshasa	15	2,541.00	5,063.00	75.00	250.00		SOW changed to focus on workplanning. Moved to June 4-12, 2016. Planned.	
	PM	Program Management	Jeanne Hamon	MSH	May 7-June 18, 2016	Provide technical and management support during close-out	Boston/Kinshasa	43	1,820.00	17,255.00	75.00	250.00		SOW changed to focus on workplanning and expanded to include other priority PM tasks. In progress.	
								88	**8,588**	**33,877**	**300**	**1,000**	-		
							Total	**359**	**50,088**	**142,876**	**1,426**	**5,600**	**-**		
															170,266.00

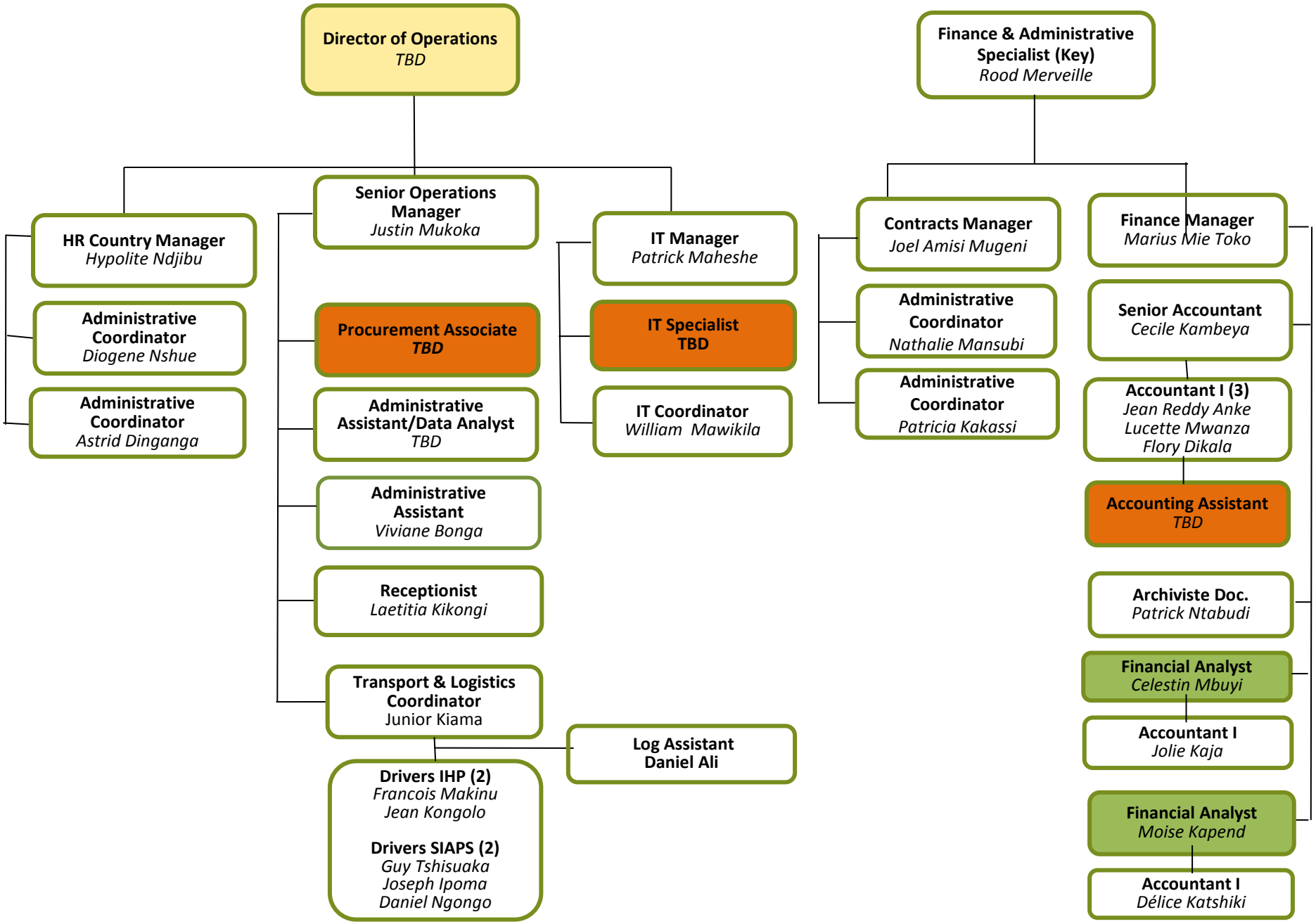
IHPplus International Travel and STTA Plan June 2015 to June 2016

#		TECHNICAL AREA	SUGGESTED PERSON	ORG	Travel dates	INDICATIVE SCOPE OF WORK	Origin/destination	Length of trips	Airfare	Per Diem (at rate of $.../day)	Airport Transfr ($100/trip)	Visa	Misc ($15/day)	STATUS	Notes (optional: add any memory aids or details to ID or explain trip in any way)
							to	days							
INTERNATIONAL TRAVEL OF LOCAL STAFF AND PARTNERS															
Quarter 1 June-September 2015*															
	PM	COP	TBD	MSH	June 2015	Home office orientation	TBD/Boston	15	2,000	302	75		0	Cancelled.	
	PM	M&E	TBD	MSH	June 2015	Home office orientation	TBD/Boston	15	2,000	302	75			Cancelled.	
	PM	IS	Derek Kahongo	MSH	June 2015	DHIS 2 Academy Benin 2015	Kinshasa/Cotonou	15	2,000	3135	75	250	0	Completed.	
								45	**6,000**	**3,739**	**225**	**250**	-		
Quarter 2 October-December 2015															
	PM	HIV/AIDS	Dorah Kashosi	MSH	Nov 15-20, 2015	Attend the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative workshop in Zambia from Nov 16-19, 2015	Kinshasa/Lusaka	6	2,000.00	1,710.00	60.00	400.00	-	Completed.	
	PM	Health	IHP Local Staff	MSH	December 11-18, 2015	Present a poster at the 8th Annual Conference on the Science of Dissemination and Implementation.	Kinshasa/Washington, D.C.	7	2,500	2030	75	250	0	Completed.	
								13	**4,500**	**3,740**	**135**	**650**	-		
Quarter 3 January-March 2016															
	PM	Malaria	Jean-Fidele Ilunga	MOH	February 14-20, 2016	Attend the iCCM/Rectal Artesunate workshop in Nairobi from Feb 14-20.	Kinshasa/Nairobi	7	2,500	2520	75	250		Completed.	
	PM	Malaria	Jeanine Musau	MSH	February 14-20, 2016	Attend the iCCM/Rectal Artesunate workshop in Nairobi from Feb 14-20.	Kinshasa/Nairobi	7	2,500	2520	75	250		Completed.	
	PM	Nutrition	Matthieu Koy	MSH	January 18-22, 2016	Attend the West Africa Multi-Sectoral Nutrition Global Learning and Evidence Exchange (MSN-GLEE) workshop in Accra, Ghana, from January 19-21, 2016	Kinshasa/Accra	5	1,500	1655	75	400	0	Completed .	
								19	**6,500**	**6,695**	**225**	**900**	-		

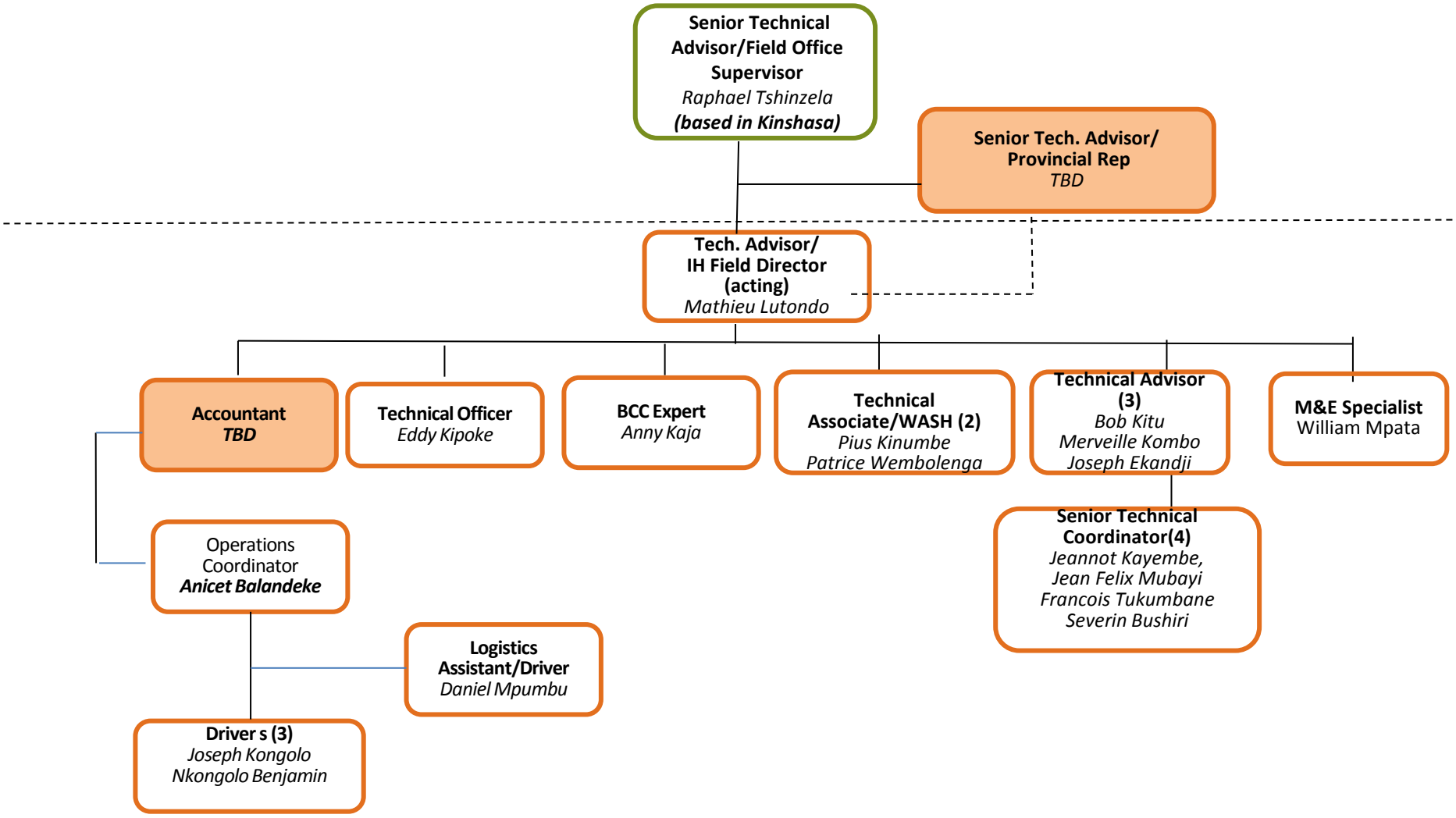
Appendix 3: DRC-IHPplus Organizational Chart



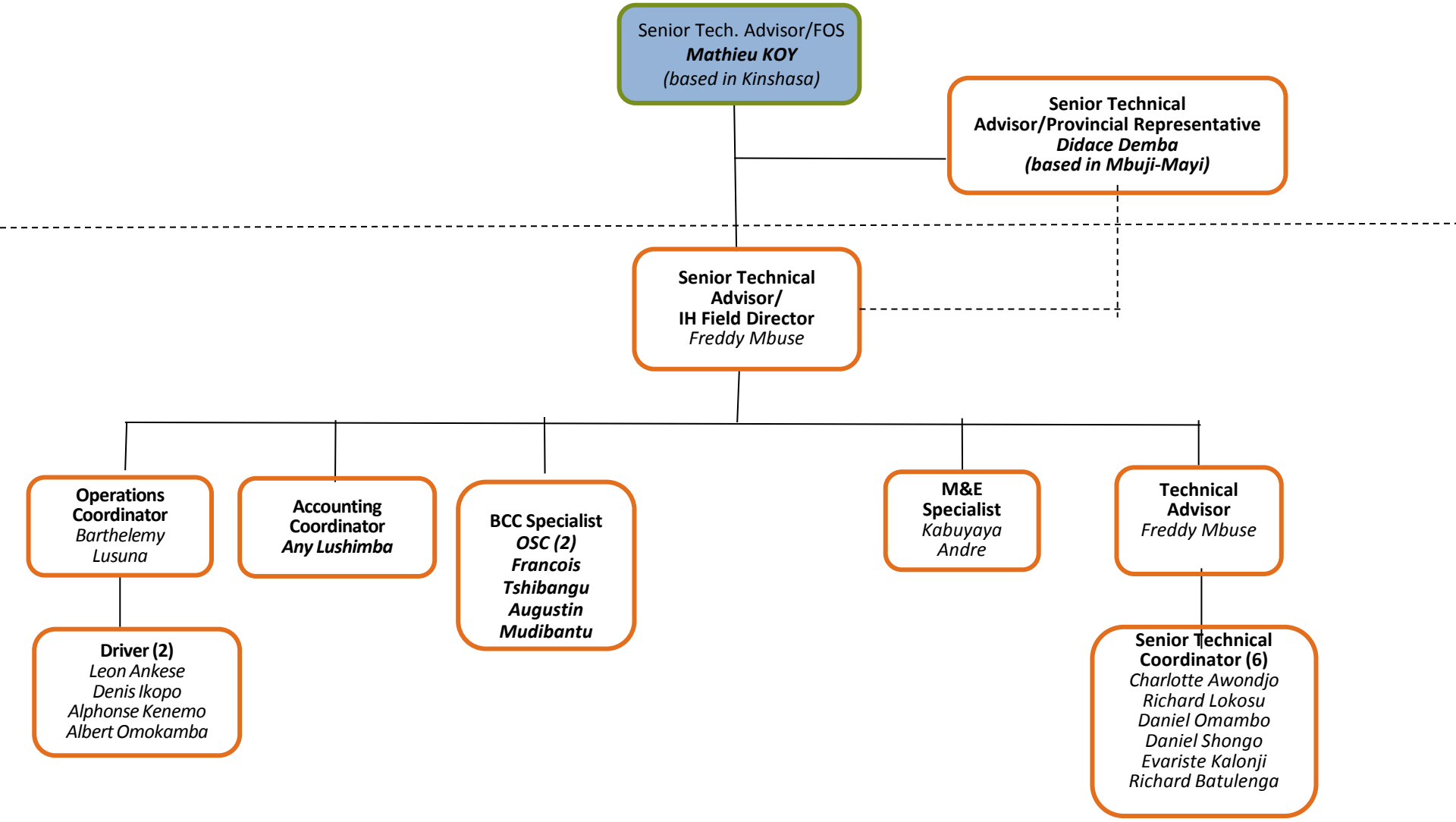
Kinshasa Office (HQ – page 2)



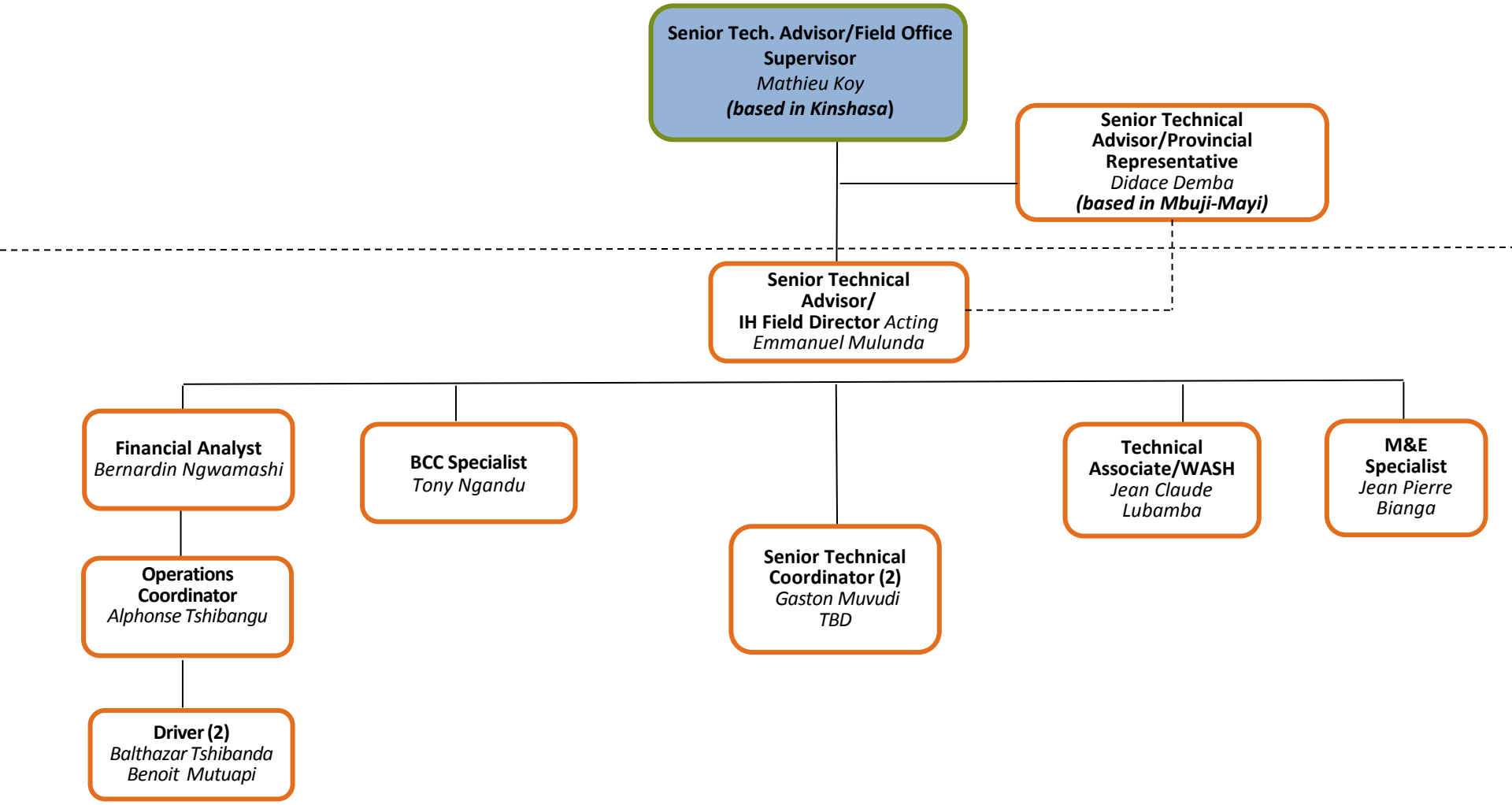
IHPplus Field Office: Kananga, Kasaï Occidental



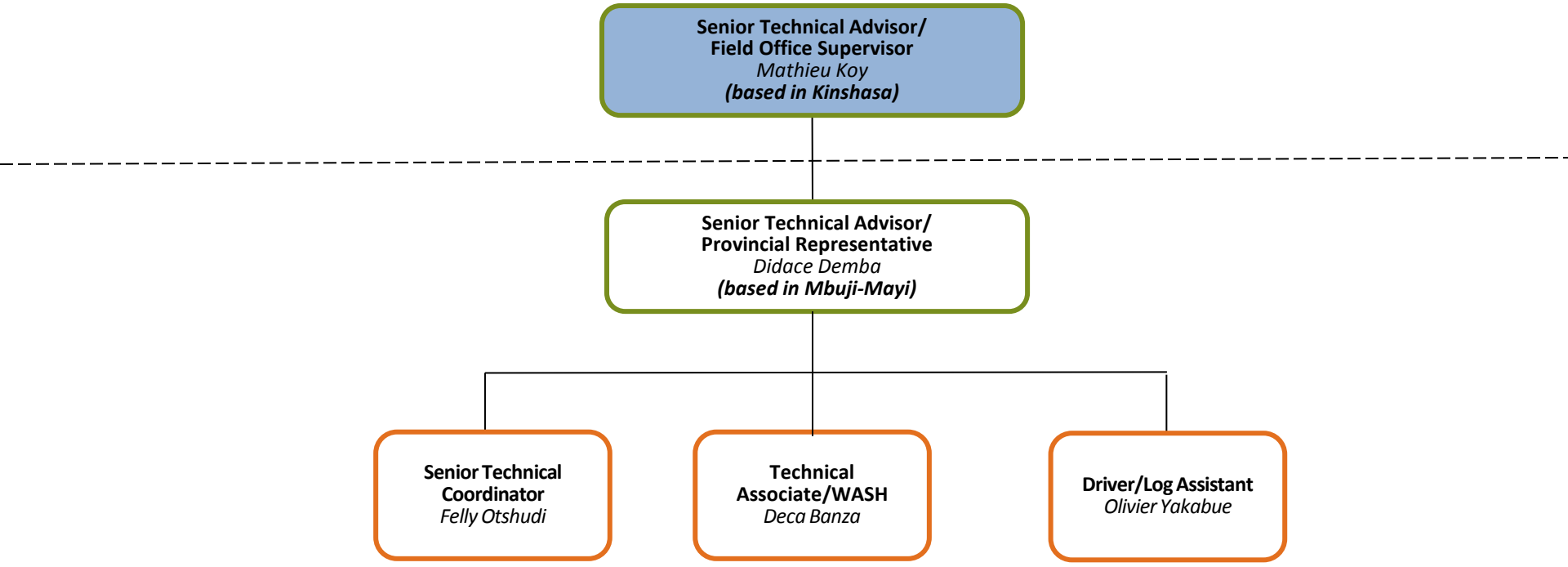
IHPplus Field Office: Lodja, Kasaï Oriental



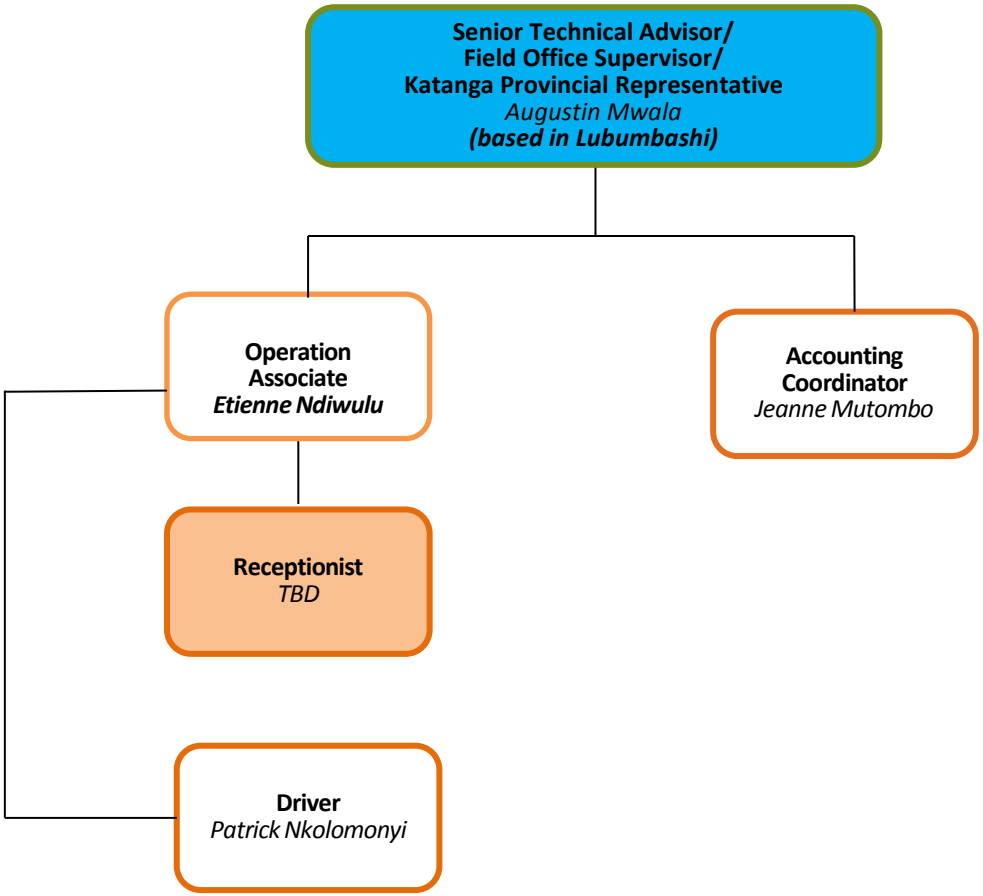
IHPplus Field Office: Mwene-Ditu, Kasaï Oriental



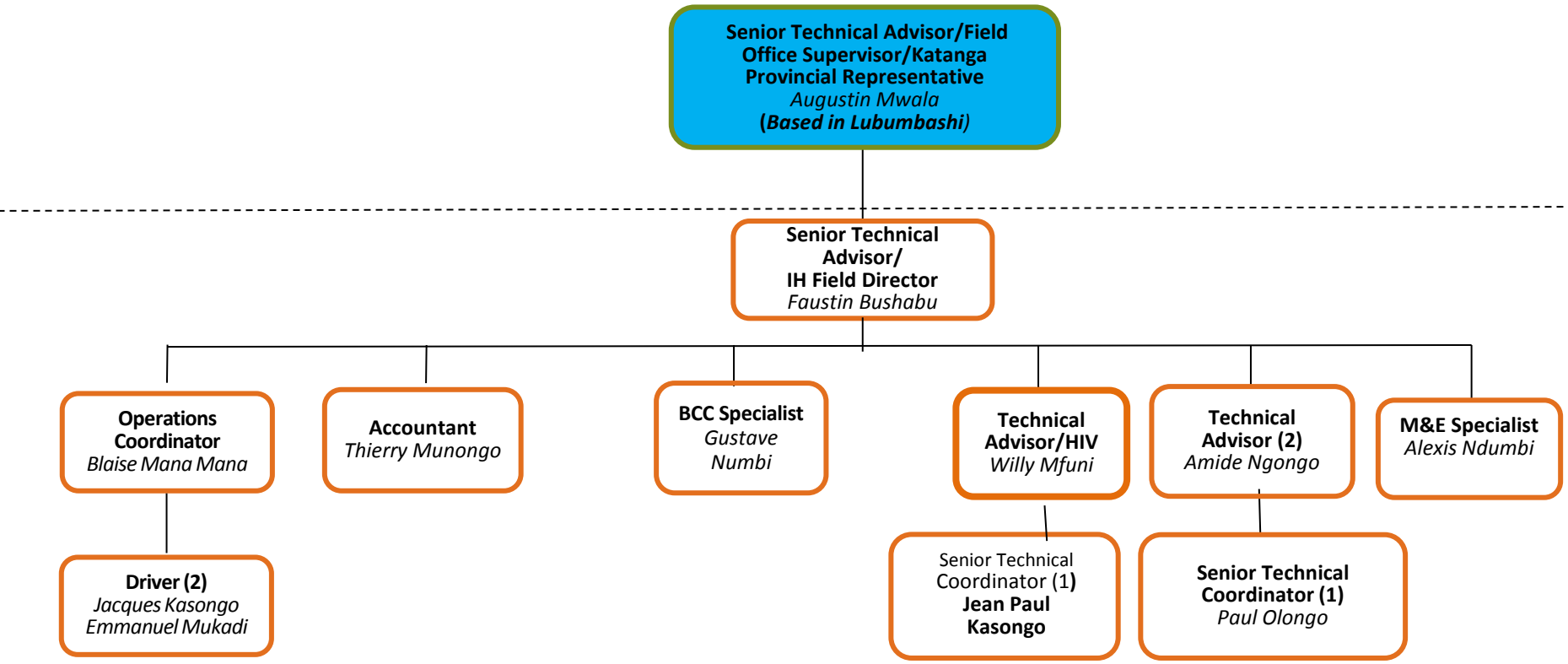
IHPplus Field Satellite Office: Mbuji-Mayi, Kasai-Oriental



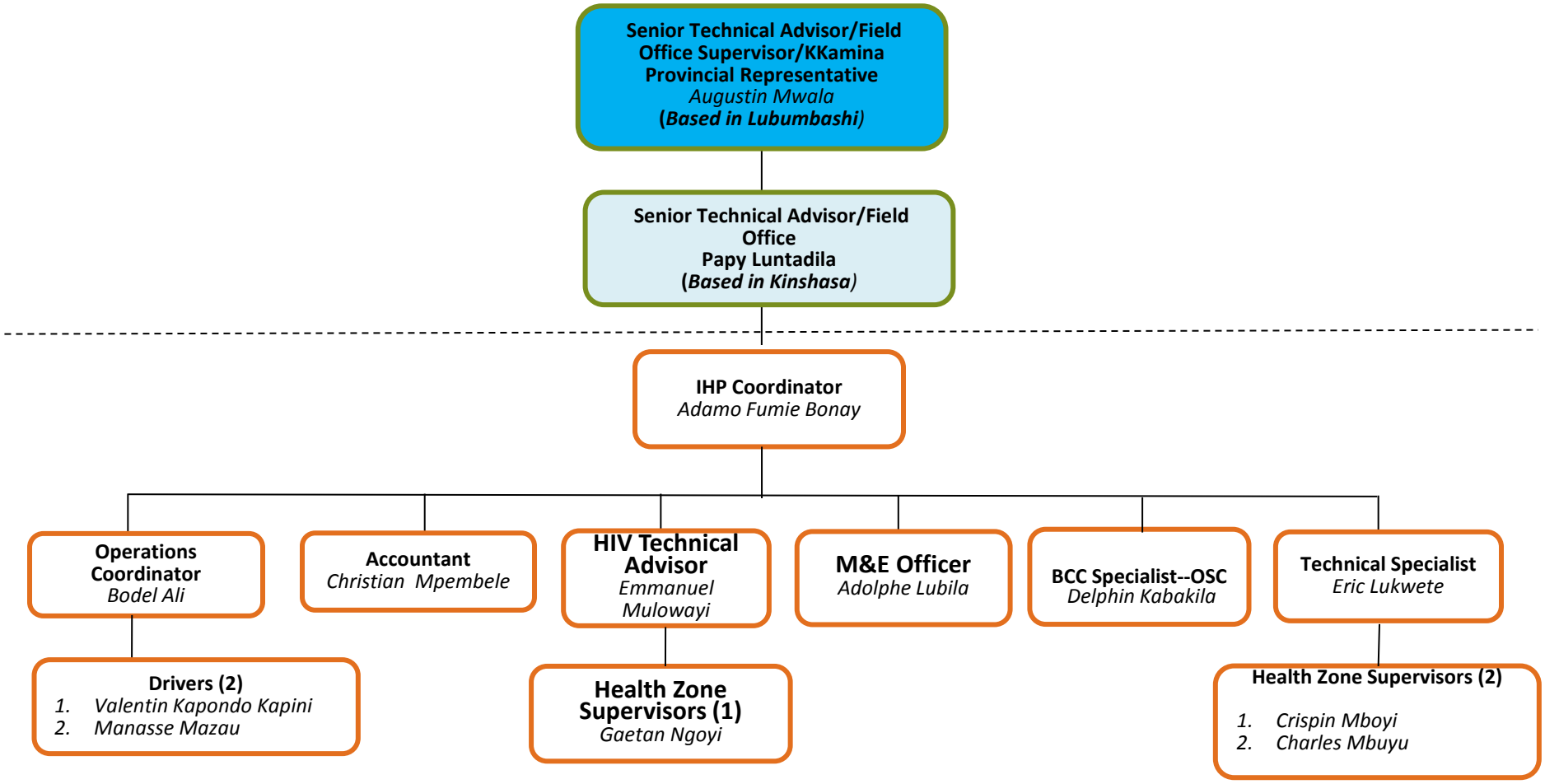
IHPplus Field Satellite Office: Lubumbashi, Katanga



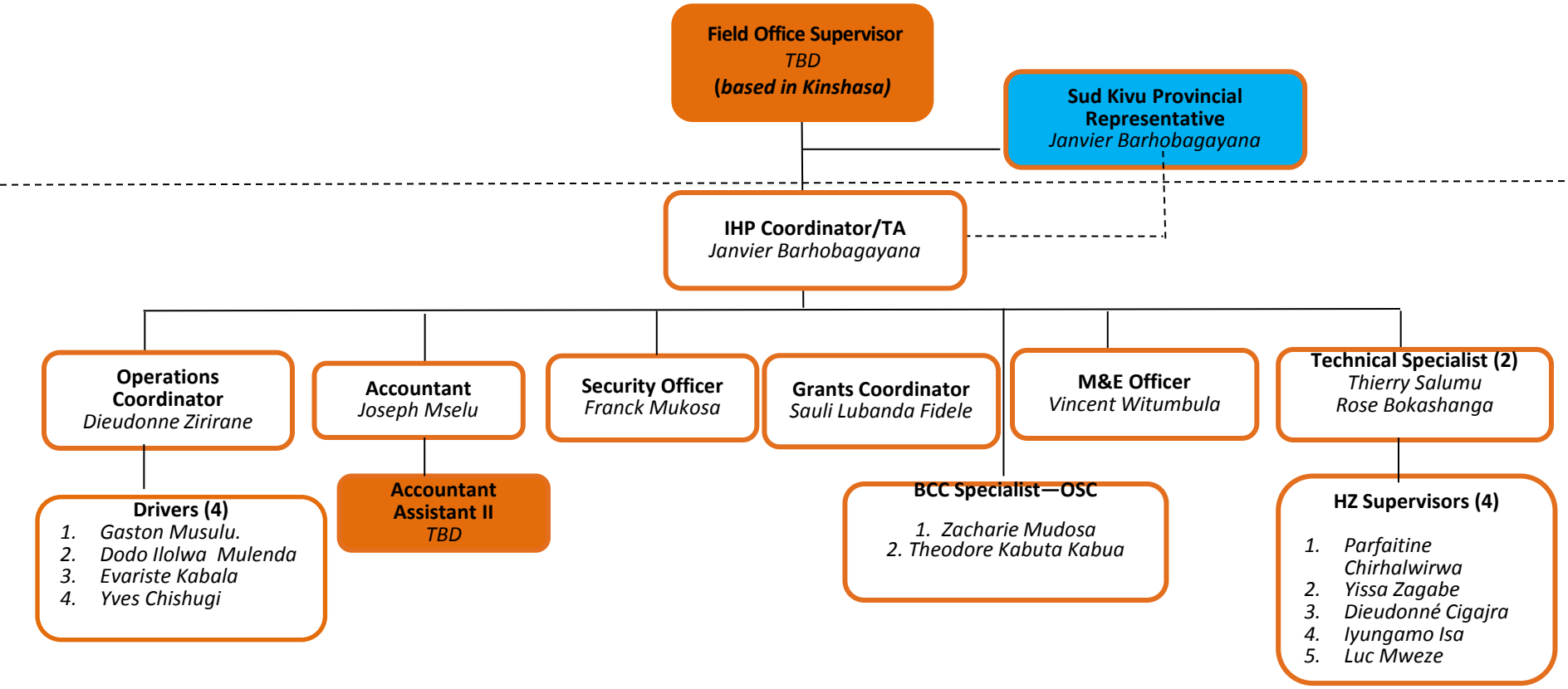
IHPplus Field Office: Kamina, Katanga



IHPplus Field Office: Kolwezi, Katanga



IHPplus Field Office: Bukavu, Sud Kivu



République Démocratique du Congo

MINISTERE DE LA SANTE PUBLIQUE

SECRETARIAT GENERAL

Programme National D'Approvisionnent En Médicaments Essentiels

P.N.A.M.

RAPPORT DE MISSION D'APPUI A LA DPS DE LUALABA POUR LA FORMATION DES CADRES PROVINCIAUX EN GESTION DES MEDICAMENTS ET AUTRES INTRANTS DE SANTE

Kolwezi, du 18 au 21 janvier 2016

Avec l'appui de :

Présenté par :

TUNGUNGA MASCOTY Etienne, *Responsable des estimations des Besoins Pays au PNAM*
AMISI KIZEGELEE Gilbert, *Responsable du service des statistiques au PNAM*
Jérémie FIKIRI, *Conseiller technique, Projet SIAPS, MSH/RDC*

JANVIER 2016

Ce rapport n'aurait pas été possible sans le soutien de l'USAID à travers les projets SIAPS et PROSANIplus mis en œuvre par MSH. Ces deux projets contribuent au renforcement des capacités de la RDC dans la gestion efficace des médicaments et autres produits de santé. Ils contribuent également à la promotion de l'accès à ces médicaments et de leur usage approprié.

Citation recommandée

REMERCIEMENTS

Nous tenons à remercier la haute hiérarchie du Ministère de la santé publique pour nous avoir mandatés dans la réalisation de cette mission de formation sur la gestion des médicaments en appui à la DPS de LWALABA.

Nos remerciements s'adressent également aux partenaires du ministère de la Santé, en l'occurrence l'USAID pour son appui technique et financier à travers les projets SIAPS et PROSANI plus mis en œuvre par MSH.

Nous avons apprécié à sa juste valeur la collaboration avec l'équipe de la DPS, la coordination provinciale de MSH (SIAPS et PROSANI plus) et les équipes cadres des ZS de BUNKEYA, DILALA, FUNGURUME, KANZENZE, LWALABA, LUBUDI, MANIKA et MUCHACHA au cours de cette mission.

Qu'ils soient tous remerciés.

I. CONTEXTE ET JUSTIFICATION

Dans le cadre des activités d'appui que le PNAM apporte aux DPS en rapport avec la gestion des médicaments, il a été noté que la maîtrise des données de consommation demeure un défi majeur dans la plupart des FOSA, entrainant ainsi des cas de ruptures de stocks et/ou des pertes des médicaments par péremption.

A côté de ce défi, on note également une faible capacité technique des prestataires doublée par la perdition (instabilité) des personnels formés.

Les dernières missions effectuées sur terrain ont rapporté l'existence d'une multiplicité des outils de gestion des données dans les Structures entrainant ainsi une grande difficulté dans la collecte et l'analyse des données, ainsi que le non-respect du circuit officiel de transmission des rapports de gestion.

Cette faible performance a été aussi épinglée par MSH/SIAPS qui a approvisionné 8 ZS dont *BUNKEYA, DILALA, FUNGURUME, KANZENZE, LWALABA, LUBUDI,MANIKA et MUCHACHA* en médicaments essentiels et autres intrants de santé dans le cadre de la mise en œuvre du projet PROSANI plus.

Eu égard de ce qui précède, les deux institutions en l'occurrence la PNAM et MSH ont jugé nécessaire de renforcer les capacités techniques des prestataires commis à la tâche de gestion des MEG dans les structures de prise en charge.

C'est pour répondre à ce besoin que la présente mission d'appui à la DPS de LUALABA a été réalisée afin de former les cadres provinciaux qui, à leur tour, procéderont à la formation des prestataires. Cette mission a été effectuée au cours de la période allant du 18 au 21 Janvier 2016.

II. INFORMATIONS GENERALES

THEME	Formation des cadres de la DPS, CDR et membres des ECZ en gestion des médicaments et autres intrants de santé			
LIEU	Salle des Conférence IMMACULATA, Kolwezi dans la Province du Lualaba			
DATE	Du 18 au 21 Janvier 2016			
DUREE	4 jours			
STRUCTURES CONCERNEES	➢ ZS ET HGR *BUNKEYA, DILALA, FUNGURUME, KANZENZE, LWALABA, LUBUDI, MANIKA et MUCHACHA ;* ➢ DPS LUALABA et CDR CAMELU			
PARTICIPANTS *(Liste de présence en annexe)*	**Catégories**	**Nombre** (Homme=H, Femme=F)	**Provenance (Structures)**	
	Pharmaciens	H : 06 F : 02	CAMELU, ZS LUBUDI, MANIKA, LUALABA, DILALA, DPS	
	Médecins	H : 13 F : 00	BCZS et HGR	
	Administrateurs Gestionnaires	H : 04 F : 00	BCZS	
	Assistants en Pharmacie	H : 00 F : 00	-	
	Infirmiers	H : 02 F : 02	ZS/FUNGURUME et HGR MANIKA	
	Autres (Préposés)	H : 07 F : 04		
	Total	H : 32 F : 08		
	Taux de Participation	**100 %** dont **M : 80 %** **F : 20 %**	Soit 40/40 Participants prévus	
TYPE DE SESSION	Session continue			

FACILITATEURS				
N°	**NOM**	**QUALIFICATION**	**INSTITUTION / STRUCTURE**	**FONCTION**
1	TUNGUNGA MASCOTY Etienne	Pharmacien	PNAM	Responsable des estimations des besoins Pays en MEG
2	AMISI KIZEGELE	Administrateur Gestionnaire	PNAM	Responsable de service des statistiques
3	Jérémie FIKIRI	Pharmacien	MSH	Conseiller technique chargé du LMIS au sein du projet SIAPS
AUTORITES RENCONTREES	***Gérard MWAMBU BOMBU MUKOJ,*** *Chef de Division Provinciale de la Santé de Lualaba*			

III. INFORMATIONS PEDAGOGIQUES

OBJECTIF GENERAL	Contribuer au renforcement des capacités techniques des cadres de la DPS, CDR et membres des ECZ dans la gestion des médicaments et autres intrants de santé
OBJECTIFS SPECIFIQUES	Les participants sont capables de :
1	Expliquer les généralités du cycle logistique de la gestion des ME
2	Sélectionner correctement les médicaments à commander
3	Acquérir correctement les médicaments
4	Distribuer correctement les médicaments
5	Assurer la qualité des médicaments
6	Assurer l'utilisation rationnelle des médicaments
7	Rapporter sur la gestion logistique des médicaments
RESULTATS OBTENUS	**40** cadres de la DPS, CDR et membres des ECZ ont été formés dans la gestion des médicaments et autres intrants de santé
METHODOLOGIE UTILISEE	L'approche active a été privilégiée avec des techniques d'apprentissage telles : 1) Brainstorming ; 2) Exposés d'orientation ; 3) Lecture individuelle ; 4) Exercices illustratifs ; 5) Travaux des groupes ; 6) Discussion en plénière.
RESSOURCES DOCUMENTAIRES	➢ Guide du formateur en gestion des médicaments ➢ Fiches techniques de gestion des médicaments au niveau du BCZS, de l'HGR et du CS ➢ Outils de gestion des médicaments au niveau du BCZS, de l'HGR et du CS ➢ Liste Nationale des Médicaments Essentiels de la RDC ➢ Echantillon d'outils de gestion tenus par les formations sanitaires

IV. SYNTHESE DU DEROULEMENT DE LA MISSION

Pour atteindre les objectifs assignés à notre mission, nous avons réalisé les activités ci-dessous :

- Participer aux réunions pédagogiques préparatoires ;
- Rencontrer les autorités politico-administratives de la Province ;
- Faciliter la session de formation ;
- Assister les participants dans les travaux des groupes.

Dès notre arrivée à Kolwezi le samedi 16 janvier, nous avons tenu une réunion préparatoire au bureau de MSH à Kolwezi. Cette réunion a porté sur : l'ajustement de l'agenda de la formation, la mise au point des aspects technique et matériel de la formation, la présentation des facilitateurs et la répartition des tâches aux facilitateurs.

Durant les 4 jours, la formation s'est focalisée sur les informations clés ci-après :

Au premier jour, après la cérémonie d'ouverture par le représentant du Chef de Division, la lecture des Termes de référence de l'atelier et la présentation des participants, il s'en est suivi un pré-test des connaissances des participants. Sur les 38 participants qui ont pris part à ce pre test, seuls 16 ont obtenu une note supérieure à la moyenne, soit **42% de réussite seulement.** Ce résultat s'est sensiblement amélioré à la fin de la formation (Voir tableau à la page 10).

En ce premier jour de la formation, les attentes des participants ont été également listées. En résumé, tous les participants ont émis le souhait de bénéficier d'une formation et des exercices pratiques qui leur permettront de mieux surmonter leurs limites et de résoudre les problèmes couramment rencontrés dans l'exercice de leur métier de gestionnaires.

L'agenda de la formation proprement-dite a porté sur diverses matières dont la synthèse est reprise dans le tableau ci-après :

Plages	**Points à retenir**
Sélection des Médicaments	La gestion des médicaments passe par un cycle comportant quatre étapes principales à savoir : la sélection, l'acquisition, la distribution et l'utilisation. S'agissant de la « sélection des médicaments », la question fondamentale est de savoir **Quels médicaments acheter.** Les facilitateurs ont mis un accent sur les documents appropriés pour la sélection des médicaments ainsi que leur importance. Il s'agit notamment de la LNME, les ordinogrammes et les DST. Avant de clore cette plage, le facilitateur a rappelé les **« 6 BONS »** qui régissent chaîne logistique des médicaments à savoir : **bons produits, en bonne quantité, dans les bonnes conditions, au bon endroit, au bon moment, et au bon coût.**
Acquisition des Médicaments	Au cours de cette plage, le facilitateur s'est appesanti sur les différents types d'acquisition des médicaments notamment **l'allocation** et **la commande ou la réquisition.** Une lumière a été apportée sur le mode calcul de la CMM, du Stock Disponible et Utilisable, du MAD, du Stock Maximum, du Stock Minimum, de la quantité à commander, de la quantité en risque de péremption ainsi que pour l'ajustement des données à tous les niveaux de la chaîne. Pour lier la théorie à la pratique, le facilitateur a procédé à la résolution d'une série d'exercices illustratifs. Ensuite les participants ont été répartis en 5 groupes et 4 Exercices pratiques leurs ont été donnés pour les travaux en groupes dont les résultats ont été par la suite présentés en plénière sous la modération du facilitateur. Retenons qu'un accent particulier a été mis sur les normes Max/Min mises

	en place en RDC pour chaque niveau de la chaîne d'approvisionnement. Ensuite, les notions sur les bonnes pratiques de réception et l'assurance qualité ont été développées. **En résumé :** Le prestataire posera les actes ci-après lors de la réception des médicaments : ➢ Réceptionner les documents qui accompagnent la livraison ; ➢ Dénombrer les colis ; ➢ Vérifier la conformité de la livraison vis-à-vis de la commande (Vérifier s'il n'y a pas de discordance entre le bordereau de livraison délivré par la CDR/fournisseur agréé et les quantités, formes et dosage du Bon de Commande) ; ➢ Vérifier la qualité physique et les dates de péremption, les numéros des lots etc. des produits livrés ; ➢ Dresser un PV de réception ; ➢ Signer le Bordereau de livraison et en conserver un exemplaire dans les archives au dépôt. S'agissant de **l'Assurance qualité**, le facilitateur a rappelé les facteurs à considérer pour assurer la qualité des médicaments. Ces facteurs se résument dans la théorie 5M dont : M : Matières M : Milieu M : Matériel M : Méthodes M : Main d'œuvre Le contenu et le rôle de chaque M dans l'assurance qualité des médicaments ont été clairement expliqués**.**
Distribution des Médicaments	Dans ce chapitre, le facilitateur est revenu essentiellement sur le **stockage** et la **tenue des outils** de gestion, avant de procéder aux exercices pratiques y relatifs. En résumé, les normes à observer en matière de **Stockage** ont été rappelées. Ces normes portent sur le classement, le rangement, le local et le matériel. S'agissant du classement, deux modes ont été expliqués dont : l'ordre alphabétique et l'ordre thérapeutique. En ce qui concerne le local, les conditions d'un local approprié ont été passées en revue dont : la construction en matériaux durable, l'aération suffisante, bon environnement extérieur, sécurité suffisante. Quant au matériel : les étagères en bois plaqué ou en métal de préférence etc. Ensuite, quelques concepts clés relatifs aux médicaments ont été définis et expliqués aux participants en vue de faciliter la compréhension des prochaines étapes. Il s'agit notamment des concepts suivants : le Médicament, Médicament altéré, Médicament falsifié (contrefait),

	Médicament corrompu, Médicament périmé, Médicament essentiel, FIFO, FEFO. Enfin, **les outils de gestion** ont été présentés, décrits et leur tenue a été clairement expliquée, soutenue par des exercices de démonstration. A cet effet, un modèle de chaque outil a été décrit, expliqué et rempli. Les outils concernés étaient : ➢ La fiche de stock ➢ Le bon de commande/Réquisition ➢ Fiche d'inventaire ➢ RUMER ➢ Fiche de température et d'humidité ➢ Fiche Hors usage ➢ Canevas de rapport d'inventaire
Utilisation rationnelle des Médicaments	Dans ce chapitre, trois points ont été développés à savoir : ➢ La prescription des médicaments ; ➢ La Dispensation ou délivrance des médicaments ; ➢ Le Suivi de l'utilisation des médicaments par rapport aux effets indésirables. Par rapport à **la Dispensation**, les tâches à exécuter sont : ✓ Reconditionner les comprimés dans les emballages en plastique propres, secs et bien fermés, sans mélanger plusieurs produits ; ✓ Eviter de reconditionner dans les papiers coton sales et adsorbants ou dans des récipients sans fermeture ; ✓ Marquer la date limite d'utilisation des produits en ajoutant 30 jours à partir de la date de reconditionnement ; ✓ Expliquer aux malades : les posologies, quand et combien de fois par jour et pendant combien de temps ; ✓ Avertir aux malades la survenue des effets indésirables éventuels En ce qui concerne **le suivi de l'utilisation des Médicaments,** le facilitateur a démontré aux participants comment procéder au suivi de la consommation des Médicaments en exhortant au malade de faire un feedback à la structure en cas d'effets indésirables autres que ceux prévenus par le prestataire de la Pharmacie.
Gestion de l'information logistique (SIGL)	A ce propos, les points essentiels du Système d'Information en Gestion Logistique (SIGL) notamment son rôle, but, les données logistiques essentielles, les informations logistiques/indicateurs, les supports, les acteurs et leurs rôles ont été développés. Notons par ailleurs que les informations logistiques à rapporter ont été énumérées et calculées avec exercices illustratifs pratiques. Ces informations sont : la CMM, le MAD, le SDU, le Taux de Perte et le capital Médicaments.

V. EVALUATION DES CONNAISSANCES DES PARTICIPANTS

Au début comme à la fin de la formation, les participants ont été soumis à des tests dont les résultats se présentent comme suit :

N°	CODE	PRE TEST (%)	POST TEST (%)	GAIN (%)
1	AB	50	56	6
2	J	67	**93**	26
3	JIMMY	73	80	7
4	PNK	47	65	18
5	JP	57	83	26
6	RUB	40	70	30
7	DT	28	53	25
8	OOA	63	83	20
9	D	43	73	30
10	A	**40**	**83**	**43**
11	DEMK	70	83	13
12	M vingt	67	80	13
13	CK	50	80	30
14	HA	46	73	27
15	XX	67	73	6
16	MM	53	63	10
17	GODARD	60	90	30
18	DSG	53	87	34
19	ISAAC	53	87	34
20	ABCDE	63	77	14
21	HT	50	80	30
22	L	40	80	40
23	Jean Marie	40	77	37
24	IM	43	70	27
25	Sylvie	36	60	24
26	Chiffre	60	73	13
27	BK	33	57	24
28	R	43	73	30
29	CL	40	67	27
30	LMMTS	43	70	27
31	MI	23	46	23
32	EK	50	67	17
33	Emelie	33	56	23
34	K3	**80**	90	10
35	PAS	77	90	13
36	EM	57	70	13
37	Eudoxie KARUMB	**13**	**33**	20
38	Deux K	43	68	25

Commentaire :

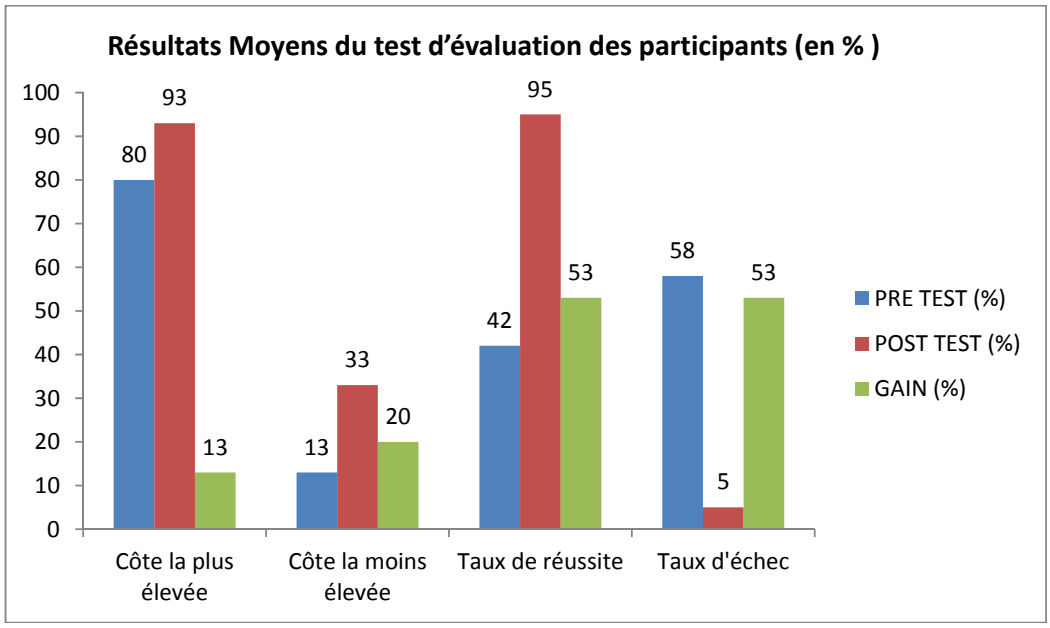
- Avant la formation, sur les 38 participants qui ont pris part au pre-test, seuls 16 ont obtenu une note supérieure à la moyenne, soit **42% de réussite seulement.**
- Après la formation, le nombre de participants ayant une note supérieure à la moyenne est passé de 16 à 36, soit **94.7% de réussite.** Ce qui fait une amélioration de**52.7%.**
- Toutefois, bien qu'en dessous de la moyenne, les 2 participants restant ont tout-de-même amélioré leurs notes après la formation. Il s'agit des participants N°31 et 37.
- Dans l'ensemble, 100% des côtes du pré-test ont été améliorés au post-test, ce qui nous rassure que cette formation a été d'une très grande utilité pour cette cible.

Par ailleurs, nous pouvons observer des cas de distinction ci-après :

- La cote de l'apprenant A est passée de 40% au pre-test à 83% au post-test ;
- La cote de l'apprenant J est passée de 67% au pre-test à 93% au post-test ;
- L'apprenant K3 qui au pré-test a obtenu la côte élevée de 80% est passée à 90%.

D'autres détails peuvent être observés dans le graphique ci-dessous :

Graphique 1 : Résultats Moyens du test d'évaluation des participants



Commentaires :

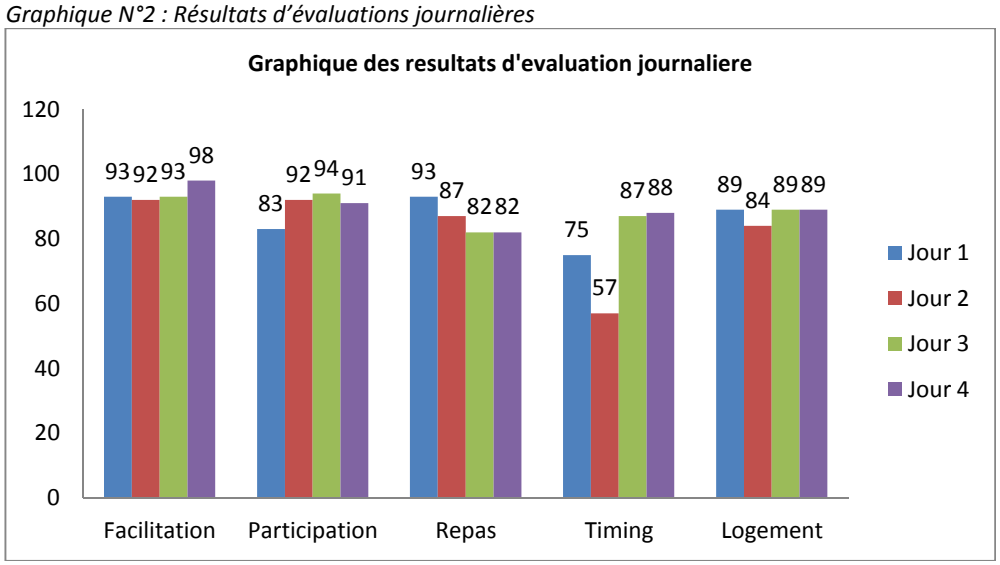
- La côte la plus élevée est passée de 80% à 93 % avec un gain de 13 %
- La côte la moins élevée est passée de 13 à 33 % avec un gain de 20 %
- Le taux de réussite a augmenté de 42% à 95 % avec un gain évalué à 53%
- Le taux d'échec a été sensiblement réduit de 58% à 5% soit un taux de réduction de 53%

VI. EVALUATIONS JOURNALIERES DES ASPECTS TECHINIQUES ET LOGISTIQUES DE LA FORMATION

Chaque jour avant la clôture de la journée, les participants procédaient à l'évaluation partielle de la formation pour permettre aux facilitateurs et organisateurs d'améliorer leurs prestations et de s'assurer que la formation se déroule comme prévu.

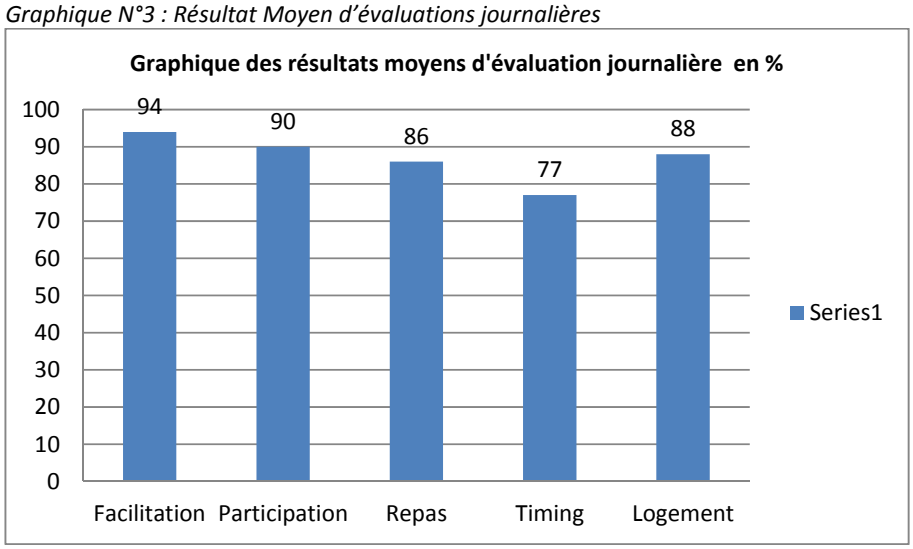
Les détails de cette évaluation peuvent être trouvés dans les graphiques ci- dessous.

Graphique N°2 : Résultats d'évaluations journalières



Dans l'ensemble cette formation a été évaluée à 84% de réussite en se basant sur les critères ou éléments d'évaluation ci-dessus notamment la qualité de la facilitation, la participation, le repas, la gestion du temps et le logement des participants.

Graphique N°3 : Résultat Moyen d'évaluations journalières



Comme nous montre ce graphique, la facilitation et la participation des apprenants sont les éléments qui ont obtenu un meilleur score moyen évalué respectivement à 94 et 90%.

VII. CONCLUSION

En se basant sur les résultats d'évaluation générale, nous affirmons que cette formation a apporté un bagage consistant de connaissances additionnelles à tous les participants. Ce fut un succès et pour les facilitateurs et pour les participants en dépit de quelques défis d'ordre logistiques.

La participation a été de **40/40 soit 100 %** de participants attendus. En terme de connaissances additionnelles, le gain de cette formation est estimée à **53%** au regard du nombre d'échecs au test de début et de la fin de la formation.

Nous espérons que dans un futur proche, les pratiques de gestion des médicaments dans les formations sanitaires de la DPS Lualaba connaitront une amélioration considérable. Une des conditions à cette amélioration est de restituer correctement cette formation aux prestataires des centres de santé le plus tôt possible. Cette restitution sera faite aux CS par ***10 formateurs provinciaux de Lualaba qui seront désignés en se référant aux 10 premières côtes réalisées par les Participants au post-test.***

VII. PLAN D'ACTION POST FORMATION

Dans le but de maintenir les acquis de cette activité, le plan d'action post formation ci-dessous a été élaboré par les participants en présence de la DPS et sous la facilitation du PNAM et MSH :

PLAN D'ACTION POST-FORMATION SUR LES 6 PROCHAINS MOIS

Février à Juillet 2016

Activités	1er trim.			2nd trim.			Résultat	Livrables	Responsable
	F	M	A	M	J	J			
Mettre en place une Commission Provinciale du Médicament (CPM)	*X*						*CPM installée dans la DPS de Lualaba d'ici fin février 2016*	*Rapport d'installation de la CPM*	*DPS, avec appui MSH/SIAPS et autres partenaires, PNAM*
Former les prestataires des CS (organisés en 3 pools de formation)		*X*	*X*				*Au moins 120 prestataires des CS sont formés en fin avril 2016*	*Rapport de formation*	*ECZS et DPS (participants à la formation des formateurs)*
Distribuer les outils de gestion PNAM dans les formations sanitaires		*X*					*60% des FOSA appuyées par IHP plus disposent des outils de gestion PNAM*	*PV de réception des outils*	*MSH et DPS*
Tenir un Atelier d'analyse et de validation des données issues du terrain et actualiser les CMM des FOSA				*X*			*Atelier tenu d'ici mai 2016*	*Rapport de l'atelier*	*ECZS, sous la coordination de la DPS et MSH*
Organiser des Supervisions conjointes DPS-MSH				*X*			*Toutes les 8 ZS formées sont supervisées avant sept. 2016*	*Rapports supervision*	*DPS et MSH*
Mettre en place les comités de quantification dans les ZS de la DPS Lualaba			*X*				*D'ici avril 2016, au moins 4 CQ sont installées dans les ZS de la DPS Lualaba*	*Rapport d'installation des CQ*	*DPS*
Quantifier les besoins provincials en se basant sur les données de consommation					*X*		*Les besoins de la DPS sont estimés sur base des données de consommation d'ici juin 2016*	*Rapport de quantification*	*DPS, ECZS avec l'appui du PNAM et MSH*

Fait à Kolwezi, le 21 janvier 2016

Proposé par:
L'ensemble des participants à la formation

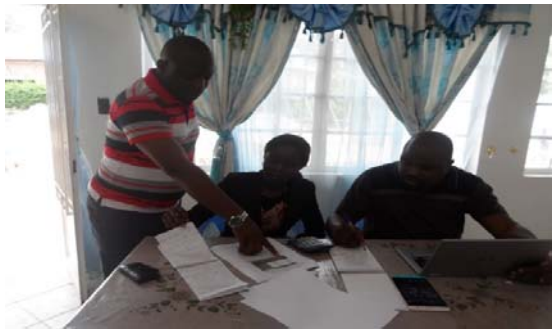
Revu par:
Etienne MASCOTY, PNAM/RDC
Gilbert AMISI, PNAM/RDC
Jérémie FIKIRI, MSH/RDC

Approuvé par:
Gerard MWAMBU BOMBU MUKOJ
Chef de Division Provinciale de la Santé

ANNEXES

ANNEXE 1 : QUELQUES PHOTOS

Séance d'exercices en groupe



Coaching lors des exercices en groupe

Vue de l'assemblée

Rencontre avec le chef de Division

Livraison et réception des médicaments IHP à la CDR CAMELU/Kolwezi

ANNEXE 2 :

TERMES DE REFERENCE DE LA FORMATION DES CADRES PROVINCIAUX DE LA DPS LUALABA SUR LA GESTION DES MEDICAMENTS ET AUTRES INTRANTS DE SANTE

I. Contexte et justification

Dans le cadre des activités visant les missions d'appui du PNAM aux DPS en rapport avec la gestion des médicaments, il a été constaté que les FoSa avaient une faible maîtrise des données de consommation, plusieurs ruptures et/ou Sur Stock des médicaments, nombreuses pertes des médicaments liées à des raisons diverses, une faible capacité technique des prestataires doublée par la perdition des personnels formés, d'une part.

D'autre part, une multiplicité et mauvaise tenue des outils de gestion dans les structures entrainant ainsi une grande difficulté dans la collecte et l'analyse des données appuyée par le non-respect du circuit officiel de transmission des rapports de gestion.

Ce constat de non performance a été aussi épinglée par MSH/SIAPS qui approvisionne huit zones de santé dont BUNKEA, DILALA, FUNGURUME, KANZENZE, LUALABA, LUBUDI, MANIKA et MUTSHASHA de la DPS/LUALABA en médicaments essentiels et autres intrants de santé dans le cadre de la mise en œuvre du projet Prosani.

Eu égard de ce qui précède, les deux institutions en occurrence, le PNAM et MSH/SIAPS, ont jugé nécessaire de renforcer les capacités techniques des prestataires commis à la tâche de gestion des MEG dans les structures de prise en charge.

C'est ainsi que, le PNAM se propose, d'effectuer une mission d'appui à la DPS Luluaba sur la formation des Cadres Provinciaux qui à leur tour procéderont à la formation des prestataires avec le financement d'USAID/MSH/SIPAS dans les ZS ciblées au cours de la période allant du 18 au 21 janvier 2016.

II. Objectif général

Contribuer à l'amélioration de l'état de santé de population.

III. Objectifs spécifiques

1. Rendre disponibles les fiches techniques de gestion des médicaments, version 2015, en MEG dans toutes les FoSa ciblées
2. Former les Cadres Provinciaux sur la gestion des médicaments ;
3. Briffer les Cadres Provinciaux sur les fiches techniques de la gestion de l'entrepôt dans le SNAME
4. Elaborer un plan d'action post formation

IV. <u>Résultats attendus</u>

1. les fiches techniques de gestion des médicaments, version 2015, en MEG dans toutes les FoSa ciblées sont disponibles
2. les Cadres Provinciaux sont formés sur la gestion des médicaments ;
3. les Cadres Provinciaux sont briffés sur les fiches techniques de la gestion de l'entrepôt dans le SNAME
4. Un plan d'action post formation est élaboré

V. Méthodologie

La méthodologie sera participative et devra s'appuyer sur les techniques ci-après :

- 20 à 25 participants par auditoire
- Exposés thématiques
- Travaux en groupes
- Restitution des travaux de groupe en plénière
- Synthèse des facilitateurs
- Evaluation journalière des participants
- Réunion pédagogique des facilitateurs

VI. Profil des participants

Les membres de l'ECZS, entre autres :

1. Pharmaciens
2. Médecins
3. Préposés à la pharmacie

VII. Outils pédagogiques.

- Fiches techniques MEG ;
- Guides technique des formations
- LNME, version 2014
- DST
- Autres

VIII. Matériels didactiques :

- Carnets A4
- Farde à rabat
- Flashdisk
- Bics
- Rames papiers
- Vidéo projecteur
- Ordinateur
- Flip chart
- Marqueur permanent (noir, rouge, bleu)

IX. Facilitateurs :

- Deux facilitateurs du niveau national
- Un délégué de MSH/SIAPS

X. DEROULEMENT DE LA FORMATION

La formation durera quatre jours et sera résidentielle : Les facilitateurs devront arriver un jour avant les participants. Cette formation sera précédée par une réunion pédagogique afin de planifier les activités.

XI. Budget : A charge de MSH/IHP plus

Fait à Kinshasa, le 05 janvier 2015

Léonard MATAMBA TSHINGOMBE, MPH
Directeur du PNAM

ANNEXE 3 : AGENDA DE LA FORMATION

HEURES	JOUR 1	JOUR 2	JOUR 3	JOUR 4	JOUR 5
8h30 à 10h30	Départ de Kinshasa Arrivée à …… Installation à l'Hôtel	Présentation des civilités des facilitateurs aux autorités sanitaires Arrivée des participants Cérémonie d'Ouverture Présentation des participants Lecture des TDR Collecte des Attentes des participants PRE TEST	Où en sommes-nous ? Lecture et adoption du rapport J1 **Activité 2 Acquérir les médicaments : plénière**	Où en sommes-nous ? Lecture et adoption du rapport J2 **Activité 3 Distribuer les médicaments : plénière**	Où en sommes-nous ? Lecture et adoption du rapport J3 Travaux des groupes: plénière **Exposé sur le Circuit du SNAME**
10h30 à 11h00	**Pause-café**				
11h00 à 12h00	Séance de travail avec l'équipe locale du PTF	**Activité 1 sélection :** - Tâche 1 : Choisir les médicaments Travaux des groupes (exercices) Plénière	**Activité 3 Distribuer les médicaments :** - Tâche 1 : enregistrer les médicaments - Tâche 2 : stocker les médicaments	**Activité 4 Utiliser les médicaments :** Tâche 1 : délivrer les médicaments Travaux des groupes (exercices) Plénière	**Briefing sur la gestion de l'entrepôt**
12h00 à 14h00	Réunion pédagogique	**Activité 2 Acquérir les médicaments :** - Tâche 1 : quantifier les besoins - Tâche 2 : passer la commande - Tâche 3 : réceptionner les médicaments - Tâche 4 : s'assurer de la qualité des médicaments	**Activité 3 Distribuer les médicaments :** - Tâche 3 : livrer les médicaments (jeu de rôle) - Tâche 4 : tenir la fiche de Stock (exercice)	**Activité 5 Gérer l'Information :** - Tâche 1 : collecter et compiler les données sur la gestion des médicaments - Tâche 2 : analyser les données Travaux des groupes Plénière	**Elaboration plan d'action post formation** Post test Evaluation des attentes des participants
14h00 à 15h00	**PAUSE REPAS**				
15h00 à 16h30		**Activité 2 Acquérir les médicaments :** **Travaux** des groupes (exercices)	**Activité 3 Distribuer les médicaments :** Tâche 5 : tenir les inventaires Travaux des groupes (exercices)	Exercices pratiques Travaux des groupes	**Synthèse de la formation** **Cérémonie de clôture**
16h30 à 17h00		Evaluation et clôture de la journée	Evaluation et clôture de la journée	Evaluation et clôture de la journée	

ANNEXE 4 : PRE ET POST TEST

A. NON CORRIGE

I. Cocher la (les) bonne (s) réponse (s) :

1. Les conditions suivantes sont susceptibles de modifier la qualité des Médicaments et autres intrants, à l'exception de :
   a) La chaleur
   b) La poussière
   c) La lumière
   d) L'aération
   e) L'humidité
   f) Les rayons solaires
2. Pour une bonne réception d'une commande, les tâches ci-dessous sont recommandées à l'exception de:
   a) Vérifier l'emballage
   b) Etablir un PV de réception
   c) Vérifier l'étiquetage
   d) Travailler en équipe
   e) Vérifier les quantités reçues
   f) Ignorer le n° lot et dates de péremption
3. Un des éléments suivants n'est pas un outil de gestion des médicaments, il s'agit de :
   a) Fiche de stock
   b) Fiche de prélèvement de la t°
   c) Bon de commande
   d) PV de réception
   e) Bon de caisse
   f) Bon de livraison
4. Le (s) bon (s) moment (s) pour passer une commande est (sont) :
   a) Lorsque le MD/ IT est absent
   b) Lorsqu'on atteint le stock maximal
   c) Lorsqu'on est en rupture de stock
   d) Lorsqu'on atteint le stock d'alerte
   e) Lorsque les produits sont périmés
   f) Lorsqu'on atteint le stock minimum
5. Pour sélectionner les produits à utiliser dans votre Fosa, vous vous servez de :
   a) La liste nationale des ME
   b) La liste modèle de l'OMS
   c) Les directives Standards de traitement/ ordinogrammes
   d) Votre propre liste
   e) Aucune bonne réponse
6. Les assertions suivantes ne respectent pas les bonnes pratiques d'entreposage des médicaments, à l'exception de :
   a) Les produits sont classés au sol, les cartons par terre
   b) Les produits thermolabiles sont dans les armoires
   c) Les étagères/armoires sont classées contre les murs
   d) Les stupéfiants/ psychotropes sont sur les étagères
   e) Aucune bonne réponse

II. Cocher (a) si c'est VRAI, (b) si c'est FAUX :

1. Un produit qui a une date de péremption proche sort le premier même si sa date d'acquisition en stock est récente. a. b.
2. Pendant l'inventaire de stock, il faut arrêter tous les mouvements du stock, sauf s'il s'agit d'une commande d'urgence à réceptionner. a. b.
3. Avec un outil informatique/ Logiciel de gestion de stock, la présence d'une fiche de stock en dur est inutile
   a. b.
4. Que signifie :
   a. FEFO :

b. FIFO :
c. DCI :
d. MEG :
e. Stock Maximum:
f. Stock Minimum :
g. SIGL :

III. Cocher la bonne réponse

Le document de transaction qui accompagne les médicaments lors de la réception dans votre structure est :

a) Le bon de livraison/Facture
b) Le PV de réception
c) La fiche de stock
d) Le registre d'entrée

IV. Cocher la (les) bonne(s) réponse(s) : Les données ci-après sont des données essentielles :

h. Quantité reçue
i. Quantité commandée
j. Quantité consommée
k. Stock disponible et utilisable
l. Quantité perdue
m. Nombre de jours de rupture des stocks
n. Recettes

V. Cocher la (les) bonne (s) réponse (s) : les informations ci-après sont essentielles :

o. Consommation Mensuelle Moyenne
p. Mois de Stock Disponible
q. Stock Maximum
r. Stock Minimum
s. Stock d'Alerte

B. CORRIGE

I. Cocher la (les) bonne (s) réponse (s) :

1. Les conditions suivantes sont susceptibles de modifier la qualité des Médicaments et autres intrants, à l'exception de :

g) La chaleur
h) La poussière
i) La lumière
j) L'aération
k) L'humidité
l) Les rayons solaires

2. Pour une bonne réception d'une commande, les tâches ci-dessous sont recommandées à l'exception de:

g) Vérifier l'emballage
h) Etablir un PV de réception
i) Vérifier l'étiquetage
j) Travailler en équipe
k) Vérifier les quantités reçues
l) Ignorer le n° lot et dates de péremption

3. Un des éléments suivants n'est pas un outil de gestion des médicaments, il s'agit de :

g) Fiche de stock
h) Fiche de prélèvement de la t°
i) Bon de commande
j) PV de réception
k) Bon de caisse
l) Bon de livraison

4. Le (s) bon (s) moment (s) pour passer une commande est (sont) :

g) Lorsque le MD/ IT est absent
h) Lorsqu'on atteint le stock maximal
i) Lorsqu'on est en rupture de stock
j) Lorsque les produits sont périmés
k) Lorsqu'on atteint le stock minimum

5. Pour sélectionner les produits à utiliser dans votre Fosa, vous vous servez de :
   f) La liste nationale des ME
   g) La liste modèle de l'OMS
   h) Les directives Standards de traitement/ ordinogrammes
   i) Votre propre liste
   j) Aucune bonne réponse

6. Les assertions suivantes ne respectent pas les bonnes pratiques d'entreposage des médicaments, à l'exception de :
   f) Les produits sont classés au sol, les cartons par terre
   g) Les produits thermolabiles sont dans les armoires
   h) Les étagères/armoires sont classées contre les murs
   i) Les stupéfiants/ psychotropes sont sur les étagères
   j) Aucune bonne réponse

II. Cocher (a) si c'est VRAI ,(b) si c'est FAUX :

1. Un produit qui a une date de péremption proche sort le premier même si sa date d'acquisition en stock est récente. a. b.
2. Pendant l'inventaire de stock, il faut arrêter tous les mouvements du stock, sauf s'il s'agit d'une commande d'urgence à réceptionner. a. b.
3. Avec un outil informatique/ Logiciel de gestion de stock, la présence d'une fiche de stock en dur est inutile
   a. b.
4. Que signifie :
   t. FEFO :**First Expired First Out**
   u. FIFO :**First In First Out**
   v. DCI : **Denomination Commune Internationale**
   w. MEG : **Medicaments Essentiels Génériques**
   x. Stock Maximum: **Stock exprimé en nombre des mois à ne pas dépasser à chaque niveau**
   y. Stock Minimum : **Stock exprimé en nombre des mois qui déclenche une nouvelle commande.**
   z. SIGL : **Système d'Information en Gestion Logistique**

III. Cocher la bonne réponse

Le document de transaction qui accompagne les médicaments lors de la réception dans votre structure est :
   e) Le bon de livraison/Facture
   f) Le PV de réception
   g) La fiche de stock
   h) Le registre d'entrée

IV. Cocher la (les) bonne(s) réponse(s) : Les données ci-après sont des données essentielles :
   aa. Quantité reçue
   bb. Quantité commandée
   cc. Quantité consommée
   dd. Stock disponible et utilisable
   ee. Quantité perdue
   ff. **Nombre de jours de rupture des stocks**
   gg. Recettes

V. Cocher la (les) bonne (s) réponse (s) : les informations ci-après sont essentielles :
   hh. Consommation Mensuelle Moyenne
   ii. Mois de Stock Disponible
   jj. Stock Maximum
   kk. Stock Minimum
   ll. Stock d'Alerte

ANNEXE 5 : FICHE D'EVALUATION JOURNALIERE

N°	Eléments d'évaluation	Echelle d'appréciation			
		1	3	4	5
1	Facilitation				
2	Participation des apprenants				
3	Qualité du repas				
4	Respect du timing				
7	Logement				

Commentaires : ……

……..

……..

ANNEXE 6 : EXERCICES ILLUSTRATIFS

1. **Après 8 mois de gestion des ME au sein du CS …, le rapport de consommation de Quinine comprimés 250mg, se présente de la manière ci-dessous :**

N°	Période	Consommation (Pièce)	Observation
1	Janvier	884	?
2	Février	410	?
3	Mars	760	?
4	Avril	425	?
5	Mai	717	?
6	Juin	764	?
7	Juillet	856	?
8	Aout	743	?
	CMM	?	?

Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine du CS disposent d'un stock physique de 2242 Comprimés dont 58, 87, 43 sont respectivement altérés, corrompus, cassés ?

2. **Après 6 mois de gestion des ME au sein de l'HGR…, le rapport de consommation de la quinine 250 mg comprimés se présente de la manière ci-dessous :**

N°	Période	Consommation	Observation
1	Janvier	184	?
2	Février	210	?
3	Mars	160	?
4	Avril	150	?
5	Mai	161	?
6	Juin	152	?
	CMM	?	?

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine de l'HGR disposent d'un stock physique de 872 Comprimés dont 24, 35 sont respectivement altérés, cassés ?
- Quelle analyse pouvez-vous faire par rapport à cette situation et quelle décision envisageriez-vous ?

3. **En date du 28 décembre 2014, après inventaire des ME dans la zone de santé de……. constituée de 5 structures de prise dont le BCZS et 4 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de Artesunate 1g injectable, se présentent de a manière suivante** :

N°	Entité	Stock Disponible(Vial)	CMM (Vial)	MSD (Mois)	Observation ou Analyse
1	BCZS	4400	1400 (Distrib)	?	?
2	HGR	800	300	?	?
3	CS1	200	110	?	?
4	CS2	250	170	?	?
5	CS3	230	250	?	?
	ZONE DE SANTE	?	?	?	?
	SD, CMM, MSD (ZS) Ajustés	?	?	?	?

- Quelle analyse pouvez-vous faire par rapport à cette situation ?
- Quelles décisions envisageriez-vous ?

4. **En date du 30 Mars 2014, après inventaire des ME dans la zone de santé de……. constituée de 10 structures sanitaires dont le BCZS et 9 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de ASAQ dont la validité es de 6 mois càd EXP : 10/14), se présentent de a manière suivante :**

N°	Entité	Stock Disponible(Cure)	CMM (Cure)	MSD (Mois)	Observation ou Analyse
1	BCZS	4736	478 (Distribut)	?	?
2	HGR	1567	273	?	?
3	CS1	372	152	?	?
4	CS2	225	154	?	?
5	CS3	343	170	?	?
6	CS4	189	115	?	?
7	CS5	232	134	?	?
8	CS6	248	110	?	?
	ZONE DE SANTE	?	?	?	?
	SD, CMM, MSD (ZS) Ajustés	?	?	?	?

- Quelle analyse pouvez-vous faire par rapport à cette situation et
- Quelle décision envisageriez-vous ?

A. Exercices des Groupes

5. **Après 8 mois de gestion des ME au sein du CS …, le rapport de consommation de TDR, se présente de la manière ci-dessous** :

N°	Période	Consommation (Pièce)	Observation
1	Janvier	1884	?
2	Février	1.410	?
3	Mars	1.760	?
4	Avril	935	?
5	Mai	1.771	?
6	Juin	1.772	?
7	Juillet	3856	?
8	Aout	1643	?
	CMM	?	?

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine du CS disposent d'un stock physique de 6422 Comprimés dont 85, 133, sont respectivement altérés corrompus, cassés ?

6. **Après 6 mois de gestion des ME au sein de l'HGR…, le rapport de consommation de la quinine 250 mg comprimés, se présente de la manière ci-dessous :**

N°	Période	Consommation	Observation
1	Janvier	1184	?
2	Février	1210	?
3	Mars	1060	?
4	Avril	1250	?
5	Mai	1361	?
6	Juin	1252	?
	CMM	?	?

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine de l'HGR disposent d'un stock physique de 4872 Comprimés dont 324, 35, 43, sont respectivement altérés corrompus, cassés ?
- Quelle analyse pouvez-vous faire par rapport à cette situation et quelle décision envisageriez-vous ?

7. **En date du 28 décembre 2014, après inventaire des ME dans la zone de santé de……. constituée de 5 structures de prise dont le BCZS et 4 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de Artesunate 1g injectable, se présentent de a manière suivante :**

N°	Entité	Stock Disponible(Vial)	CMM (Vial)	MSD (Mois)	Observation ou Analyse
1	BCZS	2400	700 (Distrib)	?	?
2	HGR	600	300	?	?
3	CS1	100	120	?	?
4	CS2	150	130	?	?
5	CS3	130	200	?	?
	ZONE DE SANTE	?	?	?	?
	SD, CMM, MSD (ZS) Ajustés	?	?	?	?

- Quelle analyse pouvez-vous faire par rapport à cette situation e
- Quelle décision envisageriez-vous ?

8. **En date du 30 Mars 2014, après inventaire des ME dans la zone de santé de……. constituée de 10 structures de prise dont le BCZS et 9 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de AL dont la validité es de 4 mois càd EXP : 08/14), se présentent de a manière suivante :**

N°	Entité	Stock Disponible(Cure)	CMM (Cure)	MSD (Mois)	Observation ou Analyse
1	BCZS	6473	678 (Distribut)	?	?
2	HGR	2256	473	?	?
3	CS1	472	232	?	?
4	CS2	325	254	?	?
5	CS3	543	270	?	?
6	CS4	289	145	?	?
7	CS5	432	234	?	?
8	CS6	348	210	?	?
	ZONE DE SANTE	?	?	?	?
	SD, CMM, MSD (ZS) Ajustés	?	?	?	?

- Quelle analyse pouvez-vous faire par rapport à cette situation et
- Quelles décisions envisageriez-vous ?

ANNEXE 7 : EXERCICES ILLUSTRATIFS CORRIGES

Question 1 : Après 8 mois de gestion des ME au sein du CS …, le rapport de consommation de Quinine comprimés 250mg, se présente de la manière ci-dessous :
Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine du CS disposent d'un stock physique de 2242 Comprimés dont 58, 87, 43 sont respectivement altérés corrompus, cassés ?

Réponse 1

N°	Période	Consommation (cé)	Observation
1	Janvier	884	Typique
2	Février	710	Typique
3	Mars	760	Typique
4	Avril	425	**Atypique**
5	Mai	717	Typique
6	Juin	764	Typique
7	Juillet	856	Typique
8	Aout	1743	**Atypique**
	CMM(Cés)	**781,8**	-
	SD(Mois)	**2054**	-
	MSD(Mois)	**2,62**	**Surstock**

Décisions à envisager notamment :
- Surseoir la livraison en cas de réquisition
- Descente sur terrain pour s'enquérir de la situation réelle

Question 2 : Après 6 mois de gestion des ME au sein de l'HGR…, le rapport de consommation de la quinine 250 mg comprimés, se présente de la manière ci-dessous :

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine de l'HGR disposent d'un stock physique de 872 Comprimés dont 24, 35 sont respectivement altérés, cassés ?
- Quelle analyse pouvez-vous faire par rapport à cette situation et quelle décision envisageriez-vous ?

Réponse 2 :

N°	Période	Consommation	Observation
1	Janvier	184	Typique
2	Février	168	Typique
3	Mars	160	Typique
4	Avril	150	Typique
5	Mai	161	Typique
6	Juin	152	Typique
	CMM(Cés)	**169,5**	-
	SD (Mois)	**813**	-
	MSD (Mois)	**5**	**Surstock**

Décisions à envisager notamment :
- Surseoir la livraison en cas de réquisition
- Descente sur terrain pour s'enquérir de la situation réelle

Question 3 : En date du 28 décembre 2014, après inventaire des ME dans la zone de santé de……. constituée de 5 structures sanitaires dont le BCZS et 4 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de Artesunate 1g injectable, se présentent de a manière suivante :

- Quelle analyse pouvez-vous faire par rapport à cette situation e
- Quelles décisions envisageriez-vous

Réponses :

N°	Entité	Stock Disponible(Vial)	CMM (Vial)	MSD (Mois)	Observation ou Analyse
1	BCZS	4400	1400 (Distrib)	**3,14**	Sous Stock
2	HGR	800	300	**2,66**	Sous Stock
3	CS1	200	110	**1,81**	Sous stock
4	CS2	250	170	**1,47**	Sous Stock
5	CS3	230	250	**0,92**	Sous Stock
	ZONE DE SANTE	**5880**	**830**	**7**	**Sur Stock**

Décisions à envisager notamment :

- Passer la commande pour le BCZS
- Réapprovisionner les structures de PEC
- Descendre sur terrain en vue de s'enquérir de la situation réelle

Question 4 : En date du 30 Mars 2014, après inventaire des ME dans la zone de santé de……. constituée de 10 structures sanitaires dont le BCZS et 9 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de ASAQ dont la validité es de 6 mois càd EXP : 10/14), se présentent de a manière suivante :

- Quelle analyse pouvez-vous faire par rapport à cette situation et
- Quelles décision envisageriez-vous ?

N°	Entité	Stock Disponible(Cure)	CMM(Cure)	MSD (Mois)	Observation
1	BCZS	4736	478 (Distribut)	**9,9**	**Surstock et Risque de péremption de3,9 mois**
2	HGR	1567	273	**5,73**	**Surstock**
3	CS1	372	152	**2,44**	**Surstock**
4	CS2	225	154	**1,46**	**Sous stock**
5	CS3	343	170	**2**	**Equilibre**
6	CS4	189	115	**1,64**	**Sous stock**
7	CS5	232	134	**1,73**	**Sous stock**
8	CS6	248	110	**2,25**	**Sur stock**
	ZONE DE SANTE	**7912**	**1108**	**7,14**	**Sur stock**
	SD, CMM,MSD (ZS) Ajustés	**9890**	**1421**	**6,95**	**Sur stock**

Décisions à envisager notamment :

- Distribuer le stock excédentaire du BCZS aux structures en sous stock
- Passer la commande pour le BCZS pour les structures en sous stock
- Réapprovisionner les structures de PEC les structures en sous stock
- Descendre sur terrain en vue de s'enquérir de la situation réelle

B. EXERCICES GROUPES CORRIGES

Question 1 : Après 8 mois de gestion des ME au sein du CS …, le rapport de consommation de TDR, se présente de la manière ci-dessous :

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine du CS disposent d'un stock physique de 6422 Comprimés dont 85, 133, sont respectivement altérés, cassés ?

Réponses 1 :

N°	Période	Consommation (Pièce)	Observation
1	Janvier	1884	Typique
2	Février	1410	Typique
3	Mars	1760	Typique
4	Avril	935	**Atypique**
5	Mai	1771	Typique
6	Juin	1772	Typique
7	Juillet	3856	**Atypique**
8	Aout	1643	Typique
	CMM(Pièce)	**1710**	-
	SD (Mois)	**6204**	-
	MSD (Mois)	**3,62**	**Sur stock**

Décisions à envisager notamment :

- Surseoir la livraison en cas de réquisition
- Descente sur terrain pour s'enquérir de la situation réelle
- Si date de péremption très proche, envisager une réalloc tion

Question 2 : Après 6 mois de gestion des ME au sein de l'HGR…, le rapport de consommation de la quinine 250 mg comprimés, se présente de la manière ci-dessous :

- Quel est le stock disponible et le MSD sachant qu'après inventaire le dépôt et l'officine de l'HGR disposent d'un stock physique de 4872 Comprimés dont 324, 35, 43, sont respectivement altérés corrompus, cassés ?
- Quelle analyse pouvez-vous faire par rapport à cette situation et quelles décision envisageriez-vous ?

Réponses 2 :

N°	Période	Consommation	Observation ou Analyse
1	Janvier	1184	Typique
2	Février	1210	Typique
3	Mars	1060	Typique
4	Avril	1250	Typique
5	Mai	1361	Typique
6	Juin	1252	Typique
	CMM(Cés)	**1220**	-
	SD (Mois)	**4470**	-
	MSD (Mois)	**3,66**	**Sur stock**

Décisions à nvisager notamment :

- Surseoir la livraison en cas de réquisition
- Descente sur terrain pour s'enquérir de la situation réelle
- Si date de péremption très proche, envisager une réallocation

Question 3 : En date du 28 décembre 2014, après inventaire des ME dans la zone de santé de……. constituée de 5 structures de prise dont le BCZS et 4 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de Artesunate 1g injectable, se présentent de a manière suivante :

- Quelle analyse pouvez-vous faire par rapport à cette situation e
- Quelles décisions envisageriez- vous ?

Réponses 3:

N°	Entité	Stock Dispo (Vial)	CMM (Vial)	MSD (Mois)	Observation/Analyse
1	BCZS	2400	700 (Distrib)	**3,42**	Sous stock
2	HGR	600	300	**2**	Sous Stock
3	CS1	100	120	**0,83**	Sous stock
4	CS2	150	130	**1,15**	Sous stock
5	CS3	130	200	**0,65**	Sous Stock
	ZONE DE SANTE	**3380**	**750**	**4,5**	Sous stock
	SD, CMM, MSD (ZS) Ajustés	**3380**	**750**	**4,5**	idem

Décisions à nvisager notamment :

- Passer la commande pour le BCZS
- Réapprovisionner les structures de PEC
- Descendre sur terrain en vue de s'enquérir de la situation réelle

Question 4 : En date du 30 Mars 2014, après inventaire des ME dans la zone de santé de……. constituée de 10 structures de prise dont le BCZS et 9 entités de prise en charge de…, les données statistiques en rapport avec l'utilisation ou la distribution de AL dont la validité es de 4 mois càd EXP : 08/14), se présentent de a manière suivante :

- Quelle analyse pouvez-vous faire par rapport à cette situation et
- Quelle décision envisageriez-vous ?

Réponses 4

N°	Entité	Stock Disponible(Cure)	CMM (Cure)	MSD (Mois)	Observation ou Analyse
1	BCZS	6473	678 (Distribut)	**9,54**	Sur stock avec risque de péremption de 5,54 mois
2	HGR	2256	473	**4,77**	Sur stock
3	CS1	472	232	**2,03**	Equilibre
4	CS2	325	254	**1,28**	Sous stock
5	CS3	543	270	**2,01**	Equilibre
6	CS4	289	145	**1,99**	Equilibre
7	CS5	432	234	**1,85**	Sous stock
8	CS6	348	210	**1,66**	Sous stock
	ZONE DE SANTE	**11138**	**1818**	**6,13**	Equilibre
	SD, CMM, MSD (ZS) Ajustés	**13923**	**2331**	**6**	Equilibre

Décisions à envisager notamment :

- Distribuer le stock excédentaire du BCZS aux structures en sous stock
- Passer la commande pour le BCZS pour les structures en sous stock
- Réapprovisionner les structures de PEC les structures en sous stock
- Descendre sur terrain en vue de s'enquérir de la situation réelle
- Redéploiement des stocks en risque de péremption

ANNEXE 8 : LISTE DE PRESENCES

N°	FONCTION	PRENOM	NOM et POST NOM	Sexe	PROVENANCE	TELEPHONE
1	Pharmacien	Cedou	TSHIKOMB KADAY	M	DPS	0814081747
2	Pharmacien	Isaac	MUKENDI N'SHIMBA	M	ZS	0814496732
3	Docteur	Jean-Marie	KAZADI WA KAZADI	M	HGR Manika	0812141810
4	Iref	Djodjo	GASILUA KAMANA	F	HGR ZS Dilala	0995705598
5	Préposée	Claudine	LENGE ILUNGA	F	BCZS Bunkeya	0813849089
6	AG	Hogenard	LOTI MUSUBA	M	ZS Mutshatsha	0977284598
7	AG	Augustin	ILUNGA MILONDA	M	ZS Lualaba	0814959090
8	Préposée	Marie-Jeanne	IYULANGOY AYAM	F	HGR/Mutshatsha	0979530977
9	Préposé	Moïse	MBUYA SANDANDU	M	ZS Mutshatsha	0995360092
10	chargé dépôt	Jacques	MUNDALA KIBWA	M	ZS Kanzenze	0819804249
11	IS SSP	Denis	MWILU KIBAMBE	M	ZS Fungurume	0824297375
12	MCZ	Serge	MUSOYA	M	ZS Kanzenze	0993860860
13	Infirmier	Sylvie	BETWA NTABANGA	F	ZS Fungurume	0818459906
14	Analyste	Fidele	KADANG SAM	M	DPS	0999514920
15	Pharmacien	Pascaline	MALEKA MAMPALA	F	CAMELU	0810351522
16	Logisticien	Emmanuel	KIYANA MUDUMA	M	CAMELU	0810375904
17	Infirmier	Eudoxie	KARUMB MWAD	F	HGR Manika	0812187669
18	EPP	Félix	MAKANGILA	M	DPS	0816072519
19	MDH	Rubeto	KAYEMBE ILUNGA	M	ZS Bunkeya	0995258739
20	Pharmacien	Jean Papy	NGANDU KASHALA	M	ZS Dilala	0994963374
21	Pharmacien	Annie	KINIMBA INAMPIN	F	BCZS Manika	0811890157
22	MCZ	Patrick	NDUWA KAMEYA	M	BCZS Dilala	0817375049
23	P. Focal PESS	Alain	BUNDA MUKAYA	M	DPS	0999505498
24	Preposé	Donantien	KASONGO MANANA	M	Kanzenze	0819756994
25	Préposé	Canny	KAPANDE KAYINA	F	ZS Lualaba	0970066175
26	MDH	Auguy	OKESE OHALE	M	ZS Fungurume	0814073170
27	MDH	D'arcy	IKOMBA YAV	M	HGR Mutshatsha	0992199353
28	Pharmacien	Godard	MALILO NGANDU	M	HGR Dilala	0997239813
29	Préposé	Esther	KITWA LUNDA	F	ZS Fungurume	0816328818
30	préposée	Emelie	MWANZA OMBA	F	ZS Lubudi	0815313800
31	MCZ	Robert	KABESYA LUKUNGA	M	ZS Lubudi	0812428900
32	Pharmacien	Rigobert	KAKAYA MUDJOKI	M	ZS Lubudi	0824971351
33	Méd. Superv	Jean de Paix	YAV MBANGU	M	ZS Manika	0810689530
34	secrétaire	Idriss	YAMBENU MULEDI	M	DPS	0974194176
35	Chargé SNIS	Bruno	MWENYA KIPIMBIE	M	DPS	0970660417
36	EPP	Julien	SALEH KUSUBA	M	DPS	0814043803
37	CB	Kiry	ISAKA IBAMBA	M	DPS	0810233499
38	CB	Dahlia	MASIA MENGO	M	DPS	0970066155
39	Pharmacien	KARL	KAYIJ KASTHIZ	M	ZS Lualaba	0999597210
40	CDPS	Gérard	MWAMBU BOMBU	M	DPS/LUALABA	0813128097

Appendix 7: Post training action plan for training of trainers on drug inventory management - Lualaba DPS - January 2016

République Démocratique du Congo
MINISTERE DE LA SANTE PUBLIQUE
Secrétariat Général

DIVISION PROVINCIALE DE LA SANTE DE LUALABA

FORMATION DES FORMATEURS SUR LA GESTION DES MEDICAMENTS DANS LA DPS DE LUALABA

PLAN D'ACTION POST-FORMATION SUR LES 6 PROCHAINS MOIS
Fevrier à Juillet 2016

#	Activités	1er trim.			2nd trim.			Résultat	Livrables	Responsable
		F	M	A	M	J	J			
1	*Mettre en place une Commission Provinciale du Médicament (CPM)*	X						*CPM installée dans la DPS de Lualaba d'ici fin février 2016*	*Rapport d'installation de la CPM*	*DPS, avec appui MSH/SIAPS et autres partenaires, PNAM*
2	*Former les prestataires des CS (organisés en 3 pools de formation)*		X	X				*Au moins 120 prestataires des CS sont formés en fin avril 2016*	*Rapport de formation*	*ECZS et DPS (participants à la formation des formateurs)*
3	*Distribuer les outils de gestion PNAM dans les formations sanitaires*		X					*60% des FOSA appuyées par IHP plus disposent des outils de gestion PNAM*	*PV de réception des outils*	*MSH et DPS*
5	*Tenir un Atelier d'analyse et de validation des données issues du terrain et actualiser les CMM des FOSA*				X			*Atelier tenu d'ici mai 2016*	*Rapport de l'atelier*	*ECZS, sous la coordination de la DPS et MSH*
6	*Organiser des Supervisions conjointes DPS-MSH*				X			*Toutes les 8 ZS formées sont supervisées avant sept. 2016*	*Rapports supervision*	*DPS et MSH*
7	*Mettre en place les comités de quantification dans les ZS de la DPS Lualaba*			X				*D'ici avril 2016, au moins 4 CQ sont installées dans les ZS de la DPS Lualaba*	*Rapport d'installation des CQ*	*DPS*
8	*Quantifier les besoins provincials en se basant sur les données de consommation*					X		*Les besoins de la DPS sont estimés sur base des données de consommation d'ici juin 2016*	*Rapport de quantification*	*DPS, ECZS avec l'appui du PNAM et MSH*

Fait à Kolwezi, le 21 janvier 2016

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GUIDE OPERATIONNEL POUR LA GESTION DU DEPOT MSH KAMINA

- Révision Mars 2016 -

TABLE DES MATIERES

PREAMBULE

Pour approvisionner les provinces appuyées par l'USAID en médicaments et autres équipements médicaux, MSH utilise 3 portes d'entrée en RDC dans le but de faciliter l'acquisition des médicaments et rationaliser les coûts de transport. Ces portes sont notamment Kinshasa, Lubumbashi et Bukavu.

Les médicaments et autres équipements médicaux destinés à couvrir les besoins des zones de santé appuyées par l'USAID dans la province du Haut Lomami entrent en RDC par Lubumbashi, et dans certains cas par Kinshasa. Ces médicaments sont entreposés et distribués par l'entrepôt MSH situé dans la ville de Kamina.

Cet entrepôt a pour mission d'assurer la gestion des médicaments dans le strict respect des normes pharmaceutiques et logistiques.

Le présent guide opérationnel décrit de manière détaillée et précise la nature et les tâches à exécuter pour les opérations spécifiques de gestion des produits stockés **au dépôt de MSH à Kamina** afin de répondre à cette mission.

Ce guide est également un instrument d'organisation de travail qui formalise les modes opératoires à suivre dans chaque cas de figure, pour permettre aux agents d'agir de façon sûre et rapide devant chaque situation.

Ces procédures formalisées aideront à traiter de la même façon les opérations de même nature, et d'éviter des traitements différents selon les agents ou même pour un même agent selon les circonstances. Elles ne se substituent pas aux fiches techniques de gestion des médicaments édictées par le Programme National d'Approvisionnement en Médicaments et disponibles. Ces dernières restent le document officiel de référence pour la gestion quotidienne des médicaments.

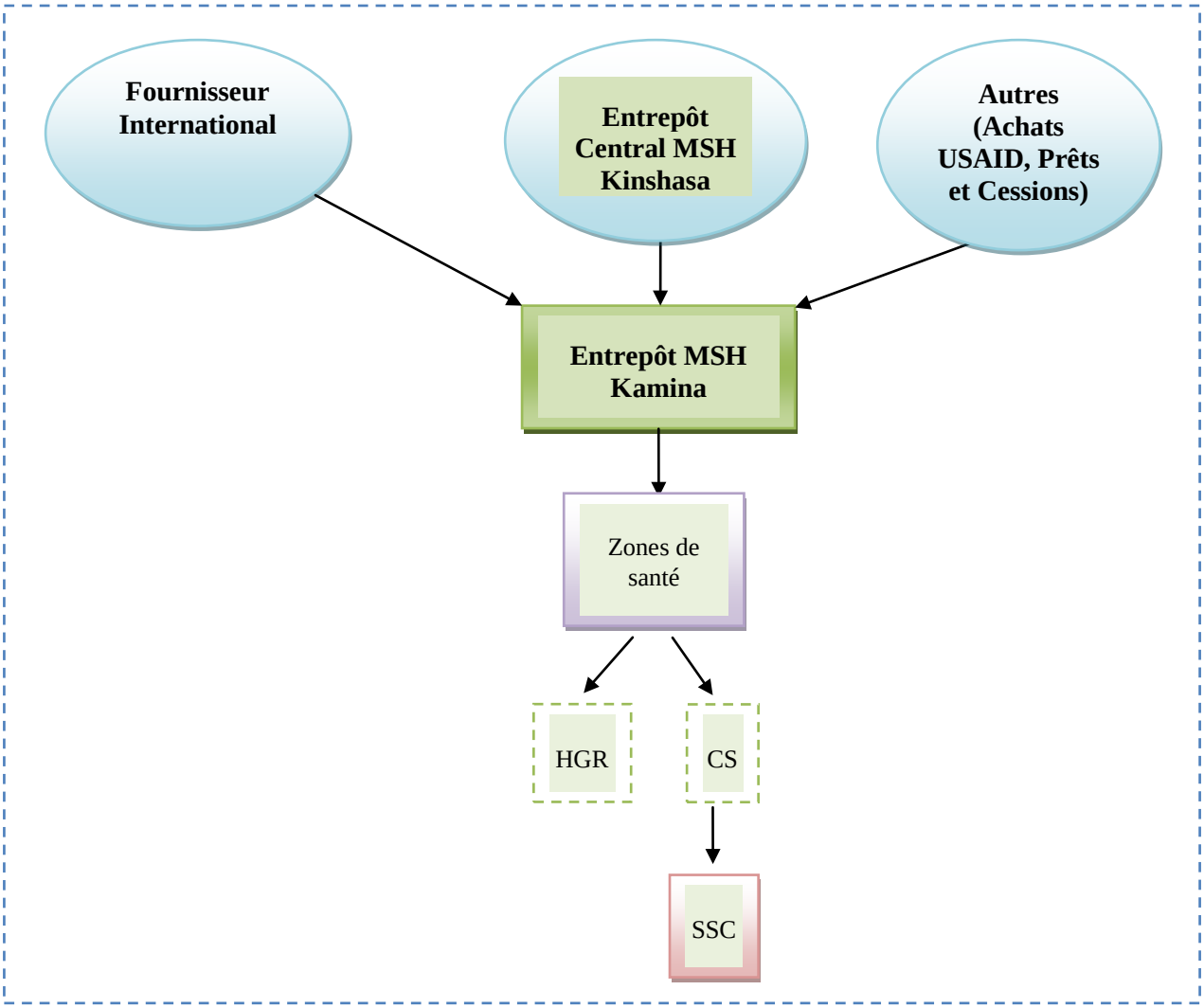
Objectifs

Les présentes procédures opérationnelles visent à donner des orientations et instructions simples, claires, précises et **obligatoires** permettant d'assurer une gestion saine et transparente des médicaments à l'entrepôt de MSH à Kamina.
De manière spécifique, elles visent à :

- Garantir la régularité des opérations de **réception, distribution et rapportage** sur les médicaments reçus et distribués ;
- Améliorer la qualité de services fournis par l'entrepôt;
- Faciliter les opérations de contrôle et de suivi ;
- Clarifier les rôles et responsabilités, et Renforcer la confiance entre les parties.

I. ORGANISATION GENERALE DU CIRCUIT D'APPROVISIONNEMENT

Le circuit d'approvisionnement en médicaments depuis l'entrepôt de MSH à Kamina s'organise de la manière suivante :



II. PROCEDURE DE RECEPTION

Cette procédure est conçue dans le but de s'assurer que les produits sont reçus de manière conformes en quantité, en qualité et en valeur au regard des documents qui les accompagnent. Elle s'applique à tout produit passant par l'entrepôt MSH à Kamina et comporte deux phases : **la phase préparatoire de la réception** et **la réception définitive.**

1. Préparation de la réception des médicaments et intrants

Avant toute expédition des médicaments à l'entrepôt de Kamina, le Conseiller technique SIAPS Kinshasa devra envoyer une pré-alerte au Conseiller technique provincial et au Gestionnaire de l'entrepôt au moins une semaine avant, accompagnée des documents suivants : les factures, les listes de colisage, la lettre de transport (LTA ou BL) si disponible afin de prendre les dispositions nécessaires liées à l'aménagement de l'emplacement de réception et la manutention.

2. Réception des médicaments au dépôt de MSH

Il est recommandé que la réception de colis se fasse de préférence au niveau du dépôt MSH. Les personnes suivantes devront participer à cette réception :

1. le représentant du transitaire,
2. le gestionnaire du dépôt,
3. le conseiller technique SIAPS à Kamina.

Toutes ces personnes contresigneront les documents de remise et reprise relatifs à cette livraison.

La réception des médicaments se fait en deux étapes :

a) Comptage et vérification des colis (Réception provisoire)

Conformément à la liste de colisage, les colis sont comptés selon leurs numéros d'identification. Le nombre total des colis doit être conforme à la liste de colisage.

La vérification consistera à s'assurer que les colis gardent leur intégrité (états d'emballage, vérifier s'ils sont originaux avec leurs scotchs, les étiquettes, repérer les produits endommagés et périmés…). Elaborer un rapport de déchargement avec le transitaire en rapport avec la conformité de comptage des colis de la réception et les observations faites.

Après vérification de la conformité entre le Bon de livraison, Bon de commande et la facture, le bon de livraison et le rapport de déchargement doivent être signés par celui qui a assuré la réception (le gestionnaire de l'entrepôt) et le transporteur. Ensuite confirmer la réception à la hiérarchie.

Le rapport de réception provisoire doit être élaboré endéans un jour.

b) Ouverture et vérification du contenu des colis (Réception définitive)

La deuxième étape (déballage) consistera à ouvrir tous les colis un par un et leur contenu vérifié en présence ou pas du représentant du fournisseur.

Vérification de la conformité de la packing list : identifier les produits et leur quantité par rapport au contenu du document, relever les écarts constatés, élaborer un **PV de Réception** qui doit être imprimé, signé par le gestionnaire de dépôt, le conseiller technique provincial et le transitaire si possible. Ensuite, enregistrer les produits et quantité dans la base de données ou logiciel. Enfin clôturer la réception, s'il y a des écarts négatifs ou des substitutions des produits constatés suivre la procédure pour la réclamation auprès des fournisseurs en transmettant en premier l'information au conseiller technique, au gestionnaire à Kinshasa puis aux Chefs des projets IHP/IHPplus et SIAPS.

Le Rapport de réception sera rédigé par le gestionnaire de l'entrepôt endéans deux jours après la vérification de tous les colis et transmis d'abord pour vérification au Conseiller technique provincial, qui a son tour après endossement, transmettra au gestionnaire à Kin, au Conseiller technaux Chefs des projets IHP/IHPplus et SIAPS.

S'il y a des réclamations à adresser au fournisseur, le Conseiller Technique provincial initiera la correspondance sur base du constat et la partagera au Conseiller technique SIAPS à Kinshasa et au Responsable de gestion des dépôts à Kinshasa. Ces derniers la feront signer par le chef de Projet IHP/IHPplus ou SIAPS (selon les cas). La lettre de réclamation doit être adressée au fournisseur au plutard deux jours après le rapport de réception.

III. PROCEDURE DE STOCKAGE, CONSERVATION ET RANGEMENT DES PRODUITS PHARMACEUTIQUES

Cette procédure a 3 objectifs principaux :

1. présenter le système de stockage des produits pharmaceutiques dans la zone destinée à l'entreposage ;
2. décrire le système de rangement des produits pharmaceutiques dans la zone de stockage ;
3. décrire les étapes mises en place pour conserver les produits pharmaceutiques dans les conditions qui garantissent la qualité.

Cette procédure s'applique à l'ensemble des produits pharmaceutiques distribués par l'entrepôt MSH à Kamina. La mise en œuvre de cette procédure est sous la responsabilité du gestionnaire de l'entrepôt.

Procédures :

1. Le stockage des produits pharmaceutiques

Les produits pharmaceutiques sont stockés uniquement sur des étagères (de préférence métalliques) et des palettes en bois.
Lorsque les produits sont stockés sur des palettes, les cartons sont empilés à 10 cm au moins du sol, à 30 cm au moins des murs et des autres piles et sur une hauteur ne dépassant pas 2,5 m.
Pour l'ensemble du stockage il faut respecter les instructions suivantes:

- Stocker les produits d'une manière qui facilite l'application du principe de gestion de stock *First expired, First out* (FEFO) soit « premier périmé, premier sorti. » ;
- Disposer les cartons de manière à ce que les flèches pointent vers le haut et à ce que les étiquettes d'identification, les dates de péremption et les dates de fabrication soient visibles. En cas d'impossibilité, écrire le nom du produit et sa date de péremption clairement sur la partie visible ;
- Placer les produits liquides sur les étagères les plus bas ou en dessous des autres produits ;
- Retirer dès constat les produits endommagés ou périmés du stock et faire rapport à la hiérarchie ;
- Entreposer les produits qui nécessitent d'être conservés au froid dans le(s) réfrigérateur(s) ;
- Entreposer les produits stupéfiants et psychotropes dans l'armoire à stupéfiants dont la clé doit être gardée par le conseiller technique provincial ou son délégué.
- Entreposer les produits inflammables dans la zone réservée à cette catégorie de produits;
- Les entrées et les sorties dans le dépôt de MSH doivent être réglementées et autorisées par le gestionnaire de l'entrepôt. Un cahier d'enregistrement des mouvements est rempli à chaque entrée et sortie ;
- Il est interdit de manger et de fumer dans le dépôt ;
- Les personnes qui travaillent dans le dépôt doivent être identifiées et fouillées à chaque sortie du dépôt, surtout les manutentionnaires ;
- La présence de sacs et autres objets similaires est interdite dans l'entrepôt (exception faite des objets privés devant se retrouver dans les bureaux des personnes commis à l'entrepôt);
- Le port des chaussures de talons longs est interdit dans l'entrepôt;
- Le(s) réfrigérateur(s) ne peuvent contenir des produits autres que les produits pharmaceutiques ;
- Il est interdit de brancher ou charger les appareils autres que ceux utilisés pour de fin de service dans l'entrepôt;

2. La conservation des produits pharmaceutiques

- Respecter les instructions du fabricant ou du fournisseur sur la procédure de stockage, ainsi que les conditions de conservation figurant sur les étiquettes ;
- Dans la zone de stockage, il faut prélever et enregistrer la température dans le registre le matin entre 8h00 et 9h00, la journée entre 12h00 et 13h00 et le soir entre 16h00 et 17h00 ;
  Lorsque la température dépasse +30°C et lorsqu'elle baisse en dessous de +15°C, le gestionnaire initiera l'intervention d'une équipe technique de froid pour la résolution du disfonctionnement ;
  Le gestionnaire fera un rapport trimestriel sur l'évolution de la courbe de température.
  MSH s'engage à pourvoir l'entrepôt d'un système d'enregistrement automatique de température et d'humidité ambiante qui sera installé dans tous les entrepôts gérés par MSH.
- Dans le(s) réfrigérateur(s), il faut prélever et enregistrer la température le matin entre 8h00 et 9h00, la journée entre 12h00 et 13h00 et le soir entre 16h00 et 17h00 ;
- Prélever et enregistrer l'humidité relative de l'air dans la zone de stockage, le matin entre 8h00 et 9h00 et le soir entre 16h00 et 17h00.

3. Le rangement des produits pharmaceutiques

Les médicaments sont classés par ordre alphabétique et par voie d'administration. Etant donné que MSH est géré par portefeuille, la classification tiendra compte également de l'appartenance à l'un ou l'autre portefeuille. Ce rangement doit respecter le principe règlementaire FEFO.

4. Etiquetage des produits pharmaceutiques

Le Gestionnaire édite pour chaque groupe d'articles une étiquette d'identification reprenant **la DCI, le dosage et la forme au besoin l'appartenance au portefeuille.** Le gestionnaire de l'entrepôt est chargé de placer l'étiquette sur la face visible du produit. En cas d'épuisement du stock du produit, l'étiquette est conservée à son emplacement.

IV. PROCEDURE DE CONTROLE DE STOCK

1. Inventaires

Les inventaires complets du stock sont réalisés trimestriellement. La commission d'inventaire est instituée par le Directeur de coordination IHP/IHPplus à Kamina. Elle sera composée du Conseiller technique SIAPS, du Gestionnaire de l'entrepôt et d'un technicien IHP/IHPplus désigné par le Directeur de coordination. Le conseiller technique SIAPS à Kamina partage un draft de rapport d'inventaire au Responsable de gestion des entrepôts à Kinshasa pour vérification et analyse. Ensuite le rapport sera transmis en

ligne à toutes les parties prenantes, notamment les conseillers techniques et les CoP IHP/IHPplus et SIAPS.

Les copies « papier » des inventaires doivent être archivées à l'entrepôt et la version électronique conservée également dans les fichiers archives.

Des inventaires ponctuels sont réalisés sur quelques items choisis au hasard (de préférence des items de valeur ou ayant un important turnover, tels que les antibiotiques, anti-malariens, etc.) doivent être réalisés indépendamment par le gestionnaire ou une personne de sa hiérarchie.

Chaque inventaire doit être comparé avec les valeurs du stock calculé, et tout écart entre le stock « théorique » et le stock « physique » doit être investigué.

Etablir un rapport d'inventaire retraçant les mouvements de la période ciblée, le stock de départ, le stock théorique, le stock inventorié et les écarts constatés.

2. Suivi de la base de données

La base de données doit être mise à jour par le Conseiller technique SIAPS à chaque mouvement de stock (entrée et sortie).

Tout écart entre le stock « théorique » et le stock « physique » devra être justifié par le Gestionnaire de l'entrepôt. En cas d'écart négatif non justifié, la responsabilité doit être établie et, au besoin, après balance générale du stock, la valeur des médicaments perdus sera remboursée par la (les) personne(s) responsable(s).

3. Justificatifs imprimés (sur papier)

Toutes les saisies dans l'ordinateur relatives à des mouvements de stock doivent pouvoir se justifier par une trace imprimée et signée : fiche de stock, factures et bons de livraison pour les entrées, bordereau d'expédition, packing-list ou procès-verbal de destruction pour les sorties.

V. PROCEDURES DE DISTRIBUTION DES MEDICAMENTS

La distribution des médicaments entre l'entrepôt à Kamina et les 13 zones de santé appuyées par le Projet IHP/IHPplus est régie par un contrat de service entre IHP/IHPplus et chaque BCZS à Kamina. Ce contrat définit toutes les modalités de collaboration entre les parties.

Le représentant Provincial de SIAPS, conjointement avec la DPS à Kamina, calcule les lignes de crédits à attribuer aux ZS sur base du prix d'achat des médicaments et les fait approuver par la DPS.

Sauf instruction exceptionnelle, les médicaments consignés à l'entrepôt de MSH à Kamina ne peuvent être distribués qu'aux zones de santé appuyées par l'USAID.

Les zones de santé (BCZS et HGR) présenteront leurs besoins sur le canevas de bon de commande standard conforme aux fiches techniques du PNAM, qu'elles exprimeront à l'entrepôt MSH à Kamina en passant par la DPS pour analyse et validation. Le Gestionnaire du dépôt distribuera les médicaments aux zones de santé, dans les limites de la valeur de ligne de crédit attribuée à chacune d'elles.

Les tâches de l'entrepôt par rapport à la fonction « distribution » sont les suivantes **:**

1. La réception des réquisitions : le gestionnaire de l'entrepôt analyse ces réquisitions pour :
   - **a.** s'assurer que les médicaments commandés sont disponibles en stock ;
   - **b.** s'assurer que le stock disponible peut bien couvrir la commande pour chaque médicament commandé ;
   - **c.** s'assurer que la réquisition présentée à l'entrepôt est conforme au modèle du PNAM et qu'elle porte la signature du demandeur.
2. Le gestionnaire de l'entrepôt prépare les colis sur base d'une fiche de commande éditée par conseiller technique selon les commandes analysées en distinguant les différentes destinations. Ensuite le conseiller technique procède à la vérification avant la livraison des colis ;
3. Le conseiller technique établit les bons de livraison, les factures et les listes de colisage au nom du destinataire. Ces documents doivent indiquer tous les médicaments effectivement livrés et sont contresignés par le Conseiller technique SIAPS et le gestionnaire;
4. Le gestionnaire de l'entrepôt informe le Logisticien / service des opérations MSH tout en mettant en copie le conseiller technique de la disponibilité de colis en vue de planifier le transport vers les différentes destinations;
5. Le gestionnaire de l'entrepôt enregistre les sorties sur les fiches de stock et le conseiller technique met à jour la Base des données ou le logiciel ;
6. Les copies des documents envoyés dans les zones de santé doivent être renvoyés à Kamina au gestionnaire après vérification et signature du destinataire ;
7. **Toute anomalie relative au contenu de l'expédition, devra faire l'objet d'une recherche et d'une communication entre le destinataire et le gestionnaire, afin de trouver à quel niveau se situe l'erreur et de corriger les données si nécessaire ;**
8. Après vérification de la conformité entre les quantités expédiées et les quantités reçues en province, le gestionnaire fait la réconciliation du stock et les preuves sont archivées dans le classeur des sorties à l'entrepôt.
9. La responsabilité première des médicaments expédiés incombe au logisticien, qui est chargé de faire le tracking des expéditions.

NB : **Aucune rature** n'est admissible sur un bordereau, qui devra être refait si besoin en était.

VI. PROCEDURE DE GESTION DES PRODUITS PRESUMES CONTREFAITS

Cette procédure a pour but de dégager tout produit contrefait et d'empêcher l'utilisation des produits de mauvaise qualité dans le circuit de distribution de MSH. Elle s'applique à tous les produits se trouvant dans le stock et ceux déjà distribués.

Procédure :

1. Produits présumés contrefaits

La présomption de contrefaçon est faite soit par le Gestionnaire, soit par le Conseiller technique à la suite d'un constat organoleptique ou d'une plainte émanant de terrain (Zones de santé ou autres destinataires).
Dans ce cas, il dresse un procès-verbal de constat qu'il transmet directement au(x) Directeur(s) de(s) projet(s). Ce dernier saisit à son tour la 3e Direction (D3) du Ministère de la Santé en vue de la transmission des échantillons au laboratoire d'analyse approprié. Dans l'entretemps les produits sont mis en quarantaine.

Au cas où les résultats sont conformes, la quarantaine sera levée. Mais, s'ils sont non-conformes, le produit en quarantaine est déclaré hors usage et un rappel de lot sera effectué conformément à la réglementation en vigueur.

2. Rappel de lot

Les situations suivantes doivent entrainer un rappel de lot :

- Changement brusque des caractères organoleptiques ;
- Réclamation des clients jugée fondée ;
- Confirmation de la toxicité ou l'inefficacité d'un lot par le service compétent ;
- Sur demande du fabricant/fournisseur.

Dans tous ces cas, le Gestionnaire /le Conseiller technique SIAPS saisit immédiatement toutes les zones de santé bénéficiaires du lot mis en cause leur demandant de retourner les quantités disponibles en stock vers la CDR. Ces produits sont déclarés hors d'usage.

VII. PROCEDURE DE GESTION DES PRODUITS HORS D'USAGE

Cette procédure a pour but d'écarter les produits non conformes et d'empêcher la circulation des produits non utilisables (périmés, corrompus, altérés, falsifiés, cassés, etc.).

1. Sortie de stock

a) Pour les produits périmés :

Le gestionnaire dresse à la fin de chaque mois une liste de produits dont la durée de vie restante est inférieure ou égale à un mois qu'il transmet à au Conseiller technique avec copie au pharmacien gestionnaire à Kinshasa et aux Directeurs des Projets.

- Pour les produits périmés, le Conseiller technique en ordonne le retrait du stock (Sortie physique, sortie dans la Base des données et sur les fiches de stock par le gestionnaire de stock).
- Un procès-verbal pour expiration ou endommagement d'items doit être signé conjointement par le gestionnaire et le Conseiller technique SIAPS.

b) Pour les produits hors d'usage autres que les périmés :

Dès le premier constat, le gestionnaire retire du stock tout produit cassé, falsifié, corrompu, altéré, etc. et invite le Conseiller technique à venir constater physiquement son état.

- Le gestionnaire déclare ce produit hors usage et en dresse la liste contresignée par le conseiller technique SIAPS qu'il remet au gestionnaire pour disposition.
- Le conseiller technique procède à la sortie informatique en produisant un document en deux exemplaires. Un exemplaire sera transmis au service des Opérations et l'autre remis à l'entrepôt pour la sortie sur la fiche de stock et le transfert du produit vers le local des produits hors usage.
- Ces produits sont consignés au fur et à mesure de leur retrait dans le local des produits hors usage dont la clé est gardée par le Gestionnaire.

2. Destruction des produits hors d'usage

Avant la fin du mois de janvier de l'année, le gestionnaire élabore la liste valorisée au prix FOB (Ex-work) de chaque lot de ces items sur base de laquelle le Conseiller technique SIAPS adresse une lettre au Pharmacien Inspecteur provincial de Kamina pour l'inviter à venir retirer les médicaments hors usage en vue de leur destruction.

Le pharmacien inspecteur, par délégation du procureur de la république dresse un procès-verbal valorisé qui atteste la destruction.
La destruction de ces médicaments doit se faire en présence du Gestionnaire ou du Conseiller technique. Une copie du PV de destruction sera transmise au Pharmacien gestionnaire à Kinshasa et aux Directeurs des Projets MSH.

VIII. DIRECTIVES SECURITAIRES (Sorties et accès au dépôt)

Afin de préserver l'intégrité des médicaments entreposés dans le dépôt de Kamina, il est demandé à tout le personnel d'appliquer scrupuleusement les règles suivantes :

1. Accès au dépôt

L'accès au dépôt ne peut être autorisé qu'au personnel MSH et ceux du Ministère de la Santé possédant un ordre de mission pour raison de service.

Toute personne étrangère à MSH non accompagnée par un personnel responsable de l'entrepôt ou de la Direction de MSH ne doit pas être autorisée à pénétrer dans le dépôt.

Sa visite sera cependant consignée dans le registre des mouvements.

Les gardiens disposent d'un registre dit « de mouvements » sur lequel doivent être reportés tous les éléments suivants :

- Tout mouvement de véhicule – MSH ou non MSH – doit être noté :
  - Heure d'arrivée
  - Heure de départ
  - Type du véhicule (4x4, camion, moto, autre…)
  - Appartenance du véhicule (ONG)
  - Immatriculation du ou des véhicules

En cas de véhicule MSH

  - Nom du chauffeur
  - Noms des passagers

- Tout mouvement de personnel, sans véhicule, entrant ou sortant du dépôt, doit également être enregistré dans le registre. (Heure d'entrée et de sortie, nom et raison de la visite)
- Toute relève de gardiens (horaire, noms) doit être consignée sur le registre
- Toute arrivée ou départ de médicaments (nombre de colis) doit être également consigné dans le registre.

Pendant le déchargement ou le chargement d'un véhicule, le gardien n'est pas chargé de compter les colis, **il doit continuer sa surveillance.**

Son rôle consiste à noter le nombre de colis, déchargés ou chargés, que lui aura communiqué l'agent de responsable de la surveillance.

Les **périodes d'accès** normales **à l'entrepôt** se font pendant les **heures ouvrables**, c'est à dire du lundi au vendredi, entre 08H30 et 17H30. Aucun accès ne doit être autorisé en dehors de ces horaires sans autorisation.

Ces mouvements sont également à noter dans le registre des gardiens.

2. Ouverture / Fermeture du dépôt (stock)

a) Clés

Actuellement, il existe six clés pour deux cadenas qui ferment la grande porte de l'entrepôt MSH à Kamina situé dans l'enceinte de BRASIMBA. En plus de la grande porte, il existe une petite porte fermée moyennant un cadenas ayant trois clés.

La clé de l'armoire pour les narcotiques et produits dangereux se trouve sur le même trousseau que les clés de l'entrepôt.

Le trousseau de clé complet est remis tous les matins au gestionnaire du dépôt, et est restitué chaque soir au Conseiller technique provincial, ou au Directeur de coordination IHP/IHPplus si ce dernier est absent.

Seuls le Conseiller technique provincial et le Gestionnaire du dépôt ont accès au dépôt; les autres personnes pouvant avoir à y faire (logisticien, ménagères, manutentionnaires) y ont un accès contrôlé uniquement en présence des détenteurs des clés.

Seul le Conseiller technique provincial du dépôt possède le trousseau de clé complet : une clé par cadenas pour l'accès à l'entrepôt et une pour l'armoire à stupéfiants.

Les autres exemplaires de clés de réserve seront gardés par le logisticien de la coordination.

b) Accès limité au stock

Seules les personnes suivantes sont autorisées à pénétrer dans l'entrepôt, en présence du Gestionnaire ou du Conseiller technique provincial :

- Le Directeur de coordination IHP/IHPplus ou son délégué,
- Le personnel de nettoyage/entretien, afin de vider les poubelles, balayer les allées et les étagères : sur demande du gestionnaire du dépôt,
- Les manutentionnaires : lors du chargement et du déchargement de colis. Limiter si possible le nombre de personnes à l'intérieur en organisant un système de travail en chaîne, et les surveiller étroitement pendant le travail,
- Le représentant du fournisseur lors de la réception des commandes et check des quantités,
- Les Agents du Ministère de santé pour raison de service,
- Le conseiller technique SIAPS ou le conseiller IHP/IHPplus en provenance du niveau national, chacun suivant son domaine d'appui, pour une supervision de routine ou autre tâche en rapport avec la gestion des médicaments et conditions de stockage.

3. Autres dispositions

Le registre des gardiens devra être vérifié au moins une fois par mois par le logisticien de la coordination. La signature et la date de vérification attestant du contrôle effectué.

En quittant l'entrepôt, tout personnel MSH devra émarger sur le registre des gardiens, en précisant la raison de sa visite.

IX. PROCEDURE DE NETTOYAGE DU DEPOT

Cette procédure est conçue dans le but d'assurer la propreté du dépôt. Elle s'applique sur tous les locaux abritant les médicaments et les consommables médicaux de MSH dans l'enceinte du dépôt de Kamina.

Procédure :
Le gestionnaire de stock élabore un calendrier de nettoyage et l'affiche dans l'entrepôt. Il s'assure que la propreté est faite de façon permanente en vue d'éviter les conditions non hygiéniques dans les installations pharmaceutiques. Cette tâche sera accomplie une fois par semaine par des agents journaliers désignés par le gestionnaire.

Le nettoyage du pavement, mur, vitre, étagère, etc. se fait à l'aide d'un tissu approprié plongé dans l'eau au savon ou autre désinfectant approprié.

Pour le dépoussiérage des produits, l'utilisation du balai et de la brosse est strictement interdite. Ce dépoussiérage se fait avec un tissu sec ou humide suivant le cas.

X. PROCEDURE DE LUTTE CONTRE LES PESTES ET RONGEURS

Cette procédure a pour but de protéger le stock des dommages causés par les pestes et les rongeurs.

Procédure :
Est considéré comme peste, tout insecte susceptible de compromettre la qualité des produits stockés (les termites, les cafards, les mouches, les larves, les fourmis, etc).
Est considéré comme rongeur, tout vertébré présent dans l'entrepôt qui constitue un vecteur menaçant le maintien de la qualité des médicaments dans le dépôt (les rats, les lézards, etc.).

Pour la première catégorie, le magasinier identifie les zones de pénétration de ces insectes dans les entrepôts et en informe le conseiller technique provincial qui prendra des mesures adéquates.

Quant aux rongeurs, le dépôt opte pour le système de pièges métalliques localisés dans les différentes zones de stockage.

Le dépôt utilisera les appâts secs (fretins ou tout autre aliment) et les recycle chaque 72 heures afin de rendre efficace le processus.

Le personnel du dépôt est tenu de :

- Inspecter les pièges chaque jour dans la matinée et avant la fermeture afin de se rendre compte de l'état de leur fonctionnement et éventuellement les débarrasser des cadavres des rongeurs attrapés et réinstaller l'appât.

- Nettoyer le piège qui a pris le rongeur et réajuster son emplacement.
- Formuler les demandes auprès du Service d'achat pour l'acquisition de matériels et aliments au début de chaque trimestre ou en cas de besoin ;
- Tenir un registre de rapportage indiquant la date, le nombre de rongeurs pris dans les pièges ainsi que les zones de stockage concernées.

NB : Pour sa protection, la personne chargée de manipuler les appâts, d'éliminer les rongeurs et de nettoyer les pièges devra se munir des gants et d'un cache-nez.

XI. PROCEDURE DE LUTTE ANTI-INCENDIE

Cette procédure a pour but d'empêcher l'incendie et/ou minimiser les dégâts liés à sa survenue. Elle porte sur la prévention et sur tout cas d'incendie déclaré dans l'entrepôt.

1. Prévention

Le Gestionnaire de l'entrepôt doit en permanence :

- se rassurer de la présence du matériel anti-incendie (extincteur, bac à sable, bêche, sceau métallique) aux endroits définis dans la cartographie anti-incendie (à concevoir) ;
- se rassurer que la personne se trouvant à proximité du matériel anti-incendie sait s'en servir en cas de besoin ;
- afficher la notice sur l'utilisation des extincteurs ;
- Veiller au bon état de l'installation électrique.

Les usagers des installations électriques à l'entrepôt doivent :

- Eviter d'utiliser une installation ou matériel électrique endommagés ou défectueux ;
- Utiliser au besoin des ampoules non chauffantes pour l'éclairage de l'entrepôt;
- Informer immédiatement le Conseiller technique de toute anomalie constatée sur les installations ou matériel électriques, qui informera à son tour le logisticien de coordination.

2. Lutte contre l'incendie

Toute personne, devant un feu naissant, doit dans la mesure du possible prendre certaines dispositions visant à la fois sa sécurité, celle des personnes se trouvant à l'entrepôt et celle des installations. Pour ce faire :

- Elle alerte par tous les moyens possibles, les autres personnes présentes sur le site ;
- Elle déconnecte tous les matériels électriques de son secteur ;
- Elle se sert des matériels anti-incendie à sa portée pour lutter contre le feu.

Le gestionnaire, le conseiller technique, le logisticien ou tout autre cadre de l'entrepôt qui reçoit l'alerte saisit la brigade anti-incendie.
Le gestionnaire de l'entrepôt ou tout autre membre de l'équipe logistique présent sur le site doit couper la source d'énergie électrique.

Après avoir maitrisé l'incendie, le gestionnaire de l'entrepôt dresse un état de lieu comprenant :

- Le point de départ du feu et sa cause si possible ;
- La description des dégâts matériels et humains ;
- La description de l'intervention.

Cet état de lieu est adressé au Conseiller technique provincial et au Directeur de coordination IHP/IHPplus qui se chargeront d'informer le niveau national pour dispositions utiles.

XII. PROCEDURE DE GESTION DE LA POLICE D'ASSURANCE

Par définition, **la police d'assurance** est un document contractuel qui régit les relations entre la compagnie d'assurance et l'assuré. Ce contrat fixe en particulier :

- la liste des évènements garantis, avec les exclusions éventuelles ;
- la garantie, c'est-à-dire l'assistance apportée à l'assuré en cas de sinistre ;
- les obligations de l'assuré ;
- les obligations de la compagnie d'assurances.

Cette procédure est conçue dans le but de permettre au gestionnaire de l'entrepôt de **prendre connaissance,** de **suivre** et de **signaler** la survenue de tout événement assuré (listé au contrat) afin de permettre à MSH de demander l'assistance (indemnisation) de son assureur (SONAS).

Procédure :

- Lors de la survenue d'un événement assuré, le gestionnaire du dépôt est tenu d'informer immédiatement le Conseiller technique qui à son tour informera le service des opérations pour des dispositions utiles ;
- La durée de validité de la police d'assurance entre le dépôt MSH et son assureur est d'une année renouvelable. A ce jour, l'assureur des entrepôts MSH est la **Société Nationale d'Assurance (SONAS)**. Le service chargé des Opérations est tenu de partager la police d'assurance disponible afin de permettre à l'entrepôt d'en faire le suivi.
- Deux mois avant l'expiration du contrat d'assurance, le gestionnaire est tenu d'informer le Conseiller technique qui devra adresser un rappel au service des opérations pour dispositions utiles.

XIII. GESTION DES PRODUITS A RISQUE DE PEREMPTION

Qu'est-ce qu'un stock à risque de péremption ?

Un stock à risque de péremption correspond à tous les items présents dans le stock du dépôt et qui, selon les prévisions de consommation, ne seront pas consommés avant la péremption.

Cette procédure est élaborée dans le but de minimiser le risque de perte des produits par péremption et éviter ainsi le gaspillage des ressources.

Procédure :

A la fin de chaque mois, le Gestionnaire du dépôt est tenu de :

- Identifier, en parcourant les fiches de stock, tous les produits dont la durée de vie avant péremption est inférieure ou égale à 6 mois;
- Elaborer la liste valorisée de ces produits et la transmettre au Conseiller technique provincial SIAPS.

Une fois informé, le Conseiller technique provincial SIAPS procèdera aux actions ci-après :

- Informer les ZS sous appui USAID dans la province du Haut Lomami de la présence de ces produits à risque de péremption au dépôt de Kamina et leur demander d'en exprimer les besoins. L'information sera également partagée avec d'autres coordinations MSH pour un éventuel besoin de redéploiement ;
- Une fois exprimée, ces besoins sont consolidés et présentés aux Directeurs des projets respectifs sous forme d'un plan de distribution pour approbation ;
- Si ces produits à risque de péremption ne peuvent pas être complètement absorbés par les ZS appuyées par l'USAID, le Conseiller technique provincial SIAPS demande l'approbation des Directeurs des projets pour que les quantités non consommées soient officiellement mises à la disposition de la DPS Haut Lomami;
- Moyennant un plan de distribution élaboré par la DPS Haut Lomami, ces quantités seront attribuées gratuitement aux autres ZS non appuyées par l'USAID;
- Les dispositions se rapportant à la prise en charge des frais de transport seront étudiées au cas par cas. Toutefois, un effort sera consenti pour éviter à MSH des charges supplémentaires, si la DPS concerné peut s'occuper du transport avec l'appui éventuel d'autres partenaires.

XIV. AUTRES DISPOSITIONS UTILES

Pour toute autre disposition de gestion non reprise dans cette procédure, la gestion se fera conformément aux fiches techniques PNAM éditées avec l'appui SIAPS et adoptées par le Ministère de la Santé Publique comme référence pour la gestion pharmaceutique en République Démocratique du Congo.

Révisé à Kamina, le 01 Avril 2016

Proposé par	Approuvé par
Jérémie FIKIRI ***Conseiller Technique SIAPS***	**Ruphin MULONGO** ***CoP SIAPS RDC***
Christian KISIMBA ***Gestionnaire responsable du dépôt MSH Kinshasa***	**Ousmane FAYE** ***CoP IHPplus RDC***

République Démocratique du Congo

MINISTERE DE LA SANTE PUBLIQUE

SECRETARIAT GENERAL

SECRETARIAT GENERAL A LA SANTE

Programme National d'Approvisionnement en Médicaments essentiels, PNAM

Kinshasa

RAPPORT DE LA MISSION D'APPUI A LA DPS HAUT LOMAMI DANS LE SUIVI RAPPROCHE DE LA CDR CEDIMEK

Du 30 mars au 05 avril 2016

Avec l'appui de :

Présenté par :

Fidèle NGOMA BAZIKANGE, Directeur Adjoint du PNAM RDC

Gilbert AMISI KIZEGELE, Chef des Services Statistiques du PNAM RDC

Jérémie FIKIRI, Conseiller technique, Projet SIAPS, MSH RDC

Christian KISIMBA KAYEMBA, Gestionnaires des dépôts MSH RDC

Avril 2016

REMERCIEMENTS

La direction du Programme National d'Approvisionnement en Médicaments essentiels, PNAM, remercie de tout cœur ceux qui, de loin ou de près, ont contribué à la réalisation de la présente mission, particulièrement l'USAID pour son appui technique et financier à travers ses projets SIAPS et IPHplus mis en œuvre par MSH.

Elle exprime aussi sa gratitude aux représentants locaux de ces projets dans la province du Haut Lomami pour leurs appuis et facilitation durant tout le séjour de la mission.

Les remerciements sont également adressés aux Autorités Provinciales du Ministère de la Santé, particulièrement à Monsieur le Chef de Division de la DPS Haut Lomami et ses collaborateurs pour leur assistance à la mission afin que les objectifs fixés soient atteints.

Les remerciements sont enfin adressés à la CEDIMEK, particulièrement à son Directeur pour sa franche collaboration et disponibilité sans lesquelles la mission n'aurait pas atteint les objectifs qu'elle s'était fixés.

Les missionnaires.

SIGLES ET ABRÉVIATIONS

AG	Administrateur Gestionnaire
AT	Assistance Technique
BCAF	Bureau de Coordination des Achats de la FEDECAME
BCZS	Bureau Central de Zone de Santé
CA	Conseil d'Administration
CB	Chef de Bureau
CD	Chef de Division
CDR	Centrale de Distribution Régionale des Médicaments Essentiels
CAO	Cadre d'Accélération des Objectifs du Millénaire
CPM	Comité Provinciale du Médicament
DPS	Division Provinciale de la Santé
ECZS	Equipe Cadre de Zone de Santé
FEDECAME	Fédération des Centrales d'Achat et de distribution régionale des Médicaments Essentiels
FdR	Fonds de Roulement
MEG	Médicaments Essentiels Génériques
SIAPS	System for Improved Access to Pharmaceuticals and Services
IHP plus	Integrated Health Project Plus
MSH	Management Sciences for Health
MSP	Ministère de la Santé
PCA	Président du Conseil d'Administration
PNAM	Programme National d'Approvisionnement en Médicaments essentiels
PTF	Partenaire Technique et Financier
RDC	République Démocratique du Congo
SG	Secrétaire Général
SNAME	Système National d'Approvisionnement en Médicaments Essentiels
TDR	Termes De Référence
USAID	United States Agency for International Developpement
ZS	Zone de Santé

I. RÉSUMÉ

Conformément à l'ordre de service collectif **N° MS.1251/SG/404/MK/2018** du 21 mars 2016 de Monsieur le Secrétaire Général à la Santé, une mission composée du directeur Adjoint du PNAM et du Chef des Services Statistiques du PNAM et Data manager du SNAME a été réalisée à Kamina pour appuyer la DPS/Haut Lomami dans le suivi rapproché de la CDR CEDIMEK.

Cette mission qui s'est déroulée du 30 mars au 05 avril 2016 a poursuivi les objectifs spécifiques suivants :

- Évaluer le niveau de mise en œuvre des recommandations de la mission d'état des lieux effectuée par le PNAM en septembre 2015.
- Renforcer les capacités gestionnaires et techniques des Cadres de la CEDIMEK sur l'utilisation des tableaux de bord de gestion, d'évaluation et financier.
- Renforcer les capacités gestionnaires et techniques des Cadres de la CEDIMEK sur les Bonnes Pratiques de Distribution.
- Tenir des séances de travail avec la DPS, le Conseil d'Administration et MSH en vue de décider sur le devenir de cette CDR.
- Participer à la réunion du Groupe de Travail Médicament du CPP-SS de la province du Haut-Lomami organisée en date du 1er avril en vue de proposer une feuille de route sur l'amélioration des services selon les défis identifiés à la CEDIMEK.

La méthodologie utilisée a été la suivante :

Descente sur terrain ;

Revue documentaire ;

Interview ;

Entretien

Observation.

II. DEROULEMENT DE LA MISSION

II.1. AGENDA DE LA MISSION

DATE	ITINERAIRE	ACTIVITES	LIEU
29/03/2016	Kinshasa-L'shi	➢ Arrivée et installation à Lubumbashi ; ➢ Séance de travail avec le staff local SIAPS	Lubumbashi
30/03/2016	Lubumbashi-Kamina	➢ Départ de Lubumbashi pour Kamina ; ➢ Rencontre avec le Chef de Division Provinciale de la Santé et l'équipe cadre de la DPS ; ➢ Séance de travail avec la CEDIMEK pour l'adoption de l'agenda et la méthodologie de travail (Partage des TDR) ; ➢ Briefing de la mission à l'équipe locale de MSH/SIAPS	Kamina
31/03/2016	Kamina	Séance de travail avec l'équipe de la CEDIMEK	Kamina
01/04/2016		➢ Participation à la Réunion de la CPM ; ➢ Débriefing la mission au Chef de Division	
02/04/2016		➢ Visite du dépôt de MSH ; ➢ Débriefing de la mission au staff local MSH ; ➢ Retour à Lubumbashi	Lubumbashi
03 et 04/04/2016		Elaboration et adoption du rapport de la mission	Lubumbashi
05/04/2016	Lubumbashi	Voyage retour à Kinshasa	Lubumbashi - Kinshasa

II.2. PERSONNES RENCONTREES

N°	NOM ET POSTNOM	INSTITUTION	FONCTION	TELEPHONE
01	Dr Patrick Banza Mpiongo	DPS/Haut Lomami	Chef de Division	0997401118 ; 0817840729
02	AG Sammy KASENDA KAMAVU	DPS/Haut Lomami	Chef de Bureau Gestion des Ressources	0814636167
03	Ph Freddy NGOIE	DPS/Haut Lomami	Chef de Bureau Bureau Inspection Contrôle	0815757526 ; 0976696950
04	Dr Joel Lebo	DPS/Haut Lomami	Coach de la DPS	0816357453 ; 0840785028
05	Dr Michel Muhemeri	DPS/Haut Lomami	AT DPS pour le compte de l'UNICEF	0997024177
06	Bijoux KIRONGOZI	CEDIMEK	Pharmacienne	0816756408
07	Mireille MBOMBO	CEDIMEK	Secrétaire Comptable	0810777493
08	Adolphe MARHEGEKO	MSH/SIAPS/Kamina	PR/TA	0972616960
09	Dr BUSH	MSH/IHPplus/Kamina	Directeur	0975789709

II.3. RESULTATS OBTENUS PAR OBJECTIF SPECIFIQUE

II.3.1. Evaluer le niveau de mise en œuvre des recommandations de la mission de septembre 2015

Le résultat de l'évaluation des recommandations de la mission d'état des lieux de la CDR CEDIMEK réalisée par le PNAM en septembre 2015 se présente dans le tableau ci-dessous :

SUIVI DES RECOMMANDATIONS DE LA MISSION D'ETAT DES LIEUX A LA CEDIMEK

RESULTAT DE L'EVALUATION					NOUVELLES RECOMMANDATIONS	
N°	RECOMMANDATION	RESPONSABILITE	DELAI	NIVEAU D'EXECUTION	Proposition	Echéance
1	Accélérer le processus d'obtention d'autorisation d'ouverture (Avis favorable d'implantation ; constitution du dossier de l'établissement)	Direction	D'ici novembre 2015	Certificat d'enregistrement ; autorisation provisoire de fonctionnement avis favorable pour facilités administratives disponibles.	La DPS se doit de donner l'avis favorable d'établissement pharmaceutique : référence à l'arrêté portant ouverture et fonctionnement des établissements pharmaceutiques en RDC.	Dans l'immédiat
2	Actualiser les statuts (identifier les nouveaux membres fondateurs, signer et notarier les statuts)	PCA	Dans l'immédiat	Travail en cours : drafts des statuts, Règlement d'Ordre Intérieur et procédures disponibles ; l'AG sera convoquée pour les adopter.	Le CD doit convoquer le Conseil d'Administration (CA) extraordinaire Convoquer l'AG ordinaire pour avaliser le statut	Avril 2016 Immédiatement après le CA extraordinaire (saisir l'opportunité des MCZS à Kamina en avril 2016 lors des différentes réunions de la DPS)

3	Organiser un CA extraordinaire (Pour désigner les nouveaux membres du CA en vue de sa redynamisation)	PCA	D'ici novembre 2015	Réalisée : deux CA ordinaires organisés après septembre 2015 (PV non disponibles)	Remettre les deux PV à la DPS ainsi qu'à la mission	Immédiatement
4	Obtenir la personnalité juridique	Direction	Dans l'immédiat	Réalisée : voir la copie F92	Impliquer la FEDECAME dans le suivi de la signature	Immédiatement
5	Signer la Convention entre la CEDIMEK et la Fedecame, (Y compris les annexes dont les directives PNAM)	PCA	D'ici décembre 2015	Non réalisée	Entrer en contact avec la FEDECAME pour dispositions utiles	Immédiatement
6	Combler les postes clés proposés par le PNAM dans le Guide des CDR : - le Pharmacien - le Gestionnaire - le Gestionnaire des Stocks - le Comptable	PCA + DPS	D'ici décembre 2015	Réalisée (fiches de description disponibles)	Régulariser la situation administrative du personnel	Immédiatement
7	Respecter les Bonnes Pratiques de Distribution; (L'entrepôt actuel ne remplit pas les normes)	Directeur technique	Dans l'immédiat	Non réalisée (existence d'un devis chiffré à plus de 45.000 dollars ; Contrainte majeure « maison de location » ; Stratégie adoptée « finaliser le chantier de la CEDIMEK ».	Finaliser le chantier Evaluer les Gaps pour les capacités de stockage et mener des plaidoyers.	Selon les disponibilités des moyens, mais de préférence d'ici la fin de l'année 2016.

8	Élaborer un plan d'action et une prévision budgétaire (A faire valider par le PCA)	Directeur	Annuelle	Non réalisée Projet 2016 disponible mais non encore validé par le CA	Valider le projet 2016 par le CA	Immédiatement
9	Doter la CDR des procédures de gestion financière et technique	Direction	D'ici décembre 2015	Travail d'actualisation en cours : drafts disponibles	Finaliser les drafts et les faire adopter par l'AG	Immédiatement
10	Ouvrir un compte en banque	Directeur	Dans l'immédiat	Non réalisée (la banque TMB a refusé faute de la personnalité juridique)	S'appuyer le parrainage de la DPS à l'instar des ZS.	Immédiatement
11	Transmettre au PNAM les tableaux de bord de gestion, financier et d'évaluation dûment remplis au PNAM en copiant la DPS	Directeur	Octobre 2015	Non réalisée (personnel actuel non formé)	Mettre à niveau le personnel	Immédiatement après l'Assemblée Générale
12	Améliorer l'archivage	Secrétaire	Permanente	Travail en cours	Finaliser le travail	Immédiatement
13	Organiser un audit externe pour certifier les comptes	Directeur	Annuelle	Non réalisée (maison d'audit externe non disponible à Kamina. Coûts élevés si l'on recourt aux maisons d'audit externe à Lubumbashi et/ou Kinshasa)	Plaidoyer pour une prise en charge de l'audit externe pour certifier les comptes	Immédiatement après l'Assemblée Générale.
14	Élaborer les fiches de description des postes de tout le personnel	Directeur	D'ici décembre 2015	Réalisée	Valider les fiches de description par le CA Remettre à chaque agent sa fiche de description des	Immédiatement

					postes valide par le CA	
15	Assurer un suivi rapproché de la CEDIMEK	DPS	Permanente	Réalisée	Elaborer les rapports de suivi rapproches et les transmettre au PNAM avec copie pour information au PCA	À l'issue de chaque suivi rapproché.
16	Appuyer trimestriellement une mission du PNAM à la CEDIMEK pour évaluer le niveau d'avancement des recommandations	MSH	Trimestrielle	Réalisée	Partager le rapport à la DPS et chez MSH	Immédiatement après la mission
17	Appuyer la participation du PNAM aux CA et AG de la CEDIMEK	MSH	Chaque fois que les réunions du CA et AG sont convoquées	RAS	Transmettre au PNAM l'invitation un mois à l'avance	Chaque fois que c'est prévu
18	Appuyer les missions d'état des lieux dans toutes les CDR et dépôts accrédités du rayon de couverture de l'USAID	MSH	Chaque fois que c'est nécessaire	Non réalisée	Élaborer les TDR et les transmettre chez MSH avec une planification de suivi	Avril 2016

COMMENTAIRES

Il ressort de l'évaluation de niveau d'avancement de mise en œuvre des recommandations faites par le PNAM à l'issue de la mission d'état des lieux à la CEDIMEK ce qui suit :

- Sur les 14 recommandations adressées à la CEDIMEK, 4 ont été réalisées (soit 28,6%) ; 4 ont été partiellement réalisées (soit 28,6%) et 6 n'ont pas été réalisées (soit 42,8%) ;
- En rapport avec la principale recommandation càd celle relative à l'amélioration de Bonnes Pratiques de Distribution, aucune avancée n'a été enregistrée. La raison sur laquelle s'appuie la direction de la CEDIMEK se situe à trois niveaux :
    a. La CEDIMEK loue un entrepôt. Selon le bailleur toute initiative d'amélioration par le locataire n'engage que ce dernier et n'aura aucun effet bénéfique sur le prix du loyer ;
    b. Le devis élaboré dans le souci du respect de BPD s'élèverait à plus de **45.000** dollars, budget dont la CEDIMEK ne dispose pas ;
    c. La CEDIMEK préfère consacrer tous ses efforts à la finalisation de son chantier pour supprimer les charges liées à la location de l'entrepôt et qui ne répond pas aux normes.
- Au regard de ce qui précède la mission a encouragé la CEDIMEK à mener un plaidoyer actif pour finaliser la construction de son dépôt d'ici la fin de cette année.
- Pour les autres recommandations, la DPS a été chargée de convoquer une réunion extraordinaire du Conseil d'Administration afin d'adopter toutes les procédures, le Statut et autres documents en souffrance à la CEDIMEK.

II.3.2. Tenir des séances de travail avec la DPS, le Conseil d'Administration de la CDR CEDIMEK, MSH (SIAPS et PROSANIplus) en vue de décider sur le devenir de cette CDR

La mission a tenu des séances de travail avec les structures suivantes :

1. Au niveau de la DPS

Trois séances de travail ont été successivement tenues avec le Chef de Division de la DPS, le Coach de la DPS et l'AT Unicef pour les activités liées au Cadre d'Accélération des Objectifs du millénaire (CAO).

- Avec le Chef de Division la mission est revenue sur les objectifs spécifiques de la mission. C'est fut aussi une opportunité de la mission pour obtenir le point de vue de la DPS sur les recommandations formulées par le PNAM en tant que membre du CA de la CEDIMEK et œil de l'Etat Congolais auprès de cette structure d'utilité publique. A l'issue de cette séance de travail, le CD a mis à la disposition de la mission le pharmacien responsable du bureau contrôle et inspection pour l'accompagner dans la suite de sa mission.

- Avec le Coach de la DPS, les échanges ont plus tourné sur les attributions du groupe de travail médicaments de la DPS et l'installation du Comité Provincial de Pilotage.

- Avec l'AT DPS pour le compte de l'UNICEF DANS les activités du CAO 4 et 5, la mission a focalisé ses échanges sur les stratégies des approvisionnements dans l'axe fluvial de la DPS Haut Lomami.

2. Au niveau de la CEDIMEK

Deux séances de travail ont eu lieu avec le Directeur de la CEDIMEK. Elles avaient pour objectif principal l'évaluation du niveau d'avancement des recommandations de la mission de septembre 2015 dont les résultats sont présentés au point 3.1.

3. Au niveau de MSH

Deux séances de travail ont eu lieu avec le Directeur de Coordination IHPplus. La première pour le briefing de la mission et la seconde pour le débriefing de la mission.

II.3.3. Renforcer les capacités gestionnaires et techniques des cadres de la CEDIMEK sur l'utilisation des tableaux de bord de gestion, d'évaluation et financier

Faute de temps, la mission n'a pas abordé ce point. La recommandation a été faite au Directeur de la CEDIMEK d'inscrire ce point a la prochaine réunion du CA pour relancer ce dossier.

II.3.4. Renforcer les capacités gestionnaires et techniques des Cadres de la CEDIMEK sur les Bonnes Pratiques de Distribution

Voir point 3.3

III. REUNION DU GROUPE DE TRAVAIL MEDICAMENTS à la DPS

Le groupe de travail médicaments, informé de la mission du PNAM à la CEDIMEK, a convoqué une réunion pour aborder un certain nombre de défis liés aux médicaments en province. La présence du PNAM à cette réunion a été d'une importance capitale pour éclairer la lanterne des membres du groupe de travail sur le **SNAME** (définition, mandat, mission, acteurs, circuit d'approvisionnement et couverture du pays en CDR) et surtout sur le niveau de réalisation des recommandations de la mission de septembre 2015 sur l'état des lieux de la CDR CEDIMEK avec formulation d'une feuille de route à la CEDIMEK et à la province pour l'amélioration des services pharmaceutiques. Voir les exposés en annexe.

Outre ce point, le groupe de travail a aussi abordé d'autres points tels que repris dans le compte rendu en annexe. Néanmoins, la mission revient sur quelques faits saillants ci-dessous. Il s'agit de :

1. **Ligne de crédit de 9ZS IHP plus.**

ZS	LIGNE DE CREDIT	LC DÉJÀ UTILISEE	SOLDE	TAUX UTILISATION
Kabongo	$ 108,278.5	34,464	73,814	31.8%
Kayamba	$ 29,295.4	22,890	6,406	78.1%
Kitenge	$ 76,006.4	25,266	50,740	33.2%
Songa	$ 50,902.9	19,547	31,356	38.4%
Kinkonja	$ 74,208.9	24,775	49,434	33.4%
Lwamba	$ 35,635.5	13,421	22,215	37.7%
Malemba	$ 80,234.3	28,745	51,490	35.8%
Mulongo	$ 89,702.3	31,171	58,531	34.7%
Mukanga	$ 62,082.4	20,449	41,633	32.9%
TOTAL	$ 606,346.73	220,728	385,619	ẋ = 36%

HGR	LIGNE DE CREDIT	LC DÉJÀ UTILISEE	SOLDE	TAUX UTILISATION
Kabongo	$ 36,092.83	10,007	26,086	27.7%
Kayamba	$ 9,765.13	5,189	4,576	53.1%
Kitenge	$ 25,335.48	7,515	17,820	29.7%
Songa	$ 16,967.63	5,821	11,146	34.3%
Kinkonja	$ 24,736.30	6,836	17,900	27.6%
Lwamba	$ 11,878.49	4,338	7,540	36.5%
Malemba	$ 26,744.78	7,596	19,148	28.4%
Mulongo	$ 29,900.78	9,065	20,836	30.3%
Mukanga	$ 20,694.15	6,283	14,411	30.4%
TOTAL	$ 202,115.58	62,650	139,466	ẋ = 31%

Observation

La mission a recommandé au présentateur de parler plutôt d'approvisionnement et non taux d'utilisation, car on parle de l'utilisation pour les médicaments qui sont consommés dans les FoSa.

2. **Solde Ligne de crédit de 9ZS IHP plus.**

ZS	LIGNE DE CREDIT	SOLDE AN4	TOTALE LC AN 5
Kabongo	$ 18,451.6	73,814	$ 92,265.89
Kayamba	$ 4,992.2	6,406	$ 11,397.91
Kitenge	$ 12,952.2	50,740	$ 63,692.59
Songa	$ 8,674.3	31,356	$ 40,030.18
Kinkonja	$ 12,645.8	49,434	$ 62,079.80
Lwamba	$ 6,072.6	22,215	$ 28,287.23
Malemba	$ 13,672.6	51,490	$ 65,162.14
Mulongo	$ 15,286.1	58,531	$ 73,817.45
Mukanga	$ 10,579.4	41,633	$ 52,212.57
TOTAL	$ 103,326.75	385,619	$ 488,945.77

HGR	LIGNE DE CREDIT	SOLDE AN 4	TOTALE LC AN5
Kabongo	$ 6,150.53	26,086	$ 32,236.81
Kayamba	$ 1,664.06	4,576	$ 6,240.40
Kitenge	$ 4,317.39	17,820	$ 22,137.86
Songa	$ 2,891.43	11,146	$ 14,037.69
Kinkonja	$ 4,215.28	17,900	$ 22,115.58
Lwamba	$ 2,024.20	7,540	$ 9,564.49
Malemba	$ 4,557.54	19,148	$ 23,706.04
Mulongo	$ 5,095.35	20,836	$ 25,931.39
Mukanga	$ 3,526.46	14,411	$ 17,937.88
TOTAL	$ 34,442.25	139,466	$ 173,908.14

DECISIONS

- Que ces Lignes de Crédit « LC » soient transmises officiellement aux ZS afin qu'elles élaborent également les LC pour les FoSa pour raison d'impartialité, de transparence et de suivi de gestion des fonds générés par les MEG;
- Qu'une orientation soit faite aux ZS pour le suivi également des LC des FoSa avec une maquette de suivi à l'appui;
- Que le Suivi de Lignes de Crédit « SULIC » des ZS soit régulièrement partagé aux membres du Groupe de Travail Médicament pour un suivi régulier.

3. Situation financière des fonds recyclés des médicaments de 9ZS IHP plus.

SITUATION FINANCIERE AN 1 à AN 3

N°	ZONE DE SANTE	LINE DE CREDIT an 1 à an 3	VALEUR MEDICAMENTS LIVRES AUX ZS	GAP	% LIVRE	RESTE A VERSER PAR LES ZS (30%)	MONTANT EPARGNE	GAP
2	KABONGO	173102	132090	41012	76%	39627	6831	32796
1	KAYAMBA	62433	46345	16088	74%	13903	2891	11013
5	KINKONDJA	154113	92250	61863	60%	27675	9429	18246
4	KITENGE	154442	113474	40968	73%	34042	9579	24463
7	LWAMBA	96022	44674	51348	47%	13402	2347	11055
6	MALEMBA	175604	91958	83646	52%	27587	10932	16656
9	MUKANGA	115993	71020	44973	61%	21306	11602	9704
8	MULONGO	188790	105233	83557	56%	31569	7012	24558
3	SONGA	108075	65004	43071	60%	19501	1811	17690
	TOTAL	**1.228.574**	**762.048**	**466.526**	**62%**	**228.614**	**62.433,9**	**166.180,5**

- Globalement pour ce qui concerne la période an 1- an 3 les Zones de Santé ont consommé 60% de la ligne de crédit et la valeur totale des médicaments non livrés aux ZS est de **466.526$;**
- La ZS de Kabongo se retrouve en tête avec 70% de consommation de sa ligne de crédit et la ZS de Lwamba la dernière avec une consommation de 47% ;
- L'irrégularité dans la transmission des commandes à la CDR et l'inaccessibilité géographique pour certaines ZS ont été identifiées comme causes principales de la faible consommation des lignes de crédit par les ZS ;
- Pour ce qui concerne l'épargne: les ZS n'ont épargné que **62.433,9$** sur **228.614$** soit **27% ;**
- La ZS de Mukanga se retrouve en tête avec une épargne de 54% suivie de la ZS de Malemba 39%. Toutefois, il est à noté que la première avait reçu les médicaments du projet GAVI RSS ;
- La ZS de Songa est la dernière avec une épargne de 9% ;
- Notons aussi que certaines ZS ont utilisé une partie des fonds épargnés et que la DPS est en train d'assurer le suivi pour que qu'elle reverse ces fonds ;
- Le PNAM a rappelé au groupe de travail que les fonds de recyclage des médicaments reversés par les ZS à la DPS doivent être versés à la CDR pour que cette dernière ouvre des lignes de crédit (compte capital médicaments en leur faveur) ;
- Le PNAM a promis de renforcer les capacités techniques et gestionnaires des membres de l'ECZS dans l'utilisation de la Fiche de Suivi.

IV. VISITE DE L'ENTREPOT MSH à KAMINA

Avant de clôturer sa mission, l'équipe a visité l'entrepôt de MSH. Il ressort de cette courte visite que **plusieurs recommandations formulées lors de la mission de septembre 2015 ont été prises en compte.** La mission a formulé les recommandations additionnelles ci-après :

- Renforcer la sécurité de l'entrepôt : il y a une porte vitrée qui donne directement dans l'entrepôt : cette porte doit être renforcée par une barrière métallique ;
- Doter l'entrepôt des étagères métalliques
- Doter l'entrepôt des petits matériels de manutention : petit diable, charriot, charriot préparateur, escabeaux, etc.

Ci-dessous quelques photos dudit entrepôt :

Porte secondaire à renforcer

Porte secondaire à renforcer

Le Directeur Adjoint du PNAM et le Chef des Services Statistiques vérifient la Fiche de T°

Palettes récusées par MSH

La mission échange

V. DIFFICULES RENCONTREES

La mission a rencontré les difficultés suivantes :

- Le temps imparti pour la mission était trop court, perturbé par le programme de vol ;
- Chevauchement des activités pour la DPS ;
- Présence des serpents venimeux dans les chambres d'hôtel des missionnaires perturbant ainsi la quiétude et le bon déroulement de travail.

Troisieme serpent tué dans la baignoire de la chambre d'un missionnaire en l'espace de deux heures (17h à 20h)

VI. CONCLUSION ET PROCHAINES ETAPES

Cette mission de suivi du niveau d'avancement des recommandations formulées par le PNAM à l'issue de la mission d'état des lieux qui a eu lieu en septembre 2015 à la CDR CEDIMEK a permis à la DPS de se rendre compte qu'elle a intérêt d'effectuer des missions de suivi rapproché à la CEDIMEK pour éviter que cette dernière ne disparaisse.

Donc la DPS se doit de s'approprier cette centrale.

Le résultat de l'évaluation des recommandations prouve à suffisance que le Conseil d'Administration doit ouvrir l'œil et le bon afin que toutes les recommandations non réalisées le soient dans l'échéance proposée.

A l'issue de la présente mission, le PNAM procédera à un plaidoyer auprès des partenaires afin que la CEDIMEK obtienne des appuis pour réaliser les audits externes et finaliser son chantier dans un bref délai.

PROCHAINES ETAPES :

- Accompagner la DPS dans le suivi du maintien du capital médicament à travers la « Fiche de Suivi de Gestion des Médicaments » en 45 étapes développé par le PNAM ;
- Appuyer la DPS et les ZS dans le maintien de la qualité des médicaments ;
- Accompagner la Cedimek dans la finalisation et l'organisation de son bâtiment en construction ;
- S'assurer que les Bonnes Pratiques de Distribution continuent d'être observées dans le dépôt MSH.

Fait à Kinshasa, le 06 avril 2016

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FROM THE AMERICAN PEOPLE

SPRING
Strengthening Partnerships, Results, and Innovations in Nutrition Globally

Adolescent Girls and Women's Nutrition: **Moving the Agenda Forward**

Sascha Lamstein, PhD
Technical Advisor and Systems Thinking for Nutrition Team Lead, **SPRING**

This presentation was made possible by the American people through the U.S. Agency for International Development (USAID) under Cooperative Agreement No. AID-OAA-A-11-00031, the Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project.

By the end of this session, **participants will:**

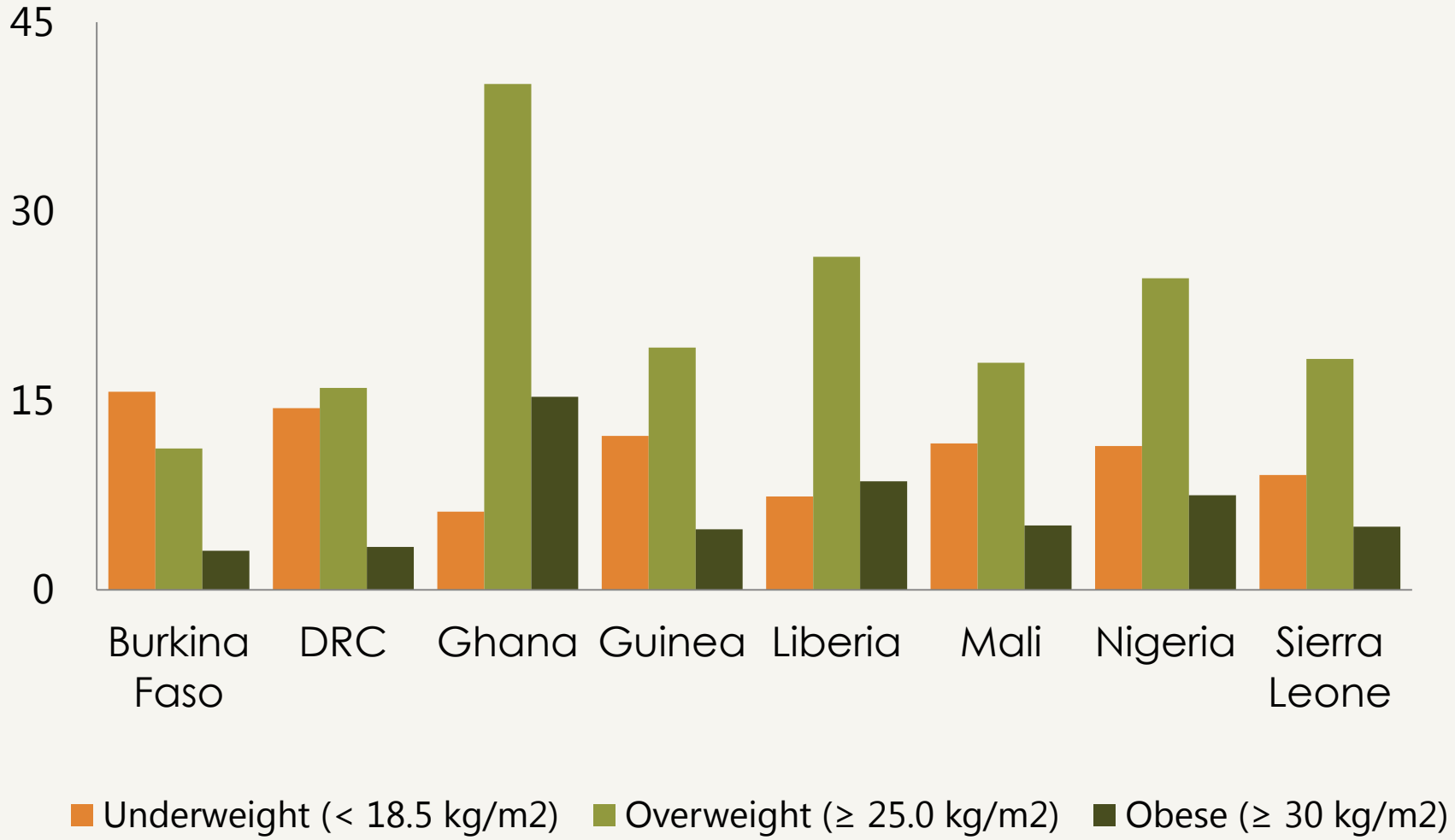
- Know the **landscape of nutrition issues** that adolescent girls and women of reproductive age (WRA) face
- Understand the **importance of increasing nutrition programming** for adolescent girls and WRA
- Be able to **identify at least two strategies** for improving nutritional status of adolescent girls and WRA

Nutrition of adolescents girls and WRA: **current context**

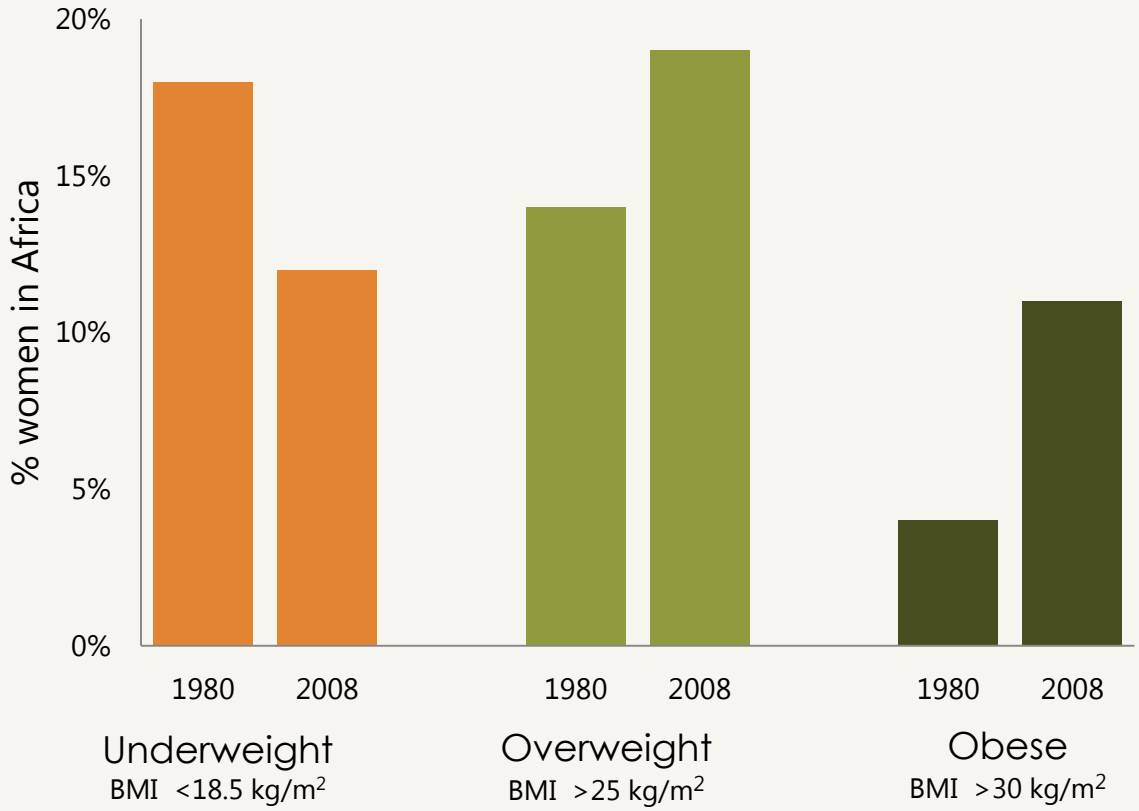
Adolescent girls and WRA represent **~30% of the population** in the MSN-GLEE countries

They are malnourished

Current percent of women underweight, overweight, and obese (most recent DHS)



The nature of malnutrition has been changing over time



As the percent of underweight women decreases, increases in overweight and obese women present a new challenge.

Prevalence of underweight, overweight and obese women in Africa, 1980 to 2008
Source: Black et al., 2013

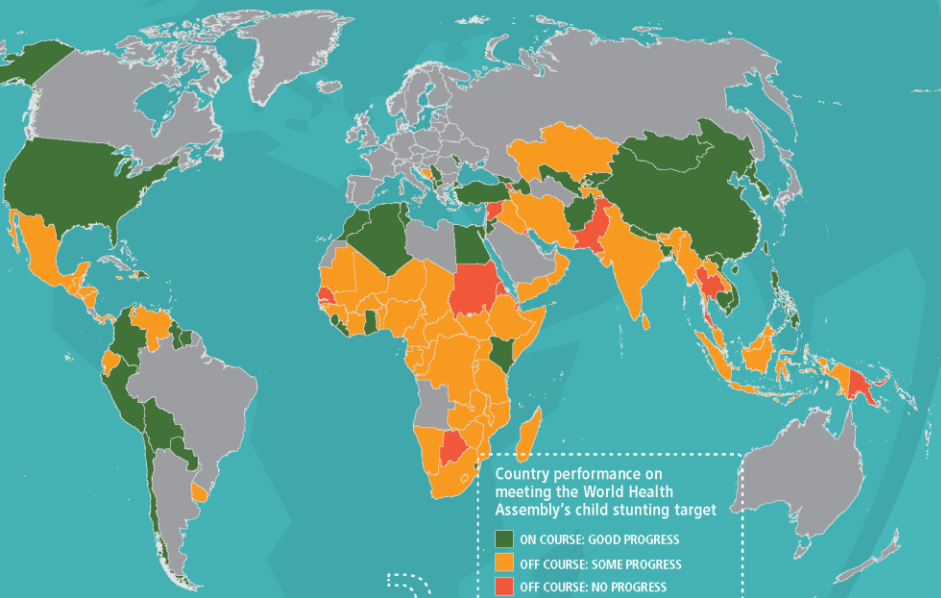
Appendix 10: Adolescent girls and woman's nutrition, moving the agenda forward by USAID and SPRING

GLOBAL NUTRITION REPORT

THINK YOUR COUNTRY DOESN'T HAVE A **NUTRITION PROBLEM**? THINK AGAIN.

Countries are making some headway on reducing undernutrition, but it's far too slow. And overweight and obesity are getting worse, not better. For more GNR data, visit **globalnutritionreport.org/the-data/**.

CHILD STUNTING



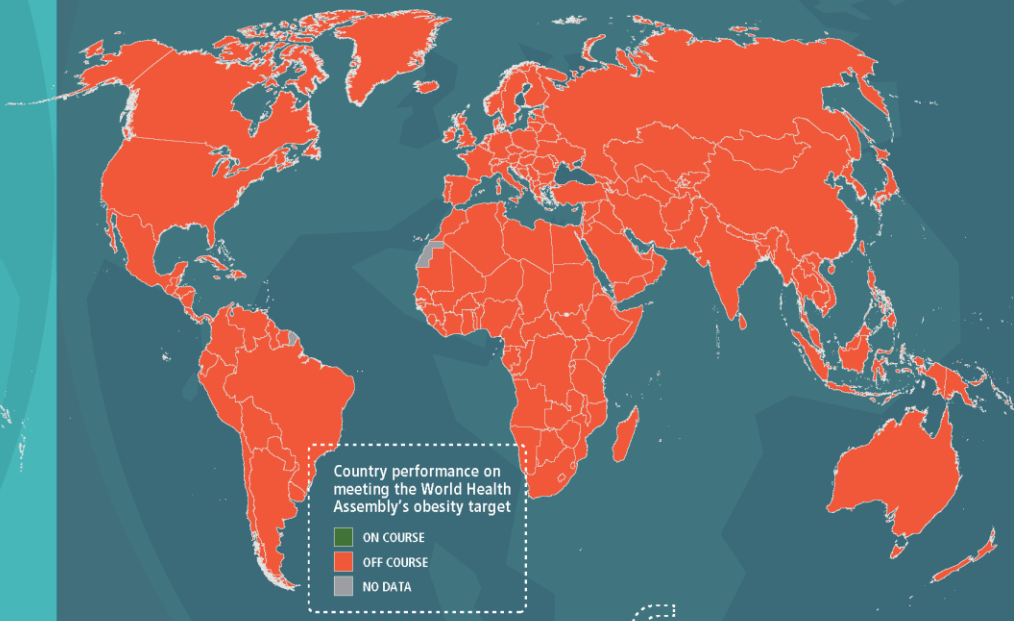
2 BILLION
people don't get enough VITAMINS AND MINERALS

795 MILLION
people don't get enough CALORIES

161 MILLION
children are chronically UNDERNOURISHED

WE HAVE A BIG **PROBLEM** WITH
UNDERNUTRITION

OBESITY



WE HAVE A BIG **PROBLEM** WITH
OVERWEIGHT & OBESITY

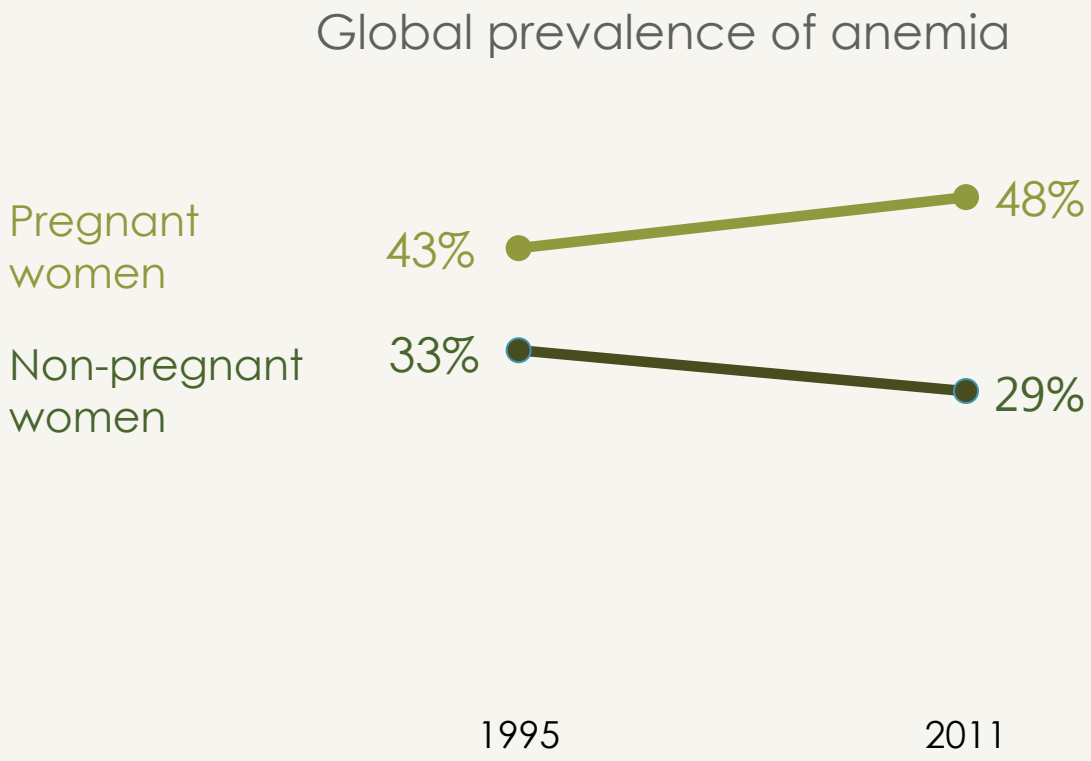
1.9 BILLION
adults are OVERWEIGHT or OBESE

1 in 12
adults has
TYPE 2 DIABETES

42 MILLION
CHILDREN are OVERWEIGHT

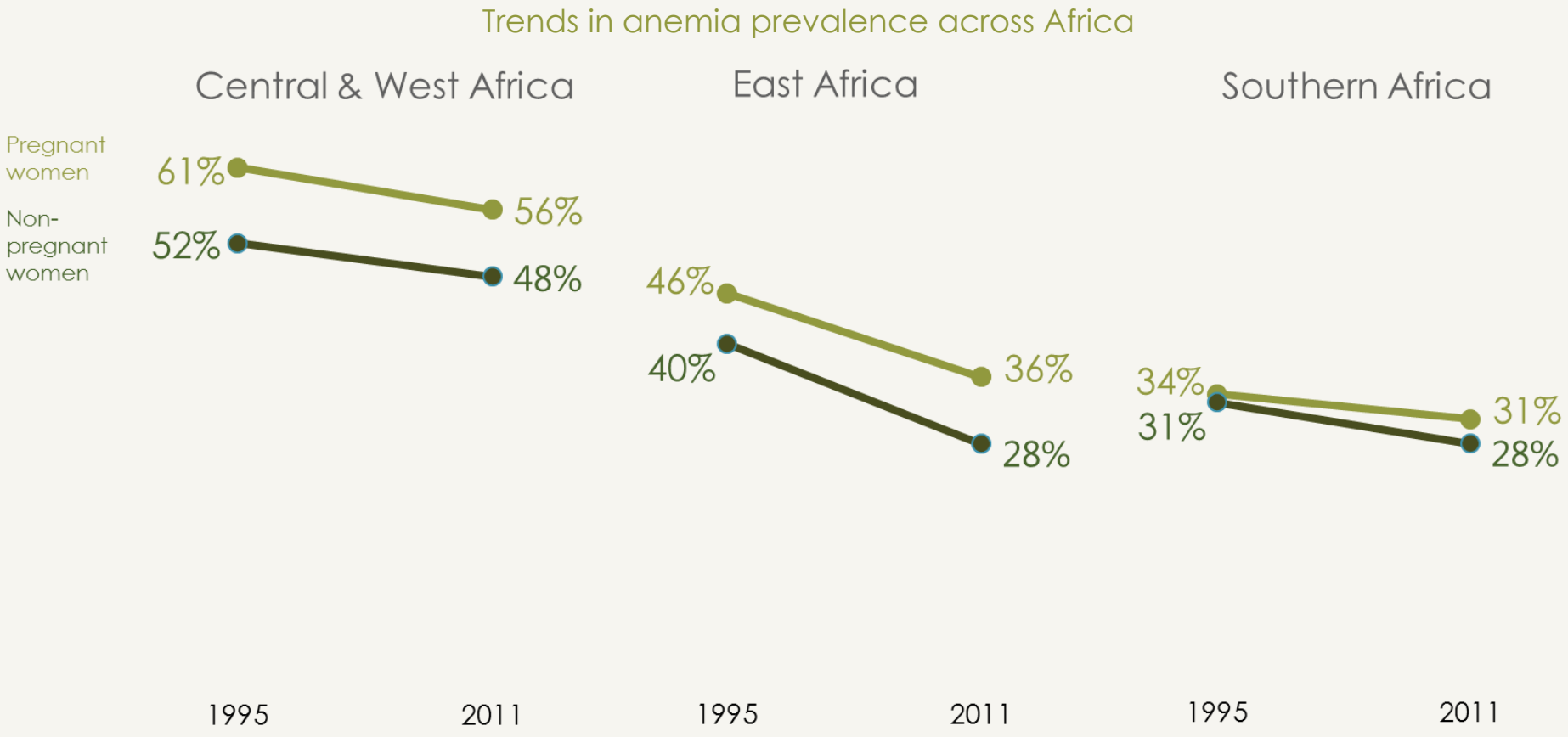
Source: *Global Nutrition Report 2015*. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the International Food Policy Research Institute (IFPRI).

They are anemic and progress has been slow



Anemia: < 110 g/L for children and pregnant women; 120 g/L for women
Source: Stevens et al., 2013

Progress varies across regions



Anemia: < 110 g/L for children and pregnant women; 120 g/L for women
Source: Stevens et al., 2013

They have micronutrient deficiencies

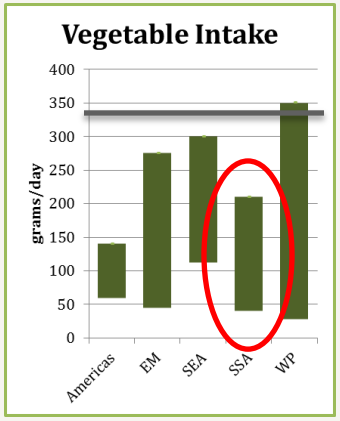
Region	Vitamin A deficiency among pregnant women[1]		Insufficient iodine intake in general population[2]	Inadequate zinc intake in general population[3]
	Night blindness (%)	Serum retinol < 0.70 umol/L (%)	Urinary iodine concentration < 100 ug/L (%)	Zinc available < EAR (%)
Globe	7.8	15.3	28.5	17.3
Africa	9.4	14.3	40.0	17.1-25.6
LAC	4.4	2.0	13.7	6.4-17.0
Asia	7.8	18.4	31.6	7.8-29.6
Europe	2.9	2.2	44.2	9.6

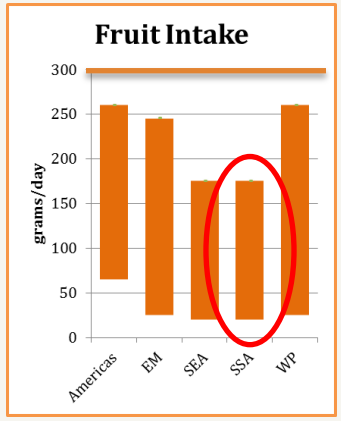
[1]reported in WHO (2009) and in Black et al (2013)
[2]reported in Andersson et al (2012) and in Black et al (2013)
[3]reported in Wessells and Brown, 2012; see also Wessells et al., 2012
EAR = estimated average requirement

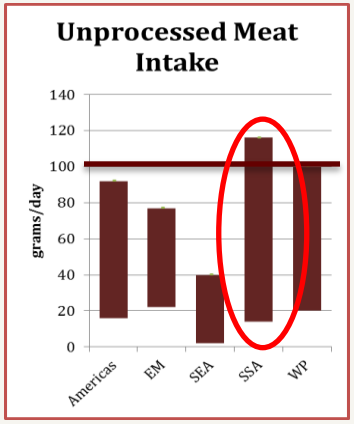
They don't eat well

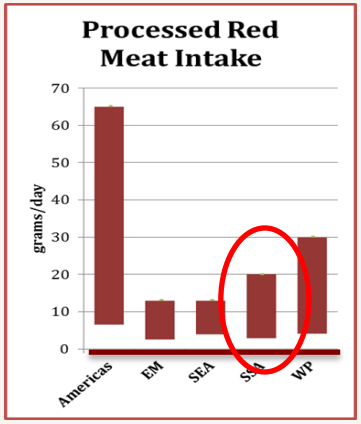
Healthy food intake is below recommended levels

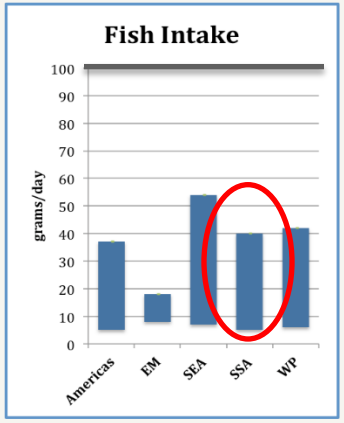
While unhealthy food intake exceeds recommended thresholds.

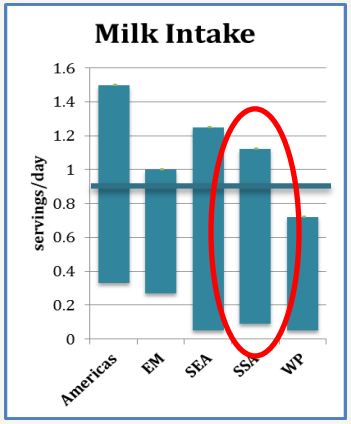


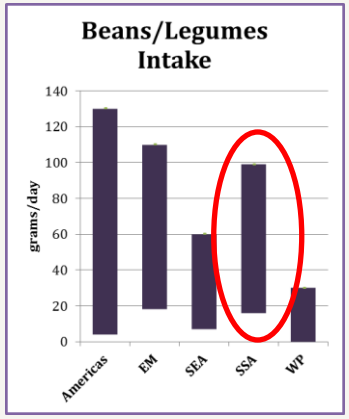


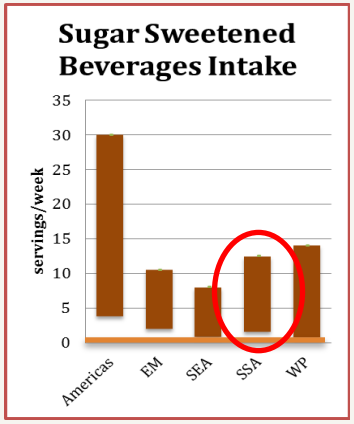










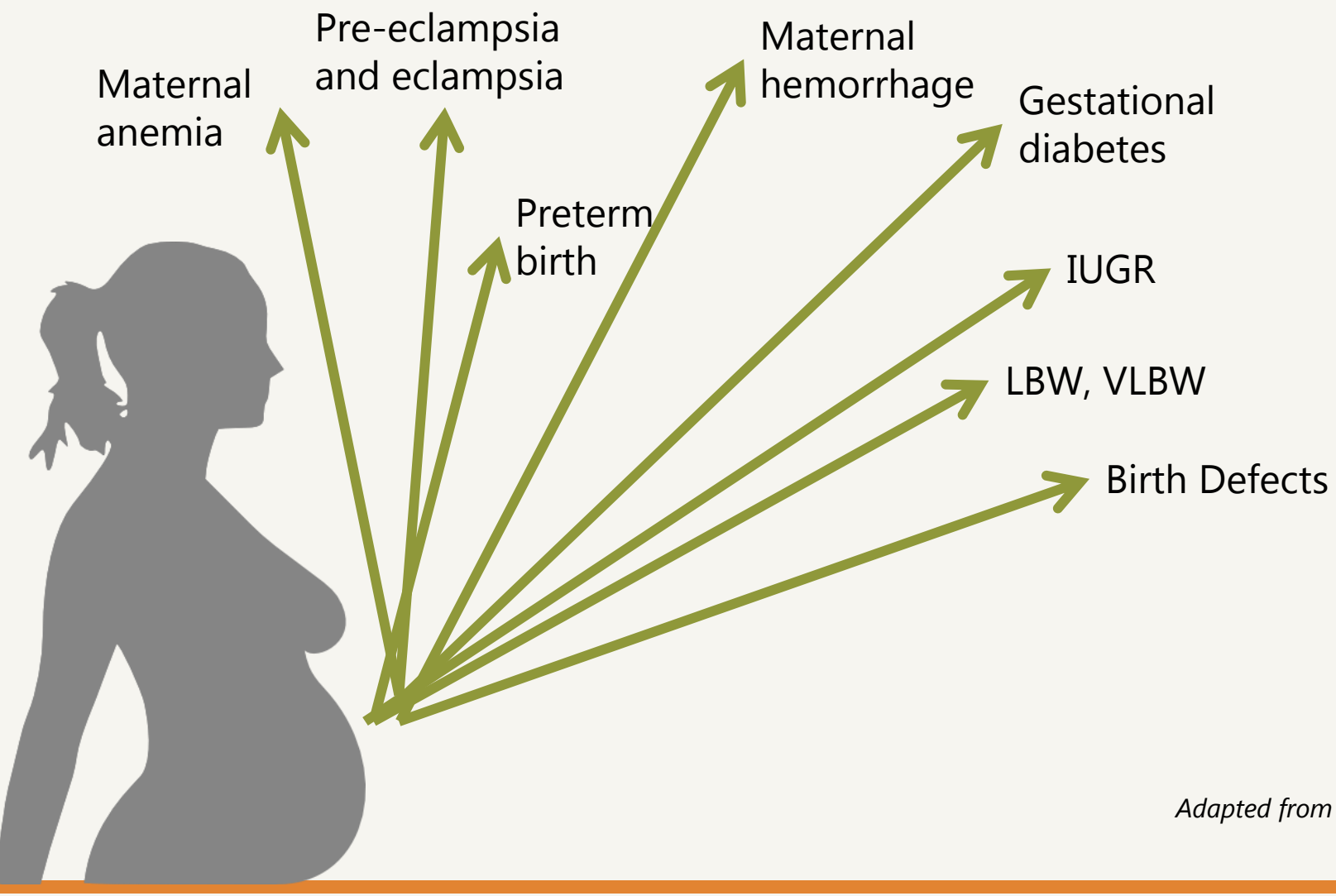


Estimated intakes of selected "healthy" and "unhealthy" foods by region among women 20-29 years. See SSA for data on Sub-Saharan Africa.
Horizontal lines represent the mean of the theoretical minimal risk exposure distribution.
Source: Imamura et al., 2015

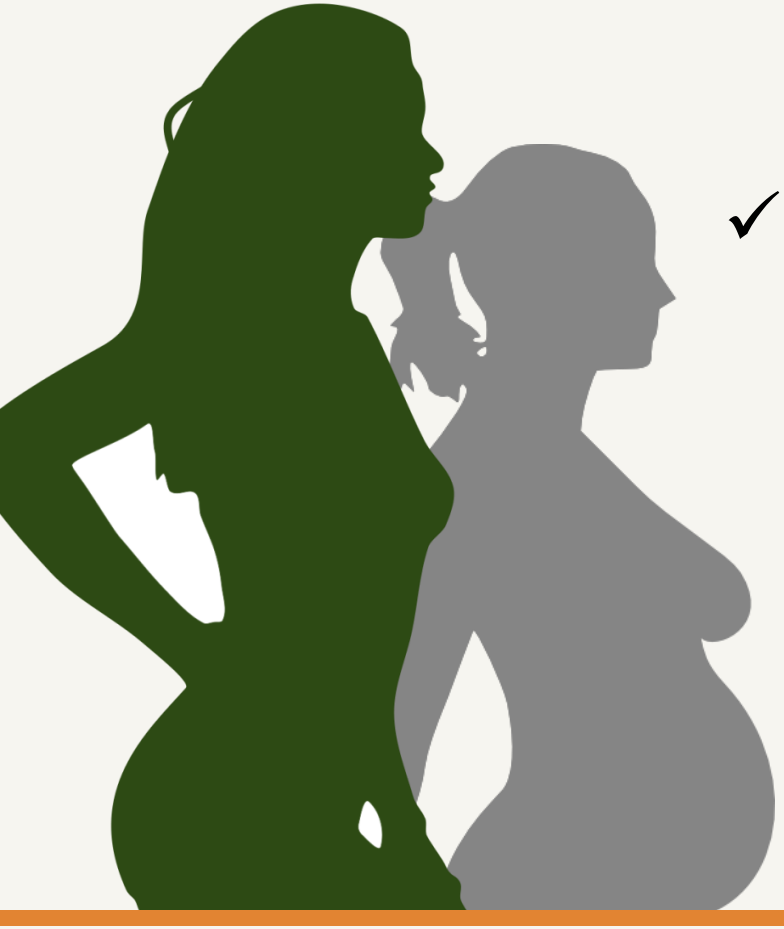
Why focus on adolescent girls and WRA?

Their nutritional status **affects others.**

Their nutrition affects others



Adapted from Wu G et al, 2012

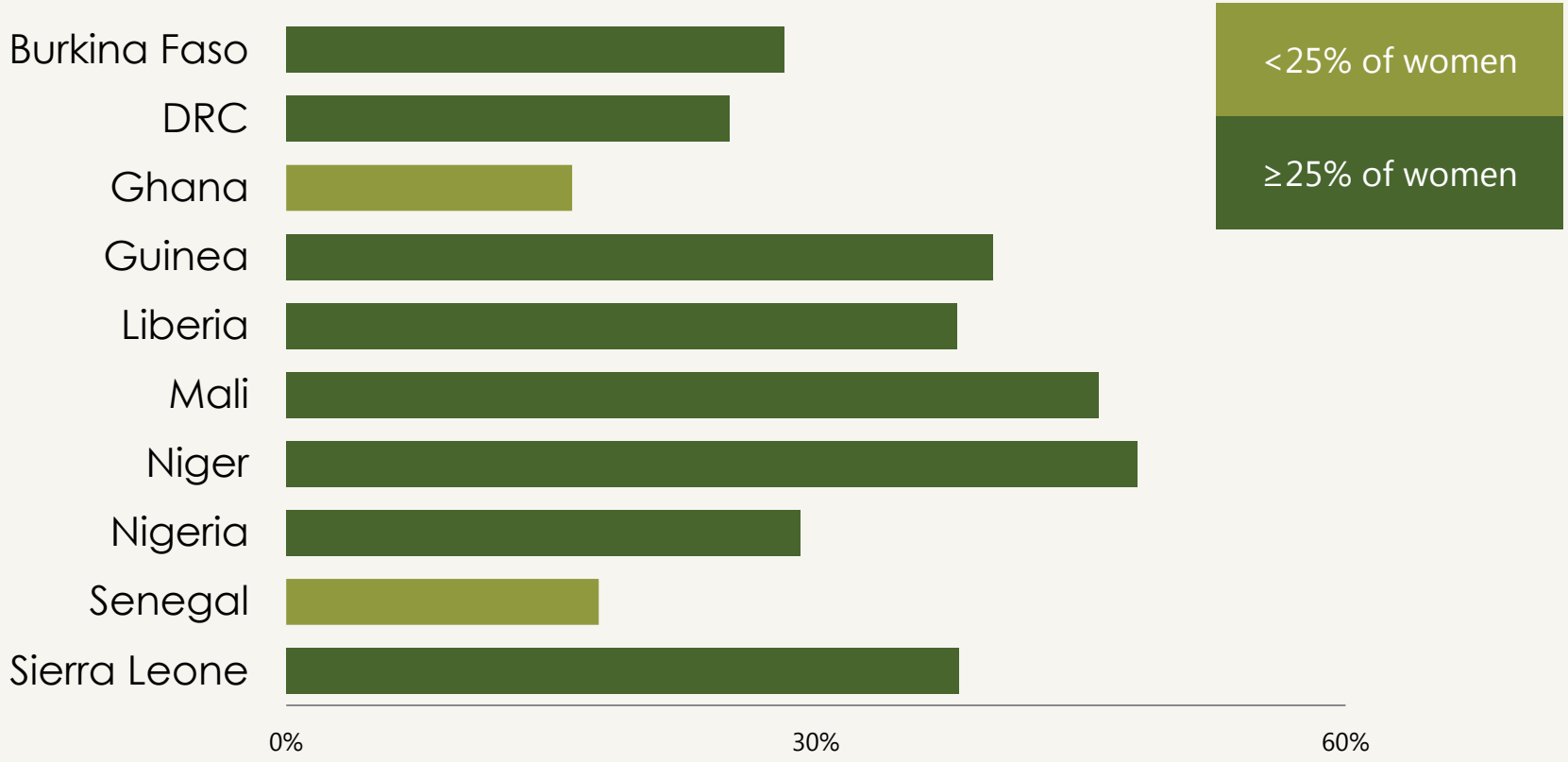


- ✓ Maternal obesity increases the risk of gestational diabetes, preeclampsia, hemorrhage, and neonatal and infant mortality (Black et al., 2013)
- ✓ Birthweight is associated with weight prior to conception and pregnancy weight gain (Young et al, under review)

- ✓ Early age at first pregnancy increases risk of anemia, LBW, VLBW, preterm birth, early term birth, neonatal mortality (Matorell, 2015)
- ✓ Short interpregnancy interval increases risk of preterm birth, early preterm birth, LBW, stillbirth, and neonatal mortality (Matorell, 2015)

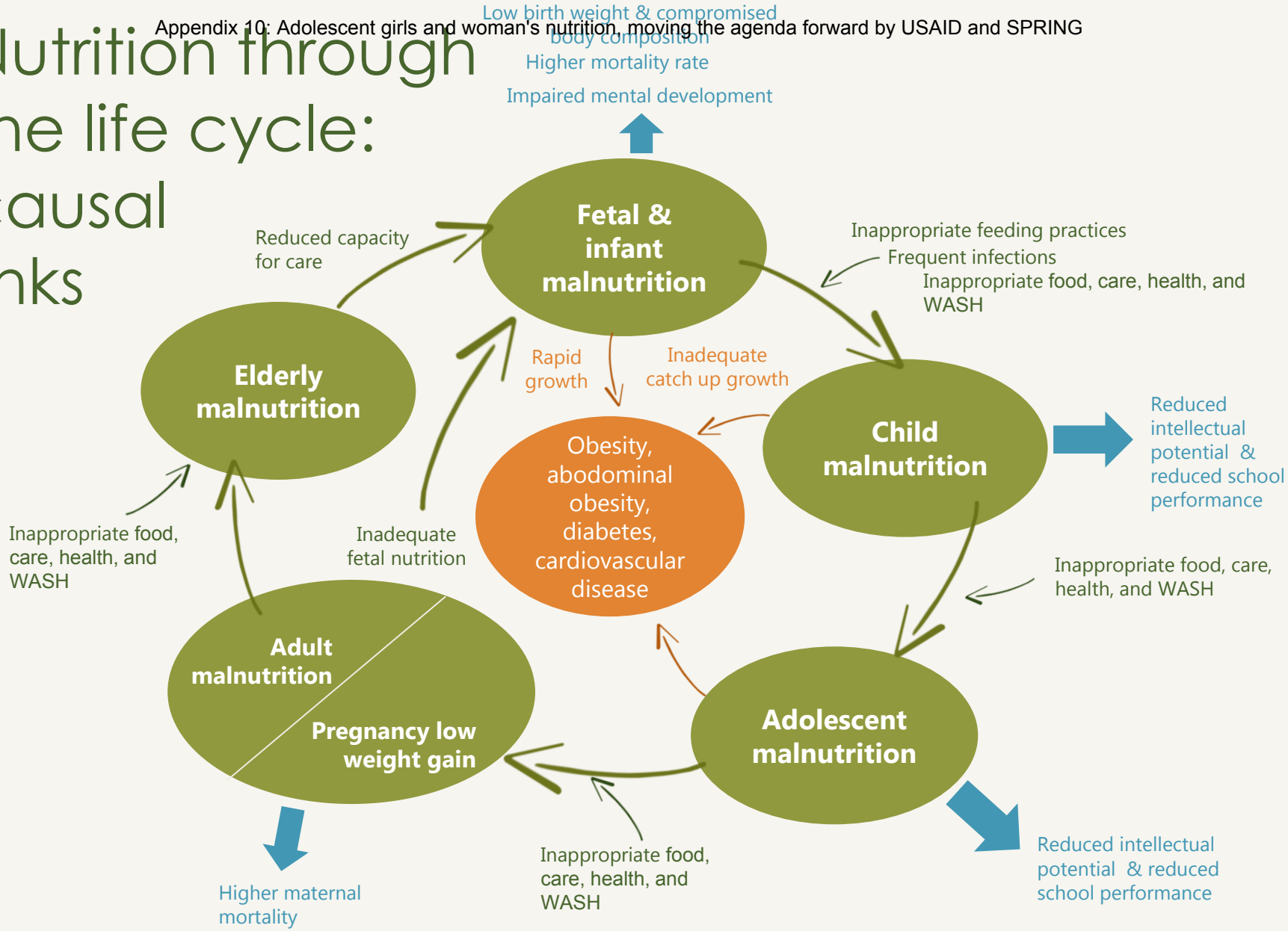
In **8 MSN-GLEE countries**, **one in four women** have given birth before age 18.

Percent of women giving birth before age 18 by country



Prevalence of women 20-24 year-olds giving birth before age 18 (Source: DHS)

Nutrition through the life cycle: causal links



Source: Every Woman Every Child (EWEC) Technical Content Workstream Working Group on Nutrition (22/03/2015) Nutrition and women's, children's and adolescents' health

Targeting girls and women only when they are pregnant is **too late** to break the intergenerational cycle of malnutrition.

The nutrition of adolescent girls and women is important for the quality of **their own lives and wellbeing**.

What has been done?

Interest in adolescent girls and women's nutrition is gaining momentum

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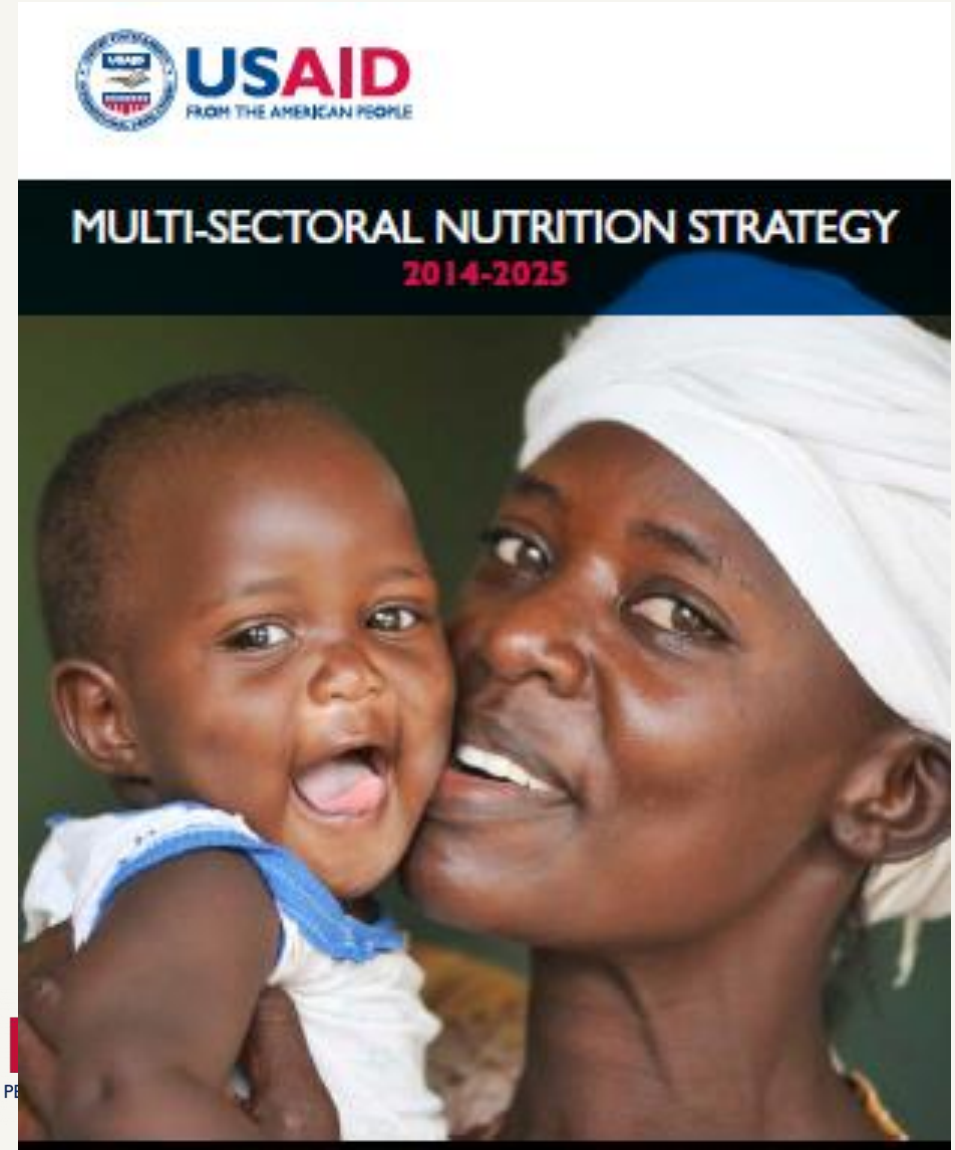
Interest in adolescent girls and women's nutrition is gaining momentum



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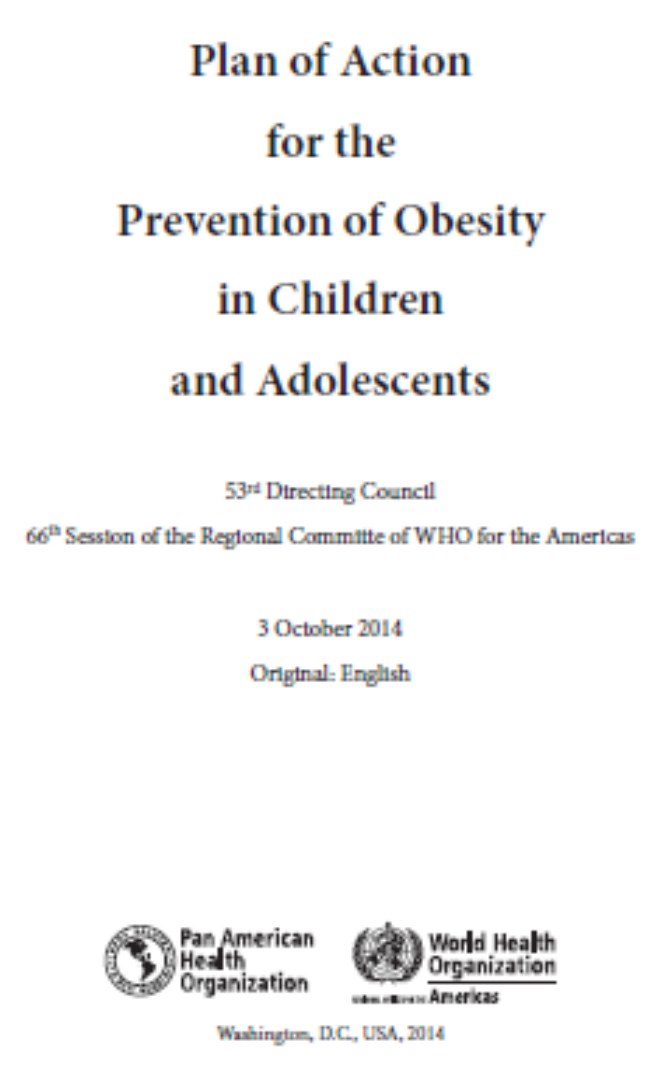
Strengthening Partnerships, Results and Innovations in Nutrition Globally

Interest in adolescent girls and women's nutrition is gaining momentum



Plan of Action

for the

Prevention of Obesity

in Children

and Adolescents

53rd Directing Council

66th Session of the Regional Committe of WHO for the Americas

3 October 2014

Original: English

Pan American Health Organization

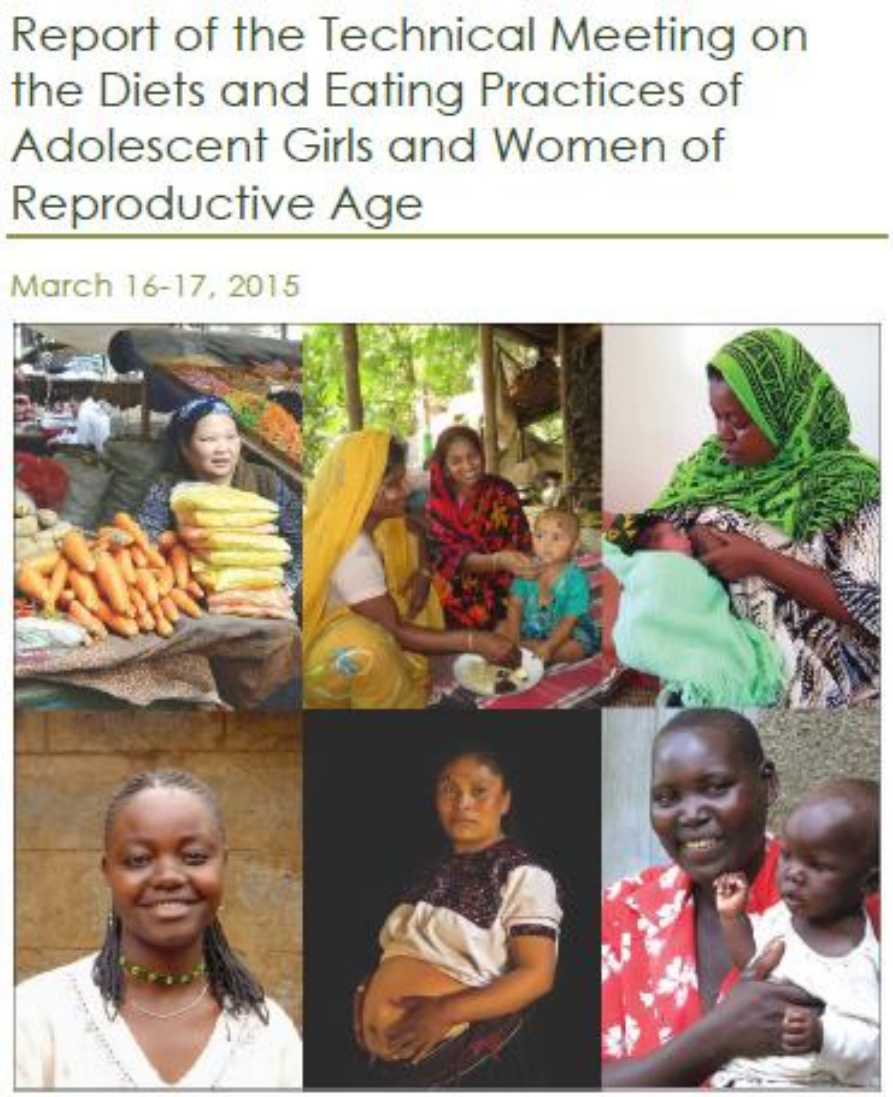
World Health Organization Americas

Washington, D.C., USA, 2014

SPRING

Strengthening Partnerships, Results and Innovations in Nutrition Globally

Interest in adolescent girls and women's nutrition is gaining momentum



ch, 2015
FANTA, PAHO/WHO

SPRING
Strengthening Partnerships, Results and Innovations in Nutrition Globally

Interest in adolescent girls and women's nutrition is gaining momentum

USAID
FROM THE AMERICAN PEOPLE

SPRING
Strengthening Partnerships, Results and Innovations in Nutrition Globally

Interest in adolescent girls and women's nutrition is gaining momentum

BUILDING A BETTER FUTURE: Supporting Future Generations through Improved Nutritional Health of Girls & Young Women

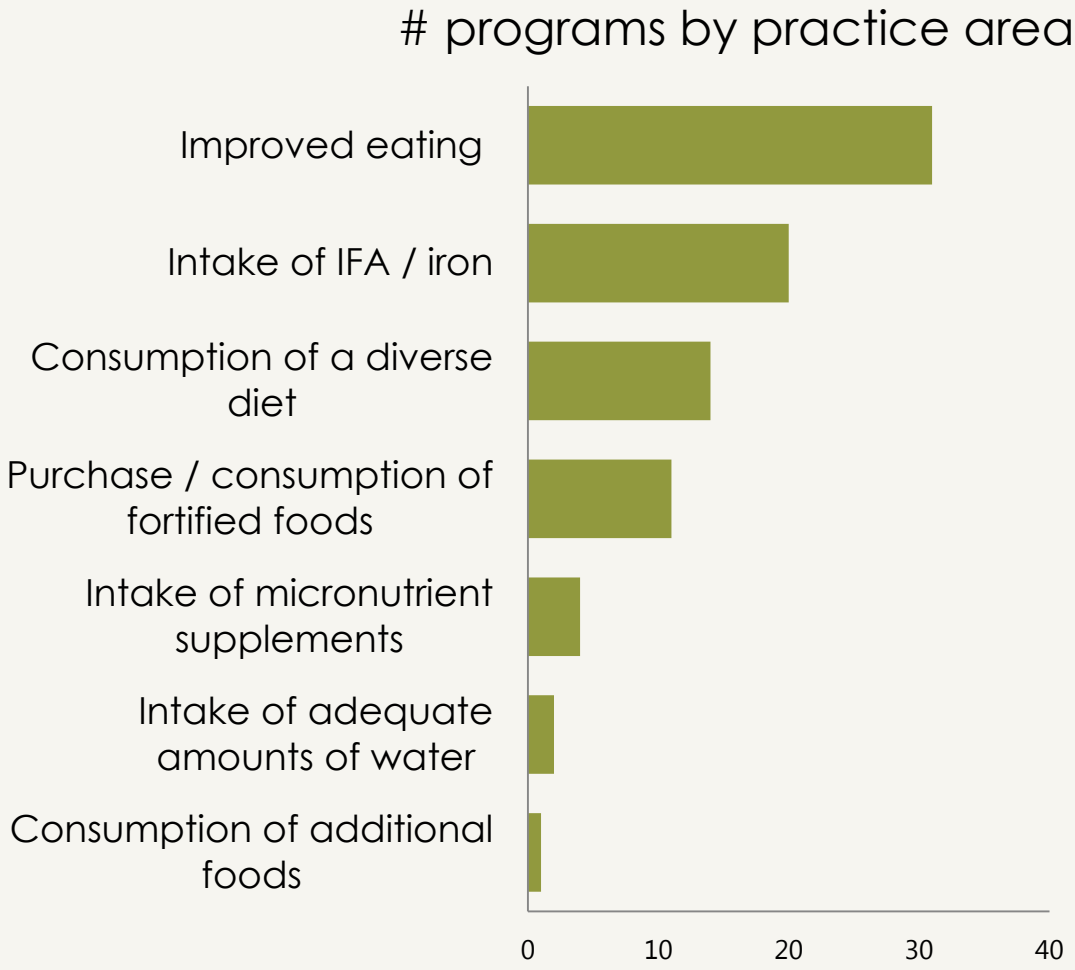
International Summit on the Nutrition of Girls & Young Women
Portland, Oregon, USA
May 2015

USAID
FROM THE AMERICAN PEOPLE

What has been done

Following a survey of institutions, a review of peer reviewed journal articles, and a review of organization/ donor websites,

54 nutrition-specific programs were identified that sought to improve nutrition (practices or status) of adolescent girls and/or WRA in LMIC (2004 to 2014)



What has been done

Programs for adolescents & WRA

9 programs for adolescent girls

46 programs for WRA

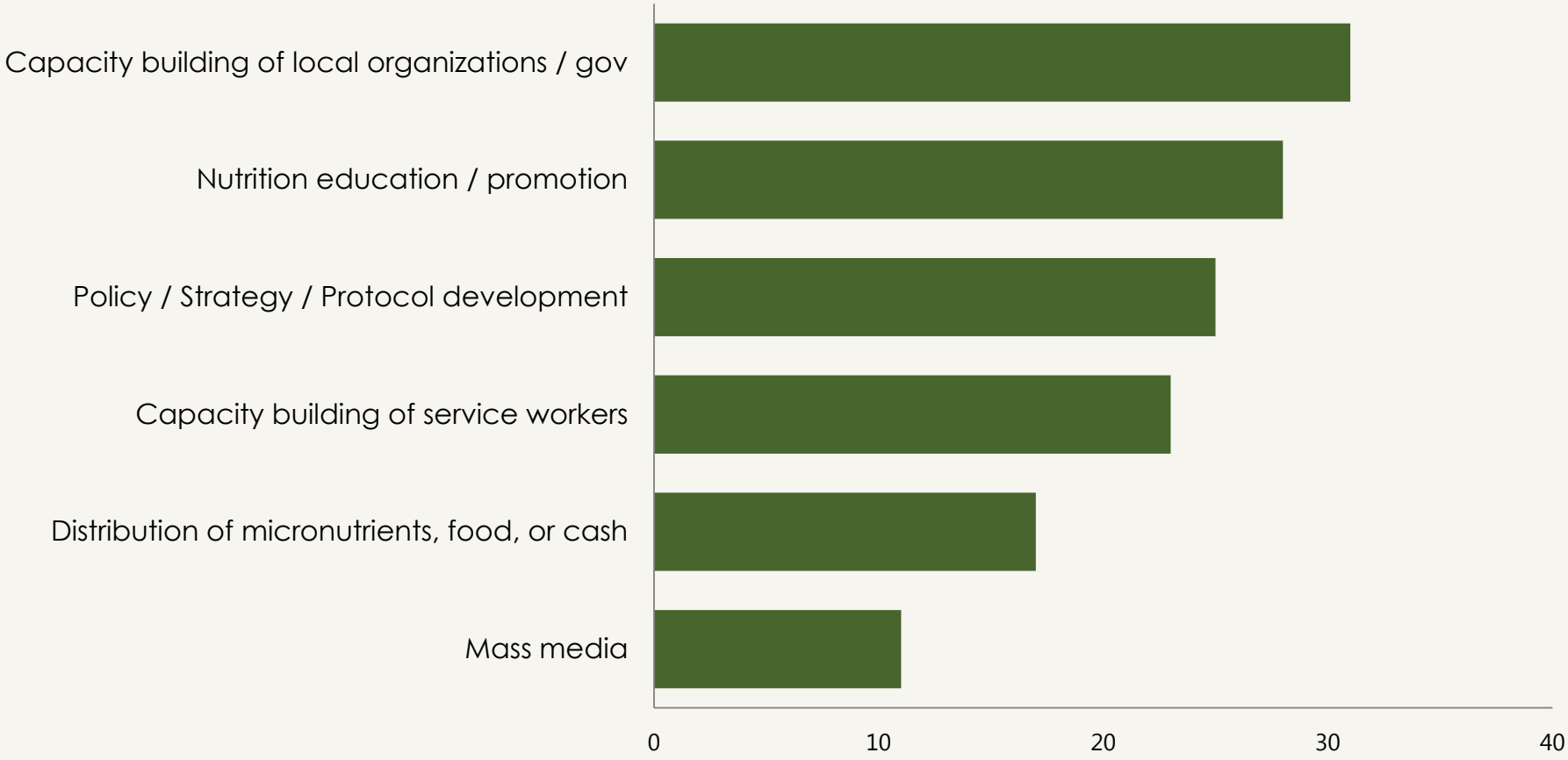
44 long-term or completed programs

15 of these provided data on effectiveness of the approach on nutrition outcomes

** The term "adolescent girl" was not always defined or was defined differently in the literature. The authors recognize overlap between these categories.*

What has been done

programs by delivery platform, strategy, or activity



What has been done

Review of SUN Nat'l Nutrition Action Plans

Conducted by Save the Children (2014)

Reviewed 22 country plans (all available)

10 included detail on adolescent health

Direct interventions included:

- Nutrition and health counselling / behavior change communication (8 countries)
- Iron folic acid supplementation (6)
- Provision of nutrient-rich food (6)

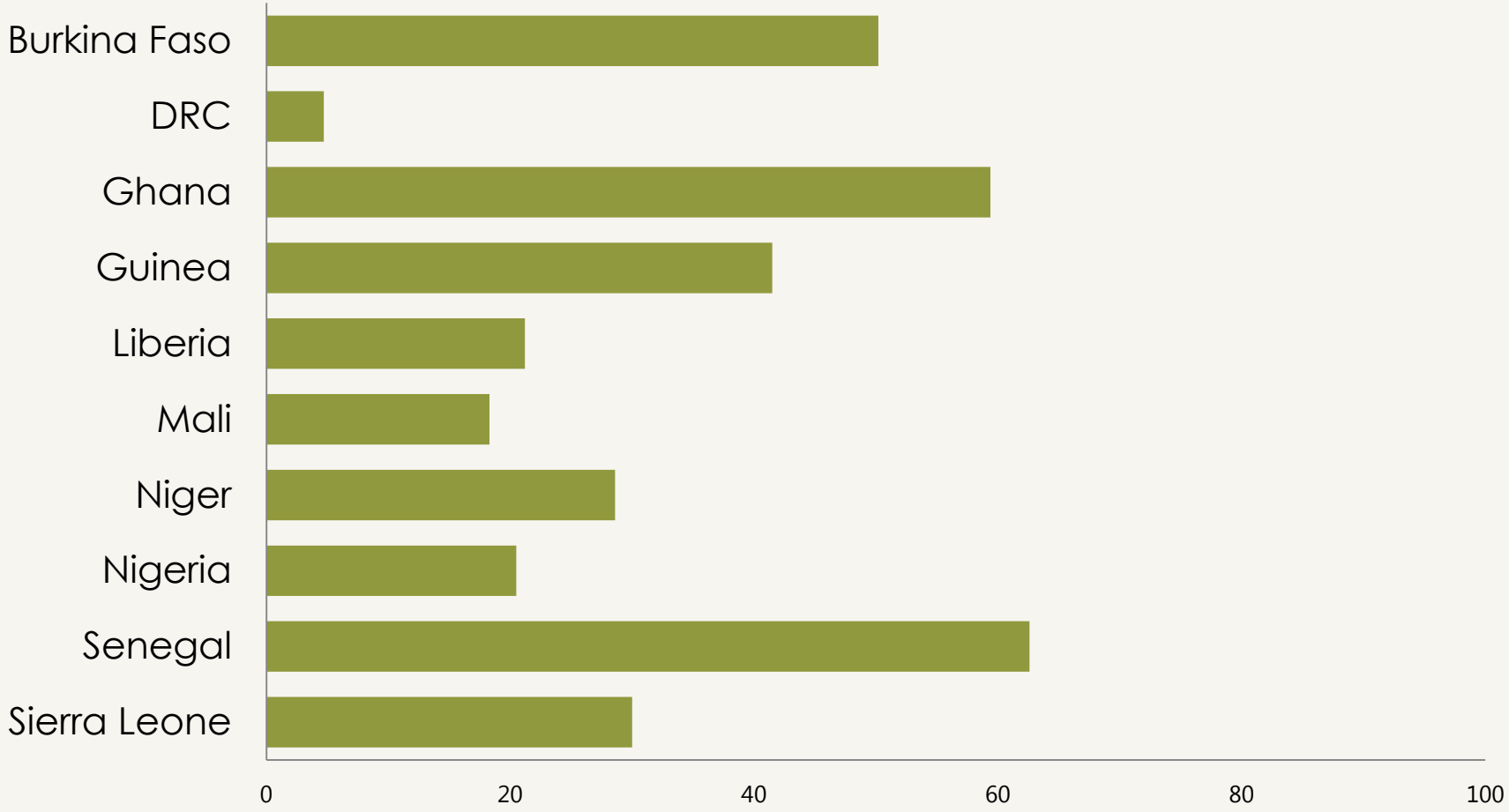
Indirect interventions included:

- Nutrition education in schools (6)
- Adolescent-friendly reproductive health services for boys and girls (5)

What has been done

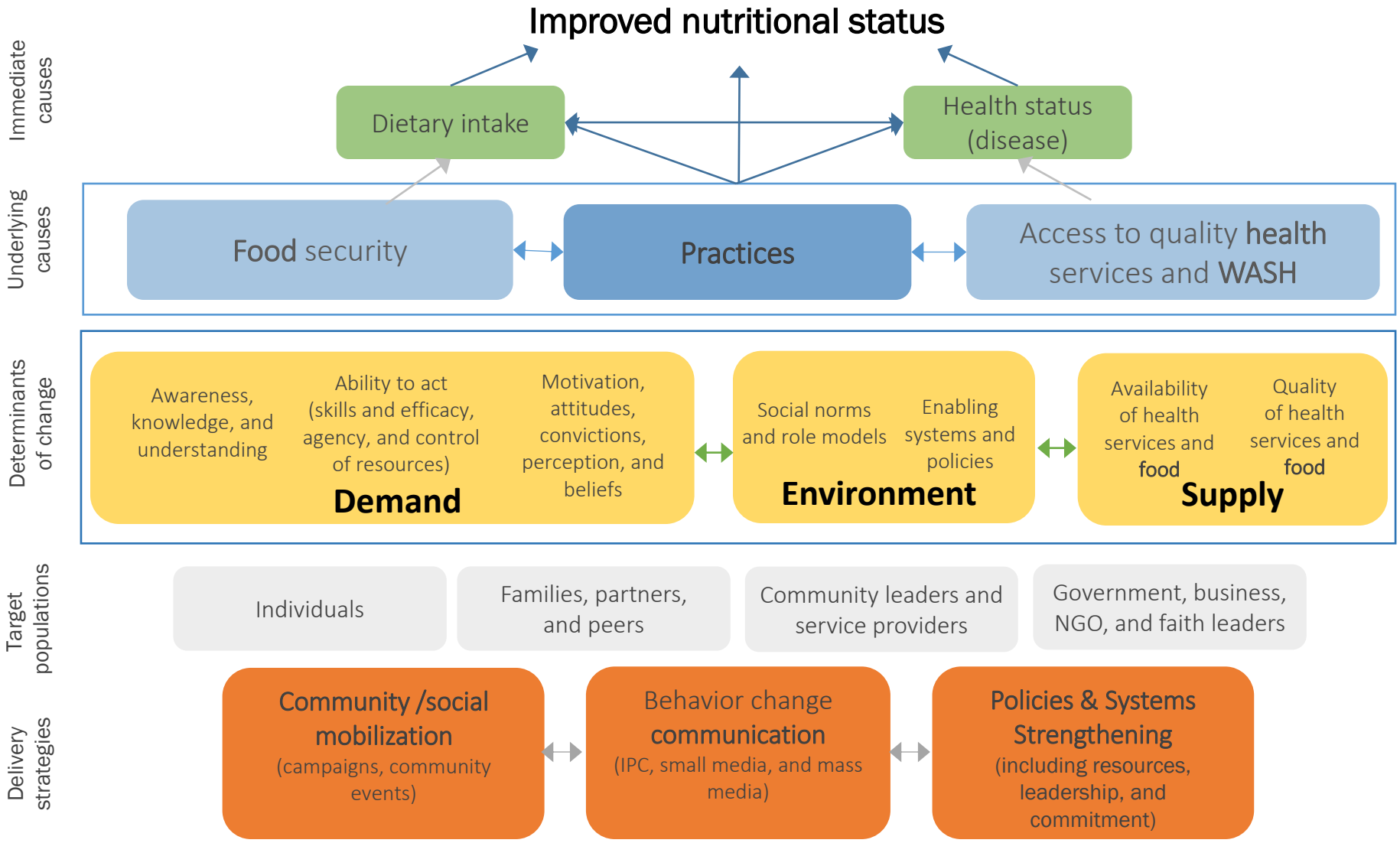
IFA supplementation

% of women who took 90+ IFA tablets among women with a child born in the last 5 years



What can be done?

What can be done?



Implementation Science - Intervention design and implementation (training, supervision, etc.)

What can **we** do? Group Work

- Break into groups – school-aged girls, adolescent girls, and WRA)
- Discuss each of the following questions:
  - ✓ What is unique about addressing the nutritional needs of this population?
  - ✓ What programs or types of interventions might be effective in improving the nutrition of this population?
  - ✓ How can we integrate greater focus on these populations into existing programs or interventions in the countries where you work?
- Be prepared to share your recommendations for improving nutrition of these populations.

For more information, please visit:
spring-nutrition.org/adolescent-and-womens-nutrition

APPENDIX 12

Organisation mondiale de la Santé

Mise à jour hebdomadaire sur l'Initiative d'Eradication de la Polio en Afrique Centrale

Mise à jour du 14 mars 2016

IST Afrique Centrale, Libreville-GABON

POINTS SAILLANTS

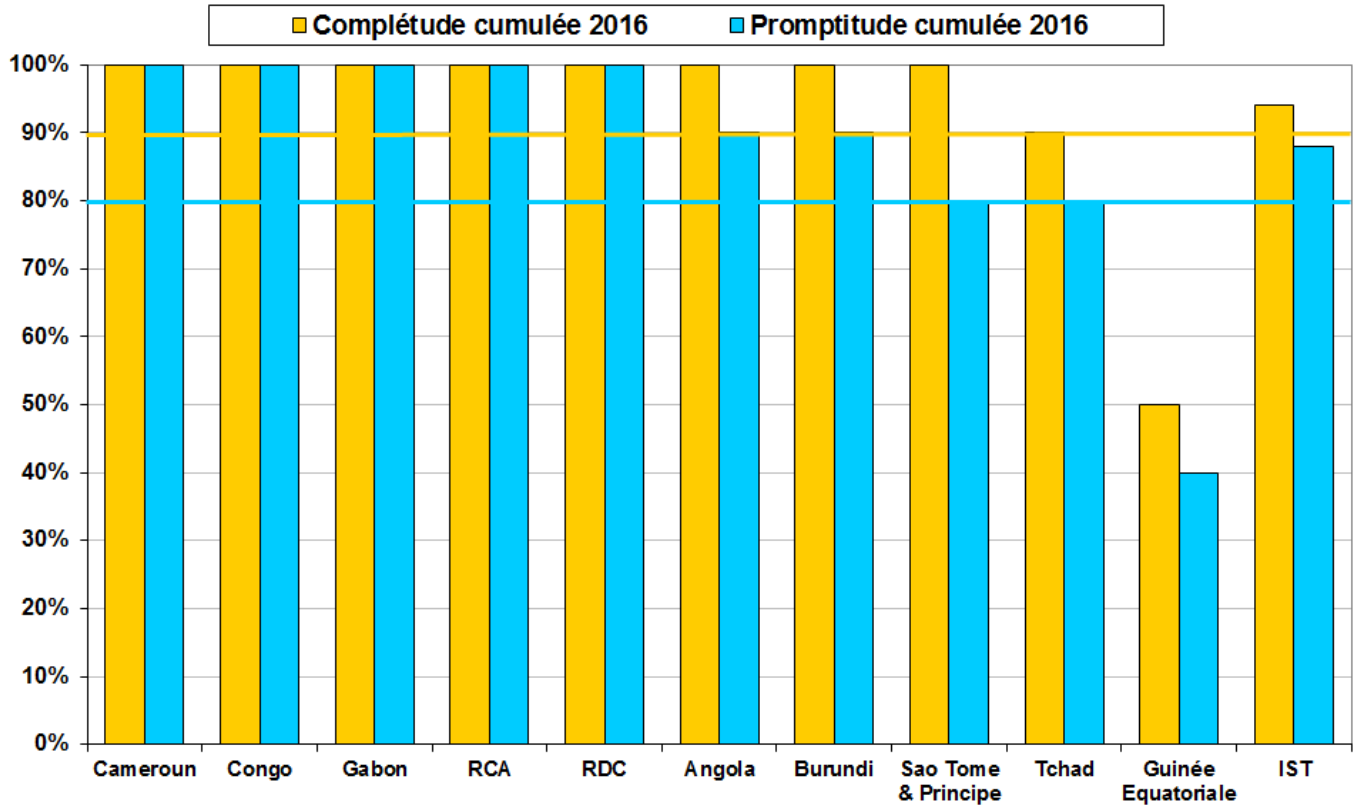
- **Pas de nouveau cas de PVS depuis 20 mois, la date de paralysie du dernier cas de PVS est le 09 juillet 2014 au Cameroun**

- **Pas de nouveau cas de cVDPV depuis 31 mois, la date de paralysie du dernier cas de cVDPV est le 12 août 2013 au Cameroun.**

- **21 cas de PFA de 2015 sont en instance de classification finale depuis plus de 100 jours dont 5 au Cameroun, 4 au Gabon, 4 au Tchad, 3 au Congo, 2 en Angola, 2 en RCA et 1 à STP.**

- ***77 cas compatibles en 2015 dont 66 en RDC, 7 en RCA, 3 au Tchad et 1 au Gabon.***

Promptitude et complétude cumulées de transmission des rapports hebdomadaires PFA et rougeole à IST, S01-S10/2016

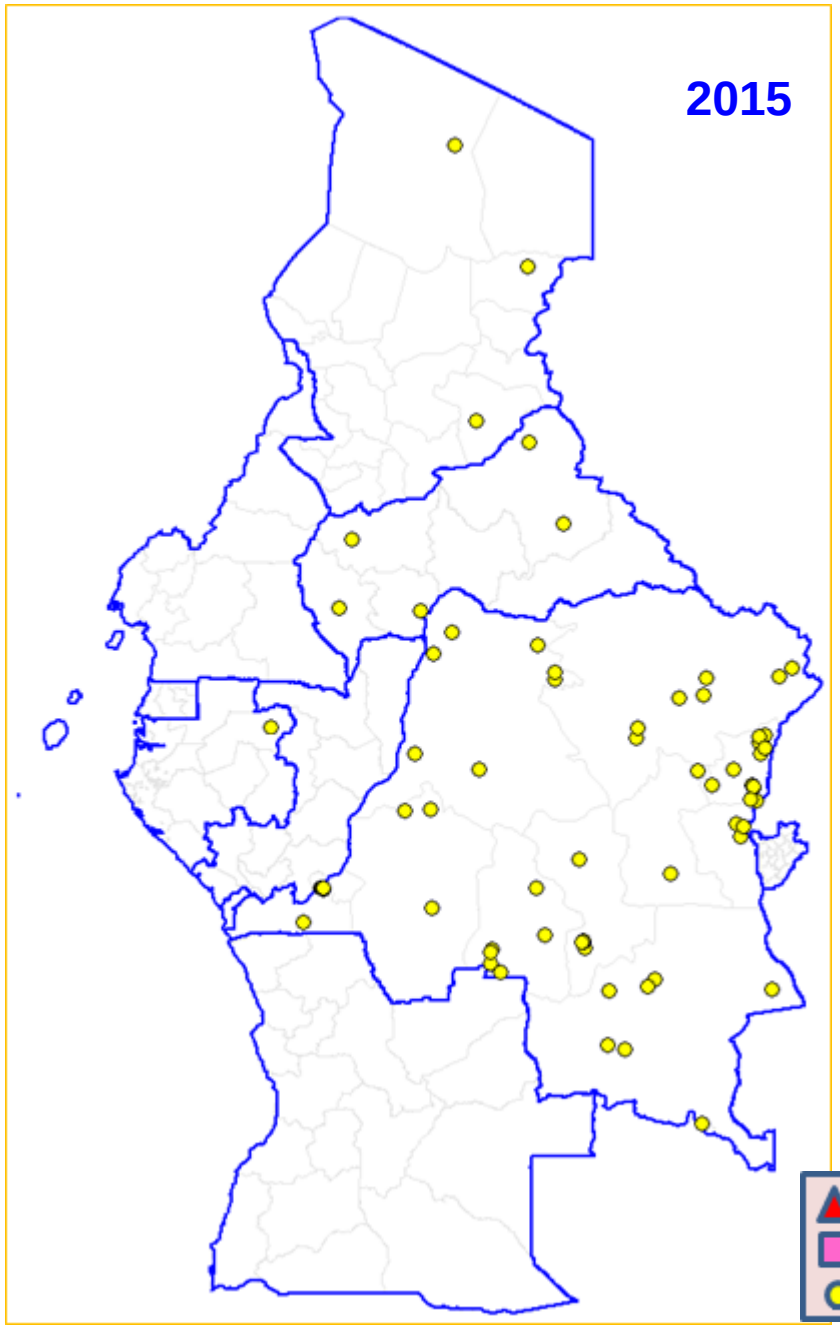


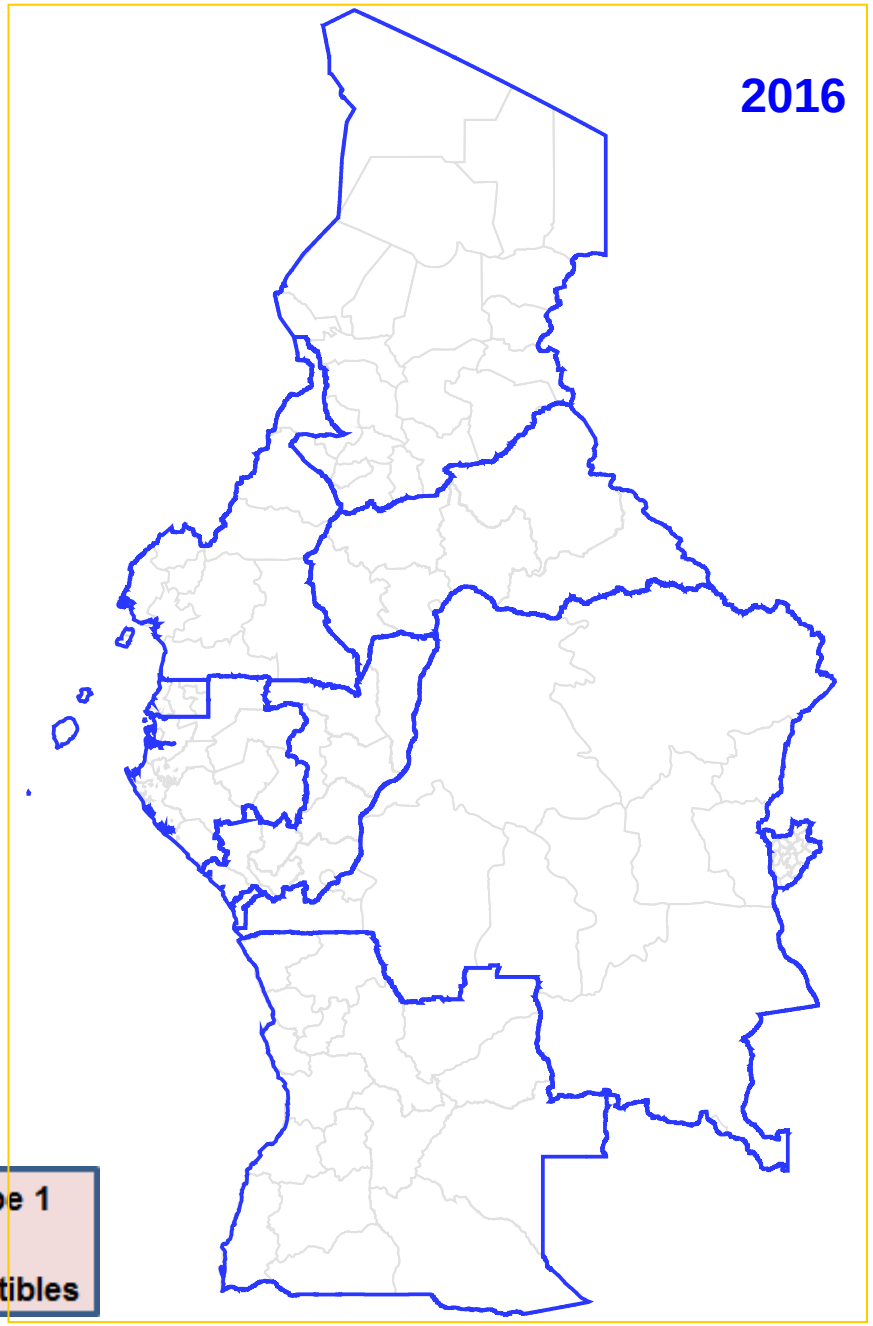
Promptitude et complétude de réception des rapports hebdo PFA à IST, S10-2016

	Etat de réception
Angola	T
Burundi	L
Cameroun	T
Congo	T
Gabon	T
Guinée Equatoriale	T
RCA	T
RDC	T
Sao Tome & Principe	T
Tchad	T
IST	S10, 2016
Complétude	100%
Promptitude	90%

T : Timely/A temps/Oportuno
L : Late/En retard/Atrasado
N : Not received/Non reçu/Não recebido

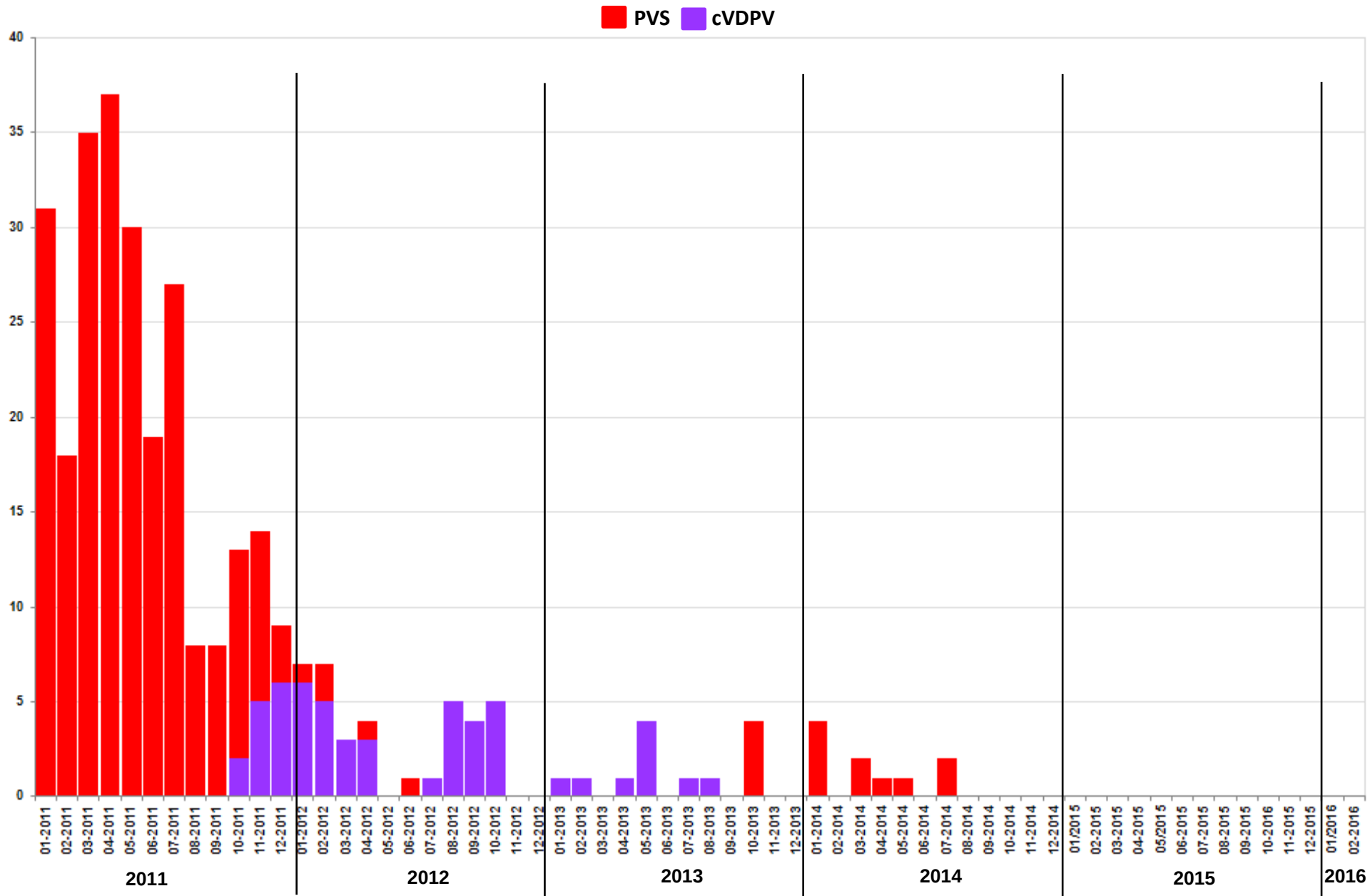
LOCALISATION DES PVS, COMPATIBLES ET cVDPV





PVS type 1
cVDPV
Compatibles

DISTRIBUTION MENSUELLE DES CAS DE PVS ET cVDPV EN AFRIQUE CENTRALE, 2011 – 2016



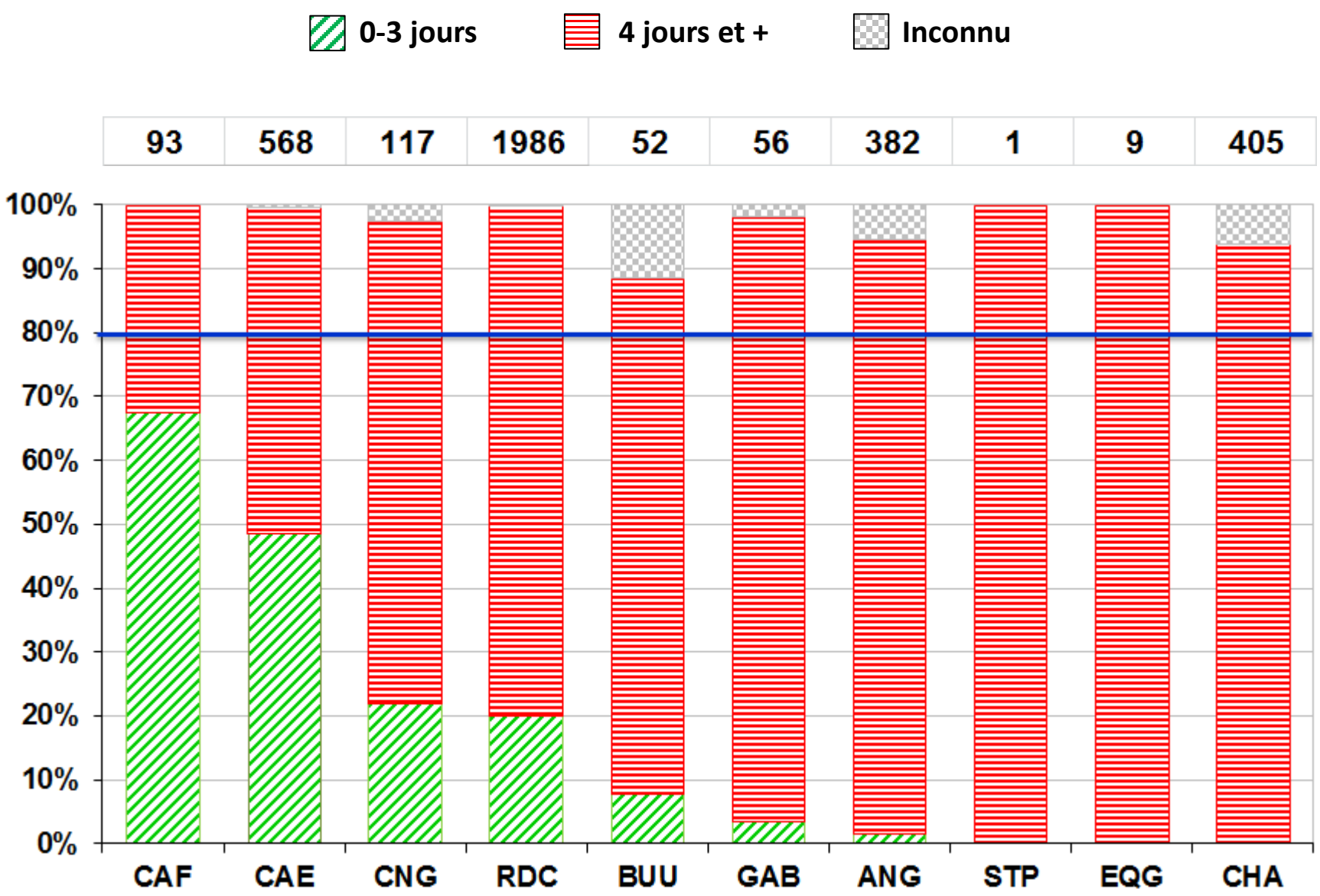
CAS DE POLIOVIRUS SAUVAGE NOTIFIES DE 2000-2016

Pays	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Date de paralysie du dernier PVS
Cameroun	0	0	0	2	13	1	2	0	0	3	0	0	0	4	5	0	0	09-juil-14
Guinée Eq.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	03-mai-14
Tchad	4	0	0	25	24	2	1	21	37	64	26	132	5	0	0	0	0	14-juin-12
Angola	55	1	0	0	0	10	2	8	29	29	33	5	0	0	0	0	0	07-juil-11
RDC	28	0	0	0	0	0	13	41	5	3	100	93	0	0	0	0	0	20-déc-11
RCA	3	0	0	1	30	0	0	0	3	14	0	4	0	0	0	0	0	08-déc-11
Congo	22	0	0	0	0	0	0	0	0	0	441	1	0	0	0	0	0	22-janv-11
Gabon	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	15-janv-11
Burundi	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	12-sept-09
STP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23-juil-92
TOTAL	112	1	0	28	67	13	18	70	74	115	600	236	5	4	10	0	0	

CAS DE cVDPV NOTIFIES DE 2008-2016

Pays	2008	2009	2010	2011	2012	2013	2014	2015	2016	Date de paralysie du dernier cVDPV
Cameroun	0	0	0	0	0	4	0	0	0	12-août-13
Tchad	0	0	1	0	12	4	0	0	0	12-mai-13
RDC	13	5	18	11	17	0	0	0	0	24-nov-12
TOTAL	13	5	19	11	29	8	0	0	0	

DELAIS ENTRE LE PRELEVEMENT DES SELLES ET L'ARRIVEE AU LABO 09/03/2015-08/03/2016



PERFORMANCE DE LA SURVEILLANCE DES PFA
09/03/2015-08/03/2016

Pays	Cas de PFA attendus	Cas de PFA notifiés	Taux annualisé de PFA non-polio	Cas de PFA av. 2 selles en 14js		Confirmé		Compa-tibles	Cas de PFA avec résultats Labo en 14js		Classif. finale en instance plus de 90 jours	Echantil-lons sans résultat de labo + de 14 jours *	Taux d'entéro-virus non polio 2015 (10%) *
				Nbre	%	VDPV	Sauvage		Nbre	%			
Angola	344	415	3,6	397	95	0	0	0	399	96	2	0	22,4
Burundi	128	63	1,5	58	92	0	0	0	54	86	0	0	5,3
Cameroun	287	622	6,5	530	85	0	0	0	613	99	5	31	8,4
Centrafrique	60	81	3,7	68	84	0	0	7	62	77	2	0	24,7
Congo	66	117	5,3	104	89	0	0	0	113	97	3	0	5,7
Gabon	23	61	6,5	53	87	0	0	1	56	93	4	2	7,6
Guinée Eq.	13	11	2,6	7	64	0	0	0	9	82	0	0	6,1
RDC	1 321	2117	4,7	1872	88	1	0	66	1963	93	0	0	10,2
S.T. & Principe	3	1	1,2	1	100	0	0	0	1	100	1	0	0,0
Tchad	206	435	6,3	406	93	1	0	3	396	91	4	22	10,9
Afr. Centrale	**2 450**	**3923**	**4,7**	**3496**	**89**	**2**	**0**	**77**	**3666**	**93**	**21**	**55**	**11,3**

	Pays ayant atteint le niveau minimum des 2 principaux indicateurs
	Pays ayant atteint le niveau minimum pour 1 seul indicateur
	Pays n'ayant atteint le niveau minimum pour aucun des 2 indicateurs

SURVEILLANCE ENVIRONNEMENTALE DES PFA
S01-S10, 2016

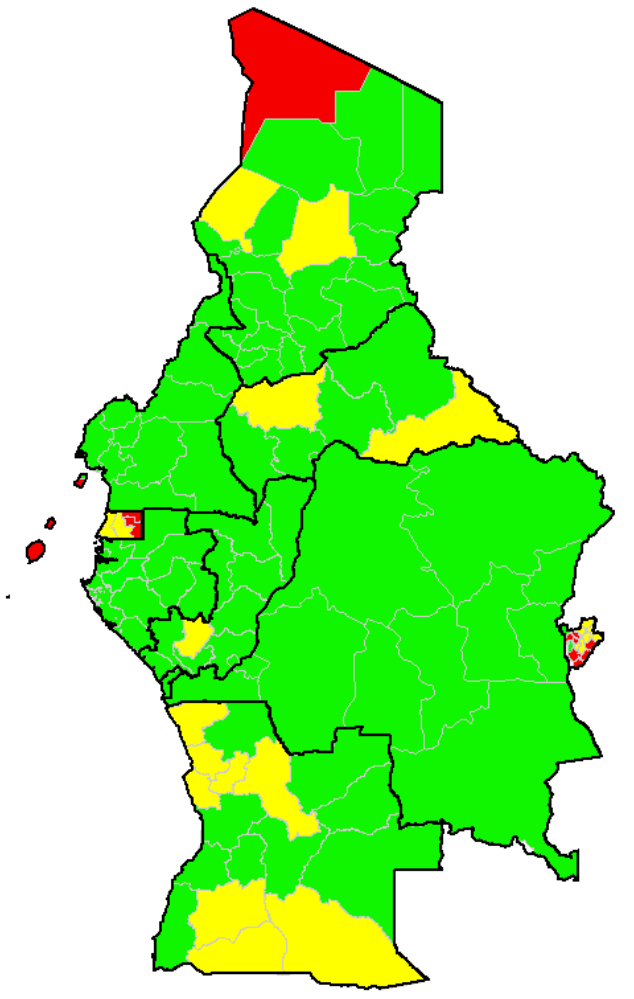
	EpiWeeks 2016									
Site Name	1	2	3	4	5	6	7	8	9	10
Luanda (Angola)										
Vala do Golf 2 (Kilamba Kiaxi)										
Rio Cambamba Bairro (Cazenga)										
Antigo Control Samba (Amostra mixturada)										
Rio Seco (Maianga)										
Yaoundé (Cameroun)										
Mokolo Marché Charbon										
Palais des Sports										
Nkomkana Immeuble Macabo										
Aurore (Face palais de sport)										
Melen 2è Pont										
Maetur Mendong										
Nkolndongo										
Mvog-Ada										
Douala (Cameroun)										
Pont Camp Yabassi										
Bas-fonds Cité des Palmiers										
Drain pamplemousse										
Derrière Jet Hotel										
Bafoussam (Cameroun)										
Bamendzi Pont										
Ngouache 2										
Sky Garden										
Kouogouo										
N'Djamena (Tchad)										
Canal Fontaine de l'Union										
Canal Chari Mongo										
Canal Pont Naga										
Canal Pont Ridina										

NEGATIVE
cVDPV2
SABIN
NEV
WPV1
SENT FOR SEQUENCING
NPENT+SABIN
WVP3
NPENT
WPV1+cVDPV2
RESULT PENDING
NOT SCHEDULED
SCHEDULED NOT COLLECTED

PERFORMANCE DE LA SURVEILLANCE DES PFA PAR REGION

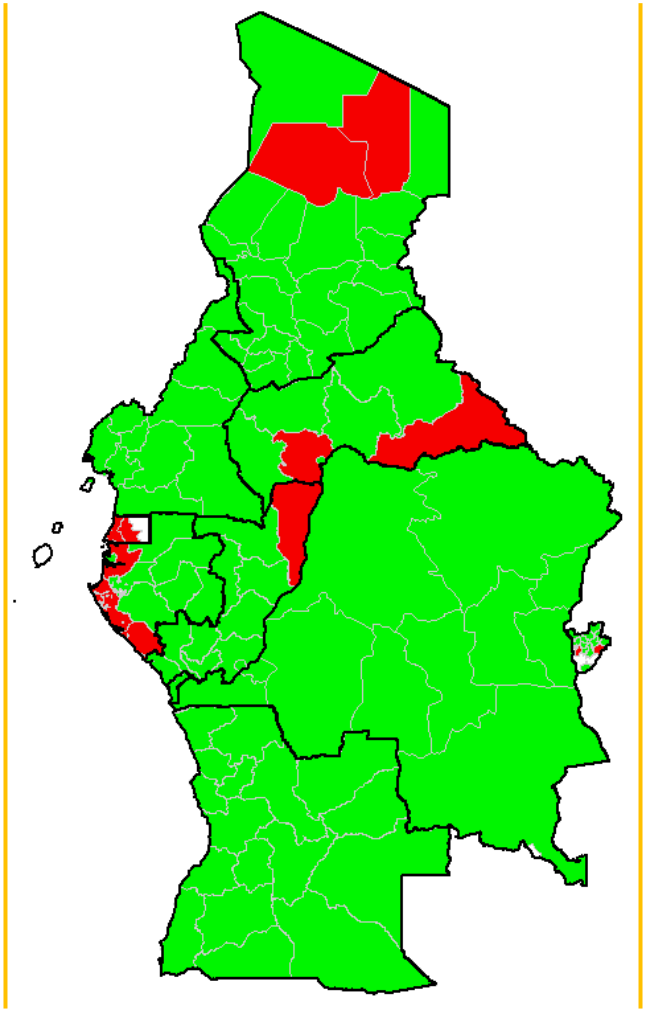
09/03/2015-08/03/2016

Taux de PFA Non Polio



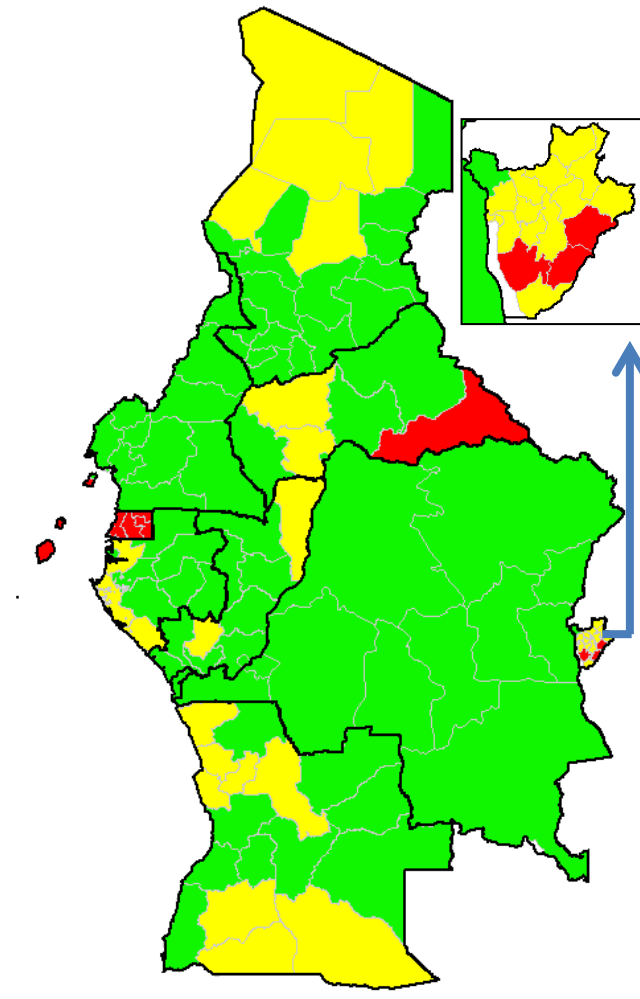
0.00 - 0.99
1.00 - 2.99
3.00 +

% Selles prélevées dans les 14 jrs



< 80
>=80
Pas de cas

Les 2 indicateurs à la fois



Aucun indicateur atteint
1 indicateur atteint
2 indicateurs atteints

AVS POLIO REALISEES EN 2016

Pays	Date du début	Date de fin	Etendue	Type de VPO	Population cible totale	Population totale vaccinée	Couverture administra-tive (%)	Résultats des évaluations indépendantes (% enfants non vaccinés)		% Parents non informés avant le passage des vaccinateurs
								Dans les ménages	Hors ménages	
Congo	25 Fev. 2016	28 Fev. 2016	JNV	VPOt	992 644	1 112 244	107	5	6	11
Cameroun *	26/02/2016	28/02/2016	JNV	VPOt	6 221 136	ND	ND	3	5	12
Tchad	26/02/2016	28/02/2016	JNV	VPOt	4 179 810	ND	ND	ND	ND	ND
RCA	04/03/2016	06/03/2016	JNV	VPOt		ND	ND	ND	ND	ND
Guinée Eq.	09/03/2016	13/03/2016	JNV	VPOt		ND	ND	ND	ND	ND

* Données partielles

AVS POLIO PLANIFIEES EN 2016

Pays	Date du début	Date de fin	Etendue	Type de VPO	Tranche d'âge	Population cible	Provinces/ districts
Angola	Mar. 2016	Mar. 2016	JNV		0-5		Tous
Cameroun	15-Apr-16	17-Apr-16	JNV	VPOt	0-5	6 221 136	Tous
Gabon	28-Mar-16	30-Mar-16	JNV	VPOt	0-5	357 296	
RDC	14-Mar-16	16-Mar-16	JLV	VPOt	0-5	761 839	Tshopo, Bas Uélé
	24-Mar-16	26-Mar-16	JNV	VPOt	0-5	18 116 773	Tous
Tchad	25-Mar-16	27-Mar-16	JNV	VPOt	0-5	4 179 810	

SURVEILLANCE CAS PAR CAS DE LA ROUGEOLE

PERFORMANCE DE LA SURVEILLANCE CAS PAR CAS DE LA ROUGEOLE, 09/03/2015-08/03/2016

Pays	Population	Nombre de cas			Avec Echantillon (%)		Avec résultat		IgM positif rougeole		IgM positif rubéole		Confirmé par lien Epidém.	Compa-tibles	Taux d'érupt° fébrile non rougeo-leuse (2)	% districts avec ≥1 cas suspect prélevé (80%)	Inci-dence /10^6
		Case-based	Linelist	Total	Nom-bre	%	Nom-bre	%	Nom-bre	%	Nom-bre	%					
Angola	24 383 300	490	0	490	489	100	436	89	17	4	193	44	0	30	1,6	57	1
Burundi	9 562 821	113	0	113	113	100	107	95	0	0	48	45	0	9	1,1	60	0
Cameroun	21 915 977	1063	484	1547	1063	100	941	89	360	38	136	14	484	29	2,5	79	39
Congo	4 681 449	359	793	1152	359	100	352	98	115	33	4	1	793	2	5,0	113	194
Gabon	1 909 897	257	0	257	257	100	215	84	32	15	34	16	0	6	9,3	69	17
Guinée Equatoriale	985 290	140	1696	1836	140	100	134	96	87	65	13	10	1657	0	7,7	83	1770
RCA	4 953 095	233	0	233	232	100	231	100	72	31	39	17	0	13	2,9	92	15
RDC	91 725 406	2350	4055	6405	2320	99	2336	101	430	18	338	14	4058	6	2,03	61	49
Sao-Tome & Pr.	192 177	3	0	3	3	100	3	100	0	0	3	100	0	0	1,56	14	0
Tchad	13 570 826	460	54	514	451	98	409	91	192	47	37	9	62	63	1,4	80	19
Afrique Centrale	173 880 238	5 468	7 082	12 550	5 427	99	5 164	95	1 305	25	845	16	7 054	158	2,2	67	48

	Pays ayant atteint le niveau minimum des 2 principaux indicateurs
	Pays ayant atteint le niveau minimum pour 1 seul indicateur
	Pays n'ayant atteint le niveau minimum pour aucun des 2 indicateurs

CAS CONFIRMES DE ROUGEOLE AU COURS DES 3 DERNIERS MOIS, 09/12/2015-08/03/2016

DISTRICTS AYANT FRANCHI LE SEUIL* DE L'EPIDEMIE DE ROUGEOLE AU COURS DES 3 DERNIERS MOIS, 09/12/2015-08/03/2016

Activités en cours

- **Appui à la riposte à l'épidémie de fièvre jaune en Angola**

- **Appui à la préparation de la 6è édition de la SAV en Afrique centrale prévue du 24 au 30 avril 2016**

- **Appui à la préparation de la riposte de PVDV de type 2 en RDC**

Activités d'éradication de la poliomyélite (IEP)

République Démocratique du Congo

Mise à jour du 15 avril 2016

Points saillants, 15 avril 2016

Situation PVS

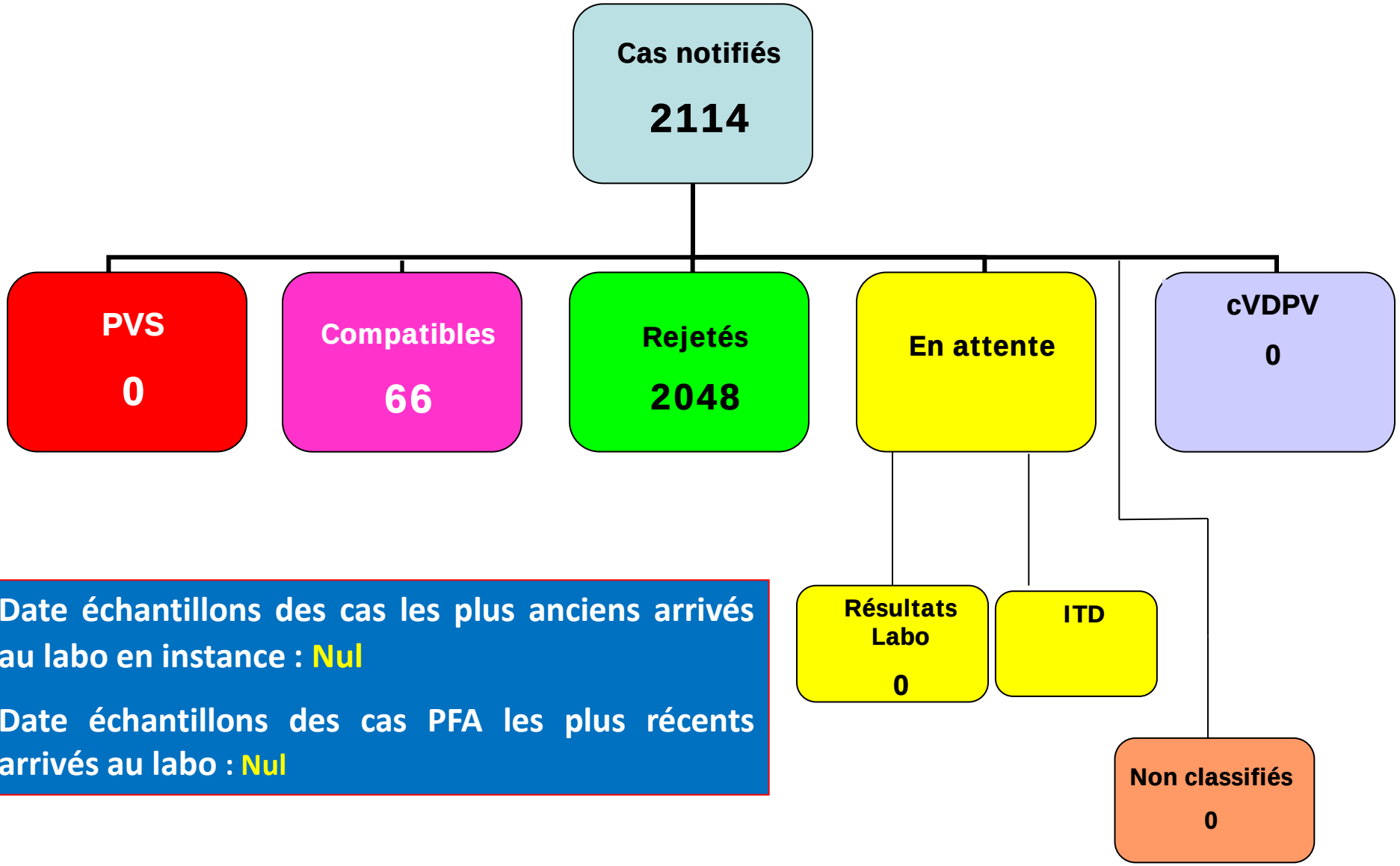
- **Date de début paralysie du dernier cas de PVS : 20 décembre 2011**
- **En 2010 : 100 cas et en 2011 : 93 cas tous du type 1**

- **Nouveaux cas PVS à ce jour : 0 cas**
- **Zones de santé ayant notifié les cas de PFA en 2016 : 266**
- **Taux de PFA NP en 2016 : 3,1**
- **% de cas de PFA avec deux selles dans 14 jours en 2016 : 89%**
- **% provinces ayant atteint 2 indicateurs en 2016 : 93%**
- Date du dernier passage des AVS dans la zone du dernier cas de PVS: **14/04/2016**

Situation cVDPV

- **De 2010 à 2012, 49 cas notifiés;**
- **Date de début paralysie du dernier cas de cVDPV : 04 avril 2012**

Classification des cas de PFA notifiés, 31 décembre 2015 (màj 15 avril 2016)



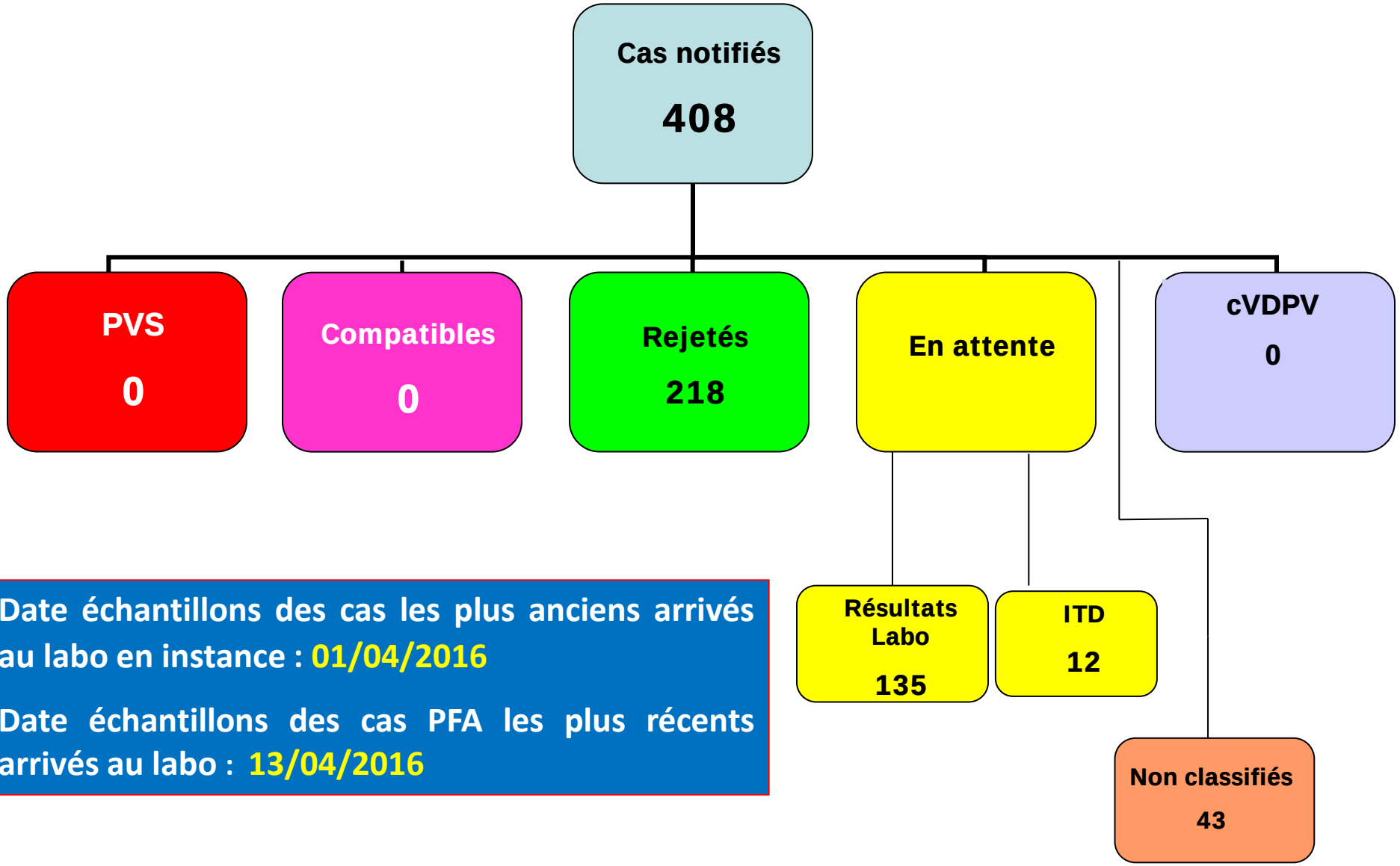
Date échantillons des cas les plus anciens arrivés au labo en instance : Nul

Date échantillons des cas PFA les plus récents arrivés au labo : Nul

Distribution des cas compatibles classifiés, 2015

Province	Nombre Cas compatibles
Bandundu	3
Bas-Congo	1
Equateur	**8**
Kasaï-Occidental	6
Kasaï-Oriental	**9**
Katanga	**7**
Kinshasa	5
Maniema	2
Nord-Kivu	**13**
Orientale	**7**
Sud-Kivu	5
RDC	**66**

Classification des cas de PFA notifiés, 15 avril 2016



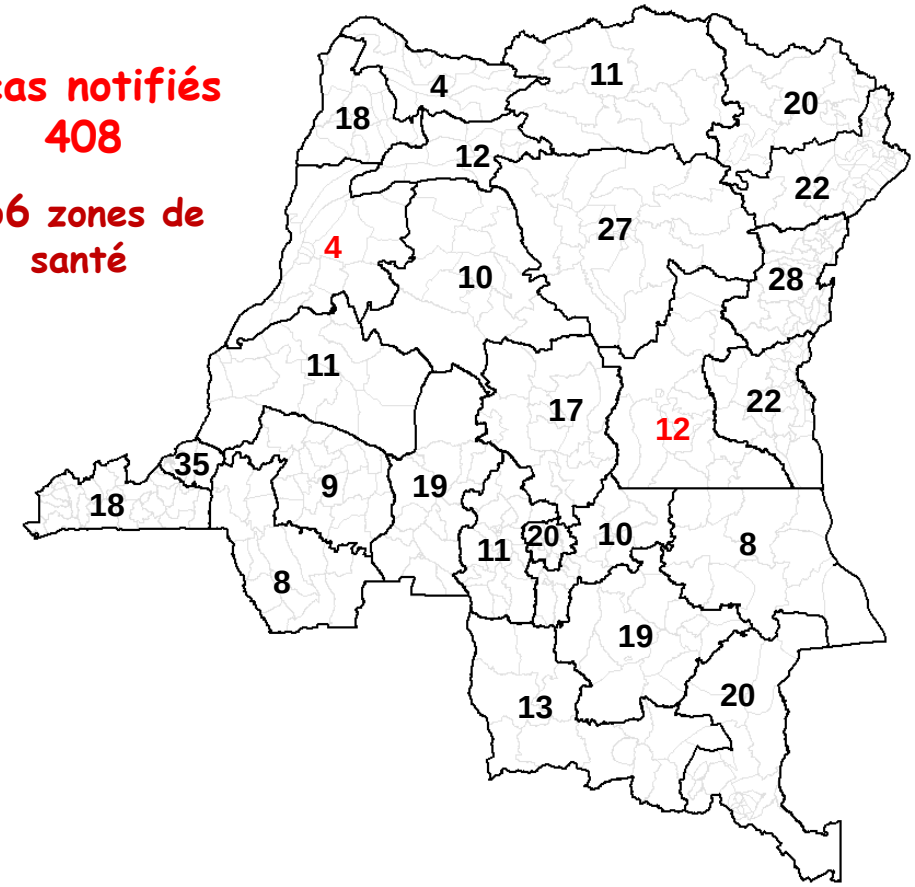
Date échantillons des cas les plus anciens arrivés au labo en instance : 01/04/2016

Date échantillons des cas PFA les plus récents arrivés au labo : 13/04/2016

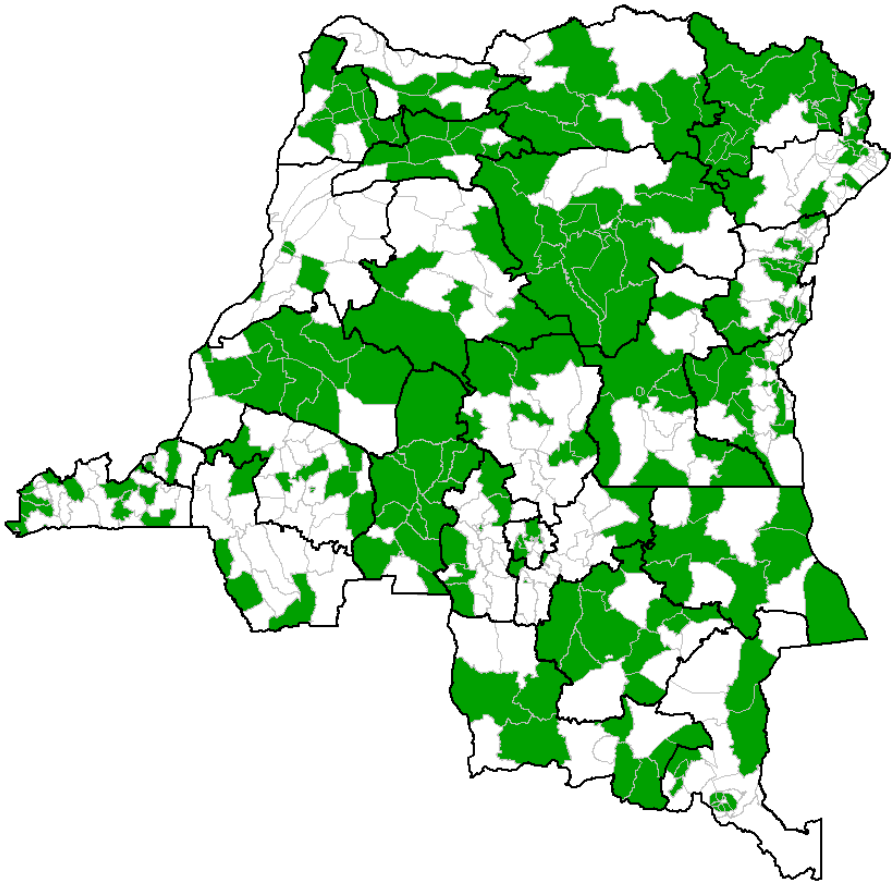
Zone de Santé ayant notifié au moins un cas de PFA, 01 janvier – 15 avril 2016

#cas notifiés
408

266 zones de santé



Chiffre en rouge signifie pas de nouveaux cas depuis le dernier SITREP



ZS ayant notifié

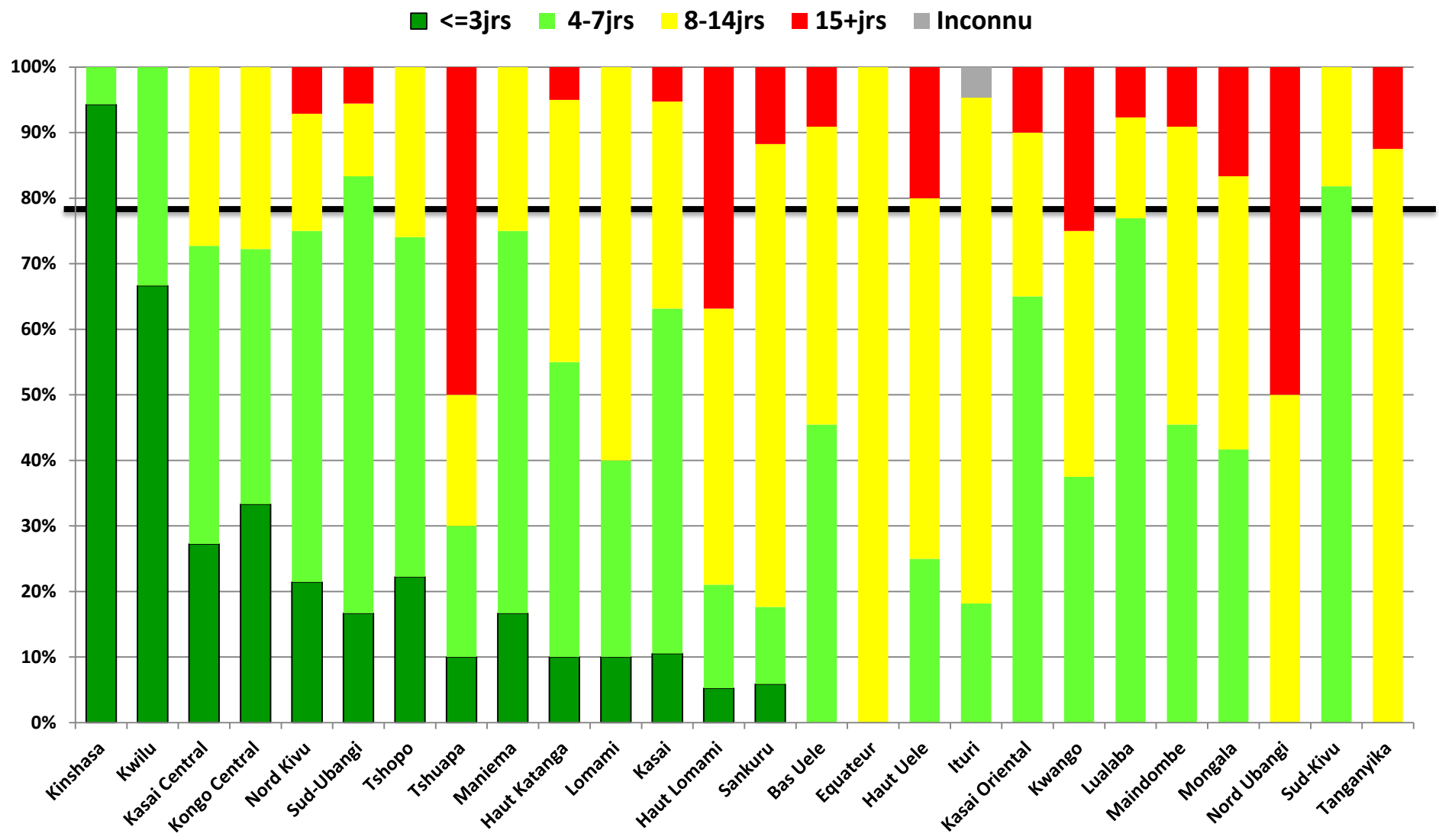
ZS silencieuse

Indicateurs de performance de la surveillance des PFA par province en 2016, 1er au 15 avril 2016

Province	PFA attendus	Total cas PFA notifiés	PFA <15 ans	Taux PFA N-P annualisé pop<15ans	PFA avec 2 selles <=14	% Cas PFA adéquats		PFA investigués <=48h		Délai moyen de transport des échantillons	PVS	cVDPV	Compatible	PFA avec résultats	Taux Entero-NP	% des zones silencieuses	% des cas Inadéquats avec Résultats de suivi au 60ème jrs
					(%)	[n]	%	nbre	(%)		(n)	(n)	(n)	[n]		(%)	
Bas Uele	6	11	11	6,8	91%	10	91%	10	91%	9	0	0	0	7	14	36%	NA
Equateur	11	4	4	1,3	100%	0	0%	4	100%	13	0	0	0	4	0	78%	50%
Haut Katanga	24	20	19	2,9	95%	16	80%	19	95%	7	0	0	0	14	14	48%	0%
Haut Lomami	18	19	16	3,2	95%	13	68%	19	100%	14	0	0	0	12	17	38%	0%
Haut Uele	9	20	18	7,7	90%	16	80%	19	95%	11	0	0	0	9	0	8%	0%
Ituri	27	22	21	2,9	86%	18	82%	21	95%	8	0	0	0	15	0	64%	0%
Kasai	21	19	19	3,3	84%	12	63%	18	95%	7	0	0	0	14	21	22%	0%
Kasai Central	22	11	11	1,9	100%	9	82%	9	82%	6	0	0	0	10	10	73%	NA
Kasai Oriental	23	20	20	3,2	80%	14	70%	20	100%	7	0	0	0	15	20	37%	0%
Kinshasa	44	35	31	2,6	91%	29	83%	33	94%	1	0	0	0	32	9	40%	50%
Kongo Central	18	18	16	3,2	100%	16	89%	16	89%	5	0	0	0	14	21	52%	100%
Kwango	12	8	6	1,9	100%	7	88%	7	88%	10	0	0	0	4	0	71%	NA
Kwilu	24	9	7	1,1	78%	5	56%	9	100%	4	0	0	0	8	0	67%	0%
Lomami	19	10	10	2,0	100%	9	90%	10	100%	9	0	0	0	6	0	63%	NA
Lualaba	11	13	13	4,5	85%	9	69%	12	92%	8	0	0	0	7	14	43%	0%
Maindombe	9	11	11	4,6	82%	5	45%	11	100%	10	0	0	0	8	0	36%	0%
Maniema	12	12	11	3,5	100%	10	83%	12	100%	6	0	0	0	9	0	50%	NA
Mongala	12	12	12	3,8	100%	11	92%	10	83%	10	0	0	0	5	0	33%	0%
Nord Kivu	39	28	28	2,6	89%	21	75%	24	86%	6	0	0	0	16	0	44%	100%
Nord Ubangi	7	4	4	2,1	100%	4	100%	4	100%	15	0	0	0	2	50	64%	NA
Sankuru	9	17	17	6,7	94%	16	94%	14	82%	10	0	0	0	12	25	56%	100%
Sud-Kivu	33	22	21	2,4	91%	20	91%	20	91%	6	0	0	0	15	7	53%	100%
Sud-Ubangi	14	18	18	4,7	56%	10	56%	13	72%	6	0	0	0	10	0	31%	33%
Tanganyika	14	8	8	2,1	75%	1	13%	8	100%	12	0	0	0	4	25	36%	0%
Tshopo	15	27	25	6,1	81%	21	78%	23	85%	6	0	0	0	17	24	26%	0%
Tshuapa	10	10	10	3,7	100%	5	50%	8	80%	14	0	0	0	4	25	58%	0%
	464	408	387	3,1	89%	307	75%	373	91%	8	0	0	0	273	11	49%	22%

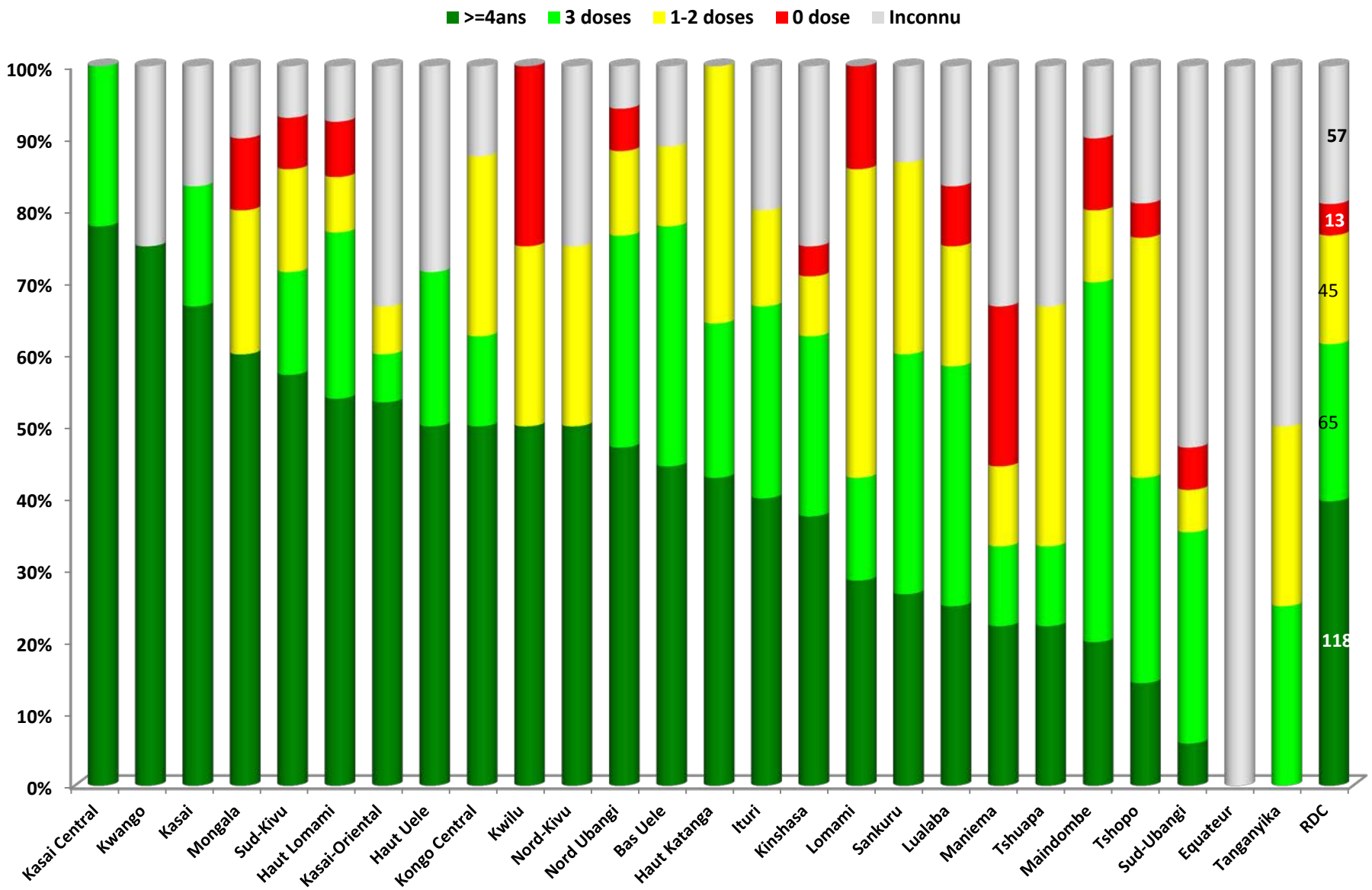
DELAIS EN JOURS ENTRE LA COLLECTE DU 2è ECHANTILLON DES SELLES PFA ET LA RECEPTION AU LABORATOIRE,

1er janvier – 15 avril 2016

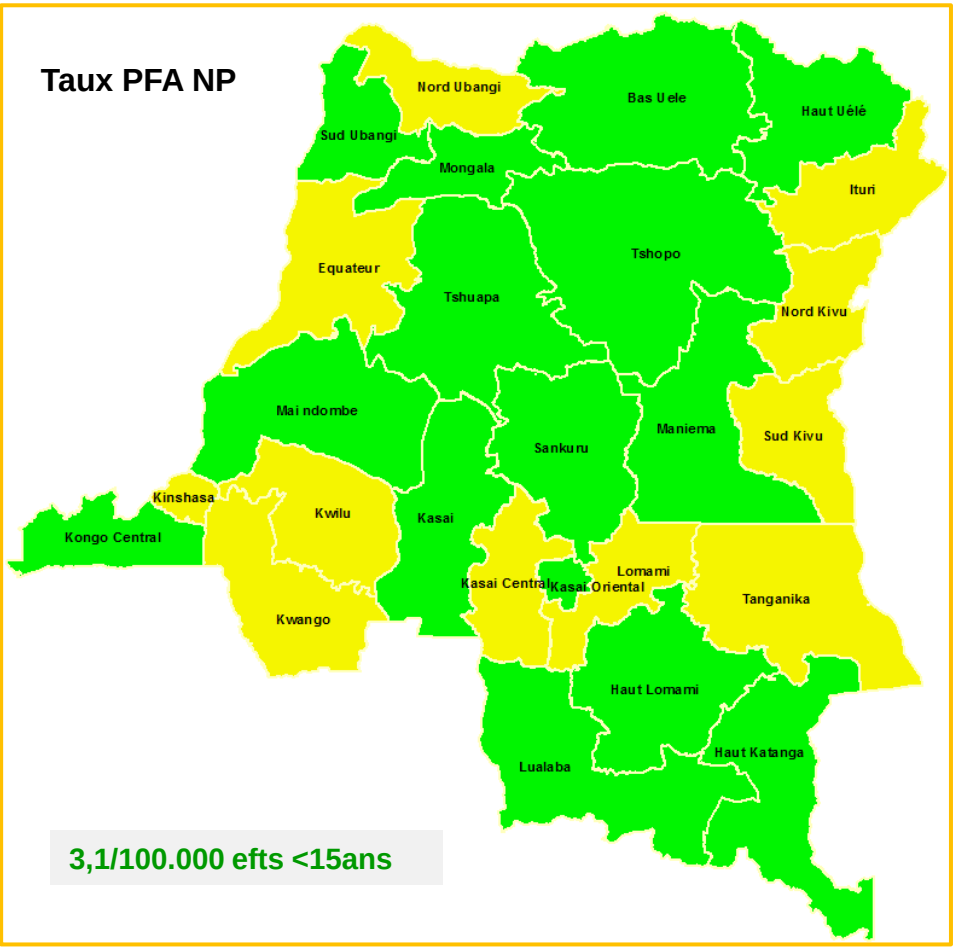


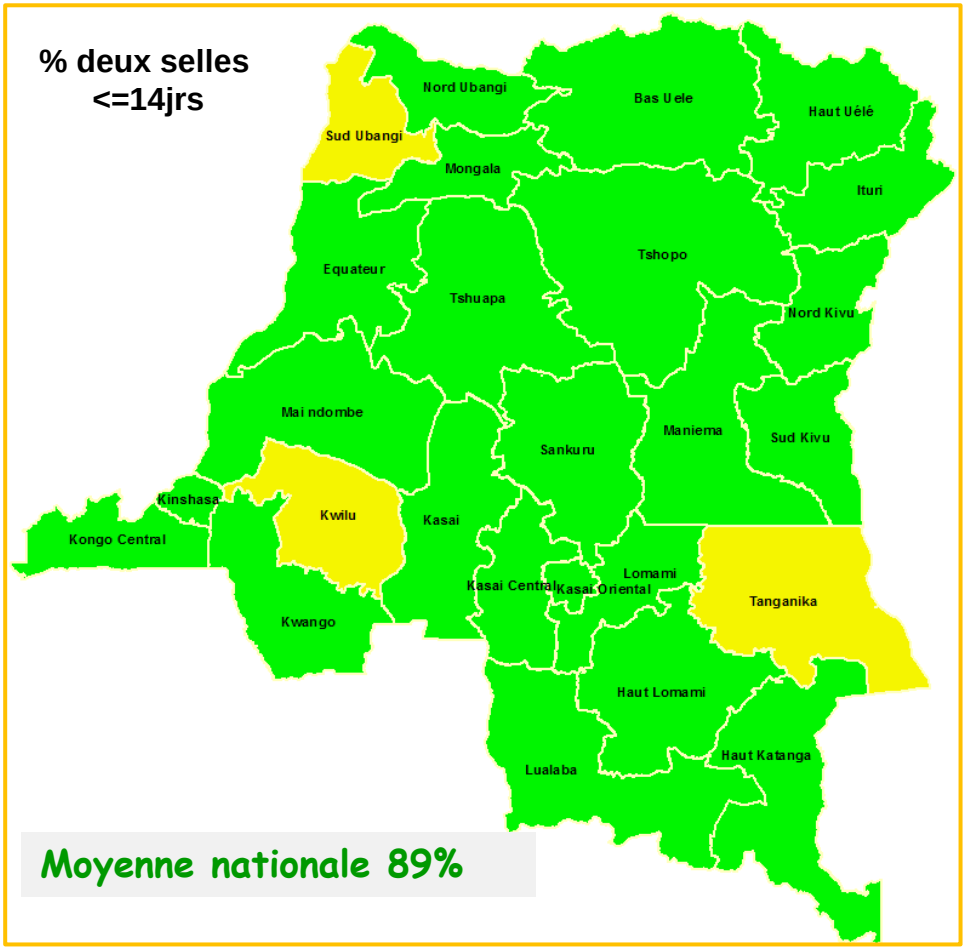
Délai moyen au niveau national : 8 jours

Statut vaccinal des cas de PFA de 6 à 59 mois notifiés par province, 01/01/2016 – 15/04/2016



Performances de principaux indicateurs de surveillance des PFA par province, 15 avril 2016





Taux PFA NP

< 1

1,0 – 2,9

>= 3

ZS silencieuse

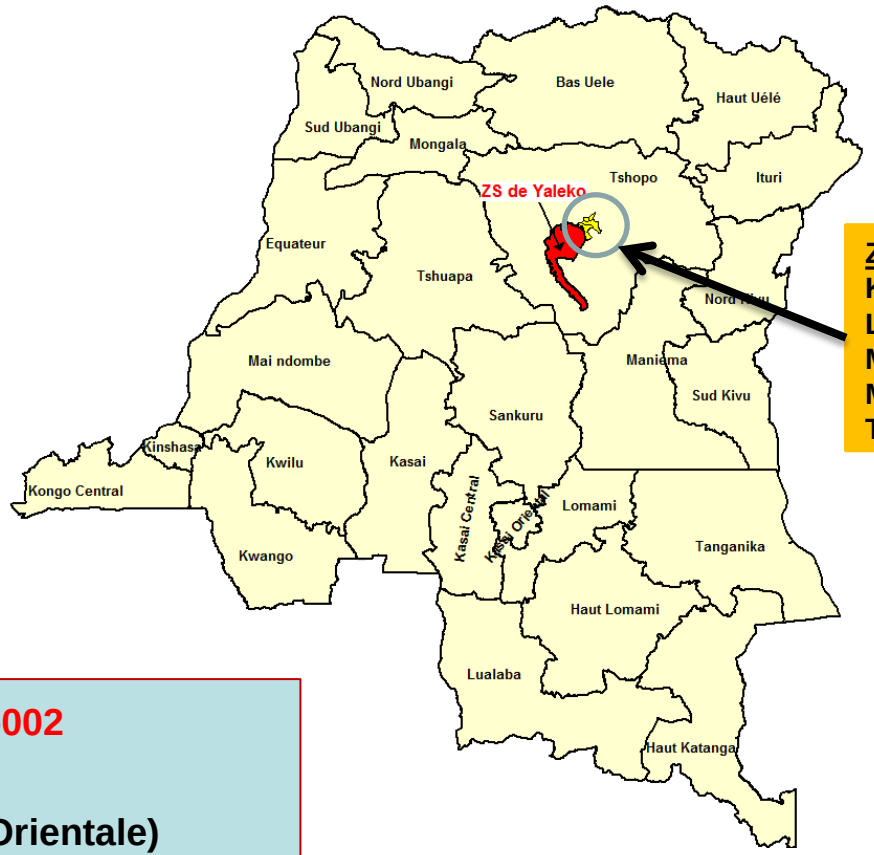
% deux selles <=14jrs

< 50%

50% – 79%

>= 80%

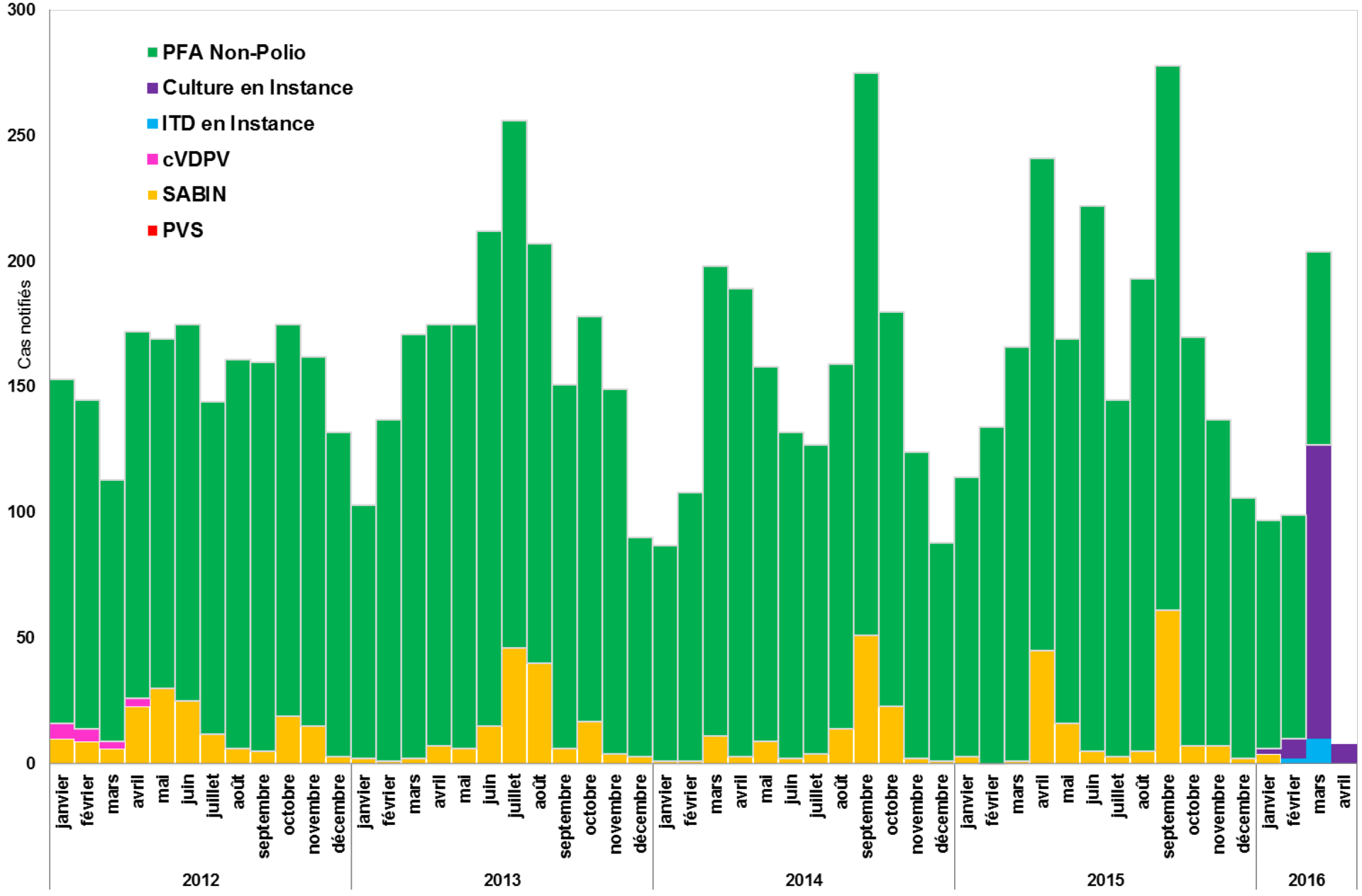
Zone de Santé de Yaleko (cas de VDPV confirmé), province de la Tshopo, 01 avril 2016



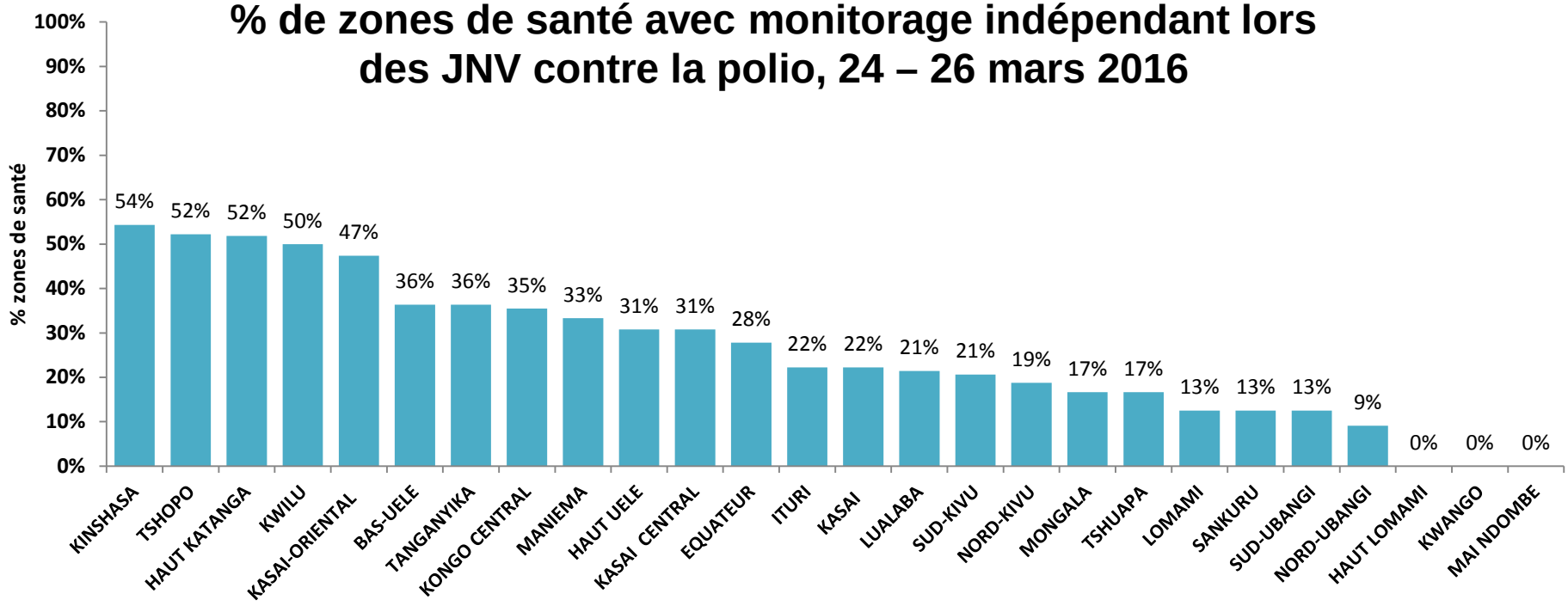
- Epid Number : RDC-TSH-YLK-16-002
- Zone de santé : Yaleko
- Province : Tshopo (ex. Province Orientale)
- Formation sanitaire proche : AS YATULIA
- Nom de l'enfant : OFONA
- Sexe : Féminin
- Date naissance : 16-11-2013
- Date début paralysie : 13-01-2016
- Nombre doses reçues : Inconnu

Confirmation du cas
par le labo : **01-mars-2016**

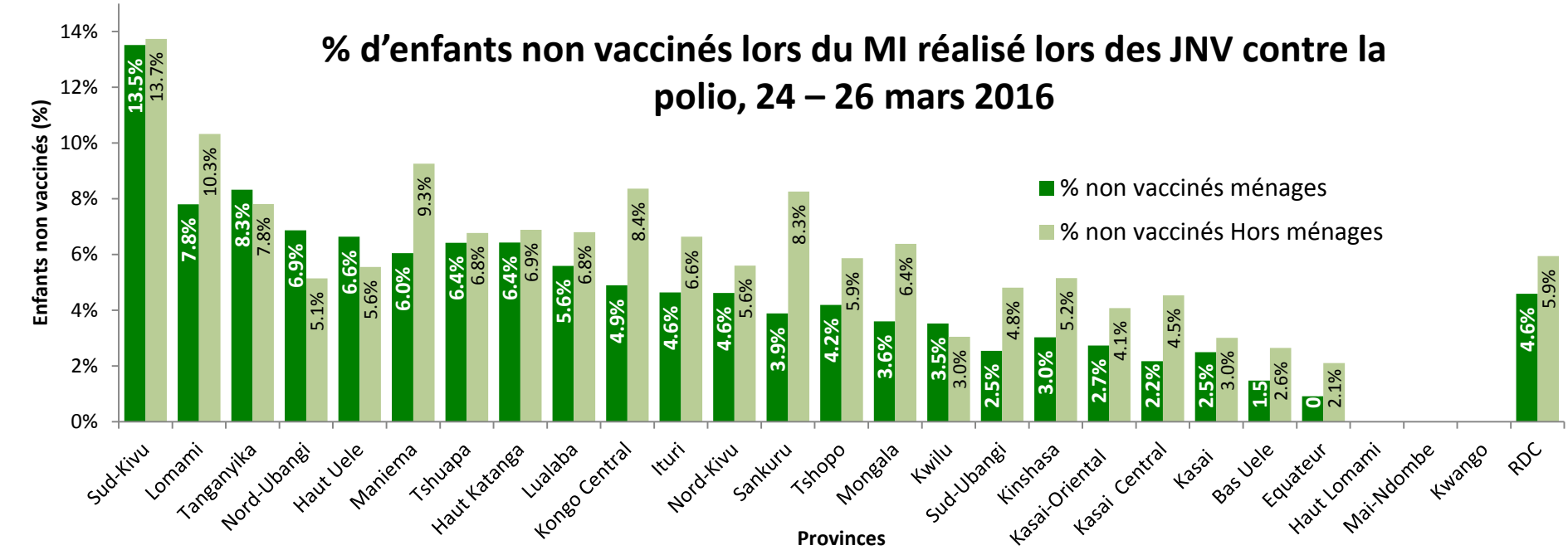
Evolution des cas de PFA selon le mois de notification
1er janvier 2012 – 15 avril 2016



% de zones de santé avec monitorage indépendant lors des JNV contre la polio, 24 – 26 mars 2016

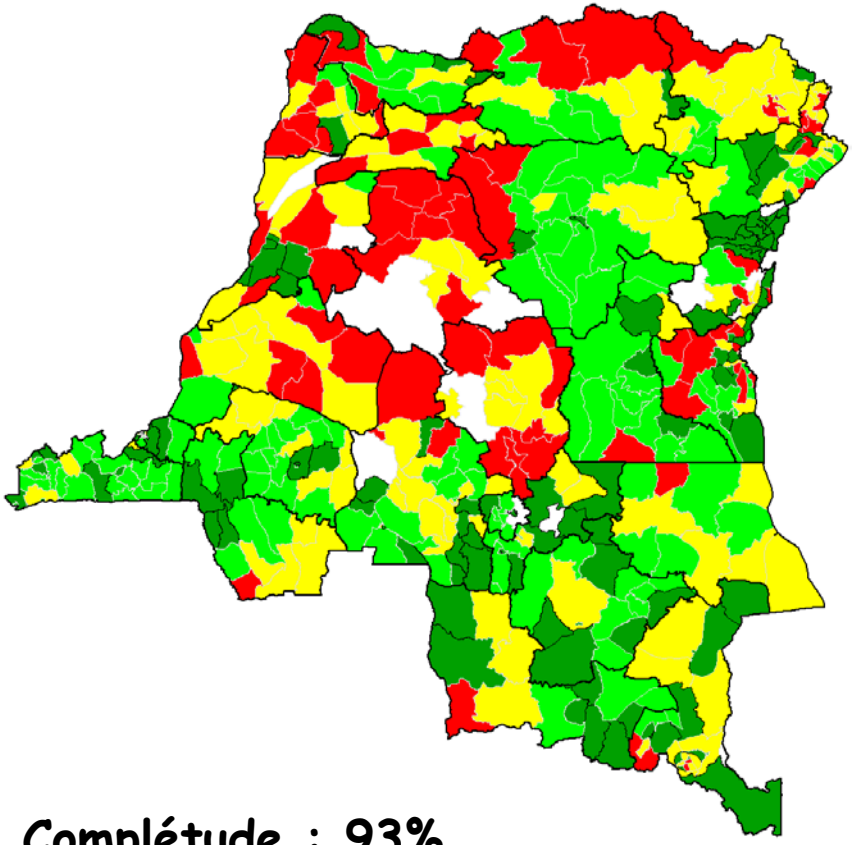


% d'enfants non vaccinés lors du MI réalisé lors des JNV contre la polio, 24 – 26 mars 2016



Couverture Vaccinale en VPO3, janvier-février 2015-2016

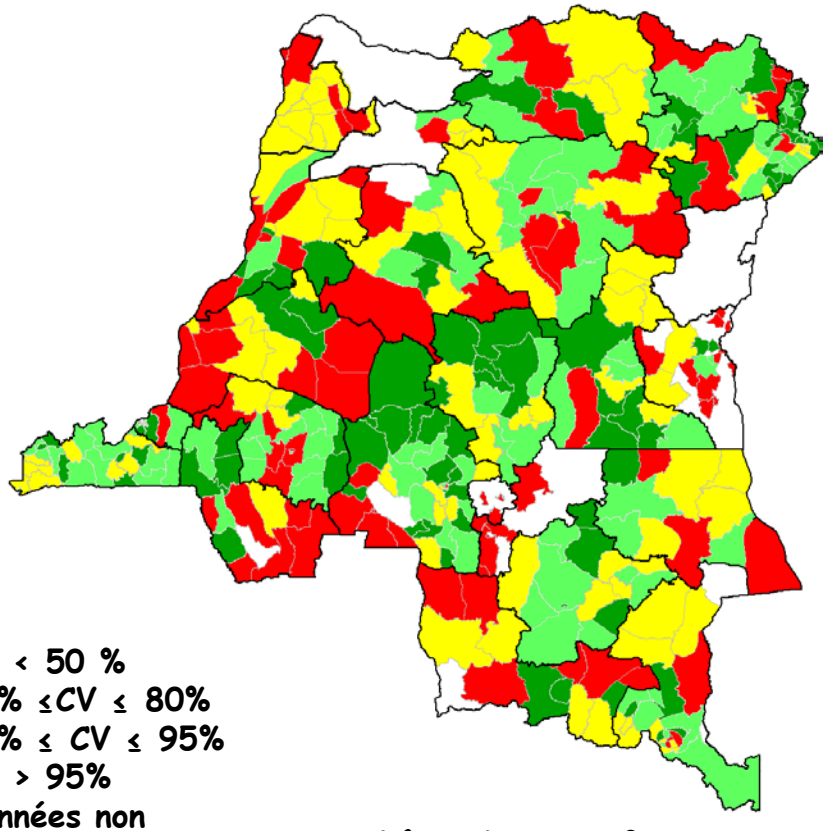
2015



Complétude : 93%
CV : 78%

CV < 50 %
50% ≤CV ≤ 80%
80% ≤ CV ≤ 95%
CV > 95%
Données non disponibles

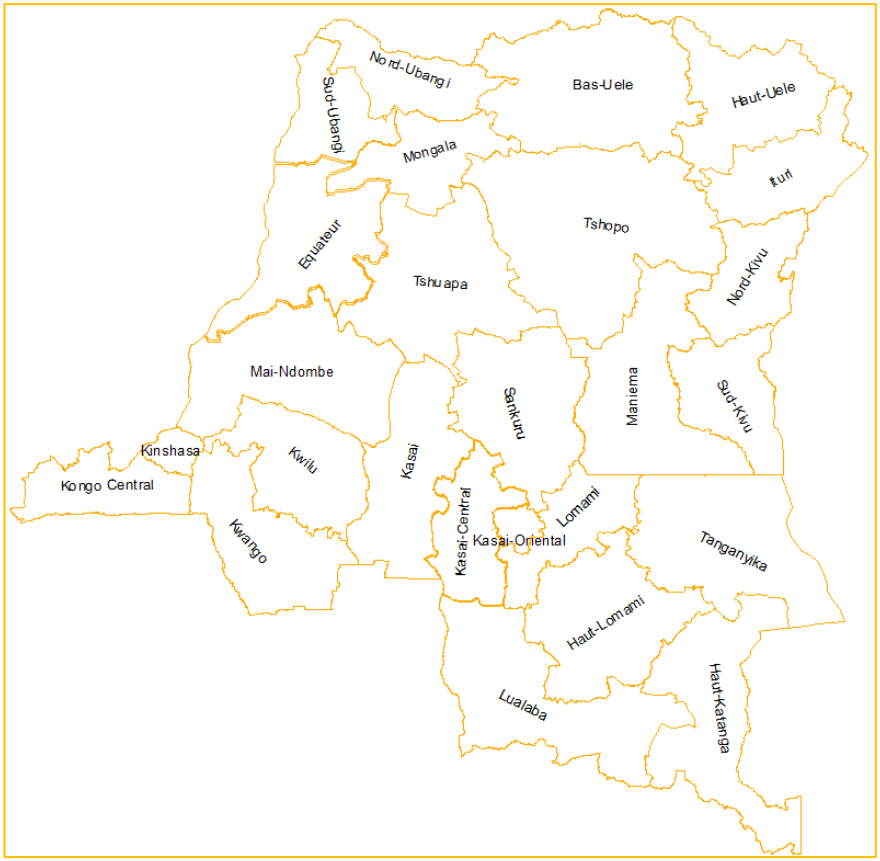
2016



Complétude: 75%
CV : 58%

Population de moins de 15 ans par rapport aux nouvelles provinces			
Ancienne Province	Nouvelle province	Pop moins de 15 ans	Nombre Zones de Santé
Bandundu	Kwango	1 200 755	14
	Kwilu	2 401 667	24
	Maindombe	886 496	14
		4 488 918	52
Bas-Congo	Kongo Central	1 829 365	31
		1 829 365	**31**
Equateur	Equateur	1 143 480	18
	Mongala	1 170 046	12
	Nord Ubangi	698 178	11
	Sud-Ubangi	1 417 957	16
	Tshuapa	992 680	12
		5 422 341	**69**
Kasai-Occidental	Kasai	2 128 702	18
	Kasai Central	2 199 911	26
		4 328 612	**44**
Kasai-Oriental	Kasai Oriental	2 321 355	19
	Lomami	1 863 864	16
	Sankuru	935 884	16
		5 121 103	**51**
Katanga	Haut Katanga	2 430 890	27
	Haut Lomami	1 833 780	16
	Lualaba	1 073 256	14
	Tanganyika	1 431 273	11
		6 769 199	**68**
Kinshasa	Kinshasa	4 377 941	35
		4 377 941	**35**
Maniema	Maniema	1 179 099	18
		1 179 099	**18**
Nord-Kivu	Nord Kivu	3 933 495	32
		3 933 495	**32**
Orientale	Bas Uele	601 272	11
	Haut Uele	867 514	13
	Ituri	2 669 428	36
	Tshopo	1 530 041	23
		5 668 255	**83**
Sud-Kivu	Sud-Kivu	3 272 193	34
		3 272 193	**34**
Total RDC		**46 390 521**	**517**

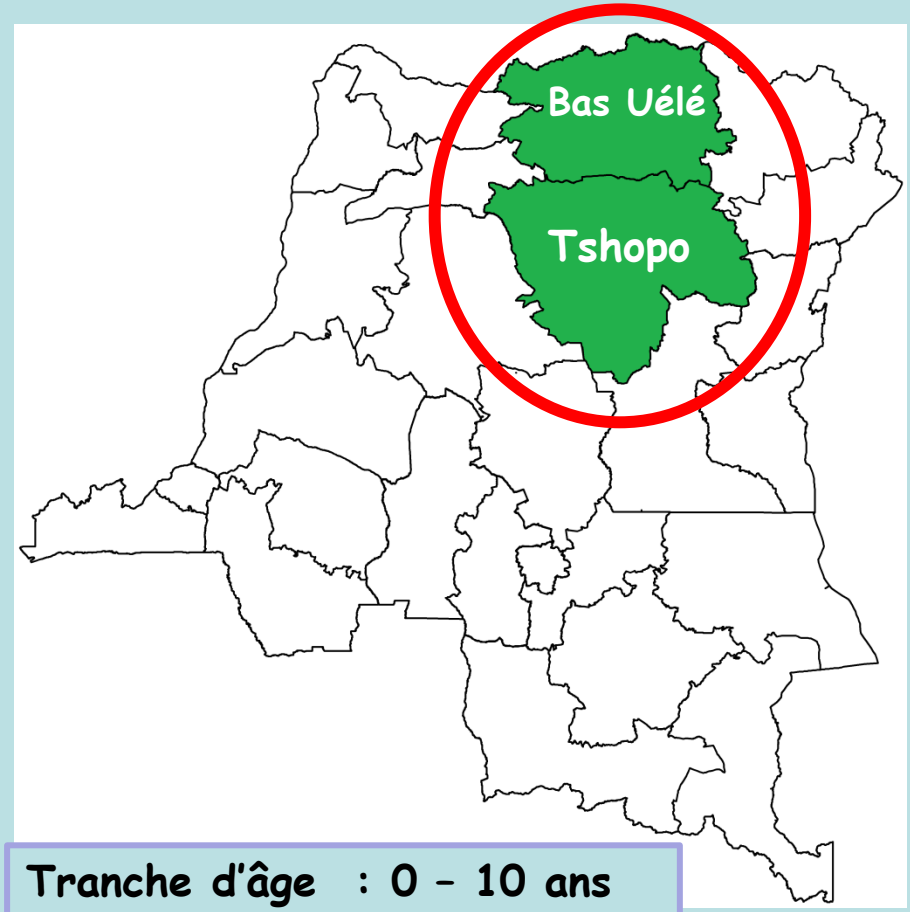
Découpage administratif de la RDC



Activités planifiées / en cours

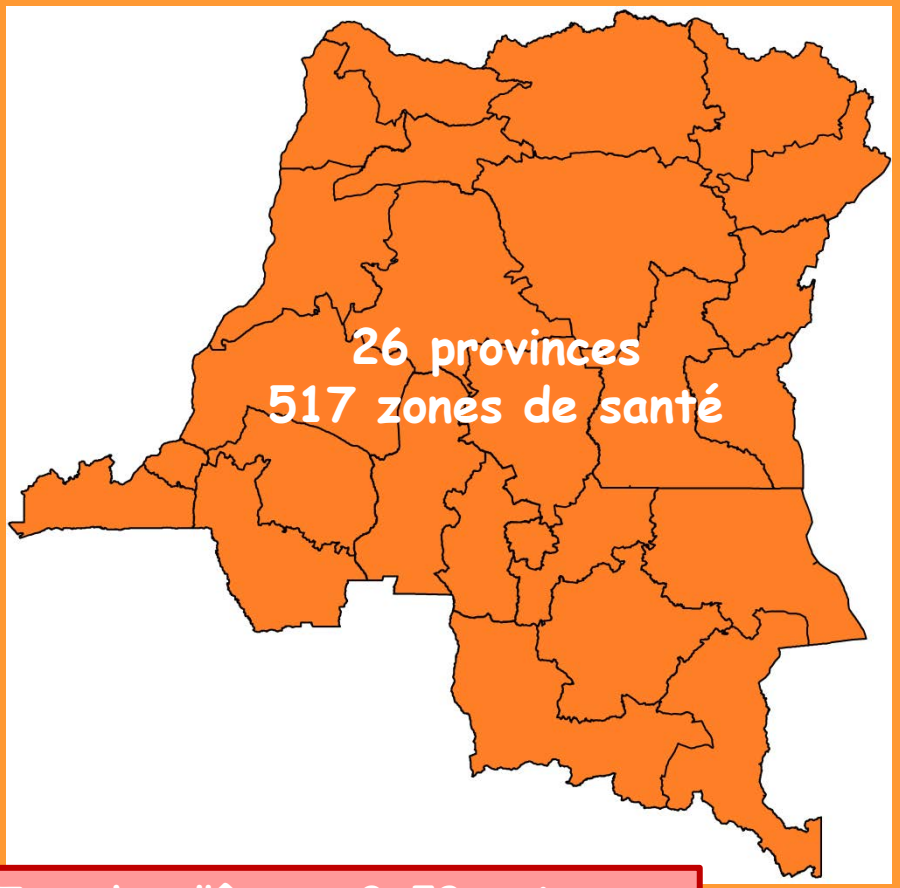
Activités planifiées/en cours

Riposte au cas de VDPV de la ZS YALEKO
25 - 27 avril 2016



Tranche d'âge : 0 – 10 ans
Population cible : 1.428.182
Nombre ZS : 34
Type vaccin : VPOt

JNV- POLIO
14 – 16 avril 2016



Tranche d'âge : 0-59 mois
Population cible : 18.116.773
Nombre ZS : 517
Type vaccin : VPOt

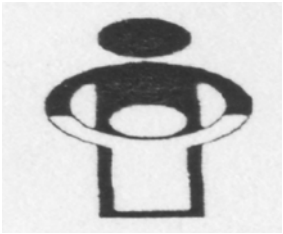
Activités planifiées/en cours

- **Suivi du déroulement des Journées nationales de vaccination (JNV) dans les provinces du 14 au 16 avril 2016 ;**

- **Mission d'investigation des cas de fièvre en cours depuis le 8 avril 2016 dans la province du Kongo Central.**

Performances de la surveillance des maladies évitables par la vaccination

Revue à mi parcours du PEV, 2016



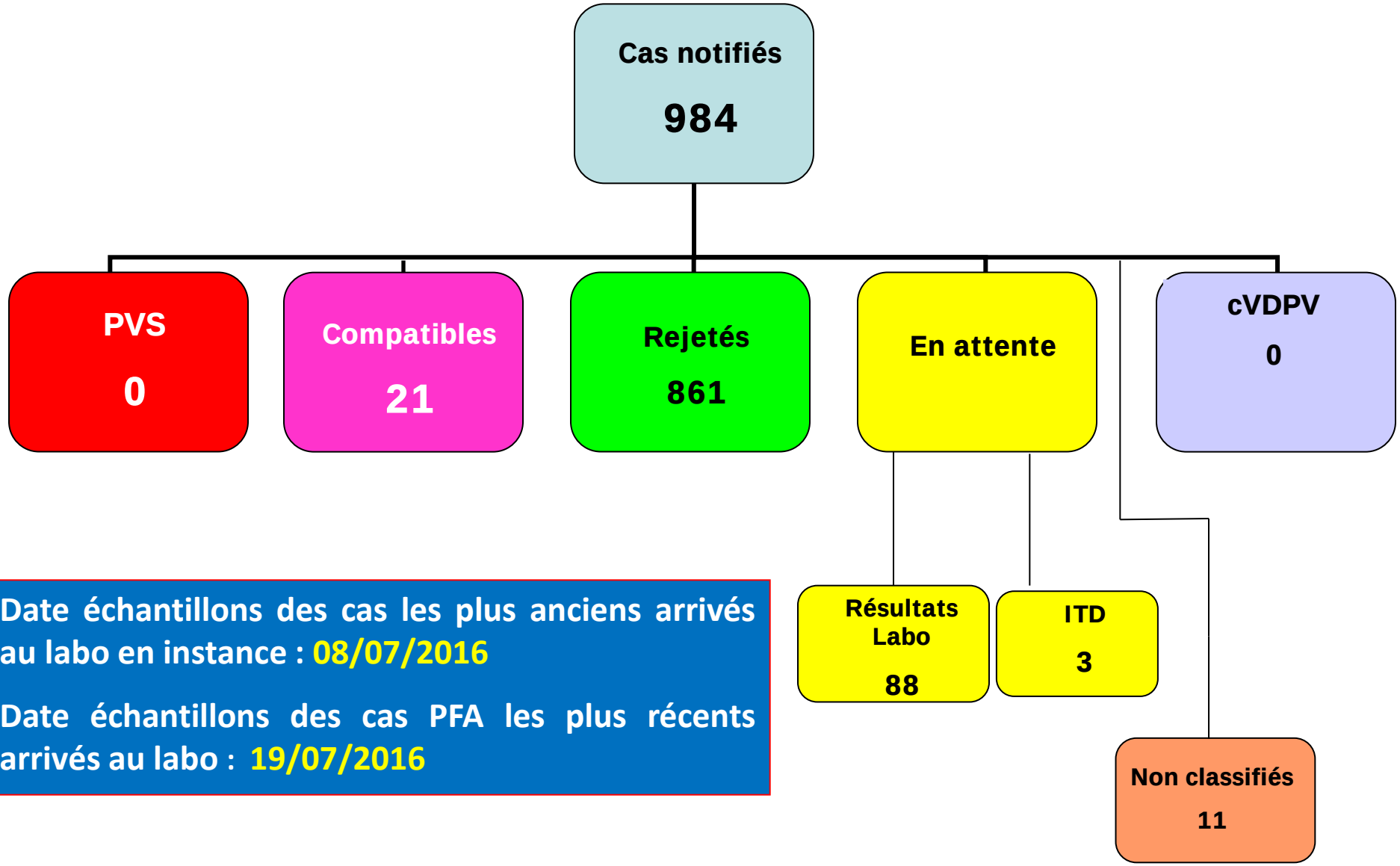
Plan

- PFA
- Fièvre jaune
- Rougeole
- TNN
- Surveillance des MAPI
- Sites en sites sentinelles: Gastroentérites infantiles à Rotavirus

- **Problèmes prioritaires**
- **Perspectives Second semestre 2016**

SURVEILLANCE DES PFA

Classification des cas de PFA notifiés, 22 juillet 2016



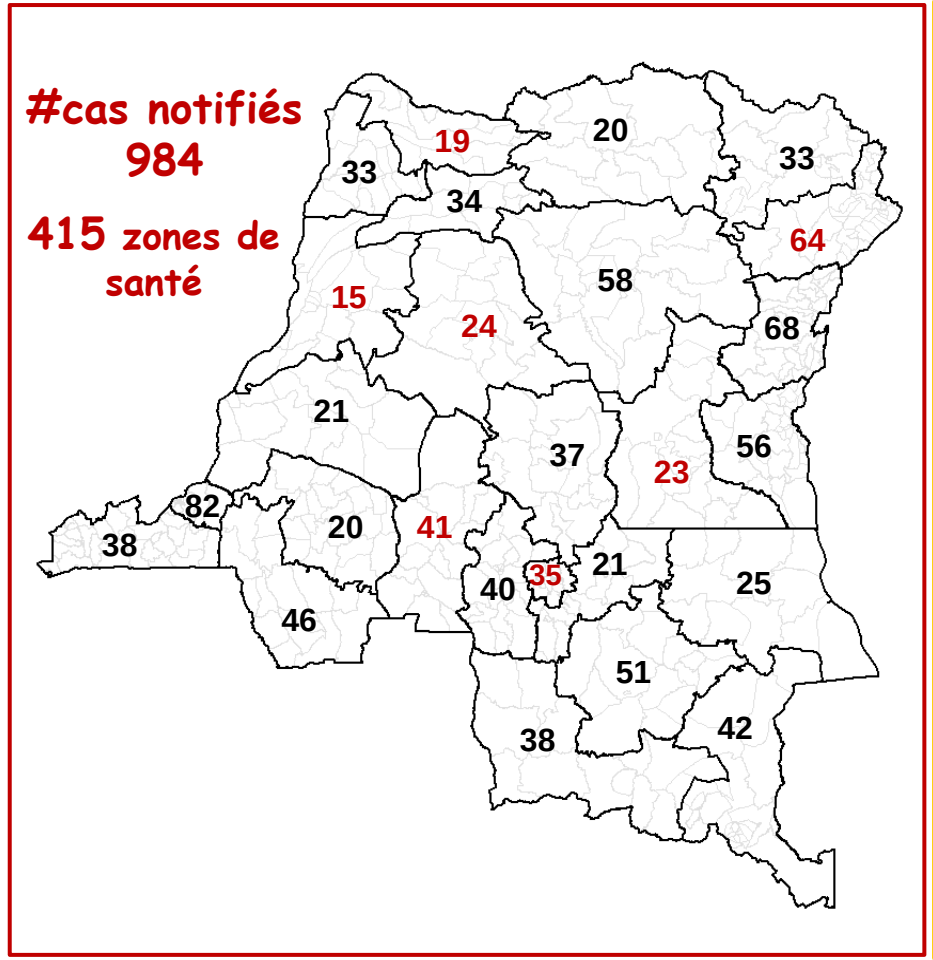
Date échantillons des cas les plus anciens arrivés au labo en instance : 08/07/2016

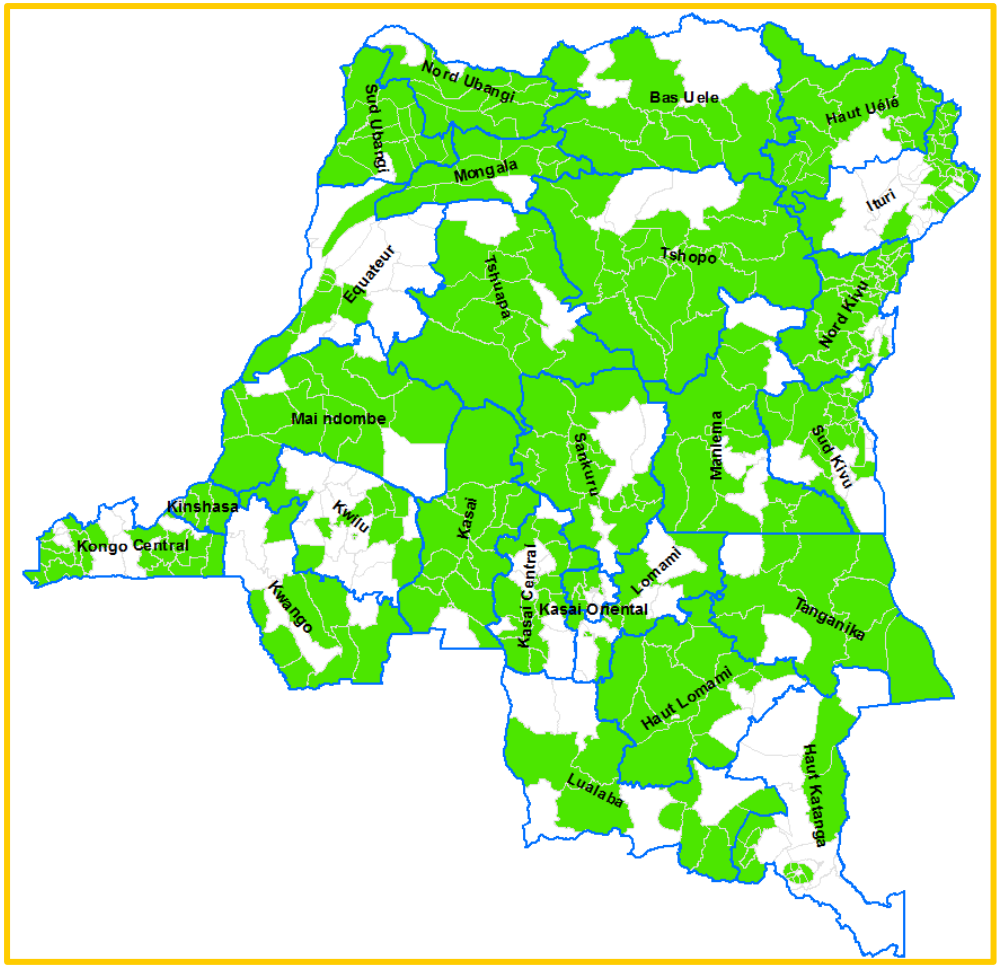
Date échantillons des cas PFA les plus récents arrivés au labo : 19/07/2016

SUIVI DE LA NOTIFICATION DES CAS DE PFA, LEUR VALIDATION PAR PROVINCE EN 2016

Ancienne Provinces	Provinces	Cas de PFA par semaine épid.																									Total cumulé Cas de PFA	Validation des Cas de PFA *(cumulés)*			
		S1	*S 2*	*S3*	*S4*	*S5*	*S6*	*S7*	*S8*	*S9*	*S10*	*S11*	*S12*	*S13*	*S14*	*S15*	*S16*	*S17*	*S18*	*S19*	*S20*	*S21*	*S22*	*S23*	*S24*	*S25*		Nbre de cas vus pour validation	% Cas vus pour validation	Nbre confirmés PFA après validation	% cas confirmés PFA
Bandundu	KWANGO	0	0	2	0	0	0	0	0	2	0	0	1	1	2	0	1	0	0	2	0	2	1	11	3	4	**32**	27	**84,4%**	23	**85,2%**
	KWILU	0	0	0	0	1	0	1	1	1	0	1	0	4	0	0	0	0	0	0	2	0	0	0	1	0	**12**	7	**58,3%**	7	**100,0%**
	MAI NDOMBE	0	0	1	0	0	1	4	2	1	2	0	0	3	0	1	1	1	0	0	0	0	0	1	1	0	**19**	15	**78,9%**	15	**100,0%**
Bas Congo	KONGO CENTRAL	0	2	0	2	4	2	0	0	0	1	0	1	4	2	0	4	1	3	1	3	0	2	2	0	1	**36**	22	**61,1%**	22	**100,0%**
Equateur	EQUATEUR	0	0	0	1	0	2	0	0	1	0	0	0	6	0	0	1	1	0	0	0	0	1	1	0	1	**15**	12	**80,0%**	12	**100,0%**
	MONGALA	0	0	0	0	0	1	0	0	1	0	0	4	4	2	8	4	0	0	1	1	2	0	0	1	0	**29**	27	**93,1%**	27	**100,0%**
	NORD-UBANGI	0	0	1	2	0	0	0	0	0	0	1	0	1	0	4	3	1	0	1	0	3	0	1	1	2	**21**	17	**81,0%**	17	**100,0%**
	SUD-UBANGI	0	0	0	1	2	1	0	3	1	1	3	5	1	0	3	5	1	0	1	0	0	0	1	0	0	**29**	13	**44,8%**	13	**100,0%**
	TSHUAPA	0	0	1	1	1	0	0	0	0	1	2	0	3	1	3	3	1	2	0	1	0	3	2	0	1	**26**	22	**84,6%**	22	**100,0%**
Kasaï Occidental	KASAI CENTRAL	1	0	1	0	1	0	1	1	0	1	0	0	5	1	4	7	1	3	0	1	2	4	0	2		**36**	25	**69,4%**	21	**84,0%**
	KASAI	0	0	3	2	0	2	1	1	3	1	1	2	5	1	0	4	2	0	0	2	1	0	1	2		**34**	29	**85,3%**	29	**100,0%**
Kasaï Oriental	KASAI-ORIENTAL	0	0	1	0	2	0	3	2	2	1	0	1	6	2	1	0	0	2	1	3	1	0	1	0	0	**29**	28	**96,6%**	27	**96,4%**
	SANKURU	0	1	2	1	2	1	2	1	1	1	0	4	2	0	4	9	1	1	0	0	0	1	0	1	3	**38**	31	**81,6%**	30	**96,8%**
	LOMAMI	0	0	2	2	1	0	0	0	1	0	1	0	1	3	0	5	1	0	2	0	1	0	0	0	2	**22**	14	**63,6%**	12	**85,7%**
Katanga	HAUT KATANGA	0	1	1	0	4	3	2	0	1	0	0	2	5	1	0	4	2	0	0	0	2	2	2	1	5	**38**	26	**68,4%**	26	**100,0%**
	HAUT LOMAMI	0	0	1	1	1	2	0	1	1	2	2	0	1	6	1	2	9	4	3	2	2	0	3	1	1	**46**	44	**95,7%**	43	**97,7%**
	LUALABA	0	0	0	0	0	0	0	0	0	0	1	4	2	7	0	0	1	0	5	0	0	0	5	1	0	**26**	22	**84,6%**	22	**100,0%**
	TANGANYIKA	0	0	1	0	0	1	0	0	0	0	0	0	0	3	3	4	4	0	2	2	0	0	0	2	0	**22**	19	**86,4%**	19	**100,0%**
Kinshasa	KINSHASA	0	2	3	1	0	4	4	0	2	1	2	5	9	2	4	6	1	7	2	1	2	0	10	2	3	**73**	58	**79,5%**	58	**100,0%**
Maniema	MANIEMA	0	0	2	0	2	0	0	1	1	1	1	3	2	0	0	2	0	2	1	0	0	2	1	1	1	**23**	17	**73,9%**	17	**100,0%**
Nord Kivu	NORD-KIVU	0	1	1	0	2	1	0	0	0	11	7	3	8	6	1	9	4	4	2	2	2	1	5	3	1	**74**	68	**91,9%**	68	**100,0%**
Province Orientale	BAS UELE	0	0	0	1	0	1	0	0	1	1	2	2	1	1	1	0	2	1	1	1	2	0	0	0	0	**18**	17	**94,4%**	17	**100,0%**
	HAUT UELE	0	0	0	0	2	0	1	1	1	3	0	4	6	5	1	0	2	0	0	0	2	2	0	3	0	**33**	31	**93,9%**	31	**100,0%**
	ITURI	0	2	0	0	0	4	1	0	0	0	7	7	4	4	5	12	2	2	1	4	0	0	3	2	0	**60**	54	**90,0%**	54	**100,0%**
	TSHOPO	1	1	0	4	2	3	0	1	0	3	3	1	5	4	1	6	7	1	0	0	1	0	3	5	0	**52**	47	**90,4%**	47	**100,0%**
Sud Kivu	SUD-KIVU	0	1	1	0	1	1	3	1	1	6	0	1	4	3	4	2	3	2	3	2	7	0	1	0	1	**48**	41	**85,4%**	41	**100,0%**
	TOTAL	**2**	**11**	**24**	**19**	**28**	**30**	**23**	**16**	**22**	**37**	**34**	**50**	**93**	**56**	**49**	**94**	**48**	**34**	**29**	**27**	**32**	**19**	**54**	**33**	**26**	**891**	**733**	**82,3%**	**720**	**98,2%**

Zone de Santé ayant notifié au moins un cas de PFA, 01 janvier – 22 juillet 2016





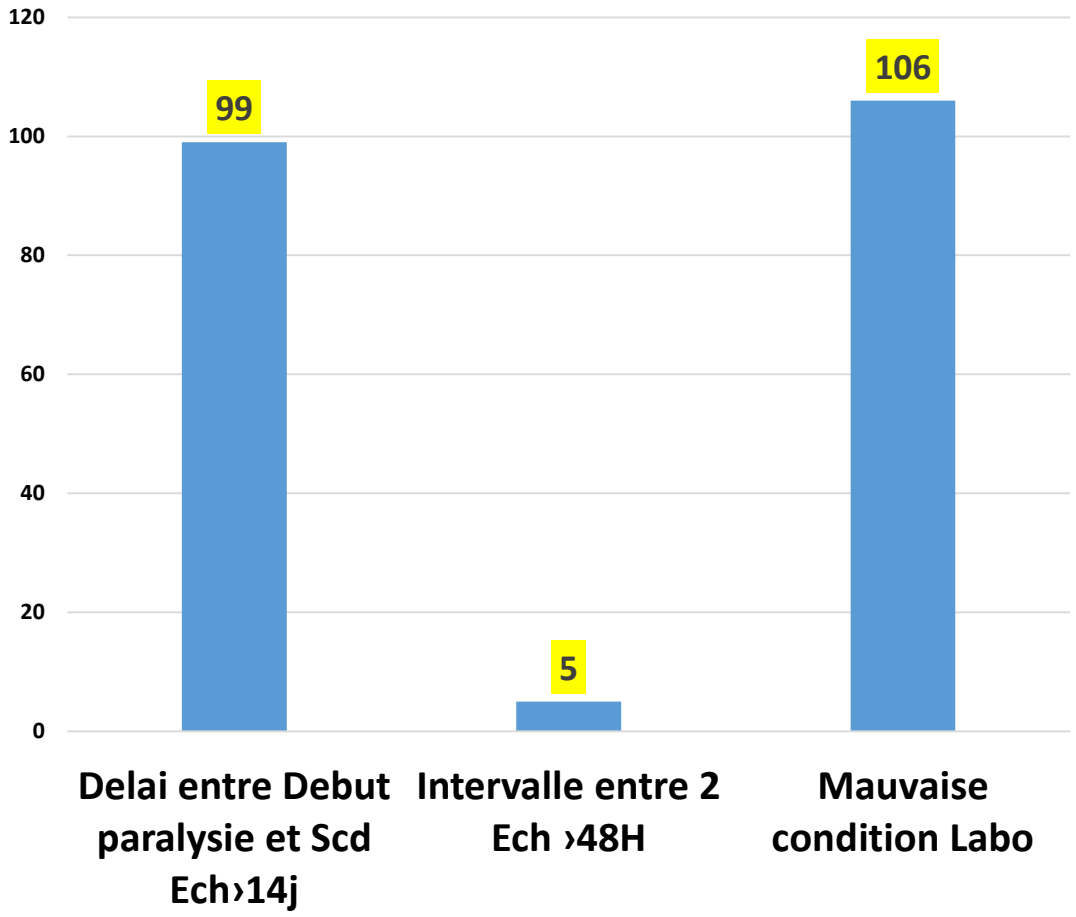
ZS ayant notifié

ZS silencieuse

Indicateurs de performance de la surveillance des PFA par province en 2016, 1er janvier au 22 Juillet 2016

Province	PFA attendus	Total cas PFA notifiés	PFA <15 ans	Taux PFA N-P annualisé pop<15ans	PFA avec 2 selles <=14	% Cas PFA adéquats		PFA investigués <=48h		Délai moyen de transport des échantillons	PVS	cVDPV	Compatible	PFA avec résultats	Taux Entero-NP	% des zones silencieuses	% des cas Inadéquats avec Résultats de suivi au 60ème jrs
					(%)	[n]	%	nbre	(%)		(n)	(n)	(n)	[n]		(%)	
Bas Uele	6	20	20	6,0	95%	19	95%	19	95%	10	0	0	0	19	21	18%	0%
Equateur	11	15	14	2,2	87%	6	40%	13	87%	17	0	0	0	15	7	50%	71%
Haut Katanga	24	42	40	3,0	95%	34	81%	40	95%	7	0	0	0	38	11	33%	50%
Haut Lomami	18	51	44	4,3	92%	35	69%	50	98%	13	0	0	0	45	27	6%	67%
Haut Uele	9	33	30	6,2	94%	28	85%	31	94%	11	0	0	0	32	6	8%	40%
Ituri	27	64	62	4,2	80%	48	75%	61	95%	10	0	0	0	59	8	31%	36%
Kasai	21	41	38	3,2	90%	32	78%	37	90%	7	0	0	0	37	11	0%	67%
Kasai Central	22	40	39	3,2	95%	36	90%	31	78%	6	0	0	0	37	11	27%	25%
Kasai Oriental	23	35	35	2,7	89%	29	83%	34	97%	6	0	0	0	33	18	21%	100%
Kinshasa	44	82	72	2,9	89%	65	79%	80	98%	1	0	0	0	78	12	11%	67%
Kongo Central	18	38	34	3,3	95%	34	89%	34	89%	6	0	0	0	37	24	23%	100%
Kwango	12	46	33	4,9	89%	35	76%	39	85%	9	0	0	0	32	6	36%	67%
Kwilu	24	20	16	1,2	90%	15	75%	18	90%	5	0	0	0	17	0	50%	0%
Lomami	19	21	20	1,9	95%	19	90%	18	86%	7	0	0	0	20	10	38%	100%
Lualaba	11	38	38	6,3	95%	34	89%	37	97%	9	0	0	0	33	6	7%	0%
Maindombe	9	21	21	4,2	90%	10	48%	20	95%	8	0	0	0	20	5	14%	86%
Maniema	12	23	21	3,2	91%	18	78%	21	91%	6	0	0	0	23	4	22%	0%
Mongala	12	34	33	5,1	97%	32	94%	30	88%	7	0	0	0	32	9	8%	50%
Nord Kivu	39	68	66	3,0	88%	53	78%	60	88%	6	0	0	0	62	6	9%	100%
Nord Ubangi	7	19	19	4,9	58%	10	53%	18	95%	18	0	0	0	18	22	0%	29%
Sankuru	9	37	37	7,1	92%	32	86%	32	86%	10	0	0	0	31	13	13%	100%
Sud-Kivu	33	56	54	3,0	91%	48	86%	53	95%	7	0	0	0	52	6	21%	71%
Sud-Ubangi	14	33	33	4,2	67%	18	55%	27	82%	7	0	0	0	30	17	6%	67%
Tanganyika	14	25	22	2,8	76%	14	56%	24	96%	12	0	0	0	22	9	9%	100%
Tshopo	15	58	56	6,6	84%	48	83%	51	88%	5	0	0	0	50	14	9%	75%
Tshuapa	10	24	24	4,3	96%	17	71%	19	79%	13	0	0	0	24	13	0%	71%
RDC	**464**	**984**	**921**	**3,6**	**89%**	**769**	**78%**	**897**	**91%**	**8**	**0**	**0**	**0**	**896**	**11**	**20%**	**63%**

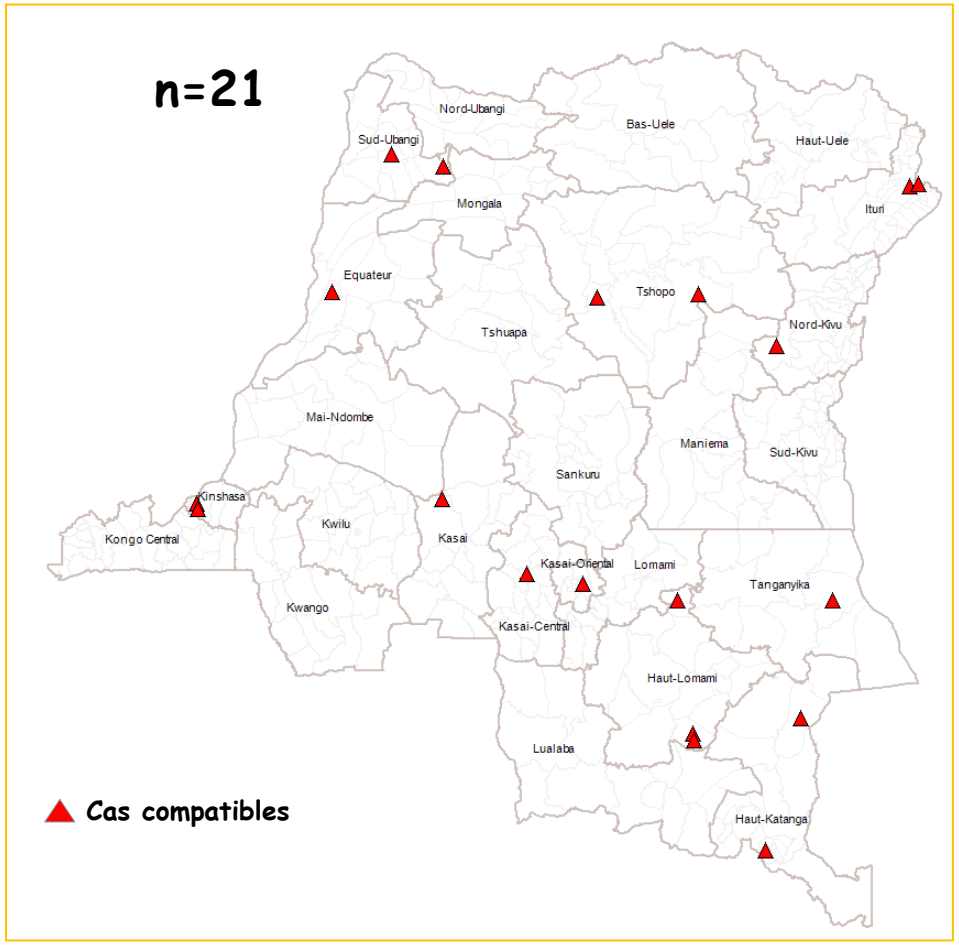
Analyse des raisons de l’inadéquation des selles



ZS	Delai 2sd Echantillon et on set	Delai 1èr et 2ème Echantillon	Condition labo échantillon
KAMINA	76	1	1
Kabondo	75	2	1
Makoro	74	1	1
Mbaya	69	1	1
Maluku II	65	1	1
Mweka	65	1	1

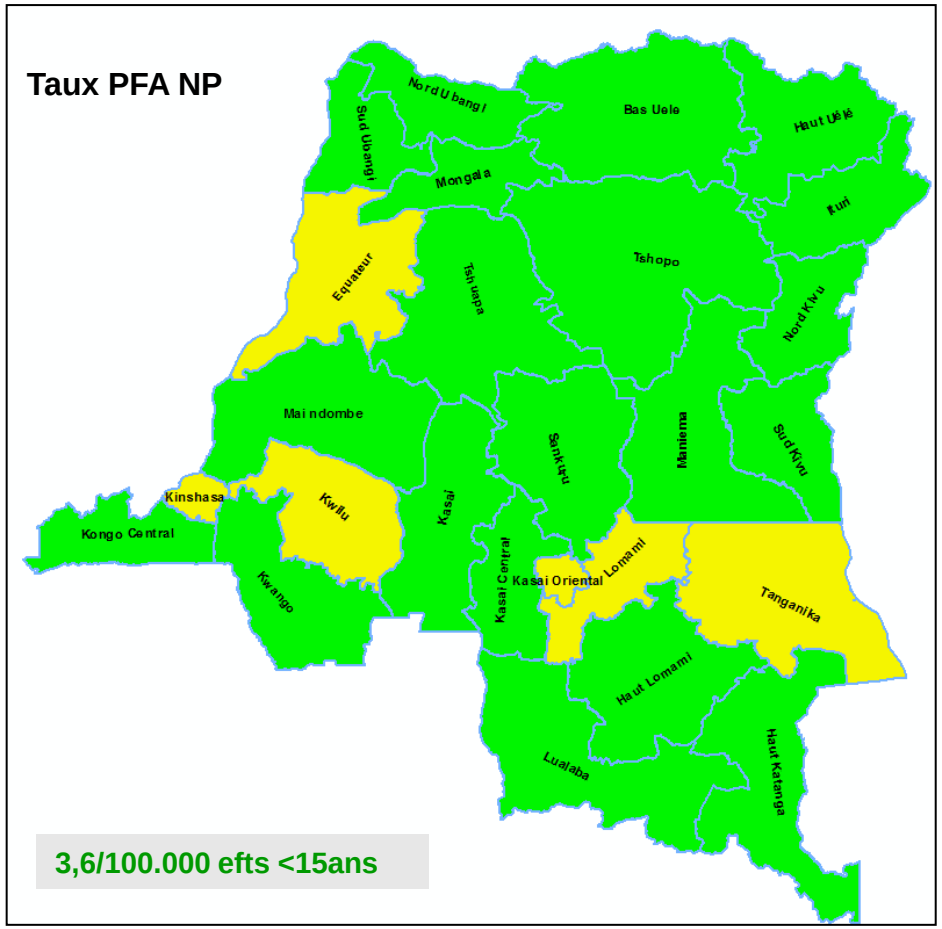
Province	ZS	Delai 2sd Echantillon et on set	Delai 1èr et 2ème Echantillon	Condition labo échantillon
Ituri	Komanda	54	33	1
Ituri	Aru	32	21	1
Sud-Kivu	Bagira-Kasha	16	4	1
Kasai	Mikope	14	4	1
Kinshasa	Binza-Ozone	13	3	1

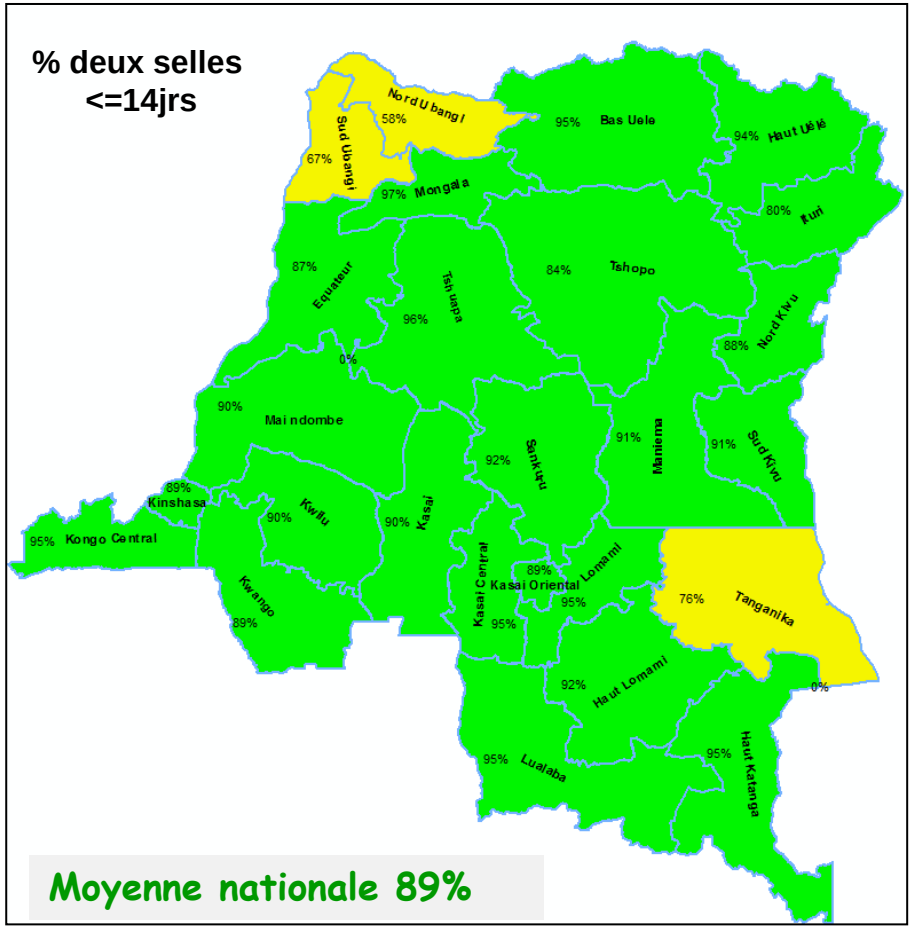
Cas PFA compatibles à la polio, 2016



N°	Province	Zone de santé	nbre cas	Numéro Epid	Date de début de paralysie
1	Equateur	Bolenge	1	RDC-EQT-BLG-16-001	02/02/2016
2	Haut Katanga	Mumbunda	2	RDC-HKA-MBD-16-001	28/01/2016
		Kilwa	3	RDC-HKA-KIL-16-002	03/02/2016
3	Haut Lomami	Bukama	4	RDC-HLO-BUK-16-006	26/03/2016
			5	RDC-HLO-BUK-16-005	07/04/2016
			6	RDC-HLO-BUK-16-004	02/04/2016
		Kitenge	7	RDC-HLO-KIT-16-004	29/02/2016
4	Ituri	Komanda	8	RDC-ITU-KOM-16-002	04/02/2016
			9	RDC-ITU-KOM-16-003	15/02/2016
			10	RDC-ITU-KOM-16-001	20/02/2016
5	Kasai	Ilebo	11	RDC-KAS-ILE-16-001	10/01/2016
6	Kasai Central	Kananga	12	RDC-KCE-KAN-16-001	25/03/2016
7	Kasai Oriental	Dibindi	13	RDC-KOR-DIB-16-002	20/02/2016
8	Kinshasa	Kimbanseke	14	RDC-KIN-KIM-16-002	10/03/2016
			15	RDC-KIN-KIM-16-001	28/02/2016
9	Nord Kivu	Walikale	16	RDC-NKV-WAL-16-003	07/03/2016
10	Sud-Ubangi	Ndage	17	RDC-SUB-NDG-16-001	01/02/2016
		Tandala	18	RDC-SUB-TAN-16-001	12/02/2016
11	Tanganyika	Kalemie	19	RDC-TAN-KAL-16-001	09/03/2016
12	Tshopo	Wanie-Rukula	20	RDC-TSH-WAR-16-001	15/01/2016
		Yahisuli	21	RDC-TSH-YSL-16-002	06/03/2016

Performances de principaux indicateurs de surveillance des PFA par province, 01 janvier - 22 juillet 2016





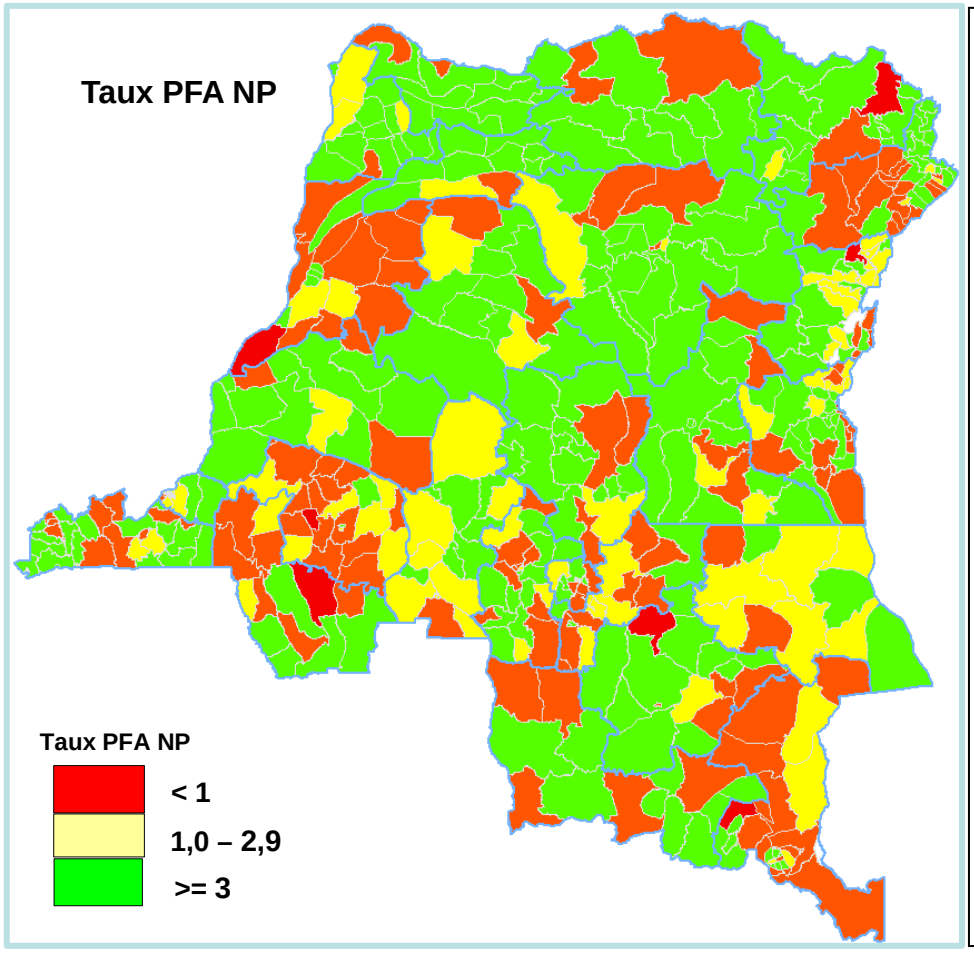
Taux PFA NP

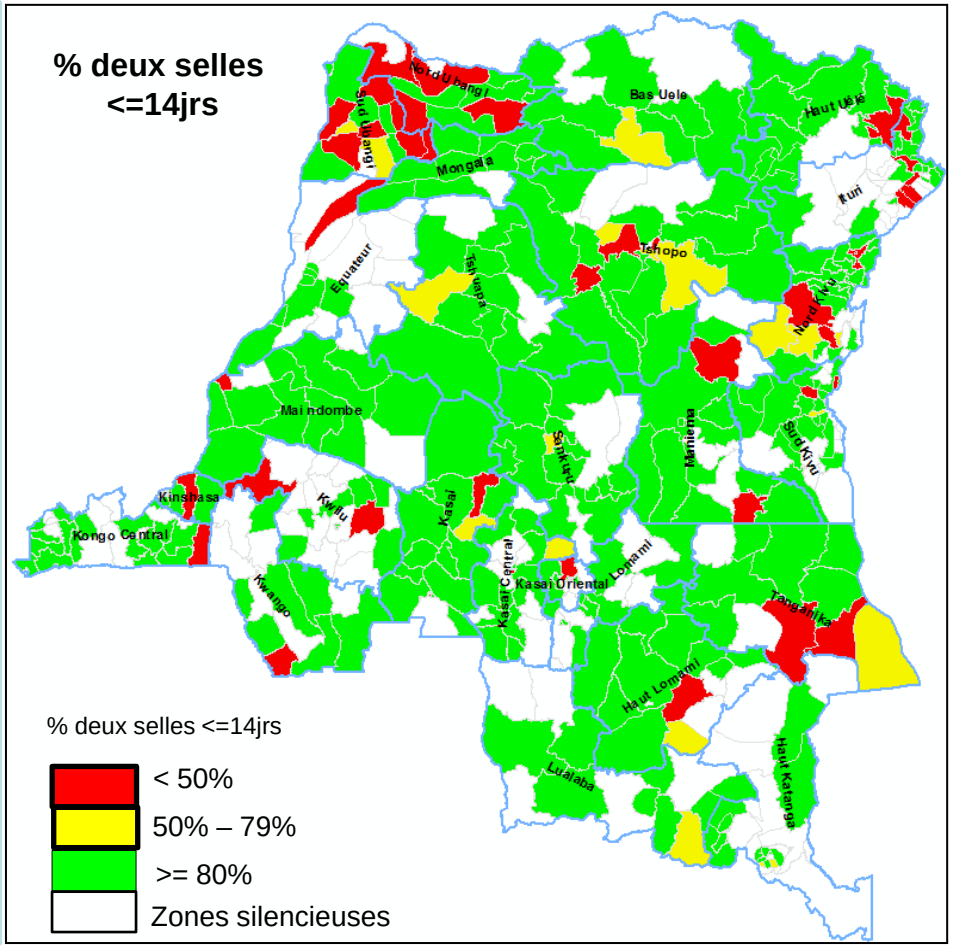
- < 1
- 1,0 – 2,9
- >= 3

% deux selles <=14jrs

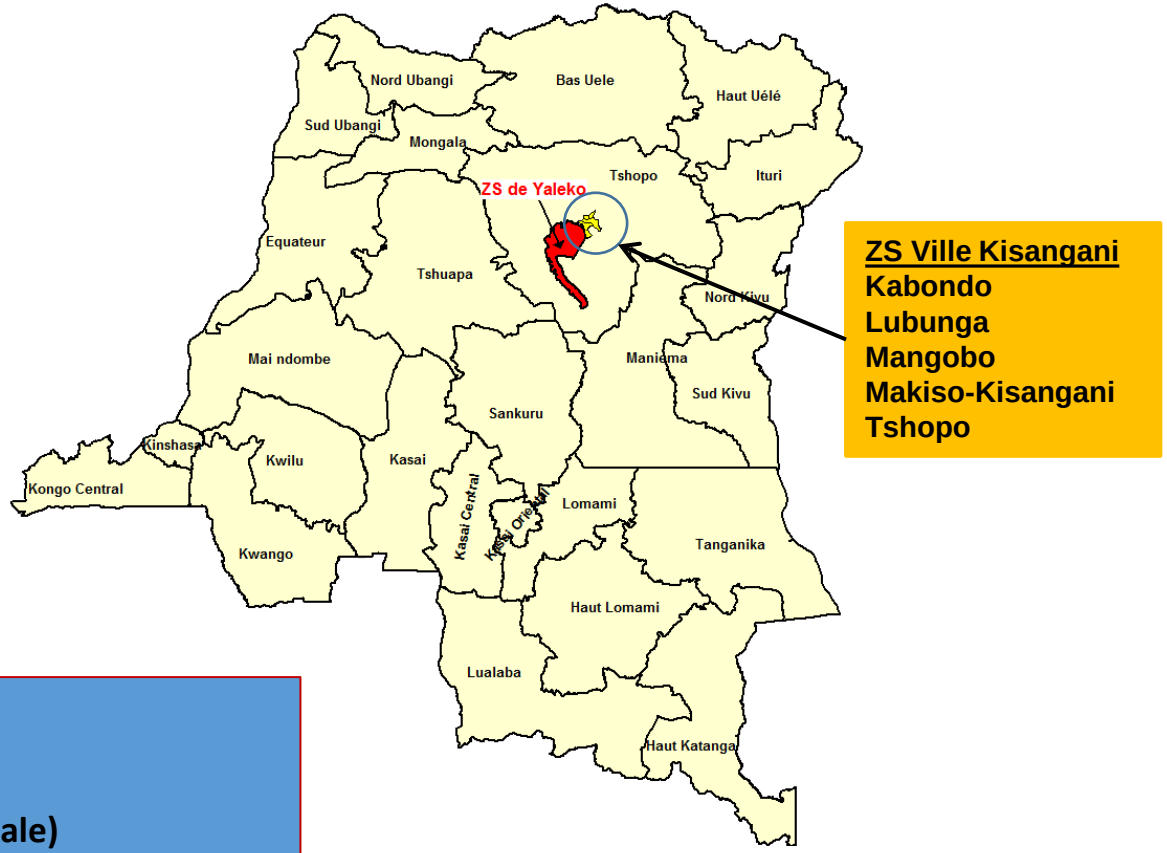
- < 50%
- 50% – 79%
- >= 80%

Performances de principaux indicateurs de surveillance des PFA par Zone de santé, 01 janvier – 22 juillet 2016





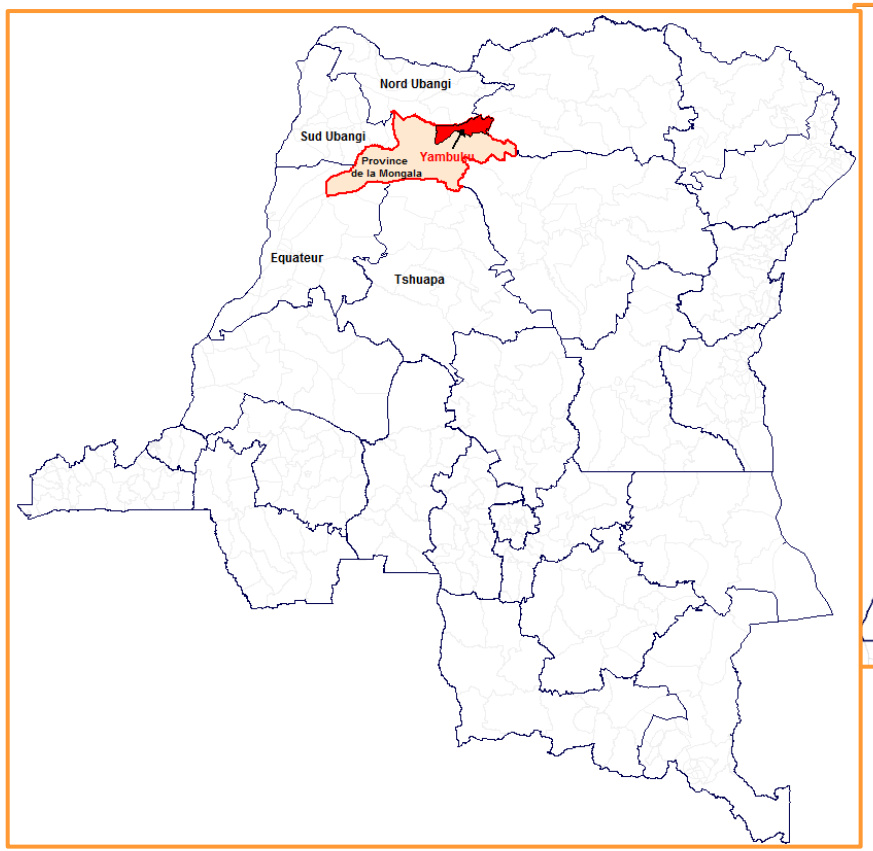
Zone de Santé de Yaleko (cas de VDPV confirmé), province de la Tshopo, 01 avril 2016

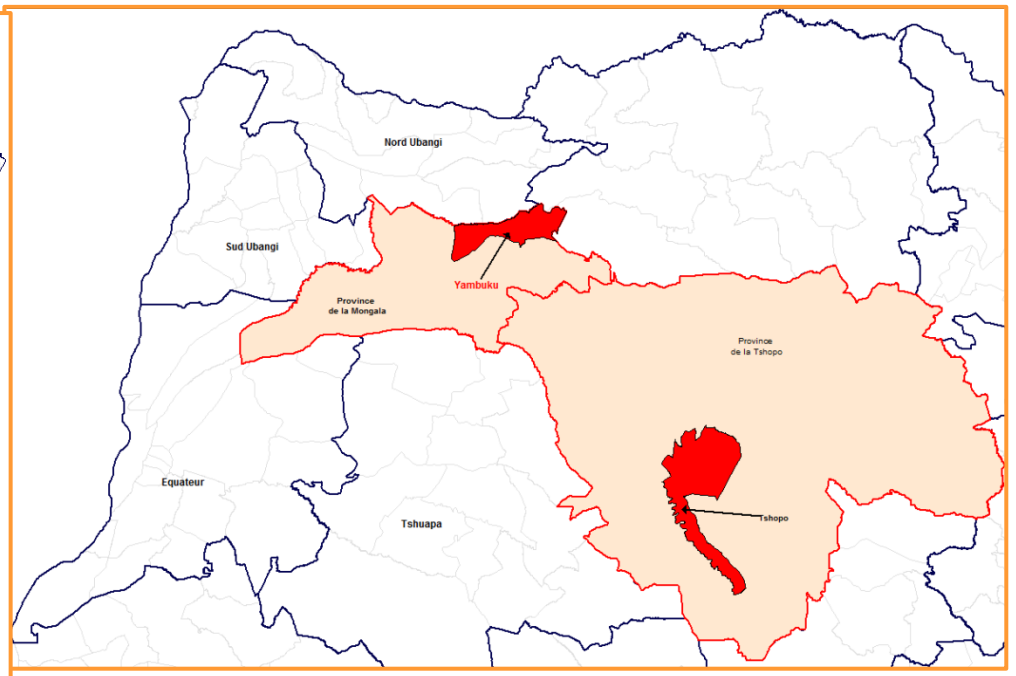


- **Epid Number** : **RDC-TSH-YLK-16-002**
- **Zone de santé : Yaleko**
- **Province : Tshopo (ex. Province Orientale)**
- **Formation sanitaire proche** : AS YATULIA
- Nom de l'enfant : OFONA
- Sexe : Féminin
- Date naissance : 16-11-2013
- Date début paralysie : 13-01-2016
- Nombre doses reçues : Inconnu

Confirmation du cas
par le labo : 01-mars-2016

Localisation du cas de VDPV de la ZS de Yambuku, Mongala, 27 mai 2016

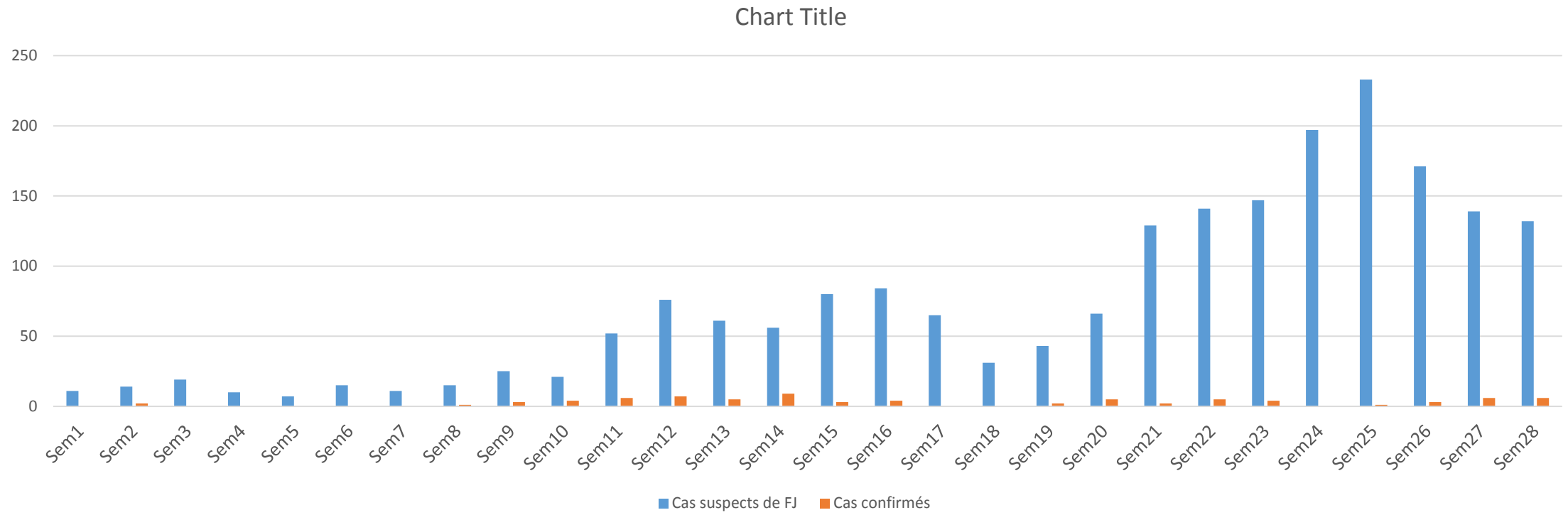




Epid Number : RDC-MON-YAM-16-003
Age : 1,3 an (27/12/2014)
Sexe : Féminin
Date début paralysie : 15 mars 2016
Total doses reçues : 0 dose en routine par non réalisation de la stratégie avancée et une seule dose le 26 mars 2016 lors de JNV
Formation sanitaire : CS YAMAMBA

Surveillance de la Fièvre jaune

Evolution des cas suspects et confirmés de FJ en RDC,Sem1-28

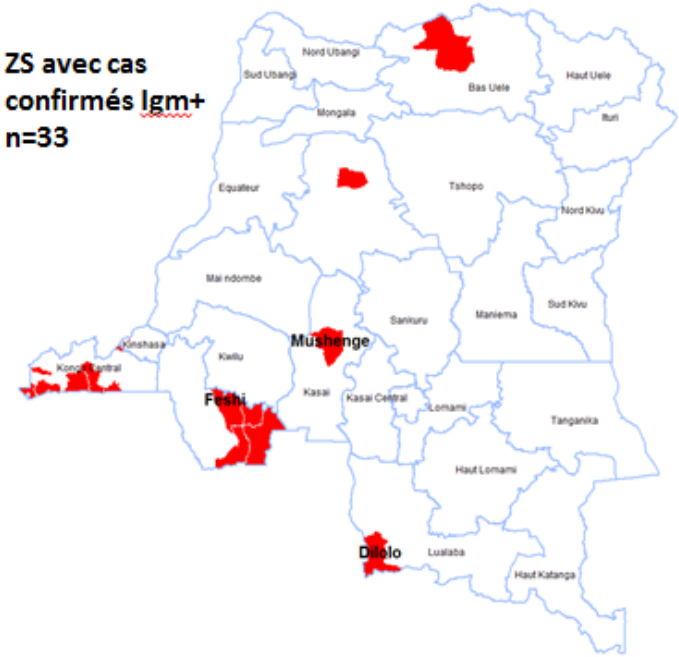


CAS IDS	CAS PRELEV	CAS CONFIRM	CAS NEGATIFS INRB	CAS IgM+ en cours	CAS IgM+ en attente de classification
2062	1857	81	1661	20	43

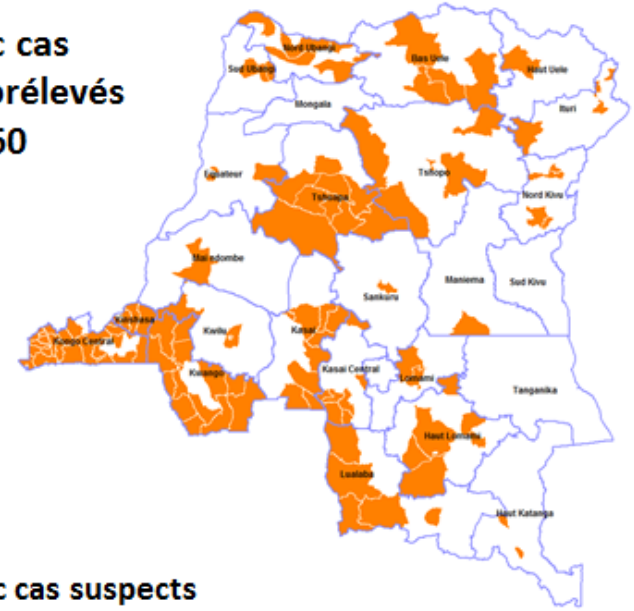
Comparaison par DPS des indicateurs de la surveillance de la fièvre jaune en RDC, semestre 2016

N°	PROVINCE	Nbre ZS	Nbez ZS avec au moins 1cas suspect de FJ	% des ZS avec au moins 1 cas suspect de FJ	Nbre des cas cumulés notifiés	Decès	Létalité	Nbre des cas prélevés	% des cas prélevés	Nbre des cas IgM+ FJ	Nbre des cas confirmés	Nbres des cas auto chtones
1	Bas Uele	11	6	54,5	35	3	8,6	23	65,7	2	1	1
2	Equateur	18	7	38,9	14	0	0,0	10	71,4	0	0	0
3	Haut Katanga	27	5	18,5	7	0	0,0	7	100,0	0	0	0
4	Haut Lomami	16	6	37,5	30	1	3,3	28	93,3	0	0	0
5	Haut Uele	13	3	23,1	6	0	0,0	4	66,7	0	0	0
6	Ituri	36	4	11,1	6	0	0,0	6	100,0	0	0	0
7	Kasai	18	12	66,7	47	6	12,8	49	104,3	1		1
8	Kasai Central	27	10	37,0	28	7	25,0	18	64,3	0	0	0
9	Kasai Oriental	19	1	5,3	1	0	0,0	0	0,0	0	0	0
10	Kinshasa	35	35	100,0	1082	11	1,0	988	91,3	42	23	6
11	Kongo Central	31	29	93,5	376	42	11,2	374	99,5	60	40	1
12	Kwango	14	14	100,0	179	18	10,1	150	83,8	19	16	3
13	Kwilu	24	11	45,8	33	3	9,1	33	100,0	0	0	0
14	Lomami	16	3	18,8	6	1	16,7	6	100,0	0	0	0
15	Lualaba	14	4	28,6	30	1	3,3	30	100,0	0	0	0
16	Maindombe	14	2	14,3	3	0	0,0	3	100,0	0	0	0
17	Maniema	18	2	11,1	2	0	0,0	1	50,0	0	0	0
18	Mongala	12	4	33,3	8	0	0,0	0	0,0	0	0	0
19	Nord Kivu	32	2	6,3	6	1	16,7	6	100,0	0	0	0
20	Nord Ubangi	11	6	54,5	28	1	3,6	22	78,6	0	0	0
21	Sankuru	16	1	6,3	2	0	0,0	2	100,0	0	0	0
22	Sud Ubangi	16	6	37,5	20	0	0,0	12	60,0	0	0	0
23	Sud Kivu	34	2	5,9	4	2	50,0	3	75,0	0	0	0
24	Tanganyika	11	3	27,3	3	0	0,0	0	0,0	0	0	0
25	Tshopo	23	5	21,7	18	0	0,0	11	61,1	0	0	0
26	Tshuapa	12	10	83,3	88	2	2,3	71	80,7	1	1	1
Tota	RDC	517	193	37,3	2062	99	4,8	1857	90,1	125	81	13

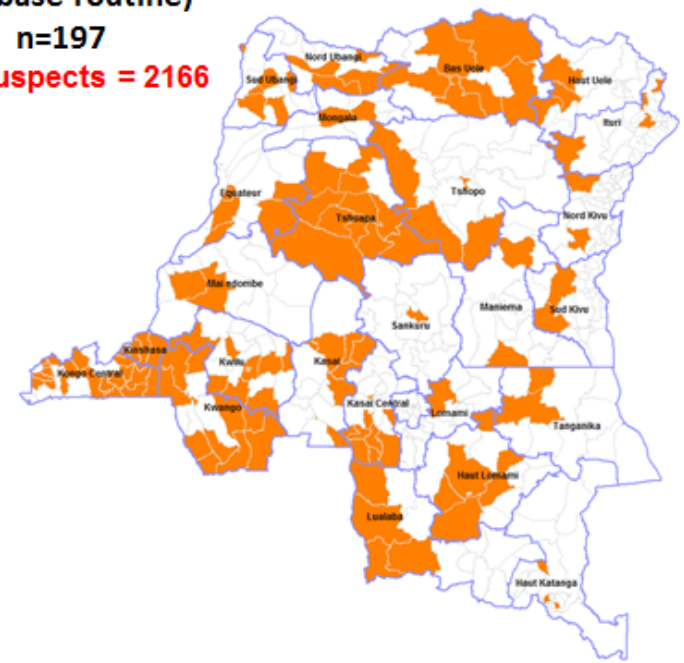
ZS avec cas confirmés Igm+
n=33

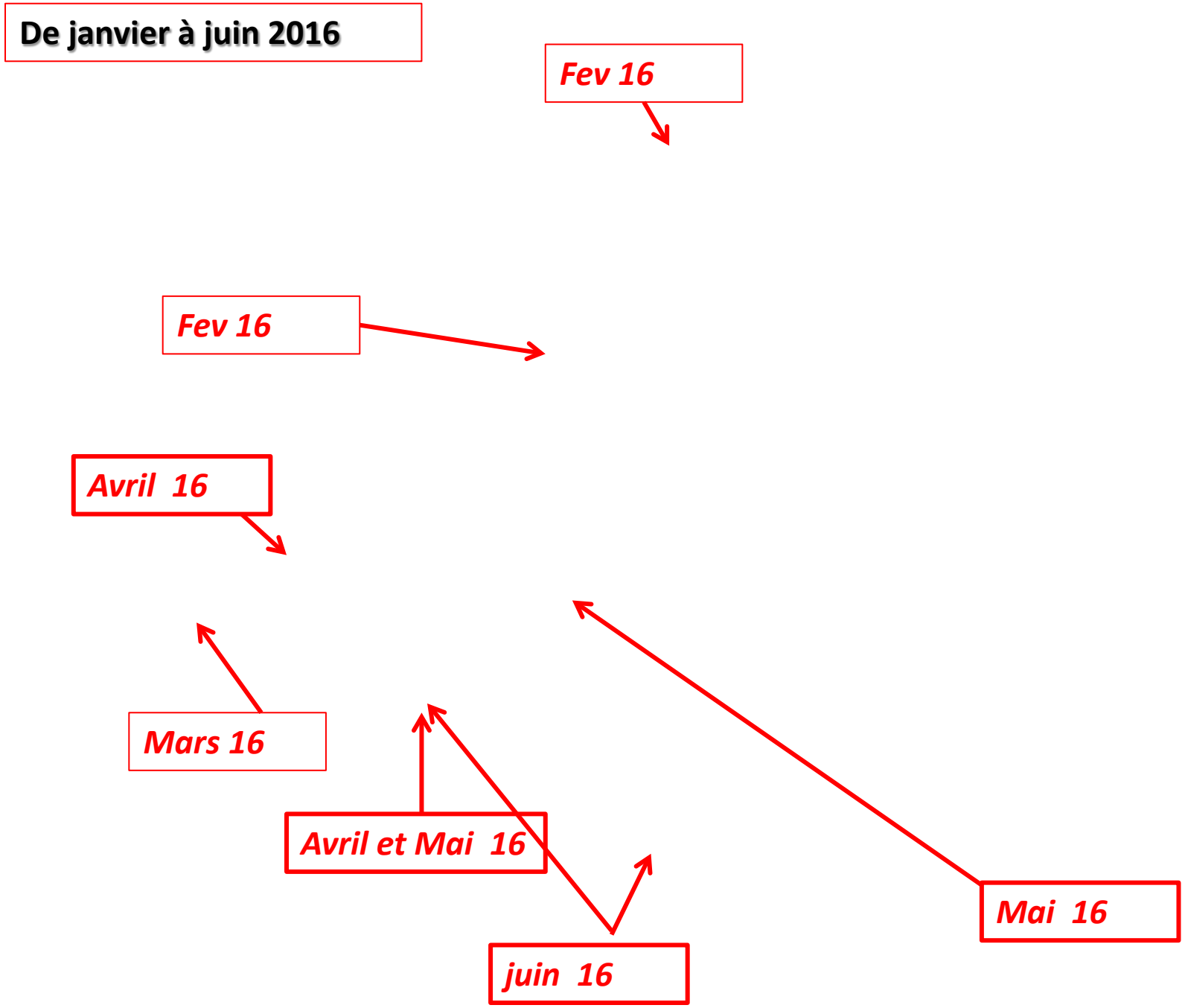


ZS avec cas suspects prélevés
n=160



ZS avec cas suspects IDS (base routine)
n=197
Cas suspects = 2166



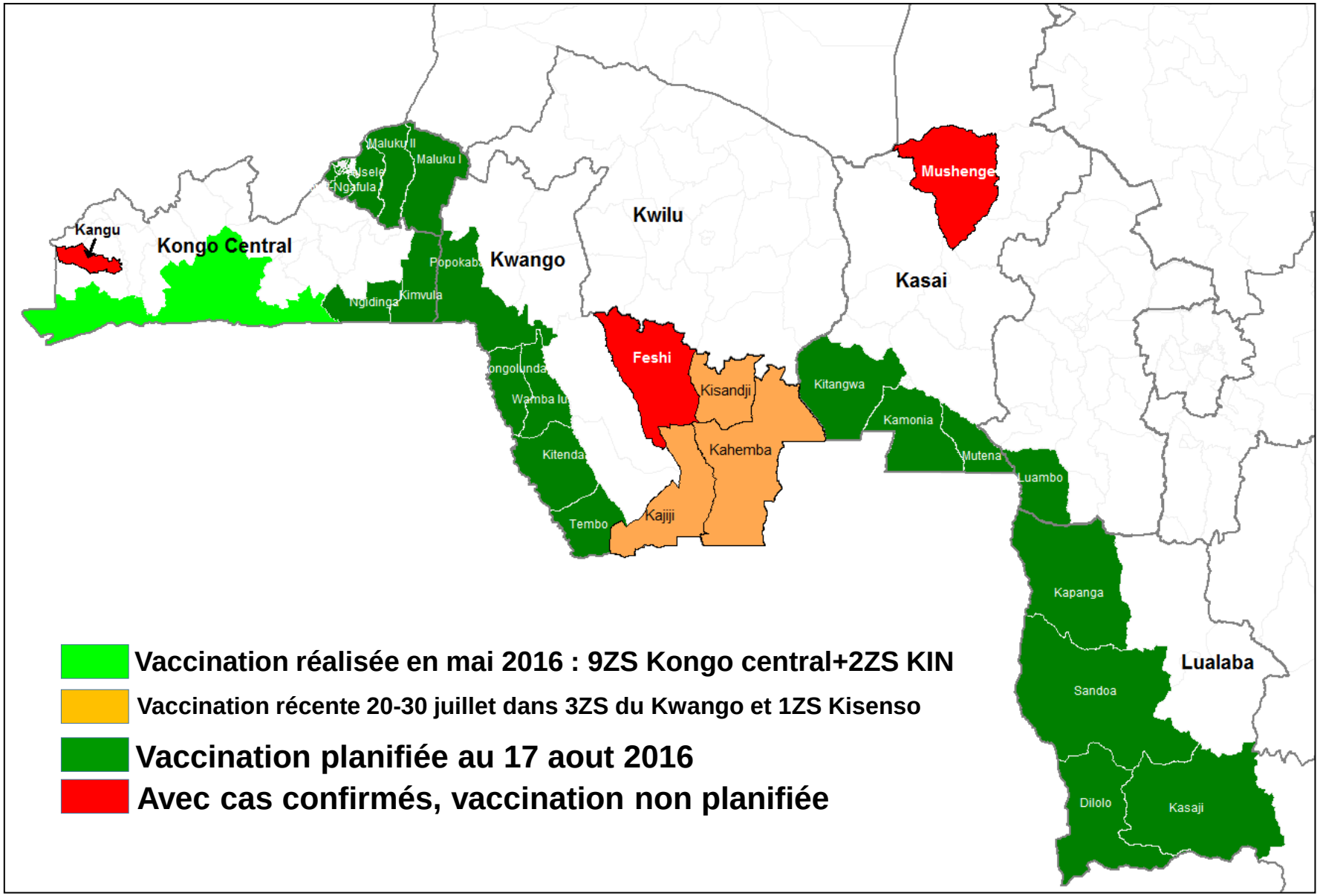

De janvier à juin 2016
Fev 16
Fev 16
Avril 16
Mars 16
Avril et Mai 16
juin 16
Mai 16

Répartition par tranche d'âge des cas IgM+ de FJ, INRB 27 juin 2016

Tranche d'âge	N	%
0 - 5 ans	6	6,7%
6 - 15 ans	8	9,0%
16 - 30 ans	37	41,6%
31 - 40 ans	26	29,2%
41 et plus	12	13,5%
TOTAL	89	100,0%

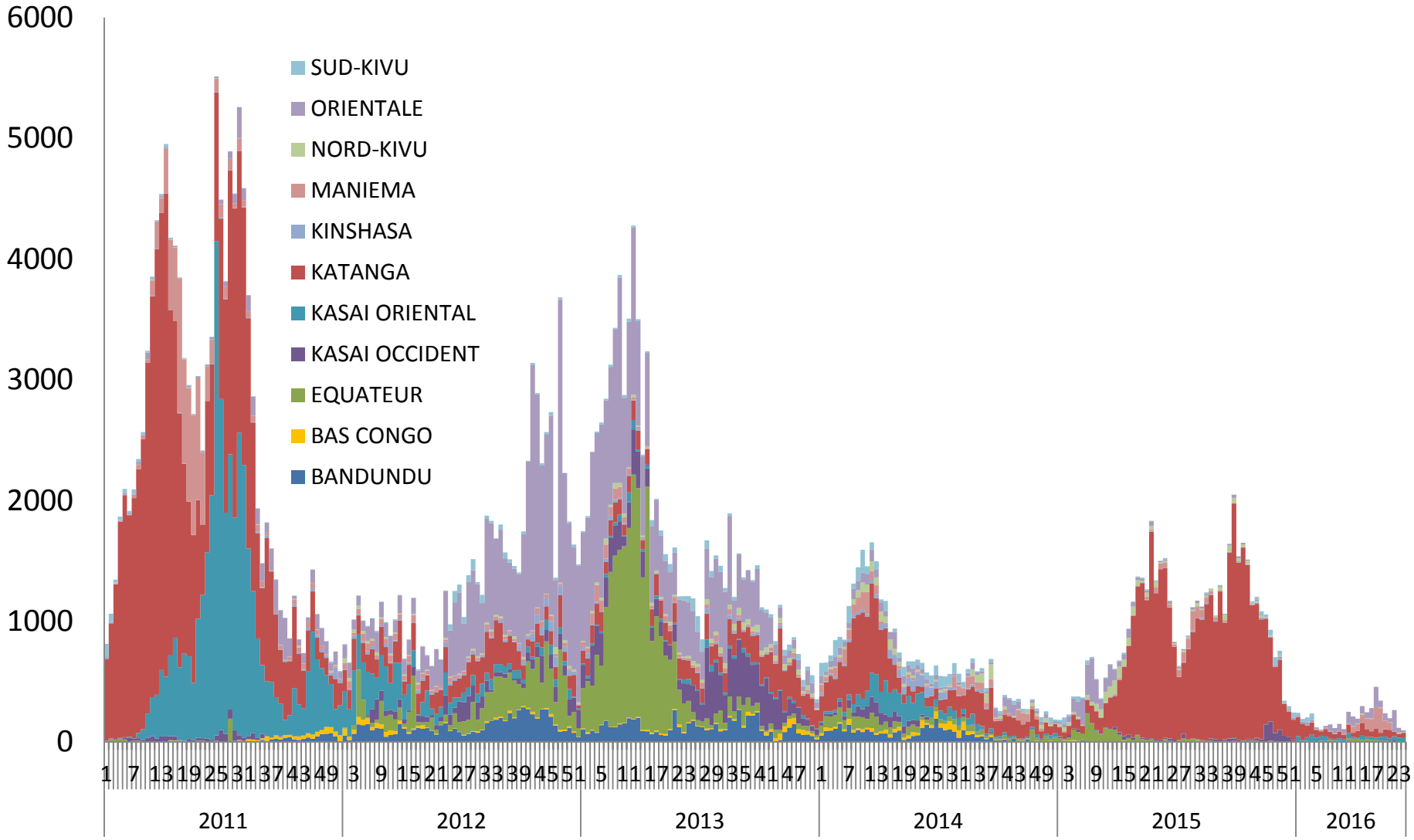
Moyenne d'âge = 27,6 ans
Médiane : 28 ans
Minima: 2 ans
Maxima : 63ans

La vaccination en réponse à l'épidémie de fièvre jaune en RDC, 2016



SURVEILLANCE DE LA ROUGEOLE

Evolution hebdomadaire des cas de rougeole par province, 2011-2016 (sem.24)



Source: DLM

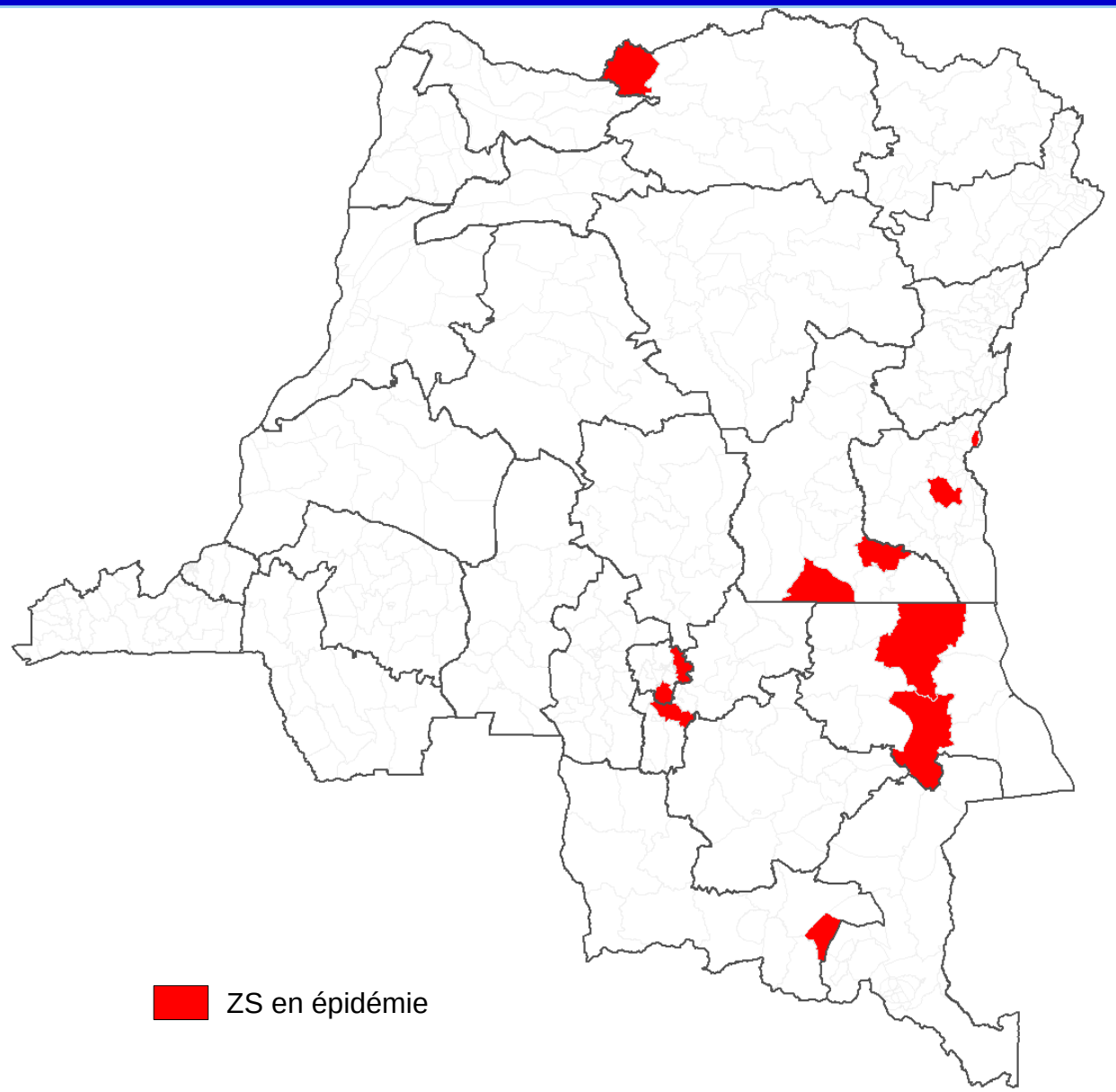
Indicateurs de surveillance de la Rougeole Sem1-28, 2016

Province	Population*	Nb des ZS	Nb de cas attendus 2016	Nb de cas enregistrés IDSR 2016	Nb total de cas notifiés et prélevés	Nb de cas confirmés par lien EPI	Nb de cas Compatible	Rougeole IgM+		Taux des affections febriles non rougeoleuses	ZS ayant notifié au moins 1 cas suspect avec prélèvement		Rubeole IgM+	
								Nb	< 10%	≥ 2/100,000 h	Nb	≥ 80%	Nb	≤ 10%
Bas-Uélé	1 252 649	11	25	707	47	291	0	24	51,1%	3,67	6	54,5%	0	0,0%
Equateur	2 382 251	18	48	26	3	0	0	0	0,0%	0,25	3	16,7%	0	0,0%
Haut-Katanga	5 064 355	27	101	366	95	0	2	1	1,1%	3,71	14	51,9%	5	5,3%
Haut-Lomami	3 820 374	16	76	228	110	0	0	4	3,6%	5,55	12	75,0%	9	8,2%
Haut-Uélé	1 807 321	13	36	192	27	0	0	0	0,0%	2,99	5	38,5%	9	33,3%
Ituri	5 561 308	36	111	319	119	0	1	1	0,8%	4,24	26	72,2%	38	31,9%
Kasai	4 434 795	18	89	8	10	0	0	0	0,0%	0,45	6	33,3%	0	0,0%
Kasai-Central	4 583 147	26	92	24	6	0	0	0	0,0%	0,26	2	7,7%	0	0,0%
Kasai-Oriental	4 836 156	19	97	77	22	0	0	10	45,5%	0,50	6	31,6%	1	4,5%
Kinshasa	9 120 710	35	182	84	101	0	0	5	5,0%	2,11	28	80,0%	17	16,8%
Kongo Central	3 811 177	31	76	36	26	0	0	1	3,8%	1,31	8	25,8%	4	15,4%
Kwango	2 501 572	14	50	12	2	0	0	0	0,0%	0,16	2	14,3%	0	0,0%
Kwilu	5 003 473	24	100	11	5	0	0	0	0,0%	0,20	4	16,7%	0	0,0%
Lomami	3 883 051	16	78	567	107	0	0	4	3,7%	5,31	11	68,8%	7	6,5%
Lualaba	2 235 950	14	45	115	44	37	0	10	22,7%	3,04	8	57,1%	0	0,0%
Mai-Ndombe	1 846 867	14	37	17	3	0	0	0	0,0%	0,32	3	21,4%	0	0,0%
Maniema	2 456 455	18	49	953	35	0	0	8	22,9%	2,20	8	44,4%	0	0,0%
Mongala	2 437 596	12	49	22	5	0	0	0	0,0%	0,41	2	16,7%	0	0,0%
Nord-Kivu	8 194 781	32	164	67	49	0	1	11	22,4%	0,93	10	31,3%	3	6,1%
Nord-Ubangi	1 454 537	11	29	85	29	0	0	3	10,3%	3,58	5	45,5%	0	0,0%
Sankuru	1 949 758	16	39	21	9	0	0	0	0,0%	0,92	3	18,8%	0	0,0%
Sud-Ubangi	6 817 070	16	136	42	28	0	0	0	0,0%	0,82	10	62,5%	0	0,0%
SUD-KIVU	2 954 077	34	59	477	41	92	0	15	36,6%	1,76	6	17,6%	2	4,9%
TANGANYIKA	2 981 818	11	60	848	89	15	0	9	10,1%	5,37	7	63,6%	3	3,4%
TSHOPO	3 187 586	23	64	34	12	0	0	0	0,0%	0,75	5	21,7%	0	0,0%
TSHUAPA	2 068 084	12	41	106	35	0	0	0	0,0%	3,38	5	41,7%	0	0,0%
RDC	96 646 918	517	1933	5444	1059	435	4	106	10,0%	1,97	205	39,7%	98	9,3%

ZS avec des **épidémies confirmées Rougeole IgM+**, S1-24 de 2016

Cas :	5444
Décès :	79
Tx létalité :	1,4%
Cas Investigués :	1059
Cas rougeole IgM+ :	106
Cas confirmés lien épid. :	435
ZS avec épidémie confirmée depuis janvier 2015 :	13

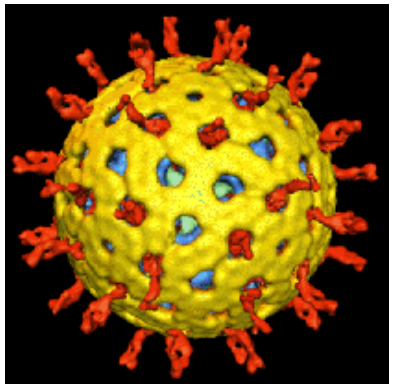
Province	Nbre ZS	ZS
BAS-UELE	1	Monga
K.ORIENTAL	2	Bibanga
		Kasansa
LOMAMI	1	Kanda Kanda
LUALABA	1	Fungurume
MANIEMA	2	Salamabila, Samba
NORD-KIVU	2	Karisimbi
		Goma
SUD-KIVU	2	Idjwi
		Mwenga
TANGANYIKA	2	Kiambi
		Nyunzu



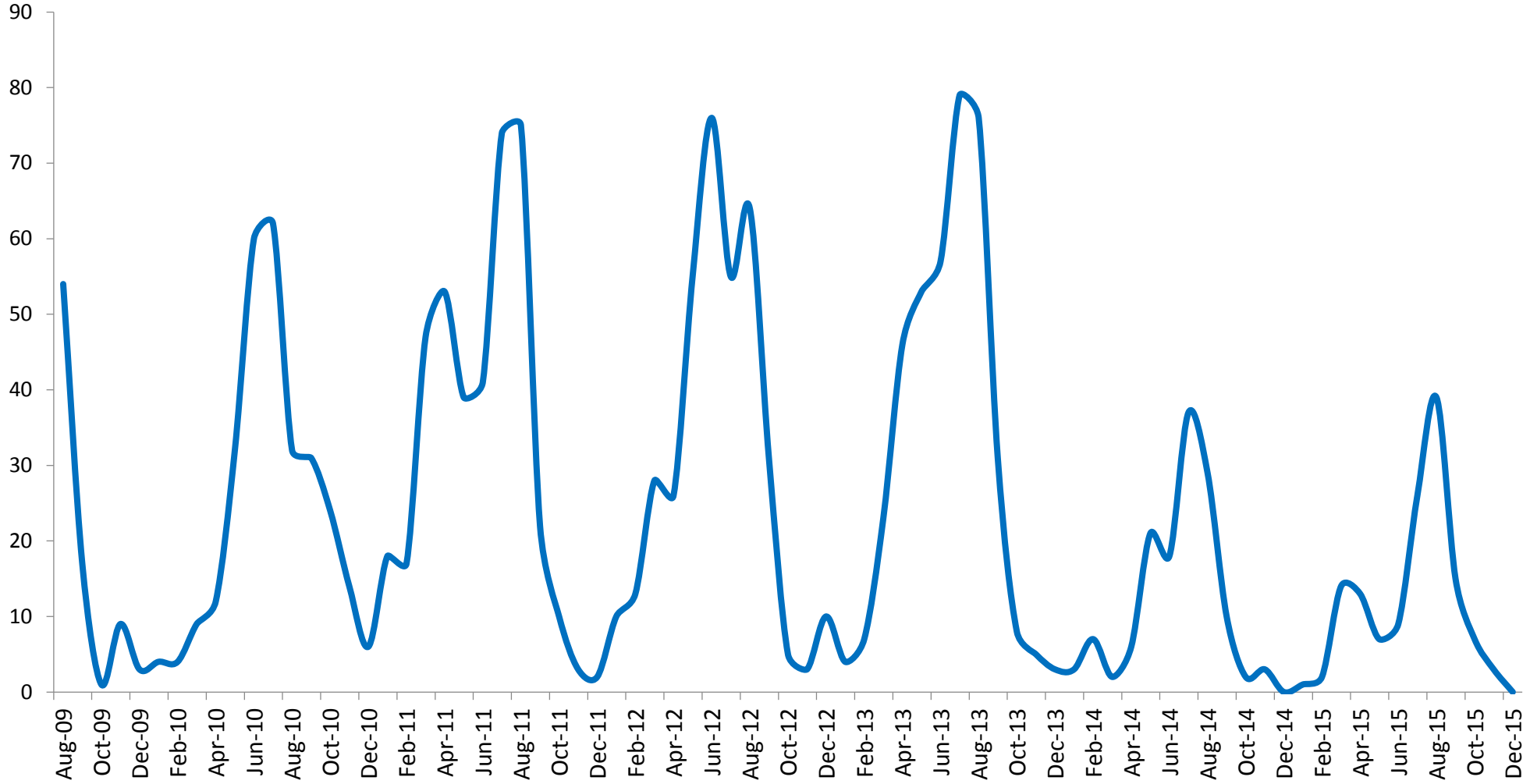
Indicateurs de la surveillance du Tétanos néonatal,1er semestre 2016,RDC

PROVINCE	Nbre des CAS Notifiés IDS	DECES	LETALITE	CAS INVESTIGUES	% des cas de TNN investigués	Nbre de ZS ayant investigué	Nbre des ZS ayant riposté autour du cas	% des ZS Nbre ayant riposté autour du cas
BAS UELE	14	8	57,1	0	0,0	0	0	
EQUATEUR	50	16	32	0	0,0	0	0	
HAUT KATANGA	10	8	80	0	0,0	0	0	
HAUT LOMAMI	36	16	44,4	0	0,0	0	0	
HAUT UELE	5	2	40	0	0,0	0	0	
ITURI	22	11	50	5	22,7	3	2	66,7
KASAI	13	9	69,2	0	0,0	0	0	
KASAI CENTRAL	7	3	42,9	1	14,3	0	0	
KINSHASA	8	3	37,5	0	0,0	0	0	
KONGO CENTRAL	9	5	55,6	0	0,0	0	0	
KWANGO	11	9	81,8	1	9,1	1	1	100,0
KWILU	13	5	38,5	0	0,0	0	0	
LOMAMI	21	10	47,6	4	19,0	3	2	66,7
LUALABA	8	6	75	0	0,0	0	0	
MAINDOMBE	19	9	47,4	0	0,0	0	0	
MANIEMA	32	12	37,5	0	0,0	0	0	
NORD KIVU	17	5	29,4	0	0,0	0	0	
NORD UBANGI	16	12	75	0	0,0	0	0	
SANKURU	16	5	31,3	0	0,0	0	0	
SUD UBANGI	43	21	48,8	0	0,0	0	0	
SUD KIVU	14	1	7,1	3	21,4	3	2	66,7
TANGANYIKA	37	19	51,4	4	10,8	2	0	0,0
TSHOPO	34	25	73,5	2	5,9	1	0	0,0
TSHUAPA	33	13	39,4	0	0,0	0	0	
MONGALA	63	29	46	0	0,0	0	0	
KASAI ORIENTAL	27	10	37	1	3,7	1	1	100,0
RDC	**578**	**272**	**47,1**	**21**	**3,6**	**14**	**8**	**57,1**

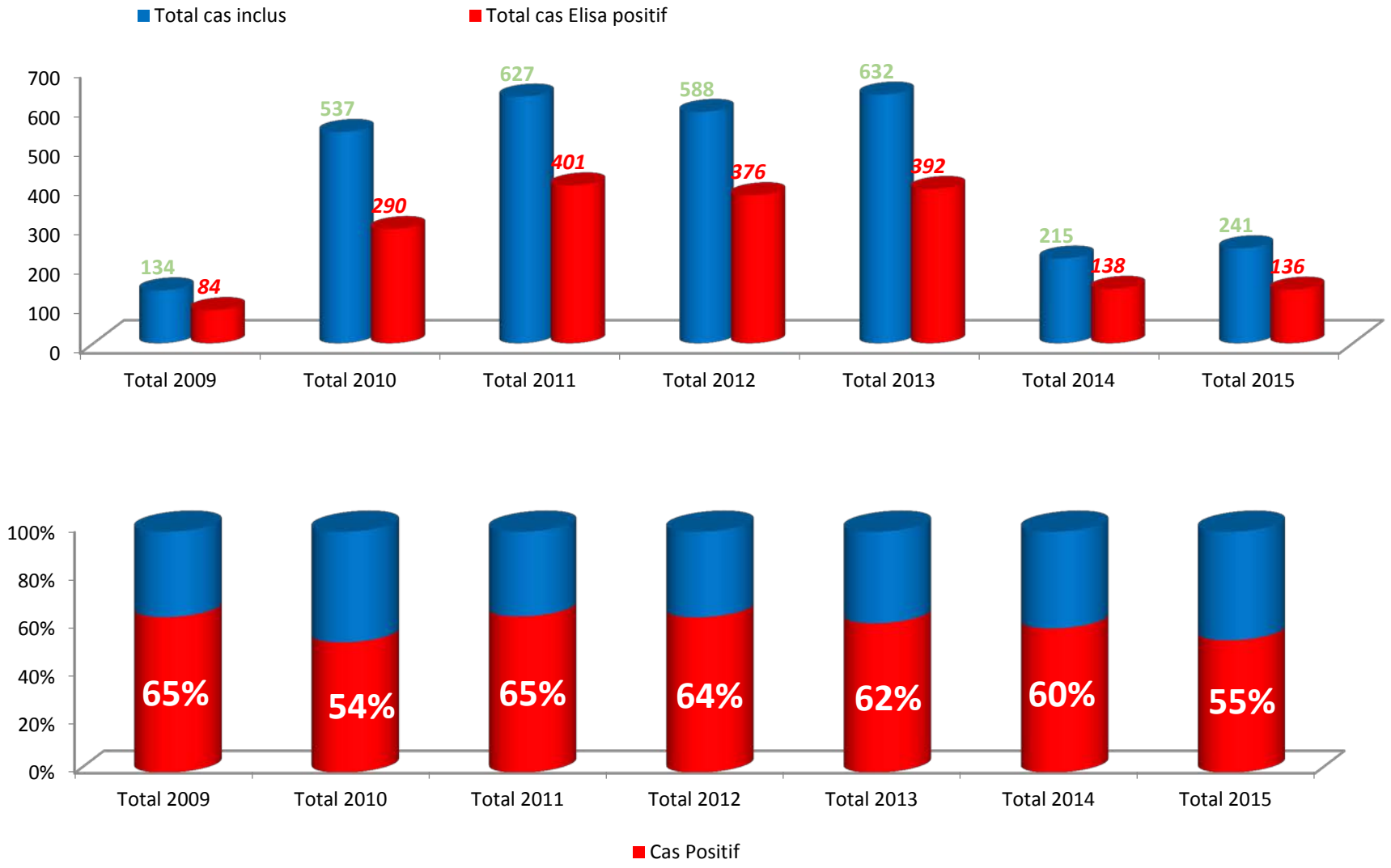
SURVEILLANCE EN SITE SENTINELLE DES GASTRO ENTERITES À ROTAVIRUS



Evolution des cas de GE dans les sites sentinelles de 2009-2015

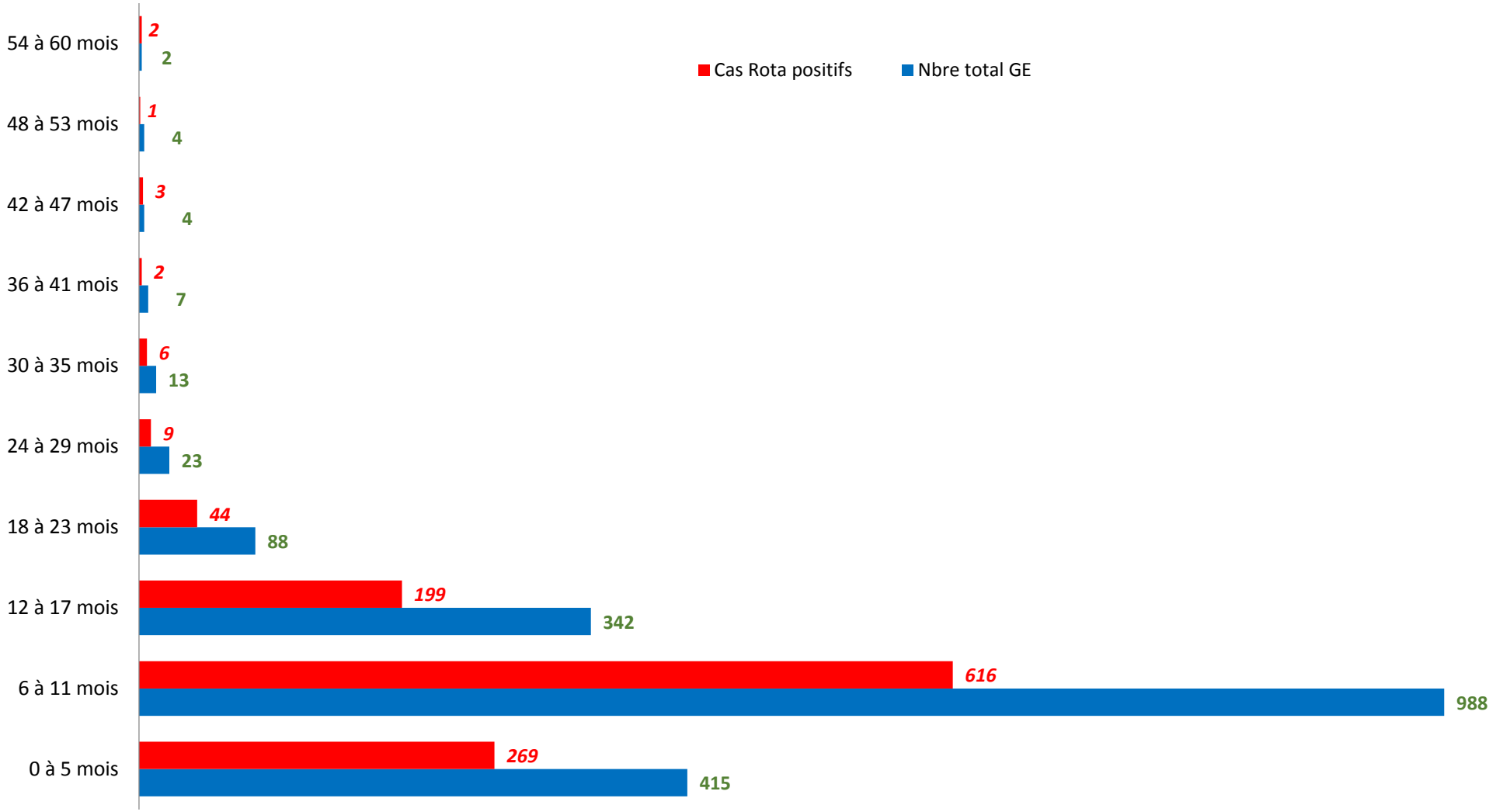


Proportion des GE infantiles attribuables au Rotavirus en RDC



En 2016,
7 sur 74
soit 9,4%

Répartition des cas de GE à Rotavirus selon les tranches d'âge



Manifestations post vaccinales indésirables

- ❖Quasi Absence de notification des MAPI en Routine
- ❖Elaboration du Manuel national de surveillance et gestion des MAPI
- ❖Projet de mise en place du Comité National de Pharmacovigilance Vaccinale (DPM,CNPV,PEV et Partenaires)
- ❖MAPI notifiées lors des AVS MenAfrivac, Fièvre jaune

PROBLEMES PRIORITAIRES

- Persistance de l'inadéquation des selles dans 14 DPS sur 26.
- Faible notification des cas suspects de fièvre jaune et rougeole en routine
- Ruptures périodiques en réactifs pour la fièvre jaune et la rougeole
- Retard dans le démarrage du comité national de pharmacovigilance vaccinale et de la surveillance des MAPI en routine
- Faible proportion des cas de TNN investigués et ayant bénéficié de la riposte autour du cas
- Financement peu sécurisé pour la surveillance en sites sentinelles MBP-ROTA Rubéole, HPV

PERSPECTIVES

- Maintenir et atteindre les indicateurs de la surveillance des cas des PFA, rougeole, FJ et TNN
- Assurer la formation en Surveillance sur les maladies prioritaires du PEV,
- Saisir les opportunités d'appui en ressources humaines d'appui au système de surveillance Stop team, BMGF
- Rendre fonctionnel le Comité de pharmacovigilance vaccinale
- Poursuivre la formation sur les MAPI

MERCI

Expérience de renforcement de la recherche active des PFA par la SBC dans le cadre du projet BMGF =» SANRU,IMC,CROIX ROUGE

- SANRU :
  - Kinshasa Maluku I, Lingwala
  - Haut Katanga : Kowe, Kashobwe, Mubunda
  - Lualaba: Manika
  - Haut Lomami: Baka
- IMC: Walikale- Itebero-Kibua
- Croix rouge:
  - Nord Kivu: Pinga, Lubero, Rwanguba
  - Equateur: Ntondo , Irebu