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BASICS

TOOLKIT FOR COMMUNITY CASE MANAGEMENT OF CHILDHOOD ILLNESSES

IMPLEMENTATION GUIDE

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The present document is one of nine elements in the USAID/BASICS Community Case Management of Childhood Illnesses Toolkit. The Toolkit includes:

Manuals and Guides
- Implementation Guide
- Trainer's Guide
- Training Exercise Manual
- Community Health Worker's Manual
- Communications Guide
- Supervisor's Guide

Facility-level tools
- Patient Form
- Patient Follow-up Form
- Data Collection Form

Adaptation of the toolkit for use in DR Congo was completed thanks to close collaboration between USAID/BASICS, the DR Congo Ministry of Health, UNICEF, WHO, GTZ, IRC, and Management Sciences for Health.

TABLE OF CONTENTS

PREFACE

Infant mortality in the Democratic Republic of Congo is one of the most alarming in Africa; 127 out of 1000 children born die before their first birthday (or about 304,800 out of 2,400,000 children <1 year). Moreover, child mortality is 213‰ (i.e. 2,500,000 who die each year out of 12,000,000 children less than 5 years in the country) (MICS 2, 2001).The DRC is among the 6 countries of the world regrouping 50% of the world's child mortality, after India, Nigeria, China, and Pakistan; and before Ethiopia..

In addition to perinatal deaths, the causes of child mortality are malaria, acute respiratory infections, diarrhea, measles, and the complications of HIV/AIDS. In half of the cases these diseases are often associated with malnutrition.

The analysis of the situation has demonstrated that 80% of children die at home without consulting a health facility. This serious situation is due to the low involvement of the community, difficult access to quality health care and medicines, self-medication, and ignorance of danger signs among others.

Given the magnitude of this problem, the Ministry of Health has adopted the strategy of establishing community-based health care to reduce infant mortality.

The development of this implementation guide for community health care sites is part of the activities related to the implementation of community-based health care. This is an important tool that outlines the essential elements to the attention of the Ministry and partners at various levels for the implementation of community health care sites in the DRC.

The goal is to provide the health supervisors at all levels, *Titulaires* and partners with a sufficient understanding on the implementation process of community health care sites in the DRC.

More specifically, this planning document for the implementation of the sites serves as a reference document for health supervisors at different stages of implementation of field activities and will enable the supervisors to familiarize with the tools used in community health care sites.

We therefore urge all those responsible for health care at all levels to meet the instructions in this document in order to standardize the process of implementation of community-based health care in the DRC.

We encourage any officer in the ministry of health and partner to provide his support for community based health care activities to succeed in the DRC. Our greatest aspiration, is that through the implementation of community health care sites, we may significantly contribute to the achievement of national objectives of reducing infant mortality and the Millennium Development Goal regarding child survival.

Dr. Victor Makwenge Kaput

Ministry of Health

ACRONYMS

B

Basics: Basic support to institutionalizing child survival

C

CA: Community Animateur - in charge of health related community mobilization

CAC: Community Animation Cell

CBNP: Community Based Nutrition Program

C-IMCI: Community Integrated Management of Childhood illness

CODESA: Health Area Development Committee

COGESITE: Site Management Committee

CPS: Preschool consultation

D

DRC: Democratic Republic of Congo

E

EGD: Essential Generic Drugs

EPI: Expanded Program on Immunization

H

HA: Health Area

HC: Health Center

HIV/AIDS: Human Immunodeficiency Virus/Aquired Immunodefiency Syndrome

HZ: Health Zone

HZCO: Health Zone Central Office

I

IMCI: Integrated Management of Childhood Illness

M

MSH: Management Sciences for Health

N

NHIS: National Health Information System

NIC: Nurse in Charge (of HC or HA)

P

PHC: Primary Health Care

PNAM: National Program for essential medicine supply

PNIRA: National program for fight against acute respiratory infections

PNLMD: National program for fight against diarrhea deseases

R

Relais: Community Health Worker(s) especially in charge of C-IMCI

RPM Plus: Rational Pharmaceutical management plus

RUMER: Register for the record of essential drugs use and returns

T

Titulaire: Nurse in charge of a health center/health area,

U

UNDP: United Nation Development Programme

USAID: United States Agency for International Development

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The Ministry of Health recognizes the need for a community-based healthcare implementation guide; and is grateful to partners who have effectively contributed in the initial phase, to the development and production of this document which will serve as an important tool for the implementation of community health care sites in the DRC. These are: WHO, UNICEF, BASICS, MSH/RPM Plus, GTZ, IRC, CRS, HNI.

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INTRODUCTION

Geographical Context

The Democratic Republic of Congo is the third largest country in Africa, covering an area of 2,345,000 km². According to projections by the National Institute of Statistics, based on data from the Census of 1984, the DRC has about 60 million inhabitants, i.e. a density of about 26 inhabitants per km ².

Due to its geographical location, the country has immense natural resources. Indeed, located astride the Equator, the country has a warm equatorial climate, humid in the center and tropical towards the north and the south, which favors dense vegetation, with half the country covered by forests, and the other half by savanna. It is estimated that nearly half of the forest resources of Africa are in the DRC. The rainfall reaches up to 2,000 mm per year. In some places, it rains eight months of the year and during the dry season of four months, temperatures can drop to 10 ° C in some areas.

The DRC is endowed with a dense hydrographic network: the Congo River which is 4,500 km long crosses the country from east to west to plunge into the Atlantic Ocean, with the second highest speed in the world (30,000 m³ of water per second). There are about fifteen lakes in the DRC, covering an area of 180,000 km ². Tributaries of the Congo River and other rivers, navigable for the most part, offer enormous opportunities for fluvial transport. As far as mineral resources are concerned; the DRC has plenty of them such that it is called a geological scandal.

The Socio - Economic situation

Notwithstanding this potential, the Congolese population lives in abject poverty due to poor governance and armed conflict. Indeed, since 1975, The DRC has been experiencing an economic crisis that has not stopped growing. Gross Domestic Product, for example, saw rates decline among the most negative over the entire decade of the 90ties: - 6.6% in 1990 and - 14% in 1999 (UNDP 2001). This economic counter-performance is followed by several problems (hyper-inflation, drastic decline in production and investment, monetary instability, weakness of budget revenues; disarray of public finances; deterioration of public infrastructure including roads, loss of human capacity, collapse of agricultural production, etc..) leading to a widespread deterioration of the health status.

The Health Status

The health status for children aged from 0 to 5 years; in the Democratic Republic of Congo (DRC); is one of the most alarming in Africa. Indeed, the DRC is among the 6 countries of the world regrouping 50% of the world's child mortality, after India, Nigeria, China, and Pakistan; and before Ethiopia.

The infant and juvenile mortality rates reach respectively 127‰ (i.e. 304,800 deaths over 2,400,000) and 213‰ (i.e. 2,500,000 deaths over 12,000,000). Hence; there are 5 children less than 5 years old who die every minute.

The major causes of death are similar to those of other developing countries, including:

- Malaria,
- Acute respiratory infections,
- Diarrhea,
- Measles,
- Malnutrition,
- HIV/AIDS
- Neo-natal causes.

Malnutrition is involved in half of the recorded cases. According to surveys, 80% of these deaths occur at home, often within 30 minutes after arrival at a health facility.

Several factors underlie this mortality, among them are:

- Low utilization of health services (around 25%)
- Inaccessible health care (distance and cost)
- The spread of drugs of dubious origin and quality in the community and used for first care in households, etc.
- Self–Medication abuse (misuse of drugs)
- Unawareness of “warning signs”,
- Late consults at HC / hospital,
- Low community involvement, etc.

Reducing mortality requires implementation of preventive, curative and promotional activities involving not only the health structures but also the community, whose active participation is indispensable.

The Integrated Management of Childhood illness (IMCI), as a priority strategy for reducing child and juvenile mortality has been gradually introduced in the DRC since 1999, both in its clinical and community aspects. However, given the size of the country, the expansion of activities is slow vis-à-vis the magnitude of child health problems.

To achieve its objective, IMCI focuses on improving family and community capacities, including the promotion of key practices in the community and community based health care for sick children. In this perspective; the DRC has put in place community health care sites.

What are the issues to be solved by community health care sites in the DRC?

Several factors have been mentioned above among the causes of infant and juvenile mortality. Community health care sites in the DRC try to address two them.

The first factor is the GEOGRAPHIC INACCESSIBILITY (distances and natural barriers). Indeed, community health care sites are set up in villages or communities located at more than 5 km away from a medical facility or cut by natural barriers, giving priority to major cities in order to cover as many children as possible.

The second factor is THE CIRCULATION OF DRUGS OF DUBIOUS ORIGIN AND QUALITY IN THE COMMUNITY, used for 1st care in households. Community health care sites in the DRC provide the population with essential generic drugs (EGD) of good quality for children's health care.

This guide was developed for stakeholders from all levels of the health system in the DRC, to serve as a basic document for instructions and guidelines for community health care in the Integrated Management of Childhood Illness.

CHAPTER I DEFINITION AND CONCEPTS OF COMMUNITY HEALTH CARE SITE

1.1. Definition of a community health care site

A site is a defined geographical area in which *one or more villages* or communities with difficult access to a health facility receive health care provided by two volunteers called *Relais,* trained and supervised to handle certain ailments, especially among children under five.

1.2. Site Objectives

1.2.1. General Objective

Improve access to health care for people who live far from health facilities or who have a difficult access to them.

1.2.2. Specific objectives:

1. Ensure adequate first aid to people without 'geographic access' to health care;
2. Ensure transfer of cases with danger/warning signs;
3. Improve the availability of quality essential generic drugs (EGD) in the community, and their rational use;
4. Improve reporting of cases of disease, and community-based monitoring;
5. Improve the key practices related to child survival;
6. Strengthen the technical capacity of health zones and Nurses in charge of health facilities for the training of *Relais*.

1.3. Site intervention package.

The package of activities implemented at the community health care site level is made of:

- The treatment of simple cases of malaria, diarrhea, pneumonia and malnutrition, including reference of cases with danger/warning signs.
- Communication for behavior change
- Community-based epidemiological surveillance
- The availability of quality essential medicines.

1.4. Management and organization of the site

For the purpose of community appropriation of sites implementation, a decision was made to establish a management committee from the community, so that the site may not be something between the two *Relais* and the nurse who oversees them.

The Site Management Committee or *COGESITE* is an offshoot of villages and towns affected by the site. Thus, community animation cells (CAC) of each village involved will be represented in the COGESITE. In addition, the *COGESITE* will be represented in the Health Area Development Committee *also called CODESA, in short, in French.*

Each *COGESITE* must have a chairman, secretary and treasurer. Its role and functions are described later in this implementation guide (Chapter 8).

Regarding *hours of operation* of the site, the *relais* does not work full-time. He has to attend to his own business/professional activities but also dedicate part of his time to community activities. It should then be discussed with the community to agree on the hours in which the *relais* can be contacted. When the *relais* attends to his business, he will leave a message at the door of his house for him to be easily found by the community whenever needed.

All details regarding the site functioning should be previously agreed upon between the COGESITE, the site *relais* and the *Titulaire*.

1.5. Stages of sites implementation

The stages of implementation of community health care sites are summarized in the table below:

	STAGES	MANAGER
1	Drugs and supplies order (timers, scales, patient charts, registers, EGD box)	Partner and HZ
2	Orientation of teams of supervisors from provinces/districts and health zones.	Provincial Health Division (From Central Level)
3	Identification and selection of sites.	HZCO,NIC/ Support of District-Province
4	Selection of *Relais* and members of Site Management Committee - COGESITE (Community Awareness and Participation)	HZCO and NIC
5	Training of trainers and supervisors (District, HZCO and NIC)	Provincial Health Division (From Central Level)
6	Training of sites *Relais*	Provincial Health Division (From Central Level)
7	Orientation of site management committee	HZCO and NIC
8	Official introduction of sites *Relais*	HZCO and NIC
9	Post-training follow up	Central level, Province - District, HZCO, NIC
10	Implementation quality assurance	Central level, Province- District, HZCO, NIC

CHAPTER II DRUGS AND SUPPLIES MANAGEMENT

Medication management is one of the pillars that support the activities of community health care sites since without them; health care becomes impossible at the sites.

2.1. List of medicine and supplies for the site

We resume in the following lines the list of drugs and supplies to prepare for the launch of community health care sites.

a) Drugs

- Antimalarial: Artesunate-amodiaquine (ASAQ) and quinine drop
- Paracetamol 500 mg tablets
- Cotrimoxazole 480 mg tablets
- ORS (Oral Rehydration Salts) sachets
- Zinc Sulphate 20 mg tablets
- Mebendazole 100 mg tablets
- Tablets of ferrous sulfate + folic acid 200mg
- Condom

b) Supplies

- Timers
- Salter Scales
- CPS cards colored with bands to be used by *Relais*
- Patient charts for 1 year of activity for *Relais*
- Site consults registers
- Register for the record of essential drugs use and returns (RUMER)
- Medicine supply order book
- Monthly reports forms
- Medicine boxes for all sites.

Instructions for filling out various management tools included on the list are described in the community *relais*' training manual as well as in the trainer's guide.

2.2. Drugs and supplies order

Once the decision is made to establish community health care sites, it is indispensable that drugs and supplies to be used by the community *relais* are available even before the start of training sessions.
This is justified by three reasons:

- Some supplies require a long lead time, for instance timers, which take at least 3 months of lead time.
- There are supplies and equipment to which the *Relais* should be familiar from their training session, including the timer, the patient chart, Salter balance, the RUMER (Register for the record of essential drugs use and returns) the register of consultation and the medication he will be using for health care.
- There shouldn't be a long time between the end of the training session and the start of actual sites' activities, lest the *Relais* would lose the newly acquired knowledge and requires a new briefing before he/she starts taking care of sick children.

The *Relais* will be provided with a two months' stock of medicines to start with; assessed taking into account the following:

- The population of less than 5 years expected at the site.
- The utilization rate of health care at the site estimated at approximately 50%
- The number of episodes of illness per child per year (3.2 for diarrhea, 4 for malaria and 8 for pneumonia)
- The total dose of tablets to be administered for each episode of illness.

For the *Relais* at the sites to know their sites' MONTHLY CONSUMPTION as well as the MINIMUM STOCK LEVEL, the facilitators and *Titulaires* will demonstrate the necessary calculations during the training session as described in the trainer's guide.

Thus, at the end of their training, the *Relais* will have a table, showing the monthly consumption and the minimum stock level for their respective sites
Subsequent adjustments will take into account the monthly consumption and the minimum stock level of the site according to rational principles of drugs quantification to avoid stock outs at the site level. The *Titulaire* and supervisors will make these adjustments in order to communicate them to the *Relais*. Each *Titulaire* shall make sure necessary drugs are available to the *Relais* in a way that guaranties effectiveness of health care for children less than 5 years.
Regular supervision of the *Titulaire* or any officer from a higher level (health zone, health district, province or central level) should have the assignment among others; of making sure that the *Relais* has enough drugs for health care.

Drugs quantification calculations at the site are included in the *Relais* training modules as well as in the trainer's guide.

2.3. Receipt and storage of medicines

Upon reception of medication at the health center, the site *Relais* will be responsible for:

- Counting the amount of medication received
- Checking the expiry date of medicines
- Checking the external appearance of each product (color, smell, shape ...)

Medications should be kept:

a) Clean and well maintained: regular sweeping and dusting of storage space
b) Ventilated: the room or the storage box must be ventilated so as not to expose the drugs to high temperatures
c) Dry: the storage place should be dry as moisture can affect product quality
d) Secure: the drugs box should always be locked to prevent theft or other loss…
e) Well-organized: i.e. a good drugs organization which makes them easier to find at the time of distribution.

2.4. Physical inventory of drugs

The inventory of drugs is a task that the *Relais* will perform each month with members of the COGESITE. The inventory will never do without the presence of at least two members of the COGESITE. During his supervisions, the *Titulaire* will ensure that the inventory of drugs is carried out monthly at the site with presence of COGESITE members.

Before ordering the drugs, the community *Relais* must make a comprehensive inventory of his stock and mention on the RUMER the quantities physically counted. He should regularly count his stock (full stock count) to ensure that the quantities recorded match those he has counted.

- *Importance of Inventory*
    - Ensure continuous monitoring of stock
    - Identify the differences between the theoretical stock and the actual inventory.
    - Identify obsolete and damaged products.

How to make an inventory:

- Count the items one by one
- Identify obsolete and damaged products, and remove them from the stock
- Note on the RUMER remaining counted quantities in the "Physical Inventory" column.

Expired drugs are products that are well preserved but for which the expiry date set by the manufacturer is exceeded. The expiry date is always indicated on the packaging.

The drugs affected or damaged are drugs that have undergone changes in appearance (color, smell, taste ...) NB: obsolete of damaged products, withdrawn from the stock must be delivered to the Health Center (HC) and returned to the central office of the health zone for destruction. These drugs are recorded as losses.

2.5. Dispensing of medicines.

The dispensing of medicines is one of the key elements of health care at the site. It affects the effective examination of the patient.
When medication is given, it is important that the patient receives:

- The appropriate medication with its name
- The correct information on how to take the drug, i.e.:
    - The exact dosage of the medicine
    - How many times per day the drug is to be taken
    - The number of days of treatment.

Dispensing process

The steps in the dispensing of drugs are described in detail in the *Relais* training module. It is very important for him to understand these different steps in order to have a correct administration of medicines.

Dispensing medication to the patient implies:

A. Drug conditioning i.e.:
    1. Drug description
    2. Count the quantity needed for a full treatment with a clean spoon
    3. Wrap each drug in a small plastic bag with closing grip
    4. Label it with the name of the drug, dosage and duration of treatment.

B. Show the medicine

Show the mother the name, form and use of the drug. Show her how to prepare and dissolve the drug

C. Explain how to take drugs i.e. (3 Hows):

1. How much of the drug; the dose of drug to be taken in terms of pills or tablets
2. How many times a day
3. How many days of treatment.

D. Verify understanding of the mother

The *Relais* is expected to have the mother repeat the 3 “hows”

E. Demonstration:

Ask the mother to crush or dissolve the drug and administer the first dose in your presence.
At the end of the drug administration, it is crucial that the *Relais* tells the mother <u>when to return immediately</u> and gives her an appointment.

CHAPTER III ORIENTATION OF PROVINCIAL/DISTRICTS AND HEALTH ZONES' SENIOR MANAGEMENT TEAMS

This orientation is a fundamental step at the beginning of the implementation of sites. At each level of the health system, it will precede the actual beginning of the intervention on the field. It will be done in cascade.

3.1. Purpose of the orientation

The orientation of senior management teams will have the following goals:

- Provide information to senior political and administrative leaders on community health care sites.
- Obtaining the support of administrative and political authorities, opinion leaders and partners for their involvement in the implementation process.
- Prepare various trainers and supervisors of intermediate and peripheral levels on the tasks they will undertake during the implementation of sites, particularly in the selection of sites and volunteers, as well as preparations for the beginning of operations.

3.2. Orientation meetings levels

Orientation meetings will be held at the following two levels:

- Health district and province level

Workshop participants will be the provincial political and administrative authorities, opinion leaders, senior management teams of the provincial medical inspection and health districts, as well as partners.
The pool of trainers from the central level will facilitate this orientation.

- Health Zone level

Participants will be the administrative and political authorities of the zone, opinion leaders, NGOs and other partners, health zone senior management teams, *Titulaires* of private health facilities, multi-sectoral platform organizations working in the zone (women associations, school and agriculture inspections, the red cross, etc.).

Trainers from the provinces and/or health district will be the ones to facilitate this orientation.

3.3. Orientation meetings steps

At each level (province/district and health zone), the orientation will consist of two stages

a) Information Awareness on the sites: It includes the definition and operation of the site, the package of activities offered at the site and the expected contribution of participants in the implementation process.
This step does not involve technical details, thus allowing the administrative authorities and political leaders to participate.
The orientation text for this step is attached to this guide.

b) Technical orientation: It will be devoted solely to technical staff. It will include all aspects of the implementation process. It will portray to the trainers/supervisors the instructions/guidelines regarding the intervention implementation process. Each participant will be prepared for the tasks he/she will be carrying out under this intervention.

CHAPTER IV IDENTIFICATION AND SELECTION OF SITES

The identification and selection of probable sites is the fact of identifying eligible villages/people for site implementation in the health area. Once all the health areas have selected the sites, the health zone will develop a mapping of sites to be established.

Eligible villages/people will not necessarily benefit from several sites, but rather will consolidated around 1, 2, 3 sites at the most in a health area. The place where the site will be installed should help improve access to health care for a number of distant villages/populations or those cut away by natural barriers. This is the same type of process when setting up sites during outreach activities like vaccination (in the EPI) or other preventive activities.

The identification on the map is not enough. Thus the support of the local population should thereafter be obtained for the selection of the site, during field visits to inform local people and their leaders in the ordinary course of a meeting.

The *Titulaire* and the HZCO will be presiding over the site selection process. However, the technical steering committee will verify and confirm whether the selection criteria were observed before the training of the *Relais*.

Site selection will be done according to certain process standards to ensure quality. Thus, it is recommended to brief leaders and the NIC or *Titulaire* so that the selection process goes according to instructions.

The purpose of this chapter is therefore to prepare the senior management teams of health districts and health zones as well as the NIC to identify the sites and select sites *Relais* and members of COGESITE following the approach recommended for the activity, including:

- The briefing of senior management teams to prepare the NIC to the selection;
- The briefing of the NIC at the selection;
- The selection of sites (with mapping of sites by HZ);
- Raising community awareness;
- Selection of volunteers.

4.1. Elements of cartography and eligibility of sites

Besides the sketches, map elements below will be very important for the sites database.
These will be:

a) Sites eligibility criteria:

The eligibility criteria for sites are:

- Geographical accessibility: sites must be set up in villages that have difficult access to the center; either because of the distance or a natural barrier (erosion, rivers, forests…)
- Population density: it is recommended that sites are installed where the need is most felt in the first place, particularly in large cities, having always in view the merger of several villages/people around the site to cover at best 80 % of eligible people in a health area.

b) Mapping elements for a health area

(Document to be produced by the *Titulaire* of the health area)

HEALTH AREA:……..HA population:……..

Health center or health post	Villages in a health area	Village Population	Distance between the village and the HC	Site	Population covered by the site	Distance between the site and the HC	Natural obstacle

Circle all the villages affected by the same site

a) Mapping elements for a health zone

(Document to be produced by the person in charge of community sensitization – the community *animateur* of the health zone central office)

It is actually a synthesis for the health zone, including the following:

HEALTH ZONE:……..HZ population: ……..

Health center or health post	HEALTH AREA	Health area Population	Population located within 5 Km from HC	Population located beyond 5 Km / or with a natural obstacle	SITE	Distance between the site and the HC	Population covered by the site	Natural obstacle

4.2. Briefing senior management teams for the selection process

a) Opportunities for the briefing

The following methodology is recommended

- Step 1: Briefing of the provincial authority, if possible with the District(s) and the health zone to avoid repetition and save time. However, if the District and the health zone are remote and it poses logistical problems, they could be briefed separately. Ideally, the health district and HZCO would provide co-facilitation of the briefing of the *Titulaires* to enhance their understanding and control of the mechanism.

- Step 2: Meeting at the health zone with the NIC and other members of the senior management team for the briefing on the selection of sites, *Relais* and members of COGESITE. That meeting, presided over by the Chief Medical Officer of the zone, would be co-facilitated by the person best informed.

The ideal would be to make the briefing during routine meetings (monthly meetings of the NIC at the HZCO for example) or take advantage of opportunities with other planned activities.

But in unusual circumstances, a special meeting may be held only for the sites. To this end, it is important that the province and the district are informed.

b) Who facilitates the briefing meeting?

We can consider 2 scenarios at a province:

1. During the introductory phase in a province, support from the central level is required for briefing and training of trainers. If the provincial Medical Inspector is informed of the process, it is unlikely for him to get involved at this level of the implementation process. The province can make use of human resources from central level. One option is to make a special briefing for a member of the senior management team of the province, district or zone, or a partner, to launch the process of site identification and selection of volunteers. Whatever the approach, it is advisable to brief the provincial level with the participation of doctors and heads of involved districts and zones and provide training for the NIC in the HZ

2. In the expansion phase: The staff from provinces, districts and health zones already trained in the process has the skills to support the new health districts and HZs, both for the identification of sites and selection of volunteers.

Financial considerations, especially at the introductory phase in a province or district can help take advantage of a province leader or a partner visit to Kinshasa to have him briefed by the central level, and gather the resources; and hence continue the briefing process in the province.

c) Content of the briefing meeting

The main content of the briefing is the identification of sites and volunteers. However, one should take advantage of this first contact to give a general idea of the intervention and processes. The plan of presentation is as follows:

1. Definition of the community health care site
2. Objectives of the Community health care site
3. Implementation stages (see above)
4. Importance of the briefing
5. The steps of the process for site identification and selection of volunteers.

Definition, objectives, package services and steps to the sites

After explaining to participants the definition, objectives, the package of activities and site implementation steps, it is important to draw attention to the fact that geographical inaccessibility of populations to health services is a major criterion for implementation of a community health care site.

Importance of the briefing

The primary interest of the briefing is to select volunteers who have met the requirements to follow the training session (noting also that these meetings should also serve as a practice ground for the establishment of pools of equipped trainers in province/district).

The secondary interest of the briefing is to ensure that the selection followed the correct approach, because a good selection is a key element for the success of the intervention.

Then the facilitator will explain to participants the various stages of the process for site identification and selection of volunteers (Sites *Relais* and members of the COGESITE), as described in section 2.3.3.

4.3. Identification and selection of sites, *Relais* and members of COGESITE

This process follows 3 steps:

- Identification of potential sites
- Raising community awareness of targeted villages/communities
- The selection of sites *Relais* and members of COGESITE

Recommendations for the 3 stages of selection:

a) As regards the identification of villages and communities candidates for sites implantation, it is recommended that the NIC first obtains the consent of the HZ on the sites identified before informing the target population. The NIC will inform the community and select the *Relais* only after approval of the HZCO, which must certify that the criteria for site selection have been met.

b) On the awareness of targeted villages/communities, it is recommended that the NIC mobilizes only villages/communities that have received the endorsement of the HZ for further activities, hence judging them as filling conditions for the establishment of sites.

Each NIC should make arrangements for the key people to attend the 2 meetings: sensitization and selection of volunteers.

c) Regarding the selection of *Relais* and members of COGESITE, it is recommended that the HZ, the partner, and if possible the district are involved in this process, to ensure that the selection criteria are met. This requires that a schedule be prepared by the HZCO for the selection of *Relais* in the health areas. If the HZCO is present, a schedule for at least 2 sites by health area per day is desirable, one in the morning and another in the afternoon.

Note that participation HZCO in the selection process is important to ensure the integrity of the process. This is confirmed by experience that shows that some *Relais* selected by the community did not inhabit the village or were simply chosen for kinship reasons, etc.

A) IDENTIFICATION OF POTENTIAL SITES

The identification of sites follows the following procedure:

1. Make a sketch of the health area (mapping of the health area)
2. Display villages located more than 5 km or isolated by natural barriers: rivers, mountains, ravines, etc.
3. Show all private health facilities, government and faith in the health area
4. Indicate the number of inhabitants for each of these villages

5. Indicate the distance of each village in relation to the HC and any health facility close to each of these villages
6. Identify on the sketch, villages and communities proposed to host the sites indicating the other villages covered by the site and the distance between villages.
7. Indicate the distance between the site and the health center.

Although the communities are the ones to choose the location of the site, it is indicated that the most populous village hosts the site. Meetings of the site should hence be held in the great community that will host the site.
It is important to ensure that the communities selected were not served by a private clinic recognized by the health zone.
Once this exercise is complete, NIC will consult with the senior management team of HZCO to finalize site selection and therefore obtaining the approval of HZCO.
It will not be necessary to organize for this purpose a validation meeting with all the NIC at the same time, because each case is unique and requires some knowledge of the terrain.
The list of potential sites available, NIC will plan outreach visits with communities.

B) COMMUNITY OUTREACH MEETING

The challenge of this stage is to ensure the participation of key people at the meeting to raise awareness.

The purpose of this outreach is to get the support and involvement of different target communities in the establishment of community health care sites, from selection and throughout all the implementation process and to the functioning of sites.

Neighboring communities separated by small distances will be encouraged to share a single site. The area will give these communities the opportunity to decide about this collaboration and to choose the members of the Management Committee and the *Relais* together.

It is therefore important to sensitize the community to use the same site because it is irrelevant to have a site in every village.

For the date and duration of the meeting, it is recommended to agree with the community on a date and time to allow the maximum number of key people to participate.

It is desirable that the meeting does not last very long, however we have to make time for answering questions and concerns of communities.

Guests at the awareness meeting will be:

- The territorial: Opportunity to invite district chief, mayor, director of territory, head of sector or group;
- The heads of villages, the elders, leaders in the community and
- The existing promotional *Relais*

For the venue, it is recommended that it takes place in the community and according to the preference of community leaders involved: residence of the head of district/group, school or HC, in short the place accepted by the head of the territory. As this is an activity for the village; it is recommended not to move the meeting, but held it in the target community, by obtaining the prior approval of local authorities.

The agenda of the meeting of awareness will be as follows:

1. Purpose of the meeting, sites importance
2. Respective roles of different people involved
3. Conditions for the success of the site
4. Criteria for selecting sites *Relais*
5. Selection process: how the selection will be made
6. Next Steps after the selection of volunteers.

B.1. WHAT DO WE SAY TO THE COMMUNITY ABOUT THE SITES' REASON OF BEING?

Why do we have the site?

A child of 0 - 5 years should start treatment in time, and not wait until his case gets worse. Therefore health care should be brought closer: less than 2 hours walk, and if the disease begins at night, health care should be quite close.

Who owns the site?

The site belongs to the community, and the HC supervises it and provides coordination of all activities in the health area.

B.2. THE RESPECTIVE ROLES OF HEALTH SERVICES AND THE POPULATION

a) The role of the health service (government and partners) is to inform the public that they support activities to develop the approach through:
   - Training and awareness workshops
   - First allocation of drugs and small equipment
   - Supervision and monitoring of the implementation

b) Through a dialogue, bring the community to identify itself the following roles:
   - Allocate space for the health care,
   - Choosing the *Relais* and members of COGESITE
   - To support the motivation of *Relais*
   - Using the services made available by the standards

B.3. CONDITIONS FOR THE SUCCESS OF THE SITE

Through a dialogue, bring the community to identify itself the criteria of a successful site, including:

- Good selection of the *Relais*. (ask the reason for this in the community)
- Support the *Relais* in their work
- A plan for transportation for emergency referrals
- Compliance with the advice given by the *Relais* to parents
- Participation in site management and other health activities
- Good harmony between the *Relais*, the committees and the public
- The use of the site by the population, etc.

B.4. CRITERIA FOR COMMUNITY SELECTION OF THE *RELAIS* AND MEMBERS OF COGESITE

1. *For the Site Relais:*

- Being a promotional *Relais* in IMCI or in another area of PHC
- Having been a role model among the promotional *Relais*: The role model *Relais* is appreciated by the health personnel and the community that chose him.
- Preferably married.
- Be less mobile and less traveler.
- Have a known residence in the area
- Good relationships with other community members.
- Know how to read and write (preferably in French, while being large)
- Availability. INSIST ON THIS CRITERION, because the *Relais* will promise to remain available to do the site work for at least 3 years.
- Should not be a health care professional or a student nurse

NB: Encourage the community to choose mothers.

2. For members of COGESITE:
    - Be a Volunteer
    - To be living in the community (house, property etc.).
    - Know how to read and write (for members in charge of certain tasks like the Secretary and Treasurer)
    - Be honest about the financial

NB: For sites' *Relais*; one should choose 3 or 4 in order of merit. Thus, one could take the next on the list if certain criteria are not met by one or the other.

B.5. HOW IS THE SELECTION DONE?

Can selection take place on the same day as the awareness?

It is desirable that the awareness and selection take place on different days.

It is recommended that the villages/communities concerned regroup them so that they can freely express their suggestions to the plenary session in front of the facilitators on the day of selection.

How can one make sure that the Volunteer lives actually in the village?

At the end of the selection by the community, ask in the plenary if each of the *Relais* and members of COGESITE chosen actually lives in village. Hesitation among responses will push the NIC to further probing.

It is desirable that a supervisor from the HZCO be present during the selection. This implies that the NIC has discussed potential dates with the HZCO.

C) FINAL SELECTION OF RELAIS AND MEMBERS OF COGESITES

Here are the steps for the final selection of the sites' *Relais*, members of COGESITE and community involvement.

1. *Recall*
    - The functions of the site (see above)
    - The expected communities support (use of the site, motivation of volunteers and transportation plan)

2. *Plenary presentation of the names of candidates* proposed by the community
3. *Statement in the plenary* if all these candidates live in the area, if they often travel or are absent.
4. *Sites' Relais testing for the final selection*

The delegate of HZCO and the NIC will move apart with the *Relais* candidates of the sites to conduct the test of READING THE PATIENT'S CHART used at the site. (Read only without translation)

5. *Plenary Presentation of candidates*
    - Ask the volunteer if he agrees to work as a volunteer for at least 3 years?
    - If he agrees, ask the community to support him and cheer.
6. *Announce to the community the next steps:*
    - Volunteers training
    - Opening of the site
    - Motivation of volunteers and access to medicines for cases that do not have any money during illness episode
    - Setting up a plan for urgent referrals.

CHAPTER V TRAINING

This chapter deals with 3 topics below:

- Strengthening the Health System
- The list and conduct of trainings on sites
- Briefing of health facilities' teams regarding the sites and referrals.

5.1. Strengthening the health system

Strengthening the health system is an important prerequisite to ensure control and ownership of activities by local teams, for the quality of the implementation process and scale up.

Three results are expected in the area of strengthening the health system, namely:

- Provincial pools capacity building
- Building coordination capacity of the health zone central office
- Capacity building of *Titulaires* for closer supervision of the sites.

a) Establishment of province and district pools.

Indeed, building the capacity of *provinces and districts pools*; ensures close training and minimizes the cost of implementation for the scale up of activities.

It is therefore important for the central level to transfer skills to provinces/districts pools through *cascading* trainings, so that the provinces, districts and health zones may take over the quality implementation. In addition, in their support, the central level will strengthen the capacity of provincial pools in terms of planning, monitoring and supervision of activities.

Once that is acquired, the central level will only be supporting the provinces/districts in monitoring and supervision.

a.1) Responsibilities of provincial and district pools of trainers

Their responsibility is to train and monitor the executive teams of health zones in the core subjects to ensure quality implementation, including:

- A good selection of sites and sites *Relais*;

- High quality training for *Relais*;
- A continuous availability of essential generic drugs and patients' charts;
- A consistent training of sites' *Relais*, with quality monitoring and supervision
- A regular data collection and analysis.

Given the high number of health zones to supervise and assist in the provinces, it is important to have a sufficient critical mass of trainers in the provincial / district pools for a more rational planning of activities in the provinces.

a.2) How does one get a decent core of trained leaders in provinces and districts?

This is a major concern when making sure that the necessary technical support expected from provincial teams actually reaches to the health zones.

Indeed, we know that health zones' management teams are automatically budgeted during training sessions organized in the health zones. This is not the case for province and district executives, who often lack support. In addition, a partner will not always fund the training of a large number of senior provincial and district leaders who are not in his support budget.

Therefore, it is recommended to make a concerted program of training with several partners to intervene in the same province and in the same district, so that the burden is shared between them; and each supports the training of 1 or 2 leaders, so that, after a series of successive training, we can have a critical mass of trained supervisors in the province and district.

b) Strengthening of coordination capacities of the central office of the health zone

The senior management team of the health zone has the responsibility to coordinate all stages of the implementation process in the area of health. It is overseen by the province/district pool which receives support from the central level in the initial implementation phase.

Indeed, during the various sessions about the sites in the health zone, the senior management team of the health zone must be associated with the province and district pools in the management of activities. The methodology of facilitation should aim at strengthening the competency of the management team of the health zone for better ownership of the implementation process. It should therefore ensure that the Health Zone becomes able to organize all activities by itself, and seeking technical support only in case of technical limitation in a certain field.

b.1) Responsibilities of the management team of the health zone.

The competence of the management team of the health zone must be strengthened to ensure the following activities:

- Selection of sites and sites' *Relais*;
- Training of sites' *Relais*;
- Training of members of COGESITES;
- The good management to ensure availability of EGD and supplies at the site;
- Post-training follow up of sites' *Relais*;
- Routine monitoring of sites and;
- Monitoring of sites' activities

b.2) Duties of technical and non-technical managers of the health zone

There are in fact 2 types of managers at the central health zone office whose capacity must be strengthened:

1. *The technical staff* - trained medical personnel (doctors, pharmacists, nurses, supervisors) who will be responsible for technical support for the implementation of sites and will ensure, among other responsibilities, the quality of health care by the sites *Relais*. Their tasks will be:

    - Brief the NIC on the selection of sites and volunteers
    - Planning the implementation and develop sites mapping in the health area.
    - Train the teams in the HZ and sites' *Relais*
    - Provide post-training support for the province/district.
    - Ensure quality control of health care in the sites (supervision of cases treatment, examination of records on the patient's charts)
    - Ensure monitoring of sites' activities in the health zone.

2. *The support staff*, which will more particularly deal with sites logistics and community involvement in the implementation of the sites. We mention here especially the Community *Animateur* who will have to work with other service colleagues to make his task easier.

The tasks assigned to the community *animateur* and his colleagues are:

- Supporting the NIC in the selection of sites and volunteers
- Ensure, in collaboration with the *Titulaires*, the availability of essential medicines, patient charts and other working documents in the sites
- Encourage community involvement in the management and use of sites
- Interview mothers of sick children and the community on site related matters
- Centralize sites' activity reports from all health areas.

b.3) Organization within the health zone management team

From the foregoing, the final recommendations for a good organization of the health zone management team will be:

- The establishment of multidisciplinary management teams;
- Designation of the community *Animateur* as a *FOCAL PERSON* in teams for the centralization of data and information to bring to the attention of the whole team;
- Good activity planning, not to mention the need to properly monitor the implementation of developed plans;
- The existence of a *SUPERVISION PLAN*, very useful in the health zone.

c) Titulaires Capacity building

The *Titulaire* is the first trainer of the sites. All the trainings that will take place in the health zone will have to involve the *Titulaire*, in order to strengthen his capacity to better assume his role.

In addition, the *Titulaire* will have to train his staff at the health center to help them as well achieve the tasks related to sites; also for him to be effectively supported such that in case of his absence sites training activities may not be hindered.

c.1) Functions of the Titulaire

The skills of the *Titulaire* must be strengthened to ensure the following activities:

- Selection of sites and sites' *Relais* in his health area; which he is expected to master the best
- Initial training of sites' *Relais*
- Post-training supervision of sites' *Relais*

- Training members of COGESITES
- Close supervision of sites, with a particular attention to the observation of treatment of cases of illness, processing of patient charts filled out by *Relais* and availability of medicines to ensure quality health care.
- The management to ensure availability of essential drugs and supplies at sites
- Compilation of activity reports from sites operating in the health area.
- Monitoring of sites' activities at the monthly meetings held at the health center.

c.2) Methods for building capacity of the Titulaire

The *Titulaire* will accompany all training and post-training sessions of the sites done in the health area, to *get accustomed to* fulfilling the various tasks assigned to him in training the *Relais* of sites .

Moreover, given that *Titulaires* are required to select sites and sites' *Relais* with the assistance of the central office, a briefing prior to the selection process is recommended for them.
The skills of the *Titulaire* and his staff will be reinforced during subsequent visits, that managing teams will conduct in the health areas.

c.3) Knowledge of the Titulaire in IMCI

The prior knowledge of nurses in clinical IMCI is important to enable them to better supervise the *Relais* and ensure health care quality. Therefore, if the *Titulaire* has not been previously trained in clinical IMCI, it is necessary to plan his knowledge *upgrade* in IMCI in the health area, following the instructions issued by the national IMCI strategy.

5.2. List and conduct of training sessions on the sites

The following are intended for the community health care sites:

1) Training of trainers (3 days)
2) Training of supervisors (2 days)
3) Training of *Relais* (5 days)
4) COGESITES training (1 day).

These courses are in cascade. The central level will accompany provinces and districts pools in the initial training sessions and post-training, to strengthen their capacities. Once they have acquired the necessary capabilities, the provinces and districts pools will take over the implementation, and the central level will then be carrying out only supervision of the provinces scheduled according to the frequency enacted by the national standards.

5.2.1. Training of trainers

a) Pool of province/district trainers

The chosen scale up approach is in fact the extension by district pool. This is justified by the proximity of the districts in relation to health zones and provides a framework for efficient and effective coordination. However, districts receive support from province leaders.

The pool of trainers of health district is composed of technical instructors of the district and the health zone central office and general reference hospitals making up the health district. We cite the following technical staff: doctors, pharmacists, nurses, nutritionists. In fact, there are the ones who lead the training sessions in health zones.

At the initial implementation phase, the training will be in the districts' pools, with province instructors; under the facilitation of the central level. Once a critical mass of trainers is formed in the province, they will ensure themselves the extension in other districts, and therefore resort to the central level support only when needed.

b) Selection of Instructors to be trained as trainers of the Sites

Given that the site deals primarily with treatment of sick children, trainers for the sites are selected among professionals and health care providers who have patients' health care in their basic training (doctors, pharmacists, nurses, etc.)

In addition, prior knowledge in IMCI is recommended. Therefore, sites supervisors are selected from the teams of IMCI trainers and providers. In the absence of this prerequisite; a prior IMCI knowledge upgrade session is recommended.

c) Training materials for trainers

The following tools are used for training of trainers:

- The trainer's guide for sites
- The memo to conduct training of trainers
- The *Relais* manual and the answers to their exercises
- The IMCI wall posters for the upgrade of skills
- Video
- Instructions on the selection of sites

- The COGESITES manual
- Evaluation tools for the *Relais* during the training session
- Post - training sites follow up and supervision tools and the data processing form for evaluating the quality of health care at the sites.

d) Conduct of training of trainers

The training of trainers lasts for 3 days, depending on the attached schedule. Three events are described at the so called training session:

- The orientation of political and administrative authorities at the opening of the training session
- The initiation of trainers to sites related materials
- The introduction to facilitation techniques for sites, as well as familiarity with monitoring, supervision and quality assurance approaches and tools.

The orientation of political and administrative authorities takes place only if this activity had not happened before. (See Chapter 4 about the orientation).

The actual training of trainers was conducted in 2 phases: first phase consists of learning sites *Relais* lessons, and the second phase is to master the facilitation technique for sites *Relais* courses, and for monitoring/supervision of the sites.

The schedule for the training of trainers is attached.

d.1) Trainers initiation phase with sites related courses

During the *first phase* related to learning courses about the sites, the trainer is formed on the instructions for sites implementation and sites *Relais*' tools. Modular content of these courses is reflected in the media below:

1) The sites implementation guide, particularly instructions on the selection of sites and volunteers.
2) Health care tools:
    - Patient care chart,
    - Referral and feedback forms,
3) Communication media,
4) Tools for site management, namely:
    - Register for consultation,

- Monthly report form,
- Register for the record of essential drugs use and returns (RUMER),
- Medicines supply order book,

5) COGESITE members training tool.

The training of trainers includes theoretical concepts, case studies and video exercises, Clinical Practice of sick children treatment according to the sites model.

d.2) The second phase on the facilitation technique and Relais monitoring and supervision tools

This phase is crucial, given that:

- The *Relais* is not part of the medical personnel and therefore does not has nurse skills as a prerequisite
- He is trained to do the "the job." He must perform his assigned work properly and ensure that at the end of his training session, he understood and mastered the specific tasks that are given to him.

e) Trainer's Guide.

To enable the trainer to better accomplish his assignment as a facilitator, a trainer's guide is available to him. This phase of training focuses on giving him familiarity with his trainer's guide, which he is supposed to keep handy (and have it in front of him) during the training session.

This guide is a combination of *Relais* manual and trainer's instructions. It is presented in two parts: The left side is a copy of the *RELAIS* MANUAL, and the right in the box is the TRAINER's methodological guide to the course lecturing at each stage of the session.
It is in the interest of harmonizing the training methodology and ensuring quality at all levels that this guide has been developed. That is why we recommend the trainers to STICK their GUIDES to themselves throughout the session.
If, under certain circumstances and at times during the session, an experienced trainer is required to adapt his own animation technique, it is recommended that he abides by the mood and course of this guide.

f) Micro-teaching lessons.

Micro-teaching lessons are very useful at this stage. The following recommendations are made to ensure the quality of training and objectives:

- The facilitator of the course will have to present himself a first “teaching demonstration” on a chosen topic, allowing participants to see.
- Each trainee will have to present at least a micro-lesson during the exercise.
- All contents of the *RELAIS* manual will be used for micro-lessons to ensure that trainees have repeated and received feedback on all the subjects.
- At the end of a micro-lesson feedback of all participants in the session is given to the presenter(s) of the lesson. The feedback should include:
    - The facilitation technique in accordance with the trainer's guide or not.
    - The relevance of the content of courses provided by the trainee(s).

This way, Micro-lessons, have among others, the benefit of teaching the trainee to prepare his courses before dispensing them, enabling him to exercise in the facilitation technique and allowing all participants to review site related lessons.

With micro-lessons, preparing lessons to give, and following the lesson led by others, constitute the means to assist the review of courses by the participants. It is therefore recommended that all the topics of the site *Relais* manual be given to trainees for micro-lessons.

g) Tools for evaluation, monitoring and supervision and quality control

These tools are presented and explained to trainees. But the latter will eventually be trained to fill them out with the support of facilitators at the training and post-training follow-up sessions of *Relais*.

These tools are:

- The evaluation sheets of the *Relais* during the training session (answers to case studies exercises, practice in management of cases of sick children)
- Post-integrated training individual follow up form
- Form for supervision of EGD and supplies
- Data processing forms for health care quality evaluation
- Sites supervision form and form for interview with the mother of the sick child.
- *Titulaire* and community meeting facilitation form

<u>Important Note</u>:

At the end of their training, trainers must be able to immediately facilitate the training of supervisors and *Relais* under the supervision of the central level.

5.2.2) Training of supervisors (NIC and CA)

a) The role of supervisors during sessions with the Relais.

The *Titulaire* and the *Community Animateur* are the supervisors of sites *Relais*.
In the various training sessions and post-training follow-up of sites *Relais*, supervisors are positioned immediately next to the *Relais* to ensure their immediate feedback and formative evaluation.
There is no need to remember that their role goes beyond training, in a close technical and logistical support to the sites. Weakness on the part of these 2 focal persons is likely to cause unsuccessful implementation of sites daily activities.
b) Activities allowing the continuous training of site supervisors.

Although the supervisors would have a 2-day training facilitated by the health zone management team supported by the district (and if need be by the province or central level), many other circumstances will help provide an ongoing training, not to mention the subsequent visits and supervision of teams of supervisors. In a formal way; the four selected training opportunities are:

- At the orientation session of health zone teams, the supervisor will be trained to prepare the selection of sites and volunteers (see Chapter 4). The duration of this session is 1 day.
- During their training, supervisors will be introduced to the management of cases by site and will receive a knowledge upgraded in IMCI. The training of supervisors lasts 2 days, and is provided by health zone management teams supported by the health district, and if necessary, by the province and central level.
- During the training of *Relais* led by the management team of the health zone and district, the supervisor will be given opportunity to perfect his skills by training a site *Relais* during the 5 days of his theory and practical training sessions.
- One month after the training of *Relais*, the supervisor will be trained at post-training monitoring and support to sites *Relais*. 3 meetings of post-training follow are conducted for sites *Relais*, in which the supervisor is actively involved as an actor next to the management teams and is, hence, exercised to different sites *Relais* follow up and supervision tasks. Post-training session meetings will last 1 day.

We recall that the training of the *Titulaires* in IMCI or upgrade of knowledge in this matter is part and parcel of capacity building planned for the implementation of sites.

In advanced stages of sites implementation, the *Titulaires* will be able to ensure the immediate supervision of

sites *Relais*, under the coordination of the health zone management team. The district, province and central level will then perform their supervision according to an established timetable.

c) Selection of site supervisors

The *Titulaires* of health areas planned for sites integration are automatically selected for training as sites supervisors. The same applies to the *Community Animateur* of the central office.

Prior knowledge in IMCI is a recommendation. However, in the absence of this prerequisite; an knowledge upgrade in IMCI is necessary, even after the training on the sites.

d) Training Tools for supervisors

The following tools are used for the session of the supervisor:

- The sites supervisor's manual and sites exercises manual
- Patients care chart
- IMCI wall post for the knowledge upgrade
- Video
- Instructions on the selection of sites
- The COGESITES manual
- The assessment tool of the *Relais* during the training session
- The site routine supervision form

The supervisors' training lasts for 2 days, according to the attached schedule.

5.2.3) Training of sites Relais

The objectives, methodology, content, schedule and duration of successive stages of this training are included in the trainers' guide.

*a) Who leads and supervises the training of s*ites *Relais?*

As a reminder, the sites *Relais* are trained by the health zone management team supported by the district and province, under the supervision of the central level, when needed, especially at the beginning of the process.
During training, they are supervised by *Titulaires* and community *Animateurs* who accompany them throughout the session.

During this session, the ratio is 1 trainer/supervisor for 2 *Relais*.

During the training and post-training sessions, supervision is about:

- Assisting the *Relais* to understand the training materials available to him
- Helping him to resolve the case studies' exercises
- Assisting the *Relais* better manipulate available materials
- Assisting the *Relais* in the management of cases during clinical field practice.
- Providing feedback to individual *Relais* throughout the training session.
- Filling out individual evaluation forms of *Relais* during case studies and practical exercises, and at the end of the training session.

d) Relais training content

The subjects covered in the training of sites *Relais* are:

- Reference to the integrated HC for danger/warning signs, management of simple cases of malaria, diarrhea, cough/cold, malnutrition, catching up in the EPI, administration of CPS and Vitamin A
- Management of sites essential drugs
- Management of site data
- Communication to mothers for adequate home care and behavioral change.
- The community-based surveillance of diseases (which will be done later and in a progressive manner).

The great interest placed on *follow up appointments of* sick children treated at the site; should be noted. Indeed, if the mother does not to a follow up appointment given by the site, the *Relais* is required to follow up on the child at home.

When monitoring the child treated at the site, the *Relais* looks for information on whether the child's health is improving or not, on the respect of given advice by the child's mother and verifies if the child has received his dose as prescribed (compliance).

The information to be collected by the *Relais* during the follow-up visit is shown on the patient care chart of the site and is part of the training content of the *Relais*.

In order to facilitate the *Relais* to learn about case management at the site, it would be better for him to have a prior knowledge to help him in the assimilation of sites matters. That is why prior skills in Community-IMCI are

preferred; and it is recommended that the training in C-IMCI/CBNP precedes that of sites. However, this does not constitute a major constraint, because the prerequisite may also depend on other previous knowledge or experience of the *Relais*

c) Place and duration of the training of Relais

The training of the site *Relais* lasts 5 days, according to the attached schedule. In addition to his initial training, the sites *Relais* will have 3 other one day post-training follow up sessions, each separated by 1 month intervals.

The post-training follow up is part of the *Relais* training. We shall discuss it in more details in Chapter 6.

Any convenient place will be used for training, if it provides an environment suitable for the achievement of objectives according to the timeframe and the methodology adopted. It may thus be the health area central office, a health facility, school or other institution which offers the environment.

d) Recruitment of sick children during the practical training sessions

During practice in training sessions or meetings monitoring meetings, the recruitment of sick children will be done either in medical training (if there are enough sick children for the *Relais*) or in the surrounding households (in case there is not enough sick children at the health facility).

How will the recruitment of sick children in the households be made?

- We announce to households in the vicinity of the place where the training session takes place; the progress of community weighing of children aged between 0-5 years in the locality, indicating the place of reunion not far from the houses.
- All children will be weighed by the *Relais*.
- Then the facilitators will sort children with symptoms of illness in order to be examined by the *Relais* (giving priority to children with cough or cold or a sign of danger). Indeed, the child with the symptom of cough or cold is an opportunity to the *Relais* to count the breathing rate for pneumonia screening, and to examine the possible symptoms of the sick child in accordance with the site patient care chart.

e) Tools and materials used for the training of sites Relais

All teaching materials for the training of *Relais* must be prepared before the session to facilitate his theoretical

and practical learning, the video study, examination of sick children, dispensing of medication and communication with the mothers for 4 mentioned diseases, namely: malaria, diarrhea, pneumonia and malnutrition.

Particular attention is given on the study of *signs of danger*. That is why the video is a must study tool during training sessions and post-training monitoring of sites *Relais*. Experience has demonstrated a lot of problems due to electricity, hence it was also recommended to produce CDs in addition to videotapes, easily used with a laptop.

Educational materials and aids used for training sites *Relais* are listed below:

- Timers
- Salter Scales
- CPS cards colored with bands
- Manuals and training materials for the site *Relais*
    - Site *Relais* Manual
    - Manual of exercises for the site
    - Site patient care charts
    - Job Aids (Maps consultants *Relais* site)
- Logistics for video
- Boxes of medicines for all sites.
- Essential drugs (samples of each product used at the site)

Important Reminder: In order to prevent the *Relais* to forget the lessons learned due to inactivity, it is recommended that the health zone management team provides a sufficient quantity of medicines and supplies for the sites to start functioning immediately after the training session. (See Chapter 2).
Moreover, in case of any delay to start the activities of the site that prevents the *Relais* to practice after the training session; a refresher training session with exercises and a recall of the management of cases of illness is required.

f) Training methodology

It is recommended that facilitators abide by the training methodology described in the trainer's guide. That is why the facilitators should stick to their guide throughout the session.

f.1). Training focused on mastering working tools.

The level of the *Relais* does not allow long reading; hence the training will be focused on helping the *Relais* to

master his own working tools. That is why the manual of the *Relais* does not have a lot of literature. This is also why formal lectures are not acceptable to the *Relais*.

f.2) The 3 verbs that the Relais has to conjugate

The site patient chart is developed in such a way that the *Relais* will write as little as possible. The *Relais* has 3 verbs to conjugate in filling out patient care charts: *"write, circle and tick."* (See Appendix)

In fact, he will only have to write the elements related to the identification. For everything else, he merely circles the written signs or treatments consistent with the child's age and marks the classifications.
The training helps the *Relais* understand on which part of the white sheet to write, circle or tick, why and how.

f.3) Positioning of the supervisor during the training session.

The position of the supervisor next to the *Relais* during the whole training session is an important character in the training methodology of the site *Relais*. The supervisor stays next to the *Relais* in all the activities of the training i.e. one supervisor for 2 *Relais*, for an immediate individual follow-up at every stage of the training.

The close training of the *Relais* helps him to assimilate a large part of the courses content and prevents the accumulation of errors whose correction could become more difficult at the end of the session.

f.4) Lessons facilitation methods and techniques

The facilitator will mostly make use of the review of *Relais* knowledge, guided reading, and demonstration.
The review of knowledge will often use a quiz, and will help perceive what the *Relais* knows already to give it less time in rehearsals, and spend more time on clarifying or supplementing the missing knowledge of *Relais*.
The different techniques and methods are described in the trainer's guide for each stage of the courses presentation. The trainer’s guide is designed so that the facilitator would find the training technique of each step of the training.

f.5) Language of courses presentation

The courses will be in the language that the *Relais* feels most comfortable with. Thus, during the guided reading, it is recommended that facilitators ask to *Relais* their understanding of items explaining concepts in their premises (which is different from a translation in local language)

g) Information to collect on the Relais during the training session

To assist the development of a database on the sites, the facilitators will collect the following information from the *Relais*: Names, sex, year of birth, educational level, occupation, married or unmarried, number of children, phone, site, health area, date of training, date of cessation of activities at the site.

h) Official Installation of the site

A plan to deploy members of the health zone management team will be developed by the Zone Medical Officer, to allow the installation of all sites straight away. The rate of installation may be two or three sites per day, taking into account the distances and logistics of the health zone.

Drugs and management tools are provided to site *Relais* during installation. Hence this kit should be available at the opening of the site.

During installation the following tasks will be accomplished:

- Introduce the *Relais* to the communities
- Recall the functioning of the Site
- Formally give medicines and supplies to communities as an input of public interest.
- Organize a meeting between the COGESITE, CAC, promotional *Relais* and other authorities to encourage collaboration at the site.
- Mobilize the population to work with and support the site.

It would therefore be desirable to plan this installation as soon as the training date is known and inform communities in advance. Measures should be taken to ensure social marketing for the site to inform and educate the community. It would be ideal to mostly give the floor to the *Titulaire* and to the COGESITE to strengthen their authority and their role in the management of the site.

5.2.4). Orientation/Training of COGESITE members

Training/orientation of a day will be held at the health center for members of COGESITE, to prepare them to fulfill their function.

Capacity building of members of COGESITE will continue as support activities spread on the ground, mainly on

subsequent field visits of the *Titulaire* and the *Community Animateur* but also during the visits of other members of the health zone management team.

During the training/orientation of COGESITE members, the central office will deploy its instructors to support the sessions led by the *Titulaires* of the health area.

The tool developed for members of COGESITE is entitled "Guidelines for the COGESITE". Its content deals with the role of COGESITE and site management tools (RUMER, supply order form, Monthly report of the site).
The role of COGESITE is taught by a guided discussion to bring more members to take ownership of their role. In this chapter, some topics discussed relate to the custody and inventory of site medicines. Debt management with patients, management of returns, how to secure revenue, etc

It is recommended that the COGESITE owns a number of documents, which are:

- A copy of Micro plan of the health care site (Secretary, Treasurer),
- A copy of the list of medicines, equipment and tools assigned to the site (Secretary)
- A copy of activity reports of the site (secretary and treasurer)
- A copy of the monthly report of site drugs inventory (Secretary, Treasurer)
- The COGESITE meetings minutes (Secretary)
- The financial report of the Community Solidarity Fund (Secretary, Treasurer)

<u>Briefing of reference health facilities staff on sites and referrals from sites</u>

a) The orientation of medical staff on sites.

The implementation of the sites requires prior guidance of all political and administrative leaders. It is in this first orientation meeting that we need to involve the greatest possible number of medical staff of the health zone, ranging from hospitals to health centers.

b) Restitution by managers and nurses trained to their colleagues.

After this first meeting of info-awareness, it is recommended that all managers and health care providers trained in the sites make restitution to their service colleagues, notably about the process of cases management at the site and site management tools. (We recall that the supervisors from the general reference hospital are part of the health zone management team)

c) Meetings of briefing to reference facilities staff.

In addition to restitution to colleagues by instructors and health care providers trained on sites, it is recommended that the Zone Medical Officer arranges briefing meetings in reference facilities. These meetings will address the reception of referrals and filling out of reference/feedback forms.
In addition, reference facilities should designate a person responsible in each institution for the management and follow up on cases referred in its structure. The elements of this monitoring could be: good reception, filling out of reference/feedback forms, the number of referrals, record keeping and feedback to sites on the timely or late referral, etc…

The reception and management of referrals have an impact on the compliance of the reference. It is important to educate reference facility staff to play a positive role in the intervention. That is why staffs who receive referrals should be briefed on the reference forms and be encouraged to fill out the feedback forms.

CHAPTER VI POST-TRAINING MONITORING

6.1. Planning of post-training follow up

The post-training follow up is part of the training process of sites *Relais* and must be budgeted with training sessions to make sure it is done.

Indeed, the post-training follow up will aim, among other things, to complete the knowledge upgrade of the *Relais* in the management of cases of illness and medication management, and strengthening the organization of the site.

a) Number of post-training follow up sessions

The strategy expects 3 sessions – one session per month; after putting in place the *Relais* and between successive follow up sessions.

b) Who oversees the post-training follow up?

The first follow up sessions are made by pools of trainers who have the capacity (with support from the central level if necessary, especially at the beginning of the process). Indeed, the post-training monitoring process requires a specific training and support to ensure that trainers have the capacity.

When the local teams have mastered the process and that the *Relais* would pose fewer problems, they will then pursue the monitoring/follow up process themselves with close support of the district/province.

Experience shows that after 2 well done post-training follow up sessions, self-confidence comes and *Relais* pose fewer problems in general. On the 3rd follow-up session, if at least 80% of the *Relais* have mastered the process, weak *Relais* will be identified and special attention will be directed towards them. Other *Relais* will return to the process of routine supervision.

c) Announcement of the dates of post-training follow up sessions

The dates of the post-training follow up sessions must be announced in time to the *Relais*. Indeed, a *Relais* should not fail to attend to a post-training follow up session, which is a continuation of his learning. The same applies to all supervisors and trainers who will receive training throughout that activity.

Therefore, the dates of the 3 post-training follow up sessions must be planned in advance from the training session.

On the last day of the training session of the *Relais*, we should announce the date and place of meeting for the post-training follow up session. Similarly, at the end of each meeting of post-training follow up session, we must announce the next date to all *Relais*, supervisors and trainers, to avoid possible absences.

d) Materials to provide

It is important to inform the *Relais* on the materials and tools to bring at the meetings of post-training follow up sessions.

Indeed, if the information is not passed, many *Relais* may come without the necessary tools. Here's what to remind them to bring:

- A Timer
- All the patient care charts which they filled out at the site
- The consultation register
- The RUMER
- The site monthly report

The HZCO will make sure that the Salter scales to be used by the *Relais* during the practice session of the post-training follow up, are available.

e) Place of post-training follow up session

The venue selection should take into account the fact that the place of meeting has to be accessible to sites *Relais*. Indeed, it is a one-day activity, which should start on time to dismiss the *Relais* early.

f) Supervision of sites associated with monitoring sessions

It is recommended to supervise the sites prior to post-training follow up session meeting. A visit on the field for sites supervision for 1 or 2 days before the meeting helps in gathering relevant information that may be discussed together in post-training follow up.

The outline of site supervision will be discussed in a related Chapter.

6.2. Objectives of post-training follow up

6.2.1. Overall objective

The post-training follow up of sites aims to complete the upgrade of sites *Relais* capacity, and to provide trainers and supervisors with skills for monitoring and supervision of sites *Relais*.

6.2.2. Specific objectives

The specific objectives of post-training follow up of sites are the following:

- Enhance the capacity of the *Relais* in the management of cases of illness;
- Enhance the capacity of the *Relais* in drugs management;
- Enhance the capacity of the *Relais* in the proper use of management tools;
- Strengthen the capacity of the *Relais* in order to avoid stock outs of essential drugs;
- Build capacity of the *Relais* on the preservation of medicines;
- Check the availability of tools for site activities;
- Strengthen the capacity of sites teams of trainers and supervisors in the supervision of *Relais* and in the processing of data from patient care charts to ensure quality health care.

At the end of the whole process of post-training follow up, the goal is that at least 80% of *Relais* properly take care of cases of illness under the observation of supervisors. While for the supervisors and trainers, the goal is that, after at least two post-training follow up sessions, they master the process and continue for themselves.
Particular attention should be given in support of the *Titulaire* who is the immediate supervisor of the *Relais*. He should be enabled to detect in time weaknesses of the *Relais* and addressed them from the outset. In addition to the supervision process of a site, the nurse should be able to carry out the examination of records to support the site for quality health care.

6.3. Facilitation methodology followed during the post-training follow up

The recommended methodology is to support the teams of supervisors and trainers. Therefore, from the first post-training follow up session, you have to let the supervisors and local trainers work for training; and supervise them. The approach will then be to:

- First brief the team managers
- Make a *demonstration* on the performance of a task

- *Let them work* and supervise them, by progressively correcting them without exposing their errors before the *Relais*.

Facilitation will be made in a way that allows following simultaneously the performance of *Relais* and understanding of the process by the team of supervisors and trainers.

6.4. Conduct of post-training follow-up sessions

The outline of the post-training follow up is attached to this guide.
The sequence of activities is as follows:

a. Introduction: overview of objectives and progress. (30 min)
b. Interview of *Relais* to review their knowledge on danger signs, the correct treatment of Malaria and signs of dehydration. (30 min).
c. Arrangement of groups, including supervisors, managers and *Relais* (15 min).
d. Recruitment of sick children
e. Observation of the management of cases of illness by the *Relais* and individual feedback. (2 hours).
f. Documentation review of records in all the patient care charts performed by the *Relais*, with immediate individual feedback. (1 h 00)
g. RUMER literature review, consultation register, site report (1 hour)
h. Processing of patient care charts by supervisors and trainers. (1 h00)
i. Video (1 h00)
j. General feedback. (1 hour)

The event is scheduled for one day. Respect for the starting time is important to allow a smooth *Relais* training and send them off around 4 p.m.

6.5. Materials and tools to prepare for post-training follow up

Here is a list of materials and tools to prepare for post-training follow up of sites:

a) What the Relais should bring at the meeting:

- A Timer
- All the patient care charts filled out at the site
- The consultation register
- The RUMER
- The site monthly report

b) What the organization should prepare for the meeting:

- Integrated individual follow up forms for each *Relais*
- Site medications and supplies review forms
- 3 or 4 Salter scales
- Colored CPS Map
- Data processing forms for evaluating the quality of care
- Video logistics, including the source of electric power
- Drugs samples for the *Relais* to practice the dispensing of medicines

Note: At the end of the meeting, we will make sure that all health care charts filled out by the *Relais*, as well as monthly reports of sites activities are collected.

Filled patient care charts will serve to complete the data processing form for evaluating the quality of care, as well as the analysis with the software application.

CHAPTER VII COMMUNITY HEALTH CARE SITE SUPERVISION

The activities of community health care sites must be integrated with other PHC activities in the health area.

7.1. Objectives

The supervision of a site aims to improve the technical and logistical capacity of the *Relais* for optimum operation of the sites. The supervision of a site is, in the first place; the responsibility of the *Titulaire* and then of the community *Animateur* of the central office of the HZ.

Other executives of the HZCO, of the province/district and central level are responsible for the technical support to the *Titulaire* as well as the community *animateur* of the HZ to enhance their ability to conduct supervision of the sites.

More specifically, activities to be done during supervision of a site are the following:

1) Ensure the availability of EGD, patient care charts and other supplies necessary to maintain the site functionality
2) Interviewing mothers who have had their children treated at the sites to ensure that the *Relais* has given counsel to the mother regarding the administration of the medicines and that the mother recognizes the danger signs and adopts good practices for the health of the child.
3) Discuss with the committees and the public to make sure that:
    - The regular meetings of communities take place for:
        - The collaboration between promotional *Relais* and sites *Relais*;
        - The inclusion of sites in the monitoring of activities within the CODESA.
    - There is an improvement in the use of sites with the help of the CODESA and other promotional *Relais*

4) Assess the knowledge of mothers on danger signs and taking drugs
5) Actively collect data and files not yet transmitted by the *Relais*.

7.2. Supervisions associated or not to post-training follow up of sites

There are indeed 2 different contexts where we can plan for the supervision of sites; the first one is when the supervision takes place 1 or 2 days before the post-training follow up session meeting, and the second one is that of a routine supervision.

When the supervision of the sites takes place prior to the post training follow up session meeting, it is not recommended to work on Goal 2 related to capacity building in health care and management because these aspects are taken into account in the post-training follow-up meeting.

In this case, the supervision will make easy to gather information that will help better focus the issues to be discussed at the post training session meeting.

This supervision will target:

- The organization of the site and the availability of essential generic drugs and patient care charts;
- Analysis of site usage by the community;
- The interview with the people (leaders, COGESITE, promotional *Relais*) on:
- The use of the site
- Their involvement in the organization/management of the site
- Their involvement in the strengthening of follow up visits to child treated at the site
- Problems faced
- Interview with a few mothers who have used the site, and verify their knowledge about danger signs.
- The active collection of reports and required forms for processing and analysis.

In case of a routine supervision, objective 2 will be one of the points of supervision in addition to other objectives.

This supervision takes into account all the objectives listed in paragraph 7.1, and outline the following:

- Capacity building of the *Relais* in health care and site drugs management, including the literature review of all patient care charts filled by the *Relais*, with immediate individual feedback.
- Observation of management of cases of illness by the *Relais* and individual feedback. (Only in case a sick child is present)
- RUMER literature review, register, site report
- Checking the availability of medicines, charts and other supplies of the site
- The verification of medicine preservation conditions
- The Interview with some mothers who have used the site, and verification of their knowledge about danger signs.
- The Interview with the population (Leaders, COGESITE, and promotional *Relais*) on the use of the site, their involvement in the organization/management of site, visits to monitor children treated at the site and problems faced.
- The active collection of reports and charts required for processing and analysis.

<u>Note:</u>

The *Titulaire* (nurse who oversees the HZCO) is required to process approximately 10 patient care charts filled out by the *RELAIS*. If he has no material time, this processing may be made with the charts which he returns to health center.

The *Titulaire* is also required to compile reports on the activities of the sites within the area he oversees, to ensure their completeness before forwarding them to the central office of the health zone.

The supervision of a site takes a minimum of 3 hours. Thus, good planning cannot have more than 2 sites per day to supervise.

7.3. HZCO and *Titulaires* capacity building in sites supervision

A focus will be placed in the capacity building of the management team of the health area and the *Titulaires* in supervision of sites.
In this regard, post-training follow up sessions constitute an effective framework for training of health area teams in the supervision of sites *Relais*.
Furthermore, during regular supervisions that the central and intermediate level will perform in the health area, they will have to support the team from the central office for the acquisition of good skills in supervision and ensure that the office oversees enough the *Titulaires* to help them perform their duties with respect to the sites.

In addition to the technical support, logistical capabilities will be provided to the team of supervisors of the health area, to enable them to better support the *Titulaires* to supervise the sites.

7.4. Recall the role of the Community *Animateur* (CA)

We wish to reiterate the importance of logistics supervisions that the community *Animateur* must ensure in the implementation of the sites. Indeed, the community *animateur* is the focal point for the sites and thus the eye of record from the central office of the health zone for all community-based activities.
It should be emphasized that the CA must plan his supervision to sites along with the *Titulaire*. In case the Titulaire did not accompany him on the site, the CA is required to keep the *Titulaire* informed on the conclusions of his supervision.
Indeed, the CA must ensure that sites are running regularly, that supplies are available, that relations with the community are good, that the site is used by the community, that the *Relais* does well his follow-up visits to children treated at the site, and that the monthly reports and patient care charts are regularly collected for processing and analysis.

The AC, in addition to the regular functioning of the sites, he is also responsible for the completeness and timeliness of data for the NHIS.

The AC is therefore required to compile monthly data from sites in health centers and to update them for the central office. (See attached an example of the form used to summarize the data for the health area).

7.5. Frequency of supervision

- The *Titulaire* of the health center must supervise the site each month. At the beginning of the implementation, if the *Relais* have many problems, the *Titulaire* may hold more frequent supervisions, either by going on the field himself, or by inviting the *Relais* at the health center for follow up according to the post-training follow up model.

  To facilitate his work, it is recommended that the *Titulaire* trains his staff at the health center to support him or replace in case of absence.
- The supervision by the central office of the health district to the *Titulaire* and the community health care site will be done once a month at the beginning of the implementation. And later, the focus will be on problematic sites for more frequent supervision. Where things work fairly well, the schedule of supervisions will be aligned to routine supervision of the central office.
- Supervision by the central, provincial and district level to the health area, the *Titulaire* and the community health care sites will be according to health standards, on a quarterly or semi-annually basis.

7.6. Supervision tools and procedures

Before each field visit, the *Titulaire* (or other supervisor) should review:

- The latest reports in order to determine the points on which to dwell and measure progress in relation to recent observations and recommendations.
- Integrated individual follow up form for the *Relais*
- The results from patient care charts data processing to identify weaknesses.

At the end of each visit of supervision at the site (or at the health center and central office), the supervisor will make annotations in the site supervision book and in his own notebook.

Here are the tools that the supervisor must prepare for the supervision of the site:

- The supervision notebook (including a report on previous supervision visit)
- Integrated individual follow up form for the *Relais* (containing consecutive information)
- The patient care charts data processing form (with the previous results)
- The supervision form on essential medicines
- The data collection form for the monthly site report.

7.7. Use of data

Data from various reports and supervision and post-training follow up will permit to draw conclusions on the objectives pursued by the implementation of community health care sites. A software tool is being developed to improve the management of data from community health care sites.

CHAPTER VIII PROCESSING OF PATIENT CARE CHARTS' DATA FOR QUALITY HEALTH CARE

(See Data processing in the appendices)

Objectives:

- Analyze the patient care charts filled out by the *RELAIS* for Quality health care.
- Quickly identify weaknesses of *Relais* to take prompt corrective action (also with assignments poorly implemented and represented by a "NO" on the data processing form)
- Follow the progress of *Relais* in the implementation process.

Who fills out the data processing form?

- The *Titulaire* trained in IMCI and in community health care sites, as well as senior managers/instructors of the HZCO, District / Province and central level called to assist the *Titulaire* in the supervision of sites
- We should explore the possibility for the community *animateur* of the HZCO to look at the aspects of completeness during his supervision.

When is the form to be completed? The opportunities include:

- During the supervisions.
- During the post-training follow up and refresher training.
- At the time of systematic data processing.

Note: Because of the complexity of the data processing, it is recommended not to involve the *RELAIS* in the processing of data from the charts he fills out, but only to provide feedback on where he has made mistakes on the patient care form.

However, when the *titulaire* and/or health supervisor is carrying out supervision, the recommendation is to first go through all the patient care charts with the *Relais* which the latter has completed, in order to give him immediate feedback on the errors he committed and to congratulate him for the tasks well performed.

The *Titulaire* and/or health supervisor will then quickly process at least 10 patient care charts to better understand the weaknesses of the *Relais* in general and identify areas on which to focus during the next supervision. *The titulaire* or supervisor can then sort the charts of those who have a cough/cold or a sign of danger. In fact, charts with cough/cold have the advantage of reviewing how the *Relais* has completed the entire problems of the child, including: danger signs, cough/cold, diarrhea, malnutrition, recuperation and other problems.

The remaining charts will be returned to the central office of the health zone for processing in the computer application in order to run automatic analysis of the quality of care in community health care sites.

Identification of the Relais involved

It is preferable to do the data processing indicating the *Relais* that took charge of the child, and separate the charts by *Relais*. In 1 site, we must ensure that the 2 *Relais* distinctively take care of sick children, each in turn. This helps to detect problematic *Relais* and their particular disability. Therefore, at each site, it is recommended that the *Relais* who treated a sick child writes his name on top of the patient care chart at the place intended for it.

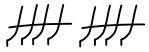
2 columns for data processing:

There are 2 columns: a column for YES and another one for NO (represented by 0 and N)

The *Titulaire* or supervisor checks on the YES column if the *RELAIS* did well, and on the NO column if incorrectly done.

How to check and complete the data processing form?

We check only as we progress on the data processing form, looking at the items affected by the patient care chart completed by the *Relais*.

And if it totals 5, we cross it over: for example: 

When we have finished processing the data, we must include the total number of results, by surrounding the figure. As for the example above, the total is 10.

And we will write: 

Consecutive months

The data processing form is developed for 6 months because of space. But for the *Relais* to be monitored for 12 months, one must then take a 2nd form for the rest of the year. It is also a must to indicate every time the month in which the *Relais* has completed the patient care charts which are being processed. For instance: MARCH 2007.

Month 1, month 2, etc...

It is 1 month of activity of the *Relais*, not the Roman calendar month. Month 2, is the 2nd month of activity, and so on.

Enter the month of the year

Month 1 or 2 and so on…match the Roman calendar month of either April, May, etc ..., according to the actual dates when the *Relais* worked and mentioned on the patient care chart..

COMPLETENESS OF THE PATIENT CARE CHART BY SECTION AND MONTH SINCE STARTING DATE

Here, we analyze the completeness of filling of the patient care chart, item by item. We look through the whole chart, and see if the *Relais* has completed the following sections of the chart:

1. Identification
2. Complaints
3. Danger/Warning signs
4. Fever
5. Diarrhea
6. Cough/cold
7. Malnutrition
8. Recuperation
9. Other problems
10. Advice on referrals
11. Treatment
12. Remedial advice
13. Follow up instructions

Reminder:

The *Relais* should progressively check on the YES or NO during his evaluation

YES NO.

And for a missing symptom, he must check on the non before skipping.

REMARKS

1. At this stage of the evaluation of the completeness of the patient care chart filling by the *Relais*, DO NOT JUDGE if the *Relais* has well or poorly filled out, as you would be judging the quality (this will follow later). Now, you only worry about the fact that the *Relais* has filled out the chart or not.
2. If the *Relais* has stopped his examination before a danger or warning sign, stop with him see if he has provided treatment/action before referral.
3. For the back of the chart, on the treatment, see if the *Relais* has *encircled* a treatment, again without judging whether this treatment was correct or not.
4. Similarly for cases to recuperate, the *Relais* will encircle only if he had checked on the front that the case should be recuperated.

5. There is a difficulty on the OTHER PROBLEMS. The chart has not given the opportunity to *Relais* to tick yes or no. Here, there is only one possibility: the *Relais* tick only if he has identified a problem. Thus, to this point, the supervisor can only tick YES.
6. Regarding the follow-up instructions. This part is completed by the *Relais* only if the sick child returns to the patient appointment. If the child has not been reviewed at a follow-up, leaving the back side of the chart blank, the supervisor must also leave a BLANK space on follow-up instructions. (Because the *Relais* did not write anything and we do not know if he knows how to fill out this part or not).

   It is only when the *Relais* STARTED FILLING OUT that part that we can analyze the completeness of this part.

   For FOLLOW UP INSTRUCTIONS (that the mother came back herself to the appointment or that the *RELAIS* made a home visit to monitor the child), the critical tasks to be checked to assess the completeness are the following:
   - Did the *Relais* check all the danger signs on the child?
   - If the child had a cough/cold during his 1st visit, when the *Relais* consulted the child again at the follow-up visit, did he count the number respiratory movements?

CORRECT NUTRITIONAL STATUS

From now on, begins the trial of the supervisor.

Does the nutritional status indicated by the *Relais*, correspond to the exact color of the weight for age chart?

This means that the supervisor should have this chart in front of him.

Difficulty: It is possible that the *Relais* did not mention the child's weight status and nutritional deficiency because of lack of scales (and/or in the absence of recent weighing chart which the *Relais* could use for reference)

In this case, leave a blank space and do not assess this item.

RECONCILIATION BETWEEN SIGNS / SYMPTOMS AND CLASSIFICATION

It is a matter to consider whether the classification is consistent with the signs/symptoms evaluated or encircled by the *Relais*. For example, signs/symptoms suggest a referral but the *Relais* has classified it as a simple case, or vice versa.

It is therefore necessary to analyze in turn the following problems:

1. Fever: Is there correlation between the signs / symptoms and the classification? In fact, we want to see the *Relais* encircle the first signs that he has observed, in order to mark the classification he has chosen. So we see the correlation at this level. But there is another possibility where the *Relais* made the wrong classification: In this case he ticks a classification without first having encircled the corresponding signs which made him decide on this classification.
2. Diarrhea: Is there correlation between the signs / symptoms and the classification? The approach is the same as for fever.

3. Pneumonia. Is there correlation between the signs / symptoms and the classification? The approach is the same as with the fever, but with a particularity:
    - We must ensure that the *Relais* mentioned in the corresponding box the number of BREATHING movements he counted on the child
    - That he made the right decision that it is FAST OR NORMAL BREATHING (in relation to age of the child), to decide whether it is happened to be pneumonia or a COUGH / COLD.
4. Fever + pneumonia: For here, the child presented the classification of FEVER in addition to the PNEUMONIA. (Do the 2 cases have a correlation?) Here, we choose YES if the *Relais* did a good match for 2 cases at the same time, i.e. FEVER and pneumonia, and we mention NO if the *Relais* did a good match for the 2 cases at the same time, or if he did right for fever and wrong for pneumonia or vice versa.
5. Cough/cold: Is there correlation between the signs / symptoms and the classification? The approach is the same as for a fever.
6. Malnutrition: Is there correlation between the signs / symptoms and the classification? The approach is the same as for a fever.

    Note:
    - Leave a blank space (or skip and do not judge) if the child has not been affected by this disease.
    - BUT, if upon arrival, the mother reported the complaint of her child, and the *RELAIS* failed to evaluate/classify it, it is a mistake.
    - We also recall that the evaluation of malnutrition and recuperation is systematic. Note a mistake if the *RELAIS* has not evaluated/classified these problems.

RECONCILIATION BETWEEN CLASSIFICATION AND TREATMENT/ACTION

In each case, analyze the treatment/action that the *RELAIS* encircled on his chart, check whether this is consistent with the classification used. At this point, verifies the NAME OF THE DRUG and/or THE ACTION he has encircled, without considering again the dose by the age of the child.
Note a particularity here: we added the classification of *danger/warning signs*. Because this classification has a guide to the reference indicated on the back of the chart.

In this way, on the list of issues to be analyzed case by case, there have:

1. Danger/Warning signs
2. Fever
3. Diarrhea
4. Pneumonia
5. Fever + Pneumonia

6. Cough/cold
7. Malnutrition

What are the treatments/actions to be considered in the patient health care quality evaluation?

a) For malaria, diarrhea and cough/cold, we will consider the medication that the *RELAIS* has encircled
b) As for malnutrition, we will consider both the drugs and the advice given.

Note:

- Remember to leave a blank space for problems that do not concern the child.
- Consider only treatments for the classifications chosen by the *RELAIS*. Do not make judgments about the quality of treatment for a complaint reported by the mother at first, but which the *RELAIS* was unable to classify afterwards.

RECONCILIATION BETWEEN AGE AND THE DOSE OF DRUG

Here, we verify if each dose of medication that the *RELAIS* has encircled corresponds to the age he had mentioned in the identification of the child.

Check for all the classifications used by the *RELAIS* encircled on his patient care chart.

RECOMMENDED PATIENT FOLLOW-UP VISIT

Here, note only if the child has been examined again at the follow up visit YES or NO.

RECONCILIATION BETWEEN SIGNS/SYMPTOMS, CLASSIFICATION AND ACTION AT THE FOLLOW-UP VISIT

During this follow-up visit, we care about 2 things:

- Danger and warning signs. Did the *Relais* reassess the danger/warning signs YES or NO
- Cough/cold. During his first visit, if the child had presented the symptom cough/cold (including pneumonia), did the *Relais* count again the respiratory movements of the child, YES or NO? Did he make the right decision after recount of the breathing movements?

Note:

Do not write anything on cough/cold at the follow-up appointment if the child did not present this symptom at their first visit to the site.

CHAPIRTRE IX MANAGEMENT COMMITTEE OF COMMUNITY HEALTH CARE SITES

8.1. The role of COGESITE

The points made in this part will be a GUIDED DISCUSSION and not a presentation to the COGESITES. These discussions will lead to a consensus. It will be the facilitator's responsibility to remind them of a role they may have forgotten.

He will discuss with participants on what initiatives they can take to improve the activities in their village.

8.1.1. Definition:

The COGESITE is the management committee of community health care sites.
It includes representatives from the villages that make up the community health care site, elected at a meeting with the community and its leaders in the presence of the *Titulaire* who will be the moderator.

Members of COGESITE come from different villages that make up a community health care site. They are elected at a meeting with the community and its leaders.

The composition of COGESITE is as follows:

- The Chairperson of the committee
- The Secretary
- The Treasurer
- 3 members

The function of the Chairperson or President of COGESITE is incompatible with that of the President of CODESA or CODEV.

8.1.2. Roles

1. Monitor the *Relais* who are health care providers, including:
    - Conduct monthly inventory of drugs administered by the site *Relais*:
    - Inspect the site revenue or returns

- Check and countersign the RUMER (Register for the record of essential drugs use and returns).
- Check and countersign the site monthly reports

2. Participate in the preparation of drugs supply order and countersign the medicines purchase order
3. Keep the returns and other resources on the site
4. Receive site commodities (medicines and other materials of the site such as a water container, cups or glasses for the first dose)
5. Ensure motivation of sites *Relais*
6. Develop conditions for access to medicines for the needy and the recovery of debts
7. Ensure recovery of funds under the arrangements
8. Ensure the establishment of a functional way of transport for urgent cases
9. Announce at the meetings of the COGESITE cases of deaths of children less than 5 years from the villages that make up the site for reporting in the site monthly data.
10. Manage Solidarity Fund
11. Support awareness activities of promotional *Relais*:
    - The use of site
    - Affordability of drug prices
    - The payment of debts of drugs
    - Collection of solidarity funds
    - Enumeration at site villages (each year, using a notebook or register of the village)
12. Regarding meetings:
    - Organize monthly meetings in which site monthly reports will be analyzed
    - Participate in meetings of the Health Area Development Committee (CODESA)

8.1.3. Clarification of roles:

Concerning the custody of medicines:

- It was recommended to provide limited quantities to sites *Relais* (stock of 2 months, taking into account the monthly requirements of each site) for the proper conservation and inventory. And these drugs are kept in the appropriate boxes made for this purpose.
- The inventory should be done by COGESITE; we have to preserve hygienic conditions in the handling of medicines.

Ownership roles:

Talk with participants in order to understand the difference between participating in an activity and playing the leading role.

This means they get to determine for each task:

- Who does what
- Where
- How
- When.

8.1.4. Debt Management:

The COGESITE is responsible for debt management at the site.

In this regard, its role is as follows:

- Incite the population to pay its debts
- Negotiate in kind debts payment
- Manage the sale of products for in kind payment under an agreed settlement
- Transfer funds obtained through the sale of goods in kind to the Treasurer.
- Recover from households health care debts for the site.

Discussions with participants on:

1. How to avoid possible unfortunate situations that may occur when recovering debts, for example:
    - People do not pay and the stock of drugs at the site decreases
    - People who have debts fleeing the site and stay away for fear of claims to pay back their debts
    - The member meeting COGESITE conflicts or confrontations in the community in collecting debts.
2. What do you think of internal rules and regulations developed at the COGESITE for debt management? Who should develop them? How should it be prepared? On what deadline?
3. Who in the COGESITE shall be accountable for debt payments? Will he do it alone or enlist the support of other members of COGESITE? How and with what frequency the COGESITE will report on the payment of debts?
4. How do you negotiate the payment of debts in kind? Who would be responsible for the sale of goods in kind?

8.1.5. Management of the Solidarity Funds:

Solidarity funds come from community activities and aim to improve their standard of living and to motivate the *Relais*. These funds can be a precursor to a health financing pool of funds - *Mutuelle de sante*.
The solidarity funds will be used for community purposes, according to the needs agreed upon in the Committee. During the training, one will have to give examples of experiences with solidarity funds and *mutuelles*

He will discuss with the participants of how this can be achieved, including for example:

- The methods of funds collection (for example, funds generated through the sale of products collected in kind, funds generated by the development of agricultural fields, etc ....)
- How will this work?
- Who will supervise, etc.

The Solidarity Fund will be managed through the mechanisms established by the internal rules and regulations document developed by the members of COGESITE with the help of the health zone central office.

The disbursement of funds will be justified by utilization for the benefit of the community. The funds release document of will be countersigned by the President of COGESITE and the Treasurer, after authorization by the full management committee of the site.

8.1.6. How to secure returns?

Talk with the *Relais* on how they think they can secure the revenue, what will be the pace of disbursement, which will keep the revenue, how do we incorporate that into the internal rules and regulations.

8.2. Tools for site management

NB: The interest of this part is to give members an understanding on the documents which they will check and countersign with the site *Relais*.

Talk with them on the schedule for checking and signing of these documents, that we assume will be monthly and for each order and shipment.

The facilitation technique for these tools is the same as that described for the site *Relais*…

Documents/Tools which the COGESITE must have:

- A copy of Micro plan of the health care site (Secretary, Treasurer),
- A copy of the list of medicines, equipment and tools assigned to the site (Secretary)
- A copy of activity reports of the site (secretary and treasurer)
- A copy of the monthly report of site drugs inventory (Secretary, Treasurer)
- The COGESITE meetings minutes (Secretary)
- The financial report of the Community Solidarity Fund (Secretary, Treasurer)

APPENDICES

X 1: SITE MANAGEMENT TOOLS

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LTATION REGISTER

N°	First and last names	Age	Sex	Mother's Name	Village	Status				Classification	Treatment	Price	Obs
						Weight	CPS	Vit A	vaccine				

aw on a double page in the draft notebook during the training)

C REPUBLIC OF CONGO

HEALTH

RUMER

icine description	Opening inventory	Entries of the month				Available stock	Daily Consumption												Monthly consumption	Stock at the end of the month	Phy inv
							1	2	3	4	5	…	…	27	28	29	30	31			
500/25 Mg																					
sunate-Amodiaquine																					
ine drops 2 %																					
cetamol tab 500 Mg																					
tab 20 Mg																					
endazole 100 Mg																					
moxazole 400/80mg																					
dom																					
enue collected during lay																					
unt deposited to the surer																					
ervations																					
ature																					

epublic of Congo
ealth

ER/REQUISITION FORM

: .....
.....
health care site: .....
d at: .....
ved by: .....

Date: .....

By: .....
Signature: .....

Drugs description	AMC	Quantity		Unit Price		Total Price	
		Ordered	Delivered	Ordered	Delivered	Ordered	Delivered
S P 500/25 Mg							
Artesunate-amodiaquine							
Quinine drops 2 %							
Paracetamol tab 500 Mg							
ORS							
Zinc tab 20 Mg							
Mebendazole 100 Mg							
Cotrimoxazole 400/80mg							
Condom							
TAL PRICE							

eived in CF: (in letters).....
: .....
gnature of the stock manager: .....
gnature of the health worker: .....

X 2: PATIENT CARE CHART

ATIC REPUBLIC OF CONGO/MINISTRY OF HEALTH

UAL PATIENT CHART FOR THE CHILDREN FILE Number.....

...../..... /..... NAME OF THE SITE *RELAIS*.....

NE: ..... HEALTH FACILITY..... SITE: .....

TION

..... Mother's Name..... Address.....

Age ..... Weight .....K Nutritional status of the child Green Yellow Red

S (Tick NO or YES) For how many days Treatment received at home

	NO	YES		
.....			.....days	.....
.....			.....days	.....
Cold.....			.....days	.....

for the other complaints.....

rning signs (TRANSFER if YES)

Tick	NO	YES
k to 2 months brought to the SITE	NO	YES
of the child , RED	NO	YES
drink or breastfeed?	NO	YES
hit all that he consumes?	NO	YES
convulsions or is convulsing now?	NO	YES
scious or not responding to external	NO	YES

ASK, SEEK Tick	NO	YES
Palmar pallor or anemia	NO	YES
Difficulty breathing or wheezing	NO	YES
Any disease that lasts 15 days or more	NO	YES
The child is often sick	NO	YES
The child is very weak	NO	YES
The child becomes sicker despite adequate care at home	NO	YES

ot to touch or history of fever within the 2 days)		NO YES	(Tick)
f:	Fever which continues after 2 days of home treatment with Artesunate + Amodiaquine and Paracetamol, (or SP + paracetamol in the absence of Art + AQ) - Fever with generalized rash	NO YES NO YES	FEVER to REFER
e site	All the problems above are absent	NO YES	MALARIA
	(loose stools = 3 times per day or more)	NO YES	(Tick)
f:	- Signs of dehydration (sunken eyes, thirst, skin fold fades slowly agitated child), or - Blood in the stool, or - Diarrhea too liquid (like water)	NO YES NO YES NO YES	DIARRHOEA to REFER
be e site	All the problems above are absent	NO YES	Simple DIARRHOEA
LD	NO ☐ YES ☐	(tick)	
	Respiratory movements = number ..... per Minute (Write)		
is	- 50 respiratory movements or more in the child of less than 1 year - 40 respiratory movements or more in the child of 1 year and more	NO YES NO YES	PNEUMONIA
is	- less than 50 respiratory movements in the child of less than 1 year - less than 40 respiratory movements in the child of 1 year and more	NO YES NO YES	COUGH or COLD
ON (items 7, 8,9 are to be found in every child)			
ON to	- Visible and severe Thinning - or the lower limbs swelling.	NO YES NO YES	Severe MALNUTRIT°

ON risk	Low weight for age: - In the YELLOW stripe, or - Stationary weight or decrease after 3 successive weightings	NO YES NO YES	Slight MALNUTRITION or Children at risk
ITION	- Normal weight (GREEN Zone), - No signs of malnutrition	NO YES NO YES	No MALNUTRITION

ON STATUS and for CPS & Vitamin A CARD CPS SEEN. NO ☐ YES ☐ (tick)

- Does the child have a problem with weights?	NO YES	*Catching up*	NO	YES
- Does the child have a problem with the vaccination?	NO YES	*Catching up*	NO	YES
- Does the child have a problem with Vitamin A?	NO YES	*Catching up*	NO	YES
LEM	ANY OTHER PROBLEM (TO REFER)	Others :Transfer ☐		

RED CASE NO YES	ADVICE FOR TRANSFERRED CASES TO THE INTEGRATED HF
e child can breastfeed or drink ntinue eastfeed in the way (or essed milk in the cup) or give r water if weaned child NT of 1 week to 2 months: ing warm	• IF FEVER: Paracetamol (½ tab with less than 3 years, ¾ tab child 3-5 years) + Bath in plain water or wrapping the head wet in case of high fever. • IF DIARRHEA: give frequently sips of ORS with a cup, (even though exclusive breastfeeding) NB:FILL THE REFERENCE CARD AND REFER

ENT

OF FEVER / MALARIA	TREATMENT OF DIARRHEA
ALARIA drugs: 2-6 month: QUININE drops 20% (1 drop/kg of 3 times per day, for 7 days) 7-11 months: Art ½ Tab + AQ ½ Tab, for 3 days OTAL 1½ Tab Art + 1½ Tab AQ) 12-59 months: Art 1 Tab + AQ 1 Tab, for 3 days te: In case of lack of ART+AQ, give the SP cording to following dosage: Child 2-11 months: SP ½ Tab single-dose, only for one day	1) Drugs a) ORS (at least 2 bags) or others liquids recommended: • ½ glass of ORS to each stool: Child < 2 years • 1 glass of ORS to each stool: Child 2 years and more (If Vomiting: Wait 10 min. then give again) b) Mebendazole: or 1 Tab of 100 mg 2 times per day for 3 days (TOTAL 6 Tab) (or 1 Tab 500 mg single-dose from one year age)

Child of 1-2 years: SP ¾ Tab single-dose, only fo one day. Child of 3-5 years: SP 1 single-dose Tab, only for 1 y amol Tab 500 Mg: (4 times/day). of less than 3 year: ½ Tab, for 2 days (TOTAL more than 3 years , ¾ Tab, for 2 days tab) e CHART 1 ent after 2 days	c) Zinc Tab for 10 days with the following dosage: • ½ tab 20 Mg, child of less than 6 months (TOTAL : 5 Tab) • 1 tab 20 mg, child 6 months and more (TOTAL: 10 Tab) 2) Advice: See CHART 2 3) Appointment after 2 days
OF PNEUMONIA AND COUGH/COLD IIA: MOXAZOLE 2 months-6 month: ¼ Tab 2 times per day for 5 2½) 6 months-3 years: ½ Tab 2 times per day for 5 5 Tab) 3 years –5 years: 1 Tab 2 times per day for 5 10 Tab) y against cough: Juice of lemon (diluted) or honey See treatment of Malaria. OUGHS OR COLD: y against cough (Juice of lemon or diluted honey) : See treatment of Malaria ee CHART 3 ntment After 2 Days	ASSUMPTION OF RESPONSIBILITY OF SLIGHT MALNUTRITION 1) Drugs a) Mebendazole: 1 Tab of 100 Mg 2 times per day for 3 for (TOTAL 6 Tabs) (or 1 Tab 500 Mg single-dose from one year age) b) Ferrous sulfate 1 tablet per day for 1 month (TOTAL 30 Tab) 2) Advice: See CHART 4 3) Appointment after 2 Days to check the application of the advice given, then Appointment after 7 days

UP (See vaccination Status & CPS & Vitamin A, and advice for catching-up if necessary)

courage the mother to continue weighting, immunization and supplementation Vitamin A to HF

FOLLOW-UP CARRIED OUT? INSTRUCTIONS FOR THE RDV OF FOLLOW-UP

TY N°1: NO YES of the child returned urned according to the fixed RDV ☐	POSSIBILITY N°2: The mother did not return ☐ Tick why she didn't return: a. Consultation with traditional practitioners and traditional treatment ☐ b. Lack of money ☐

urned immediately to the
rsening health of the child

c. Improved child
d. Mother's Activities: saleswoman, fields, work, illness in family ...
e. Death
f. Other causes:

LD STATE AGGRAVATED? (Ask the mother) NO YES (tick) IF YES, REFER

CHILD HAVE A NEW COMPLAINT? NO YES IF YES,TAKE A NEW CARD

WARNINGS SIGNS

	NO	YES
child is unable to drink or breastfeed		
child vomits all that it consumes		
l convulsions or convulsing now		
conscious or very weakened		
icult breathing (pulling or whistle)		
mar paleness (anemia)		
child becomes sicker		

REFER IF PRESENCE OF ONE SIGN ONLY

	NO	YES
• Fever that persists despite treatment		
• Appearance of rash widespread and / or pruritus		
• Blood in the stool,		
• Diarrhea too liquid (like water)		
• Or another anormal phenomenon		

D HAD COUGH OR COLD, number of Respiratory movements /minute Fast Respiration? NO YES

REFER IF YES

HE CHILD RECEIVED HIS DRUGS AS PRESCRIBED. Did he receive his DOSE? NO YES

remaining quantity of the drugs in the bag of the mother.

CONTINUE THE CHILD TREATMENT

ther to remind you how she administered the drugs (review the "3 HOWs")
nother has well administered the drugs, congratulate and encourage TO CONTINUE
nother has administered the drugs inappropriately, demonstrating the dispensation (review "3 HOWs") then ask her to repeat and to
er a dose in your presence. Check her understanding.

X 3: FOLLOW UP AND SUPERVISION TOOLS

ENT CARE CHARTS DATA PROCESSING FORM
ation of health care quality

vince:.....	District:.....	HZ:.....	HF:.....	Site:.....
ne of *Relais*:				

MPLETENESS OF THE PATIENT CHARTS BY SECTION AND MONTH SINCE THE BEGINNING OF FUNCTION												
	Month 1		Month 2		Month 3		Month 4		Month 5		Month 6	
ate the month of the r												
tions of the chart	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
tification												
nplaints												
nings signs												
er												
rhea												
gh/cold												
nutrition												
ching-up												
er problems												
ce for cases to refer												
Treatment												
Catching-up advice												
Follow-up ructions												
e nutrition status rect?	Y	N	Y	Y	Y	N	Y	N	Y	N	Y	N
HERENCE BETWEEN SIGNS/SYMPTOMS AND CLASSIFICATION												
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
er												
rhea												
umonia												

er + pneumonia												
gh/cold												
itional problem												
HERENCE BETWEEN CLASSIFICATION AND TREATMENT/ACTION												
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
nings signs												
er												
rhea												
umonia												
er + pneumonia												
gh/cold												
nutrition												
HERENCE BETWEEN AGE AND THE DRUGS DOSAGE												
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
erence												
er												
rhea												
umonia												
er + pneumonia												
gh/cold												
nutrition												
TIENT FOLLOW-UP VISIT IS RECOMMANDED												
ried out?												
NSISTENCY BETWEEN SIGNS/SYMPTOMS, CLASSIFICATION AND ACTION AT THE FOLLOW-UP TIME												
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
ning Signs												
gh/cold												

_____ Health Facility:_____ SITE: ..... Relais Name ……..

INDIVIDUAL RECORD SHEET OF MONTHLY FOLLOW-UP OF THE SITE RELAIS

r the Community *Relais*.

1, no = 0)	MONTH EVALUATION				
f warning signs. ASK: warning signs as you know?	FOLLOW-UP 1	FOLLOW-UP 2	FOLLOW-UP 3	FOLLOW-UP 4	FOLLOW-UP 5
k or to breastfeed					
he consumes					
current or recent)					
consciousness					
e Malnutrition					
Pulling					
thresholds of the fast breathing for:					
o 11 months (less than 1 year)					
o 5 years (1 year and more)					
child at the site. How do you make sure that he dequate treatment at home against fever					
paracetamol or SP + Paracetamol					
ook for the dehydration signs in children?					
h slowly fades					

form

of Community health Care site:	FOLLOW-UP 1	FOLLOW-UP 2	FOLLOW-UP 3	FOLLOW-UP 4	FOLLOW-UP 5
TION					
general warning signs?					
e mother about cough/Cold symptoms?					
e the child to count the respiratory					
e under costal pulling					
valuate the weight/age					
valuate the vaccination status					
valuate the status of Vitamin A					
espiratory movements counting					
e respiratory movements by the Relais					
e respiratory movements by the Instructor					
CATION: has correctly classified the child					
NT					
a good dose of cotrimoxazole for pneumonia					
d serious cases					
d advice for the home care:					

I II RESPECT OF STAGES FOR ESSENTIAL DRUGS ADMINISTRATION

SPOTS	FOLLOW-UP 1	FOLLOW-UP 2	FOLLOW-UP 3	FOLLOW-UP 4
ugs: ounted well the necessary quantity for one complete treatment				
ell the packaging with the drug name, the dosage and the treatment duration				
g to the mother: e mother the name, the shape of medicament and what it treats (or its utility)				
e mother: How much per dose = a, s/day = b, for how many days=c				
derstanding of the mother: made REPEATING to the mother the *"3 hows"* for each drug.				
d the mother to administer the first dose in his presence.				

ne Relais													
of TOOLS MANAGEMENT:	RUMER												
	Consultation register at the site												
	Monthly Report												
AVAILABILITY and the number of days of Stock out		Availability	Days of stock out	Availability	Days of stock out	Availability	Days of stock out	Availability	Days of stock out	Availability	Days of stock out	Availability	Days of stock out
unate-amodiaquine (3+3)													
ne drops 20 %													
etamol 500 Mg													
Tablets 20 Mg													
ndazole 100 Mg													
noxazole 400/80mg													
s sulfate+ folic acid (200 mg tab)													
om													
ALS AVAILABILITY													
nt charts													
ional balance													
ional timer													

ns of conservation of the drugs:

- Do you have a box for the drugs conservation?
- Is the box ventilated?
- Is there moisture at the place where the drugs are stored?
- Is there heat at the place where the drugs are stored?

W FORM WITH THE MOTHER
E..... HEALTH ZONE..... HEALTH FACILITY.....
..... Names of the Relais.....

t the time of visit of the child to the community health care site, ASK o say to you what the relais told him about:	Mother 1	*Mother 2*	Mother 3	Mother 4	Mother 5	Mother 6	Mother 7	Mother 8	Mother 9	Mother 10	TOTAL
ntity to be administered to the child for each dose											
ber of daily dose to the child (how many times per day)											
of treatment to administer the drugs to the child (for how many days)											
of crushing the tablets											
of mixing the tablets crushed with water.											
inistration of another dose if the child vomits within half an hour											
k the mother if the Relais told her to prepare the Drug and to give the first the Site in front of him											
mother to recall what the relais told her about appointment for returning to with the child.											
he mother to recall what the relais told her about when to return tely to the Site with the child without awaiting the Appointment											
mother to recall what the relais told her about the means of prevention seases from which their children suffered											
EDGE OF THE WARNING SIGNS BY THE MOTHER											
less than 2 months brought to the SITE											
al status of the child, RED											
d is unable to drink or to breastfeed											
d vomits all that he consumes											
d had convulsions or is convulsing now											
d is unconscious or not responding to the external stimuli											
or palmar pallor											
breathing											
ase which lasts 15 days or more											
d is often sick											
d becomes sicker despite the adequate care at home											
d is very weak											

Supervisor..... Observations and recommendations (to the back of the chart)