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# DEMAND-SIDE DETERMINANTS TO INTEGRATED COMMUNITY CASE MANAGEMENT CARE-SEEKING

Lessons from the Democratic Republic of Congo

August 2016

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## **DISCLAIMER**

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# DEMAND-SIDE DETERMINANTS TO INTEGRATED COMMUNITY CASE MANAGEMENT CARE-SEEKING

LESSONS FROM THE DEMOCRATIC  
REPUBLIC OF CONGO

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## ACRONYMS

<b>ACT</b>	Artemisinin-based combination therapy
<b>ARI</b>	Acute respiratory infection
<b>ASH</b>	African Strategies for Health
<b>CDR</b>	Regional Distribution Center for medicines ( <i>Centre Distribution Régionale</i> )
<b>CHW</b>	Community Health Worker
<b>DHO</b>	District Health Office
<b>DMT</b>	District Management Team
<b>DRC</b>	Democratic Republic of Congo
<b>FBO</b>	Faith-based Organization
<b>FGD</b>	Focus group discussion
<b>HZ</b>	Health Zones
<b>ICCM</b>	Integrated Community Case Management
<b>IHP</b>	Integrated Health Project
<b>KSPH</b>	Kinshasa School of Public Health
<b>MCHIP</b>	Maternal and Child Health Integrated Program
<b>MOH</b>	Ministry of Health
<b>MSH</b>	Management Sciences for Health
<b>NGO</b>	Non-governmental Organization
<b>ORS</b>	Oral Rehydration Salts
<b>PNLMD</b>	National Program to Combat Diarrheal Disease ( <i>Programme Nationale de Lutte Contre les Maladies Diarrhéiques</i> )
<b>RDT</b>	Rapid Diagnostic Test
<b>SSA</b>	Sub-Saharan Africa
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VHC</b>	Village Health Committee
<b>WHO</b>	World Health Organization

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# I. EXECUTIVE SUMMARY

## Background

Despite significant progress over the past two decades in reducing child mortality worldwide, a large proportion of children in Sub-Saharan Africa continue to die of preventable and treatable causes—including malaria, diarrhea, and acute respiratory infections (ARIs)—before their fifth birthday. Integrated Community Case Management (iCCM) is an equity-based strategy aimed at improving access to basic treatment services for children with these illnesses outside the reach of health care facilities. Although the strategy has been adopted by several low- and middle-income countries, iCCM services appear to be under-utilized in many areas. Achieving high levels of iCCM service utilization requires careful attention to both supply- and demand-side elements, the latter of which often receive less attention in program design and implementation.

In order to enhance understanding of demand-side factors that influence the use or non-use of iCCM services and to identify strategies to address them, USAID’s Africa Bureau commissioned ASH to conduct a multi-country study in Africa. In close consultation with USAID, Senegal and the Democratic Republic of Congo (DRC) were selected for inclusion because of their high child mortality rates and their heavy reliance on the iCCM strategy to improve child health outcomes. This report details findings from DRC.

## Objective

The objective of this study was to examine the demand-side determinants of use or non-use of iCCM services in Senegal and DRC and to provide recommendations—based on identified best practices, innovations, and lessons learned—to inform the introduction and/or scale-up of other iCCM programs.

## Methodology

Qualitative research was conducted in two provinces of DRC—Kasai Central and Lualaba—in four health zones and eight community care sites therein. The study team conducted a document review, key informant interviews, and focus group discussions (FGDs) with caregivers of children under five, community health workers (CHWs) providing iCCM services, CHW supervisors, Village Health Committees (VHC), chief health zone doctors, community leaders, and officers working for technical and financial partners that support iCCM programs. The methodology and data collection tools developed by ASH are adaptations of those developed by USAID’s Maternal and Child Health Integrated Program (MCHIP) for a 2012 study conducted in Mali.

## Key Findings

A total of 454 people participated in this study through 137 individual interviews and 29 FGDs. The results indicate that the iCCM strategy overall is well received by the populations it serves. It addresses three diseases of great concern for children’s health. Education of the population before the establishment of a community care site was found to facilitate the site’s subsequent use. This education consisted of responding to the concerns of parents both on the importance of the site and its limits in caring for children under the age of five during a community meeting led by the nearby health center’s head nurse. Additional identified facilitators included the provision of free care, monthly incentives paid to CHWs who provide iCCM services (called “site relays”), and the lack of competing private healthcare professionals or itinerant medicine vendors.



Several barriers to iCCM service utilization were identified, including a preference toward using traditional medicine to treat certain diseases. Frequent stock-outs and the relative unavailability of the community site relays were reported in all the sites and are likely to encourage the use alternative providers, particularly where they are present and due to their low cost of care, ability to extend credit for payment, or occasional ability to give injections, which are considered to be a more effective treatment than tablets. Some disease danger signs, especially those related to malaria, are better known than those for other diseases, as reported by site relays and caregivers of young children. Moreover, a time lag ranging from 24 to 48 hours between observing the onset of the child's disease at home and seeking care was reported.

## Recommendations

The findings of this study reveal a range of demand-side factors—often acting simultaneously—that influence care-seeking behavior of caregivers across multiple districts in DRC. Despite the introduction of the iCCM program in DRC over a decade ago, many of these factors continue to prevent services for malaria, diarrhea, and ARIs from reaching populations most in need. Experiences reported by key actors in the two provinces, four health zones, and eight community sites suggest the following recommendations to improve the uptake of the iCCM program:

- Strengthen human resources and medication management systems in the provincial health divisions
- Encourage supportive supervision (from technical and financial partners) for the relays and information, education, and communication sessions for communities
- Establish a mechanism to motivate the relays and ensure a regular supply of inputs and equipment
- Regulate fees paid by users to site relays to improve financial accessibility of iCCM services
- Strengthen integration of community site relays into the national health system through increased supportive supervision from health zone management teams and improved control of site management and inventory of inputs and medications
- Increase community awareness of services offered by site relays and collaboration in the implementation of the program
- Coordinate services with community leaders and private care facilities



## 2. BACKGROUND

Sub-Saharan Africa (SSA) is the region with the highest rate of child mortality in the world. While the region experienced promising acceleration in reducing the number of child deaths from 1990 to 2015, rapid population growth across SSA now threatens this progress.<sup>1</sup> Currently, the 10 countries with the highest rate of infant and child mortality are all in SSA, where most deaths of children under the age of five are due to preventable and treatable causes.<sup>2</sup> In 2015, malaria, diarrhea and pneumonia accounted for 1.1 million (37%) deaths of children under the age of five in SSA.<sup>3</sup>

Accelerating the reduction of under-five mortality, particularly in SSA, will require a focus on expanding access to care for the most vulnerable populations, as evidence shows significant disparities in under-five mortality rates within countries. According to a 2010 UNICEF report, across all regions, under-five mortality is higher in rural areas, in the poorest households, and among less educated mothers.<sup>4</sup>

iCCM is an equity-based strategy that aims to improve access to essential treatment services for children outside the reach of healthcare facilities. In 2012, UNICEF and WHO issued a joint statement supporting the iCCM to train, supply, and supervise community health workers (CHW) to treat children with malaria (in the countries affected by this disease), diarrhea, and pneumonia using artemisinin-based combination therapies (ACT), oral rehydration salt (ORS), and zinc tablets and oral antibiotics.<sup>5</sup> While appropriate and timely treatment of childhood malaria, diarrhea, and pneumonia is one of the most powerful interventions to reduce mortality among young children, facility-based services alone do not reach the populations most in need. A review by the Child Health Epidemiology Reference Group (CHERG) estimated that community management of these three diseases by CHWs could result in 70%, 60%, and 70-90% reductions in under-five mortality due to pneumonia, malaria, and diarrhea respectively.<sup>6</sup>

Despite the reported success of this strategy in several low- and middle- income countries, iCCM services in other countries appear to be under-utilized, as determined by utilization rates for iCCM services when compared to the incidence rates of those conditions among the catchment population at risk. Utilization of iCCM services is influenced by a variety of factors including: lack of recognition by family members of the condition or its severity; access issues once care-seeking behavior is initiated, such as financial barriers (e.g., user fees) or non-financial barriers (e.g., cultural norms or behaviors); system issues (e.g., actual or perceived concerns of lack of CHW skills, equipment, or drug stock outs); difficulties in accessing the CHW due to distance or lack of availability due to the CHW's need to work or provide other voluntary services.

The low use of iCCM services emerged as a major cause of concern at the 2014 *Integrated Community Case Management Evidence Review Symposium* in Accra, Ghana.<sup>7</sup> Several publications in the 2014 Journal

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<sup>1</sup> UNICEF. Levels and Trends in Child Mortality Report 2015. Available at: <http://data.unicef.org/child-mortality/under-five.html>

<sup>2</sup> H, Wang, et al. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 2014.

<sup>3</sup> UNICEF, WHO, The World Bank, and United Nations Population Division. Levels & Trends in Child Mortality: Report 2015. New York: UNICEF, 2015

<sup>4</sup> UNICEF. Progress for Children: Achieving the MDGs with Equity. Sept 2010. [http://www.unicef.org/protection/Progress\\_for\\_Children-No.9\\_EN\\_081710.pdf](http://www.unicef.org/protection/Progress_for_Children-No.9_EN_081710.pdf).

<sup>5</sup> M. Young, C. Wolfheim, D. Marsh, D. Hammamy. World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children. *American Journal of Tropical Medicine and Hygiene*. 87 (Suppl 5), 2012.

<sup>6</sup> WHO & UNICEF. WHO/UNICEF Joint Statement on Integrated Community Case Management: an equity-focused strategy to improve access to essential treatment services for children. June 2012.

<sup>7</sup> Diaz, T., Aboubaker, S., Young, M. Current scientific evidence for integrated community case management (iCCM) in Africa: Findings from the iCCM Evidence Symposium. *Journal of Global Health*, December 2014, Volume 4, No. 2.

of Global Health supplement further confirmed those concerns.<sup>8</sup> An analysis of routine data from multiple countries with iCCM programs in SSA revealed that on average, only 27% of expected cases of malaria, diarrhea, and pneumonia were treated using the iCCM approach every year.<sup>9</sup> In 2009, UNICEF Malawi conducted a bottleneck analysis which revealed that despite the availability of CHWs trained in iCCM of malaria (66%) and clinics supplied with ACTs (50%) only 26% of malaria cases were actually taken to a trained CHW and 13% were treated with ACTs.<sup>10</sup>

Lastly, a paper highlighting results from a Child Health and Nutrition Research Initiative (CHNRI) exercise on global research priorities for iCCM found the research objective to “identify determinants of non-use of iCCM services by caretakers and develop strategies to increase the uptake of iCCM” as the fourth ranked research priority amongst more than 70 global iCCM experts.<sup>11</sup>

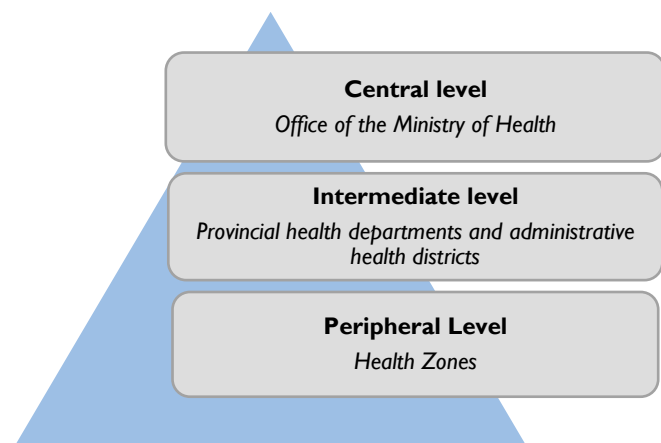
With funding from USAID’s Africa Bureau, the African Strategies for Health (ASH) Project, in partnership with the Kinshasa School of Public Health (KSPH), conducted this study in DRC to enhance the understanding of possible demand-side factors that influence the use or non-use of iCCM services. This report is complemented by a similar study in Senegal.

### 3. COUNTRY CONTEXT

DRC has a population of 77.3 million (2015) and is growing at a rate of 2.7% (2013) per year.<sup>12</sup> Many of DRC’s health indicators have improved in recent years, with notable declines in child and infant mortality. Between 2007 and 2014, the mortality rate of children under the age of five decreased from 148 to 104 deaths per 1,000 live births.<sup>13</sup> During the same period, the infant mortality rate decreased from 92 to 58 deaths per 1,000 live births.<sup>14</sup> Despite these reductions, in 2015 an estimated 304,600 children under five years of age died in the DRC.<sup>15</sup>

The health system in the DRC has three levels: the central level that includes the office of the Ministry of Health (MOH), the intermediate level that is made up of 11 provincial health departments and 48 administrative health districts, and the peripheral level with 516 health zones and more than 6,000 health centers. Over half of all health zones in the

**Figure 1. DRC’s health system pyramid**



<sup>8</sup> Diaz, T., Aboubaker, S., Young, M. Current scientific evidence for integrated community case management (iCCM) in Africa: Findings from the iCCM Evidence Symposium. *Journal of Global Health*, December 2014, Volume 4, No. 2.

<sup>9</sup> Oliphant, NP et al. [Multi-country analysis of routine data from integrated community case management \(iCCM\) programs in Sub-Saharan Africa](#). *Journal of Global Health*. Dec 2014.

<sup>10</sup> Oliver, K., Young, M., Oliphant N., Diaz, T., Kim, J. Review of Systematic Challenges to the Scale-up of Integrated Community Case Management. UNICEF Maternal, Newborn and Child Health Working Paper. Apr 2012.

<sup>11</sup> Wazny, K, et al. Setting global research priorities for integrated community case management (iCCM): Results from a CHNRI (Child Health and Nutrition Research Initiative) exercise. *Journal of Global Health*, December 2014, Volume 4, No. 2.

<sup>12</sup> WHO Country Profile. Democratic Republic of Congo. 2015. <http://www.who.int/countries/cod/en/>

<sup>13</sup> Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) and ICF International. 2014. Democratic Republic of Congo Demographic and Health Survey 2013-14: Key Findings. Rockville, Maryland, USA: MPSMRM, MSP et ICF International.

<sup>14</sup> Ministère du Plan et Macro International. 2008. Enquête Démographique et de Santé, République Démocratique du Congo 2007. Calverton, Maryland, U.S.A. : Ministère du Plan et Macro International.

<sup>15</sup> UN Interagency Group for Child Mortality Estimation (IGME) in 2015. Available at: <http://www.childmortality.org>

country are supported either by faith-based organizations (FBOs) or non-governmental organizations (NGOs).<sup>16</sup>

About 80% of under-five deaths in DRC occur in the community where there is a lack of financial and geographic accessibility to primary health care facilities, which in many cases are located more than five kilometers (km) from village households.<sup>17</sup> These barriers limit the utilization rate of health services to just about 25%.<sup>18</sup> To target the high under-five mortality rate and inequity in accessing care, DRC introduced a national iCCM strategy in 2005. The iCCM program is currently managed and coordinated by the MOH's National Program to Combat Diarrheal Disease (PNLMD). The Program indicates that 3,630 community sites are operational with site relays trained and distributed in 461 health zones (HZs) covering a population estimated at 7,727,556 inhabitants in 2015. The iCCM program is not present in 54 of DRC's HZs and the need for community sites is estimated at 12,111 sites to cover a population of 12,912,628.<sup>19</sup>

**Figure 2. Map of DRC and study sites and HZs**



The iCCM program in DRC relies on the voluntary unpaid work of CHWs, called community relays, which are elected by the communities they serve. Two types of relays are involved in the provision of iCCM services in DRC:

- **Site relays** (*relais de site/recosites*) are formally trained to detect, treat and manage malaria, diarrhea, and pneumonia cases at the community level using RDTs, ACTs, ORS, zinc, and paracetamol; and
- **Community relays** (*relais promotionnel*) do not directly provide treatment, but provide support to community mobilization and information, education, and communication (IEC) activities at the village level.

Site relays are expected to provide families with a basic integrated package of care and refer complicated cases to the nearest health facility. They provide health services at a community site (*site/aire de santé*), which is not necessarily a structure, rather refers to a defined geographical area of a given number of villages or communities that benefit from the health services. Site relays are volunteers, and therefore most continue to engage in activities outside of their community health work in order to support their families.<sup>20</sup>

Site relays are connected to primary public health services through supply and supervisory systems. Site relays are provided with monthly reporting forms to maintain continuous records of the services they provide (number of sick children by type of illness, quantity of medicine dispensed, and quantity of

<sup>16</sup> Jarrah, Z., Klein, M., Collins, D. 2014. The Cost of Integrated Community Case Management in Sud-Ubangi District, Democratic Republic of Congo.

<sup>17</sup> Ministry of Public Health, National Program to Combat Diarrheal Disease (PNLMD), Situation Regarding the Development of Community Sites in DRC (Situation de l'évolution des Sites des soins Communautaires en RDC), Report, August 2015

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> Ministère de la Santé, Secrétariat Général. Sites de Soins Communautaires : Guide de Mise en Œuvre. 2007.

medicines remaining in the site's stock at the end of each month). They submit complete monthly reports to the head nurse (*infirmière titulaire*) at the HZ's health center, who then incorporates needs into the health center's procurement requests. Medicines are distributed from the Regional Drug Distribution Center to the Central Health Zone Office on a quarterly basis, and further disbursed each month to health centers and community sites. In addition to ensuring the appropriate availability of medicines at community sites, the head nurse is tasked with providing supportive supervision to the relays on a regular basis. iCCM monitoring activities take place quarterly at the Central Health Zone Office. They bring together head nurses and site relays across the HZ to verify data quality, identify gaps, address challenges, and schedule supervision visits. Routine data are compiled and presented to technical and financial partners and to the Provincial Health Division.

The iCCM program in DRC is financed and sustained primarily through FBO and NGO support. The community sites sampled for this study are supported by a single implementer, the USAID Integrated Health Project (USAID-IHP).<sup>21</sup> This technical and financial support includes the orientation and training of cadres at the provincial and health zone levels; identification of community sites; selection of relays; training of trainers, relay supervisors, and community site relays; provision of medicines and supplies to community sites; and monthly supervision by the head nurse and quarterly supervision by the HZ team and/or partners. Upon establishing a new site, USAID-IHP provides sites with a start-up stock of medications approved by the MOH in addition to basic materials (e.g., timers, MUAC tape, bottles, cups) and management tools (e.g., register, patient form, job aids, supervision booklet). Community participation in financing the program is limited. While USAID-IHP provides sites with medicines, small equipment, and supplies, they do not necessarily support community site operational costs. Thus, for sustainability reasons, some health zones opt to implement small user fees as incentives for relays. The government allows relays to charge such fees; however, a lack of regulation may lead to variation in patient costs across community sites.

## 4. STUDY OBJECTIVES

The specific objectives of this study were to:

- Identify demand-side factors that influence the use or non-use of iCCM services in DRC and identify possible contributory supply-side factors;
- Solicit recommendations from target users, CHWs, and other key stakeholders to determine how to best use available resources (i.e., time, equipment, human, and financial) at all levels to increase the use of iCCM services; and
- Define best practices and innovations, as well as lessons learned from the most successful iCCM programs that could be adapted or replicated on a larger scale.

Findings from this study were analyzed to develop practical programmatic recommendations for increasing demand for and uptake of iCCM services in DRC. Together with the findings from Senegal, they may be relevant for other countries in the region.

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<sup>21</sup> USAID-IHP was implemented from 2010-2015 by Management Sciences for Health (MSH) in partnership with International Rescue Committee and Overseas Strategic Consulting, Ltd (OSC). At the time of this study, project activities continued under a subcontract via Pathfinder/Evidence to Action with implementation by MSH and OSC.

## 5. METHODOLOGY

### 5.1 SITE SELECTION

This study was based on the collection of data in geographic areas where the iCCM program is implemented and where programmatic data on the use of services is available. It was preceded by a pre-test in the Kisantu HZ in Bas Congo province to test the data collection tools and adjust them as needed. Data collection took place in March 2016 in two provinces: Kasai Central and Lualaba. In each province, two HZs were selected for inclusion. Only HZs supported by an iCCM technical and financial partner were selected. In this study, a single partner, USAID-IHP, provided data on the community sites in the HZs that it supports. In total, eight community sites were visited based on data from the HZs on the utilization of community sites in 2014. See section 5.4 for a detailed description of the site selection methodology and related limitations encountered.

The level of utilization of iCCM services in each HZ was calculated by dividing the number of treated cases by CHWs by the number of expected cases. The number of expected cases was determined based on national-level disease incidence among the target population of under-five children living in the catchment area and the proportion of expected individuals seeking treatment from the public sector. The table below gives the names of selected HZ and community sites, as well as the utilization rates of iCCM services by HZ. Annex I provides a detailed explanation of how estimated iCCM utilization rates were calculated from routine programmatic data on service delivery at community care sites.<sup>22</sup>

**Table I. Estimated iCCM service utilization rates by HZ, 2014**

Province	HZ	Community Sites	Utilization rate of community sites			
			Fever	Diarrhea	Pneumonia	iCCM average
Lualaba	Kanzenze	Kamponda Kisangama	10%	6%	16%	11%
	Lualaba	Misampa Kabobo	18%	8%	7%	11%
Kasai Central	Bilomba	Kayembe Mfuamba	10%	5%	6%	7%
	Dibaya	Kabalanga Tshiebue	14%	9%	12%	12%

### 5.2 DATA COLLECTION

Ethical approval for this study was granted from the KSPH Ethics Committee (*Le Comité d’Ethique de l’Ecole de Santé Publique de l’Université de Kinshasa*) in January 2016. This study used a qualitative approach to data collection, using in-depth interviews and FGDs. At the community level, the recruitment of participants was ensured with the support of a social mobilizer from the village one day before the meetings took place. Individual written consent for participating in the study and for recording the conversation on the recording device was requested and obtained by each investigator before the proceeding with the meetings.

<sup>22</sup> Routine programmatic data used to calculate utilization rates from the Kasai Central Province HZs were obtained from the central health zone office records. Data from the Lualaba Province HZs were provided by USAID-IHP.

In each province, data collection was conducted in the communities' local languages by a team of four investigators recruited competitively and trained in qualitative data collection by a team composed of a supervisor and his/her assistant, all from the University of Kinshasa. The interviews were conducted in French at the HZ level and in the provinces.

In-depth interviews were conducted with iCCM supporting and implementation actors, including the head of the Provincial Health Division, the head HZ physician and his staff, technical and financial partners in the province, and the head nurse of the health center that serves the selected community sites. Interviews were also conducted with community members, namely community leaders, alternative care providers, community site relays, and mothers of children under five. FGDs were led at the HZ and community levels with homogenous groups, including caregivers, men and women, site relays, and members of the village health committees. One focus group brought together the head nurses from the health centers in the Dibaya HZ in the Kasai Central province. The interview and FGD guides (Annex 2) reviewed the following specific sub-topics for each type of respondent: (i) knowledge about childhood diseases; (ii) availability of health services; (iii) decisions concerning seeking treatment; (iv) supervision, evaluation, and motivation of community health workers, and (v) the prospect for improving iCCM supply and demand.

Overall, 137 in-depth interviews and 29 FGDs of around 10 persons each were conducted. A total of 454 participants took part in this study. Details on all the interviews and focus groups conducted are in the table below.

**Table 2. Distribution of interviews and FGDs conducted by province**

Respondent	Province		Total
	Kasai Central	Lualaba	
	In-depth interviews		
Caregivers of children under five	40	40	80
Site relays	4	4	8
Head nurses	4	2	6
Alternative care providers	8	8	16
Zone head physicians	2	1	3
Community leaders	8	8	16
Technical and financial partners	6	2	8
<b>TOTAL</b>	<b>72</b>	<b>65</b>	<b>137</b>
	Focus group discussions		
Caregivers, mothers	5	4	9
Caregivers, fathers	4	4	8
Community health workers	2	1	3
Village health committees	4	4	8
Head nurses	1	0	1
<b>SUBTOTAL</b>	<b>16</b>	<b>13</b>	<b>29</b>

### 5.3 DATA ANALYSIS

The Principal Investigator and two experts reviewed transcriptions of recorded interviews and FGDs and developed a coding scheme. Transcriptions were coded and analyzed using Atlas Ti software. Utilization, accessibility and availability, quality of care, and demand for iCCM services were identified as key themes for the analytical framework. Specific questions related to these themes are outlined in Table 3 below.



**Table 3. Key research themes and questions**

Theme	Key Questions
<b>Utilization</b>	<ul style="list-style-type: none"> <li>• What are the basic determinants of use and non-use of iCCM services?</li> <li>• When do families make a decision to seek care outside of the household for a sick child (timing of care-seeking)?</li> <li>• What is the decision-making process and who makes the final decision?</li> <li>• Why do families seek care for a sick child from alternative providers?</li> </ul>
<b>Access/ Availability</b>	<ul style="list-style-type: none"> <li>• How important is the financial barrier as a determinant of access for use of iCCM services?</li> <li>• What are communities' perceptions of CHWs?</li> <li>• What are the communities' perceptions of the services offered by CHWs?</li> <li>• How significant is the difference of geographic accessibility between CHW sites and other sources of care (health facilities, alternative providers, etc.) in making iCCM the first choice in care?</li> <li>• What supply-side issues exist and how much of an impact might these have on utilization?</li> </ul>
<b>Quality</b>	<ul style="list-style-type: none"> <li>• How do mothers define "quality" services at CHW sites and health facilities and how does perception of "quality" influence use?</li> <li>• How does the quality of care delivered by alternative providers differ from that of frontline health workers in the public system?</li> <li>• Is care sought from certain alternative providers more for one disease than for others? If so, what and why?</li> </ul>
<b>Demand</b>	<ul style="list-style-type: none"> <li>• What kind of health promotion activities or events would users value most?</li> <li>• What do mothers know about CHWs and their roles in their communities?</li> <li>• Would the addition of other services to the CHW's current package of care, increase utilization of CHW services? If so, what services?</li> <li>• How willing are CHWs to offer additional services?</li> </ul>

## 5.4 STUDY LIMITATIONS

This study was designed to collect data on demand-side factors influencing the uptake of iCCM services in two HZs with relatively high estimated iCCM service utilization rates and two HZs with relatively low iCCM service utilization rates. However, a number of factors prevented this site selection methodology from being implemented as intended. In order to accurately estimate utilization rates, study site selection depended heavily on the availability and quality of routine programmatic data that is reported by community sites. While data on the utilization of malaria services from site CHWs was readily available in multiple provinces, the study team faced limited availability of programmatic data on the full package of iCCM services (malaria, diarrhea, and ARIs) provided by the same implementing organization. Additional limitations addressed during site selection include the feasibility and cost of the study team's travel to the sites, as well as security and cultural identity concerns (e.g., language, way of life, diet, and perception of gender and family norms).

Programmatic data on the provision of the full package of iCCM services was shared with the study team by one technical and financial partner, USAID-IHP, which operates in 78 HZs in four provinces in DRC. Kasai Central and Lualaba were selected as study provinces, after the Nord Kivu and Kasai Oriental provinces were eliminated. Nord Kivu is marked by security and access concerns and the cultural identity of Kasai Oriental was deemed too similar to that of Kasai Central. The two adjacent provinces form a larger, interconnected Grand Kasai community. The selection of HZs followed a



similar methodology, as calculations to estimate iCCM service utilization rates yielded fairly constant figures across the HZs in the selected provinces.

Utilization rates were estimated using (i) the proportion of children under five living in the intervention site area, (ii) the incidence of expected cases of malaria, diarrhea, and acute respiratory infections, (iii) cases of malaria, diarrhea, and ARIs actually received by CHWs, and (iv) the average utilization rate of iCCM services for all three illnesses. Several limitations with these calculations are important to note. Calculations used nation-wide estimates of incidence rates of malaria, diarrhea, and ARIs. Provincial and HZ level incidence rates of these diseases, if available, could provide a more accurate estimate of the use of iCCM programs. Finally, in calculating utilization rates, the study team did not account for the proportion of the population who is expected to seek care from alternative providers (e.g., public health facilities, private providers, traditional healers, and medicine vendors).

A further study limitation relates to the small sample size of just four of DRC's 516 HZs. This sample size therefore does not provide a comprehensive view of all demand-side factors impacting the use or non-use of iCCM services across the country and findings may not be generalizable. However, findings and recommendations should be relevant to program planners and donors in other contexts who seek to start-up or scale iCCM interventions.

## 6. KEY FINDINGS

Data collection took place in Kasai Central and Lualaba provinces, situated in south-central and southern DRC respectively. In Lualaba province (previously part of Katanga), men are the main income providers for their families and many of them work in mineral quarries. Women have low levels of education and typically stay home to care for their families and households. The province is marked by multiple private health care providers in villages, including itinerant medicine vendors. Community care sites in the Kanzenze HZ cover a population of 2,227 people, of which an estimated 445 are under five years of age. In Lualaba HZ, community care sites cover 1,536 people, including about 307 children under five. The Kasai Central province (previously part of Kasai Occidental) is characterized by a largely agricultural community. Some individuals also engage in small commerce activities and others raise animals for an income. Women have low education levels and polygamy is prevalent. Private health care providers are fairly limited in the province. In the Dibaya HZ, 16,456 people are covered by community care sites, of which about 3,291 are under-five children. In the Bilomba HZ, community care sites cover a population of 13,527, including 2,705 children under five years of age.<sup>23</sup>

The following sub-sections present findings from interviews and FGDs as they relate to each of the key research themes and questions outlined above in Table 3. Respondents identified several factors that influence care-seeking from site relays for iCCM services. It is evident that behavior is not driven by one factor in isolation; rather, the relationship between the identified determinants is complex. Factors often interact with one another and discussion of them may overlap in certain areas of the following sections.

### 6.1 UTILIZATION

This section explores the basic determinants of use and non-use of iCCM services. Interviews and FGDs with caretakers and other community members sought to understand the decision-making process for seeking care outside of the household, including the timing of doing so, who is involved in

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<sup>23</sup> Population data were provided by the central health zone office records for Kasai Central Province HZs and by USAID-IHP for Lualaba Province HZs.

making decisions, and why families might seek care for a sick child from alternative providers as opposed to the site relay.

### 6.1.1 Timing of care-seeking

Across the surveyed sites, the majority of participants said that the time for making a decision about seeking care depends on the onset of danger signs (especially convulsion) and the severity of the disease. Most caregivers cited a few of the following danger signs: (i) heavy breathing, (ii) groans accompanying fever, (iii) dehydration due to diarrhea, (iv) physical weakness in cases of severe coughing, (v) convulsion, (vi) repeated vomiting, (vii) refusal to eat and drink, (viii) lack of energy, and (ix) trouble breathing. Danger signs of malaria were mentioned most frequently by caregivers and even by the community site relays. It should be noted, however, that some caregivers and site relays mentioned non-specific signs such as red eyes, sores on buttocks, weight loss, palpitation, gnashing of teeth, and loss of appetite. This is the case with younger mothers and even some adults who gave these responses.

The majority of caregivers of young children cited the community site relays, HZ nurses, and community leaders (pastors, village heads, and prominent figures) as their main sources of health information.

*“The health information we receive comes from health personnel passing in our village and from our village heads.” - Mother/caregiver*

Regarding the decision to seek care, the majority of participants in Kasai Central sites emphasized that the decision to seek care outside the household occurs soon after the onset of the disease and usually within 24 hours. This observation practice is likely encouraged by the distribution of family care kits (which include paracetamol, oral rehydration serum, and zinc) to the households with the support of UNICEF. In Lualaba sites, care-seeking appeared to be more delayed, occurring primarily in cases where the disease persists, two or more days after the onset.

A minority of caregivers in Kasai Central sites further indicated that care-seeking may be delayed during harvest or planting season. They identified their extended stay outside the village when they are working in their fields as an obstacle to returning to the village to take their sick children for medical care.

*“As we are in the field work season, it may be difficult for us to go to the (care) site with the children.” – Mother/caregiver*

### 6.1.2 Decision-making process

In all sites, the sick child’s father is typically the decision-maker in regards to the pathway of care. When the father is not present during a time of illness, the mother may defer to her in-laws or wait for her husband’s return.

*“It is the papa who decides to go for care for the child; in his absence it is the child’s grandfather who decides.” - Mother/caregiver*

However, many participants, particularly in Kasai Central province, noted the unpredictability of disease and the repeated absence of the father from the home. In such cases, or when the father is otherwise negligent (often due to the presence of multiple wives), a child’s mother may have the autonomy to decide when to seek care outside the home. Many interviewed mothers asserted that their input is critical in the decision-making process. Fathers are often absent from the home when signs of illness first appear and because mothers spend so much time with their children every day, they are more sensitive to changes in their health status.

*“In case of my absence, the mother can also decide to take the child to the hospital.” – Father*

*“Of course it is the mother because she is often in the home full-time and at the side of her children while the husband has many occupations, he can have several wives and not be able to spend the night with the children.” - Mother/caregiver*

On the question of what leads families to seek care from alternative providers, participants noted that the recourse to a given type of provider is dictated by the nature of the child’s disease. All the participants mentioned the case of the spleen (*kibeka*) and the depressed head/skull/fontanelle as requiring the use of traditional medicine. For care that calls for using the health center, a number of participants cited their lack of money as a significant barrier. In such cases, they resort to itinerant medicine vendors where they are available. In the Lualaba sites visited, such vendors were more numerous, while they were rarely mentioned in the Kasai Central sites.

*“The lack of money is a constraint that we have to face in case of a transfer to the health center where care is adequate.” - Mother/caregiver*

Respondents indicated they use private healthcare professionals mainly when they seek services that relays do not provide, such as injections, which are perceived to be a more effective and faster treatment in comparison to medications taken orally. Additionally, they turn to private providers in instances when:

- stock-outs of medicines at the community site encourage the use of the health center and other alternative providers;
- there is a low supply of equipment or work tools such as thermometers, microscopes, and personal scales at the community site;<sup>24</sup> or
- the site’s community health worker becomes involved in an interpersonal conflict.

Respondents explained the influence of conflicts over land between two families or two clans in their decision to seek care from an alternative provider. Several participants indicated that interpersonal or inter-human conflicts may drive caregivers to seek treatment for their children outside of the site if the site relay becomes involved in a conflict.

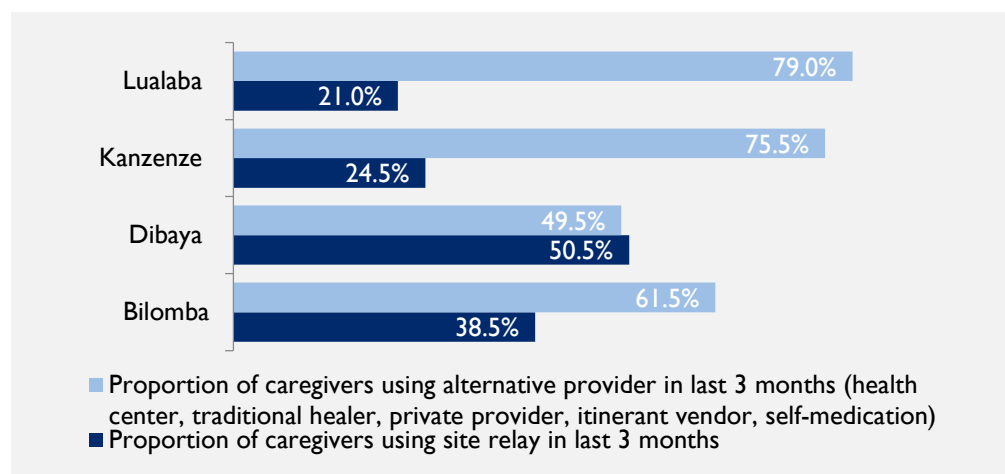
*“How can I take my sick child to a site relay who doesn’t respect another man’s wife and has no regard for anyone” - Father*

Interviewed caregivers were asked to report where they sought care for their children when they fell ill with symptoms of malaria, diarrhea, and/or pneumonia over the course of the preceding three months. Figure 3 below reveals that caregivers of young children in Kasai Central province (Dibaya HZ, Bilomba HZ) report seeking iCCM services from site relays more frequently than do caregivers in Lualaba province (Lualaba HZ, Kanzenze HZ). The difference in frequency of care-seeking from relays as compared to alternative providers is much more pronounced in Lualaba province.

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<sup>24</sup> Site relays are not expected to be equipped with materials such as microscopes; however, caregivers may perceive microscopes—often found at higher level facilities—to be associated with a higher quality of care.

**Figure 3. Caregivers' reported care-seeking behavior by HZ**



## 6.2 ACCESSIBILITY AND AVAILABILITY

This section assesses the impact of financial accessibility, geographic accessibility, and communities' perceptions of site relays and the services they offer on caretakers' decisions to seek services from site relays as the first point of care. It also explores supply-side issues, such as medicine supply and health worker motivation and supervision, which may impact the utilization of iCCM services.

### 6.2.1 Financial accessibility

Participants' opinions about the financial accessibility of iCCM services from community care sites varied by location. In Kasai Central sites, the majority of interviewed caregivers maintained that care is not paid for at the site. In some cases, however, with the consent of the head health center nurse, site relays received a kind of gratuity from caregivers of around 500 francs (~USD 0.50) as an incentive. Without clear communication to the community, the head nurse recently instructed site relays not to collect gratuities from parents following the introduction of a small monthly incentive initiated by the HZ's technical and financial partner. As a result, the majority of participants indicated that they do not currently pay community site relays (while a few rare caregivers affirmed having recently paid), which facilitates access to iCCM services. In Lualaba sites, nearly all participants maintained that care is paid to the sites, which really impacts on access to services. Given that the population lives in extreme poverty, participants indicated that their lack of money prevents them from seeking health care.

*"Yes, the care is paid for, the price varies between 1,000fc to 4,000fc for the duration of the sick child's treatment." – Mother/caregiver*

### 6.2.2 Perception of the relays and services provided

In all surveyed communities, site relays have a strong relationship with their communities. They are perceived positively, which facilitates the utilization of iCCM services they provide. Site relays are perceived as *Munganga* which translates to nurse in Western medicine. In the majority of the sites visited, the site relays are educated and considered community leaders (pastors and teachers). Site relays are welcoming and respected for the services they provide in managing common diseases among young children. The majority of caregivers indicated that the services themselves are also well received

by the clients, understanding that the iCCM strategy limits site relays to caring for only three targeted diseases, while children die from other diseases as well.

### 6.2.3 Geographic accessibility to health services

Community sites have the advantage of being located mainly within the villages they serve, while other sources of care, such as the health centers, are farther away and pose a significant accessibility challenge to populations. While health centers are perceived to offer guaranteed quality services by qualified health care professionals, caregivers in Kasai Central sites indicated that the long distances and poor road conditions deter them from seeking care outside their communities. The proximity of community care sites to households therefore facilitates their more frequent use. However, some community sites serve multiple villages. Participants in both provinces noted that when this is the case, the inhabitants of the village where the site was not established find the distance and relative remoteness a barrier to its use.

*“We experience many difficulties getting to the TSHILELA health center due to the distance and poor road conditions...we must make our way through dense bush to get there.” – Father*

In Lualaba sites, participants noted that the relative presence of and proximity to alternative care providers may limit the uptake of services from site relays. Private healthcare professionals, traditional healers, and itinerant medicine vendors that are situated next to community sites tend to replace relays when stock-outs of medicines occur. Participants also use them for injections (which relays are not trained to provide) and treatment of diseases of a cultural nature (which are believed to be untreatable with modern medicine).

### 6.2.4 Supply-side issues

Community perceptions of stock-outs and other supply-side issues can undermine the credibility of community sites and relays, and encourage caregivers’ use of alternative, perhaps inappropriate, pathways of care.

#### 6.2.4.1 Availability of medicines and supplies

Participants perceived frequent and/or prolonged (specifically in Lualaba province) medicine stock-outs as constituting barriers to the utilization of iCCM services at community sites. HZ directors, Provincial Health Division teams, technical and financial partners, and officials from the Regional Distribution Center for medicines (CDR) were asked about their perception of why community sites experience frequent and/or prolonged medicine stock-outs. Respondents cited a range of varying determinants, including the following:

- Lengthy procurement processes
- Delays in ordering medicine by the HZ’s central office
- Free medicines provided to the community site, which may constitute a loss of revenue to the health center team<sup>25</sup>
- Limited involvement of Provincial Health Division in estimating needs and ensuring orders are placed according to the established schedule
- HZ technical and financial partners’ use of CDR as storage warehouse, disrupting appropriate stock management practices

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<sup>25</sup> Health centers are subject to cost-recovery and profit margin principles. Head nurses place comprehensive medicine orders, covering health centers and community sites across the HZ. The ultimate destination of the medicines is not distinguished in the order, so head nurses may be more incentivized to keep a greater portion of the ordered medicines for sale at the health center level.

#### 6.2.4.1 Availability and motivation of site relays

Many participants, particularly caregivers, expressed their concern that volunteer relays are not incentivized to conduct their community health work, which impacts the accessibility and availability of services, in addition to the quality of care they provide. Participants cited relays' absence from the community site, at times for several days, as driven by his/her need to otherwise support his/her family. In Kasai Central sites, prolonged unavailability of relays was not specifically mentioned, perhaps because the sites selected are mainly run by relays with a permanent job outside the domain of agriculture. For example, relays who are also teachers and pastors may have a steady income and known, reliable work hours. This means they are available to provide health services on a more regular basis. Alternatively, farmers' work and income is subject to nature's volatility, which may cause them to be unexpectedly absent from the community site. Participants in Kasai Central also noted that their relays make known their hours of availability and share their mobile phone number widely so that parents can reach them in the case of emergency.

Participants suggested that financial and non-financial incentives can increase site relays' motivation. For example, in Kasai Central, incentives such as a small monthly payment or a bicycle loaned by the technical and financial partner have provided some assistance. A relay with a bicycle is more motivated to pick up medications at the health center to replenish stocks and transport patients from the village to the health center in the case of referral. Recognition of site relays through monitoring and supervision by the health center head nurse was also cited as an important incentive. Key informants, including chief health zone doctors and head nurses, identified several strengths and weaknesses of site relay supervision activities. The most common responses are included in the table below.

**Table 4. Strengths and weaknesses of supervision activities**

<b>Strengths</b>
<ul style="list-style-type: none"><li>• Supervision and correction of deficiencies in iCCM strategy</li><li>• Monitoring the availability of site relays</li><li>• Monitoring and control of support received from partners</li><li>• Monitoring the implementation of recommendations from site relays</li><li>• Record-keeping of services provided to children</li></ul>
<b>Weaknesses</b>
<ul style="list-style-type: none"><li>• Inadequate resources to organize regular supervision, especially in hard-to-reach sites</li><li>• Lack of motivation/incentives provided to site relays</li><li>• Insufficient time given to supervision activities</li><li>• Failure to adhere to supervision schedule in times of limited resources</li><li>• Chief nurse's preoccupation with several overlapping activities</li></ul>

## 6.3 QUALITY OF CARE

This study assessed how caretakers' perception of service quality might influence their use. Interviews and discussions sought to understand how communities define the quality of services provided at community sites and health facilities. They also explored how the quality of care delivered by alternative providers differs from that of frontline health workers in the public system and for what diseases caretakers are more likely to turn to alternative providers.

### 6.3.1 Comparison to alternative services

In regard to the quality of treatment, participants across all surveyed HZs indicated a distinction between services provided by the site relays and those provided by the health center. They perceive the site relay as a bridge to primary health care services, or as an emergency health agent. His/her services are understood to be limited to providing treatment for a few childhood diseases such as diarrhea, malaria, cough and pneumonia. Participants in Lualaba sites noted the site relays' lack of qualifications in medical sciences as a possible deterrent to seeking their services. Despite being trained at the HZ level, participants acknowledged some deficiencies in their management of diseases of children under five. On the other hand, the health center provides many services and has an educated staff, permanent providers, and medicines and tools for treating a range of more complicated diseases. While participants place services offered at health centers high on a gradient of preference, they appreciate the quality of the limited services provided by relays in their communities.

*“It is very beneficial to the community because the treatment that is given at the site, in everyone’s opinion, is effective and it heals children. We are happy that [the relay] is here.” – Key informant*

*“Since the installation of the site in our village, we have observed a great change in the treatment of childhood illnesses because we go heal our children at the site and we stopped using practices like going to traditional healers.” –Mother/caregiver*

The site relays noted that the factors that may limit the use of their services included the perception by the community that injections are more effective than the oral medications they administer and the fact that they are limited to treating only three diseases.

In Kasai Central sites, caregivers also mentioned the scarcity or even nonexistence of private healthcare professionals in the immediate vicinity of their community sites, in addition to fewer recognized healers (by trade), mainly in the Bilomba HZ and a partially in the Dibaya HZ. However, the Lualaba province is characterized by a higher presence and use of alternative care providers. Most of the participants indicated that they had already taken recourse to healers, private healthcare professionals, and itinerant medicine vendors. They went first to private healthcare professionals for several diseases such as diarrhea, fever, pneumonia, and repeated vomiting because private healthcare professionals also treat with injections and have a more reliable stock of medicines available, as compared to the community sites.

*“We buy medicines from itinerant vendors because it makes the task easier; instead of traveling long distances [by foot] to go to the health center, we buy medicines at a lower cost and the child is healed.” – Father*

Caregivers unanimously reported that there are certain specific diseases such as convulsion (*nkoyi*), diphtheria, depressed fontanelle, and diseases of the spleen that don't respond to Western medicine. These diseases are successfully treated by traditional medicine and at a lower cost, on credit or even by barter. While recourse to healers for these diseases occurs more frequently in Lualaba province, caregivers across all surveyed sites recognized the quality of treatment provided by traditional medicine. Some participants in Kasai Central explained that the population has more faith in ancestral spirits and plants with therapeutic value than in medicines provided without charge that are considered to be of poor quality.

*“Yes, religious convictions may discourage us from looking for a solution with the relay. Based on my faith, disease can be cured with plain water.” – Community leader*



## 6.4 DEMAND FOR ICCM SERVICES

This section addresses communities' knowledge of and demand for iCCM services. It examines what health promotion activities communities found most useful, caretakers' understanding of site relays and their roles in their communities, whether the provision of additional services might increase utilization of relays' services, and how willing relays are to offer additional services.

Participants (primarily caregivers, technical and financial partners, and community leaders) cited the following as pre-conditions considered to be very important for health promotion and increased demand for iCCM services:

- A broad promotion and popularization of the iCCM strategy at the community level, with involvement from community health workers, village chiefs and religious leaders;
- The organization of health education sessions and if possible a video forum with appropriate educational materials on the three diseases and the services relays provide against them;
- Community involvement in the selection of the relay;
- Proper training of the relays in the treatment of the three diseases;
- Free treatment at community sites;
- A regular supply of medicines in the community sites;
- A correct estimate of medication needs at the level of the HZ central offices;
- A clear distinction between medicines for health centers and those for community sites; and
- Providing an incentive bonus so that the site relays will be more available at the community site.

In Kasai Central province specifically, caregivers, site relays and community leaders described the value of the involvement of community leaders in generating demand for the iCCM program. For example, they explained that the village chief immediately informs residents when the site has been resupplied with medicines after a stock-out. This way, caregivers remain informed and do not need to expend time and resources finding alternative means of treating their sick children.

*“We just have to involve the village heads, pastors and community health workers and sensitize them to bring us timely information and also free care.”- Mother/caregiver*

Across all surveyed sites, participants were well aware of the role of the relays in the community and the packages of iCCM services that they offer. They were unanimous in saying that iCCM services provide health care to children under the age of five suffering from three diseases: malaria, diarrhea, and pneumonia. This treatment is carried out by a community site relay who has been trained by the HZ and put in place by the health center's chief nurse. In Kasai Central, participants noted that inhabitants were consulted to express their choice in the selection of the community site relay. Respondents expressed their knowledge that the relay is equipped to provide sick children with ACT after the results of the rapid diagnostic test (RDT), ORS, zinc, and paracetamol. Most of the caregivers mentioned that the site relays did not have thermometers or microscopes, the latter of which they are not actually expected to have. For the vast majority of caregivers interviewed, the scope of treatment provided by site relays must be expanded to other key child health issues such as anemia and malnutrition, as well as infusion services for dehydrated children. Several caregivers (men and women) also noted that the lack of injections at the community sites is a shortfall of the program.

*“All diseases are dangerous, we must instead increase the treatment for other diseases such as anemia, malnutrition, and a service to care for dehydrated children.” - Mother/caregiver*

*“Yes, in addition to tablets and other drinkable products, we would like to start providing injections for children. The other weakness that we see is the effectiveness of the community site relays. We need more of them to ensure a permanent presence at the site.” - Father*

Site relays did not explicitly comment on this desire for expanded treatment, however they did indicate that they referred a number of children to health centers for anemia and malnutrition. Relays have requested that they be trained regularly and benefit from formative supervision. Many noted that the training they receive is too short. They recognize that they are not nurses, and have not much considered the possibility of treating more illnesses, given that they already experience challenges of frequent and prolonged stock outs of medicines for the three diseases they are currently tasked with treating. Relays are concerned about having to send sick children home without receiving treatment because the community site lacks appropriate medicines.

Caregivers indicated that the community site relays provide supplementary services during vaccination campaigns that provide revenue to them. The participants in the focus groups were of the opinion that the site relays should be engaged more in both encouraging people in the community to take children under the age of five to the community sites when danger signs appear, and to warn the community about epidemics. Many participants, particularly in Lualaba province, expressed their desire for the community sites to be converted into health posts and other sites established to cover the entire HZ because some villages are more than 50 km away from the referral health centers.

## **7. DISCUSSION AND RECOMMENDATIONS**

The results of this study indicate that iCCM services provided through site relays are welcomed by communities, as they addresses three principal diseases that are most concerning to caregivers. The contribution of the health center’s head nurse appears to be an important factor in the successful establishment of a new community site. Because head nurses participate in vaccination campaigns and provide pre- and post-natal care for women in the community, they are considered a type of community leader. Their involvement is important in educating the community about the iCCM strategy and instilling in caregivers a sense of trust in the site relays’ capacity to effectively identify and treat childhood illnesses (through training and supervision by the health zone management team). This strategy worked particularly well in the Bilomba HZ in Kasai Central province, where the head nurse called a community-wide meeting to explain the importance of iCCM and when its limits necessitate referral to the health center, and to respond to any community concerns.

Findings suggest that the presence of alternative health care providers (predominately found in Lualaba province), such as itinerant medicine vendors and private professionals, can negatively impact the community’s use of iCCM services. This is particularly true when alternative services are perceived to be of high quality, are provided free of charge or at a low cost, and encompass a greater range of services (including injections). The use of traditional medicine is systematic for diseases that, according to the culture, cannot be treated by Western medicine. Caregivers’ recourse to alternative providers is also motivated by perceived frequent and prolonged stock-outs of medicines at the community sites.

This study showed that there are many causes of stock-outs in the sites. These include delays in ordering medicine by the health zone’s central office, free medicines provided to the site (which may constitute a loss of revenue to the health center team), and the limited involvement of the Provincial Health Division in estimating needs and actively controlling of the pace of ordering and consumption of medicine by the HZs. Moreover, some partners and provincial officials cited the lack of integration of HZ partners in the national medicine supply system as a challenge.

The unavailability of relays, interpersonal conflicts involving relays, lack of motivation for relays, and the relays' lack of professional qualifications were mentioned as barriers to the use of iCCM services. Several gaps were also cited in the frequency of community site supervisions and the use of data for appropriate guidance in both the HZ management teams and the provincial teams.

Furthermore, nuanced gaps in caregivers' knowledge of danger signs of disease were revealed. Despite a relatively strong level of understanding portrayed by the majority of respondents, certain signs were mentioned in a scattered and unsystematic way, including convulsion, unconsciousness, and inability to eat or drink. There are notable delays in care-seeking, as many caregivers observed the course of the sick child's disease at home for two or more days from its onset before turning to the relay or the health center. Therefore, it is critical that iCCM programs increase the IEC sessions targeting not only caregivers of children under five, but also other decision-makers and community members. These sessions should also explain the important benefits of early care-seeking from relays as pre-referral treatment.

Table 5 outlines key facilitators of and barriers to use of iCCM services, as identified by study participants. It also provides practical programmatic recommendations—aimed primarily at community stakeholders, iCCM program implementers, district management teams and facility staff—for increasing demand for and uptake of iCCM services in DRC and other countries in the region.

**Table 5. Summary of facilitators, barriers, and recommendations**

Utilization	
Facilitators	Barriers
<ul style="list-style-type: none"> <li>Care-seeking behavior outside of the home after the onset of disease, usually within 24 hours</li> <li>Understanding of danger signs of disease, especially for malaria</li> </ul>	<ul style="list-style-type: none"> <li>Delayed care-seeking behavior outside of the home after the disease persists, usually 48 hours or more after the onset</li> <li>Preference toward self-medication (perhaps fostered by the availability of iCCM family kits)</li> <li>Religious convictions and faith in therapeutic value of ancestral spirits and plants</li> <li>Interpersonal conflicts involving site relays</li> </ul>
Recommendations	
<ul style="list-style-type: none"> <li><b>Improve community understanding of disease and options for care:</b> Health workers, community mobilizers, and community leaders should enhance education efforts in communities where caregivers delay seeking care for their sick children. Messaging from different sources should be streamlined for all household decision-makers on the importance of early care-seeking for key child illnesses at the community site as well as on the appropriate use of family medicine kits, where applicable.</li> </ul>	
Access & Availability	
Facilitators	Barriers
<ul style="list-style-type: none"> <li>Establishment of the community site within the village (as opposed to sites that serve multiple villages)</li> <li>Known work hours of relay</li> <li>Phone number of relay made available to community when services are needed outside of work hours</li> <li>Perceived status of relays as educated, community leaders</li> </ul>	<ul style="list-style-type: none"> <li>High cost of iCCM services</li> <li>Presence of alternative care providers (private providers, itinerant vendors, and traditional healers)</li> <li>Repeated absence of relay at the community site</li> <li>Unavailability of mobile phone network as a means of communication</li> <li>Remoteness of sites that serve several villages</li> <li>Frequent and prolonged medicine stock-outs</li> </ul>

<ul style="list-style-type: none"> <li>• Respect for relays and their service to the community</li> <li>• Distance to and difficulty accessing (poor road conditions, lack of transportation) health centers outside of the community</li> </ul>	<ul style="list-style-type: none"> <li>• Perceived low supply of tools such as thermometers, microscopes, and personal scales at community site</li> <li>• Inability of caregivers to take sick children for care during harvest or planting season</li> </ul>
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**Recommendations**

- **Reduce perceived supply-side issues:**
  - *Availability of supplies* – Ensuring the consistent availability of medicines and supplies at community sites can be achieved by strengthening the capacity of relays and HZ staff to carry out correct estimates of medicines needs on schedule. The central government should play a coordinating role of aligning efforts made by technical and financial partners and the national supply chain system. A mechanism must also be established to distinguish orders and deliveries for community site commodities from other HZ facilities to ensure community sites receive appropriate stocks. A regular supply of inputs and reporting tools in addition to supervision and capacity building at the community level will strengthen record-keeping to better monitor the utilization of sites and availability of medicines.
  - *Availability/capacity of relays* – The MOH should assist in identifying focal points at the provincial level for the management of community sites. Focal points would monitor data to help generate supervision topics and oversee the management of medicines. Site relays must receive more regular, formative supervision from health center staff. To do so, the capacity of HZ staff to train and supervise site relays should be strengthened. The MOH and technical and financial partners should provide HZ staff with financial and material support to make supervision visits at community sites. The MOH could also assess the feasibility of implementing and institutionalizing alternative supervisory methods—such as a peer mentoring model or the use of mobile technology—that have been successful in other programs or pilots to complement the current approach. Finally, the government should explore opportunities to support—through institutionalization and/or incorporation into district budgets—established mechanisms (e.g., bicycles, periodic fee for performance) to motivate site relays to provide consistent, reliable, and quality care in the community site.
- **Improve financial accessibility of iCCM services:** To improve financial accessibility of iCCM services, innovative financing mechanisms (e.g., elimination of fees or creation of village funds) should be implemented to consistently provide iCCM services free of charge at the point of care. The MOH should consider systematically regulating any fees/gratuities paid by patients to site relays. Communication to the community on the implementation or elimination of fees/gratuities must be clear.
- **Ensure appropriate placement of community sites:** Provincial and HZ teams should collaborate with private healthcare facilities to integrate them into primary care activities and avoid establishing community sites close to these facilities.

**Quality**

<b>Facilitators</b>	<b>Barriers</b>
<ul style="list-style-type: none"> <li>• Motivation of relays through regular supervision of head nurse or HZ management team</li> <li>• Bicycles enable relays to transport patients to health center for timely referral and for more frequent re-stock of medications</li> </ul>	<ul style="list-style-type: none"> <li>• Perceived lack of qualification of relays in medical sciences</li> <li>• Perceived lack of motivation among relays and absence from community site</li> <li>• Services provided by relays limited to pneumonia, malaria, and diarrhea, while children die from other diseases as well</li> <li>• Perception that injections are more effective than oral medications provided by relays</li> </ul>

**Recommendations**

- **Implement more accurate monitoring of quality of care:** Record-keeping should be strengthened at the community site level so that partners and different tiers of the MOH can better monitor the quality of services provided as well as the quality and timeliness of patient referrals to health centers. Site relays should be consistently supplied with and trained on the use of appropriate recording and reporting tools. To assure

quality in their use, site relays should be better integrated into the national public health system by strengthening ties with HZ staff and facilities. Head nurses and partners should engage more regularly in formative supervision of site relays. The central government should reinforce its endorsement of national, standardized training of site relays on iCCM best practices. Certificates of completion—validated by the government—could be provided to CHWs to boost their perceived credibility and competence as qualified health service providers in their communities.<sup>26</sup> Further incentives should be introduced to site relays to increase their motivation to provide quality care at the community level (e.g., bicycles help ensure referrals are carried through in a timely manner).

Demand	
Facilitators	Barriers
<ul style="list-style-type: none"> <li>• Village chief informs residents when the site has been resupplied after a stock-out</li> <li>• Strong understanding of the role of relays and the package of iCCM services they offer</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of awareness-raising and education sessions for the community on the role of the relay before the site is established</li> <li>• Participants not involved in the selection of relays</li> <li>• Caregivers' desire for relays to provide injections and services that treat more childhood diseases (e.g., anemia, malnutrition)</li> </ul>
Recommendations	
<ul style="list-style-type: none"> <li>• <b>Enhance IEC activities to increase demand for iCCM services:</b> Prior to establishing a new site, the HZ staff and partners should enhance promotional activities in the community. Community members should be actively engaged in the complete process, including the selection of their site relay. Technical and financial partners should supply community sites with materials to enhance IEC efforts by promotional relays and by site relays at patient visits. Caregivers, fathers, parents-in-law, and other household decision makers should receive targeted communication on the value of iCCM services.</li> <li>• <b>Involve community stakeholders:</b> Community leaders must be actively involved in carrying out IEC activities, promoting the use of iCCM services, and informing the community of any changes to the program (e.g., availability of services offered by site relays and medicine stocks at community site).</li> </ul>	

## 8. CONCLUSION

In order to provide more equitable coverage of iCCM and other proven child survival interventions, attention must be paid to the demand-side barriers and enablers encountered by caregivers when seeking health care for their children. Many caregivers included in this study indicated that, despite the availability of CHWs and iCCM services in their communities, a range of factors influenced their decision if, when, and where to seek care for their sick children. Findings revealed that barriers to or enablers of appropriate care-seeking are often complex and affected by a range of issues related to caregiver knowledge and awareness, cultural and societal norms, community engagement, and access, availability, and quality of services, among others.

While this study examined demand-side drivers of the use or non-use of iCCM services across four health zones and eight community care sites in DRC, its findings and recommendations may be relevant for other low-resource settings and countries that are considering introducing, modifying, or scaling up an iCCM program at the community level. As governments and implementing partners do so, efforts to address demand-side drivers of care-seeking must be incorporated into the iCCM strategy alongside an appropriate supply of child health services in order to promote equitable access to health care for children.

<sup>26</sup> Ochieng B.M., Akunja, E., Edwards, N., Mombo, D., Marende, L., Kaseje, D.CO. Perceptions of health stakeholders on task shifting and motivation of community health workers in different socio demographic contexts in Kenya (nomadic, peri-urban and rural agrarian). BMC Health Services Research, 2014. DOI: 10.1186/1472-6963-14-S1-S4

## ANNEX 1. CALCULATION OF ICCM UTILIZATION RATES

**Utilization (U) = # of iCCM cases received by CHW (n) / total # of expected cases of ARI, malaria, and diarrhea (z)**

The total # of expected cases (z) is calculated using the following data points:

- 1) Total village population (v)
- 2) Percentage of village that is under-five years of age (2014 Senegal DHS has 20% of the population under-five years of age)
- 3) Total target population (p) = v \* 20%
- 4) Disease incidences for ARI, diarrhea, and fever (i) (see explanation on incidence calculation below)
- 5) Total number of cases in target population based on incidence (x)
- 6) Percentage of target population that would seek care from alternate health provider such as health facility or traditional healer (r). This percentage will be an estimate based on 'expert opinion' and may vary from village to village and even by disease.

$$p * i = x$$

$$x - (x * r) = z$$

### Incidence Rates for the iCCM Interventions

Incidence rates for each intervention are calculated based on the prevalence rates reported in the 2014 Demographic Health Survey (DHS) for DRC. These incidence rates are national averages for the country and relate to each of the three intervention areas overall. Thus, if 19% of children were reported to have diarrhea, these cases could be treated through iCCM or other means, such as at a health post. For each disease the DHS reports the percentage of children who had symptoms in the two weeks prior to the survey. To convert from prevalence to incidence rates, we took the two-week prevalence figure and annualized it based on the average duration of each disease. For example, 19% of children were reported to have had diarrhea in the two weeks prior to the DHS survey. A meta-analysis of zinc treatment for diarrhea (Lukacik, 2008) shows that the average duration of an episode is 4.07 days. To adjust to an annual figure, we divided 52 weeks by 2.6 (the number of two-week periods including the duration of the episode) to arrive at 20.15. This figure is then multiplied by the 19% prevalence rate to arrive at an incidence rate of 3.85 episodes per year.

	Prevalence - DHS <sup>27</sup>	Average Duration (Days)	Adjustment Factor to Annual Figure	Incidence (Episodes per Year)
Diarrhea	19%	4.07	20.15	3.85
ARI	7%	5.00	19.16	1.28
Fever	30%	5.00	19.16	5.65

<sup>27</sup> Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) et ICF International, 2014. Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014. Rockville, Maryland, USA : MPSMRM, MSP et ICF International.

Province	Kasaï Central		Lualaba	
Health Zone	Dibaya	Bilomba	Kanzenze	Lualaba
Population covered by CHW	16,456	13,527	2,227	1,536
% covered population <5	3,291	2,705	445	307
# expected malaria cases (calculated using above formula)	18,595	15,285	2,516	1,735
# malaria cases seen (2014)	2,536	1,521	264	318
Malaria utilization	14%	10%	10%	18%
# expected ARI cases	4,212	3,462	570	393
# ARI cases seen (2014)	501	194	92	28
ARI utilization	12%	6%	16%	7%
# expected diarrhea cases	12,671	10,415	1,714	1,182
# diarrhea cases seen	1,141	506	96	92
Diarrhea utilization	9%	5%	6%	8%
Average	12%	7%	11%	11%



## ANNEX II. QUESTIONNAIRES

### A. INDIVIDUAL INTERVIEW FOR CARETAKERS WITH SICK CHILDREN AGED 0 TO 59 MONTHS

**Free and Informed Consent Form for Individual Interviews:  
Caretakers of children aged 0 to 59 months**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Individual Interview Guide:**  
Caretaker of sick children aged under 5

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

**Demographic Information**

Gender \_\_\_\_\_

Age \_\_\_\_\_

Relationship to sick child aged 0 – 59 months \_\_\_\_\_

# of persons living in household \_\_\_\_\_

# of living children under the age of 5 \_\_\_\_\_

# of deceased children \_\_\_\_\_

# years of school attended \_\_\_\_\_

Please list all sources of household income (including ownership of livestock)

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**TOPIC I: Perception of healthcare and services**

Can you tell me about the concerns of people in your community regarding treating childhood diseases such as diarrhea, malaria, and pneumonia?

What changes have you noted in the treatment of childhood diseases over recent years? (Explore: in terms of access, cost, quality, diversification of services, health workers' skills, etc.)

Tell us about your sources of information on child health?

What do you think of the level of information for women on the prevention and treatment of disease?

Do you know the danger signs indicating that the sick child should be taken for treatment? (Explore: if the new generation is better informed about diseases such as: malaria, diarrhoea, ARIs and malnutrition, the procedure for seeking care for children under 5)

Do you know what kind of services your local CHW can provide for sick children?

Do you think that CHWs are respected providers for sick children within your community? Why or why not?

## TOPIC 2: Care possibilities

Can you tell us what services are available in your community for treating sick children? (Explore this for the health centers, CHWs, traditional healers, itinerant care givers, etc.)

What do you think are the benefits of consulting each of these types of providers?

NB: If possible draw up a list of care providers in order of preference, and ask them to justify the rank of each provider.

(Explore to see: the difference between the quality of care offered by alternative caregivers and those of first line health workers (CHW, facility-level staff)?

Are the services of certain alternative care providers more sought for certain diseases or health problems, compared to others? If so, which health issues and why?

Tell us which care providers are usually consulted by mothers of children under 5 and for which problems? (If the CHWs are not mentioned, ask why not? Explore: the nature of the disease, the geographical location of the care provider, reasons for the choice, etc.)

Do mothers often advise each other to go to certain care providers? If so, for which kinds of health issues?

## TOPIC 3: Experiences/use of services

Can you tell us about your experiences in dealing with a sick child? (Explore: the nature of the disease, person who chose the care provider, person who paid the costs, satisfaction etc.)

In your experience, with which care providers have you been satisfied? And with which care providers have you not been satisfied? Give your reasons. (Explore: diversification of services, quality of services, attitudes of the care providers, cost of treatment etc.)

What do you think the determining factors are for quality health care?

What kind of care provider would you recommend to other mothers? Does your recommended provider differ based on the health problem? (Explore which illnesses/diseases the respondent lists and how they correspond to different care providers.)

Can you tell us about the main constraints you have most often had to face in ensuring care for your child? (Explore: distance from the site/lack of transportation, shortages of inputs, cost of medicines/services, social constraints, etc.)

Do finances play a role in where you decide to take your sick child for treatment?

What about your location and distance to nearest health facility? Does this have an impact on who you seek out for care?

Have you ever taken your child to be treated by a CHW and they did not have the drug your child needed? If yes, what did the CHW do?

Do the current services that CHWs can provide for your sick children meet your expectations? If so, how? If not, why?

#### TOPIC 4: Decision to seek treatment

At what point, in your family, do you decide to take a sick person to a care provider? What is the decision making process and who makes the final decision? (Explore: example of a recent care of seeking treatment for a sick child)

In your family, who has the final choice in selecting a care provider for the treatment of your children? Is your opinion taken into account?

What do the decision-makers in your family think of the services offered by CHW versus those at the health facility? What kind of care provider do they prefer? Why?

Why do families bring their children for treatment by alternative care providers even though treatment is available from trained CHWs or from the local health center?

#### TOPIC 5: Prospects for improvement

Do you think there are some aspects of the CHW services that could be improved? If so, which ones?

What can be done to encourage decision-makers to bring their child to the CHWs for treatment for diarrhea, malaria, and pneumonia?

What do you think of a possible diversification of CHW services? What kind of services should be prioritised?

Are there any other issues that we did not discuss that influence your decision on whether or not to seek care for your sick child from a CHW?

## **B. INDIVIDUAL INTERVIEW FOR COMMUNITY HEALTH WORKERS**

### **Free and Informed Consent Form for Individual Interviews: Community Health Worker**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Individual Interview Guide:**  
CHWs

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

**Demographic Information**

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

**TOPIC 1: Roles and responsibilities of a CHW**

Can you tell us a bit about your role and responsibilities in your village as a CHW? How long have you been doing this work?

Can you tell us about the various training courses you have attended as well as the technical skills that you have acquired in child healthcare?

Can you describe the specific training(s) you have had in iCCM?

Do you believe there is high burden of childhood illness in your village? If so, do you believe the iCCM services you provide meet the demands of your target population? If not, why not?

On average how many sick children do you see a week? How many of those, do you refer to health centers for treatment?

**TOPIC 2: Problems and challenges**

What is the degree of support and level of community involvement in your activities?

What problems or challenges do you most often face in your role as a CHW? How have you managed these problems? What support do you receive and from who?

What have been the main challenges for you as a CHW in providing iCCM services? Have you been able to find solutions to overcome these challenges? If so, what?

Do you experience drug-stock outs for iCCM medicines frequently? If yes, how do you think drug stock-outs can be minimised?

What do you think the barriers are to accessing healthcare in your community? (Explore: drug stock-outs; cost of services/medicines, remoteness of the site etc.)

How are CHWs perceived by the community? Are CHWs respected? (Explore: trust, appreciation of skills, sociability etc.)

How important is the financial barrier, or means to pay, in accessing iCCM services?

How does the presence of other care providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services? Are the services of certain alternative care providers more sought for certain diseases or problems than others? If so, which ones and why?

Are certain alternative care providers more affordable than others? (Explore who and if they believe this has an impact on utilization of services by this type of provider)

Do you think the public is adequately informed about the iCCM services you provide? If yes, how so? If not, why not?

What channels of communication have you used to raise awareness of the services you provide amongst the population? In collaboration with whom? Are they effective?

### TOPIC 3: Supervision

Tell us about the kinds of support you have received from your supervisors or local NGO workers?

(Explore further to know the frequency, areas, time allocated, etc.)

Can you describe the supervision mechanism and frequency for iCCM?

(Explore: actors involved, frequency, location, monitoring methods etc.)

Which aspects of your iCCM services does the supervision focus on?

What do you think are the strengths and weaknesses of the supervision activities?

How do you report on your iCCM services?

What specifically, do you report? How frequently? And to whom?

### TOPIC 4: Motivating CHWs

Can you tell us about any issues related to your working conditions that you feel have an impact on the quality of services you can provide? Are you satisfied with your working conditions? If so, why? If not, why not?

Is there support or are there materials/equipment that you need to improve your working conditions and performance as a CHW providing iCCM services?

What are the advantages and disadvantages linked to your work? Explain?

Can you tell us about your expectations in terms of remuneration?

What types of remuneration do you receive as a CHW? (Explore: per diems, salaries, performance incentives, in-kind gifts from community)



## TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

How can iCCM services provided by CHWs be improved and/or sustained?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

Are there any other issues that we did not discuss that you believe influence your ability to provide care for sick children?

## C. INDIVIDUAL INTERVIEW FOR CHW SUPERVISORS

### Free and Informed Consent Form for Individual Interviews: CHW Supervisors

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

## Individual Interview Guide:

### CHW Supervisor

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

### Demographics

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

### TOPIC 1: Roles and responsibilities

What do you know about your district's iCCM strategy? Have CHW supervisors been involved? If so, what role have they played?

Can you tell us about the CHWs' iCCM activities in your health district? What are the CHWs' roles?

Do you think the implementation of the iCCM has taken into account the community's concerns about treating childhood illnesses? If yes, why? If not, why not?

Can you tell us about the various training courses you have attended or conducted as part of supervising CHWs provision of iCCM services? What were the aims of these training courses? Were they adequate?

### TOPIC 2: Problems and challenges

What are the main challenges that the CHWs face in providing iCCM services? What have you done to help address these problems?

What are the main challenges you face as a stakeholder in implementing and supporting the provision of iCCM services? Have you been able to meet these challenges? If so, how?

What do you think are the barriers to accessing iCCM services offered by the CHWs? (Explore: drug and FP input stock-outs; cost of services/medicines, remoteness of the site, etc.)

How important is the financial barrier as a determining factor in the low use of iCCM services?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

How does the presence of other service providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services?

Are the services of certain alternative care providers more sought for certain diseases or health problems than others? If so, which health issues and why?

Do you think the public is adequately informed about CHW services? If so, how? If not then why not? What channels of communication are used to raise awareness amongst the population? Are they effective?

### TOPIC 3: Stakeholders' roles in improving iCCM services

What groups or categories of people should be involved to encourage the use of iCCM services provided by the CHWs? (Explore: nature of the potential groups, ages and positions of the resource people)

What role could do you think CHW supervisors should play in promoting iCCM?

In what way should primary health centers be involved in promoting the iCCM services? What should they be doing and how?

What kind of health promotion activities or events might users appreciate the most?

### TOPIC 4: Support/Monitoring/Assessment

Tell us about the kind of support CHWs receive from their supervisor? (Explore to know the frequency, the areas covered, the time apportioned, etc.)

Can you describe the supervision mechanism for supervising the CHWs' iCCM services? (Explore: the actors involved, the frequency, the monitoring means, etc.)

What do you think are the strengths and weaknesses of your supervisory activities?

How are the CHWs' iCCM services assessed? By whom and how frequently? (Explore: can the results of the supervision and assessments contribute to decision-making and correcting deficiencies.)

### TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns should be taken into account?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM? If so, what are they?

What needs to be done to improve the quality of the supervision?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

## **D. INDIVIDUAL INTERVIEW FOR ALTERNATIVE CARE-GIVERS**

### **Free and Informed Consent Form for Individual Interviews: Alternative Care-Givers**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Individual Interview Guide:**  
Alternative Care-Givers

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

**Demographics**

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

**TOPIC 1: iCCM Services**

Can you tell us about your role and responsibilities in your village? How long have you been doing this work?

Can you tell us about the services you offer? What are your skills in treating childhood illnesses such as diarrhea, malaria, and pneumonia?

What specific training(s) have you received?

Which health issues are you consulted for by the people in your community?

Can you tell us about the characteristics of your clients/patients? (Explore: age, income, sex, distance from the care provider, etc.)

What do you think is distinctive about the services you provide, compared to other care providers?

Have you heard about iCCM services? If so, what have you heard?

What do you know about the CHWs and the mission they have been assigned? Who are their target groups? What kind of care are they consulted for?

**TOPIC 2: Perception of the CHWs**

How do care providers such as you perceive the CHWs?

Do you think the members of your community have a preference between you and the CHWs? If so, what is the preference and why?

What do you think of the CHWs' skills? Do you think that the services treating childhood illnesses that the CHWs offer are appropriate for the demands of the people in your area? If not, what are the population's expectations?

Is there any collaboration between you and formal service providers? If so, can you describe the nature of this collaboration?

### TOPIC 3: Problems and challenges

Do you think the implementation of iCCM services has taken into account the presence of alternative care providers? What is the level of support and involvement of alternative care providers in iCCM services?

What do you think are the main barriers to utilising healthcare for the people in your community? (Explore: geographic access, medicine and FW input stock-outs, cost of services/medicines, distance from the site, rivalry between care providers, etc.)

How important is the financial barrier as a determinant low use of community-based health services?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

Are the services of certain alternative care givers sought more for a particular disease or health problem than another? If so, which health issues and why?

Which communication channels do you use to raise awareness about childhood illnesses amongst the population? Are they effective?

### TOPIC 4: Prospects for improvement

Which groups or categories of people should be involved to encourage the use of your services? (Explore: nature of the potential groups, ages and positions of resource people)

Can you tell us which aspects of iCCM services provided by CHWs are not appreciated by the community? And which aspects should be strengthened?

Do you think alternative care providers should play a role in promoting iCCM services? If so, how? Who should define this collaboration framework?

What kinds of health promotion activities or events might users appreciate the most?

### TOPIC 5: Suggestions and recommendations

How do you think iCCM services offered by the CHWs could be improved?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

## **E. INDIVIDUAL INTERVIEW FOR DISTRICT CHIEF MEDICAL OFFICERS AND DISTRICT iCCM FOCAL POINTS**

### **Free and Informed Consent Form for Individual Interviews Chief Medical Officers and District iCCM Focal Points**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx



### Individual Interview Guide:

District Chief Medical Officer and iCCM Focal Person

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

### Demographics

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

### TOPIC 1: Knowledge of iCCM Services

Can you tell us about your role and responsibilities within your facility? How long have you been working in this facility?

How long have you been a stakeholder in implementing iCCM services?

What do you know about the main objectives of the iCCM approach?

Who do you think the beneficiaries of iCCM are and how/why do they benefit?

### TOPIC 2: Problems and challenges

What are the main problems/challenges you have had to deal with in supporting implementation of iCCM? Have they been resolved? If so, how? If not, why not? (Explore: are there planning problems, input shortages for the activities, etc.)

What do you think are the barriers to accessing iCCM services offered by the CHWs?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What channels of communication are currently used to raise awareness of iCCM services amongst the population? Are they effective?

### TOPIC 3: Stakeholders' role in improving iCCM

Which groups or categories of people need to be involved to encourage the use of iCCM services offered by CHWs? (Explore: the nature of potential groups, ages and positions of resource people)

What role can partners play in promoting iCCM? Who should define the framework of this collaboration?

#### TOPIC 4: Support and Monitoring Initiative

How are the CHWs' iCCM services coordinated at village level, in the local health zone and at the level of the health district?

Can you describe the supervision mechanism for iCCM? Does your facility supervise the CHWs' activities? If so, how?

Tell us about the kind of support planned to help the CHWs improve the quality of the iCCM services they provide? By whom and how? (Explore: frequency, areas, time allocated, actors involved, the monitoring means, etc.)

What do you think are the strengths and weaknesses of your supervisory activities? (Explore: lack of funds, logistics, resources, planning failures, etc.)

Do the CHWs report iCCM data to the district level? If so, how frequently? What kind of information is included?

#### TOPIC 5: Suggestions and recommendations

What needs to be done to ensure the success of iCCM?

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM services? If so, what are they?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

## **F. INDIVIDUAL INTERVIEW FOR TECHNICAL & FINANCIAL IMPLEMENTATION PARTNERS**

### **Free and Informed Consent Form for Individual Interviews Technical & Financial Implementation Partners**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Individual/Small Group Interview Guides:**  
Technical and Financial Implementing Partners

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

**TOPIC 1: Project Relevance**

Please tell us about the objective of your project. What are your specific roles and responsibilities on the project?

In what ways does your project support implementation of iCCM in the district?

What do you hope to achieve in terms of support to iCCM services?

Who do you coordinate and collaborate with and at what levels?

**TOPIC 2: Problems and challenges**

What are the main problems/challenges you have faced or observed with regards to iCCM implementation? (Explore: are there planning problems, input shortages for the activities, availability of the population etc.)

Why do you think there is low utilization of iCCM services in this district? In your opinion what are the obstacles to utilizing iCCM services? (Explore: drug and FP input stock-outs; cost of services/medicines, remoteness of the site etc.)

What channels of communication are used to raise awareness of iCCM services amongst the population? Are they effective?

**TOPIC 3: Stakeholders' Role in improving iCCM**

Which groups or categories of people need to be involved to encourage the use of iCCM services offered by the CHW? (Explore: the nature of potential groups, ages and positions of resource people)

What role can partners like you play in promoting iCCM?

What role could partners play in making iCCM implementation sustainable?

What kind of health promotion activities or events might users appreciate the most? Can you talk about some examples of strategies for effective community mobilization?

**TOPIC 5: Suggestions and recommendations**

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

Are drug-stock outs an issue for CHWs providing iCCM services? If so, how can drug stock-outs be minimised?

Do you have any suggestions for managing progress made in iCCM?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM? If so, can you explain them?

What needs to be done to improve the quality of supervision of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

## **G. FOCUS GROUP DISCUSSIONS FOR CARETAKERS WITH SICK CHILDREN AGED 0 TO 59 MONTHS**

### **Free and Informed Consent Form for Focus Group Discussions: Caretakers with sick children aged 0 – 59 months**

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Focus Group Discussion Guide:**  
Caregivers of sick children 0 – 59 months

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

**Gender** \_\_\_\_\_  
**Age** \_\_\_\_\_  
**# of children** \_\_\_\_\_  
**# years of school attended** \_\_\_\_\_

TOPIC 1: Healthcare services and providers

Can you talk about the concerns of people in your community regarding treating childhood diseases such as diarrhea, malaria, and pneumonia?

Do you know the danger signs indicating that the sick child should be taken for treatment? (Explore for malaria, diarrhoea, ARIs and malnutrition, the procedure for seeking care for children under 5?)

Can you tell us about the kinds of care providers sought by the people in your community to treat sick children? (Explore this for the health center, CHW, traditional healers, travelling salesmen, etc.)

What do you think are the benefits of consulting each of these types of providers?

NB: If possible draw up a list of care providers in order of preference, and ask them to justify the rank of each provider.

(Explore to see: the difference between the quality of care offered by alternative caregivers and those of CHWs)

Are the services of certain alternative care providers more sought for certain diseases or health problems than others? If so, which health issues and why?

TOPIC 2: Knowledge of iCCM services

Are you familiar with iCCM services? If so, what can you tell us about them? (who are they provided by, what illnesses do they treat, etc.)

For those of you who have heard about iCCM services, how did you hear about iCCM services? From whom?

What kind of information would you like to know about the services CHWs can provide for sick children in your community?

Do you believe the information on CHW services is currently adequate?

### TOPIC 3: Perception of the CHWs

How is the CHW perceived by the members of your community?

Is it important to members of your community if the CHW is male or female? If yes, which is preferred and why? Is any other characteristic of the CHW important to the community?

Can you tell us about your expectations and your definition of quality service from the CHWs treating sick children? Do the CHW's current services meet your expectations? If so, why and how? If not, why not?

If you do not currently utilize CHWs when your children are sick, where do you take your sick child? Why?

What does the community think of the CHW's skills? What does the population think of the quality of iCCM services provided by the CHWs?

Tell us about the aspects of his/her services that you appreciate and the aspects that you don't. What do you expect from a CHW? (Explore the following aspects: skills, approach, attitude to patients and carers, etc.)

Do you think there is any difference between the iCCM services offered by the CHWs and those offered by health center health workers and private health workers? If so, please explain?

Do families not comply with the treatment and/or advice and guidance given by the CHWs? If yes, why not?

Do families ever refuse referral by the CHW of serious cases to the health center? If yes, what can be done and how?

### TOPIC 4: Access to care

Can you tell us about the main problems linked to accessing health services for sick children? (Explore: distance from the site, shortages of inputs, cost of medicines/services etc.)

Are iCCM services adapted to the demands of the community? If so, how? If not, why not?

How important is the financial barrier as a determining factor for low utilisation of iCCM services?

Have you ever taken your child to be treated by a CHW and they did not have the drug your child needed? If yes, what did the CHW do?

### TOPIC 5: Decision to seek services

In general, when do families decide to seek care outside the household when a child is ill?

What is the decision-making process and who takes the final decision?



Why do families get their children treated by alternative care providers even though treatment is available from trained CHWs?

Do you think that the distance between CHW sites and other sources of care (healthcare facilities, itinerant care givers etc.) come into the decision-making process for the first choice of services?

#### TOPIC 6: Prospects for improvement

Do you think there are some aspects of the CHWs' provision of iCCM services that could be improved? If so, what?

Which strategies do you think would be effective to attract and encourage people to consult the CHWs? What kind of health promotion activities or events might users appreciate the most?

Are there any other issues that we have not yet discussed that influence your decision on whether or not to seek care for your sick children from a CHW?

## H. FOCUS GROUP DISCUSSION FOR CHWS

### Free and Informed Consent Form for Focus Group Discussions: Community Health Workers

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

## Focus Group Discussion Guide:

### CHWs

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

### Demographics (record for all participants)

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

### TOPIC 1: Roles and responsibilities of a CHW

Can you tell us a bit about your role and responsibilities in your village as a CHW? How long have you been doing this work?

Can you tell us about the various training courses you have attended as well as the technical skills that you have acquired in child healthcare?

Can you describe the specific training(s) you have had in iCCM?

Do you believe there is high burden of childhood illness in your village? If so, do you believe the iCCM services you provide meet the demands of your target population? If not, why not?

On average how many sick children do you see a week? How many of those, do you refer to health centers for treatment?

### TOPIC 2: Problems and challenges

What is the degree of support and level of community involvement in your activities?

What problems or challenges do you most often face in your role as a CHW? How have you managed these problems? What support do you receive and from who?

What have been the main challenges for you as a CHW in providing iCCM services? Have you been able to find solutions to overcome these challenges? If so, what?

Do you experience drug-stock outs for iCCM medicines frequently? If yes, how do you think drug stock-outs can be minimised?

What do you think the barriers are to accessing healthcare in your community? (Explore: drug stock-outs; cost of services/medicines, remoteness of the site etc.)

How are CHWs perceived by the community? Are CHWs respected? (Explore: trust, appreciation of skills, sociability etc.)

How important is the financial barrier, or means to pay, in accessing iCCM services?

How does the presence of other care providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services? Are the services of certain alternative care providers more sought for certain diseases or problems than others? If so, which ones and why?

Are certain alternative care providers more affordable than others? (Explore who and if they believe this has an impact on utilization of services by this type of provider)

Do you think the public is adequately informed about the iCCM services you provide? If yes, how so? If not, why not?

What channels of communication have you used to raise awareness of the services you provide amongst the population? In collaboration with whom? Are they effective?

### TOPIC 3: Supervision

Tell us about the kinds of support you have received from your supervisors or local NGO workers?

(Explore further to know the frequency, areas, time allocated, etc.)

Can you describe the supervision mechanism and frequency for iCCM?

(Explore: actors involved, frequency, location, monitoring methods etc.)

Which aspects of your iCCM services does the supervision focus on?

What do you think are the strengths and weaknesses of the supervision activities?

How do you report on your iCCM services?

What specifically, do you report? How frequently? And to whom?

### TOPIC 4: Motivating CHWs

Can you tell us about any issues related to your working conditions that you feel have an impact on the quality of services you can provide? Are you satisfied with your working conditions? If so, why? If not, why not?

Is there support or are there materials/equipment that you need to improve your working conditions and performance as a CHW providing iCCM services?

What are the advantages and disadvantages linked to your work? Explain?

Can you tell us about your expectations in terms of remuneration?

What types of remuneration do you receive as a CHW? (Explore: per diems, salaries, performance incentives, in-kind gifts from community)

## TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

How can iCCM services provided by CHWs be improved and/or sustained?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

## I. FOCUS GROUP DISCUSSION FOR COMMUNITY LEADERS

### Free and Informed Consent Form for Focus Group Discussions: Community Leaders

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Focus Group Discussion Guide:**  
Community Leaders

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

TOPIC 1: Knowledge of iCCM

What is your role in the community?

What do you know about iCCM services? Has the Village Health Committee been involved? If so, what role does it play?

Can you tell us about the iCCM services CHWs' provide in your health zone?

Do you think the implementation of iCCM services has taken into account the community's concerns about treating childhood illnesses disease? If so, why? If not, why not?

TOPIC 2: Perception of the CHWs

How are they perceived by the people in the community?

What do you think prevents people from consulting CHWs for childhood illnesses?

Can you tell us about the strengths and weaknesses of the iCCM services in your area?

Do you believe your village/community benefits from the iCCM services that CHWs provide? Why or why not?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What do you think of the quality of the iCCM services offered by the CHWs compared to the services offered in your local health center?

### TOPIC 3: Roles of Community Leaders

Do community leaders play a role in monitoring the CHWs in the local health zone? If so, what role?

Can community leaders play a role in promoting iCCM services in the community? If so, what role and how? If not, why not?

### TOPIC 4: Suggestions and recommendations

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Do you have any suggestions for increasing utilization of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?



## J. FOCUS GROUP DISCUSSION FOR VILLAGE HEALTH COMMITTEES

### Free and Informed Consent Form for Individual Interviews: Village Health Committees

#### INFORMED CONSENT

My name is \_\_\_\_\_, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of \_\_\_\_\_.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of \_\_\_\_\_ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey?      YES /\_\_\_/      NO /\_\_\_/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee \_\_\_\_\_

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date .....

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

**Focus Group Discussion Guide:**  
Village Health Committees

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

**Demographics (record for all participants)**

**Gender** \_\_\_\_\_

**Age** \_\_\_\_\_

**# of Children** \_\_\_\_\_

**# years of school attended** \_\_\_\_\_

**TOPIC 1: Knowledge of iCCM**

How long have you been members of the Village Health Committee?

What are your roles and responsibilities as part of the Village Health Committee?

What do you know about iCCM services? Has the Village Health Committee been involved? If so, what role does it play?

Can you tell us about the iCCM services CHWs' provide in your health zone?

Do you think the implementation of iCCM services has taken into account the community's concerns about treating childhood illnesses disease? If so, why? If not, why not?

**TOPIC 2: Perception of the CHWs**

How are they perceived by the people in the community?

What do you think prevents people from consulting CHWs for childhood illnesses?

Can you tell us about the strengths and weaknesses of the iCCM services in your area?

Do you believe your village/community benefits from the iCCM services that CHWs provide? Why or why not?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What do you think of the quality of the iCCM services offered by the CHWs compared to the services offered in your local health center?

### TOPIC 3: Roles of the VHC

Does the Village Health Committee play a role in monitoring the CHWs in the local health zone? If so, what role?

Can the Village Health Committee play a role in promoting the iCCM services in the community? If so, what role and how? If not, why not?

### TOPIC 4: Suggestions and recommendations

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Do you have any suggestions for increasing utilization of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

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