INTEGRATED COMMUNITY CASE MANAGEMENT OF CHILDHOOD ILLNESS:

Documentation of Best Practices and Bottlenecks to Program Implementation in the Democratic Republic of Congo (DRC)

January 2012

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ACKNOWLEDGEMENTS

ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
ARI	Acute Respiratory Infection
ASF	Association de Santé Familiale
AXxes	Bilateral USAID project managed by a consortium of NGOs: Protestant Church in the Congo, World Vision, Catholic Relief Services, and MERLIN
BASICS	Basic Support for Institutionalizing Child Survival
BCZ	Health Zone Central Office
CCISD	Centre de Coopération Internationale en Santé et Développement
CCM	Community Case Management
CDD	District Commissioner
CIDA	Canadian International Development Agency
COGESITE	Site management committee
CRS	Catholic Relief Services
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
ECC	Christ's Church in Congo
ECZS	Health Zone's Management Team
FG	Focus Group
HA	Health Area
HZ	Health Zone
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IRC	International Rescue Committee
IT	Nurse in-charge
LLITN	Long-Lasting Insecticide-Treated Net
LQAS	Lot Quality Assurance Sampling
MCHIP	Maternal and Child Health Integrated Program
MICS	Multiple Indicator Cluster Survey
MPH	Ministry of Public Health
MSH	Management Sciences for Health
NARIP	National Acute Respiratory Infection Program
NDDCP	National Diarrheic Diseases Control Plan
NGO	Non Governmental Organization
NHDP	National Health Development Plan
NHIS	National Health Information System
NMCP	National Malaria Control Program
NRHP	National Reproductive Health Program
ORS	Oral Rehydration Salts

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PARSS	Project in support of health sector rehabilitation
PNDS	Plan National de Développement Sanitaire/National Health Development Plan
PRORE	Promotional Relay
PSI	Population Services International
RDT	Rapid Diagnostic Test
RUMER	Drugs use and proceeds books
SR	Site Relay
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

Why iCCM?

Although infant and child mortality rates have declined appreciably in most developing countries, children under five continue to die at unacceptably high rates, often of preventable causes such as malaria, diarrhea, and pneumonia. According to a recent analysis, it is estimated that pneumonia is responsible for 18% of under-five deaths, diarrhea for 15%, and malaria for 8%.[1] Although simple, cost-effective interventions are available for these diseases, a major challenge remains: in most countries where morbidity and mortality among children is high, access to health facilities and/or the quality of services offered still represent major challenges.

Integrated Community Case Management (iCCM) of childhood illness is one strategy to reduce morbidity and mortality in the under-five population by providing the delivery of high-quality services through paid or volunteer community health workers (CHWs) to hard-to-reach populations.

In Africa, many countries are still in the early stages of their iCCM programs—focusing on advocacy activities, or in the preliminary stages of introducing the approach for a single disease at a time. However, a few countries, including Senegal, the Democratic Republic of the Congo, Rwanda, Madagascar, and Niger, have begun to implement the approach on a national scale.

As these countries expand their programs and move towards scale-up, there are important lessons and promising practices to share on the process of adoption, introduction, and implementation on a larger scale. The lessons and practices are based on the experience of these specific national programs and should be adapted to the contextual needs of other countries.

Overview of iCCM in the Democratic Republic of Congo (DRC)

Infant and child mortality rates in DRC have decreased from the world record levels in 2001 (respectively at 121 and 121 per thousand) to 97 and 158 per thousand in 2010. However, tremendous efforts are still required to achieve the Millennium Development Goals.

The Constitution that was adopted through elections in 2006 provides for devolution of powers to the provinces and more autonomy in management as well as dividing the country into 26 provinces. These new provisions were not yet effective at the time of the documentation team's visit in October 2010. The health system is comprised of three tiers, namely a central level, an intermediate level with 11 Provincial Health Inspectorates and 65 health districts, and a peripheral level that in theory groups 515 Health Zones (HZ) with 393 general referral hospitals and 8,266 health centers.

Under the leadership of the Ministry of Public Health (MPH), the Democratic Republic of Congo (DRC) has been successfully implementing iCCM since December 2005. As of September 2010, 716 community sites were operational, covering an estimated 1,692,379 persons. With five years of experience and well-documented lessons learned, the DRC program has a number of important lessons to offer other countries interested in implementing similar approaches. While other countries were still hesitant, DRC decided to introduce iCCM to address the huge challenges it is faced with in terms of the population's access to basic healthcare. The lessons should be shared and adapted to the context of other interested countries.

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[1] Black, Robert E. et al. "Global, regional, and national causes of child mortality in 2008: a systematic analysis," *The Lancet*, Volume 375, Issue 9730, 5 June 2010.

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THE DOCUMENTATION EXERCISE

METHODOLOGY AND GOAL

In September-October 2010, the MPH and its partners conducted a documentation of the introduction, implementation and expansion of iCCM over five years to highlight factors of success and bottlenecks.

The methodology of this exercise included a review of documents, in addition to quantitative and qualitative methods for data collection from a sampling of national, regional, district, and community-level sources. The qualitative data focused on opinions and perceptions, while quantitative methods were used to gather data on stock status and CHW performance scores. The team included two persons from MCHIP, one from Population Services International (PSI), one from WHO's regional office, two national consultants, and eight local facilitators (to conduct focus group discussions).

By identifying the successes and best practices of the DRC program, by recognizing its weaknesses to correct and prevent them, and by having a clear vision of the future of the program, this report has a two-fold aim: 1) to serve as a global learning tool that helps other countries that are looking for ideas to accelerate and expand their own iCCM efforts, and 2) to continue to inform program implementation in DRC.

AN ANALYSIS OF THE DATA FINDINGS LED TO THE FOLLOWING KEY LESSONS
Establishing a Favorable Policy Environment and Effective Institutional Support

- *Commitment and leadership of authorities at the highest levels:* The commitment of key people in the MPH, and administrative and political authorities at the intermediate levels who served as champions of the approach was a pre-condition to good coordination and successful resources mobilization.

- *A clear vision:* A clear vision was defined and sustained by the MPH in regards to integrated services, with a capacity to influence donors and redirect funding that was initially meant for malaria.

- *Partnership between the MPH and implementing partners (NGOs):* Through the partnership, it became possible to harmonize, standardize and fund the iCCM strategy, documents, and implementation throughout DRC and across a big number of partners. Throughout the process, progress was shown in a clear and concise way and was shared with all the concerned actors and other countries in the sub-region.

- *The lack of a long-term extension plan:* The lack of a long term extension plan constrains the prioritization and the strategic distribution of technical, financial and human resources. The national health development plan that was in the process of adoption in 2010 was an important step for developing such a plan. Program coordination and monitoring is needed at the decentralized level. There is a need to ensure capacity-building on a routine and ongoing basis for optimal program implementation. Decentralization of power and management autonomy that are planned for the future account for the importance of provincial and district-level structures.

- *Weakening of advocacy:* Weaken of advocacy at all levels as the strategy was expanded. Advocacy is essential and should be sustained and maintained throughout the scaling up process in order to mobilize and secure the required human and financial resources.

Reinforcing Links between the Health System and the Communities

- *Structured supervision approaches:* Post-training monitoring meetings are an effective and realistic option for ensuring quality and performance compared to routine supervision that can be costly and difficult to implement. Supervision of supervisors is also important.

- *The ITs in health facilities played a critical role in establishing the strategy:* Without this formal linkage with the health system, it would have been difficult to establish or maintain a quality iCCM program.

- *Integration of the data from community care sites into the national health information system:* From the very beginning, special attention was paid to collecting information and special efforts were made to these regards.

Delivery of Quality Community-Based Services to Households

- *Effective technical and operational documents*: Technical and operational documents were well-codified and available, such as the implementation guide, and the package of training and supervision materials. The documents clearly describe the community relays' duties, delineate their field of competency, appoint structures to support them, and explain the processes for training relays, and monitoring and supporting the program.

- *Immediate integration of the management of three diseases and malnutrition in the community approach under the country's integrated vision for IMCI*: The standard package of services offered in community care sites target the biggest killer diseases, namely malaria, diarrhea, and pneumonia. The Ministry has succeeded several times in influencing its partners in redirecting vertical projects into an integrated approach.

- *Plan to move directly to expansion without going through a pilot phase, as an example of making good use of lessons learned from other countries (Senegal):* From the very beginning, tasks and duties were delegated and expansion was gradually planned for.

- *Program's dynamism:* The program's dynamism was illustrated by the introduction of the family planning program in sites.

- *Frequent stock outs at sites due to weaknesses in the logistics chain:* It is important that partners define standards from the beginning and harmonize the supply chain for drugs and small equipment needed for the iCCM programs, incorporating it in the health sector's logistics system where possible.

- *Management of acute malnutrition:* The iCCM strategy is not always implemented in line with the acute malnutrition management protocol recommended by WHO, though it has a shared curative objective and the activity concerns the same community workers.

- *Linkage with other community based programs:* Tapping into the potentialities offered by the linkages with other community-based programs (such as immunization and community-based family planning) allow for potentially benefiting from economy of scale. Meanwhile, it is important to ensure that iCCM operates effectively and that the addition of new components does not jeopardize achievements.

- *The issue of relays' financial motivation:* As it relies on volunteers, the iCCM program is always subject to debates on sustainability. Some countries have embarked on making payments to community-based health workers while others refuse. The decision is up to each country but in any case, there is a need to explore forms of incentives.

Designing and Implementing BCC Activities for iCCM

- *Utilizing existing community structures:* The approach using churches and existing community structures proved to be a proximity strategy that is better suited to the context, simpler and less

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expensive. Resources that are already in place – namely church leaders and existing community groups – are used to convey messages to their immediate communities.

- *Establishing a comprehensive and coherent package of curative and preventive services from the beginning to avoid prevention being a secondary activity*: From the very beginning, iCCM should be seen as model for improving child health where prevention of common illnesses (through the promotion of hygiene, water, sanitation, family planning, immunization, etc.) plays a central role.

CONCLUSION

Despite the problems and challenges it is faced with, the Government of DRC was successful in mobilizing a large number of partners in introducing and expanding iCCM in ten of the country's eleven provinces in 2010. Key factors that account for this success include strong leadership and political commitment at all levels, commitment of relays at sites, unfailing support from technical and financial partners, an innovative Information, Education, Communication (IEC) approach, clearly developed technical guidelines, and the support of administrative authorities at the operational level. Though the approach has not yet been scaled up to the national level, the lessons learned from DRC can be transferred to other countries that strive to reduce child mortality.

DRC will have to address a number of challenges to expand and institutionalize the strategy throughout the country: develop a strategic plan and a multi-year inclusive budget; address the issues with the supply chain management, especially stock outs; ensure that roles and duties are clearly defined at all tiers; and revitalize promotion and prevention in order to achieve better synergy of actions.

INTRODUCTION

Globally, there has been tangible progress in reducing infant and child mortality, Nevertheless, in most developing countries, a small number of common conditions still cause much suffering and account for approximately 70% of under-five deaths. As estimated in the paper "Countdown to 2015"[2], in the DRC in late 2008, diarrhea accounted for 18% of under-five mortality, malaria for 17% and pneumonia for 16%. Over two thirds of infant and young child deaths can be prevented through simple, effective, and low-cost interventions.

Simple and cost-effective interventions are known: the administration of antibiotics for pneumonia, the combined use of oral rehydration salts (ORS) and zinc tablets to treat diarrhea, and artemisinin-based combination therapy (ACT) to fight malaria. If these interventions are implemented on a large scale, they can significantly contribute to reducing child mortality and achieving the Millennium Development Goals (MDGs).

These interventions are already being implemented through the Integrated Management of Childhood Illness (IMCI) program at health facilities. However, in most countries where morbidity and mortality among children is high, access to health facilities and/or the quality of services offered still represent major challenges and children continue to die at home. Integrated Community Case Management (iCCM) by paid or volunteer community health workers (CHWs) is an option that supports the delivery of services to hard-to-reach populations. This strategy consists in providing community health workers (CHWs) with sufficient skills to correctly diagnose and treat malaria, diarrhea, and pneumonia in children.

Global advocacy has been underway during the past 9 years for iCCM covering diarrhea, pneumonia, and malaria. This approach is gaining ground for two reasons: it is an appropriate response to the health needs of hard-to-reach populations, and results show that community case management (CCM) contributes significantly to reducing mortality among children under five. In Africa, many countries are still in the early stages of their iCCM programs–focusing at present on advocacy activities or in the preliminary stages of introducing the approach for a single disease at a time. However, several countries, including Senegal, the Democratic Republic of the Congo, Rwanda, Madagascar, and Niger, have begun to implement iCCM on a national scale.

DRC has significant experiences to share in service delivery at community sites. While several other countries were still hesitant, DRC decided to initiate iCCM to tackle the huge challenges it was faced with in terms of its populations' access to basic health care.

This document provides lessons for the global community to help countries scale up their programs. The first section introduces the methodology used to document successes and bottlenecks in the DRC program and provides an overview of the history and current status of the program. Using an internationally-recognized framework of iCCM benchmarks shown in Annex 1, the next section presents the key findings for eight programmatic components of the iCCM benchmarks, namely: 1) coordination and policy setting, 2) financing, 3) human resources, 4) supply chain management, 5) service delivery and referral, 6) communication and social mobilization, 7) supervision and performance quality assurance, and 8) monitoring and evaluation (M&E) and the health information system. The final section on lessons learned is organized around four critical themes:

- Establishing a favorable policy environment and effective institutional support

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[2] http://www.countdown2015mnch.org/

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- Reinforcing sustainable links between the health system and the communities

- Making quality services available to households

- Designing and implementing behavior change communication (BCC) activities for iCCM.

By assessing the successes and best practices of the DRC program, by recognizing its weaknesses in order to correct and prevent them, and by having a clear vision of the future of the program, this report has a two-fold aim: 1) to help other countries that are looking for ideas to accelerate and expand their own iCCM efforts, and 2) to continue to inform program implementation in DRC.

1. CONTEXT

1.1 GEOGRAPHY

The Democratic Republic of Congo has a surface area of 2,345,000 km². It is the second most populated country of Sub-Saharan Africa, with a population estimated at 64,420 million. The population distributes unevenly on the territory, with 69.6% living in rural areas, against 30.4% in urban areas. In rural areas, geographical accessibility is a constant challenge: according to the National Health Development Plan (NHDP) 2011-2015, only 35% of the population lives within 5km of a medical facility. DRC's dense hydrographic network (River Congo and lakes), as well as the dense vegetation (half of the country is covered by forest and savanna) particularly restrict the population's access to health services.

Figure 1: Administrative map of DRC

1.2 ADMINISTRATIVE SYSTEM

The administrative structure of the country is organized around 11 Provinces. Because of the country's vast size, the system follows a strong hierarchy: each province is divided into districts, districts are, in turn, divided into territories (called communes in urban areas), territories, into sectors or chiefdoms, and sectors and chiefdoms into villages or localities. Overall there are 25 administrative districts, 21 towns, 145 administrative territories, and 77 communes.

The Constitution of the Third Republic, adopted by election in 2006, provides for the devolution of power towards provinces, increased management autonomy, as well as a new division into 26 provinces. These new provisions were not yet implemented at the time of the documentation team's visit in October 2010.

1.3 HEALTH SYSTEM

The Ministry of Public Health (MPH) is structured in three tiers, namely:[3]

- **The central level** consisting of the Minister's Office and the Secretariat General which is comprised of 13 Directorates and 52 Specialized Programs. It has a standard-setting and regulatory responsibility. It lays down policies, strategies, standards and guidelines.

- **The intermediate level** including 11 Provincial Health Inspectorates and 65 Health Districts. It ensures technical support, monitoring, and implementation of instructions and policies at the level of Health Zones. In 2010, the country still had 11 Provincial Health Inspectorates although their number should reach 26 after decentralization.

- **The peripheral level** in theory includes 515 Health Zones (HZs), with 393 General Referral Hospitals and 8,266 Health Centers. This level is in charge of implementing the primary healthcare strategy, including community activities, with supervision and support from the intermediate level.

At the community level, community relays ensure the link between health centers and families. The health center team, with support from a Community Animator from the HZ, coaches community relays in their daily activities. The basic terminology used in DRC is summarized in the following text box.

Text Box 1: Basic Terminology Used in DRC

- *Health Province and District*: Form the intermediate level of the health pyramid. Their role consists in providing technical support to health zones.* In DRC, health districts *ensure roles similar to those of provinces or regions in most other French-speaking countries.* They are geographically much larger.

- *Health Zone (HZ)*: Is the operational unit of the National Health Policy's implementation. It is a decentralized organization in charge of planning and implementing the Primary Healthcare strategy and operating in accordance with the strategies, instructions, and standards laid down by the central level of the health system.* *In DRC, HZs ensure roles similar to those of Health Districts in most other French-speaking countries.*

- *Community care site*: Clearly defined geographic area where one or several hard-to-reach village(s) or community(ies) benefit from care delivery by two volunteer relays trained and supervised to manage specific common conditions, especially in under-five children.**

- *Health Zone Community Animator*: HZ staff in charge of all community activities.

- *Community Relays*: Term which refers to any "volunteer, from a village or street, appointed by the residents of the said village or street, to ensure the link between individual family members and the health service. As such, he/she agrees to devote part of his/her time to activities of community interest to contribute to the development goals of his/her village/street in a sustainable way".*** In practice, there are two types of community relays:
  - *Site Relays (SR)*: Relays who received formal training, enabling them to manage sick children at the community level.
  - *Promotional Relays (PR)*: Relays trained to conduct health-related communication activities and mobilization in their community. *They mainly work on Information, Education, and Communication.*

SOURCES:
*RECUEIL DES NORMES DE LA ZONE DE SANTE, August 2006
**SITES DES SOINS COMMUNAUTAIRES : GUIDE DE MISE EN ŒUVRE, 2007
***MANUEL DES PROCEDURES DU RELAIS COMMUNAUTAIRE, CELLULE D'ANIMATION COMMUNAUTAIRE ET COMITE DE DEVELOPPEMENT DE L'AIRE DE SANTE, accessible on http://www.sanru.cd/Documents.ph

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[3] NHDP 2011–2015

1.4 CONFLICTS AND SOCIAL SITUATION IN THE COUNTRY

The armed conflicts that have been prevailing in the country since 1996 destroyed the structure of the Congolese society and have had dramatic consequences on the populations' economic and health situation. Poverty reaches appalling proportions, affecting 71% of the population. The extent of poverty varies significantly according to whether one resides in urban or rural areas, as well as according to socio-professional categories. NHDP 2011-2015 even states that over 40% of management and collaboration executives are considered poor.

Retrospective surveys reveal an extremely high mortality rate in armed conflict-affected populations and the number of deaths attributable to war since 1997 is estimated at 3.8 million. In conflict-affected areas, the child mortality rate was extremely high.

1.5 INDICATORS

The eastern half of the country recorded an estimated 408 deaths for 1,000 live births in 2002.[4] DRC was always classified among the first six countries which jointly account for 50% of infant mortality in the world, with India, Pakistan, China, Nigeria, and Ethiopia. The different actions conducted in the health sector contributed to reducing the mortality rate. Infant and child mortality rates decreased from the sad world records of 2001–i.e., 121 and 213 per thousand respectively[5]--to 97 and 158 per thousand respectively in 2010. Substantial efforts still need to be made to achieve Millennium Development Goals.

Regarding childhood illnesses, malaria, acute respiratory infections (ARIs), diarrhea, and malnutrition are the leading conditions in DRC.

- **Malaria** is the leading cause of mortality among children under five. The number of children under five that die from malaria is estimated at approximately 180,000 per year. Although significant efforts were made as part of malaria control, major challenges still need to be addressed. Indeed, access to means for control remains poor: according to the results of the last multiple indicator cluster survey (MICS) 2010, 38% of the population uses long-lasting insecticide-treated nets (LLITN) and 39% has access to treatment.[6]

- **ARIs.** According to the Demographic and Health Survey (DHS) 2007, 15% of children under five had cough with short and fast breathing within two weeks prior to the survey. Advice or treatment from a health facility or health provider was sought in only 42% of cases of children showing symptoms of ARI.

- **Diarrheic diseases**. Concerning diarrhea, 39% of the children who had diarrhea received oral rehydration therapy (ORT), i.e., one packet of Oral Rehydration Salts (ORS) or homemade solution, 62% received ORT or increased amounts of fluids, while on the other hand, 20% of the children who had diarrhea received no treatment at all.

- **Malnutrition** is a major cause of morbidity and mortality among children and women. It is estimated to cause over 35% of under-five deaths. Only 36% of children under 6 months benefitted from exclusive breastfeeding; 46% of Congolese children under five have very low weight for age and are stunted or suffer from chronic malnutrition. A quarter (24%) of them suffers from severe stunting.

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[4] Ministry of Public Health, 2010: NHDP 2011–2015
[5] Ministry of Planning, 2001, Multiple Indicator Cluster Survey
[6] Ministry of Planning, 2010, Multiple Indicator Cluster Survey

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IMCI remains a strategy to control morbidity and mortality in children under five. However, until 2009, its implementation coverage remained poor: out of 515 health zones, 219 had integrated the clinical aspect of the approach, 214 the promotion of key practices, and 94 community care sites.[7]

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[7] IMCI annual activity report 2009

2. GOAL AND OBJECTIVES OF THE DOCUMENTATION

2.1 GOAL

The overall goal of this documentation exercise is to share DRC's experiences in integrated management of childhood illnesses in community care sites to contribute to orienting and extending this approach in DRC and developing countries.

2.2 SPECIFIC OBJECTIVES

- Collect data on DRC's experience on the community-based care for childhood illnesses.

- Document the good practices that led to successful management of childhood illnesses in community care sites in DRC.

- Document past and present bottlenecks to the implementation of the management strategy at the level of the community care sites and actions taken to address them.

- Identify lessons learned and challenges from the DRC experience to inform the orientation of current programs and development of future programs.

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3. METHODOLOGY

The methodology used for this documentation combines a literature review with in-field qualitative data collection techniques based on semi-structured interviews and focus group. The tools, as well as list of the international and national experts who took part in the collection for the documentation's purpose, are provided in Annex 10.

3.1 METHODOLOGY USED FOR THE LITERATURE REVIEW

Program Reports Review

All available documents were collected, summarized, and analyzed with special attention on iCCM in DRC. The documents reviewed include policy documents, workshop reports, training reports, supervision reports, regular project reports, specific studies, and evaluation reports, as well as international online resources and publications on IMCI at the community level.

Review of Existing Data

Routine data from the different levels of the health system were also collected and analyzed to develop better understanding of successes and possible gaps. The aim was to analyze trends in terms of program performance, coverage, and quality over time.

Data sources included, among others: Demographic and Health Surveys, Multiple Indicator Cluster Surveys, health system data, monthly reports from ASCs, monthly reports from care site community relays, data on supplies, supervision reports, and monitoring tools from district, regional, and central levels.

3.2 SEMI-STRUCTURED INTERVIEWS

The semi-structured interviews were conducted by the external team with:

- **Key informants**, including MPH representatives (National and Provincial levels); members of the successive steering committees; United Nation organizations and donors; and implementing partners, to cover the history of the program, opinions on program success and challenges related to policy, advocacy, ownership, and sustainability. A total of 17 persons were interviewed.

- **Program managers and implementation officials,** including officials and technical focal points and trainers from MPH (National and Provincial levels) and program managers from NGOs, to better understand specific technical issues about training, resource management, supervision, service delivery, the referral system, procurement, communication, social mobilization, the M&E system, and the health information system. A total of 43 persons were interviewed.

3.3 FOCUS GROUP DISCUSSIONS

Locally trained facilitators conducted focus group discussions (FGDs) with the following groups:

- **Support groups**, (for example, Church officers) with emphasis on their specific roles in supporting the program, factors of success and potential issues, the support currently provided and planned in the future, as well as the overall effectiveness of the support system. A total of 36 religious leaders participated in 4 FGD sessions.

- **Nurses in charge (IT)**, when their supervisors were unavailable, and pertained to their opinion as workers in the field on the current and past iCCM situation, their views on their specific role, factors of success and barriers, as well as their assessment of the strategy's effectiveness and suggestions for the future. A total of 61 nurses participated in 9 FGD sessions.

- **Community relays,** on trainings and supervisions, their level of self-confidence to perform their job, current and past challenges, opinions on success factors and potential barriers, and suggestions for the future. A total of 64 community relays participated in 9 FGD sessions.

- **Beneficiaries**, including mothers or caretakers of children already treated by Community relays, on their interest in and opinion of the service provided, program contributions to their family's health, and care seeking behavior in families, including the decision-making process. A total of 138 mothers and caretakers participated in 15 villages.

- **Management committees of the sites** (COGE-Site), (who provide institutional support of the local community for iCCM, on their opinions on Community relays, roles of committee members in supporting the program, success factors and potential problems, current support they provided and plan to provide , and the effectiveness of the support system in general. A total of 72 committee members participated in 13 villages.

3.4 METHODOLOGY USED FOR DATA COLLECTION
Site Selection
Sites were selected on the basis of technical and logistical criteria, including the diversity and specificity of the programmatic approach, performance, duration, coverage, and logistics and financial feasibility of the data collection. The nine Health Zones (HZs) from six Provinces are: HZs of Binza Meteo, Biyela, and Makala in the province of Kinshasa; HZ of Kimpese in the province of Lower Congo; HZs of Tshikaji and Demba in the province of Western Kasai; HZs of Bibanga in the province of Eastern Kasaï; HZ of Lualaba in the province of Katanga; and HZ of Kenge in the province of Bandundu.

3.5 SCOPE AND LIMITATIONS OF THE DOCUMENTATION
The sampling is a purposive one and is representative of the various levels of the health system in DRC, i.e., the central level, the intermediate level, and the peripheral level. Community care sites were selected on the basis of technical and practical criteria, without seeking to meet scientific requirements.

3.6 ANALYTICAL FRAMEWORK
For the analysis, the documentation team used the standard iCCM benchmarks presented in Annex 1, in order to capture key components of iCCM programs as defined by the global community. Within each benchmark, the team used the objectives to analyze the data.

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4. HISTORICAL OVERVIEW

4.1 EARLY COMMUNITY INVOLVEMENT IN HEALTH CARE IN DRC

In DRC, health care delivery by community workers stems from the concept of primary health care (PHC). The history of PHC goes back to colonial times when non-profit associations and several private companies conducted interventions. Several public companies, whose first pioneers were the Medical Service of the independent State of Congo (1888-1908) and the Medical Service of the Belgian Ministry of Colonies (1908-1960), were also involved in such interventions. Since then, commitment efforts were resumed by the successive political and administrative authorities, as illustrated by the credits made available to missionaries who contributed to control trypanosomiasis and smallpox (1916).[8]

After the Alma Ata Conference in 1978, with the international community's impetus and support from WHO and UNICEF, DRC immediately drew up its PHC strategy and concurrently reorganized its health system. The effort resulted in a three-level pyramid system which is currently still in force in DRC: a central level, an intermediate level comprised of provinces and districts, and a peripheral level comprised of HZs, which are in charge of implementing the strategy.

Unfortunately, with the years 1990 to 2002 came a period described as the "dark period." International cooperation was put to a halt in 1990; generalized plundering occurred, first in 1991, then in 1993; armed conflicts devastated the country from 1996 to 2002, causing its division into Occupied areas and State areas.

4.2 PHASE I: ADVOCACY FOR COMMUNITY CASE MANAGEMENT

2003 is the year DRC emerged from a long armed conflict which threw the country in an unprecedented social and economic crisis. In April 2003, political transition institutions were established. The following paragraphs recount the progress of iCCM beginning in 2003.

2003

- **Acceptance of a community approach.** The Transition government was established and MPH sought solutions to improve the population's health condition, opening up to the idea of using Community volunteers.
- **Community approach to childhood illnesses.** The National Program to Control Diarrhea Diseases (NPCDD) is established to manage the introduction of community integrated management of childhood illnesses (c-IMCI).

2004

- **Decision to adopt an integrated approach from the very beginning.** In October, the results of research on ARIs at the community level in Senegal were presented during a coordination meeting on c-IMCI. The successful experience of Community volunteers in correctly managing cases of pneumonia and administering antibiotics aroused much interest from DRC's MPH. After this presentation, the process accelerated very quickly. Unlike in Senegal, the four conditions, namely malaria, diarrhea, acute respiratory infections, and malnutrition, were immediately integrated in community care sites.

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[8] Ministry of Public Health and SANRU III project (2004), Evolution des Soins de Santé Primaires en RDC (Trends of primary healthcare in DRC)

2005

- **Establishment of a Steering committee.** In September, the official letter by the Secretary General of Health (Annex 3) was published. An implementation plan was then developed and extension criteria were defined, followed by field surveys aimed at guiding the selection of the first sites.

4.3 PHASE II: INITIAL TRAINING

2005

- **Launching of the first sites:**
  - October: training of the pool of national trainers
  - December: first sites in the Kenge HZ, Province of Bandundu (financial support from Germany Technical Cooperation GTZ), then in the Demba HZ in Western Kasaï (financial support from IRC), and in the HZ of Mont Ngafula in Kinshasa (financial support from UNICEF).

- **Adoption of the ACT in the national protocol for malaria treatment.** The new protocol was adopted in 2005, almost coinciding with the launching of the first Community care sites. The new iCCM strategy was brought into line with the national protocol.

- **Alternate and provisional action for malaria treatment at the site level.** A major practical problem arose: ACTs were not yet available at the selected HZs. Instead, health posts used Sulfadoxine-pyrimethamin (SP). Relays were trained to temporarily use SP to be immediately operational. However, the first training modules and tools also included the official treatment protocol using ACT. ACT was introduced gradually according to the drug's availability. By 2010, all sites were using ACT.

2006

- **Beginning of the training of provincial trainer pools** in June, in the Province of Kinshasa. Later in 2007, the setting up of the pools of trainers in the Eastern Province and the Province of South-Kivu were continued with financing from WHO.

- **Updating of diarrhea treatment at the community level.** The first meeting of the technical group working on CCM to establish a Zinc Task-Force was held in November. A first batch of 3.5 million zinc tablets, bought by UNICEF, arrived in December 2006. Other partners contributed to procurement, for instance USAID contributed through the AXxes project.

- **Efforts towards official registration of zinc.** Since the decision to introduce zinc was made after the revision of the National Essential Drugs List (NEDL) in 2005, a special group worked towards its official registration and future introduction on NEDL.

2007

- **Review of Community-Based Care and Inter-Country Exchange on c-IMCI organized in Kinshasa.** In October, His Excellency, the Minister of Health, personally chaired the conference attended by ten other African Countries. At that time, DRC already had 421 trained relays in 212 care sites, with 119 of them operational.

- **Updating** of the "Community Care Site Implementation Guide" with foreword by the Minister (Annex 2).

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4.4 PHASE III: SCALE-UP

Because the program initially decided to immediately proceed to scale-up, i.e., the pilot phase was skipped, the progress of the strategy in DRC went unhindered.

2008

- **Consolidation of the scale-up through a program to build the management capacities of the provinces.** The efforts focused on 1) creating a budget line intended to support sites at the provincial level, 2) mobilizing partners, 3) advocating with political and administrative authorities, and 4) decentralizing the sites' management. The program covered the provinces of Kinshasa, Bandundu, and Eastern Kasai. Two provincial Ministers visited the sites to ascertain realities and directly discuss with relays and beneficiaries of community care.

- **The Inter-Country Review Conference held in Madagascar** in August, during which DRC's successful experience in integrated community approach aroused keen interest throughout the world: 163 representatives from twenty-two countries in Africa, Asia, and America attended this conference which was chaired by the Prime Minister of the Malagasy Government.

- **A study on Rapid Diagnostic Test (RDT) was reoriented towards the setting up of an integrated approach.** In June, a pilot study was launched in the HZ of Kimpese in Lower Congo to test the feasibility and acceptability of use of RDTs and ACTs (Artesunate-Amodiaquine) to manage uncomplicated malaria in community care sites. The study, funded by UNDP and the World Fund, was conducted by the Kinshasa School of Public Health. The MPH required that SRs be trained to manage diarrhea and pneumonia. During this 12-month study, two additional specific aspects were explored: 1) the capacities of site relays to correctly manage RDTs, and 2) the management of uncomplicated malaria cases in children and adults. The results of the study—whose abstract is provided in Annex 5—were conclusive. Unfortunately, the activities came to a halt when the project ended as relays stopped receiving financial incentives from the project.

2009

- **Churches were mobilized to disseminate key messages** on child health, with emphasis on signs of danger and appropriate care seeking.

- **Scale-up continued**. In September, ten out of the eleven provinces were reached and 78 of the 515 HZs.

2010

- **A community malaria treatment project is reoriented towards an integrated approach:** the Canadian Agency for International Development (CAID) funds a project to offer ACT at the community level in 4 countries.[9] In DRC, MPH required the integration of malaria treatment to those with pneumonia and diarrhea in community sites. The project is implemented by Population Services International/Association de Santé Familiale (PSI/ASF), in collaboration with National Diarrheic Diseases Control Plan (NDDCP) and National Malaria Control Program (NMCP), in all sixteen HZs of the District of South-Ubangi in the Province of Equateur. The project, initiated in April 2010 for a term of two and a half years, included an impact study of the infant mortality reduction approach. During the first phase, part of the intervention zones served as control zones and afterwards benefitted from the intervention during the second phase. More than 700 community care sites will be set up, with more than 1500 SRs.

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9 http://www.acdi-cida.gc.ca/CIDAWEB/cpo.nsf/vWebProjByPartnerEn/1DA3D0CB2964D550852574C700372A30

- **Introduction of family planning in community care sites.** In June, the National Reproductive Health Program (NRHP) and NDDCP, in charge of coordinating c-IMCI, tested the integration of family planning. The community-based distribution of contraceptives was launched in 6 HZs, with support from NRHP, NDDCP, as well as USAID through projects AXxes and MCHIP.

Figure 2: Key stages of Community Case Management in DRC

	2004	2005	2006	2007	2008	2009	2010
POLICIES and NATIONAL DIRECTIVES		Adoption of ACT in the national protocol		Adoption of the implementation guide	Diarrhea treatment policy revised	Adoption of PNDS (National Health Development Plan) / ARI policy revised	
DIARRHEA		Home-based fluids and ORS			Use of zinc and low-osmolarity ORS	Multimedia campaign on zinc	
MALARIA		Introduction of treatment with ACT		Review of first phase of implementation of iCCM / Inter-country exchange on IMCI-c in Kinshasa	Feasibility study on the use of RDTs and ACTs including case management in adults		
ARI	Recommendation for community case management of ARI	Introduction of treatment with cotrimoxazole			Expansion of treatment with cotrimoxazole	Treatment period reduced from 5 days to 3	
Malnutrition		Management of moderate malnutrition					
Family Planning						Introduction of family planning	

5. FINDINGS

To ensure that the analysis of findings from the documentation exercise captures what are considered to be key components of iCCM programs, this section follows the iCCM benchmarks endorsed by the CCM Task Force, presented in Annex 1. The benchmarks include eight components, namely: 1) coordination and policy setting, 2) financing, 3) human resources, 4) supply chain management, 5) service delivery and referral, 6) communication and social mobilization, 7) supervision and performance and quality assurance, and 8) M&E and the health information system.

5.1 COORDINATION AND POLICY SETTING

This section presents findings, as well as promising practices and challenges, under iCCM coordination and political framework in DRC.

High Level Commitment

Many signs show that there has been strong ownership of the program by the highest levels of the MPH, namely the fact that the Minister chose to sign the implementation guide's foreword and to chair several meetings or an official letter by the Secretary General of the MPH appointing the national steering committee (Appendices 2 and 3). The steering committee's responsibility was to develop standards, strategies, guidelines, and protocols as well as to mobilize funds and lead advocacy. Some of the major strategic decisions initiated by the committee include: 1) moving directly to the initial implementation phase without having a pilot phase to avoid delays, and 2) integrating immediately malaria, ARI, diarrhea, and malnutrition at the community level.

> *"The implementation's strength comes from the involvement of the Minister and the Secretary General of the Ministry of Public Health and from backing the strategy's implementation through various speeches and texts by the authorities, further illustrating their commitment."*
>
> ~Interview of a central Officer at the MPH

The inter-country review held in DRC in 2007 was led by the highest authorities in charge of health and has significantly leveraged advocacy, experience-sharing, definition of main orientations for the approach of community childhood illnesses management and community-based care.

Technical Coordination

The management of the IMCI strategy in DRC is shared between: 1) the National IRA Control Program (NICP) that is in charge of the clinical component, and 2) the National Diarrheic Disease Control Program (NDDCP) that is in charge of the community component. From the inception of the intervention, NDDCP has been ensuring effective coordination of the various actors, setting up a framework for collaboration that was able to accommodate a number of partners while maintaining the Ministry's options. The technical sub-group successfully conducted advocacy at the National Malaria Control Program (NMCP) for the adoption of the full package of activities at the sites as illustrated by the reorientation of two projects: 1) in 2008, a research on the use of ACTs and RDTs by relays in Kimpese opted to apply the full package, and 2) in 2010, a project funded by ACDI to promote the use of ACTs was reoriented to provide the full integrate package in the care sites (cf. section on background). Making decision

through consensus can be a lengthy and tedious process as some of the programs involved do not report to the NDDCP though this did not have negative impact on collaboration.

In 2010, there were no strategic or scale up plan with clearly identified funding and the setting up of sites in most cases was negotiated on a case-by-case basis between the Ministry and partners interested in the program.

From a technical and operational vantage, the strategy of case management at the community care sites is well codified. Policy, strategic, and implementation documents are available that clearly describe the duties of the site relays, delineate their areas of competency, identify structures in charge of supporting them, and support and explain the process for training relays and for monitoring and supporting the program. However, it would be good to further disseminate these tools to the intermediate and operational levels.

The Provincial Minister of Health, accompanied by the *Commissaire de District*, received by the traditional village chief during a community site visit in Muni Kenge

Decentralized Level

Things are moving at different paces at the decentralized level:

- On one hand, the most peripheral HZs are directly in charge of making the program operational in application of the guidelines developed by the central level. Wherever the iCCM strategy is implemented, the roles of the HZ are clear and translate into planning, implementation, monitoring, and management of activities.

    - On the other hand, the districts and the provinces, as intermediate tiers between the central level and the HZ, should provide "technical support," whose meaning remains unclear. Some management staff at the province level benefited from capacity-building from USAID through the BASICS project in 2009, including the provinces of Bandundu and east Kasaï. The results of the investment in leadership and ownership development are still tangible in 2010: the documentation team had the opportunity to visit the sites with the provincial minister in the HZ of Kenge, in the province of Bandundu. Such visits boost the enthusiasm

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of actors in the villages and of the local authorities and generate impressive mobilization. Unfortunately, capacity development in the regions and the districts run up against financial obstacles. Partners in charge of monitoring had funding only for implementation in the HZ, which are usually very scattered and far from the provinces and this situation resulted in low ownership in the regions and districts.

The provinces have working groups called "Maternal, Neonatal, and Child Survival groups" that should contribute more actively to coordination.

Promising Practices in the Area of Coordination and Policy Setting

- **Clearly expressed comm**itment of political authorities at the highest levels as reflected by the Ministry and senior officials' involvement.

- **A position that is clearly defined and supported** in regards to the integrated service package.

- **Representation of all stakeholders** and technical and financial partners in the Steering Committee.

- **Roles and duties clearly defined** at the central and operational levels.

- **Competency-building initiated** at the decentralized levels resulting in strong ownership and leadership by the provincial ministers.

Challenges and Barriers

- Lack of a strategic plan that should **guide the prioritization and the distribution** of technical, financial, and human resources: without the plan, it is impossible to define quantified objectives, to plan for expansion per priority zones, and to ensure adequate monitoring of progress and coverage.

- **Lack of long-term positioning of partners**, which requires investing significant efforts in resources mobilization.

- Not enough coordination meetings during the extension phase, **which hindered information-sharing** especially in regards to the new guidelines on the different programs concerned.

- No progress in regards to the actions initiated to build skills at the decentralized level**: the role played by the districts is less clear**.

Table 1 : Successes, bottlenecks, and solutions in terms of coordination and policy setting

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ Political commitment at the highest level (national steering committee established by a letter of the Secretary General, implementation guide with a foreword by the Minister) ▪ Immediate start-up of the initial phase without a pilot step	▪ Irregular disbursement of funds by partners, affecting compliance with standards	Solutions adopted: ▪ Advocacy meetings organized to mobilize additional resources and plan sites' activities in the action plans

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Expansion Phase		
▪ Existence of documents providing norms (implementation guide) ▪ Revitalization of the approach during the inter-country review organized in DRC in 2007 ▪ Clear distribution of roles and duties in regards to coordination at the central level: the NDDCP was in charge of c-IMCI and the NICD was in charge of clinical IMCI ▪ Technical and financial partners' support to the country's decision to initiate and accelerate expansion	▪ Not enough coordination meetings at the national level to monitor the strategy's implementation ▪ No clear plan for scaling up ▪ Low ownership of the approach at the intermediate tiers (provinces and districts) ▪ Resistance from some influential partners of the MPH who advocated for making the development of health facilities a priority	**Solutions suggested :** ▪ Develop a single plan for IMCI coordination activities ▪ Appoint an IMCI provincial focal point at the central level (10th bureau) ▪ Clarify roles and duties as regards IMCI coordination at the intermediate level ▪ Intensify support and coaching of the management teams in the districts and provinces to develop ownership

5.2 FINANCING

This section presents the promising practices, as well as challenges and barriers, under iCCM financing in DRC.

Funding by the Government

The government budget share allocated to health in general and to maternal and child health in particular is very low. Needs in the country are so immense and diverse that the social sector tends to fall in the background of the government's priorities. When the major infrastructure projects underway will be completed, the Government plans to increase gradually the budget shares allocated to social and production sectors (cf. figure below).

> *"The country is currently faced with many challenges for relaunching social and economic development and some sectors such as infrastructures, security, etc. are the government's top priorities.*
>
> *One of the biggest weaknesses of c-IMCI implementation in DRC is the lack of substantial support from the central government as partners do not cover the entire country. We fully rely on external support for implementing the strategy. There is no funding from the Government."*
>
> ~From interview a central Officer at the MPH

In the absence of a specific budget line for community-based activities, the Government's contribution is limited to the salaries of civil servants involved in the program and the public facilities used by the program. On the other hand, health is one of the sectors where competencies have been transferred to local collectivities as part of the country's decentralization process. With good sensitization at the province level, resources can be mobilized from the decentralized funds to support health activities implementation at the

community level. The two provinces that benefited from capacity-building already have a budget line to support community sites.

Figure 3: Strategic shares of the Government's budget for the five development sectors from 2006 to 2010 and orientations from 2011 to 2015
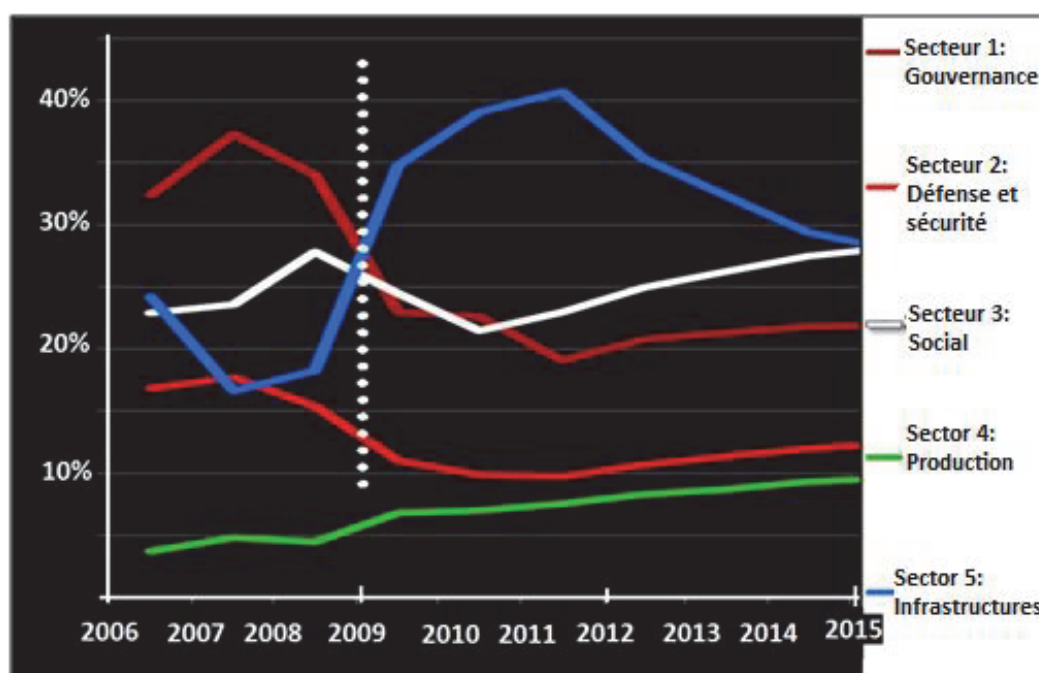
Financial Commitments of Financial Partners

Though most of the partners of the health sectors did not initially have a specific budget line for care sites, many restructured their budget to allow for site support. The list of financial partners and their respective fields of intervention are provided in Annex 6. Roughly speaking, their financial contributions come in the form of support to the central level, namely supporting the NDDCP and the Steering Committee, supply of inputs (such as timers and zinc), the development of strategic and technical documents, or in the form of support to implementation in the field through training, post-training monitoring and supervision, supply with drugs and inputs, and logistic and financial support in organizing meetings and workshops.

It should be noted that at activity start-up in 2004 and 2005, none of the partners in place planned for specific financial support to the community sites. Each of the financial partners had its own budget cycle, its own objectives, and budget lines that were barely flexible. Tedious efforts were required to address this situation:

- A door-to-door advocacy of the programs and projects underway to identify those budget lines that could be re-negotiated and reoriented to allow for supporting community sites.

- Financial set-up to ensure that the fragmentary contributions can be complementary and synergic as a whole. USAID, through the BASICS project, played a key role in this mobilization effort and the World Bank worked to maintain the initial momentum. WHO, UNICEF, and USAID funded the development of the approach and GTZ, UNICEF, and the World Bank funded the relay to support initial implementation.

One issue that was noted was the lack of medium- and long-term financial positioning, which jeopardizes funding security: in most cases, projects involved were short-term and supported implementation in limited geographical areas. However, some opportunities have arisendue to the interest of the Global Fund, for example, pursuant to the country's submission of a proposal under Round 10.

Furthermore, the lack of a strategic plan, as stated in the previous section, does not allow for anticipating needs at the scale up phase. The National Health Development Plan (NHDP) that has been finalized and is in the process of approval will provide a starting point for the partners' alignment.

> *"We believe that this approach is promising and that the big project of community care sites funded by ACDI with ASF/PSI Congo in South Ubangi at Equateur (targeting 16 HZ with about 700 community sites) offers a big opportunity in the same way as under the proposal the Global Fund's Round 10, we included a clearly defined component on the community sites with the use of ACTs and RDTs in about one hundred HZ. We hope that our application to Round 10 will be successful. It will breathe life for scaling up the approach."*
>
> ~Dr. Angwalu, Deputy Director, NMCP

Beneficiaries' Participation

Though it is minimal in terms of financial value, the beneficiaries' direct participation in the cost of care has a high symbolic value. Health services must be paid for in most sites. Thus, relays hand the ITs all the proceeds of the care sites and the site management committees are in charge of controlling the funds. However, in most cases, there are no such committees or they are inactive.

The tariffs are set at the discretion of the HZ and the implementing partners: they are set per illness episode, at the same price as in the health facilities, and include both service provision and drugs needed at each illness episode. However, as the subsidized drugs are sold at a discount price; users' participation is not sufficient to ensure resupplying.

Tariffs vary across HZ and are not standardized (FC 300, FC 400, and FC 500). High rates seem to impede the use of the services. There are neither guidelines in regards to setting tariffs nor attempts to standardize them. Some partners even advocate for free care.

Promising Practices in the Area of Financing

- **Decentralization** with transfer of competency to provinces and local collectivities, which open up possibilities for resources mobilization.
- **Symbolic participation** of the beneficiaries in the cost of care.
- Planned increase in the **share of social sectors** in the central Government's budget.
- Development of a PNDS to **align partners on the same objectives and priorities**.

Challenges and Barriers

- **Very little financial** contribution by the Government.
- **Possibilities for financial mobilization** from decentralized authorities not yet fully tapped into.
- **No budget line** for community-based activities.

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- Impossible to negotiate **long-term positioning of financial partners**, to plan in advance, and to mobilize potential resources beyond the life of the projects underway.
- **Cost recovery system** in place does not allow for resupplying as commodities are highly subsidized.

Table 2 : Successes, bottlenecks, and solutions in terms of financing

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ Flexibility of partners who restructured their budgets and plans to accommodate care sites	▪ NA	Solutions adopted: ▪ Joint funding of some activities by the different partners
Expansion Phase		
▪ Ongoing support of the traditional funding agencies ▪ Opportunities with new donors (ACDI, the Global Fund) ▪ Opportunities to use the budget allocated to health at the provincial level for community-based activities ▪ Communities' participation in funding the sites through the payment of fees ▪ Beneficiaries' participation	▪ Very little governmental financial contribution to community-based activities ▪ Current funding insufficient compared with the country's size and the significance of the challenges ▪ Lack of local authorities' involvement in budgeting activities in most cases ▪ No estimates of the cost for setting up case management at community site care and for sustaining their activities	Solutions adopted: ▪ Implement the PNDS to build a common vision Solutions suggested: ▪ Develop an advocacy plan for community-based activities ▪ Conduct persistent advocacy among provincial assemblies and the national assembly for the allocation of a realistic budget share to community-based activities ▪ Plan activities by estimating needs at all levels (with the participation of local authorities, the civil society, etc.)

5.3 HUMAN RESOURCES

This section presents findings, as well as promising practices and challenges, under iCCM human resources in DRC.

Human Resources Development

Substantial efforts were done to develop and build competencies in support of iCCM. The efforts were systematic and reached all the levels of the health system.

- **Training of health workers**: The development of expertise at the central level was initiated early in the implementation of the strategy.
  - The introduction of iCCM in a province always starts with the training of a pool of trainers on the technical contents as well as on training techniques. The trainers from the central level provide coaching to the trainers in the field and help them conduct their first trainings. The ITs and the management team benefit from this training of trainers which is immediately followed by the training of relays. The coaching continues until the pool of

trainers fully masters the process, which has an emphasis on practical aspects and on practice of case management itself.

- Lot Quality Assurance Sampling (LQAS) was used as methodology for monitoring behavioral change in the sites. A core of 35 central LQAS trainers was established with the technical support of IRC and USAID through the BASICS project. Some HZs benefited from LQAS training, including five convergence HZs supported by UNICEF in the province of Kinshasa (15 HZ management officers were trained). USAID, through the AXxes project, also supported the training and data collection on newborn care in the provinces of South Kivu, Katanga, and east Kasaï.

- **Training relays in sites:** The relays are trained by the provincial or district-level pool of trainers during five days in collaboration with the IT in charge of their supervision. The training is a hands-on training with more than 30% of the time devoted to practice sessions with sick children, simulation, and other exercises.

  - Generally speaking, all the relays in the sites indicated that the training they received *built their confidence in their ability to manage illnesses* in children under five in their communities. They feel that the training was of high quality and are proud of their newly acquired skills. Overall, it seems that the relays can master complex tasks such as administering RDTs in malaria areas, as found by the study carried out in the HZ of Kimpese.

  - All of the relays in the sites reported benefiting from post-training monitoring and are appreciative of this form of support. During the monitoring sessions, observations tend to focus more on the filling of case management forms during a consultation under the supervision of a coach/supervisor, on counting breathing, on counseling mothers, and on report writing.

"I am happy with the training I received as I know now how to administer drugs to children."
~(Focus group with relays in the site of Kenge)

"The monitoring helped us master counting breathing."
~(Focus group in Tshikaji)

The documentation team noted that are some disparities in regards to the length of training: it was ten days in Kenge; seven in Kimpese; five in Tshikaji, Demba, and Lualaba; and two in Bibanga. Such irregularities only reinforced the central level's decision to conduct close monitoring to ensure compliance with standards and procedures and are one of the reasons why the central level has expressed its wish to be present at the training in new districts.

- **Training of communities:** The iCCM implementation guide provides for a training of communities on the sixth day but little attention has been paid to this aspect to date and no follow-up has been done to strengthen it.

- **Training of volunteers from Churches:** Volunteers from Churches played an important role in iCCM's communication activities. The training was done according to a cascade approach where religious leaders are first sensitized on the topics to develop ownership of the approach and then in turn selected trainers in their respective churches. The training of volunteers is conducted in each church, with the objective of training as many people as possible to sensitize the communities. For instance, in the province of Makala in 2008, a group of 40 religious leaders were sensitized on danger sign identification and selected 58 delegate trainers. More than 1,000

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members in their respective churches were then trained. This approach was expanded throughout the HZ of Makala and other HZs later on.

As of September 2010, more than 2,000 relays are available in the country, out of which 700 were trained in the last year of activity. The graph below shows that despite the lack of a strategic plan, the MPH and its partners managed to mobilize resources to steadily develop human capacity for iCCM.

Figure 4: Progress of efforts to build competencies at the different tiers of the health systems, from January 2006 to September 2010
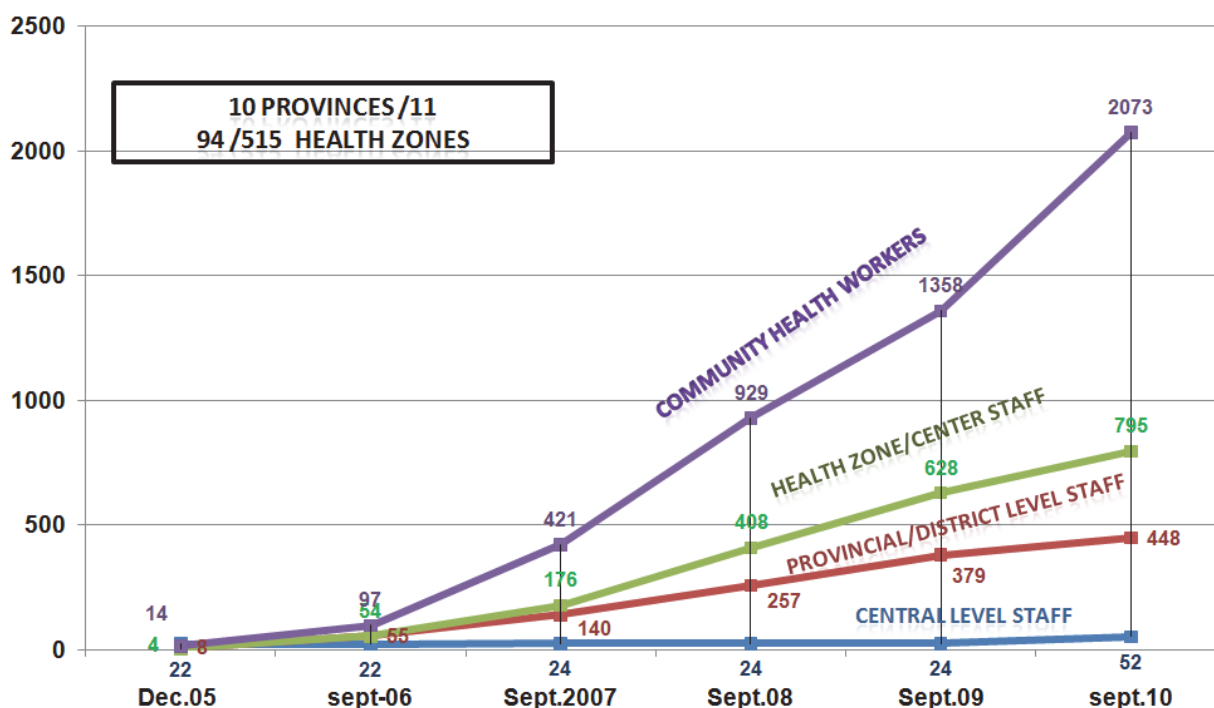
SOURCE : MCHIP in the Democratic Republic of Congo (DRC) - Final Report 1 April 2009–31 July 2011

Recruitment Procedures

The procedures for recruitment are participatory. The site relays are elected by community vote based on the following selection criteria: literacy, volunteering, permanent residence in the communities, courage, humility, honesty, respect, and absence of conflicts. The ITs are involved in the identification of sites and facilitate the organization of the relay's election.

The ITs, the trained relays, and the communities establish a Site Management Committee (COGESITE) and the members of the committee are in charge of managing the site, sensitizing, and mobilizing the entire village to use the site.

> *"We are MaluMalu (organizers of the relay's election) for the community."*
> ~(Focus group with ITs in Kenge)

> *"We asked the village/locality chief to provide us with two volunteers from his village for a training in the HZ so that they can manage the sites"*
> ~(Focus group of IT in Bibanga)

"The site was set up in the village by the management team of the HZ central office and the IT. The population was informed in preparation of the site's establishment and we selected the relays ourselves to avoid that BCZS or the IT chooses someone that is unknown to the community or who is not appreciated by the community."

~(Focus group COGESITE in Lwalaba)

"A big number of COGESITE have played a role in sensitization and have contributed to selecting relays."

~(Focus group COGESITE in Kimpese)

Community Health Workers during a directed focus group discussion in Binza Meteo

The Issue of Relays' Motivation

The issue of community relays' motivation always result in heated debates as they work as volunteers and do not receive financial incentives. Some managers believe that the risk of loss of motivation is high in the absence of financial or material incentives. However, other financial compensation systems are in place, such as the relays' participation in the budgeted preventive activities such as immunization or vitamin A supplementation campaigns. It was further reported that some COGESITE support their care sites by performing farming activities for them, which constitutes an in-kind form of incentive for relays. On the other hand, the population sees itself as too poor to be able to contribute any financial or material support to the relays working in the sites.

Despite the situation, *the retention rate is good*: the figure below shows that over the first three years of implementation, more than nine relays out of ten have remained in activity. The transparency in the selection process, the social structure and solidarity, as well as the communities' efforts to express their appreciation to the relays have undoubtedly contributed to motivation.

"The members of the COGESITE practice farming activities to allow the site to operate well. They give the food produced to the relays."

~(Focus group with ITs in Kenge)

Figure 5: Retention rates among relays in the sites from 2006 to 2008 according to a rapid assessment (cumulative number)
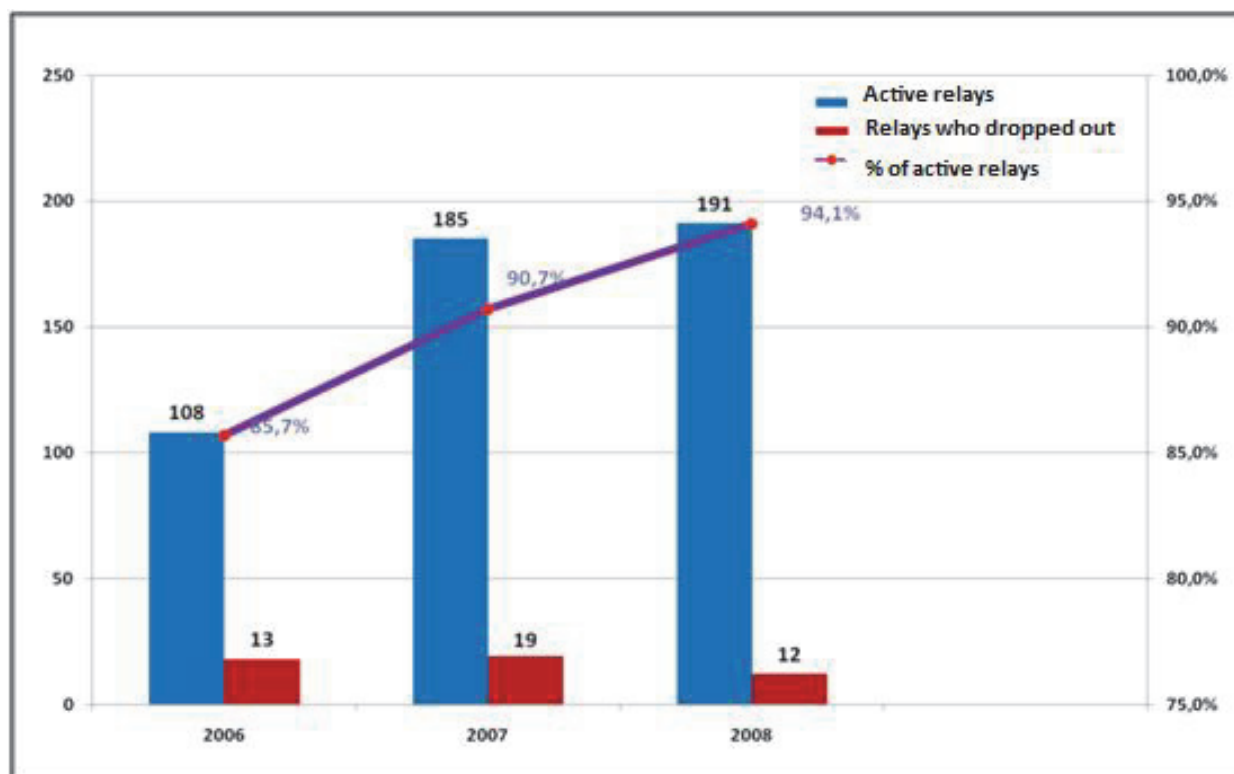
The interviews and focus groups yielded a number of suggestions to make up for the lack of financial incentives, including:

- Providing them with means of transportation (bicycles) and other small equipment such as torches to enable them to work even at night.
- Developing cards that would grant special status in civil protection when traveling.
- Building sheds in the relays' plots for community activities.
- Involving relays in the quarterly monitoring meetings.
- Regular monitoring visits by the different tiers of the Ministry of Public Health.

In any case, DRC's experience clearly shows that there is a *need to conduct thorough reflection on the impact of any financial incentive offered to relays and to anticipate such impact on the long run.* For instance, when financial partners stopped their support to the relays in the HZ of Kimpese at the end of the research on malaria in 2009, the activities of relays involved in the program stopped immediately due to the lack of a sustainability plan and low ownership among the beneficiary communities.

Community Health Worker using an individual management form and a growth chart, Kimpese

Importance of Promotional Relays

Before the strategy of case management in the community care sites was introduced, all the relays provided preventive, educational, and promotional services.

The high level of technical skills required for the case management and the handling of drugs by the sites relays called for close monitoring to avoid any blunder that would put children's lives at risk and jeopardize the strategy as a whole. Understandably, communities, community leaders, and health workers place more value on the status of site relays as there is no possibility for promotion later, if one is not initially selected by the community itself. On the other hand, the introduction of church volunteers, *a less expensive approach, has resulted in attention shifting away from the promotional relays in place, which has generated some frustration.*

Promising Practices in the Area of Human Resources

- Taking into account the **entire health system** in capacity-building.
- **Codified training** done according to a cascade approach.
- **Transparency** of recruitment procedures.

Challenges and Barriers

- **Noncompliance** with the training duration and procedures, which then required rectification and intervention at the central level,
- **Financial** motivation issues unsolved,
- **Attention shifting away** from the work done by promotional relays.

Table 3 : Successes, bottlenecks, and solutions in terms of human resources

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ Relay's experience in the community	▪ Lack of financial motivation	▪ N/A
Expansion Phase		
▪ Availability of a pool of competent trainers, present and motivated at all the tiers of the health system ▪ Community relays' skills meeting the community's and supervisors' expectations, including on complex tasks (such as administering RDTs as shown in the feasibility study in the HZ of Kimpese) ▪ Existence of a process for selecting and recruiting based on pre-set objective criteria ▪ Communities' participation in selecting relays ▪ Enhancing the value of the community relays' works through visits by IT and physician during the supervisory visits ▪ A low cost approach through the use of churches, allowing for reaching more people	▪ ITs and management teams of HZ can move out at any time ▪ Risk of loss of motivation among community relays due to the lack of financial or material incentives, according to some managers ▪ Lack of ownership of the approach by some management team members especially at the intermediate level ▪ Feeling of being marginalized among promotional relays to the benefit of site relays that are granted more attention by c-IMCI partners ▪ Lack of resources to routinely trained at the different tiers so that each can fulfill their respective roles	**Solutions adopted:** ▪ Implement the PNDS to build a common vision **Solutions suggested:** ▪ Have the government improve the social conditions of workers ▪ Plan new trainings for the new teams in health facilities ▪ Strengthen supervisory visits and other visits both for promotional and site relays ▪ Further explore the issue of motivation, taking into account suggestions by the communities

5.4 SUPPLY CHAIN MANAGEMENT

This section presents findings, as well as promising practices and challenges, under iCCM supply chain management in DRC.

The National Supply System

DRC's iCCM supply system is very complex: a mapping of the National Essential Drugs Supply System published in 2010[10] pointed out that there are 19 supply agencies and 99 distribution pipelines mobilizing 52 different partners in the country. The report acknowledges that such fragmentation affects the efficiency of the supply cycle as a whole, creates wide disparities, and goes against responsibility-taking by the public sector actors.

Drugs are generally supplied as a grant by partners: the selling price (lower than actual cost) is intended to serve as an operating fund at the local level. Commodities are sold at loss, which

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[10] Programme National d'Approvisionnement en Médicaments et OMS (2010) : Cartographie des systèmes d'approvisionnement et de distribution des médicaments et autres produits de santé en RDC

makes it impossible to ensure sustainability. Each partner provides support as it sees fit in its intervention zone and there is neither harmonization of tariffs nor long-term strategy for commodities.

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Text Box 2 : List of Drugs and Inputs Required at Community Sites[11]

Drugs

- Antimalarials: Artesunate-amodiaquine (ASAQ) and quinine drops
- Paracetamol 500mg tablets
- Cotrimoxazole 480mg tablets
- ORS sachets
- Zinc sulfate 20mg tablets
- Mebendazole 100mg tablets
- Iron sulfate 200mg tablets (or iron sulfate and folic acid tablets)
- Condoms

Inputs

- Timers
- Salter scales
- CPS forms with color strips to be used by relays
- Case management for one year of activity by relays
- Consultation logs at the sites
- Essential drugs used and revenues register (RUMER)
- Drugs order book
- Monthly report formats
- Drug case for all sites

SOURCE: iCCM implementation guideline

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Strategic Challenges

A report from a survey on drug prices in DRC, published in 2007 by the National Essential Drug Supply Program,[12] pointed out the *weakness of the pharmaceutical regulatory authority*. The report highlighted the existence of fraudulent massive drug entries in the country as well as illegal distribution pipelines. Drugs suppliers are not always pre-qualified and the origins of the drugs are diverse. The documentation team believes these findings are still valid as of 2010.

The population takes part in paying the drugs' costs but due to the context of widespread poverty, the Ministry and its partners cannot consider full cost recovery that would allow for self-sustained stock renewal and sustainable drug supply. According to the 2007 survey on the drug's price, households have to spend half of their daily wages to treat one ARI episode. On the other hand, prices vary across HZs depending on the partner supporting the strategy. Thus, the

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[11] Sites de soins communautaires: Guide de mise en oeuvre, updated in 2007
[12] Programme National d'Approvisionnement En Médicaments Essentiels et OMS (2007) : Enquête sur les Prix des Médicaments en République Démocratique du Congo

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country is faced with the dilemma of *providing drugs at a very low price to its very poor population and the need to recover a certain amount to maintain the system.*

Management Practices at the Sites

The forecasts of the sites' needs are integrated into the needs of their supervising health facility for the entire health area served. *Drugs management is monitored by ITs during their supervisory visits as well as by COGESITE members.* Some products such as ACTs and zinc require special attention due to their very short shelf life. The relays take part in the monthly reviews of health workers to discuss drugs management, among other topics. Management tools are generally available, including RUMERs, daily tally forms, and order books. Though some relays reported that their needs have not always been included in the orders of the health area, this situation does not seem to be a major and widespread problem.

Given the small amount of drugs that need to be stored, relays generally use *wood cases that are well ventilated and ensure safety*. This allows for easy handling of drugs, for verification at a glance, and for saving room. Relays usually provide care in their own homes. Some relays complained about not having the wood cases, which could expose their own children to risks of accidents.

Drugs of questionable origin sold near a health center in Lukangu

The renewal of small equipment such as the batteries of timers and scales is not routinely addressed: the supply of materials and equipment is usually a one-time action during the sites' opening.

Stock Outs

Little change has been noted in the DRC since a survey conducted in community sites in three provinces[13] in 2008. The survey highlighted significant availability issues: for instance, in west Kasaï, only 24% of the sites had ACTs for malaria treatment; in the province of Bandundu, there was no ACT (even at health facilities), but 77% of the sites had SP in stock; and in the province of Kinshasa, 55% of the sites had ACTs. The report concluded that the issue of drugs availability at sites was a *general problem that is related more to the essential drug supply system than to the operation of sites*, the sites being one element of a wider health system.

In the case of stock outs, trained community site relays attempt first to get their supply from itinerant sellers, private pharmacies, and drug depots. These constitute a very well developed network in DRC and some of them pile up stocks in preparation of possible stock outs. *The origins and quality of the commodities are undoubtedly questionable* and on the other hand, the community management strategy has officially granted legitimacy to the relays among the population. Thus, the risks of blunders are huge. Sometimes, sites receive gifts of drugs that do not meet standards or their needs.

As said earlier, the issue of drug stock outs is not specific to the iCCM strategy: health facilities are also regularly faced with stock outs of essential drugs.

Promising Practices in Supply Chain Management

- **A simple and standardized approach** for quantifying needs.
- **Management tools available** (RUMER, tally forms, order/requisition books).
- Wood cases adapted to the **service provision setting** (relays' homes), easy to handle, allowing for verification at a glance, and meeting safety standards.

Challenges and Barriers

- A very **complex supply system**.
- **Difficult to ensure regulation** in the pharmaceutical sector.
- Impossible to establish a **sustainable strategy** for stock renewal.
- Massive fraud and illegal distribution pipelines**, jeopardizing the quality of drugs**.
- **Frequent stock outs** at the sites.

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[13] MbumbaKinsaku. B., et G. BukasaKaleka. (2008), Disponibilité et dispensation des médicaments essentiels au niveau des sites des soins communautaires des provinces du Kasaï occidental, Bandundu et Kinshasa en République Démocratique du Congo, USAID/MSH Strengthening Pharmaceutical Systems

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Table 4 : Successes, bottlenecks, and solutions in the area of supply chain management

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ Availability of drugs thanks to partners' support	▪ Non mastery of quantification methods	Solutions adopted: ▪ Equip community sites with a start-up drug stock that covers at least 2 months
Expansion Phase		
▪ Regular discussions on drugs management during the monthly reviews of health workers ▪ Drugs management monitoring ensured during supervision by the ITs as well as the COGESITE members ▪ Availability of management tools (RUMER, daily tally sheet, order/requisition books) ▪ Drugs stored in appropriate cases meeting standards in most sites ▪ Training of all people involved in drugs management (ECZ, IT, relays and COGESITE members) ▪ Supplying with drugs based on the intervention packages at sites	▪ Use of non-prequalified suppliers and sources of drugs depending on partners ▪ Frequent drug stock outs: problem due to the weakness of the system in general ▪ Inappropriate management of drugs by some ITs ▪ Supplying out of the approved pipeline and use of commodities of dubious quality ▪ Impossibility of cost recovery in the context of poverty ▪ Mismatch between donated drugs and actual needs ▪ Expiration date of certain drugs is quickly attained (ACTs and Zinc) ▪ No systematic renewal of small equipment	Solutions suggested: ▪ Establish an appropriate supply system ▪ Provide cases or cabinets for keeping drugs ▪ Organize training/refresher training sessions on drugs management for ITs or strengthen supervision ▪ Proceed with in-kind payment, by a mutual health insurance scheme ▪ Make committees responsible for solving the issue of drugs donated that do not meet standards ▪ Reinforce the monitoring of drugs management by the health facility staff ▪ Renew materials and equipment taking into account the issue of sustainability

5.5 SERVICE DELIVERY AND REFERRALS

This section presents findings, as well as promising practices and challenges, under iCCM service delivery and referrals in DRC.

The rationale for using community-based services to manage childhood illnesses is obvious in DRC and is two-fold: 1) infant mortality rates are still very high at 158 per thousand in 2010,[14] and 2) geographic access to healthcare services can be especially difficult in some areas due to geographic conditions and the context of insecurity. Only 35% of the population lives within 5km of a health facility.[15]

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[14] MICS 2010
[15] PNDS 2011–2015

The Service Package

The community care sites unquestionably meet the country's priorities:

- The traditional package for children includes treatment of the three big killer diseases: malaria with ACT, diarrhea with zinc and ORS, and pneumonia with cotrimoxazole. The immediate integration of the three diseases' management was a strategic choice that was made deliberately from the beginning.

- In regards to nutrition, the current interventions are limited to the identification of severe cases and referral to appropriate services as well as counseling for mild malnutrition. For acute malnutrition iCCM to progress and expand, the malnutrition management protocol at sites must be updated to be in line with UNICEF and WHO's recommendations.

- The delivery of family planning services in the community sites was initiated in 2010.

Coverage

As of 2010, the population covered with the strategy was estimated at 1.7 million, including 320,000 children under five. The number of operational sites being 1,117, the average number of people per site is 1,500. Progress in regards to coverage is shown in the figure below.

Map of Bibanga Health Zone, hung at the central office

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Figure 6: Trends in population covered by community sites in DRC, 2005 to 2010

	Dec - 05	Sep - 06	Sep - 07	Sep - 08	Sep -09	Sep - 10
Number of sites trained	12	54	224	510	716	1 117
Number of HZ trained	1	8	30	52	78	94
Number of provinces covered	1	3	6	9	10	10
Number of population covered by the	10,869	82,598	506,192	743,984	900,726	1,692,379
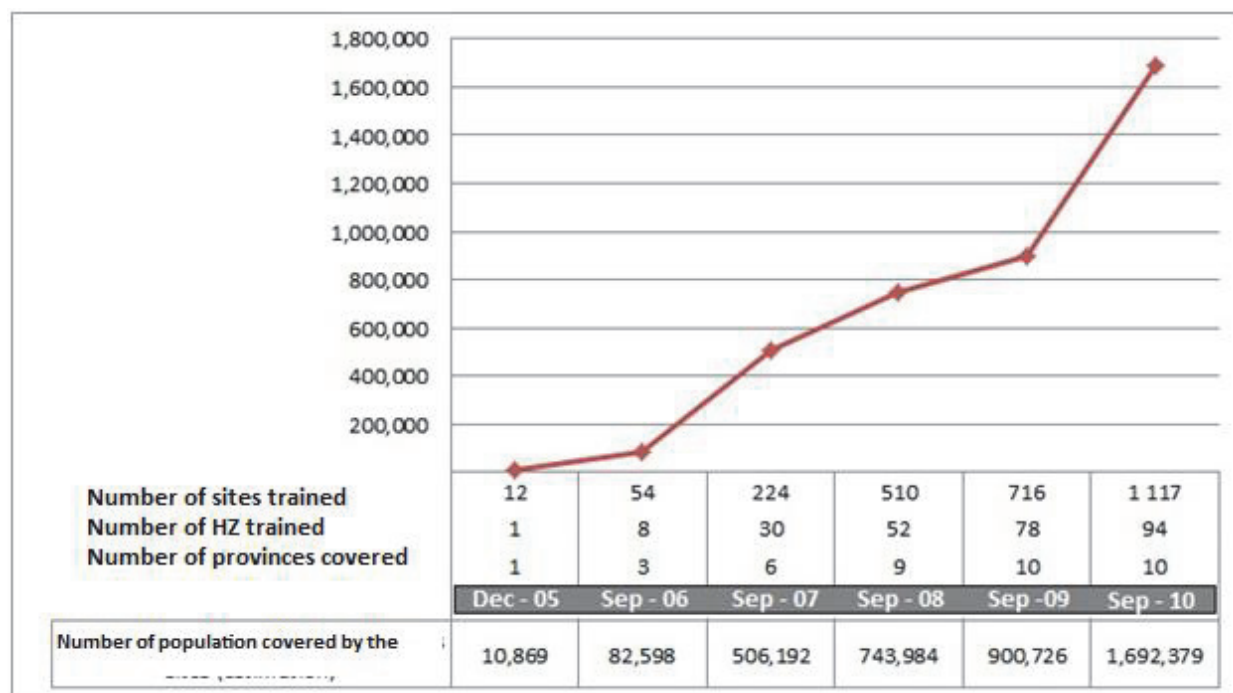
SOURCE: MCHIP in the DRC - Final Report 1 April 2009–31 July 2011

Views on the Services Offered

Mothers appreciate the work done by the site relays for a number of reasons, including: 1) they are convinced that their children are managed properly, 2) they are appropriately welcomed by the site relays who demonstrate willingness to perform their tasks properly, and 3) services are closer to them. The beneficiary mothers feel that they may call upon the relays at any time in the day and have the assurance that their needs will be met. However, they acknowledge that the care sites have their limitations and that it is necessary to turn to health facilities when the treatment provided by relays fails.

> *"Our relay is competent. He offers quality services on an ongoing basis."*
> ~(Focus group with mothers in Tshikaji)

> *"When my child was sick, the relay came to my home to look for the child and treat him."*
> ~(Focus group with mothers in Kimpese)

> *"My twins had diarrhea, they were treated at the site but did not heal."*
> ~(Focus group with mothers in Demba)

COGESITE members and religious leaders also express unanimous appreciation of the strategy, referring to a number of benefits: 1) several villages are covered, providing access to care to a larger population, 2) relays demonstrate human qualities and have good relationships with the communities, and 3) they feel that the use of traditional healers and witchcraft has decreased among the population.

> *"What pleases us the most with the relays is their good performance, their simplicity, their volunteering, and the way they welcome us."*
> ~(Focus group with leaders in Tshikaji)

"The establishment of care sites in the village is lauded by all. Morbidity and mortality have decreased. Social conflicts due to unexplained causes of death among children have stopped and we are no longer wasting our resources by paying traditional healers."

~(Focus group with leaders)

"With the sites being there, the population turns away from traditional healers and exorcists. We are happy with the services of our relay."

~(Focus group with COGESITE)

"Mothers with children are able to identify danger signs in a sick child."

~(Focus group with leaders)

Referrals and Counter-referrals

Community relays have the capacity to identify cases that need to be referred. The trust between the IT and the relays that developed during the training, supervision, and coaching sessions makes it easier to implement the referral system. However, families do not always follow referrals and few of the referred actually reach health facilities due to two factors: 1) traveling is difficult due to remoteness and other geographical obstacles, and 2) families worry about the cost of services that they would have to pay once at health facilities.

On the other hand, counter-referral is seldom done and feedback from the ITs on referred cases is almost non-existent.

Promising Practices in Service Delivery and Referral

- **Immediate integration** of the three illnesses (ARI, malaria, and diarrhea) to address the main causes of mortality and the country's pressing needs.

- **Integration of preventive activities.**

- **Mastery of referral procedures** and compliance with the procedures by the relays.

- Referral system facilitated by **promotion and good relationship** with health workers.

Challenges and Barriers

- **Physical remoteness and geographic obstacles**, making it difficult to travel to health facilities upon referral.

- Concerns regarding the **cost of services** to be paid once at the health facilities.

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Table 5 : Successes, bottlenecks, and solutions in terms of service delivery and referral

| FINDINGS | | SOLUTIONS |
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ N/A	▪ N/A	▪ N/A
Expansion Phase		
▪ Relays always available at sites when their services are requested ▪ Decrease in the use of illegally-supplied drugs and inappropriate care, only for the diseases included in the service package ▪ Good knowledge of danger signs among relays who always refer to the health posts ▪ Immunization outreach and enrolment into other programs such as family planning facilitated by c-IMCI ▪ Integration of technical updates in the iCCM strategy guidelines	▪ Remoteness of health facilities and high cost of their services impeding the referral system ▪ Poor performance of counter-referral	Solutions suggested: ▪ Encourage special rates for referred people ▪ Strengthen supervision to improve the performance of counter-referral ▪ Strengthen supervision to improve performance and reorient relays on their tasks and duties

5.6 COMMUNICATION AND SOCIAL MOBILIZATION

This section presents findings, as well as promising practices and challenges, under iCCM communication and social mobilization in DRC.

Communication and social mobilization encourage communities to adopt health behaviors, including timely use of healthcare services and compliance with treatment instructions. As in most countries, care site relays conduct this aspect of interpersonal communication during consultations. There are different categories of relays involved in health education and social mobilization for health.

Limitations of Traditional Approaches

When iCCM for childhood illnesses was introduced in DRC, it was decided that the site relays – in charge of managing illnesses in children – required sustained supervision and coaching. This decision resulted in a strategy that progressed at two different paces.

On the other hand, DRC's population size and its huge land as well as the cost of training promotional relays impeded the implementation of some communication approaches. Indeed, it was hardly feasible to comply with the ratio of one relay (to be trained during five to seven days) per 15 to 20 households when the total number of households is 12,185,185 (DHS 2007).

As a consequence, lighter approaches had to be developed to rapidly reach a large portion of the population while keeping costs low.

Involvement of Religious Leaders and Existing Community Groups

USAID, through the SANRU project, introduced the concept of institutional relays in 2002. These are clergy people, teachers, and other influential people who are trained to serve as trainers and coaches of volunteers in their own parishes or communities. In 2008, USAID, through the BASICS project, resumed the approach and developed it further by directly involving church and community organizations' coaches and volunteers at the local level in communication.

The approach was initiated in two health areas in the HZ of Malaka. Within two months, more than 1,000 church members were able to sensitize 14,000 of their neighbors in two health areas. The results of a first survey using the LQAS method showed that the proportion of mothers who know at least two signs of danger increased from 25% to 84% from May to July 2008.

Given these encouraging results, the approach was expanded to the entire HZ of Malaka as well as in several other HZs. In 2009, USAID, through collaboration with its MCHIP and AXxes projects, expanded the approach to its support zones through collaboration with other partners and included family planning in it.

Mothers prepare for a directed focus group discussion

Lessons have been learned from this experience: 1) proximity communication with ripple effect, 2) the issue of lack of financial incentives with mobilization agents, and 3) scaling up that is easily doable and gradual incorporation of messages and key practices in the minimal package based on the actual needs perceived by the communities.

Other proximity communication approaches were also reported such as the listening clubs in some HZs that strengthen the adoption of key health practices, and the involvement of other community-based groups, such as mothers' groups.

The country should revise all of its strategies and develop a national communication plan to make good use of all resources available, building complementarities and synergies among the different actors.

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Promising Practices in Communication and Social Mobilization

- Development of an **innovative approach** using churches.
- **Use of the LQAS** methodology to track results.

Challenges and Barriers

- Attention initially focused on **clinical aspects and delays** in launching communication activities.
- **Limited attention paid** to monitoring communication activities.
- **Initial advocacy** did not take into account communication and social mobilization needs.
- **Communication approach** not fully integrated in the activity package.
- **No national communication plan.**

Table 6 : Successes, bottlenecks, and solutions in terms of communication and social mobilization

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
- Authorities' involvement - Availability of human resources	Lack of funding	N/A
Expansion Phase		
- Involvement of political and administrative authorities and religious leaders in social mobilization - Relays trusted by the communities, which facilitated the adoption of health behaviors - Long experience in social mobilization, which facilitated iCCM - Listening clubs and community-based organizations, including mothers' groups	- No national communication plan - Poor coverage with communication channels - Promotional relays do not benefit from the same level of monitoring and coaching as site relays - Cultural and religious obstacles	Solutions suggested: - Share successes and develop a national communication plan - Continue advocacy with all decision-makers - Encourage the involvement of religious leaders in communication and social mobilization - Consider prioritizing promotional relays that meet site relay recruitment criteria at the beginning of implementation in health areas - Reinforce synergy between promotion relays and site relays in planning and monitoring - Include budget for training in communication in the budget of sites

5.7 PERFORMANCE QUALITY ASSURANCE

This section presents findings, as well as promising practices and challenges, under iCCM supervision and performance quality assurance in DRC.

Supervision Approaches

The strategy includes three types of support to ensure quality and performance by relays: post-training monitoring meetings, routine supervision visits, and supervision of supervisors. With the understanding that supervision by the ITs from their health facilities can be uncertain, the strategy based post-training capacity-building on the monitoring meetings that group site relay cohorts attended for one-day sessions.

The monitoring meetings include the following elements:

- Observation of case management.

- Review of knowledge (supported by a video show) and tools.

- Exchanges on successes and challenges of implementation.

A series of at least three monitoring visits at one-month intervals is first planned; the first monitoring visit occurs four to six weeks after the relays have been officially installed. It is recommended to conduct at least one visit per quarter and no less than two per year. To ensure that the visits are actually conducted, the related costs are directly included in the training budget.

Training of trainers and actors enables the local level to take over and be in charge as soon as the process is learned. However, the central level continues supervising the process to ensure compliance with norms and procedures. According to the zones' management teams, most relays demonstrate good results after two post-training visits. After a third monitoring visits, relays with poor performance are identified and are targeted with special monitoring. The other relays move on to the routine supervision system.

- **Routine supervision** first falls to the ITs (health facility) and the community animators (central office of the HZ). They are supported by higher level officials as described earlier. In the activity, supervision focuses on document reviews, verification of equipment and materials and especially drugs stocks, and in some cases on observation of case management and discussions with the health committee members.

  - The supervision not only improves the relays' performance but is also perceived as a motivational factor and builds the communities' trust: indeed, the communities feel that the relays are important when they see ITs or the HZ chief medical officers visiting the sites. Supervision is faced with a variety of difficulties ranging from the lack of financial resources to big distances to travel to natural obstacles such as rivers, forests, and to insecurity resulting from the presence of armed groups. Some innovations such as monitoring by phone were reported.

- **Finally, the supervision of supervisors** comes as a logical continuation of building the HZ central team and ITs' capacity to ensure supervision of the sites. Post-training monitoring offers the central and provincial levels the opportunity to observe the coaching of relays byzones and to support them in improving their performance. As described in the coordination section, the provincial and district levels are still learning to play/fulfill their roles and their actions do not yet cover the entire country.

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IT and Health Workers: Key Actors in the Supervision and Coaching of Relays

As direct supervisors, ITs and community animators in the HZ are key actors in the support given to care sites. Their actions determine the quality of the services provided and the regularity of activities. As one way to motivate them, they have to involve site and promotional relays in activities for which compensation is provided such as immunization and vitamin A distribution campaigns.

> *"My role consists in supporting the site relays in activities such as immunization, and screening for common diseases. I also check that the relays perform the tasks that they were taught during training."*
>
> ~(Focus group with ITs in Bibanga)

> *"My role is to immunize children when the relays conduct community-based weighing."*
>
> ~(Focus group with ITs, Lualaba)

Some ITs complained about the lack of transportation means to conduct supervision visits. Meanwhile, most of the logistical resources, when they exist, are located in the central office of the HZ.

Community Health Worker in front of the hut where he receives sick children in Muni Kenge, showing his IMCI tools and his low supply stock

Quality of Care

Quality of care is routinely monitored in DRC following two processes: 1) a review of case management forms filled by site relays for each new case, and 2) a review of the site relays' individual monitoring forms filled by the supervisors during their observation of case management. The observation often occurs during the post-training monitoring visits.

Data analysis is facilitated by the computer application described in the Monitoring and Evaluation section. Some of the results from the review of the case management form and direct observation forms taken from the MCHIP final report[16] are presented below.

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[16] Maternal and Child Health Integrated Program (MCHIP), Democratic Republic of Congo (DRC) Final Report: 1 April 2009–July 2011

- **Review of case management forms:** 15,741 forms were filled by the site relays from October 2009 to June 2011. The results show that:
  - Based on signs and symptoms noted, almost all the relays classified properly the children presenting the five most common conditions.
  - Performance is excellent in regards to correspondence between the classification and treatment provided for malaria (94%), pneumonia (92%), and malnutrition (81%). The scores were somewhat lower for the proper treatment of diarrhea (62%), coughing with no complications (60%), and danger signs (63%).
  - Drug dosage based on the children's age is almost perfectly mastered, except for diarrhea (86%).

Figure 7: Site relays' performance as seen through the review of case management forms filled in the country - October 2009 to June 2011


	Proper classification	Proper treatment for classification
Malaria (n= 9,889)	98%	94%
Diarrhea (n=3,963)	99%	62%
Pneumonia (n=2711)	98%	92%
Coughing/flu (n=3017)	94%	60%
Mild malnutrition (n= 1,167)	99%	81%
Danger signs (n=1,100)		63%

	Drug dose appropriate for child's age
Malaria (n=9,344)	94%
Simple diarrhea (n=2464)	86%
Pneumonia (n= 2503)	93%
Mild malnutrition (n=942)	100%
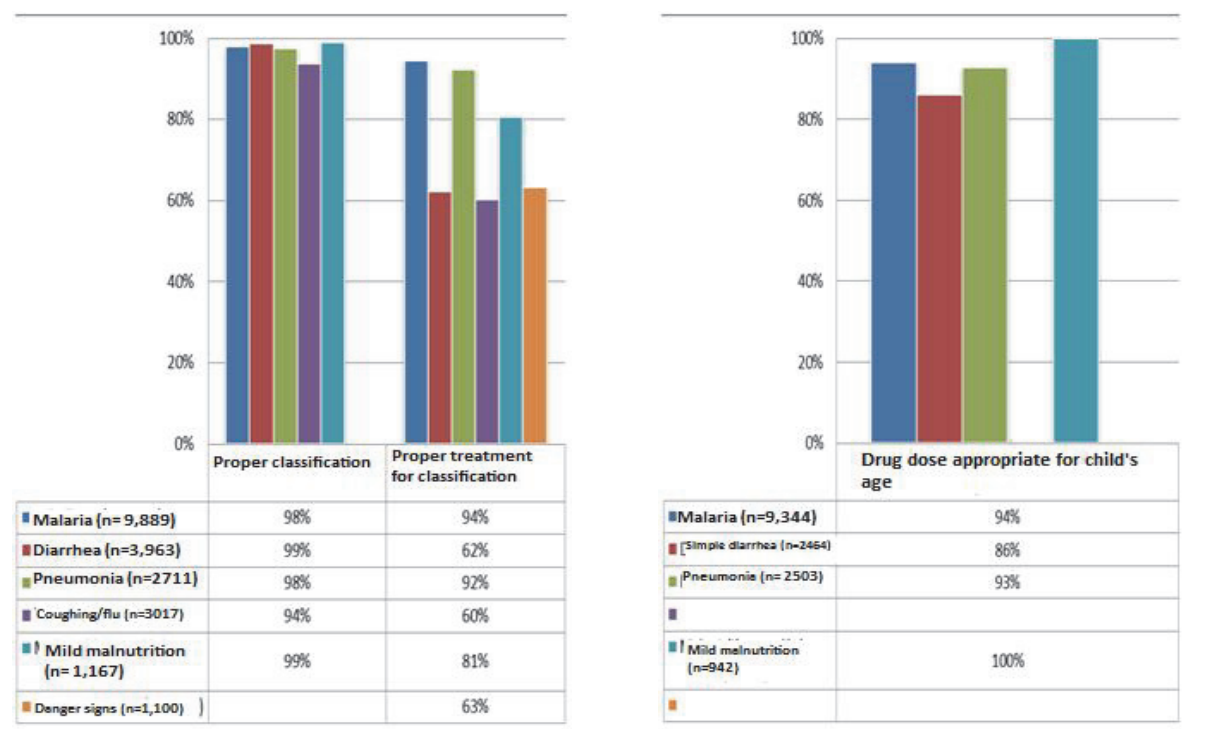
- **Review of direct observation data:** During the reporting period, 1,208 direct observation forms collected during post-training sessions were reviewed. As of late September, some relays took part only in one post-training sessions while others took part in several, the maximum number being five. The performance of each site relay is recorded at each monitoring visit in order to target his/her weaknesses and monitor progress over time. The review showed performance at each successive monitoring visit. More than 60% of the forms (762) come from HZs supported by USAID through the AXxes project, and 29% (352) from HZs supported by ACDI through PSI. These are HZs that organized post-training monitoring during the reporting period. The main findings are as follows:
  - The relays' knowledge and skills in regards to assessment and treatment improve throughout the monitoring sessions in each category, which clearly demonstrates the value of monitoring.

- The knowledge of at least two danger signs is high from the beginning but the knowledge of all danger signs is very low at the beginning. Though this latter knowledge improves with additional monitoring contacts, there seems to be significant fluctuations. On the other hand, asking and looking for danger signs seems to be high from the beginning, which may be due to the fact that the relays use a form that mentions all danger and alert signs.

- As shown in the figure below, *the capacity to count breathing frequency calls for special attention*. This action requires repeated practice to be mastered.

Figure 8: Trends in relays' knowledge of danger signs in a sick child by relays over monitoring sessions – October 2009 to June 2011
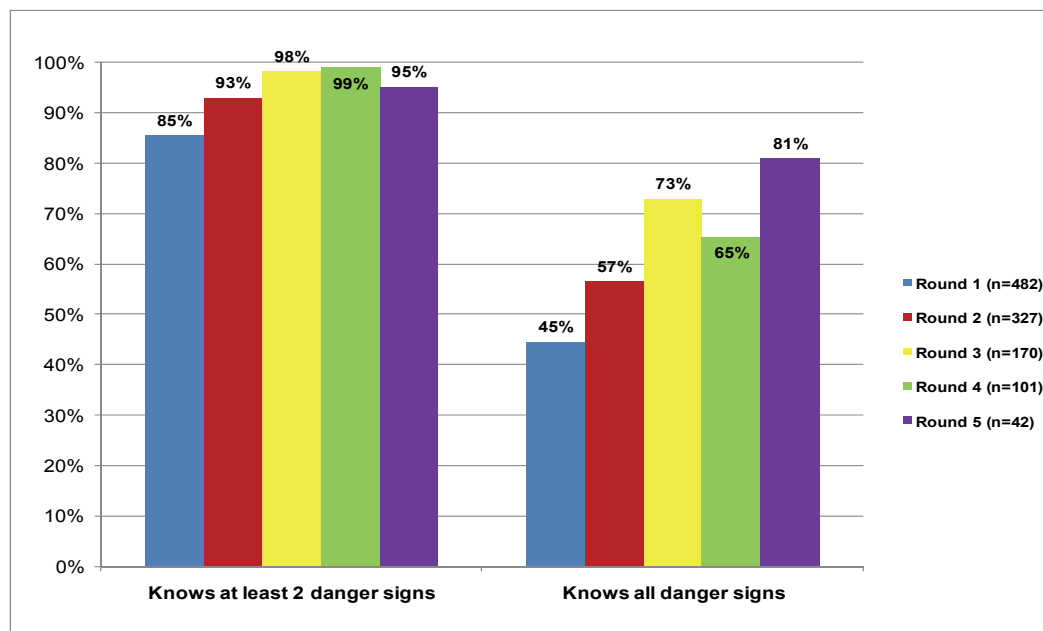
SOURCE: MCHIP in the DRC - Final Report 1 April 2009–31 July 2011
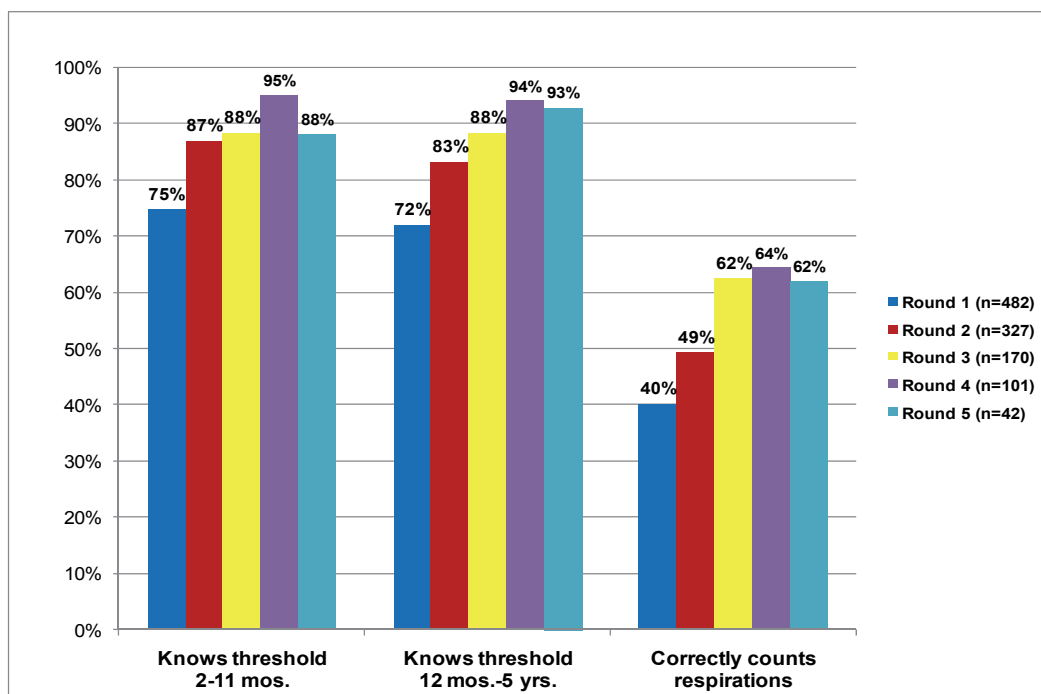
Figure 9 : Relays' knowledge of age threshold and capacity to properly count breathing frequency in a sick child over monitoring sessions – October 209 to June 2011

Promising Practices in Performance Quality Assurance

- Development of a **routine supervision approach**.
- Use of **group monitoring meetings** to make up for difficulties in conducting supervision visits at the sites.
- Use of data to target the **relays' weaknesses**.
- Development of a computer application to **monitor quality**.

Challenges and Barriers

- Continuation of **skills-building** at the provincial and district level dependent on funding that is not guaranteed
- Slow **capacity development** of the provinces and districts to be in charge of relays, including resources mobilization

Table 7: Successes, bottlenecks, and solutions in terms of supervision and performance quality assurance

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ N/A	▪ N/A	▪ N/A
Expansion Phase		
▪ Supervision strategy well defined, tools adapted and developed ▪ Awareness of supervision's importance among all actors at all levels ▪ Availability of a pool of qualified supervisors ▪ Availability of means of transportation (cars and motorcycles) in the HZ supported by partners ▪ Supervision done by ITs at an adequate frequency, especially in rural areas	▪ Inadequate supervision of relays by ITs, especially in urban and peri-urban areas where most health facilities are private ones ▪ Supervision fully dependent on partners' support (tools, fuel, etc.) ▪ Supervision made very difficult by natural obstacles and insecurity in some care sites ▪ Inadequate means of transportation for supervision, especially in regards to IT ▪ Trained management staff can easily move out	Solutions suggested: ▪ Incorporate activities in support to sites in performance reviews of health districts and conduct regular assessments ▪ Have the HZ central office support ITs from private health facilities in supervising site relays ▪ Strengthen feedback to relays ▪ Advocate with support partners for transportation means at the relays' sites ▪ Advocate with partners for logistic and financial resources

5.8 MONITORING AND EVALUATION AND THE HEALTH INFORMATION SYSTEM

This section presents findings, as well as promising practices and challenges, under iCCM M&E and the Health Information System in DRC.

Sites Data and National Health Information System (HIS)

The system for monitoring and evaluating iCCM implementation was defined at the strategy's inception and has been improved over time. This responsibility was distributed between the HZs at the operational level and at the central level at the beginning, while the role of the intermediate levels (district and province) was in the process of development.

Important efforts were made to integrate the data from care sites into the national HIS. Many ITs incorporate the data on cases treated in the community sites in their health facilities' monthly reports. In some cases, the community animators at the HZ collect the site's report and incorporate the data at the HZ level. Two problems were mentioned:

● The terminology used for IMCI is not identical to the terminology in the national HIS, which compels people reporting to make some reclassifications,

● Logistic issues, such as the lack of means of transportation and stock outs of tools, result in problems in forwarding data. Special efforts are often required to forward data.

Quarterly reviews are organized by the HZ management teams with partners and in some cases they also serve to support the provincial and central levels. The data from the direct observation

of iCCM during the monitoring and from the individual iCCM forms are forwarded to the central level for review.

It is impossible to distinguish the contributions of community care sites within the current standard tools NHIS. However, some HZs have taken steps to collect, analyze and locally use data from iCCM sites.

Computerized Database for Monitoring Quality of Care

A computerized database was developed in DRC to enter data. It covers data on case management, observation of relays' performances, and information on sites and relays. The database has a user-friendly interface that requires no more than basic computer literacy. It is linked to a relational database and has users' interfaces with two features: a data entry function and an automated report generation function. The second function has been initiated but has not yet been finalized. An overview of the interface is shown in Annex 9.

The codes in the database correspond to the official codes of provinces, districts, HZs, and health facilities used by the Ministry for future integration into the national system. Data entry and analysis are done at the central level. Attempts to decentralize data management in several zones failed due to three major logistic issues: 1) repeated power outage in the HZ, 2) the lack of human resources to enter data, and 3) the lack of maintenance of computers, resulting in frequent breakdowns and virus infections.

The documentation team noted that the use of information was very limited compared to its potentiality. As the case management forms are forwarded to the central level to feed into the database, no copies are filed at the intermediate level, which is another problem.

LQAS Methodology for Monitoring Social Mobilization

Measuring changes in mothers' knowledge and practices pursuant to behavioral change communication activities is quite an issue as traditional surveys are very costly. DRC opted for the Lot Quality Assurance Sampling methodology as its survey approach as this methodology offers the possibility to routinely collect data at lower cost using the management teams under their regular supervision and coaching activities. This method was used for measuring the changes resulting from the communication activities conducted by churches.

Clearly, this is a highly promising practice. However, the documentation team noted that its potentiality has not yet been fully tapped into or used. The trained teams did not continue with regular and successive surveys as initially planned and no discussion as to expanding the scope of surveys was done afterwards.

Promising Practices in M&E and the Health Information System

- Constant efforts to **integrate data from community activities** into the national HIS.
- Development of a **specific computerized tool** for data management.
- **Innovative initiative to monitor behavioral change outcomes** using LQAS.

Challenges and Barriers

- **Centralized management of the computerized** database and poor use of the data generated,
- **No follow-up of the LQAS activity** and trained staff under-used for continuation of the activity.

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Table 8: Successes, bottlenecks, and solutions in terms of M&E and the health information system

FINDINGS		SOLUTIONS
SUCCESSES/STRENGTHS	BOTTLENECKS	
Initial Phase		
▪ Availability of well-developed monitoring and evaluation tools	▪ Concurrent management of data from community care sites with the partners' support ▪ Impossible to conduct manual analysis of all the data generated by sites	Solutions adopted: ▪ Set up a computerized database at the central level
Expansion Phase		
▪ Information system operational: national health information system ▪ Computerized database available for monitoring the performance of site relays ▪ Data collection tools available at the community sites, and monitoring and evaluation tools at the different tiers ▪ Reports regularly prepared by relays with the ITs' support ▪ Community sites data integrated into the national HIS, either by ITs in health facilities or by community animators in HZ ▪ Compliance of HZ management teams with the quarterly reviews when financial resources are available ▪ Establishing LQAS as a methodology for monitoring BCC outcomes	▪ Failure of the first attempt to decentralize database management due to major logistic issues ▪ Poor use of the information generated by the computerized database (analysis for feedback and improved decision-making) ▪ No filing of case management forms at sites and intermediate levels, limiting possibilities for local reviews and use of information ▪ Logistic issues limiting the system's effectiveness: problems encountered by relays in forwarding data	Solutions suggested: ▪ Develop a community-level health information system ▪ Equip IT and relays with phone sets for communication ▪ Equip HZs, districts and provinces with modems to facilitate data forwarding ▪ Align sites' data on the provisions of the Ministry's national HIS ▪ Set up a health database at the district and province levels ▪ Harmonize IMCI terminology with the terminology of the national HIS or prepare equivalences

6. LESSONS LEARNED

The lessons learned are organized into four broad categories: establishing a favorable policy environment, reinforcing links between the health system and the communities, rapidly scaling up the delivery of quality services by CHWs to households, and optimizing behavior change within the program.

The documentation of the DRC's iCCM program highlighted the strengths that allowed for initiating and expanding the program. Weaknesses were also identified to show which crucial points need to be addressed when initiating iCCM interventions. In fact, both strengths and weakness constitute critical elements to be taken into account in implementing iCCM.

6.1 ESTABLISHING A FAVORABLE POLICY ENVIRONMENT AND EFFECTIVE INSTITUTIONAL SUPPORT

The Strengths Were as Follows:

- *Commitment and leadership of authorities at the highest levels, key people in the MPH, and administrative and political authorities at the intermediate levels who served as champions of the approach.* The Minister of Health, the heads of the concerned departments, and provincial directors were personally committed to the approach from the beginning, which was a pre-condition to good coordination and successful resources mobilization.

- *A clear vision defined and sustained by the MPH in regards to integrated services,* with a capacity to influence donors and redirect funding that was initially meant for specific diseases. The ministry's influence is reflected in the redirection of funds intended for malaria to the integrated approach, namely funds from the Global Funds intended for malaria research in Kimpese in 2008, and funds from ACDI in the province of Equateur in 2010.

- *Partnership between the MPH and implementing partners (NGOs).* Through the partnership, it became possible to harmonize, standardize, and fund the iCCM strategy, documents, and implementation throughout DRC and across a big number of partners. Throughout the process, progress was shown in a clear and concise way and was shared with all the concerned actors and other countries in the sub-region.

Points to Be Taken into Account from Inception Include:

- *The lack of a long-term extension plan,* which constrains the prioritization and the strategic distribution of technical, financial, and human resources. The national health development plan which was in the process of adoption in 2010 was an important step for developing such a plan that would allow for setting quantified objectives, anticipating the approach's expansion, checking gradual implementation in priority zones and ensuring monitoring of progress and coverage over time.

- *Program coordination and monitoring at the decentralized level.* There is a need to ensure capacity-building on a routine and ongoing basis in order for optimal program implementation. Decentralization of power and management autonomy that are planned for the future account for the importance of provincial and district-level structures.

- *"Weakening" of advocacy* at all levels as the strategy was expanded. Advocacy is essential and should be sustained and maintained throughout the scaling up process in order to mobilize and secure the required human and financial resources.

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6.2 REINFORCING LINKS BETWEEN THE HEALTH SYSTEM AND COMMUNITIES

The Strengths Were as Follows:

- *Structured supervision approaches:* post-training monitoring meetings are an effective and realistic option for ensuring quality and performance compared to routine supervision that can be costly and difficult to implement. Supervision of supervisors is also important.

- *The ITs in health facilities played a critical role in establishing the strategy:* without this formal linkage with the health system, it would have been difficult to establish or maintain a quality iCCM program.

- *Integration of the data from community care sites into the national health information system.* From the very beginning, special attention was paid to collecting information and special efforts were made in this regard.

6.3 RAPIDLY SCALING-UP THE DELIVERY OF QUALITY SERVICES BY CHWS TO HOUSEHOLDS

The Strengths Were as Follows:

- *Technical and operational documents well-codified and available,* such as the implementation guide, the package of training and supervision materials. The documents clearly describe the community relays' duties, delineate their field of competency, appoint structures to support them, and explain the processes for training relays, monitoring, and supporting the program.

- *Immediate integration of the management of three diseases and malnutrition in the community approach under the country's integrated vision for IMCI.* The standard package of services offered in community care sites target the biggest killer disease, namely malaria, diarrhea, and pneumonia. The Ministry has succeeded several times in influencing its partners in redirecting vertical projects into an integrated approach.

- *Plan to move directly to expansion without going through a pilot phase, as an example of making good use of lessons learned from other countries (Senegal).* From the very beginning, tasks and duties were delegated and expansion was gradually planned for.

- *Program's dynamism,* illustrated by the introduction of the family planning program in sites.

Points to Consider from Inception Include:

- *Frequent stock outs at sites* due to weaknesses in the logistic chain. It is important that partners define standards from the beginning and harmonize the supply chain for drugs and small equipment needed for the iCCM programs, incorporating it in the health sector's logistic system where possible.

- *Management of acute malnutrition.* The iCCM strategy is not always implemented in line with the acute malnutrition management protocol recommended by WHO, though it has a shared curative objective and the activity concerns the same community workers.

- *Tapping into the potentialities offered by the linkages with other community-based programs* (such as immunization and community-based family planning) and potentially benefit from economy of scale. Meanwhile, it is important to ensure that the iCCM operates effectively and that the addition of new components does not jeopardize achievements.

- *The issue of relays' financial motivation.* As it relies on volunteers, the iCCM program is always subject to debates on sustainability. Some countries have embarked on making payments to

community-based health workers while others refuse. The decision is up to each country but in any case, there is a need to explore forms of incentives.

6.4 DESIGNING AND IMPLEMENTATING BCC ACTIVITIES FOR ICCM

The Strengths Were as Follows:

- The approach using churches proved to be a proximity strategy that is better suited to the context, simpler and less expensive. Resources that are already in place – namely church leaders and existing community groups – are used to convey messages to their immediate communities.

Points to Be Taken into Account from the Inception Include:

- Defining a comprehensive and coherent package of curative and preventive services from the beginning to avoid prevention being a secondary activity: from the very beginning, iCCM should be seen as model for improving child health where prevention of common illnesses (through the promotion of hygiene, water, sanitation, family planning, immunization, etc.) plays a central role.

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CONCLUSION

Though faced with several obstacles relating to governmental structure, the Ministry of Public Health was successful in mobilizing partners to implement the iCCM approach in ten of the country's eleven provinces. Given the constraints prevailing in DRC and the timeframe of five years, this is an impressive achievement.

Several factors account for this success, namely leadership and political commitment at all levels, the motivation and will of relays, unfailing support from technical and financial partners, an innovative IEC approach, clearly developed technical guidelines, and the support of administrative authorities and the MPH's staff who provided technical support and encouragement to relays on a daily basis. Though the approach has not yet been scaled up to the national level, the lessons learned from DRC can be transferred to other countries who strive to reduce child mortality.

DRC will have to address a number of challenges to expand the strategy throughout the country and institutionalize it: develop a strategic plan and a multi-year budget; address the issues with the supply chain management, focusing on essential drugs and management tools stock outs; ensure that roles and duties are clearly defined at all tiers; and revitalize promotion and prevention in order to achieve better synergy of actions.

The main recommendations from this experience are presented in the following table:

Table 9: Main Recommendations for DRC

MAIN RECOMMENDATIONS FOR DRC'S PROGRAM	
Coordination and policy development	▪ Revitalize the steering committee, hold regular coordination meetings, and open up the team ▪ Share more widely in the country policy documents, implementation guidelines, and the package of training and supervision materials ▪ Define more clearly the technical roles of MPH staff at the intermediate levels (chief medical officer at the provincial and district level) ▪ Identify focal points for the intermediate levels (province and district) ▪ Include the community care sites approach as one of the priority strategies for reducing child mortality among the population living far from health facilities ▪ Continue advocacy with senior officials and decision-makers at the MPH to counter reluctance to support the scaling up of the approach.
Funding	▪ Prepare a multi-year comprehensive strategic plan and a budget for scaling up ▪ Recommend funds mobilization at the provincial level and assist provincial assemblies in preparing realistic budgets for community-level health activities
Human resources	▪ Carefully assess the pros and the cons of providing financial incentives, taking into account the long-term impact of the community site program as a whole ▪ Reassess the work of promotional relays, enhance their status, and reinforce the complementarities between their work and the work of site relays ▪ Plan for routine training of all new staff in health facilities and at the district level

MAIN RECOMMENDATIONS FOR DRC'S PROGRAM	
Supply chain management	▪ Urgently address the complex challenges of the supply chain management. ▪ Conduct more regular monitoring and supervision of drugs management ▪ Organize training and refresher training sessions in drugs management for head nurses ▪ Establish a system for renewing some equipment such as scales and timers
Service delivery and referrals	▪ Set up a standardized rates system based on specific criteria (a same health zone, depending on the socioeconomic status) ▪ Encourage discount rates for patients referred by community sites to health facilities
Communication and social mobilization	▪ Add key family practices and information on community care sites to BCC messages ▪ Keep on engaging religious leaders and community-based groups in social mobilization ▪ Revitalize the use of the LQAS methodology to monitor the outcomes of BCC activities
Supervision, performance, and quality assurance	▪ Ask HZ central offices to encourage IT to give feedback to relays during their routine supervision visits ▪ Ask HZ central offices to negotiate with partners to equip the community care sites with transportation means
Monitoring and evaluation and health information system	▪ Team at the decentralized levels should be more involved in data management in order to have up-to-date information for decision-making ▪ Review data collected from community care sites and tools used and align them with the MPH's national HIS ▪ Strengthen human and institutional capacities in charge of c-IMCI coordination to monitor and assess the strategy's implementation in DRC

ANNEX 1. ICCM BENCHMARKS FRAMEWORK

COMPONENT	ADVOCACY AND PLANNING	PILOT AND EARLY IMPLEMENTATION	EXPANSION/SCALE-UP
Component One: Coordination and Policy Setting	Mapping of CCM partners conducted	MOH leadership to manage unified CCM established	MOH leadership institutionalized to ensure sustainability
	Technical advisory group (TAG) established including community leaders, CCM champion & CHW representation		
	Needs assessment and situation analysis for package of services conducted		
	Stakeholder meetings to define roles and discuss current policies held	Discussions regarding ongoing policy change (where necessary) completed	Routine stakeholders meetings held to ensure coordination of CCM partners
	National policies and guidelines reviewed		
Component Two: Costing and Financing	CCM costing estimates based on all service delivery requirements undertaken	Financing gap analysis completed	Long-term strategy for sustainability and financial viability developed
	Finances for CCM medicines, supplies, and all program costs secured	MOH funding in CCM program invested	MOH investment in CCM sustained
Component Three: Human Resources	Roles of CHWs, communities and referral service providers defined by communities and MoH	Role and expectations of CHW made clear to community and referral service providers	Process for update and discussion of role/expectations for CHW in place
	Criteria for CHW recruitment defined by communities and MOH	Training of CHWs with community and facility participation	Ongoing training provided to update CHW on new skills, reinforce initial training
	Training plan for comprehensive CHW training and refresher training developed (modules, training of trainers, monitoring and evaluation)		
	CHW retention strategies, incentive/motivation plan developed	CHW retention strategies, incentive/motivation plan implemented and made clear to CHW; community plays a role in providing rewards, MoH provides support	CHW retention strategies reviewed and revised as necessary.
			Advancement, promotion, retirement to CHWs who express desire offered

COMPONENT	ADVOCACY AND PLANNING	PILOT AND EARLY IMPLEMENTATION	EXPANSION/SCALE-UP
Component Four: Supply chain management	Appropriate CCM medicines and supplies consistent with national policies (inclusion of RDTs where appropriate) and included in essential drug list	CCM medicines and supplies procured consistent with national policies and plan	Stocks of medicines and supplies at all levels of the system monitored (through routine information system and/or supervision)
	Quantifications for CCM medicines and supplies completed		
	Procurement plan for medicines and supplies developed		
	Inventory control and resupply logistic system for CCM and standard operating procedures developed	Logistics system to maintain quantity and quality of products for CCM implemented	Inventory control and resupply logistics system for CCM implemented and adapted based on results of pilot with no substantial stock-out periods
Component Five: Service Delivery and Referral	Plan for rational use of medicines (and RDTs where appropriate) by CHWs and patients developed	Assessment, diagnosis and treatment of sick children by CHWs with rational use of medicines and diagnostics	Timely receipt of appropriate diagnosis and treatment by CHWs made routine
	Guidelines for clinical assessment, diagnosis, management and referral developed	Review and modify guidelines based on pilot	Regular review of guidelines and modifications as needed
	Referral and counter referral system developed	Referral and counter referral system implemented: community information on where referral facility is made clear, health personnel also clear on their referral roles	CHWs routinely referring and counter referring with patient compliance, information flow from referral facility back to CHW with returned referral slips
Component Six: Communication and Social Mobilization	Communication strategies including prevention and management of community illness for policy makers, local leaders, health providers, CHWs, communities and other target groups developed	Communication and social mobilization plan implemented	Communication and social mobilization plan and implementation reviewed and refined based on monitoring and evaluation
	Development of CSM content for CHWs on CCM and other messages (training materials, job aids etc.)	Materials and messages to aide CHWs	

COMPONENT	ADVOCACY AND PLANNING	PILOT AND EARLY IMPLEMENTATION	EXPANSION/SCALE-UP
	Materials and messages for CCM defined, targeting the community & other groups	CHWs dialogue with parents and community members about CCM and other messages	
Component Seven: Supervision & Performance Quality Assurance	Appropriate supervision checklists and other tools, including those for use of diagnostics developed	Supervision visit every 1-3 months, includes reviewing of reports, monitoring of data	CHWs routinely supervised for quality assurance and performance
	Supervision plan, including number of visits, supportive supervision roles, self-supervision etc. established	Supervisor visits community, makes home visits, provides skills coaching to CHWs	Data from reports and community feed-back used for problem solving and coaching
	Supervisor trained in supervision and has access to appropriate supervision tools	CCM supervision included as part of the CHW supervisor's performance review	Yearly evaluation that includes individual performance and evaluation of coverage or monitoring data
Component Eight: M & E and Health Information Systems	Monitoring framework for all components of CCM developed and sources of information identified	Monitoring framework tested & modified accordingly	Monitoring and evaluation through HMIS data performed to sustain program impact
	Standardized registers and reporting documents developed	Registers and reporting documents reviewed	OR and external evaluations of CCM performed as necessary to inform scale-up and sustainability
	Indicators and standards for HMIS and CCM surveys defined		
	Research agenda for CCM documented and circulated	CHWs, supervisors and M&E staff trained on the new framework, its components, and use of data	

ANNEX 2. PREFACE OF THE ICCM IMPLEMENTATION GUIDELINE SIGNED BY THE MINISTER OF HEALTH

PREFACE

La mortalité infantile en République Démocratique du Congo est l'une des plus alarmantes en Afrique ; sur 1000 enfants qui naissent 127 meurent avant leur premier anniversaire (soit 304.800 sur 2.400.000 enfants < 1 an).

Par ailleurs, la mortalité infanto-juvénile s'élève à 213‰ (Soit 2.500.000 qui meurent chaque année sur les 12.000.000 d'enfants de 0-5 ans que compte le pays) (MICS 2, 2001).

La RDC est parmi les 6 pays du monde regroupant 50% de mortalité infantile mondiale, après l'Inde, le Nigeria, la Chine, le Pakistan, et avant l'Ethiopie.

Outre les décès périnataux, les causes de la mortalité infantile sont le paludisme, les infections respiratoires aigues, la diarrhée, la rougeole, et les complications du VIH/SIDA. Dans la moitié des cas, ces maladies sont souvent associées à la malnutrition.

L'analyse de la situation a montré que 80 % des enfants meurent à domicile sans consulter une structure de soins. Cette situation grave est due entre autres à la faible implication de la communauté, à l'accès difficile aux soins et aux médicaments de qualité, à l'automédication et à l'ignorance des signes de danger.

Vu l'ampleur de ce problème, le Ministère de la santé a adopté la stratégie de mise en place des soins à base communautaire pour réduire la mortalité infantile.

L'élaboration du présent guide de mise en œuvre des sites des soins communautaires fait partie intégrante des activités liées à la mise en œuvre des soins à base communautaire. Il s'agit d'un outil important qui retrace les éléments essentiels à l'attention des responsables du Ministère et partenaires à différents niveaux pour l'implantation des sites des soins communautaires en RDC.

Le but est de donner aux Cadres de santé de tous les niveaux, aux Infirmiers Titulaires ainsi qu'aux Partenaires une compréhension suffisante sur le processus de mise en œuvre des sites des soins au niveau communautaire en RDC.

De façon spécifique, ce document de planification de la mise en œuvre des sites servira comme document de référence aux cadres de santé à différentes étapes de mise en œuvre des activités sur terrain et permettra de familiariser les cadres avec les outils des sites des soins communautaires.

Nous exhortons donc tous les responsables de santé à tous les niveaux à respecter les indications contenues dans le présent document afin que soit standardisé le processus de mise en œuvre des soins à base communautaire en RDC. Nous encourageons tout cadre du Ministère et tout partenaire à s'investir pour que

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rèussissent les activités de prise en charge communautaire en RDC. Notre souhait le plus ardent est que, à travers la mise en œuvre des sites des soins communautaires, nous puissions contribuer de façon très significative à l'atteinte des objectifs nationaux de réduction de la mortalité infantile et de l'Objectif du Millénaire relatif à la survie de l'enfant.

Dr Victor Makwenge Kaput

Ministre de la Santé

RDC

ANNEX 3. OFFICIAL LETTER ALLOWING THE LAUNCH OF THE INITIAL PHASE OF ICCM

REPUBLIQUE DEMOCRATIQUE DU CONGO
MINISTERE DE LA SANTE

Kinshasa, le ..**0.3...SEPT 2005**

LE SECRETAIRE GENERAL   Ref :MS.1251/MGB/SG/03/1321/MMB/2005.

Transmis copies pour information
- A Son Excellence Monsieur le Ministre de la santé
- A Son Excellence Monsieur le Vice-Ministre de la santé.

Objet : Pilotage de la phase initiale des SITES des soins communautaires
- Termes de référence
- Désignation de l' Equipe.

Aux Cadres et Partenaires de santé dont les noms ci-dessous repris ,
     (Tous) à KINSHASA/GOMBE

Madame, Messieurs,

En vue de permettre aux populations éloignées des Centres de santé ou coupées par des barrières naturelles de bénéficier des premiers soins et d'un encadrement adéquat nécessaires pour la réduction de la mortalité infanto-juvénile, une phase initiale des soins à base communautaire va démarrer dans quelques Zones de santé en RDC. Et il est important que cette étape initiale soit entourée de toute l'attention permettant de tirer des leçons utiles pour la survie de l'enfant en RDC.

La RDC a déjà retenu la promotion des pratiques-clés parmi ses priorités au niveau communautaire. Mais, il s'avère que des poches des populations éloignées ou inaccessibles auront besoin, en plus de la promotion des pratiques-clés, de l'encadrement pour la référence devant un signe de danger ou d'alerte, et de la dispensation des premiers soins de qualité aux enfants dans les 24 heures qui suivent le début de la maladie, en cas de paludisme, diarrhée, IRA, malnutrition.

C'est pourquoi la RDC veut démarrer la mise en œuvre des sites des soins communautaires. Dans cette phase initiale, Il est donc important que l'intégration se fasse par étape et soit suffisamment documentée. L'infirmier Titulaire devra être implique dans le la supervision directe de sites, et un accent particulier devra être mis sur la participation communautaire à la base.

Afin de mieux encadrer cette phase initiale, il est mis en place une Equipe Technique de Pilotage au niveau central, dont les membres ont été identifies selon leur profil et leur disponibilité, au travers des Directions, Programmes et Organismes impliqués.

Cette Equipe sera évaluée sur base des résultats produits , au regard des termes de référence ci-après :

1. Piloter la phase initiale de la mise en œuvre des sites communautaires en RDC,
2. Elaborer un plan de mise en œuvre des activités des sites des soins communautaires,
3. Elaborer les documents de stratégies et les outils de formation et de gestion des activités à soumettre à la validation du sous groupe PCIME-Communautaire,
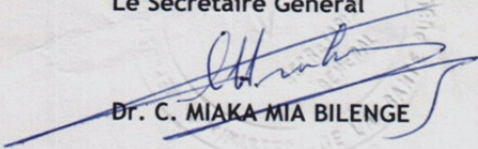
1

4. Organiser l'atelier de validation pour les stratégies et les outils de l'approche,
5. Finaliser les documents de stratégie et les outils de formation et de gestion après l'atelier de validation,
6. Pré tester les outils de formation et de gestion lors d'une session de formation dans une ZS pilote,
7. Obtenir la validation sur les documents amendés après le pré test,
8. Assurer les formations des cadres et des relais des sites dans la phase initiale,
9. Assurer les suivi post-formations et la supervision des sites en accompagnement des cadres des provinces, districts et des BCZS de la phase initiale,
10. Introduire les activités dans les sites communautaires pilotes pendant la phase initiale,
11. Préparer les éléments d'évaluation de l'Approche-Site à la sanction du sous groupe PCIME-C et du groupe de travail PCIME,
12. Préparer les éléments de changement de politique en matière de médicaments dans la communauté,
13. Mettre en place une base des données informatisée pour documenter à suffisance l'expérience de la phase initiale.

Les personnes dont les noms suivent sont désignées comme membres de l' Equipe Technique de Pilotage des sites des soins communautaires:

1. Dr KANZA NSIMBA, PNLMD
2 Dr ILUNGA MUBAYI, PNIRA
3. Dr DIANA,   GTZ
4. Dr KINI, OMS
5. Dr Willy KABUYA, MSH (RPM+)
5. Ph Paul KABANGA, PNAME
6. Dr LEBUKI, PRONAMUT
7. Dr BELEWETE, 5è direction
8. Dr WANT ILUNGA, SANRU III
9. Dr ATUA, PNLP
10. Dr NGOYI, PNLP
11. Mr Raoul KAMANDA, PNCPS
12. Dr BAKUKULU ITEMA, PNLMD
13. Dr MUBIALA, UNICEF
14. Dr NDJOLOKO Bathé, 4è Direction.
15. Dr Valentin MUKINDA, GTZ.
16. Dr Pascal NGOY LEYA, IRC
17. Dr BEKONDA, Horizon-Santé
18. Dr MATSHIFI, CRS.
19. Dr BOLAMBA, Cabinet du Ministre
20. Dr MBALA NSIMBA, Secrétariat Général.

Veuillez agréer, Madame et Messieurs les Cadres et Partenaires de la Santé, mes sincères salutations et félicitations.

Le Secrétaire Général

Dr. C. MIAKA MIA BILENGE

ANNEX 4. FOCUS GROUP DISCUSSION GUIDELINE USED DURING THE DOCUMENTATION (FRENCH)

POINTS-CLÉS DE L'INTRODUCTION

- Merci de nous avoir accordé cette interview. Nous sommes réunis pour parler des leçons apprises sur l'approche Prise en Charge Intégré des Maladies de l'Enfant dans la Communauté et des pratiques familiales à promouvoir en RDC. Votre groupe a été spécialement choisi pour nous aider dans cet exercice, en raison de vos expériences personnelles respectives. Cette interview prendra approximativement une heure et demie. Il est maintenant … heure, nous conclurons vers … heure.

- Naturellement, nous voulons savoir où les choses vont bien et où ils ne vont pas bien. Il n'y a pas de censure. Tout ce qui est dit est intéressant. Chacun écoute les autres ; chacun parle à son tour. Nous voudrions recueillir votre opinion, même si certains aspects vous semblent négatifs car c'est la seule manière que nous allons apprendre.

- Avec votre permission, nous allons procéder à un enregistrement afin de pouvoir étudier les sujets débattues ici en profondeur. Soyez rassurés que tout ce qu'on se dit ici restera confidentiel.

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GUIDES DE QUESTIONS

COGESITE

THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT

Implications dans la mise en place des sites des soins communautaires	1. Racontez comment le site des soins communautaires a été érigé dans votre village.
	   ■ Combien de temps après sa mise en place, le site des soins a-t-il commencé à fonctionner ? Trouvez-vous que ce temps est raisonnable ? Expliquez.
	   ■ Quels étaient les rôles que vous avez joués pendant cette mise en place du site ?
	2. Comment le relais communautaire a-t-il été choisi ? – Croyez-vous que c'est le bon processus ? – pourquoi ?

Fonctionnement du comité de gestion du site	3. Dans le quotidien, actuellement, décrivez les rôles du comité de gestion du site - Quels sont les rôles que vous trouvez les plus importants ? – Pourquoi ?
	4. Comment le comité fonctionne-t-il ?
	   ■ Qui en sont les membres ?
	   ■ Quelle est la périodicité des réunions ?
	   ■ Quelles sont les sujets discutés pendant ces réunions ?
	   ■ Existe-t-il des PV des réunions tenues ? – Si OUI, demander un échantillon et faire une copie si possible…

Implications dans la gestion du site des soins	5. Donnez des exemples concrets d'actions prises par le comité de gestion du site pour soutenir le site des soins. Quels genres d'action ? – quand ? – quels en étaient les résultats ? 6. Est-ce qu'il y a de récompenses en argent ou en nature que la population ou le Comité donnent aux relais ? – Trouvez-vous qu'ils méritent que la communauté contribue à les motiver ? – Expliquez. 7. Trouvez-vous que le comité peut faire plus que ce qu'il faitactuellement ? – Expliquez.

Appréciation des actions menées au niveau du site des soins	8. Pensez-vous qu'il est nécessaire d'avoir un site des soins dans ce village ? – Pourquoi ?
	   ■ Que trouvez-vous de différent avant et après l'ouverture du site des soins ?
	9. Comment appréciez-vous les actions menées au niveau du site des soins ?
	   ■ Dans quels cas vous êtes les plus satisfaits des relais communautaires ? – Expliquez.
	   ■ Dans quels cas vous êtes les moins satisfaits desrelais communautaires ? – Expliquez.

Suggestions	10.Y a-t-il des points spécifiques que vous suggérez que les relais communautaires fassent différemment ? - en plus ? – en moins ? - Expliquez

LEADERS RELIGIEUX

THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT
Implications dans la mise en place des sites des soins communautaires	1. Racontez comment le site des soins a été érigé dans cette zone. ▪ Combien de temps après les discussions initiales que les sites des soins ont-elles commencé à fonctionner ? Trouvez-vous que ce temps est raisonnable ? Expliquez ▪ Quels étaient les rôles que vous avez joués pendant cette mise en place des sites ? 2. Comment les sites ont été choisis ? – Croyez-vous que c'est le bon processus ? – pourquoi ?
Implications dans le fonctionnement du site	3. Décrivez les rôles que vous avez joué dans le démarrage des activités dans les sites - Quels sont les rôles que vous trouvez les plus importants ? – Pourquoi ? 4. Et les rôles que vous jouez maintenant dans le fonctionnement ? - Quels sont les rôles que vous trouvez les plus importants ? – Pourquoi ?
Appréciation des actions menées au niveau du site des soins	5. Pensez-vous qu'il est nécessaire d'avoir un site des soins dans ces villages ? – Pourquoi ? ▪ Que trouvez-vous de différent avant et après l'ouverture des sites des soins ? 6. Comment appréciez-vous les actions menées au niveau du site des soins ? ▪ Dans quels cas vous êtes les plus satisfaits des relais communautaires ? – Expliquez. ▪ Dans quels cas vous êtes les moins satisfaits desrelais communautaires ? – Expliquez.
Suggestions	7. Y a-t-il des points spécifiques que vous suggérez que les relais communautaires fassent différemment ? - en plus ? – en moins ? – Expliquez.

INFIRMIERS TITULAIRES

THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT...
Implications dans la sélection des relais	1. Comment les relais ont-ils été choisis ? ▪ Croyez-vous que c'est le bon processus ? – pourquoi ? ▪ Comment étiez-vous impliquésdans le choix ? 2. Avez-vous participé aux formations des relais ? – Comment ?
Soutien des IT aux relais	3. Décrivez vos rôles auprès des Relais ▪ Quels sont les rôles que vous trouvez les plus importants ? – Pourquoi ? ▪ Quelle est la périodicité de votre rencontre avec les relais ? ▪ Quelles sont les sujets que vous discutez avec les relais quand vous les voyez ? 4. Donnez des exemples concrets d'actions que vous avez faites pour soutenir les relais. C'était quoi ? – quand ? – quels en étaient les résultats ?

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*Integrated Community Case Management of Childhood Illness:
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THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT...
Rapportage et interactions avec les relais	5. Comment les relais vous font le rapportage des activités ? – Trouvez-vous qu'ils le font correctement ? – si oui, quel a été votre apport pour cela ? – si non, quels sont les problèmes ? – avez-vous des suggestions ? 6. Utilisez-vous les données provenant des Relais ? – Comment ? Donnez des exemples. 7. Trouvez-vous que votre interaction avec les relais est suffisante ? – Pourquoi ? – Pouvez-vous faire plus ? - Expliquez
Système de référence des cas sévères	8. Est-ce que vous recevez tous les malades référés par les relaisà votre centre de santé ? Si non, quels sont les problèmes à votre avis ? Expliquez ?
Gestion des médicaments	9. Décrivez comment les relais reçoivent les médicaments qu'ils utilisent – d'où viennent les médicaments ? – Est-ce qu'ils les achètent ? Comment ça se passe ? Qui détermine le prix ?– Qui les procure ? 10.Avez-vous connu des ruptures de stock au niveau des sites ? – Si oui, combien de fois ? – C'était quand la dernière fois ? – Savez-vous quelles sont les causes ? – Expliquez. En cas de rupture qu'est qu'on fait au niveau des sites ? 11. D'après vous, est-ce que les relais ont des difficultés à gérerles médicaments ? – lesquelles ? – Avez-vous des suggestions ?
Appréciation des actions des relais	12. Trouvez-vous utile d'avoir un site des soins communautaires en plus de vos centres de santé ? – Expliquez. ▪ Que trouvez-vous de différent avant et après l'ouverture des sites des soins ? 13.Comment appréciez-vous les actions menées au niveau des sites des soins ? ▪ Dans quels cas vous êtes les plus satisfaits du travail des relais ? ▪ Dans quels cas vous êtes les moins satisfaits du travail des relais ?
Soutien de la communauté aux relais	14. Est-ce que vous connaissez des actions prises par le comité de gestion du site pour soutenir les sites des soins. Donnez des exemples ? –quels en étaient les résultats ? 15.Est-ce qu'il y a des récompenses en argent ou en nature que la population ou le comité donnent aux relais ? – Trouvez-vous qu'ils méritent que la communauté contribue à les motiver ? – Expliquez. 16.Trouvez-vous que le comité peut faire plus que ce qu'il faitactuellement ? – Expliquez.
Suggestions	17. Y a-t-il des points spécifiques que vous suggérez que les relais fassent différemment ? – Expliquez.

MERES

THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT...
Attitudes des ménages et prise de décision sur les recherches de soins	1. Ces derniers temps, qui a eu des enfants malades ? – racontez ce qui s'est passé. Qu'avez-vous fait pour les soigner ? Est-ce que tout le monde dans le village fait pareil ? – Si non que font les autres personnes en général ? 2. Quand l'enfant est malade, y-a-t-il des soins que vous donnez en premier lieu à domicile ? – lesquels et pour quelles maladies ? ▪ Si la maladie persiste ou s'aggrave à qui vous adressez-vous en premier lieu ? 3. Quelles décisions prenez-vous seules en tant que mères en ce qui concerne les recherches de soins pour vos enfants quand

THÈME À COUVRIR	QUESTIONS D'INTRODUCTION ET D'APPROFONDISSEMENT...
	ils sont malades ?
	▪ A partir de quel moment devez-vous prendre en compte la décision de votre mari/conjoint ?
	▪ Y-a-t-il déjà eu de divergences de points de vue entre vous et votre mari/conjoint sur les décisions à prendre ? – Donnez des exemples.
Services offerts au niveau des sites	4. Connaissez-vous le site des soins communautaire ?
	▪ Où se trouve le site des soins le plus proche d'ici ?
	▪ Qui sont les personnes qui y travaillent ? – Qu'est-ce qu'ils peuvent faire pour vos enfants ? – Expliquez
	▪ Qui vous a informé sur l'existence du site des soins et des services offerts ? – Quand ? – Comment ?
	5. Pensez-vous qu'il est nécessaire d'avoir un site des soins dans ce village ? – Pourquoi ?
	6. Quelles sont les heures d'ouverture du site des soins ?
	▪ Pour celles qui sont déjà allées chercher des soins dans les sites des soins, comment avez-vous fait pour trouver le relais communautaire ?
	7. Que trouvez-vous de différent avant et après l'ouverture du site des soins ?
Appréciation des actions des relais	8. Quand votre enfant a de la fièvre, est-ce que le relais utilise un test au niveau des sites des soins ? *(POUR LA ZONE DE SANTE DE KIMPESE)*
	▪ Trouvez-vous que c'est utile ? – expliquez pourquoi ?
	▪ Quand le test est négatif, et qu'on ne vous donne pas de médicament contre le paludisme, qu'est-ce que vous dites aux relais communautaires ? – Comment ils répondent ?
	9. Comment appréciez-vous les actions menées par les relais au niveau du site des soins ?
	▪ Pensez-vous que les relais communautaires sont suffisamment compétents pour prendre en charge vos enfants ? Expliquez.
	▪ Dans quels cas hésitez-vous à confier vos enfants au relais communautaire ?
Connaissance des mères déjà servies par les relais	10. Quels sont les signes de danger qui vous amènent à chercher immédiatement des soins ? – auprès de qui allez-vous chercher ces soins ?
	11. Quand vous recevez les traitements de la part des relais communautaires, avez-vous des difficultés à les administrer une fois à domicile ? – si oui, quels genres de difficultés ? – si non, comment les relais font-ils pour vous aider ? - Décrivez.
	12. Quand il n'y a pas des médicaments dans le site que fait le relais ?
Suggestions	13. Y a-t-il des points spécifiques que vous suggérez que les relais communautaires fassent différemment ? – Des services en plus pour vous ou pour votre famille ? – Expliquez.

RELAIS

THÈME À COUVRIR	QUESTIONS PRINCIPALES ET QUESTIONS DE SUIVI...
Activités menées	1. Pouvez-vous décrire les activités que vous faites dans le cadre des sites de soins communautaire ? ▪ Combien d'enfants malades voyez-vous en moyenne – par jour, par mois ? – vous trouvez que c'est beaucoup ? C'est peu ? – Pourquoi ? ▪ Comment vous organisez-vous pour accomplir à la fois vos devoirs familiaux et le travail de relais communautaire de site ? 2. Utilisez-vous ou avez-vous le test de diagnostic rapide pour décider si un enfant a le paludisme ? *QUESTION RESERVEE A LA ZS KIMPESE* ▪ Trouvez-vous que c'est utile ? – expliquez pourquoi ? ▪ Que faites-vous lorsque le test de diagnostic rapide (TDR) est négatif ? ▪ Que pensent les mères de l'utilisation des tests de diagnostic rapide (TDR) ? – Quand le test est négatif, que disent les mères ? – Que répondez-vous ?
Formations de relai chargé de soins au site communautaire	3. Avez-vous été formé en soins communautaires ? Si oui pendant combien des jours ? ▪ Quand est-ce que vous avez reçu cette formation ? 4. Quelle est votre opinion sur la qualité des formations ? ▪ A quel point le contenu vous a-t-il aidé dans l'accomplissement de votre travail ? Expliquez. ▪ Auriez-vous préféré des cours plus longs ? plus courts ? pourquoi ? 5. Quels aspects auriez-vous suggéré de changer dans la formation pour les rendre plus utiles et plus efficaces ?
Suivi post formation	6. Combien de suivis post formation avez-vous bénéficiédepuis votre formation ? – A quand remonte le dernier suivipost formation ? – A quand remonte le dernier suivi formation/ recyclage ? 7. Quelles sont les remarques / feedbacks retenus lors du dernier suivi post formation ? – Avez-vous pu prendre en compte l'ensemble des remarques / feedbacks ? ▪ Si oui, Pensez- vous que ces remarques / feedbacks vous ont aidé à améliorer votre travail de relai de site ? – Expliquez comment. ▪ Si non, pourquoi ? – Quels étaient les points les plus difficiles ?
Supervision	8. Avez- vous reçues des visites de supervisions de la part de l'infirmier titulaire du centre de santé ou d'un autre superviseurdans votre site ? ▪ Si oui, combien de foisdepuis la formation ? - Par qui ? - Combien de temps chaque fois ? ▪ Quand avez-vous reçu la dernière supervision ? ▪ Sur quoi portait la dernière supervision ? – Expliquez. 9. Comment appréciez-vous cette supervision ? ▪ en quoi les supervisions vous ont-elles aidé dans l'accomplissement de votre travail ? Expliquez. ▪ Quels sont les points que vous appréciez le plus dans les supervisions ? Expliquez.

THÈME À COUVRIR	QUESTIONS PRINCIPALES ET QUESTIONS DE SUIVI...
	▪ Quels sont les points que vous appréciez le moins dans les supervisions ? Expliquez.
	10. Quels aspects désirez-vous renforcer ou changer dans les supervisions pour les rendre plus utiles et plus efficaces ?
	▪ La fréquence ? – Expliquez.
	▪ La façon de mener les supervisions ? – Expliquez.
	▪ Le profil du superviseur ? - Expliquez.
	▪ Autres ?
Gestion des médicaments	11. Décrivez comment vous recevez les médicaments – D'où viennent les médicaments ? – Est-ce que vous les achetez ? – Qui vous les procurent ?
	12. Avez-vous déjà connu des ruptures de stock des médicaments depuis que vous faites ce travail ? – Si oui, combien de fois ? – C'était quand la dernière fois ? – Savez-vous quelles sont les causes ? – Expliquez. Quand vous n'avez pas des médicaments qu'est ce vous faites ?
	13. Avez-vous déjà connu des ruptures de stock des fiches de prise en charge des enfants malades ? – Si oui, combien de fois ? – C'était quand la dernière fois ? – Et Que faites-vous lorsque vous avez des ruptures de fiches ? – Expliquez.
	14. Connaissez-vous des difficultés à gérerles médicaments ? – lesquelles ? – Avez-vous des suggestions ?
	15. Quels sont les outils de travail que vous utilisez au site ? Comment vous recevez ces outils (balances, minuteurs, caisses à médicaments, RUMER, fiche de prise en charge, carnet de commande,…) ?
	16. Les membres du comité de gestion des sites (Cogesite) sont-ils impliqués dans la gestion des médicaments des sites ? Expliquez comment
Système de rapportage	17. Décrivez comment vous élaborez et envoyez vos rapports d'activités – quels outils vous utilisez ? - à qui vous envoyez les rapports ? – à quel rythme ? Qui vous aide ? - Comment ?
	18. Y-a-t-il des moments où vous ne pouvez pas envoyer les rapports ? Si oui, combien de fois ? C'était quand la dernière fois ?
	19. Quelles sont les causes ? – Expliquez. ?
	20. Recevez-vous des commentaires sur vos rapports de la part de vos superviseurs ? – Quels genres de commentaires ? – Est-ce que ce sont des commentaires utiles ? – Expliquez.
	21. Connaissez-vous des difficultés à élaborer et envoyer vos rapports d'activités ? – lesquelles ? – Avez-vous des suggestions ?
Soutien de la communauté	22. Comment la communauté soutient-elle vos activités ?
	▪ Y-a-t-il des personnes qui vous assistent pour faire les séances de mobilisation ? – Qui sont-elles ? Comment travaillent-elles avec vous ?
	▪ Est-ce que vos communautés vous donnent une certaine forme de motivation ? - Si oui, décrivez sous quelle forme et comment ? Si non, décrivez pourquoi ?

THÈME À COUVRIR	QUESTIONS PRINCIPALES ET QUESTIONS DE SUIVI...

Soutien des leaders communautaires, notables ou autorités locales	23. Comment les leaders communautaires, notables ou autorités locales soutiennent-ils vos activités ?
	  ▪ Quel est votre opinion sur l'importance du soutien de vos leaders ?
	  ▪ Qu'attendez-vous de plus auprès des leaders ? – Expliquez.

Motivation	24. Vous êtes volontaire depuis un certain temps et vous le restez jusqu' à aujourd'hui. Quelles sont les raisons qui vous retiennent ? – Expliquez.
	25. Connaissez-vous des relais communautaires qui ont abandonné travail ?
	  ▪ Si oui, pourquoi certains de vos collègues ont-ils abandonné ?
	  ▪ Etes-vous aussi tenté d'abandonner ? – Expliquez.
	  ▪ Certains d'entre vous pensent-ils abandonner un jour ? – Ce serait pour quelles raisons ?
	26. Avez-vous des suggestions qui vous rendraient plus motivés et plus intéressés à ce travail ? – lesquelles ? – Expliquez.

CONCLUSION

Y-a-t-il des questions que nous n'avons pas posés lors de cet entretien et qui vous semblent importantes ? – Lesquelles ? – SVP donnez-nous votre opinion.

RESUMER LES POINTS ESSENTIELS ICI --- Ai-je récapitulé vos pensées correctement ? - Y a-t-il quoi que ce soit que vous voudriez ajouter ou modifier ? Merci beaucoup de votre disponibilité. Les informations que vous nous avez fournies permettront d'améliorer le programme de Prise en Charge Communautaire, non seulement en RDC, mais également dans d'autres pays.

ANNEX 5. ABSTRACT OF THE STUDY ON COMMUNITY MANAGEMENT OF MALARIA WITH USE OF RDT IN 2008

Feasibility of the use of artésunate-amodiaquine and rapid diagnostic test in home-based management of uncomplicated malaria: D.R. Congo pilot study.

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Introduction: In the Democratic Republic of Congo, over 80% of malaria is managed in the community where microscopy is limited. Through integrated management of childhood illness (IMCI), community health workers (CHWs) implemented home-based management of uncomplicated malaria (HMM) uses artésunate-amodiaquine (AS-AQ) for children 6-59 months, since 2005. Before moving to scale, we need to capitalize this experience by studying also the feasibility of RDT and AS-AQ's use among patients aged over 5.

Methods: Eighteen isolated communities' sites of Kimpese district were selected. Three CHWs per site were trained during five days. The treatment was presumptive for children 6-59 months and on the basis of positive RDT for patient aged over 5. All patients were followed up by CHWs witch were supervised monthly by 15 supervisors with checklists. Education's campaigns were regular. Community's acceptability was assessed through focus group and interviews.

Results: Correct diagnosis and treatment were respectively 99.6% and 88% among patients aged 6-59 months (n=673) against 99.8% and 96% for those aged over 5 (n=631). 62.8% of children under 5 were treated within 24 hours of onset of fever. RDT was prepared correctly in 93.5%. Community acceptance was high and no severe adverse event was reported.

Discussion: Preliminary results showed that the use of AS-AQ and RDT by CHWs is feasible and acceptable. This approach may improve malaria control especially in endemic isolated communities through IMCI. Training, regular supervisions and community education are primordial. Problems relating to sustainability and CHW's clearly defined status are still major challenges.

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ANNEX 6. LIST OF FINANCIAL PARTNERS AND RESPECTIVE INTERVENTION AREAS

	TYPE OF SUPPORT	PROVINCES	HZ	YEAR OF TRAINING
GTZ	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshops	BANDUNDU	Kenge	12/3/2005
UNICEF	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshop, supply of Zinc tablets and timers to the whole country.	EQUATEUR	Gemena	7/7/2007
			Gbadolite	7/7/2007
		KINSHASA	Mt Ngafula1	10/22/2006
			Mt Ngafula2	2/22/2006
			Binza Meteo	6/29/2006
			Selembao	6/29/2006
			Makala	6/29/2006
Health net international	Training, drug and supply in supported area	KASAI OCC.	Bilomba	9/10/2006
IRC	Training, post-training follow-up, drug and supply supported area, introduction of LQAS, logistical and financial support in organizing meetings and workshops	KASAI OCC.	Demba	1/7/2006
			Mutoto 1st Gr	1/26/2007
			Lukonga	1/26/2007
		KINSHASA	Kikimi	12/8/2008
			Kimbanseke	12/8/2008
			Biyela	12/8/2008
		PROVINCE ORIENTALE	Ubundu	6/30/2007
		SUD KIVU	Kalehe	10/21/2006
			Kabare	12/9/2007
CRS	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshops	KASAI OR.	Bena Dibele	4/17/2008
			Djalo	4/17/2008
			Tshumbe	4/17/2008
			Kalenda	6/5/2008
			Kanda Kanda	6/5/2008
OMS	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshops	KASAI OR.	Vangakete 1st Gr.	9/18/2008
			Minga	9/18/2008
			Omendjadi 1sr Gr.	9/18/2008
		PROVINCE ORIENTALE	Bunia ituri	6/25/2007
			Rwampara	6/25/2007
			Komanda	6/25/2007
			Nyakunde	6/25/2007

	TYPE OF SUPPORT	PROVINCES	HZ	YEAR OF TRAINING
			Damas	6/25/2007
			Lita	6/25/2007
			nizi	6/25/2007
			Bambu	6/25/2007
		SUD KIVU	Kalonge 1st Gr.	6/1/2007
			Buniakiri 1st Gr.	6/1/2007
			Kaniola 1st Gr.	6/1/2007
			Mubumbamu 1st Gr.	6/1/2007
			Mwana 1st Gr.	6/1/2007
			Fizi	6/1/2007
			Minembwe	6/1/2007
			Haut Plat.	6/1/2007
CCISD/PARSS	Training, drug and supply in supported area	BANDUNDU	Nioki	5/27/2008
			Tande Mbelo	6/27/2008
			Bandzow Moke	9/26/2008
			Bokoro	9/26/2008
			Bososbe	9/26/2008
			Inongo	9/26/2008
			Kiri	9/26/2008
			Mimia	9/26/2008
			Oshwe	9/26/2008
			Penzua	9/26/2008
ECC/PMURR	Training	MANIEMA	Kindu	6/23/2008
			Alunguli	6/23/2008
ESP/Global Fund/PNLP	Training, drug and supply in supported area	BAS-CONGO	Kimpese	9/24/2008
AXXES/USAID	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshops	KASAI OCC.	Mutoto 2nf Gr	6/5/2009
			Lubondaie	4/25/2009
			Bulape	4/18/2009
			Tshikaji	3/7/2009
		KASAI OR.	Vangakete 2nd Gr.	9/18/2008
			Omendjadi 2nd Gr.	9/18/2008
			Lodja	3/20/2009
			Pania mutombo	3/7/2009
			Bibanga	3/7/2009
			Lusambo	3/7/2009
		SUD KIVU	Kalonge 2nd Gr.	3/24/2009
			Buniakiri 2nd Gr.	3/24/2009

	TYPE OF SUPPORT	PROVINCES	HZ	YEAR OF TRAINING
			Kaniola 2nd Gr.	3/13/2009
			Mubumbamu 2nd Gr.	5/8/2010
			Mwana 2nd Gr.	6/11/2010
			Mwenga	5/13/2010
			Kamituga	7/21/2010
			Kitutu	7/26/2010
			Lemera	6/18/2010
			Nyangezi	5/26/2010
			Uvira	4/2/2009
			Nundu	4/2/2009
			Ruzizi	4/2/2009
			Kaziba	3/13/2009
			Idjwi	3/9/2009
		KATANGA	Songa	4/10/2009
			Kabongo	4/9/2009
			Kitenge	3/31/2009
			Kikondja	3/13/2009
			Malemba Nkulu	3/13/2009
			Mulongo	3/20/2009
			Kayamba	5/6/2010
			Lwamba	5/7/2010
			Mukanga	5/10/2010
			Kanzenze	3/25/2009
			Lualaba	2/28/2009
			Fungurume	3/25/2009
			Mutshatsha	4/7/2009
			Bunkeya	3/25/2009
			Dilala	4/2/2010
			Lubudi	4/18/2010
ASF/PSI/CIDA	Training, drug and supply in supported area, logistical and financial support in organizing meetings and workshops	EQUATEUR	Ndage	9/12/2010
			Bokonzi	9/16/2010
			Bwamanda	8/8/2010
			Mawuya	10/7/2010
			Bolu	10/7/2010
			Tandala	8/8/2010

	TYPE OF SUPPORT	PROVINCES	HZ	YEAR OF TRAINING
MSH/RPM+	Technical support in drug logistics, logistical and financial support in the organization of community sites, financial support in training and post-training follow-up, logistical and financial support in organizing meetings and workshops	EQUATEUR		Since the beginning until the end of the project
		KASAI OCC.		
		KASAI OR.		
		KINSHASA		
BASICS & MCHIP/ USAID	Technical support to the Ministry of Health and partners: development of training modules, management and supervision tools, planning, training of trainers and coach and relays, post-training follow-up, conception of a software for data management, introduction of LQAS, introduction of synergetic approach combining family planning and CCM, logistical and financial support in organizing meetings and workshops	In all 10 Provinces since the beginning	All HZs	Since the beginning
13		10	94	

ANNEX 7. INDIVIDUAL CASE MANAGEMENT FORM (FRENCH)

DATE _____/ _____ / _____   NOM DU RELAIS DE SITE _____

ZONE DE SANTE DE _____   CENTRE DE SANTE DE _____   SITE DE _____

1. IDENTIFICATION   VERT ou JAUNE ou ROUGE

Noms_____ Nom de la mère _____ Adresse _____

Sexe   M / F   Age_____ Poids _____ Statut nutritionnel de l'enfant_____

2. PLAINTES

(cocher NON ou OUI)	NON	OUI	Depuis combien de Jours	Traitement reçu à domicile
Fièvre				
Diarrhée				
Toux ou Rhume				
SPECIFIER pour les autres plaintes				

3. RECHERCHER LES SIGNES DE DANGER ou d'ALERTE (REFERER si OUI)

DEMANDER, RECHERCHER cocher	NON	OUI	DEMANDER, RECHERCHER cocher	NON	OUI
Nourrisson de 1 Sem à 2 mois amené au SITE	NON	OUI	Anémie ou pâleur palmaire	NON	OUI
Statut nutritionnel de l'enfant, ROUGE	NON	OUI	Respiration difficile avec tirage ou sifflement	NON	OUI
L'enfant est-il incapable de boire ou de téter ?	NON	OUI	Toute maladie qui dure 15 jours ou plus	NON	OUI
L'enfant vomit tout ce qu'il consomme ?	NON	OUI	L'enfant est souvent malade	NON	OUI
L'enfant a-t-il convulsé ou convulse maintenant ?	NON	OUI	L'enfant est très affaibli	NON	OUI
L'enfant est inconscient ou ne répond pas aux stimuli externes	NON	OUI	L'enfant devient plus malade malgré les soins adéquats à domicile	NON	OUI

4. FIEVRE (= Chaud au toucher ou antécédents de fièvre dans les 2 jours) (Cocher) OUI NON

à REFERER si :	• Fièvre qui continue après 2 jours de traitement à domicile
	   – avec Artésunate + Amodiaquine et Paracétamol,
	   – (ou SP + paracétamol en l'absence de Art + AQ)
		NON	OUI	**FIEVRE à REFERER**

	• ou fièvre avec éruptions cutanées généralisées	NON	OUI	
FIEVRE à traiter au site	• Tous les problèmes ci-haut sont absents	NON	OUI	**PALUDISME**

5. DIARRHEE (= Selles liquides 3 fois par jour ou plus)   (Cocher) OUI NON

à REFERER si :	• Signes de déshydratation (yeux enfoncés, assoiffé, pli cutané s'efface lentement, enfant agité), ou	NON	OUI	**DIARRHEE à REFERER**
	• Sang dans les selles, ou	NON	OUI	
	• Diarrhée trop liquide (comme de l'eau)	NON	OUI	
DIARRHEE à traiter au site	• Tous les problèmes ci-haut sont absents	NON	OUI	**DIARRHEE simple**

6. TOUX ou RHUME   (Cocher) OUI NON

	Mvts respiratoires= Nbre par Minute (Ecrivez)			
La RESPIRATION est RAPIDE	• 50 Mvts respiratoires ou (+) chez l'enfant de moins de 1 an	NON	OUI	**PNEUMONIE**
	• 40 Mvts respiratoires ou (+) chez l'enfant de 1 an et plus	NON	OUI	
La RESPIRATION est NORMALE	• moins de 50 Mvts respiratoires chez l'enfant de moins de 1 an	NON	OUI	**TOUX ou RHUME**
	• moins de 40 Mvts respiratoires chez l'enfant de 1 an et plus	NON	OUI	

7. MALNUTRITION (les points 7, 8,9 sont à rechercher chez tout enfant)

MALNUTRITION SÉVÈRE à referrer	• Amaigrissement visible et sévère,	NON	OUI	**MALNUTRIT° Sévère**
	• ou oedèmes aux membres inférieurs.	NON	OUI	
MALNUTRITION légère Ou enfant à risque	• Poids faible pour l'âge : – Dans la bande JAUNE, ou	NON	OUI	**MALNUTRITION**
	– poids stationnaire ou qui baisse après 3 pesées successives	NON	OUI	
PAS DE MALNUTRITION	• Poids normal (Zone VERTE),	NON	OUI	**PAS de MALNUTRITION**
	• pas de signes de malnutrition	NON	OUI	

8. STATUT VACCINAL et pour CPS & Vit A   CARTE CPS VUE. (Cocher) OUI NON

	NON	OUI	*Rattrapage*	Non	Oui
• L'enfant a-t'il un problème avec les pesées	NON	OUI	*Rattrapage*	Non	Oui
• L'enfant a-t'il un problème avec la vaccination	NON	OUI	*Rattrapage*	Non	OuI
• L'enfant a-t'il un problème avec la Vit A	NON	OUI	*Rattrapage*	Non	Oui

9. AUTRE PROBLEME   TOUT AUTRE PROBLEME (à référer)   **AUTRE : Référez**

10. CAS REFERE CONSEILS POUR LES CAS A REFERER AU CAS INTEGRE

Si l'enfant peut téter ou boire, continuer à téter en route (ou lait exprimé à la tasse) ou donner de l'eau sucrée si enfant sevré - NOURRISSON de 1 Sem. à 2 mois : le maintenir au chaud	SI FIEVRE : Paracétamol (½ Co à moins de 3 ans, ¾ Co enf 3-5 ans) + bain à l'eau ordinaire ou enveloppement humide de la tête en cas de forte fièvre.
	SI DIARRHEE : donner fréquemment des gorgées de SRO avec la tasse, (même si allaitement exclusif)
	NB : REMPLIR LA FICHE DE REFERENCE ET REFERER

11. TRAITEMENT

TRAITEMENT DE LA FIEVRE/PALUDISME
1) Médicaments
   a) **ANTI PALUDIQUE :**

   • Enf 2-6 mois : QUININE gttes 20%(1 gtte/kg de poids, 3 fois par jour, pdt 7 jours)

   • Enf 7-11 mois : Art ½ Co + AQ ½ Co, pdt 3 jrs (TOT 1½ Co Art + 1½ Co AQ)

   • Enf 12-59 mois : Art 1 Co + AQ 1 Co, pdt 3 jrs
   Remarque : en cas d'absence d'ART+AQ, donner la SP selon la posologie suivante :

   • **Enf 2-11 mois : SP ½ Co à dose unique, 1 seul jour**

   • **Enf. 1-2 ans : SP ¾ Co à dose unique, 1 seul jour.**

   • **Enf. 3-5 ans : SP 1 Co à dose unique, 1 seul jour**
   b) **Paracétamol** Co 500 mg : (4 fois/jour).

   • Enf de moins de 3 an : ½ Co, pdt 2 jours (TOT 4 Co)

   • Enf plus de 3 ans, ¾ Co, pdt 2 jours (TOT 6 Co)
2) Conseils : Voir CARTE 1
3) RDV après 2 jours

TRAITEMENT DE LA DIARRHEE
1) Médicaments
   a) **SRO** (au moins 2 sachets) ou autres liquides recommandées :

   • ½ verre de SRO à chaque selle : Enfant < 2 ans

   • 1 verre de SRO à chaque selle : Enf.2 ans et plus (Si Vomissement : attendre 10 min. puis redonner)
   b) **Mébendazole** : ou 1 Co de 100 mg 2 fois par jour pdt 3 jours (TOT 6 Co) (ou 1 Co 500 mg dose unique dès âge de 1 an)
   c) **Zinc Co** pdt 10 jours, à raison de :

   • ½ Co 20 mg, enf de moins de 6 mois (TOT : 5 Co)

   • 1 Co 20 mg, enf de 6 mois et plus (TOT : 10 Co)
2) Conseils : Voir CARTE 2
3) RDV après 2 jours

TRAITEMENT DE Pneumonie et de Toux/rhume
1) PNEUMONIE :
   a) **COTRIMOXAZOLE**

   • Enf 2 mois-6 mois : ¼ Co 2 fois par jr pdt 5 jrs (TOT 2½)

   • Enf 6 mois-3 ans : ½ Co 2 fois par jr pdt 5 jrs (TOT 5 Co)

   • Enf 3 ans –5 ans : 1 Co 2 fois par jr pdt 5 jrs (TOT 10 Co)
   b) **Remède contre la toux** : Jus de citron (dilué) ou miel
   c) Si fièvre : Voir traitement de paludisme.
2) TOUX OU RHUME SIMPLES :
   a) **Remède contre la toux** jus de citron ou miel dilué)
   b) Si fièvre : Voir traitement de paludisme.
3) Conseils : Voir CARTE 3
4) RDV après 2 jours

PRISE EN CHARGE DE LA MALNUTRITION LEGERE
1) Médicaments
   a) **Mébendazole** : 1 Co de 100 mg 2 fois par jour pdt 3 jrs (TOT 6 Co) (ou 1 Co 500 mg dose unique dès âge de 1 an
   b) **Fer** 1 Comprimé par jour pendant 1 mois (TOT 30 Co)
2) Conseils : Voir CARTE 4
3) RDV après 2 jours pour vérifier l'application des conseils donnés, puis RDV après 7 jours

12. RATTRAPAGE (Voir Statut vaccinal & CPS & Vit A, et conseils pour rattrapage si nécessaire)

Dans tous les cas, encourager la mère à poursuivre les pesées, la vaccination et la supplémentation en Vit A au CS

13. VISITE DE SUIVI EFFECTUEE ? OUI NON **INSTRUCTIONS POUR LE RDV DE SUIVI.**

A.	POSSIBILITE n°1 : La mère de l'enfant est revenue		POSSIBILITE n°2 : La mère n'est pas revenue	OUI
	Cocher si : • Revenue selon le RDV fixé ☐ • Revenue immédiatement suite à l'aggravation de la santé de l'enfant ☐		Cocher pourquoi elle n'est pas revenue : a. Consultation de tradi-praticien ou traitement traditionnel ☐ b. Manque d'argent ☐ c. Enfant amélioré ☐ d. Activités de mère : vendeuse, champs, travail, maladies en famille… ☐ e. Décès ☐ f. Autres causes : ☐	

B.	L'ETAT DE L'ENFANT EST-IL AGGRAVE ? (Demander à la mère) (cocher)	NON	**OUI**	SI OUI, REFERER

C.	L'ENFANT A-T'IL UNE NOUVELLE PLAINTE ?	NON	OUI	SI OUI, PRENDRE UNE NOUVELLE FICHE

D.	RECHERCHER LES SIGNES DE DANGER et d'ALERTE REFERER SI PRESENCE D'UN SEUL SIGNE					
	• L'enfant incapable de boire ou de téter	NON	**OUI**	• Fièvre qui persiste malgré traitement	NON	**OUI**
	• L'enfant vomit tout ce qu'il consomme	NON	**OUI**	• Apparition des éruptions cutanées généralisées et/ou du prurit	NON	**OUI**
	• A convulsé ou convulse maintenant	NON	**OUI**	• Signes de déshydratation	NON	**OUI**
	• Iinconscient ou très affaibli	NON	**OUI**	• Sang dans les selles	NON	**OUI**
	• Respiration difficile (tirage ou sifflement)	NON	**OUI**	• Diarrhée trop liquide (comme de l'eau)	NON	**OUI**
	• Pâleur palmaire (anémie)	NON	**OUI**	• Ou autre phénomène anormal	NON	**OUI**

E.	SI L'ENFANT AVAIT TOUX OU RHUME, Nbre de Mvts		Resp/minute Respiration rapide ? **REFERER SI OUI**	NON	**OUI**

F.	VERIFIER SI L'ENFANT A RECU SES MEDICAMENTS COMME PRESCRIT. A reçu sa dose ? • Vérifier la quantité restante des médicaments dans le sachet de la mère.	NON	**OUI**

G.	CONSEILLER DE CONTINUER LE TRAITEMENT DE L'ENFANT • Demander à la mère de rappeler comment elle a administré les médicaments (revoir les «3 COMBIENS») • Si la mère a bien administré les médicaments, FELICITER ET ENCOURAGER A CONTINUER • Si la mère a mal administré les médicaments, démontrer la dispensation (revoir les «3 COMBIENS») puis demandez-lui de répéter et d'administrer une dose en votre présence. Vérifiez sa compréhension

ANNEX 8. ICCM DASHBOARD IN DRC, FROM JANUARY TO DECEMBER 2006 (FRENCH)

ANNEE 1

PROVINCE	BDD	KASAI OCC.							KINSHASA					KASAI OR.	EQUATEUR				SUD KIVU		TOTAL
DISTRICTS	Kwango	Lulua	Luiza						Lukunga				Funa	Muene Ditu	Mband	Sud Ub	Nord Ub		Katana	Walungu	
PARTENAIRE	GTZ	IRC	HEALTH Net						UNICEF et Rotary					CRS	Unicef				IRC		
ZONE DE SANTE	Kenge	Demba	Mutoto	Lukonga	Bilomba	Ndekesha	Dibaya	Kabondo Dianda	Bukama Kasai	Mt Ngafula2	Binza Meteo	Sele mbao	Mt Ngafula1	Makala	Makota	Kanda Kanda	Mba	Gem	Gbado	Kalehe	Kabare	
Prévisions et réalisations																						
– Nbre Centres de Santé	15	22								14	11	18	16	14						10	15	**149**
– Sites projetés	25	20								16	13	15	13	13								**110**
– Sites ouverts	8	5								8	7	7	7	7								**50**
– Relais projetés	44	40								32	20	30	26	26								**208**
– Relais formés	14	10								15	14	14	14	14								**97**
– Date formation	Dec 05	Jan 06								Fev 06	Juin 06	Juin 06	Juin 06	Juin 06								
– Date ouverture sites	Déc. 05	Mars06								Mars 06	Sept 06	Sept 06	Sept 06	Sept 06								
Suivis post-formations																						
Janvier 2006																						
Février 2006	S1, 26																					
Mars 2006	–																					
Avril 2006	S2, 2									S1, 25												
Mai 2006	–	S 1, 24								S2, 26												
Juin 2006	S3, 20	S2, 27																				
Juillet 2006		S3, 25								S3, 8												
Août 2006																						
Septembre 2006		S 4,28								S 4,22												

ANNEE 2

PROVINCE		KASAI OCC.						KINSHASA				KASAI OR.		EQUATEUR			SUD KIVU		TOTAL
DISTRICTS (BDD)	Kwango	Lulua				Luiza	Tshi mbulu	Haut Lomami	Kasai	Lukunga			Funa	Muene Ditu		Mband	Sud Ub	Nord Ub	Katana	Walungu	
PARTENAIRE	GTZ	IRC				HEALTH Net		ECC		UNICEF et Rotary				CRS		Unicef			IRC		
ZONE DE SANTE	Kenge	Demba	Mutoto	Lukonga	Bilomba	Ndeke sha	Dibaya	Kabondo Diand	Bukama	Mt Ngafula2	Binza Meteo	Sele mbao	Mt Ngafula1	Makala / Funa	Makota	Kanda Kanda	Mba	Gem	Gbado	Kalehe	Kabare	TOTAL
Prévisions et réalisations																						
– Sites projetés	25	22	15	15	15	15	7	7	7		5		15	6	6	5	7	7	7	20	20	226
– Sites ouverts													7							14		21
– Relais projetés													30							32		62
– Relais formés										2			13							14		29
– Date formation										Oct 06			Oct 06							Oct 06		
– Date ouverture sites										Nov 06			Dec 06							Nov 06		
Suivis post-formations																						
Octobre 2006														S1, 28								
Novembre 2006											S1, 22	S1, 21										
Décembre 2006										S5	S2, 2	S2, 2	S2,	S2,								
…																						
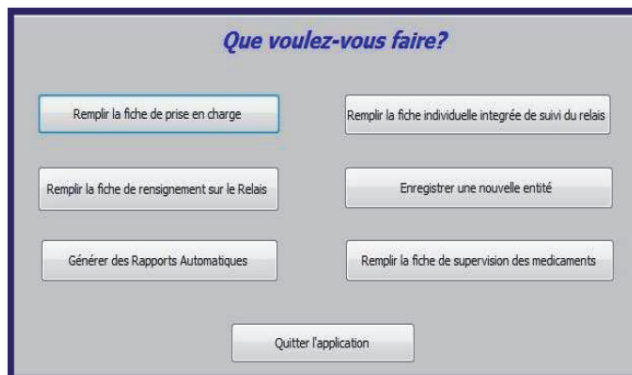
ANNEX 9: OVERVIEW OF THE INTERFACE OF THE ICCM COMPUTERIZED DATABASE IN DRC

LOGIN SCREEN:

TASK OPTIONS:

REQUEST FOR ANALYSIS:

SAMPLE RESULTS:

RapSupMedic

Résultats sur la Disponibilité / Rupture de stock aux Sites

Veuillez Spécifier la Période (date) de suivi : _____

1. Proportion des sites avec disponibilité des médicaments lors des visites de suivi   [Afficher]

	Disponibilité (N= Sites)
ACT	%
Quinine	%
Paracétamol	%
SRO	%
Zinc	%
Mébéndazole	%
Cotrimoxazole	%
Fer	%

2. Proportion des sites avec disponibilité des Matériels lors des visites de suivi   [Afficher]

	Disponibilité (N= Sites)
Fiches de prise en charge	%
Balance fonctionnelle	%
Minuteur fonctionnel	%
Note de référence et de contre référence	%
Fiches de rapport mensuel	%
Emballage pour les médicaments	%

3. Proportion des sites avec rupture de stock de médicaments d'au moins 5 jours   [Afficher]

	Rupture de stock (N= Sites)
ACT	%
Quinine	%
Paracétamol	%
SRO	%
Zinc	%
Mébéndazole	%
Cotrimoxazole	%
Fer	%

[Quitter]

ANNEX 10. THE DOCUMENTATION TEAM AND THE KEY ACTORS OF THE ICCM APPROACH IN THE DRC

DOCUMENTATION TEAM

Raharison Serge from MCHIP, Cyaka Yves from PSI, Tall Fatim from WHO, Swedberg Eric from Save the Children, Mpanya Alain and Kabeya Duda

LIST OF ACTORS IN THE IMPLEMENTATION OF COMMUNITY SITES IN THE DRC

Conception, Advocacy and Decision Phase

Dr. Miaka, Dr. Kanza Nsimba Maurice, Dr. Bakukulu Jean Tony, Dr. Jean Fidèle Ilunga, Dr. Kabuya Willy, Dr. Kini Brigitte, Dr. Ngoie Pascal, Dr. Matshifi Denis, Dr. Mubiala Joachim, Dr. Diana Van Daele

Initial/Learning Phase

Dr. Makwenge Kapu, Dr. Daniel Verna, Dr. Célestin Traore, Dr. Papy Luntadila, Dr. Diankenda Flore, Dr. Want Ilunga, Dr. Ndela Britou, Dr. Mibulukini Benoit, Dr. Ngoie Mutambay Bernard , Dr. Mpeti Emmanuel, Dr. Mukinda Valentin, Dr. Mayakasa Charles, Dr. Swele Micheline, Dr. Belewete Elias, Mme. Zikudieka Lucie, Dr. Bitika Alain, Dr. Molinda Pélagie, Mme. Brigitte Nsaka, Dr. Francis Litongu, Mr. Tshitshi, Mr. Muela, Mr. Empele, Mr. Bukasa Gabriel, Dr. Freddy (Kenge), Mr. Dosite, Mr. Fenelon Tshiyoyo, Dr. Petelo, Mr. Kanza Jonathan , Mr. Mongaba Blaise, Dr. Mukendi Didier.

Extension/Scale-Up Phase

Dr. Kalume Tutu, Dr. Albert Kalonji, Prof Dr. Tshefu Antoinette, Dr. Otshudiema John, Dr. Lukanu Philippe, Dr. Jd Nlandu, Dr. Ngoy Mukuta Bernard, Dr. Nsiala Adrien, Dr. Mbo Marie-Louise, Dr. Monganza Claudine, Mme. Wembodinga Chantal, Dr. Deddy Ntumbak, Dr. Charles Kazadi, Dr. Nelson Bambwelo, Dr. Tshamala Freddy, Dr. Bitika Alain, Dr. Sumba Jean Pierre, Dr. Gisèle Kalend, Dr. Molowayi Willy, Mr. Mukadi Jeanpy, Dr. Bolanteyi Leopold, Dr. Kalend Gisèle, Dr. Muamba Josué, Dr. Tshamala Freddy, Mme. Yuma, Mme. Tshala Béatrice, Dr. Lubuku Polycarpe, Dr. Tonda André, Dr. Embeke Narcisse, Mr. Kahongo Derek, Dr. Batubenga Crispin, Dr. Mandja, Dr. Bola Jean Claude, Dr. Burhole Manu, Mr. Mpuruta.

TECHNICAL SUPPORT

Wansi Emmanuel