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

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CHAMPION COMMUNITY APPROACH

IMPLEMENTATION MANUAL

Democratic Republic of Congo

Photo: Lynn Lawry; OSC Ltd. *Champion Community Capacity Building, December 2016, Tshumbe*

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Acronyms

AC	Animateur Communautaire-community health worker (CHW)
ANC	Antenatal Care
BCC	Behavior Change Communication
CAC	Cellule d'Animation Communautaire
CBO	Community-based Organization
CCPC	Champion Community Steering Committee
CHN	Community Health Nurse
CHV	Community Health Volunteer
CLTS	Community Led Total Sanitation
CMO	Community Mobilization Officer
CMT	Community Mobilization Team
CODESA	Comité de Développement Sanitaire
CPCC	Champion Community Steering Committee
CRS	Catholic Relief Services
CSO	Civil Society Organization
CUG	Closed User Group
DFID	Department for Internal Development-United Kingdom
DHIS	District Health Information System – DHIS2 Project Specific Indicators
DPS	Divisions Provinciales de Santé
DPT/HepB/HIB	Diphtheria, pertussis, tetanus, and hepatitis B and Haemophilus influenzae type b Pentavalent vaccine
E2A	Pathfinder/Evidence to Action
ETL	Education Through Listening
FBO	Faith-based organization
FP/RH	Family planning/Reproductive health
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSA	Health Surveillance Assistants
IEC	Information, education and communication
IHP/IHPplus	Integrated Health Project/Integrated Health Project Plus
IPC	Interpersonal Communication (door-to-door or household visits)
IPS	Inspection Provinciale de la Santé
IPTp	Intermittent Preventive Treatment in Pregnancy
IR	Intermediate result
M&E	Monitoring and evaluation
MSH	Management Sciences for Health
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
NCHS	National Community Health Strategy 2017-2021
NGO	Non-governmental organization
OSC	Overseas Strategic Consulting, Ltd.
OVC	Orphans and Vulnerable Children

PNDS	*Plan National de Développement Sanitaire* (PNDS) 2016-2020 (National Health Care Strategy)
RECO	Community health volunteer
SBC	Social and behavior change
SBCC	Social and behavior change communication
SHSA	Senior Health Surveillance Assistants
SILC	Savings and Internal Lending Communities
SGBV	Sexual and Gender-Based Violence
SMART	Specific, Measurable, Attainable, Reliable and Time bound
SMS	Short Message Service or "cellular messaging"
STI	Sexually Transmitted Infection
TA	Traditional Authority
TB	Tuberculosis
UNICEF	United Nations Child Fund
USAID	United States Agency for International Development
USG	United States Government
VSLA	Village Savings and Loan Association

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Introduction

This manual was developed to guide the implementation of the Champion Community approach for IHPplus and its partners. The manual was created to increase participant knowledge of the Champion Community strategy and approach and to provide staff and stakeholders with information, basic concepts, procedures, and the necessary guidelines for coordination of implementation at all stages of the strategy, and to be able to measure its effectiveness.

The aims are to strengthen the capacity of grassroots community facilitators to better communicate health issues and address problems faced by the intervention provinces and health zones at the community level through the use of strategies adopted in the strategic communication plan for social and behavior change (SBCC) and to plan activities.

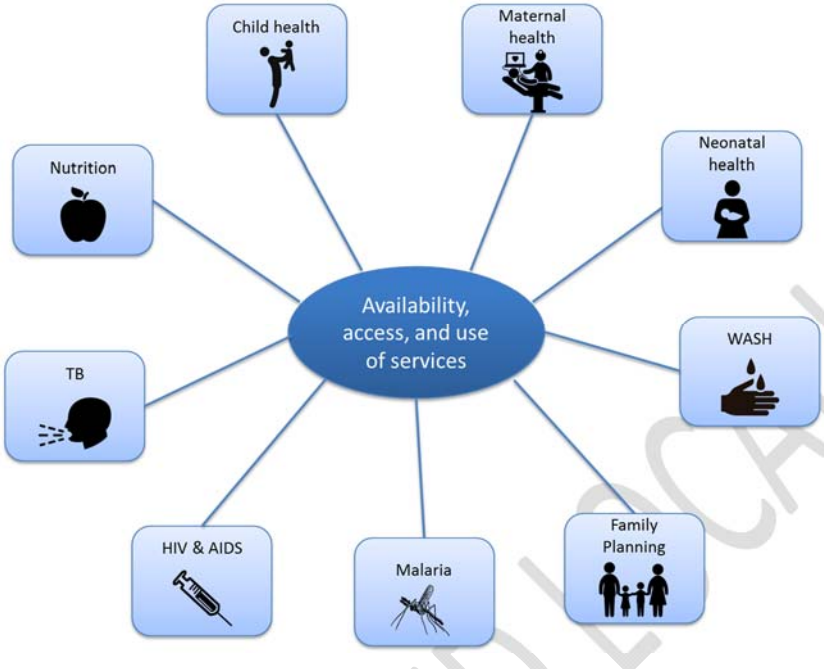
The manual is subdivided into seven parts. The first part explains the definitions and basic concepts, the history, the vision, the objectives of the Champion Community approach, and how it generates health development. The second part explains how to utilize communication strategies in the implementation of the Champion Community approach to produce the adoption of healthy behaviors in the population. The third and fourth parts present the challenges faced by IHPplus and the implementation framework of the Champion Community, including its variations such as Champion Men and Champion Youth. The fifth part explains the role of women as Champion Mamas (Mothers' Action for Maternal Advancements). Finally, the sixth and seventh part provide information on the steps to the implementation and sustainability of the approaches and interventions and techniques for monitoring and evaluating the activities of the Champion Communities.

This manual is intended to be a "living document" and thus can be updated on a regular basis to reflect the development of Champion Communities in the Congolese context and based on evaluation and learning updated with further context. Case studies should be added during the process of development of the Champion Communities and successes documented to illustrate the effectiveness of the Champion Community approach as a modality for behavior change.

Background

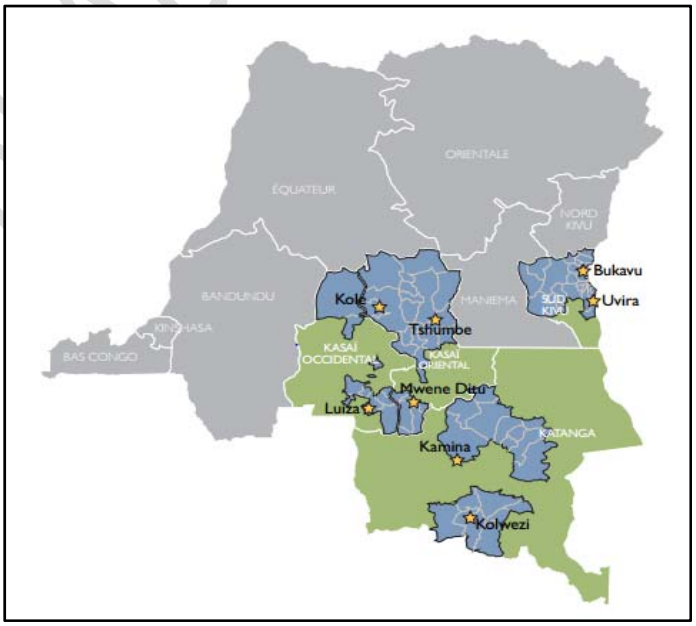
The United States Agency for International Development (USAID) Integrated Health Project (IHP) 2010-2015 and the Integrated Health Project Plus (IHPplus; 2016 to 2018) was implemented by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd. (OSC), under a subcontract via Pathfinder/Evidence to Action (E2A) with the government of Democratic Republic of the Congo (DRC) to strengthen the country's health system at every level. The activities focused on maternal, newborn, and child health, family planning, nutrition, malaria, tuberculosis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), and water, sanitation, and hygiene (WASH)—applying many proven, low-cost, high-impact innovations on a large scale. (Figure 1)

Figure 1: IHPplus objectives and focus areas



The project's health systems strengthening component included improved implementation of selected policies, program advocacy, and decision-making, particularly at the provincial levels. IHPplus worked in 126 target health zones in nine *Divisions Provinciales de Santé* (DPS): 1) Kasaï; 2) Kasaï Central; 3) Lomami; 4) Kasaï Oriental; 5) Sankuru; 6) Haut Lomami; 7) Lualaba; 8) Sud Kivu; 9) Haut Katanga (formerly the four provinces of Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu). (Figure 2)

Figure 2: IHPplus intervention health zones



OSC, a subcontractor on IHP and IHPplus, was specifically tasked to implement activities that increase the demand for quality priority health services related to Intermediate Result 3 (IR3) through Social and Behavior Change Communications (SBCC). OSC focused on increasing knowledge, attitudes and practices to increase health-seeking behaviors, and in particular high impact health services, in target health zones. (Table 1)

Table 1: IR3 IHPplus

Intermediate Result 3: Knowledge, attitudes, and practices to support health-seeking behaviors increased in target health zones	**IR 3.1**: Health-sector community outreach linkages ✓ CODESA ✓ Youth outreach groups
	IR 3.2: Health advocacy/community mobilization organizations ✓ Education through listening (ETL) ✓ CODESA
	IR 3.3: Behavior change campaigns ✓ BCC messaging

Champion Communities and the National Health Strategy 2016-2020

Maternal, newborn, and child health (MNCH) in DRC is hindered by excess mortality from preventable causes such as early marriage (18%), low prevalence of contraception (8%), elevated rates of an unmet need for contraception (28% adults; 31% adolescents), and the high prevalence and complications of pregnancy among adolescents.[1] The most recent mortality rates are 846 maternal deaths/100,000 live births, 28 neonatal deaths per 1000 live births, and 58 infant deaths per 1000 live births.[2]

However, there are many other factors present in DRC that lead to excess mortality and poor MNCH, including poor nutrition, lack of adequate services for antenatal and postnatal care, poor immunization coverage for women and children, and elevated rated of malaria and low treatment rates.[3] In addition, the elevated sexual and gender based violence rates in DRC have a profound effect on MNCH.[4] Pregnant women are at the greatest risk for interpersonal violence with associated immediate risks to the mother and unborn child.[5] Increases in chronic problems such as depression, substance abuse, bleeding, lack of access to prenatal care, and poor maternal weight gain have been documented in pregnant survivors.[6]

[1] Demographic and Health Survey, Democratic Republic of Congo (2013-2014). https://dhsprogram.com/publications/publication-FR300-DHS-Final-Reports.cfm.
[2] Ibid.
[3] Demographic and Health Survey, Democratic Republic of Congo (2013-2014). https://dhsprogram.com/publications/publication-FR300-DHS-Final-Reports.cfm.
[4] Demographic and Health Survey, Democratic Republic of Congo (2013-2014). https://dhsprogram.com/publications/publication-FR300-DHS-Final-Reports.cfm, Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Democratic Republic of Congo. JAMA. 2010. 304(5):553-562 and Scott J, Polak S, Kisielewski M, McGraw Gross M, Johnson K**,** Hendrickson M, **and Lawry L**. A Mixed-Methods Assessment of Sexual and Gender-based Violence in Eastern Democratic Republic of Congo to Inform National and International Strategy Implementation. International J of Health Planning and Management. 2012; DOI: 10.1002/hpm.2144.
[5] J. Campbell, C. Garcia-Moreno, and P. Sharps, Abuse during Pregnancy in Industrialized and Developing Countries. Violence Against Women, 2004.
[6] Ibid.

Children of abused women have a higher risk of death before reaching age five and violence during pregnancy is associated with low birth weight of babies.[7] Forced and unprotected sex and related trauma increase the risk that women will be infected by sexually transmitted infections (STI) and HIV in addition to physical trauma that can be associated with this violence.

Building a strong community health system is core to DRC's development agenda: the *Plan National de Développement Sanitaire* (PNDS) 2016-2020 was developed by the Government of DRC in collaboration with its partners to bring effective and realistic solutions to the health problems of the people of the DRC.[8] The main objective of the PNDS is to improve the health status of the population and to promote the health of well-being of everyone within the framework of universal health coverage. A secondary goal and objective of the strategy is to increase coverage and utilization of health services and health quality by the population with equity and financial protection by improvement of health coverage. Other main goals include the rational implementation of functional care systems, improving the quality of the service packages offered to the population, improving the resilience of structures and health services in the face of epidemics, emergencies and disasters, and improving the supply of structures secondary and tertiary referral to increase the proportion of organized, and accessible health structures geographically. These goals are to integrate services, provide care and increase quality health services by 30 to 60%.[9]

At the community level, the goal is to increase the proportion of community participation structures involved in the provision of some care services (promotional, preventive and curative), at the health zone level by 50%. To do this, the PNDS focuses on strengthening community dynamics, promoting health services and extending community care sites to health areas lacking coverage in accordance with health zone coverage plans.

DRC has 516 health zones with 393 general referral hospitals (GRH). There are 8,504 health areas with 8,266 health centers intended to extend primary health care to approximately 5,000-10,000 persons. The health zone is managed by a health zone management team headed by the Chief Medical Officer who is responsible for the oversight and development of a health system that provides integrated, continuous, quality, and holistic health care at the health area level through the health centers. The Champion Community approach, which is owned and sustained at the health area level, is established to encourage community members to decide their health priorities and teach them to sensitize on priority health issues within their communities. This Champion Community approach through the health area level fits within the PNDS to strengthen the community dynamics that help in the promoting health services and the health of communities.

[7] Ibid.
[8] PNDS (2016-2020), http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/democratic_republic_of_congo/pnds_2016-2020_version_finale_29_avril_2016.pdf.
[9] Ibid.

Select Definitions and SBCC Concepts

Community: For the purposes of this manual, local community is defined as the relationships between people living in a common space: It is a local space constituted of a village or grouping of villages within a health area, or an area occupied by persons who organize themselves to pursue their interests.

Community Approach: By noting that the main determinants of health and disease are socio-economic and cultural, it is about making communication a tool for social change and not just a change in behavior. The community approach recognizes the community as an active "partner" for change, which itself has the definition of the problems experienced, the means and the solutions to solve them.

Champion Community: This Champion Community approach is based on ownership and sustainability. Communities participate in the approach and strive to achieve objectives they have set themselves. Communities that fulfill workplan objectives within the timeframes they have set are considered "Champion Communities." The goal is to gain NGO status and create income generation that allows them to continue the process of behavior change through SBCC independently.

Autonomous Champion Communities: Successes achieved by communities adhering to the approach can motivate neighboring communities to emulate them and adopt the approach. This creates autonomous generation of Champion Communities to extend the reach.

Health communication: A broad term that describes strategies to share information that can lead to better health outcomes. Activities can vary widely, depending on the objectives, audience, and communication channels and can include a health communication designed to advocate essential changes in health regulations to policymakers; or the use of interpersonal communication to promote actions that prevent childhood illness and promote breastfeeding.

Health education: Any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes.

Information, education, and communication (IEC): The use of mass media in disseminating health information which can range from didactic one-way communication to entertaining methods that give recommendations to an audience. Fundamentally, the IEC approach assumes that people will follow health advice when they are provided with the “correct” information.

Peer education: Based on the involvement of "peers" in educational activities, this approach tends to help them to adopt behaviors favorable to their sexuality/health but also in relation to lifestyles.

Proximity approach: The communication action comprises a set of messages delivered to individuals or groups by health professionals trained to ensure face-to-face contact with the target population.

Social mobilization: A process of rallying to action by a large number of people to achieve a societal goal through individual efforts. It engages different levels of society such as decision makers and managers, providers, the media, non-governmental organizations, the community and users.

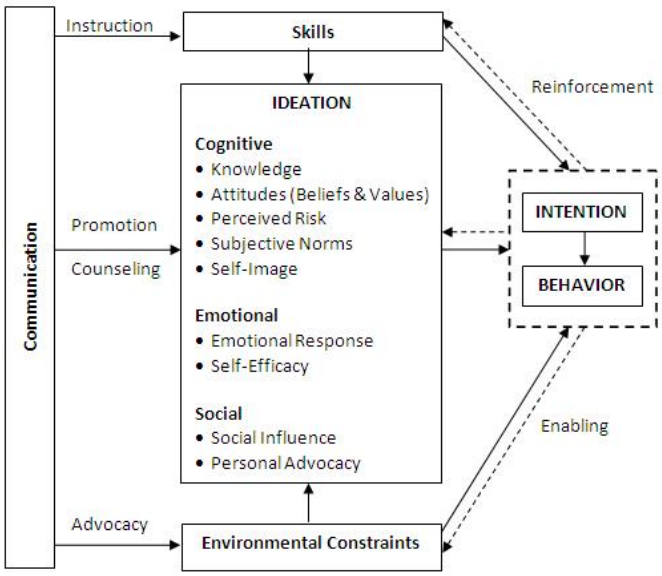
Social marketing: It is a comprehensive and systemic approach involving the design, implementation and monitoring of programs to gain acceptance or rejection of ideas. Social marketing tends to provide good service, to the right person, at the right time at a decent price. It is also a proximity approach, it guarantees a certain ease of communication on sensitive topics.

Social and Behavior Change Communication: A framework that uses the strategies of advocacy, social and behavior change communication (SBCC) and community mobilization to influence both individual and societal change (Figure 3). SBCC includes the systematic application of interactive, theory-based and research-driven communication processes and strategies to address change at individual, community, and societal levels through mass media, mid-media and interpersonal communication.

SBCC core elements:

- Communication using channels and themes that fit a target audience's needs and preferences
- Behavior Change through efforts to make specific health actions easier, feasible, and closer to an ideal that will protect or improve health outcomes
- Social Change to achieve shifts in the definition of an issue, people's participation and engagement, policies, and gender norms and relations.

Figure 3: How SBCC and BCC change behavior[10]



In this model or SBCC conceptual framework (Figure 3), promotion leads to ideational change or how individuals and populations view given practices and behaviors and is designed to have a cognitive, emotional and social effect on a behavior. The model specifies how and why communication affects intention and behavior: indirectly through its effects on skills, ideation, and environmental constraints.

[10] From: https://www.measureevaluation.org/prh/rh_indicators/service-delivery/bcc

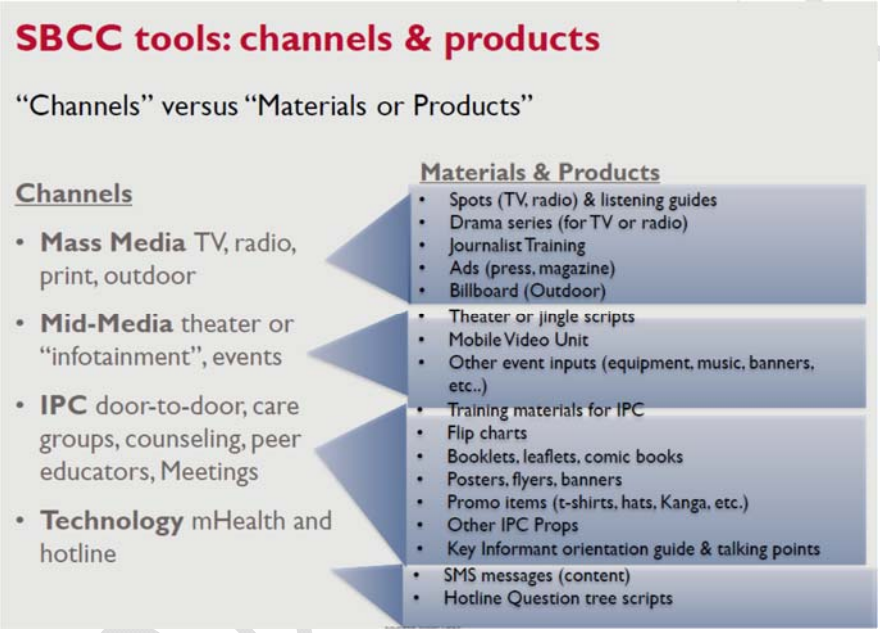
Communication is meant to influence a person's intent to practice a certain behavior and to follow through in doing so. In any population, there are inevitably environmental constraints to behavior change that exist; among them, politically based barriers, resource limitations, legal constraints, and other factors. Advocacy becomes a powerful tool to confront these constraints at the macro level and to minimize barriers to positive behavior at the individual level.

BCC programs include a wide range of interventions (Figure 4) that fall into three broad categories:

- Mass media (radio, television, billboards, print material, the internet);
- Interpersonal communication or IPC (client-provider interaction, care groups etc.); and
- Community mobilization.

Any of these three types of communication can generate the results measured by these core indicators, including changes in knowledge, attitudes, intentions, and behavior. The Champion Community approach uses all three of these interventions to maximize the effect (improved health) and maximize behavior change.

Figure 4: Examples of SBCC tools: Channels and products



Accelerator behaviors and/or the continuum of care approach for MNCH includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood to reduce maternal, neonatal and child deaths and improve health. However, barriers to MNCH are more than the lack of access to focused antenatal care (ANC). Minimal education and little desire for contraception which impact maternal health and mortality.[11] If ANC is understood by women as sick visits instead of focused (preventive) ANC or health care providers do not administer ANC as

[11]Gakidou E, Cowling K, Lozano R, Murray CJL. Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. The Lancet. 2010; 376 (9745): 959 – 74; and Ahmed S, Qingfeng L, Lui L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. The Lancet. 2012; 380 (9837):111 – 25.

prescribed, women, infants and children suffer. The proper use of mosquito nets especially for pregnant women and children has an impact on health; simply supplying a net does not ensure it is used correctly. Early and exclusive breastfeeding has a tremendous impact if practiced; if not, it puts a significant number of newborns and infants at risk for diarrhea and death.[12] The overall lack of knowledge of danger signs, low use of skilled attendance at birth and the preferred use of largely untrained birth attendants or home births put women and newborns at significant risk and represent barriers to MNCH. Other less well understood factors present barriers to MNCH and include time and distance needed to fetch clean water, especially while pregnant and the overall lack of clean water. Finally, the presence of systematic and accepted violence in the community, largely addressed to women and children due to negative social norms will continue to add to barriers to health for women, newborns and children.

Understanding the accelerator behaviors, in the DRC context, specific to each coordination is paramount to address behaviors through specific messaging.[13] In this understanding, only then can messaging and social mobilization change deeply held beliefs, develop and cultivate a critical mass of supporters, expose communities to better services/solutions, create precedents and inevitably help communities realize health and enact behavior change.

Background

The Champion Community approach is an innovative and successful community mobilization tool that has been employed in several countries. Champion Communities foster community mobilization and institutionalize community leadership to engage community members in improving health outcomes, conducting outreach within their community, and becoming invested and involved in the development of their community.

In Madagascar, the approach significantly contributed to improving health indicators at the local community level. The approach was implemented for the first time in Madagascar from 1999 to 2003 on the Jereo Salama Isika-Linkages project supported by USAID at the request of the MOH to ensure the promotion of community mobilization and the attainment of specific health objectives.

Subsequently, it was scaled up by the Voahary Salama Consortium (with Packard financing). In 2004, the Santénet 1 project implemented the approach, followed by the Santénet 2 project. The results were convincing: the approach under these two USAID funded projects gave rise to 800 Champion Communities throughout Madagascar. The USAID-funded MIKOLO project (2011) used the approach to increase the adoption of health-seeking behaviors in family planning and reproductive health; MNCH; HIV/AIDS prevention; WASH; and malaria prevention and treatment utilizing several levels of Champions at the household, *fokontany*, and commune levels.

Recently Ethiopia and Jordan have also begun to experiment with the approach by focusing on behavioral changes of adolescents and young people and other organizations are using Champion Communities to address similar gender issues.

[12] Darmstadt GL, Bhutta ZA, Cousens S, Adam T, Walker N, De Bernis L. Evidence-based, cost-effective interventions: how many newborn babies can we save? Lancet. 2005; 365(9463):977-88; World Health Organization. Opportunities for Africa's Newborns. http://www.who.int/pmnch/media/publications/oanfullreport.pdf. Accessed 11 Dec 2015.

[13] Lawry et al. A mixed methods assessment of barriers to maternal, newborn and child health in Gogrial West, South Sudan. January 19, 2017 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0269-y.

The USAID-funded Integrated Health Project (IHP), followed by IHPplus, used the Champion Community approach to improve the enabling environment for, access to, and quality of health services in 126 target health zones across the provinces of Kasaï Occidental, Kasaï Oriental, Katanga, and Sud Kivu in the Democratic Republic of Congo (DRC). Focus areas include RH/FP, MNCH, malaria, WASH, nutrition, tuberculosis (TB), HIV and AIDS, and gender-based violence. Adapting the original approach, IHP and IHPplus created Champion Communities, Champion Mamas, and Champion Men; all of which are independent, sustainable, and naturally transitioning due to the attainment of non-governmental development organization (NGO) status and successful income generation. In doing so, these Champion Communities can obtain outside funding to continue sensitization projects in their communities. They have also motivated and mentored neighboring communities to emulate them and adopt the approach. Thus, for every Champion Community developed in IHPplus, on average, three autonomous Champion Communities have geographically extended the reach of community mobilization, improved health outcomes, and improved outreach to other communities; an example of value for money.

The Champion Community Approach: Objective, Vision, and Aim

The main objective of the Champion Community method is to promote community mobilization. The approach helped IHPplus achieve the following objectives:

- Engendered and increased enthusiasm and commitment within community members by strengthening the managerial capacities of community organizations and by setting up structures that can supervise communities
- Created a culture that encourages actions that achieve the approaches' objectives
- Ensured community members commit themselves resolutely to overcoming challenges and work towards project goals by signing contracts and independently implementing health improvements
- Monitored activities carried out by the Champion Community measured against the action plan
- Impact evaluation of indicators from the action plan to refine activities
- Celebrate the successes of communities attaining "Champion Community" status

The vision of the Champion Community Approach is to have local communities that are distinguished by the determination and willingness of their members, leaders and political-administrative authorities to achieve a very high level of community health and development.

The aim of the Champion Community approach is to accelerate behavior change through community mobilization activities, with the effective participation and involvement of the stakeholders involved, who are convinced of the priority of family and community health and of the management of its human resources for the development of the community. This commitment is achieved through a combined effort of decision-makers and all community and traditional leaders to undertake joint activities to achieve pre-defined health goals.

How Champion Communities foster community-level health development

IHP and IHPplus integrated the sustainable Champion Community approach into its strategy for SBCC and community health communications as a "bottom up" approach to support the work done at the health area level but implementing the health messaging and community ownership at the village level.

The Champion Communities play the role of accompanying the project's communications strategies, facilitating, promoting, and accelerating the achievement of IHPplus' health objectives. The method utilizes existing community organizations and structures (if available). It has the advantage of integrating other sectors, such as agriculture and rural development, inducing synergy in the implementation of activities at the grass-roots level. To successfully support development actions at community level, the approach, for IHPplus, was ideal and fits into the PNDS national health strategy. The Champion Community approach is based on the following principles:

Participatory Planning

Participatory planning is essential for:

- Identifying health problems specific to the local context
- Resolving gender and youth barriers to care and highlighting gender specific issues
- Finding appropriate solutions to these problems
- Selecting participants for implementation within the community
- Defining strategies to be put in place with the community
- Carrying out follow-ups and evaluations of activities in partnership with the community

Create enthusiasm of the community to improve health

- Increase understanding of the approach through targeted training in a participatory way between stakeholders
- Accompany community volunteers and community workers for community mobilization within the communities
- Provide technical capacity building for the achievement of the action plan objectives

Encourage community members to adopt health-friendly practices and take ownership of successful actions

Champion Communities help their communities to understand and realize the benefits of achieving a very high level of health at the individual, family and community level for development. This is reflected in the fact that the community is supported to take charge of their state of health, which will have a significant impact on the productivity of the population and the socio-economic development of the community. For example, the approach encourages people to change attitudes and behaviors to contribute to the reduction of morbidity and mortality from various diseases and/or conditions, especially for mothers and children. The same applies to other areas of health.

Regional Exchanges: Sharing successes and improvements in the search for new strategies

The involvement of all the stakeholders in the approach of defining the objectives to be achieved in the behavior change messaging is a key factor for success. Exchanges for discussion and problem solving among diverse groups are important for continuing to define and improve the Champion Community approach. Yearly regional or zonal exchanges become useful for inter- and intra-group communication.

There were four regional conferences by local language to ensure participation of women.

- 27-28/4/2018 Bukavu and Uvira (Bukavu)
- 27-8/4/2018 Luiza and Mwene Ditu (Mbuji Mayi)
- 3-4/5/2018 Kamina and Kolwezi (Lubumbashi)
- 3-4/5/2018 Tshumbe and Kole (Lodja)

Objectives of the conferences:

- To serve as a regional exchange of experiences between the champion communities of the eight coordinations
- Support and develop the creation of networks to maintain inter-and intra-community exchange of experience even after the end of IHPplus
- Consolidate interdependence and teamwork with or without partners support for the sustainability of the achievements of community development and the approach
- Further support the ability of Champion Communities to seek support from other donors and/or partners
- Document (written and video) the successes and challenges of the approach through the lens of the Champion Communities themselves
- Develop lessons learned and recommendations for the future of the approach in DRC based on the views and discussions of the Champion Communities

Both IHPplus and autonomous Champion Communities were invited. One male, one female and one youth member, elected by the community attended. Each Champion Community gave a short and precise presentation to highlight successes and challenges. There were two, 90-minute sessions, one on the first day, and the other on the second day.

These working groups were:

- Mediated by BCC specialists, DPS, and Chief Medical Officers
- Topics included income generation, women and youth, successes, challenges and the future of the approach
- The "Five Whys" method was stressed to develop ideas more than just surface concepts
- Presentations after each working group with discussions and questions
- A full report of the conferences pending

Observations:

- Conference objectives were accomplished
- Discussions were "vibrant"
- Women were the word of reason when discussing the future of the approach and the need to rely on income generation
- There was still some resistance to changing the handout mindset even with outside funding and income generation; some Champion Communities were more resistant than others
- Networks established between groups with the Kamina and Kolwezi Champion Communities electing a committee to arrange communication and other exchanges between the groups
- The Bukavu Champion Communities met after the conference to also establish a means to communicate and to have smaller exchanges between groups.
    - Champion Mamas in Ruzizi established a second autonomous Champion Mamas in Katana after the conference

The full report has been sent under separate cover.

Opportunities for the Establishment of a Champion Community

Internal Opportunities

Among the factors that favor the implementation of the Community Champion approach include the current administrative structures that are already in place and well-structured from top to bottom:

- The MOH at the national level
- The DPS level
- The zonal level of health, through the placement of a Chief Medical Officer
- Health areas with a local health centers that serve a catchment area of approximately 10,000 persons

Other support structures in place and functional from the strengthening of IHPplus for community mobilization:

- For intervention health zones, IHPplus has an office at the Coordination level (Table 2)
- At the health area level, the *Comité de Développement Sanitaire* (CODESA), which coordinates the activities of volunteers (*relais communautaires*) within community structures and have capacity built through the project which can include women's groups, youth leaders/groups like the Scouts and community mobilizers or community health worker (CHW) (*Agent Communautaire* [AC])
- Stakeholders and partners such as non-governmental organizations (NGOs), community-based organizations (CBOs), civil society organizations (CSOs), and faith-based organizations (FBOs) that have interest in community mobilization initiatives and/or contribute to development projects at the community level

Table 2: Coordination Offices for IHPplus (May 2018)

COORDINATION	Local Provincial or IHPplus Office
Luiza	DPS/Kasaï Central
Kole	DPS/Sankuru
Tshumbe	DPS/Sankuru
Mwene Ditu	DPS/Lomami
Kamina	DPS/Haut Lomami
Kolwezi	Bureau IHPplus
Uvira	Bureau IHPplus (Bukavu)
Bukavu	Bureau IHPplus

External Opportunities

The following external factors are favorable and/or necessary for the implementation and sustainability of the Champion Community approach:

- External partner support and trust
- Local health authority support, trust and involvement
- Confidence and support at all levels of engagement of local leaders (traditional, religious, opinion leaders and community leaders)
- Approval and support from the health zone authorities and the Ministry of Public Health which was the mainstay of IHP and IHPplus
- Availability of health services and products at the health facility level[14]
- A strong and engaged Champion Community Steering Committee (CPCC)[15]
- Other USAID initiatives and projects, other donor programs that work in collaboration with the project

When does a community become a "Champion Community"?

A community becomes "Champion Community" when it improves health indicators as defined by the action plan within a period of at least six months among the 3-4 health areas of implementation. The indicators should be prioritized by all participants involved at the community level and by data collected at the health center and in the community. They should also be defined by available local resources or those mobilized to ensure the necessary support to achieve the objectives (i.e., the services are available at the health facility level).

A community is considered a “Champion Community” when the following criteria are met:

- Coverage of 20-40,000 persons/beneficiaries in 3-4 health areas[16]
- Training on the Champion Community approach among the members
- Members represent all health areas within the Champion Community
- The Champion Community has a gender balance that includes *at least* ~40% men, ~30% women and ~30% youth
- Throughout the implementation process, administrative, traditional and community leaders are involved
- Works within community structures as described within the PNDS
- The group has an action plan that is updated every six months/annually
- Progress has been made according to the Champion Community action plan and indicators

The goals set by the community and its partners should not be too easy or too difficult to achieve. In general, three to five goals per action plan cycle is the most appropriate. The major consideration in this framework is that the community determines its objectives that require a reasonable effort of the population to do the community mobilization. This requires freedom and ownership of decision-making by the community to design realistic community mobilization approaches with well-defined indicators.

[14] For community mobilization efforts to succeed, there must be a functional health facility or the SBC efforts at the community level will not be effective.

[15] Includes the elected President, Vice-President, Secretary, Treasurer, health center nurse/CHW or the like, village or territorial chief among others

[16] In DRC, this varies due to the differing sizes of the health areas and the Champion Community refers to 3-4 health facilities and sometimes more if there are private health centers in the health areas.

In doing so and seeing success it is our experience that communities feel motivated to continue efforts to ensure the welfare of its population.

Champion Community in Kole Photo: Lynn Lawry OSC Ltd.

''The vision of the Community Champion approach is to have local communities that stand out''

Champion Community Sub-groups

Champion Men

Social norms and values influence how women and children are protected or harmed. Social norms do not function in isolation but are defined in local culture and tradition as a type of cultural identity. Changes to these norms require engagement and consensus over time to make positive changes in social norms, especially in regard to women, including early marriage, protection of women and children, and SGBV.[17] There are however, statistics that support changing norms in communities. For example, SGBV has a profound effect on MNCH, and pregnant women are at the greatest risk and associated immediate risks to the mother and unborn child.[18] Children of abused women have a higher risk of death before reaching age five and violence during pregnancy is associated with low birth weight of babies.[19] However, it should be noted that violence affects the community at large such that girls, boys and women and men all suffer from violence. In addition, addressing early marriage and the inability to negotiate sex, education, prevention, and testing are important to decrease the 75% greater risk of HIV among girls who marry early.[20] Contraception is an effective primary prevention

[17]World Health Organization. Changing cultural and social norms that support violence. http://www.who.int/violence_injury_prevention/violence/norms.pdf (Accessed December 11, 2015).

[18]Campbell J, Garcia-Moreno C, Sharps P. Abuse During Pregnancy in Industrialized and Developing Countries. Violence Against Women 2004; 10(7): 770-789.

[19]Asling-Monemi K, Peña R, Ellsberg MC, Persson LA. Violence Against Women Increases the Risk of Infant and Child Mortality: A Case Study in Nicaragua. *The Bulletin of the World Health Organization* 2003; 81: 10-18.

[20]Clark, S. (2004). "Early Marriage and HIV Risk in Sub-Saharan Africa." Studies in FP35(3) pp. 149-160 and Adhikari RK. Early marriage and childbearing: risks and consequences. In: Bott S, Jejeebhoy S, Shah, Puri C, eds. Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia. Geneva: World Health Organization 2003: 62–66.

strategy that decreases maternal mortality by 44%; additionally, satisfying the unmet need for contraception decreases this risk another 29%.[21] Finally, education is a primary indicator for health especially among women. It is well known through demographic health studies that mothers with no education have higher rates of children with stunting and nutritional deficiencies than mother with at least secondary education. Furthermore, for every one-year increase in the average education of reproductive-age women, a country will experience a 9.5 percent decrease in the child deaths. With more schooling, women tend to have fewer children and space births more widely, both of which also reduce child mortality, therefore, education is a message that is important for the health of communities and vitally important for MNCH.[22]

Champion Men addresses these issues at a local level and allows communities to find ways to change perceptions and social norms that result in better health for their communities. Champion Men is a sub-group of the Champion Community that strives to change men's attitudes towards women and increase dialogue among household members in communities where they work. (See Annex XI for the Champion Men Implementation Guide.)

Engage Champion training, Tshumbe Photo: Lynn Lawry OSC Ltd.

[21]Ahmed S, Qingfeng L, Lui L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. The Lancet 2012; 380 (9837):111 – 125.

[22] Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. Gakidou, Emmanuela et al. The Lancet, 2010. 376 (9745): 959 – 974.

Champion Women (Champion Mamas)

Champion Mamas, Mulangaliro UVIRA Photo: Lynn Lawry; OSC Ltd.

A sub-group of the Champion Community, women within the Champion Community take on a more intrapersonal approach (case management approaches) by identifying pregnant women and/or women with children <2 years in their community to ensure women make antenatal and postnatal care visits, recognize danger signs of pregnancy, and child health issues, have assisted delivery at the health centers, are seen for symptoms of malaria during pregnancy, bring in their children for vaccinations, understand the importance and adhere to early, exclusive and longer term (at least up to 23 months) breastfeeding , among other prioritized MNCH topics for communities. Like the Champion Community, Champion Mamas may have a separate income generation project to support activities for MNCH and/or to support/pay for emergency evacuations for community women. In DRC, Champion Mamas efforts have statistically documented increases in access to care. They have also had measurable statistical impact on MNCH.

Champion Youth

Another specialized sub-group of the Champion Community is for youth within the Champion Community who take on youth specific messaging in the community. Common messages include family planning, staying in school, drugs, alcohol, early marriage and HIV/AIDS. Champion Youth in DRC have been used by the MOH to communicate specific health messages tied to mini-campaigns. And although Champion Youth tend to use mass media in some cases they will employ interpersonal approaches for at risk groups. Schools and sporting events have been usual places for BCC messages to be passed for youth specific health needs. Some Champion Youth have used gaming (foosball tables) as a means for gathering youth where messages can be passed; others have used soccer events to reach larger groups

of youth. Youth have been the most creative in message development modalities including puppet shows, plays, songs and creation of soccer teams that not only compete, but deliver messages during games. In DRC, the use of Champion Youth can be implemented in areas where youth clubs do not exist, or they can be integrated into youth clubs to ensure sustainability. A handful of Champion Youth have applied for NGO status (RACOJ Champion Youth in Mwene Ditu gained NGO status in March 2018) and have gotten outside funding which has made their efforts sustainable.

Champion Youth, Lodja, DRC Photo: Lynn Lawry

Puppet Show, Madagascar Photo: Lynn Lawry

Priority Intervention Strategies of Champion Communities for Community Mobilization within IHPplus

IHP and IHPplus' *Tuendeni-Kumpala* BCC strategy included community mobilization interventions such as the Champion Community approach, ENGAGE Champions (Champion Men), Champion Mamas, VITALITY Champions (Champion Youth), and mobile-phone based interventions (mHealth) which included SMS campaigns, Closed User Groups, and community-based hotlines ("Green Line"). The Champion Community approach first implemented in 2012 by the IHP project was a participatory framework used to create a platform for communities to identify and respond to local health challenges and was scaled up for IHPplus. Overall, BCC campaigns were implemented to increase awareness, change detrimental health behaviors and increase the use of high-impact health services, products and practices defined as:

- Family planning
- Maternal and child health (MNCH)
- Nutrition
- Malaria
- TB
- HIV and AIDS
- WASH

In addition to existing strategies for community mentoring and mobilization, the strategy used new approaches to strengthen community dynamics and increase knowledge, demand, and use of health services and products improving the health of targeted Congolese families--especially women and children.

The Community Champion approach was one of the approaches for IHPplus that was the backbone of IHPplus health systems strengthening through SBCC activities in the project's original 78 health zones. As a community initiative, the main principle of the approach was to strengthen cohesion and community dynamics, to develop the community by engaging its members in the improvement and management of their own health and its socio-economic development. To achieve this, the commitment of community members to self-promotion of their health is fundamental and crucial and was at the heart of the IHPplus efforts to reduce maternal, newborn, and child mortality through improved access to MNCH (including nutrition), FP/RH, malaria, and WASH services; improved quality of these four priority health services; strengthened health systems in support of MNCH, FP/RH, malaria, and WASH; and increased community demand for these priority services. Supplementing and building the capacity of the Champion Communities, other complimentary SBCC approaches were also used: ETL, "Cellular messaging (SMS)" and / or partnerships with radio listening groups, community radio stations, peer education, "town crier" messaging (mini-campaigns), mini dramas, and household visits (IPC). Part of the Champion Community approach to develop ownership was to allow the community to decide "what works" for them.

Education Through Listening

Education Through Listening is a participatory approach to education and community mobilization that is based on the theory of stages of behavior change (knowledge, approval, intention, practice, advocacy) and stage theory (Prochaska & Declementis), also developed in four stages (Pre-contemplation, Contemplation, Preparation, Action, Maintenance, and Relapse). These different stages constitute the stages of change for the community that a good mobilizer must master in order to lead his or her community to the expected or desired change. For Champion Communities, ETL will have a key in community education on health communication to enact behavior change that will improve access to MNCH, FP/RH, malaria and WASH services.

Community Radio

Community radios complete the Champion Community approach by increasing the scope and repetition of BCC messages through a hybrid strategy of paying for radio spots or programs or utilizing Champion Community resources available. Media are compulsory partners for the dispensation of useful health information. For the most part, they have or can develop media coverage where they promote health dialogue and measure their impact on improving health behaviors. Community radio in Bukavu and Uvira and other areas of DRC plays a significant role in BCC and is an accepted medium for health messaging. In other countries, activities like, workshops, and organization of journalist visits to the communities create opportunities for interviews with members of the Champion Community. One Champion Community in Uvira has a journalist as one of its members. That Champion Community, Afya Ka Wote has a regular radio spot each week where messages are passed to all communities in the health zone.

SMS Messaging

SMS messaging is a very promising approach by enabling the Champion Community to deliver BCC messages to a large number of people instantly and affordably. This strategy involves sending messages to the population via cell phones on the various health themes, either during communication campaigns for behavior change or during routine activities.

The success of this strategy at the level of the Community Champion approach requires the creation at the level of the local communities of telephone directories of members of households, leaders (community and religious), private health structures, NGOs, CSOs and other community participation structures. SMSs related to education and public awareness of health are launched using a specific software for this purpose (Frontline), where to register numbers corresponding to the cellular telephone network from this directory, messages related to health improvement will be sent to everyone from the selected telephone networks. Even with low levels of cell phone penetration, messages are passed via social networks that allow penetration of messages far beyond the number of phones in a community.

"Town Crier" Mini-Campaigns

Messages via megaphone to address the socio-cultural barriers identified via formative research. Utilized by Champion Communities during mini-campaigns, these mini-campaigns are conducted at the health area level and are partially supported by the province and/or zone. Vaccination, tuberculosis, and malaria campaigns were the most common campaigns uniformly across health zones in IHPplus.

Polio Mini-Campaign, April 2016, Tshumbe Photos: Lynn Lawry OSC Ltd.

Hotlines

Messages that explicitly link with service delivery efforts through referrals via hotlines that can be called for campaign information, emergencies or other needed mass information via cellular phones.

Framework for Implementing the Champion Community Method

This chapter describes the steps and procedures for the effective implementation of the Community Champion approach at the community level.

The methodological approach to implementation is as follows:

- Implementation structures
- Steps in the implementation process
- Activities in the approach
- Participatory monitoring

Implementation Structures and Stakeholders

The public structures and stakeholders in DRC include:

- MOH
- Provincial Health: *Inspection Provinciale de la Santé* (IPS) and *DPS*
- Health zone: Chief Medical Officer
- Health area health centers including nurses, and CHWs if present

At the community level:

- RECOs
- CODESA
- Local Supervisors
- Champion Community Steering Committee (*Comité de Pilotage Communauté Championne*)
- Champion Community Executive Committee
- Community
- Health Center (one/health area)
- Youth groups (Scouts), women's groups, traditional and religious leaders
- Other key partners

Private structures:

- Religious denominations/ FBOs
- Schools
- NGOs (local and international)
- CSOs/CBOs

IHPplus and other USAID and national partners, national sectors (education, environmental health, health education, social welfare, community development, youth, agriculture), provincial assemblies, and partners represented at the provincial, health zone, health area, and community levels are responsible for:

- Support, technically and financially, and holding introductory meetings at all levels
- Support the Champion Community in setting the objectives to be achieved and signing of the letter of commitment for the implementation of the approach
- Support the training of Champion Community members and other community involvement structures involved in the process
- Make available communication materials and media at chosen administrative levels (of implementation)
- Design and plan with BCC campaigns/mini-campaigns and other approaches that might be utilized
- Provide technical support to the monthly meetings of Champion Communities
- Monitor and evaluate activities related to the Champion Community action plan
- Support certification ceremonies

Roles and Responsibilities of the Implementing Bodies for the Champion Community Approach

The Champion Community approach is operational at the health area level. The Champion Communities represent 20,000-40,000 people within 3-4 health areas, depending on the size and distance of the health areas, within an implementation health zone.

RECO

The *Relais Communautaires* (RECO) are representatives from households within each village. They are elected by the village to form the 3-5 members of the *Cellule d'Animation Communautaire* (CAC). The RECOs can be members of the CODESA and/or the Champion Community.

Roles:

- As members of the CAC, CODESA and/or Champion Community, they represent the health concerns of the village in their respective health areas
- When they are part of the Champion Community, they represent the development concerns of the village; not simply the health issues

CODESA

Each CODESA represents one health area and is made up of no more than 15 persons. These will include persons from women's groups, youth groups, Chiefs, and representatives from across sectors within the villages. Each village elects volunteers from households within the village that form the CAC which is 3-5 RECOs from the village. From each of the CACs, representative of all the villages, 15 persons are chosen to be representative in the CODESA. Each of the CODESAs have an executive committee (President, Vice President, Secretary).

Roles:

- Advocate the health needs of the villages within the health area to the health center
- Through ETL, sensitize households in the villages (interpersonal communication)
- Refer patients from their villages within the health area to the health center
- Serve as part of the CPCC for the Champion Communities

Local Supervisors

These supervisors (usually a health center nurse), are the liaisons between the CODESA, CPCC, the Champion Community, community mobilizers and the health center at the health area level

Roles:

- Facilitate and aid in data collection by the Champion Community on the action plan indicators at level of health centers
- Share these data with the provincial and zonal health authorities
- Technically support SBC activities such as mini-campaigns and home visits by the Champion Community
- Mediate problems addressed by the CPCC
- Ensure women, minorities, youth and disabled persons are represented and participate in the Champion Community activities and/or encourage the development of Champion Subgroups based on identified community priorities (ENGAGE and/or VITALITY Champions, Champion Mamas)

Champion Community Steering Committee

The steering committee is composed of select (elected) committee members (President, Vice-President, Secretary and elected counselors or local supervisors (nurse from the catchment health facility), chief, religious and/or other traditional leaders. Within the DRC context, the community should be encouraged

to include women and youth. The CCSC is a technical decision-making body responsible for central coordination and monitoring of SBCC activities outlined in the action plan and supervision of activities.

Roles:

- Assist the Champion Community in carrying out activities to achieve the objectives of the SBCC community-level approach at the village level
- Accompany the Champion Community in the implementation of the action plan when necessary
- Attend mini-campaigns to lend support to SBCC activities
- Lead meetings on the achievements of the development of the Champion Community
- Conduct community-building meetings to achieve community goals
- Hold monthly meetings to monitor progress of activities and self-assessment
- Inform all stakeholders and the community about the objectives set by the Champion Community (health and development), and the work to be implemented
- Provide solutions to problems related to the implementation of the SBCC action plan
- Manage conflicts
- Write, share and approve monthly report to members, other stakeholders and the supporting project
- Report and attend monthly meetings with provincial and zonal health leadership

Executive Committee (President, Vice-President, Treasurer, Secretary and Advisors) of the Champion Community

These members are elected by the community and should be vibrant, active, committed, imaginative, literate (can read and write), and engaging. They must have good community standing, be good mediators, natural group leaders and have listening skills. They must have a sense of volunteerism, a sense of community, and a desire to bring the community together around health priorities. They also sit on the steering committee which includes other stakeholders.

Our experience has shown that helping the community to elect people as above ensures success. Failure happens when select committee members are not team players, have power issues, or other agendas that do not have the community objectives in mind.

President

- Coordinates Champion Community activities
- Represents the Champion Community at all levels of implementation
- Chairs the meetings of Champion Community and the Executive Committee
- Monitors and evaluates Champion Community activities
- Develops the activity tracking chart of action plans
- Ensures the quality of the implementation process and seeks for continuous improvement
- Plays the role of relaying community competence processes to the implementation of the Champion Community approach
- Leads the development and mentoring of autonomous Champion Communities in other health areas or health zones
- Follows-up and execute decisions made at the Champion Community or steering committee meetings

2. Vice-President
- Assist the President in carrying out duties
- Replaces and or sits in for the President when necessary

3. Secretary
- the administration of the Champion Community
- Prepares and disseminates the report and other minutes of meetings and/or activities.
- Shares with Champion Community members all relevant information in collaboration with other members of the steering and executive committee
- Maintains administrative records

4. Treasurer
- Oversees all aspects of the financial management of the income generation
- Keeps the Champion Community up-to-date with all finances related to the Champion Community
- Works closely with other members of the Select Committee to safeguard the organization's finances
- Ensures transparent financial reporting
- Lead for banking, book keeping and record keeping
- Maintains accounting and financial records

Community members

All individual initiatives or group initiatives that contribute to the advancement of health and development goals are welcomed within the Champion Community approach since there are many indicators of health. For example, education is a primary indicator of health therefore, teachers are encouraged to be part of the approach. Women and youth add value to address specific issues related to women and child health and youth specific issues such as early marriage, alcohol and drug abuse etc.

Roles
- Participate as RECO, CODESA and/or Champion Community member
- Participate in the Champion Community outreach activities
- Mobilize community groups such as teachers, churches, women organizations and youth groups for community outreach

Based on the SBCC strategic approach assessment for IHP/IHPplus, this "bottom up" approach adds, and is not duplicative, of the approach that is focused at the provincial, zonal or national level and allows communities to become agents of change for development and improved health outcomes.

Health Center Roles and Duties

All activities related to the achievement of the Champion Community action plan objectives revolve around the Health Center. For most Champion Communities, a health center nurse is part of the Champion Community and helps the community understand health issues that are identified by the community.

Roles:
- Collaborate with CODESA and CCSC to develop a SBCC plan

- Ensure seamless and coordinated Champion Community health SBCC activities
- Ensure the messages are correct and incorporate community health/National policy guidelines on health and messaging
- Facilitate the achievement of health objectives by offering quality service to the population
- Fill out the community activity tracking table monthly to establish the gap between baseline and achievement data with community effort
- Work with project level M&E to ensure data is available to track impact
- Participate in the drafting of the evaluation report carried out by the Champion Community, project and the other partners

Bridging Core Community Agents (Women and Youth)

Women and youth are key members of the communities and participate in youth clubs and mother care groups to aid in improvement of MNCH access and increased utilization of priority services that decrease maternal and child morbidity and mortality. Within the Champion Community approach, they can also create Champion Youth and Champion Mama sub-groups to identify vulnerable groups (pregnant women, children, youth etc.) for interpersonal or targeted SBCC.

Roles:

- Community outreach workers (mother care groups, youth clubs, Champion Youth, Champion Mamas) and other grassroots community workers are/can be the active participants in the Champion Community approach, as they are responsible for certain health tasks that they have voluntarily agreed to perform
- They are intermediaries between the households/village/population and the health center, they are responsible for providing household-oriented IPC activities and maintain permanent contact with community members that focus on specialized issues such as breastfeeding or out-of-school youth, drugs and alcohol
- They thus ensure the dissemination of SBCC targeted educational messages and direct suspicious cases to the health centers especially for priority services
- Participate in health education trainings that can assist in the identification of vulnerable, sick, or lost to follow up cases and report to the health center:
    - All cases of morbidity, measles, malaria etc.
    - All cases of mortality with the alleged cause occurring in the community
    - All cases oriented / accompanied at the health center
    - Use health advice cards during home visits
    - Prepare the weekly monitoring report

To maintain confidence between the volunteers and the health center it is important to create a team spirit climate that allows a coordinated effort to affect the goals of the project and aid in the health and development of the communities.

Other Key Partners

These include local and international NGOs, CBOs, CSOs, FBOs, local authorities such as police or judicial representatives, and private partnerships with companies in the area. All of these groups have technical capacity building possibilities through training. Examples from DRC include GBV awareness through USAID partners working with the USHINDI project, or soap making from local NGOs. Partner mapping is helpful for each Champion Community to better understand the resources available to them.

Champion Community Summaries and Impact by Coordination

IHP/IHPplus utilized a phased implementation of the Champion Community approach between 2012-2016. During this time, 35 project implemented Champion Communities were established. In 2016, autonomous Champion Communities began developing. These communities are mentored by project implemented Champion Communities. As of 2018, there are eight other autonomous Champion Communities in development, many of which developed during a time when the sub-contracts for the project were not funded. This shows the approach is sustainable and will continue even after the end of the project. Among the autonomous Champion Communities, Champion Mamas, Champion Men and Champion Youth developed. In March of 2018, the first autonomous Champion Community gained NGO status (Champion Youth RACOJ in Mwene Ditu). As of June 2018, there are 73 Champion Communities in 34 health zones and eight coordinations. (Table 3)

Table 3: Summary of IHPplus Champion Community Approach Implementation 2012-2018

Coordination	IHP+	IHP+ NGO	IHP+ NGO (In Process	Autonomous	Autonomous NGO	Autonomous (In Process)	Nonfunctional	Total # Functional	Health Zones Covered
Bukavu Champion Men (1) Champion Mamas (1)	4	4	0	1	0	1	1 (Walungu)	5	Katana Mwana Walungu
Kamina	3	3	0	9	0	0	0	12	Kabongo Malemba Songa
Kolwezi	3	3	0	2	0	4	0	5	Dilala Fungurume Kanzenze Manika Lualaba
Kole	4	4	0	5	0	2	0	9	Bene Dibele Lodja Kole Lomela Tshudi Loto
Luiza	8	6	1	6	0	1	0	14	Bilomba Luiza Dibaya Ndekesha Luambo Kalomba
Mwene Ditu Champion Youth (2)	4	2	1	4	1	1	0	8	Bibanga Kalenda Kanda Kanda Wikong Mwene Ditu
Tshumbe Champion Men (1)	2	1	0	2	0	0	1 (Dikungu)	4	Djalo Djeka Katako Minga Tshumbe
Uvira Champion Men (1)	5	5	0	2	0	0	0	7	Nundu Ruzizi

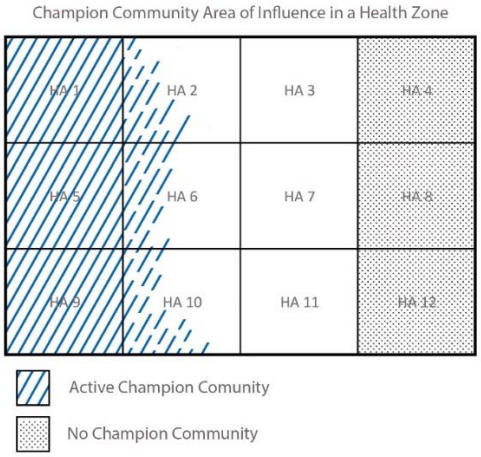
Champion Mamas (2)									Uvira
Totals	**33**	**28 (85%)**	**2**	**31**	**1**	**9**	**2**	**64 (73 including in process)**	**34**

Impact Evaluation of Health Indicators

Each Champion Community chose a set of health indicators in their action plans. They used community mobilization to change behavior and increase uptake and access to high priority services for MNCH. As each Champion Community covers 3-4 health areas a comparison needed to be completed to 3-4 health areas where there are no Champion Communities. To limit any crossover effects from messaging in nearby health areas, the furthest health areas were chosen for comparison. (Figure 5)

The District Health Information System (DHIS 2), as of 2017, subgroups data by health areas. Prior to 2017, only health zone level data was available and therefore it was not possible to look at comparisons for Champion Community impact since a Champion Community does not cover an entire health zone. The following analyses are for all of 2017. Chi-square (proportions) and two-sided T-tests (counts for the number of visits) analyses were utilized to compare Champion Community health area indicators with the same indicators in non-Champion Community health areas. As of 2018, not all Champion Community action plan indicators could be analyzed, for example, data was not collected or was too unrealizable in DHIS/DHIS2 at the health areas levels for WASH, tuberculosis (TB), GBV[23], latrines, potable water, and HIV/STD indicators. Health area indicators available for analysis included antenatal care (ANC-1 or ANC-4 -one visit and four visits), family planning acceptance of modern methods, vaccinations for DPT/HepB/HIB (3 doses of Pentavalent diphtheria, pertussis, tetanus, and hepatitis B and Haemophilus influenzae type b) and measles for children 0-11 months, breastfeeding (exclusive for six months and breastfeeding up to 23 months), moderate malnutrition rates among children 6-53 months, and the number of malaria visits for diagnosis and treatment.

Figure 5: Champion Community Messaging Influence in Health Areas



The following sections present the summary of each Champion Community by health zone within each of the eight coordinations where the approach was implemented followed by the analysis of indicators

[23] Although the number of cases that present in 72 hours and the number of cases that receive PEP are (in some health areas) collected, the data is highly unreliable and incomplete for all health areas.

specific to each IHPplus and autonomous Champion Community and an analysis of both IHPplus and autonomous Champion Communities ("all") if present. A statistically significant p-value of <0.05 was used in both the Chi-square and T-test analyses which means if the p-value was less than 0.05, we are 95% sure the result did not occur by chance. The analysis cannot be construed to represent cause and effect. These data show that Champion Communities are associated with changes in behavior and/or improvement in indicators. As each Champion Community areas are very different, context must be taken into account to explain the results coherently and is done so in each section prior to the table of results.

It is not possible to control for all confounders; only a randomized control trial or a longitudinal study could control for most confounders. Therefore, where both Champion Community health areas and non-Champion Community health areas have high rates such as for vaccination, it should be assumed that vaccination campaigns (provincial/zonal/national level campaigns) in those areas contributed to the rates and are not solely due to the Champion Community SBC mobilization efforts. However, if there are statistically different rates of an indicator (such as breastfeeding) among indicators that do not have campaigns, it is reasonable to assume that the increased rates are associated with the work of the Champion Community behavior change efforts.

Finally, for community mobilization effort to succeed, there must be an equally functional health facility or the SBC efforts at the community level will not be effective. Intermittent Preventive Treatment in Pregnancy with sulfadoxine-pyrimethamine (IPTp) is part of ANC visits and reflects the capacity and supply at the health facility/health zone level and therefore does not reflect the SBC efforts at the community level. IPTp (two doses) comparisons are presented in the analysis to triangulate the capacity at the health facility level only but should not be considered an indicator of the SBC efforts.

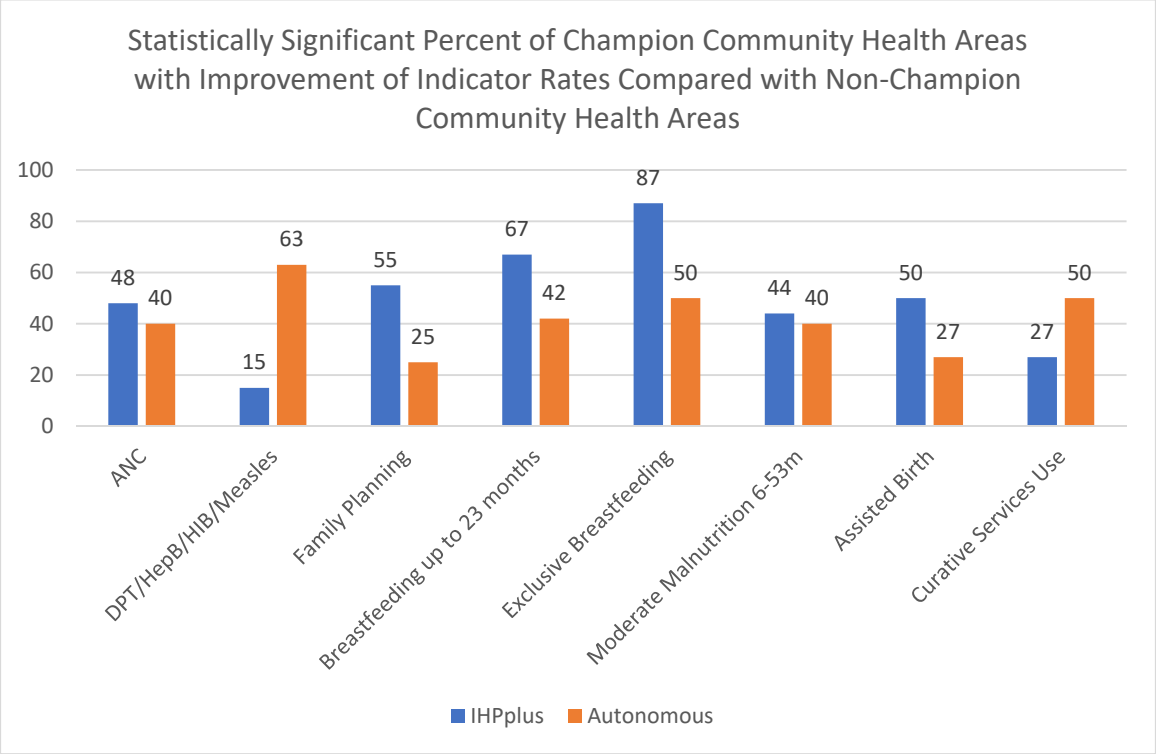
Summary of Impact Evaluation of Health Indicators

Champion Communities had different action plans based on participatory assessments of local health needs. Using aggregated health area data for 2017 for Champion Communities with action plans that included ANC-1 and ANC-4, statistically significant improvement was seen or ANC in 48% of IHPplus Champion Communities and 40% of autonomous Champion Communities who worked on increasing the number of pregnant women attending ANC. (Figure 6) Vaccinations (DPT/HepB/HIB and measles) did not improve as much due to the large number of health zone campaigns that worked concurrently in Champion Community health areas and across health zones. Most of the Champion Community health areas and non-Champion Community health areas had vaccination rates above 80%; some as high as 99%. Therefore, where campaigns were less effective or absent, 15% of IHPplus Champion Communities had higher rates than non-Champion Community health areas in contrast to 63% of the autonomous Champion Communities that had statistically higher rates when compared with health areas with no Champion Communities. For family planning (acceptance of modern methods) rates 55% of IHPplus Champion Community and 25% of autonomous Champion Community health areas had statistically higher rates than comparison health areas. For breastfeeding up to 23-month rates, 67% of IHPplus Champion Community health areas and 42% of autonomous Champion Community health areas had higher rates of adherence when compared with non-Champion Community health areas.

For Champion Communities that worked on exclusive breastfeeding, 87% of IHPplus and 50% of autonomous Champion Community health areas had better rates than non-Champion Community health areas. Moderate malnutrition rates among children 6-53 months was statistically lower among 44% of IHPplus Champion Communities and 40% of autonomous Champion Communities health areas.

For IHPplus Champion Communities working on increased assisted birth rates, 50% had statistically significant increases in these rates whereas 27% of autonomous Champion Communities had higher rates when compared with health areas with no Champion Communities. Finally, for the Champion Communities that worked on curative service rates, 27% of IHPplus Champion Community health areas and 50% of autonomous Champion Community health areas were able to statistically improve rates of attendance for curative services.

Figure 6: Overall Summary of the Percent of Champion Communities with Improved Indicator Rates



Regarding malaria referrals for treatment and diagnosis, for Champion Communities that worked on malaria, trended higher but only Kamina had statistically significant differences when compared with non-Champion Community health areas. The following sections discuss these results by coordination, health zone and type of Champion Community (IHPplus or autonomous).

Bukavu Coordination

This coordination was one of the first areas to establish Champion Communities. There are four IHPplus Champion Communities, all of which are NGOs, including a sub-group of Champion Men and one functioning autonomous Champion Community and a developing Champion Mamas group as of 2018. (Table 4) Walungu health zone has a Champion Community that is no longer active. Walungu suffered from lack of support at the health zone level for health facility operation and therefore the community mobilization efforts of the Champion Community were hampered by the lack of available health services for the community. As part of the small grants pilot through IHPplus, these Champion Communities, with the exception of one that used funds to buy a motorcycle, did well and completed their contracted objectives. One Champion Community currently has outside funding. These Champion Communities are in insecure areas that are frequently subjected to rebel violence and conflict but yet continue to perform and succeed with their action plans.

Table 4: Summary of Bukavu Coordination Champion Communities

Name	Year Established	# Members	Health Zone	Health Areas Covered	Action Plan Objectives	NGO Status	Outside Funding
Bukavu IHP/IHPplus Established Champion Communities							
NGO Bololoke	2013	Total 250 Women 68 Men 80 Youth 102	Walungu	Cagome Nyandja Kalole Bideka	ANC-4 Vaccinations Family planning	Yes	IHPplus 5000 USD
NGO Tuwe Mfano	2012	Total 360 Women 150 Men 90 Youth 110	Katana	Kabushwa Kabamba Mugeri Nuru	ANC-4 Vaccinations Family planning Breastfeeding (exclusive and up to 23 mos) Nutrition Malaria HIV GBV Potable water	Yes	IHPplus 5000 USD
NGO Kenguka **+ Champion Men**	2013	Total 584 Women 170 Men 240 Youth 115	Katana	Ciranga Izimero Luhihi Musheshwe	ANC-4 Vaccinations Family planning Breastfeeding (exclusive and up to 23 mos) Nutrition Malaria HIV GBV Potable water	Yes	IHPplus 5000 USD
NGO Rhusimane	2014	Total 44 Women 20 Men 24	Mwana	Mulambi Luchiga Kakwende Kashadu	ANC-4 Vaccinations Family planning Breastfeeding (exclusive and up to 23 mos) HIV Potable water	Yes	IHPplus 5000 USD Gesellschaft fur Internationale Zusammenarbeit (GIZ) 3600 USD
Autonomous Champion Communities							
CC Zuki	2016	Total 86 Women 30 Men 40 Youth 26	Katana	Birava Lugendo Irambira Ishungu Chishugi	ANC-4 Vaccinations Family planning	In Progress	None
Autonomous Champion Communities (in development)							
CC Mamas	2018		Katana				
Inactive Champion Communities							

CC Rhugwasanye	2012		Walungu				

The **Katana** health zone has two IHPplus Champion Communities and one autonomous Champion Community that covers five health areas. ANC-4 rates were higher overall for all Champion Community health areas (IHPplus and autonomous) when compared with health areas without Champion Communities. (Table 5) Vaccination rates were not different in Champion Community health areas and non-Champion Community health areas and were between 95-99% due to vaccination campaigns across the health zone. (Table 5) The autonomous Champion Community does not have statistically significant rates of ANC-4 but they have only been working since late 2017. Family planning (modern methods) had much higher rates in Champion Community health areas than non-Champion Community health areas. Referrals for treatment and diagnosis for malaria were not statistically different between Champion Community health areas and non-Champion Community health areas (CC: t-value = 1.5, p =0.15; Autonomous CC: t-value = 1.9, p = 0.9; All CCs: t-value = 1.7, p = 0.09). Breastfeeding rates were higher in non-Champion Community areas and not surprisingly, due to lower breastfeeding rates, children 6-59 months have much higher rates of moderate malnutrition in Champion Community health areas when compared with non-Champion Community health areas. The new Champion Mamas plan to address breastfeeding and malnutrition in Katana. Katana Champion Communities also worked on gender based violence; however, in the DHIS2 data, there was only one case reported in Champion Community health areas and one in non-Champion Community health areas therefore reliable statistics could not be done.

In **Mwana** health zone, ANC-4 visits were higher in Champion Community health areas and although family planning trended higher (18% versus 9%), there was no statistical difference between Champion Community health areas and non-Champion Community health areas. There were no statistical differences between Champion Community health areas and non-Champion Community health areas measles or DPT/HepB/HIB vaccine rates. It should be noted that there are robust vaccination campaigns at the health zone level and rates were close to 100% for all health areas.

In **Walungu** health zone, IHPplus Champion Community had either similar rates to non-Champion Community health areas or lower rates (ANC-4) than areas without Champion Communities. This health zone has problems at the health facility levels and therefore the rates may represent the issue of care at the health facilities associated with the Champion Communities and not community mobilization efforts.

Table 5: Bukavu Coordination Champion Community impact analysis

Health zone	Action plan indicator	Health area	All CCs %	All CCs X^2	All CCs P	Health area	IHPplus %	IHPplus X^2	IHPplus P	Health area	Autonomous %	Autonomous X^2	Autonomous P
Katana	ANC-4	CC No CC	86 74	4.5	**0.03**	CC No CC	91 74	10.0	**0.001**	CC No CC	78 74	0.4	NS
	IPTp	CC No CC	97 95	0.5	NS	CC No CC	100 95	2.7	NS	CC No CC	91 95	1.2	NS
	DPT/HepB/HIB	CC No CC	99 95	2.7	NS	CC No CC	99 95	2.7	NS	CC No CC	99 95	2.7	NS
	Measles	CC No CC	95 96	0.11	NS	CC No CC	95 96	0.11	NS	CC No CC	94 96	0.42	NS
	Family planning	CC No CC	52 15	30.7	**<0.001**	CC No CC	62 15	46.6	**<0.001**	CC No CC	35 15	10.7	**0.001**
	Breastfeeding up to 23 months	CC No CC	74 91*	16.8	<0.001	CC No CC	81 91*	4.1	0.04	CC No CC	68 91*	6.2	<0.001

	Exclusive breastfeeding	CC No CC	36 65*	16.8	<0.001	CC No CC	45 65*	8.08	0.004	CC No CC	28 65*	27.5	<0.001
	Children 6-59 mos with moderate malnutrition	CC No CC	60 29	19.4	<0.001	CC No CC	63 29	23.3	<0.001	CC No CC	58 29	17.1	<0.001
Mwana	ANC-4					CC No CC	84 69	6.2	**0.01**				
	IPTp					CC No CC	62 66	0.3	NS				
	DPT/HepB/HIB					CC No CC	99 98	0.3	NS				
	Measles					CC No CC	95 96	0.11	NS				
	Family planning					CC No CC	18 9	3.5	NS				
	Breastfeeding up to 23 months					CC No CC	44 85*	36.7	<0.001				
	Exclusive breastfeeding					CC No CC	37 41*	0.33	NS				
Walungu	ANC-4					CC No CC	50 81*	21.2	<0.001				
	IPTp					CC No CC	72 93*	15.2	<0.001				
	DPT/HepB/HIB					CC No CC	98 98	0.0	NS				
	Measles					CC No CC	91 96	2.05	NS				
	Family planning					CC No CC	7 11	0.97	NS				

**Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Kamina Coordination

This coordination has both IHPplus and autonomous Champion Communities in each of the implementation health zones. (Table 6) The three IHPplus-implemented Champion Communities have NGO status and performed well with the IHPplus small grants, completing goals and utilizing funds as per the signed contract. Nine autonomous Champion Communities exist and were established when the sub-contract for IHPplus was terminated suggesting that the Champion Community approach is sustainable as the development of other Champion Communities occurred without project assistance or staff in the field. Until 2017, Kabongo Champion Communities had only one female member which may help to explain why the MNCH indicators did not show statistical differences. However, in late 2017, the number of women increased dramatically and the autonomous Champion Communities that developed included nearly half women. These Champion Communities are remote. It takes two days to reach the Malemba-Nkulu Champion Communities from Kamina and 10 hours (depending on the road) to reach Songa and Kabongo. For nearly six months of the year, due to the rainy season, these Champion Communities cannot be accessed by road.

Table 6: Summary of Kamina Coordination Champion Communities

Name	Year Established	# Members	Health Zone	Health Areas Covered	Action Plan Objectives	NGO Status	Outside Funding

Kamina IHP/IHPplus Established Champion Communities							
NGO Nshi Mikulu (NGO NSMIK)	2012	Total 47 14 Women 21 Men 12 Youth	Kabongo	Kina Lubyayi Kime	ANC-1, ANC-4 Assisted Birth Vaccination Family planning Malaria STD TB Diarrhea Trash burn pits	NGO	IHPplus 5000 USD
NGO Songa Mbele (NGO Songa)	2012	Total 72 11 Women 19 Men 42 Youth	Songa	Samba Kipukwe Lukanvwe	ANC-1 ANC-4 Vaccination Family planning Curative services Malaria Diarrhea Trash burn pits	NGO	IHPplus 5000 USD
NGO Nkulu A Manyinga (NGO NKUM)	2013	Total 64 21Women 32 Men 11 Youth	Malema	Muko Mutombo Kabala Kabozya	ANC-4 Vaccination Family planning Latrines Malaria/ITN use Cholera HIV	NGO	IHPplus 5000 USD
Autonomous Champion Communities							
Nsele	2014	Total 42 14 Women 16 Men 12 Youth	Kabongo	Nsele Kamwenze Djombo	Assisted birth Vaccination Family planning GBV HIV/STD Curative services	No	None
Songa Mission	2015	Total 46 23 Women 20 Men 3 Youth	Songo	Songo Kafungo Katongola	Assisted birth ANC-1 ANC-4 Vaccination Family planning	No	None
Kabulo	2017	Total 39 14 Women 17 Men 8 Youth	Songo	Kabulo Kantengu Mwale	Assisted birth ANC-1 ANC-4 Vaccination Family planning Curative services	No	None

Mwambayi	2017	Total 52 18 Women 23 Men 11 Youth	Kabongo	Mwambayi Mwanya Kavula	Assisted Birth ANC-1 ANC-4 Vaccination HIV/STD Malaria/ITN	No	None
Kametemete	2017	Total 64 28 Women 32 Men 4 Youth	Malemba	Kamete Nyoka Kasulwa	ANC-1 ANC-4 Vaccination Potable water	No	None
Mwenze Nkulu Wa Kunyemenwe	2017	Total 72 22 Women 28 Men 22 Youth	Malemba	Nyoka Lwandwe Seya	ANC-1 ANC-4 Vaccination Family planning Curative services	No	None
Tuba Katanta	2017	Total 74 23 Women 30 Men 21 Youth	Malemba	Kyamakanza Kasulwa Tuba	ANC-1 ANC-4 Vaccination Family planning Malaria Diarrhea Cholera	No	None
Mpungu Wa Bele	2017	Total 54 20 Women 25 Men 9 Youth	Malemba	Manga Songwe Kabwe Mulongo	ANC-1 ANC-4 Vaccination Malaria HIV Diarrhea Cholera	No	None
Kalenge	2017	Total 73 28 Women 32 Men 13 Youth	Malemba	Butombe Mutombo Lupitshi Nkole	Assisted birth ANC-1 ANC-4 Vaccination Family planning HIV/AIDS/STIs	No	None

Family planning rates (acceptance of modern methods) remain low and were not statistically different in any of the Champion Community or non-Champion Community health areas of the three health zones assessed. (Table 7)

In health areas with Champion Communities in the **Songa** health zone, ANC, assisted birth, exclusive breastfeeding and childhood immunization rates were better than health areas with no Champion Communities suggesting the presence of Champion Communities are associated with improvements in uptake and access to services, in addition to behavior change among their communities. Only the autonomous Champion Communities had significantly different rates of curative service use. There were no significant differences among health areas with or without Champion Communities for family planning rates among IHPplus or autonomous Champion Communities.

Kabongo health zone Champion Communities suffered from lack of female members among their Champion Communities until 2017. And although they have since remedied this issue, these Champion Communities did not perform as well as other health zones. Immunization, ANC and use of curative service rates were not significantly different from health areas without Champion Communities despite the trend to higher rates. However, Champion Community health areas (IHPplus and autonomous) had higher rates of assisted birth and exclusive breastfeeding rates than health areas with no Champion Communities. This suggests the presence of Champion Communities are associated with improvements in assisted birth and exclusive breastfeeding rates in 2017. The number of female members more than doubled in these Champion Communities in 2017.

In **Malemba** health zone, health areas with Champion Communities, including the autonomous Champion Communities, all health indicators (ANC rates, childhood immunizations, malaria diagnosis and treatment and family planning referrals) were better than in health areas with no Champion Communities with the exception of curative service use, which, despite a trend for higher rates was only statistically significant among the autonomous Champion Communities. These data suggest the presence of Champion Communities are associated with improvements in uptake and access to services in addition to behavior change among their communities. Assisted birth rates were not statistically significant.

In 2015, health zone health authorities utilized the Malemba IHPplus Champion Communality for community mobilization around malaria. At that time, the Chief Medical Officer stated the number of cases of malaria was increasing and every household needed a mosquito net and education on mosquito net use. After the Champion Community campaigns, malaria cases dropped dramatically in the health areas where the Champion Community is active. In 2015, prior to the campaigns, 300 transfusions for malaria induced anemia were required. By 2016, the number of transfusions for the year dropped to just 15 and the majority of households were using mosquito nets at night and not utilizing them for fishing or fencing. Using DHIS2 malaria indicators for referral and treatment of malaria in 2017, health areas with Champion Communities and autonomous Champion Community health areas referred more patients for diagnosis and treatment of malaria than health areas that do not have a Champion Community.[24] (Figure 7) It should be noted that the autonomous Champion Community health areas worked for less than six months of 2017 yet still were able to show a statistical difference in referrals when compared with health areas with no Champion Communities.

Figure 7: Mean Number of Malaria Referrals for Diagnosis and Treatment among Kamina Coordination Champion Communities in 2017

[24] Using a T-Test for two independent means with 95% confidence IHPplus Champion Community Health Areas compared to health areas with no Champion Communities: t-value 2.79; p = 0.01. Autonomous Champion Community Health Areas compared to areas with no Champion Communities: t-value 1.87; p = 0.03.

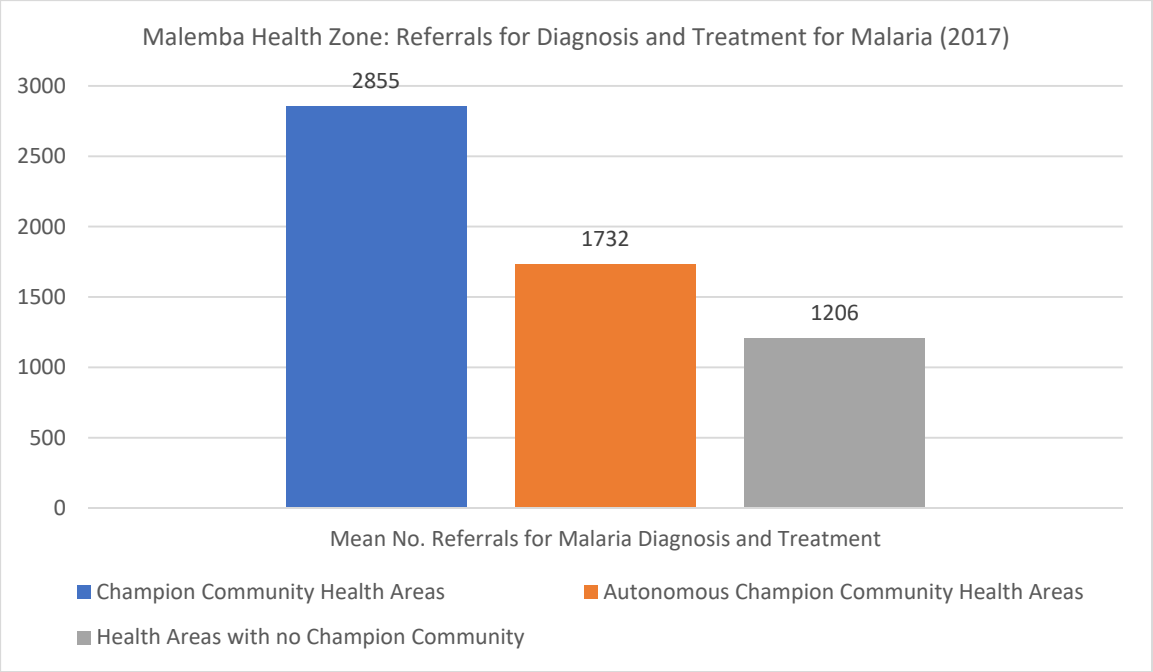


Table 7: Kamina Coordination Champion Community Impact Analysis

Health Zone	Action Plan Indicator	Health Area	All CCs % P	All CCs X^2		Health Area	IHPplus % P	IHPplus X^2		Health Area	Autonomous % P	Autonomous X^2	
Songa	Assisted birth	CC No CC	61 54	1.0	NS	CC No CC	69 54	4.7	**0.02**	CC No CC	54 54	0.0	NS
	ANC-1	CC No CC	79 66	8.8	**0.002**	CC No CC	84 78	1.2	NS	CC No CC	74 54	8.7	**0.003**
	ANC-4	CC No CC	64 46	6.5	**0.01**	CC No CC	66 54	0.77	NS	CC No CC	62 38	11.5	**<0.001**
	IPTp	CC No CC	84 72	4.2	**0.04**	CC No CC	85 72	5.0	**0.02**	CC No CC	83 72	3.5	NS
	DPT/HepB/HIB	CC No CC	91 71	12.9	**<0.001**	CC No CC	91 91	1.0	NS	CC No CC	91 52	3.7	**<0.001**
	Measles	CC No CC	92 77	16.1	**<0.001**	CC No CC	93 93	1.0	NS	CC No CC	90 61	22.7	**<0.001**
	Exclusive breastfeeding	CC No CC	69 33	25.9	**<0.001**	CC No CC	68 33	24.5	**<0.001**	CC No CC	70 33	27.4	**<0.001**
	Curative services use	CC No CC	30 21	2.0	NS	CC No CC	27 33	0.4	NS	CC No CC	33 19	5.0	**0.02**
	Family planning	CC No CC	19 13	1.3	NS	CC No CC	19 17	0.13	NS	CC No CC	19 12	1.8	NS
Kabongo	Assisted birth	CC No CC	58 35	10.0	**0.001**	CC No CC	51 35	5.2	**0.02**	CC No CC	65 35	18	**<0.001**
	ANC-1	CC No CC	87 79	2.2	NS	CC No CC	81 71	2.7	NS	CC No CC	94 88	2.2	NS
	ANC-4	CC No CC	58 50	1.3	NS	CC No CC	57 51	0.7	NS	CC No CC	59 49	2.0	NS
	IPTp	CC No CC	80 51	18.6	**<0.001**	CC No CC	74 48	14.2	**<0.001**	CC No CC	83 54	19.5	**<0.001**
	DPT/HepB/HIB	CC	64	1.2	NS	CC	56	0.5	NS	CC	76	6.1	**0.01**

		No CC	72			No CC	61			No CC	66		
	Measles	CC No CC	68 71	0.3	NS	CC No CC	52 69	6.0	**0.01**	CC No CC	72 74	0.1	NS
	Exclusive breastfeeding	CC No CC	55 36	9.8	**0.001**	CC No CC	47 36	4.08	**0.04**	CC No CC	64 36	19.2	**<0.001**
	Curative services use	Cc No CC	58 50	1.2	NS	CC No CC	57 51	0.4	NS	CC No CC	59 49	2.0	NS
	Family planning	CC No CC	22 19	0.3	NS	CC No CC	19 16	0.3	NS	CC No CC	26 22	0.4	NS
Malemba	Assisted birth	CC No CC	72 75	0.20	NS	CC No CC	79 75	0.45	NS	CC No CC	65 75	2.4	NS
	ANC-1	CC No CC	86 69	8.2	**0.003**	CC No CC	91 76	8.2	**0.004**	CC No CC	82 63	9.0	**0.003**
	ANC-4	CC No CC	55 30	12.8	**<0.001**	CC No CC	71 41	18.3	**<0.001**	CC No CC	40 20	9.5	**0.002**
	IPTp	CC No CC	83 63	10.1	**0.001**	CC No CC	93 87	2.0	NS	CC No CC	74 39	16	**<0.001**
	DPT/HepB/HIB	CC No CC	90 77	6.1	**0.01**	CC No CC	93 88	1.4	NS	CC No CC	87 66	19.3	**<0.001**
	Measles	CC No CC	90 75	7.8	**0.005**	CC No CC	93 84	3.9	**0.04**	CC No CC	88 66	21.0	**<0.001**
	Curative services use	Cc No CC	40 30	2.1	NS	CC No CC	40 32	1.3	NS	CC No CC	41 29	9.3	**0.002**
	Family planning	CC No CC	15 12	0.38	NS	CC No CC	16 11	1.1	NS	CC No CC	15 12	0.04	NS

Kole Coordination

In total, there are nine Champion Communities in Kole, with two more developing as of 2018. Four Champion Communities were established by IHPplus between 2013-2014, all of which have NGO status. In 2016, one autonomous Champion Community developed and in 2017, four other autonomous Champion Communities developed. (Table 8) As of late 2017 and by May 2018, there are two further Champion Communities in development. These Champion Communities are very remote. It takes two days at 7km/per hour for 10 hours a day to reach these Champion Communities from Lodja. In addition, there are few if any other NGOs working in these areas. Cordaid has a boat that comes to the area infrequently and has accepted proposals for education materials for the Lomela Champion Community.

Table 8: Summary of Kole Coordination Champion Communities

Name	Year established	# members	Health zone	Health areas covered	Action plan objectives	NGO status	Outside funding
Kole IHP/IHPplus Established Champion Communities							
NGO Tokadjimo	2014	Total 17 Women 5 Men 8 Youth 4	Kole	Kole Pilote Kole Yango Ishenga	Assisted birth ANC-4 Breastfeeding (exclusive and up to 23 mos) Family planning Curative services Malaria HIV/STI	Yes	None

					GBV TB WASH Latrines		
NGO Towadje	2014	Total 25 Women 10 Men 8 Youth 7	Kole	Banda Duka Ndjoka IngenguaNienie Shongomboyo	ANC-4 Breastfeeding (exclusive and up to 23 mos) Vaccination Family planning Curative services HIV/STI TB Malaria GBV WASH	Yes	None
NGO Oyangelo wa Demba Ki	2013	Total 115 Women 33 Men 54 Youth 28	Lomela	Yangunda Lomela pilote Vango Shaie Onyangondo	ANC-4 Breastfeeding (exclusive and up to 23 mos) Vaccinations Family planning Curative services TB Malaria/ITN HIV/STI GBV WASH Latrines	Yes	Cordaid
NGO Lomba Laso Le Demba	2014	Total 117 Women 12 Men 78 Youth 18	Lodja	Pilote Ok Shapembe Fin de terme Elema	Assisted birth ANC-4 Family planning Nutrition Malaria	Yes	None
Autonomous Champion Communities							
CC Demba Kii Ndeka Tshe	2016	Total 89 Women 54 Men 30 Youth 18	Lodja	Alengo Lokenye Lushakoyi Kalemie	ANC-1 ANC-4 Vaccinations Breastfeeding (exclusive and up to 23 mos) Family planning	No	None
CC Loseno Ohomba	2017	Total 77 Women 81 Men 14 Youth 42	Lomela	Shambi Pokaongo Lokala	Assisted birth ANC-4 Vaccinations Breastfeeding (exclusive	No	None

					and up to 23 mos) Family planning HIV/STI WASH		
CC Lonya Lo Lonya	2017	Total 48 Men 21 Women 27 Youth 11	Lomela	Odjila Mukumari Alanga Diamamba Edjola	ANC-4 Danger signs of pregnancy Family planning Malaria	No	None
CC Efulanto	2017	Total 166 Men 20 Women 106 Youth 40	Lodja	Okitandeke Edingo Asami	Assisted birth ANC-4 Vaccinations Breastfeeding (exclusive and up to 23 mos) Family planning Curative services GBV WASH Malaria/ITN	No	None
CC Bena Dibele	2017	Total 42 Men 11 Women 17 Youth 14	Bena Dibele	Asami Kabondo Lodilo	ANC-4 Vaccinations Family planning HIV TB WASH Latrines	No	None
Autonomous Champion Communities (in Progress)							
Tshudi Loto	2017	Total 48 Men 21 Women 27 Youth 11	Tshudi Loto	Tshudi Centre Loto	HIV Condom use		
Amour du Prochain	2018		Lomela	Yombo Elingampango Ipembe Bayaya Ikoto			

The autonomous Champion Community in **Bena Dibele** health zone made statistically significant increases in both ANC-1, ANC-4 and DTC/HepB/HIB rates when compared with non-Champion Community health areas. Family planning rates were not different between Champion Community and non-Champion Community areas. (Table 9)

The IHPplus established Champion Community in **Kole** health zone were able to increase rates for the acceptance of breastfeeding up to 23 months and modern methods of family planning in health areas they covered as compared with non-Champion Community health areas. They also have statistically significantly less children 6-53 months old with moderate malnutrition. Other indicators not statistically

different from non-Champion Community health areas included assisted birth, ANC-4, measles vaccination, exclusive breastfeeding and curative service use rates. DTC/HepB/HIB rates were statistically higher in non-Champion Community health areas. Although the mean number of referrals for diagnosis and treatment for malaria (1948 vs 940; t-value 0.08, P = 0.77) trended higher among the health areas with the IHPplus Champion Communities, the differences were not statistically different.

Both the IHPplus and autonomous Champion Communities in **Lodja** health zone were able to get nearly every pregnant woman to at least one ANC visit with rates of 99-100% and assisted birth rates which were statistically higher than health areas with no Champion Community. ANC-4 and family planning rates were not statistically significantly increased but are trending higher than non-Champion Community health areas for both the IHPplus Champion Communities and autonomous Champion Communities. All the Champion Communities worked on nutrition but only the autonomous Champion Communities were able to statistically lower the rates of moderate malnutrition among children 6-53 months. Autonomous Champion Communities worked on vaccinations, breastfeeding and curative services. They had higher rates of vaccination and curative service use when compared with other health areas, but breastfeeding (exclusive or up to 6 months) rates were not statistically different. The mean number of visits for diagnosis and treatment of malaria were not different for IHPplus or autonomous Champion Communities (IHPplus; 1864 vs 2166, t-value -0.50, P = 0.63 and autonomous; 2341 vs 2166, t-value 0.32, P = 0.76) in Lodja health zone.

Lomela health zone has both IHPplus and autonomous Champion Communities. The autonomous Champion Community was developed late in 2017 and therefore is working on improving indicators. By the end of 2017, health areas without a Champion Community had better rates of breastfeeding up to 23 months but had lower rates of exclusive breastfeeding when compared with health areas without Champion Communities. The IHPplus and autonomous Champion Communities, even with trends of higher rates of vaccination and family planning rates, the differences were not statistically different compared to non-Champion Community health areas. Neither IHPplus nor autonomous Champion Communities had statistically different mean number of visits for diagnosis and treatment for malaria when compared with health areas without Champion Communities (IHPplus; 1785 vs 1066, t-value 1.75, P = 0.11 and autonomous; 1532 vs 1066, t-value 1.30, P = 0.22).

Tshudi Loto health zone has a newly developing autonomous Champion Community as of late 2017. As it only covers two health areas, it is not considered a Champion Community yet and therefore the indicators it is working on were not analyzed.

Table 9: Kole Coordination Champion Community Impact Analysis

Health zone	Action plan indicator	Health area	All CCs %	X^2	P	Health area	IHPplus %	X^2	P	Health area	Autonomous %	X^2	P
Bena Dibele	ANC-1									CC No CC	98 89	6.6	**0.009**
	ANC-4									CC No CC	86 63	13.9	**<0.001**
	IPTp									CC No CC	44 56	2.8	NS
	DPT/HepB/HIB									CC No CC	86 75	3.85	**0.04**
	Measles									CC No CC	85 84	0.04	NS

	Family planning									CC No CC	19 16	0.3	NS
Kole	Assisted birth					CC No CC	78 82	0.5	NS				
	ANC-4					CC No CC	68 69	0.02	NS				
	IPTp					CC No CC	51 55	0.3	NS				
	DPT/HepB/HIB					CC No CC	71 85 *	5.71	0.02				
	Measles					CC No CC	74 70	0.39	NS				
	Breastfeeding up to 23 months					CC No CC	66 52	4.05	**0.04**				
	Exclusive breastfeeding					CC No CC	78 85	1.62	NS				
	Children 6-59 mos with moderate malnutrion					CC No CC	66 82	6.65	**0.009**				
	Curative services					CC No CC	50 48	0.08	NS				
	Family planning					CC No CC	31 19	3.8	**0.05**				
Lodja	Assisted birth	CC No CC	95 82	8.30	**0.003**	CC No CC	94 82	6.81	**0.004**	CC No CC	97 82	11.97	**<0.001**
	ANC-1	CC No CC	99 93	4.7	**0.03**	CC No CC	100 93	4.7	**0.03**	CC No CC	99 93	4.7	**0.03**
	ANC-4	CC No CC	81 75	1.0	NS	CC No CC	82 75	1.4	NS	CC No CC	80 75	0.7	NS
	IPTp	CC No CC	60 68	1.4	NS	CC No CC	62 68	0.8	NS	CC No CC	58 68	2.1	NS
	DPT/HepB/HIB									CC No CC	99 87	11.06	**<0.001**
	Measles									CC No CC	99 91	6.74	**0.009**
	Breastfeeding up to 23 months									CC No CC	68 76	1.58	NS
	Exclusive breastfeeding									CC No CC	82 80	0.13	NS
	Children 6-59 mos with moderate malnutrion	CC No CC	77 86	2.69	NS	CC No CC	79 86	1.69	NS	CC No CC	75 86	3.85	**0.04**
	Curative service use									CC No CC	66 52	4.05	**0.04**
	Family planning	CC No CC	25 29	0.4	NS	CC No CC	19 29	2.7	NS	CC No CC	30 29	0.02	NS
Lomela	Assisted birth									CC No CC	81 86	0.91	NS

	ANC-4	CC No CC	76 86	3.2	NS	CC No CC	77 86	2.7	NS	CC No CC	74 86*	4.5	0.03
	IPTp	CC No CC	88 85	0.3	NS	CC No CC	88 85	0.3	NS	CC No CC	89 85	0.7	NS
	DPT/HepB/HIB	CC No CC	72 62	2.26	NS	CC No CC	72 62	2.26	NS	CC No CC	73 62	2.76	NS
	Measles	CC No CC	70 67	0.21	NS	CC No CC	70 67	0.21	NS	CC No CC	70 67	0.21	NS
	Breastfeeding up to 23 months	CC No CC	43 21	11.21	**<0.001**	CC No CC	48 21	16.13	**<0.001**	CC No CC	38 21	6.95	**0.008**
	Exclusive breastfeeding	CC No CC	87 99*	11.06	<0.001	CC NO CC	86 99*	12.18	<0.001	CC No CC	88 99*	9.95	0.002
	Curative services					CC No CC	56 60	0.33	NS				
	Family planning	CC No CC	28 25	0.2	NS	CC No CC	28 25	0.2	NS	CC No CC	28 25	0.2	NS

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Kolwezi Coordination

IHPplus established three Champion Communities all of which have NGO status. (Table 10) Since 2017, two autonomous Champion Communities have developed. In 2015, four other autonomous Champion Communities were in development but have failed to integrate the necessary 3-4 health areas to become a Champion Community. These Champion Communities are not remote and are 3.5 hours on a paved road from Lubumbashi. There are numerous other NGOs working on some of the same indicators and in the areas where these Champion Communities work. Two of the three Champion Communities have outside funding from other organizations. As these Champion Communities are neither remote nor isolated, their priorities may represent issues of urbanization such as HIV, STDs, drugs and alcohol and GBV. Health services across the coordination are better than most coordinations as they are easily accessible when compared with other coordinations.

Table 10: Summary of Kolwezi Coordination Champion Communities

Name	Year established	# members	Health zone	Health areas covered	Action plan objectives	NGO status	Outside funding
Kolwezi IHP/IHPplus Established Champion Communities							
NGO Ushindi	2014	Total 22 Women 4 Men 12 Youth 6	Dilala	Kanina Umoja Noa	ANC-4 Vaccinations Family Planning	Yes	World Vision 15,000 USD IHPplus 8600 USD
NGO La Gazelle	2014	Total 28 Women 9 Men 15 Youth 4	Fugurume	Dipeta 1 Dipeta 2 Kasolondo Mpala	ANC-4 Vaccinations Family planning HIV TB	Yes	ProVIC 2000 USD E2A 2500 USD Lubudi Territorial Administration 500 USD

NGO Tusikilizane	2014	Total 22 Women 8 Men 9 Youth 5	Kazenze	Mpala Tshala 1 Tshala 2 Tshamundenda 1 Tshamundenda 2	ANC-4 Vaccinations Family planning	Yes	None
Autonomous Champion Communities							
Mapendo	2017	Total 22 Women 8 Men 13 Youth 1	Manika	HGR Manika Métho Moïse Tshombe	Family planning HIV Malaria	No	None
Kesho na Léo	2017	Total 22 Women 11 Men 8 Youth 3	Lualaba	Mupamdja Musompo Mwanfwe	ANC-4 Vaccinations Family planning HIV TB	No	None
Autonomous Champion Communities (in development)							
Kakanda	2015	Total 22 Women 10 Men 8 Youth 4	Fugurume	Kakanda	ANC-4 Vaccinations Family planning TB Malaria	No	None
Tenke	2015	Total 22 Women 8 Men 9 Youth 5	Fugurume	Tenke	ANC-4 Vaccinations Family planning TB	No	None
Kapata	2018	Total 22 Women 9 Men 7 Youth 6	Dilala	Kapata	ANC-4 Vaccinations Family planning	No	None
Luilu	2018	Total 22 Women 10 Men 10 Youth 2	Dilala	Luilu	ANC-4 Vaccinations Family planning	No	None

Dilala health zone has one IHPplus Champion Community and a developing autonomous Champion Community that currently covers only two health areas and therefore has not met criteria as a Champion Community. The IHPplus Champion Community did not have statistically significant differences in heath indicators from health areas with no Champion Community. For ANC-4, the Champion Community performed worse than other health areas. (Table 11)

Fungurume health zone's IHPplus Champion Community did not have statistically different indicators from health areas with no Champion Community with the exception of referral of malaria cases for diagnosis and treatment where the Champion Community had a mean number of visits of 1922 versus 743 visits from the health areas with no Champion Community (t-value = 2.06; P = 0.04). For vaccinations (DPT/HepB/HIB and measles), the Champion Community health areas has lower rates than health areas with no Champion Community.

The IHPplus Champion Community in **Kanzenze** health zone performed worse for vaccination and family planning rates when compared with health areas without a Champion Community and had similar rates to health areas without Champion Communities for ANC rates.

Lualaba health zone has a new autonomous Champion Community. Other than family planning (acceptance of modern methods), the Champion Community performed worse (DPT/HepB/HIB) or had rates similar to health areas with no Champion Community.

Manika health zone has two autonomous Champion Communities. Although there was a trend for higher rates for family planning and the mean number of referrals for diagnosis and treatment for malaria (2388 vs 1308; t-value 0.86, P = 0.4) among the health areas with the autonomous Champion Communities, the differences were not statistically different.

Table 11: Kolwezi Coordination Champion Community impact analysis

Health Zone	Action Plan Indicator	Health Area	All CCs %	P	X^2	Health Area	IHPplus %	P	X^2	Health Area	Autonomous %	P	X^2
Dilala	ANC-1					CC	66		1.9				
						No CC	75		NS				
	ANC-4					CC	27		4.9				
						No CC	42*		0.02				
	IPTp					CC	82		1.8				
						No CC	74		NS				
	DPT/HepB/HIB					CC	68		0.02				
						No CC	67		NS				
	Measles					CC	62		3.4				
						No CC	49		NS				
	Family planning					CC	13		2.0				
						No CC	7		NS				
Fungurume	ANC-4					CC	31		0.09				
						No CC	29		NS				
	IPTp					CC	58		0.5				
						No CC	63		NS				
	DPT/HepB/HIB					CC	74		23.9				
						No CC	98*		<0.001				
	Measles					CC	71		20.4				
						No CC	95*		<0.001				
	Family planning					CC	27		0.0				
						No CC	27		NS				
Kanzenze	ANC-1					CC	90		1.8				
						No CC	95		NS				
	ANC-4					CC	30		0.09				
						No CC	32		NS				
	IPTp					CC	60		11.7				
						No CC	82*		<0.001				
	DPT/HepB/HIB					CC	79		20.4				
						No CC	99*		<0.001				
	Family planning					CC	9		25.9				
						No CC	40*		<0.001				
Lualaba	ANC-4									CC	34	1.04	NS
										No CC	41		
	DPT/HepB/HIB									CC	81	9.2	0.002

				No CC	95*		
	Measles			CC No CC	75 80	0.72	NS
	Family planning			CC No CC	90 11	124.8	**<0.001**
Manika	Family planning			CC No CC	16 11	1.0	NS

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Luiza Coordination

IHPplus established eight Champion Communities, of which six have NGO status. (Table 12) One of the IHPplus Champion Communities is in process and one has not submitted the paperwork for NGO status. Three of the six with NGO status have gained outside funding for SBCC projects. Six autonomous Champion Communities exist with one of these also implementing Champion Men. This coordination suffered from conflict starting in 2016 until present. However, the small grants that these Champion Communities received were misused. Instead of following the contract they signed, they used the money for income generation, focused their efforts on income generation, and did not meet agreed-upon community mobilization targets. Of all the Champion Communities, these Champion Communities appear to be having a harder time changing their handout mindset.

Table 12: Summary of Luiza Coordination Champion Communities

Name	Year Established	# Members	Health Zone	Health Areas Covered	Action Plan Objectives	NGO Status	Outside Funding
Luiza IHP/IHPplus Established Champion Communities							
NGO Tuibake	2012	Total 35 Women 6 Men 21 Youth 8	Dibaya	Mupoyi Tshimayi Kabeya Madi Dibaya	ANC-4 Breastfeeding (exclusive) Family planning Curative services GBV HIV/STD WASH Latrines Potable water	Yes	IHPplus 4000 USD APROBES
NGO Sanga Bantu	2013	Total 35 Women 8 Men 20 Youth 7	Dibaya	Fuamba Lukula Tshikisha Mukwandianga	ANC-4 Breastfeeding (exclusive) Curative services TB GBV	Yes	IHPplus 4000 USD
NGO Tudisange	2012	Total 40 Women 20 Men 12 Youth 8	Luiza	Kamayi Kakamba Kabuanga Tutante	ANC-4 Breastfeeding (exclusive) Family planning	Yes	IHPplus 4000 USD CISP 500 USD

					Curative services GBV WASH Latrines Potable water		
NGO Bobumue	2012	Total 45 Women 10 Men 20 Youth 15	Bilomba	Bilomba Nzujikalamba Tshipangamukulu tshisuku Luabala	ANC-4 Breastfeeding (exclusive and up to 6 months) Family planning Curative services WASH Latrines Potable water	Yes	IHPplus 4000 USD FDSS 1150 USD UNICEF 600 USD
NGO Koleshayi	2013	Total 45 Women 12 Men 20 Youth 13	Ndekesha	Mombela Kazumba Kashinde Ndekesha	ANC-4 Breastfeeding (exclusive and up to 6 months) Nutrition Family planning Curative services WASH Latrines Potable water	Yes	IHPplus 4000 USD
NGO Tuye Kumpala	2013	Total 45 Women 15 Men 20 Youth 10	Kalomba	Kasanga Luebo Katshiabala Kalomba Tshitadi	ANC-4 DTC/HepB/HIB Family planning Nutrition	Yes	IHPplus 4000 USD
CC Tsuikionkani	2016	Total 30 Women 10 Men 13 Youth 5	Luambo	Ngovo Musodi Muanda Kalendu Mbunwe Lueta	CPN4 Measles Family planning TB WASH Potable water	In Process	None
CC Kuikosihila	2016	Total 28 Women 10 Men 13 Youth 5	Luambo	Luambo Kangambobaka Minkolo Kasombishi Kalamba Mbuji	CPN4 Measles Family planning TB WASH Latrines Potable water	No	None
Autonomous Champion Communities							
CC Dilubuluka	2016	Total 28 Women 8 Men 15 Youth 5	Ndekesha	Kaka Muanzambala Kafuba Tshitshi	ANC-4 Breastfeeding (exclusive) Nutrition	No	Mentoring CC gave pigs for breeding

					Family planning Curative services WASH Latrines Potable water		
CC Diakaja **+ Champion Men**	2016	Total 25 Women 8 Men 10 Youth 7	Luiza	Kakala Kazea Mpikambuji Moma	ANC-4 Breastfeeding (exclusive and up to 6 mos) Family planning Curative services GBV WASH Latrines Potable water	No	Mentoring NGO gave sheep for breeding
CC Buimpe	2016	Total 25 Women 8 Men 13 Youth 4	Dibaya	Kaulu Katongodi Lumbudi Luekeshi	ANC-4 Breastfeeding (Exclusive and up to 6 mos) Family planning Curative services GBV HIV/STD TB WASH Latrines Potable water	No	Mentoring CC gave pigs for breeding
CC Tudibamue	2016	Total 25 Women 5 Men 15 Youth 5	Bilomba	Majiba Mutefu Ntumbukambulu	ANC-4 Breastfeeding (Exclusive) Family planning Curative services WASH Latrines Potable water	No	Mentoring CC gave pigs for breeding and beans for planting
CC Tujukayi	2016	Total 25 Women 8 Men 10 Youth 7	Dibaya	Moyo Tshilela Tshidimba Benabitende	ANC-4 Breastfeeding (exclusive and up to 6 mos) Family planning Nutrition Curative services GBV HIV/STD TB WASH Latrines	No	None

					Potable water		
CC Muibaki	2016	Total 25 Women 6 Men 12 Youth 7	Kalomba	Mbuku Fuamba Mutondo Nsuana	ANC-4 DTC/HepB/HIB Family planning Nutrition	No	None
Autononous (In Process)							
TBA	2018		Ndekesha				

Of the coordinations where the approach is implemented, the Champion Communities of Luiza, with the exception of Dibaya, performed poorly. (Table 13)

In **Bilomba** health zone, IHPplus and autonomous Champion Communities performed worse than areas without Champion Communities for ANC-4, and breastfeeding, both exclusive and up to six months. The autonomous Champion Community had higher rates of moderate malnutrition among children 6-53 months. There were no differences among rates for family planning and curative service use in health areas with and without Champion Community presence. With the exception of moderate malnutrition rates and curative service rates, both the IHPplus and autonomous Champion Community health areas had higher rates of all of their indicators (ANC-4, breastfeeding and family planning) than health area with no Champion Community in the **Dibaya** health zone.

Kalomba, Luamba, Luiza and Ndekesha health zones had no statistically significant differences for ANC-4 or family planning for health areas with or without IHPplus or autonomous Champion Communities. In some cases, the rates for these indicators were higher in the non-Champion Community health areas and statistically significant (e.g., Luiza among autonomous Champion Communities and among both IHPplus and autonomous Champion Communities in Ndekesha). The only exception was for breastfeeding rates among IHPplus Champion Communities in Luiza and IHPplus and autonomous Champion Communities in Ndekesha which were statistically higher than health areas with no Champion Communities. In Kaloma, the rate of children 6-53 months with moderate malnutrition was statistically higher than areas with no Champion Communities despite working on nutrition in these health areas.

Table 13: Luiza Coordination Champion Community impact analysis

Health zone	Action plan indicator	Health area	All CCs %	All CCs X^2	All CCs P	Health area	IHPplus %	IHPplus X^2	IHPplus P	Health area	Autonomous %	Autonomous X^2	Autonomous P
Bilomba	ANC-4	CC No CC	50 58	1.3	NS	CC No CC	41 58*	5.7	0.02	CC No CC	59 58	0.02	NS
	IPTp	CC No CC	46 56	2.00	NS	CC No CC	40 56*	5.1	0.02	CC No CC	53 56	0.18	NS
	Curative service use	CC No CC	37 39	0.08	NS	CC No CC	34 39	0.54	NS	CC No CC	41 39	0.08	NS
	Family planning	CC No CC	31 32	0.02	NS	CC No CC	36 32	0.35	NS	CC No CC	27 32	0.60	NS
	Breastfeeding up to 23 months									CC No CC	12 50*	3.75	<0.001
	Exclusive breastfeeding	CC No CC	5 7	0.35	NS	CC No CC	10 7	0.57	NS	CC No CC	1 7	4.68	0.03
	Children 6-59 mos with moderate malnutrion									CC No CC	76 53*	11.55	<0.001

Dibaya	ANC-4	CC No CC	75 58	6.5	**0.01**	CC No CC	79 58	10.2	**0.001**	CC No CC	72 58	4.3	**0.04**
	IPTp	CC No CC	81 56	12.5	**<0.001**	CC No CC	84 56	6.5	**0.01**	CC No CC	79 56	10.2	**0.001**
	Breastfeeding up to 23 months									CC No CC	82 50	22.82	**<0.001**
	Exclusive breastfeeding	CC No CC	54 7	52.10	**<0.001**	CC No CC	49 7	43.75	**<0.001**	CC No CC	59 7	61.49	**<0.001**
	Children 6-59 mos with moderate malnutrion									CC No CC	53 53	0.0	NS
	Curative service use	CC No CC	40 39	0.02	NS	CC No CC	40 39	0.02	NS	CC No CC	37 39	0.08	NS
	Family planning	CC No CC	52 32	8.2	**0.004**	CC No CC	55 32	10.8	**0.001**	CC No CC	50 32	6.7	**0.009**
Kalomba	ANC-4	CC No CC	65 64	0.02	NS	CC No CC	70 64	0.81	NS	CC No CC	61 64	0.19	NS
	IPTp	CC No CC	79 83	0.52	NS	CC No CC	78 83	0.79	NS	CC No CC	79 83	0.52	NS
	DPT/HepB/HIB	CC No CC	65 64	0.02	NS	CC No CC	70 64	0.81	NS	CC No CC	61 64	0.19	NS
	Children 6-59 mos with moderate malnutrion	CC No CC	87* 64	14.29	<0.001	CC No CC	99* 64	40.62	<0.001	CC No CC	76* 64	3.34	NS
	Family planning	CC No CC	15 10	1.14	NS	CC No CC	14 10	0.75	NS	CC No CC	16 10	1.56	NS
Luambo	ANC-4					CC No CC	91 83	2.82	NS				
	IPTp					CC No CC	92 89	0.5	NS				
	Measles					CC No CC	96 86	6.10	**0.01**				
	Family planning					CC No CC	21 20	0.03	NS				
Luiza	ANC-4	CC No CC	78 89*	4.3	0.03	CC No CC	80 89	3.0	NS	CC No CC	76 89*	5.8	0.01
	IPTp	CC No CC	45 58	3.3	NS	CC No CC	47 58	2.4	NS	CC No CC	43 58*	4.5	0.03
	Curative service use	CC No CC	26 33	1.1	NS	CC No CC	34 33	0.22	NS	CC No CC	18 33*	5.9	0.01
	Exclusive breastfeeding	CC No CC	61 62	0.02	NS	CC No CC	82 62	9.92	**0.002**	CC No CC	40 62*	9.68	0.02
	Breastfeeding up to 23 mos									CC No CC	48 53	0.05	NS

	Family planning	CC No CC	61 56	0.51	NS	CC No CC	69 56	3.6	NS	CC No CC	53 56	0.18	NS
Ndekesha	ANC-4	CC No CC	59 78*	8.3	0.003	CC No CC	56 78*	10.9	<0.001	CC No CC	62 78*	6.09	0.01
	IPTp	CC No CC	61 70	0.02	NS	CC No CC	62 60	0.08	NS	CC No CC	70 60	2.1	NS
	Breastfeeding up to 23 months									CC No CC			
	Exclusive breastfeeding at 6 months	CC No CC	62 41	8.82	**0.002**	CC No CC	63 41	14.69	**<0.001**	CC No CC	56 41	4.50	**0.03**
	Curative service use	CC No CC	35 43	1.3	NS	CC No CC	39 43	0.33	NS	CC No CC	32 43*	9.0	0.002
	Family planning	CC No CC	32 43	9.0	0.002	CC No CC	39 43	0.33		CC No CC	23 43*	9.0	0.002

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Dibaya Champion Communities were especially successful with breastfeeding. A 23-year-old female in Dibaya said:

> "The Champion Community came to my house because they saw that I was pregnant. They told me about breastfeeding and not giving water to the baby until she is 6 months old. I have 3 children, and the first two I always gave water and they were sick. For this baby (3 months old), I have not given water and this is the healthiest baby I have had. She has not had any diarrhea, and I am very happy so I shared the message with other women at the church."

This visually appearing well fed, alert baby is unlike many of the infants seen in villages in DRC. In comparison, this baby was calm, had significant brown fat[25] at the neck line, and was alert and playful during the discussion with her mother.

Mwene Ditu Coordination

Mwene Ditu has four IHPplus Champion Communities, two of which are NGOs. (Table 14) One of the IHPplus Champion Communities is awaiting the final paperwork for NGO status. There are four autonomous Champion Communities; two which are Champion Youth and one of these (RACOJ) which gained NGO status in March 2018 in addition to becoming the first Champion Youth established and the first autonomous Champion Community to gain NGO status and gain outside funding. Another of the autonomous Champion Communities has submitted paperwork for NGO status. There is one autonomous Champion Community in development, as it needs to add one health area to be considered a Champion Community. This coordination overlapped with E2A projects on family planning. E2A opted to pay Champion Community members (15USD/person/month) to mobilize for family planning which undermined the IHPplus approach and caused the Champion Community members to abandon the action plans and income generation projects they developed for sustainability and independence. By reinforcing handouts instead of independence, these Champion Community members succumbed to short-term assistance instead of thinking forward and for the future. This coordination also had a period of time where there was no field BCC specialist. Once a BCC Specialist was back in the field, the Champion Communities that abandoned their action plans were re-established in 2017 and some of the undermined Champion Communities opted to forego the funding from E2A.

Table 14: Summary of Mwene Ditu Coordination Champion Communities

Name	Year established	# members	Health zone	Health areas covered	Action plan objectives	NGO status	Outside funding
Mwene Ditu IHP/IHPplus Established Champion Communities							
CC Tutante	2014	Total 496 Women 288 Men 192 Youth 16	Bibanga	Bibanga Lukangu Tshikuyi Manja	Assisted birth ANC-4 Family planning Curative Services WASH TB	In process	None
NGO Thuyany Kuruth	2014	Total 40 Women 9 Men 16 Youth 15	Wikong	N.D.G. Carrière Kayind	ANC-4 Family planning Curative services Malaria WASH	Yes	None
NGO Bujitu Bwetu	2014	Total 70 Women 21 Men 25 Youth 24	Kanda	Kapangu Bakwa Bowa Kabwela	Assisted birth ANC-4 Breastfeeding (exclusive and up to 6 mos) Nutrition WASH	Yes	None

[25] A type of fat among infants that shows high rates of nutrition.

CC Tokay Kuhal	Juin 2014	Total 259 Women 74 Men 123 Youth 62	Kalenda	Kalenda Gare Tshilomba Kabiji	ANC-4 Family planning Malaria TB WASH	No	None
Autonomous Champion Communities							
CC Lukata	2016	Total = 22 Femmes=6 Hommes=9 Jeunes=7	Mwene Ditu	Matobo B.I.K Bondoyi	Family planning TB WASH	No	None
NGO Champion Youth RACOJ	2015	Total = 500 Girls 282 Boys 218	Mwene Ditu	Musampi Regideso Bondoyi Mandam	GBV Early marriage Family planning HIV/STI	Yes	Unicef Afya Santa
CC Communion Fraternelle	2016	Total 31 Women 12 Men 11 Youth 8	Kalenda	Tshikala Lubambala Kabwe	Family planning Nutrition WASH	In Process	None
Champion Youth Bukebikebi	2016	Total 36 Girls 12 Boys 24	Bibanga	Bibanga Lukangu Tshikuyi Manja	GBV Early marriage HIV/STD	No	None
Autonomous Champion Communities (in progress)							
CC Tuya Kumpala	2016	Total 25 Women 9 Men 12 Youth 4	Kanda	Tshisawu Kanda	Assisted birth Breastfeeding (exclusive and up to 6 mos) Family planning WASH	No	None

In **Bibanga**, rates of ANC-1 use in all health areas are 80-90%; however, IHPplus Champion Community health areas rates were higher than non-Champion Community health areas and statistically significant. Assisted birth, ANC-4 rates in the IHPplus Champion Community health areas and non-CC health areas were not statistically different. In the IHPplus implemented CC health areas, rates for family planning and curative service use were higher than health areas with no Champion Community. The autonomous Champion Community which covered the same health areas as the IHPplus Champion Community had several different action plan indicators including HIV and sexual violence; however, there were no data to assess these in DHIS2. (Table 15)

The **Kalenda** health zone autonomous Champion Community health areas did not improve family planning rates when compared with non-Champion Community health areas. The IHPplus Champion Community became inactive after another organization offered to pay members to focus on objectives of the donor. They abandoned their action plan (ANC-4, FP, Malaria and TB) and even stopped their income generation project as the other organization gave them gifts. In doing so, the sustainability and independence of this Champion Community was undermined and therefore, the mentorship also ended for the autonomous Champion Community in this health zone which may explain the high rates of family planning use. They are currently working for E2A on family planning only which helps to explain the

rates in the IHPplus Champion Community health areas but they are being paid to do this work ($15/person/month) which is not sustainable. The IHPplus Champion Community worked (2015-2016) on nutrition and were able to get moderate malnutrition rates among children 6-23 months down to 4% compared with 34% in health areas with no Champion Communities.

In **Kanda** health zone, the IHPplus Champion Community had better rates of ANC-4 and family planning than health areas without Champion Communities. Malaria visits (mean number of visits) for diagnosis and treatment were higher among the health areas where the Champion Community was working; however, the difference failed to reach statistical significance. (4765 vs 3295; t-value = 1.30, P = 0.23). There were no statistical differences for assisted birth rates and moderate malnutrition rates among children 6-23 months despite lower rates in the Champion Community health areas.

In **Mwene Ditu** health zone, there are two autonomous Champion Communities; including one Champion Youth sub-group. The Champion Youth worked on HIV and sexual violence. Both Champion Communities worked on family planning and although they had higher rates of acceptance of modern methods, the differences did not reach statistical significance when compared with health areas with no Champion Communities.

Wikong health zone has only one IHPplus Champion Community. Rates of curative services use were not different from the health areas without Champion Communities. However, they were able to statistically different rates whereby, 89% of reproductive age couples utilize modern methods of family planning compared to 40% of couples in health areas without Champion Communities.

Table 15: Mwene Ditu Coordination Champion Community Impact Analysis

Health zone	Action plan indicators	Health areas	All CCs %	All CCs X^2	All CCs P	Health areas	IHPplus %	IHPplus X^2	IHPplus P	Health areas	Autonomous %	Autonomous X^2	Autonomous P
Bibanga	Assisted Birth					CC	99	1.02	NS				
						No CC	97						
	ANC-1					CC	80	3.0	**0.04**				
						No CC	90						
	ANC-4					CC	42	0.50	NS				
						No CC	47						
	IPTp					CC	83	0.29	NS				
						No CC	80						
	Family planning					CC	41	4.4	**0.04**				
						No CC	27						
	Curative services use					CC	69	7.5	**0.006**				
						No CC	50						
Kalenda	ANC-4					CC	33	4.67	0.03	CC	42	0.51	NS
						No CC	48*			No CC	48		
	Family planning					CC	70	69.5	**<0.001**	CC	14	0.17	NS
						No CC	12			No CC	12		
	Children 6-59 mos with moderate malnutrion					CC	4	29.2	**<0.001**	CC	51*	5.9	0.02
						No CC	34			No CC	34		
Kanda	Assisted birth					CC	80	0.12	NS				
						No CC	78						
	ANC-4					CC	71	6.2	**0.013**				
						No CC	54						
	IPTp					CC	80	2.4	NS				
						No CC	88						
	Family planning					CC	86	95.3	**<0.001**				
						No CC	17						
	Children 6-59 mos with moderate malnutrion									CC	47	1.28	NS
										No CC	55		
Mwene Ditu	Family planning									CC	9	0.64	NS
										No CC	6		
Wikong	ANC-4					CC	63	0.55	NS				
						No CC	68						
	IPTp					CC	87	1.8	NS				
						No CC	80						
	Family planning					CC	89	52.4	**<0.001**				
						No CC	40						
	Curative services use					CC	39	0.02	NS				
						No CC	40						

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Tshumbe Coordination

This coordination has two IHPplus implemented Champion Communities; one with NGO status and two autonomous Champion Communities. (Table 16) The inactive Champion Community in Dikungu had leadership issues that could not be resolved. This inactive Champion Community also misappropriated

the funds for income generation, leaving projects incomplete and no ability to develop funding for messaging.

Table 16: Summary of Tshumbe Coordination Champion Communities

Name	Year established	# members	Health zone	Health areas covered	Action Plan Objectives	NGO Status	Outside Funding
Tshumbe IHP/IHPplus Established Champion Communities							
NGO Djalo Ndjeka:Tonge Kame dia pudipudi ka dembadiaso	2013	Total 30 Women 6 Men 16 Youth 8	Djalo	Djalo Catholique Ombeka Vimbo Ekanga	Assisted birth ANC-4 Family planning GBV DTC/HepB/HIB Measles TB	Yes	None
CC Minga	2014	Total 9 Women 4 Men 3 Youth 2	Minga	Ekaya ShengaMukundji Okunu	Assisted birth ANC-4 Curative services	No	None
Autonomous Champion Communities							
CC Tshumbe: Tosene dia yongeyangelokaso	2015	Total 34 Women 12 Men 18 Youth 4	Tshumbe	Tshumbe 1 Tshumbe 2 Kalema	Assisted birth ANC-4 DTC/HepB/HIB Measles Family planning Nutrition Malaria	No	None
CC Katako Kombe: Demba Ki	2017	Total 21 Women 12 Men 6 Youth 3	Katako Kombe	Omekadingele Lotola Lotahe	Assisted birth ANC-4 Family planning GBV DTC/HepB/HIB Measles HIV Exclusive breastfeeding Malaria/ITN use TB Potable water WASH Latrines	No	None
Inactive Champion Communities							
CC Dikungu	2013	1	Total 31 Women 9 Men 18 Youth 4	Dikungu	Dikungu Okako Opombo Tese		

Champion Community health areas in **Djalo Djeka** health zone did not have better rates of assisted birth, ANC-4, family planning, or vaccination rates when compared with non-Champion Community health areas. ANC-4 and family planning rates did trend higher but did not reach statistical significance.

In **Katako** health zone, family planning and exclusive breastfeeding rates were statistically higher than health areas with no Champion Community. (Table 17) ANC-4 and vaccination trended towards higher

rates, but these differences are not statistically significant to date. This autonomous Champion Community also worked on malaria. The mean number of visits for diagnosis and treatment (mean = 3526) was higher than the mean number of visits (mean = 1484) for malaria diagnosis and treatment in health areas with no Champion Communities, however the trend was not statistically significant (T-value = 1.6; P = 0.16).

The IHPplus Champion Community in **Minga** health zone had statistically significant higher rates of ANC-1, ANC-4, curative service use and family planning rates than health areas with no Champion Communities.

In **Tshumbe** health zone, the autonomous Champion Community had higher rates of ANC-4, curative service use and family planning when compared with non-Champion Community health areas. Assisted birth and vaccinations rates were not statistically different despite trending towards higher rates in health areas with the Champion Community. There was no statistical difference between the Champion Community health areas and non-Champion Community health areas for malnutrition rates among children 6-23 months. The mean number of visits for malaria diagnosis and treatment (mean = 1482) was higher than the mean number of visits (mean = 194) for malaria diagnosis and treatment in health areas with no Champion Communities, however the trend was not statistically significant (T value = 1.58; P = 0.19).

Table 17: Tshumbe Coordination Champion Community impact analysis

Health Zone	Action Plan Indicator	IHPplus				Autonomous			
		Health Area	%	X^2	P	Health Area	%	X^2	P
Djalo Djeka	Assisted Birth	CC No CC	90 82	2.65	NS				
	ANC-4	CC No CC	96 91	2.05	NS				
	IPTp	CC No CC	72 65	1.13	NS				
	DPT/HepB/HIB	CC No CC	89 94	3.53	NS				
	Measles	CC No CC	89 96	3.53	NS				
	Family planning	CC No CC	46 56	2.01	NS				
Katako	Assisted birth					CC No CC	83 77	1.12	NS
	ANC-4					CC No CC	68 57	2.5	NS
	IPTp					CC No CC	79 84	0.8	NS
	Exclusive breastfeeding					CC No CC	94 63	28.46	**<0.001**
	DPT/HepB/HIB					CC No CC	91 88	0.47	NS
	Measles					CC No CC	91 85	1.70	NS
	Family planning					CC No CC	28 16	4.2	**0.04**
Minga	Assisted birth	CC No CC	88 63	16.8	**<0.001**				

	ANC-1	CC No CC	87 62	16.4	**<0.001**				
	ANC-4	CC No CC	67 37	18.0	**<0.001**				
	IPTp	CC No CC	64 69	0.5	NS				
	Curative services use	CC No CC	55 30	12.8	**<0.001**				
	Family planning	CC No CC	31 5	12.7	**<0.001**				
Tshumbe	Assisted birth					CC No CC	88 78	3.54	NS
	ANC-4					CC No CC	78 61	6.8	**0.009**
	IPTp					CC No CC	80 80	1.0	NS
	DPT/HepB/HIB					CC No CC	85 83	0.15	NS
	Measles					CC No CC	79 74	0.69	NS
	Curative services use					CC No CC	79 39	33	**<0.001**
	Family planning					CC No CC	22 8	7.6	**0.005**
	Children 6-59 mos with moderate malnutrion					CC No CC	36 33	0.19	NS

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Uvira Coordination

Uvira is one of the oldest coordinations for Champion Communities. There are five IHPplus Champion Communities that have now become NGOs, two of which have Champion Men sub-groups (Table 18). In addition, there are two autonomous Champion Communities and a new autonomous Champion Mamas that was started after the regional exchange conferences in May 2018 along with two other developing Champion Communities.

Table 18: Summary of Uvira Coordination Champion Communities

Name	Year established	# members	Health zone	Health areas covered	Action plan objectives	NGO status	Outside funding
IHP/IHPplus Established Champion Communities							
NGO Amkeni **(added Champion Men March 2018)**	2013	Total 43 Women 17 Men 20 Youth 6	Nundu	Mboko Nundu Kaboke 2	ANC Vaccinations Family planning Nutrition WASH Latrines HIV	Yes	IHPplus 5000 USD Fondation Fondalmu + IHP 1500 USD World Bank 3750 USD

							Geades, Fondalmu
NGO Mwangaza	2013	Total 68 Women 29 Men 24 Youth 15	Uvira	Kasenga cepac Kasenga etat Kiyaya	ANC-4 Vaccinations Family planning Malaria Cholera Potable water Latrines	Yes	International Rescue Committee 1500 USD Association De Santé Familiale 2000 USD IHPplus 5000 USD Panzi Foundation CPAC
NGO Afya Kwa Wote	2013	Total 37 Women 11 Men 16 Youth 10	Uvira	Kavimvira Kilomoni Kala	ANC-4 Vaccinations Family planning Malaria Nutrition TB GBV Potable water Latrines	Yes	Adventist Development and Relief Agency 18,000 USD Health zone (Uvira) IHPplus 5000 USD
NGO Mulangliro + Champion Mamas	2013	Total 22 Women 9 Men 8 Youth 5	Ruzizi	Sange Etat Nazareno Sange Cepac.	ANC-4 Vaccinations Family planning Breastfeeding (exclusive and up to 23 months) Nutrition GBV	Yes	IHPplus 5000 USD
NGO Uamusho	2013	Total 25 Women 11 Men 8 Youth 6	Ruzizi	Kiliba cepac Kiliba sucki Cebeka Kakando	ANC-4 Vaccinations Family planning Breastfeeding (exclusive and up to 23 months) Nutrition Malaria GBV TB	Yes	IHPplus 5000 USD
Autonomous Champion Communities							
CC Kigurhe	2016	Total 16 Women 5 Men 7 Youth 4	Ruzizi	Kigurhe Rumingu Kigoma	ANC Vaccinations Family planning	No	None

					Breastfeeding (exclusive and up to 23 months)		
CC Afya Bora	2018		Nundu	Mukolwe, Bitobolo Lusenda		No	None
Autonomous Champion Communities (in development)							
CC Mamas	2017	Total 61 Women 44 Youth 17	Ruzizi	Cite de Sange	ANC Vaccinations Family planning Breastfeeding (exclusive and up to 23 months)	No	None
TBA	2018		Uvira			No	None
TBA	2018		Uvira			No	None

In the **Nundu** health zone, there is one Champion Community. They have focused primarily on family planning and have higher rates of family planning (modern methods) compared with health areas without a Champion Community. The ANC-1 rates are high and are not statistically different for Champion Community and non-Champion Community health areas. But for ANC-4, the Champion Community health areas performed worse than health areas with no Champion Community. Immunization rates were 98% for Champion Community health areas and were not statistically different from health areas without Champion Communities, this may simply reflect an already high percent of vaccination coverage and health zone level vaccine campaigns across the coordination. (Table 19)

Ruzuzi health zone has two IHPplus Champion Communities and one autonomous Champion Communities that began in 2016 to work on improving water sources in their communities. The IHPplus Champion Community which include a Champion Mamas sub-group who work specifically on maternal health issues, in their health areas there were higher rates of ANC-4, family planning, and breastfeeding rates (exclusive and breastfeeding up to 23 months) than health areas with no Champion Communities. And although the malnutrition rates are lower in the Champion Community health areas, they did not reach statistical significance in 2017. The autonomous Champion Community has significantly higher rates of breastfeeding than non-Champion Community health areas and has rates above 90% for vaccinations but has not done well on getting women to ANC when compared with non-Champion Community health areas. Malaria visits for diagnosis and treatment were higher among the health areas where the Champion Community is working; however, the difference failed to reach statistical significance. (Mean no. visits 2516 vs 1693; t-value = 0.88, P = 0.40)

For the **Uvira** health zone, the Champion Community health areas had statistically higher rates of ANC-1, ANC-4, vaccination and family planning rates. DPT/HepB/HIB rates trended to be higher in Champion Community areas (88% vs 80%) but were not statistically different from non-Champion Community health areas. Malaria visits for diagnosis and treatment were higher among the health areas where the Champion Community is working; however, the difference failed to reach statistical significance. (Mean no. visits 2099 vs 1693; t-value = 0.43, P = 0.68)

Table 19: Uvira Coordination Champion Community impact analysis

Health zone	Action plan indicator	Health Aarea	All CCs % P	X^2		Health Area	IHPplus % P	X^2		Health Area	Autonomous % P	X^2	
Nundu	ANC-4					CC No CC	70 82*	3.9	**0.04**				
	IPTp					CC No CC	74 86*	4.5	**0.03**				
	DPT/HepB/HIB					CC No CC	98 99	0.56	NS				
	Measles					CC No CC	98 97	0.2	NS				
	Family planning					CC No CC	79 58	10.2	**0.001**				
Ruzizi	ANC-4	CC No CC	35 27	1.5	NS	CC No CC	46 27	7.8	**0.005**	CC No CC	24 27	.27	NS
	IPTp	CC No CC	53 41	2.9	NS	CC No CC	59 41	6.5	**0.01**	CC No CC	48 41	0.99	NS
	DPT/HepB/HIB	CC No CC	93 94	0.08	NS	CC No CC	91 94	0.65	NS	CC No CC	96 94	0.42	NS
	Measles	CC No CC	92 91	0.06	NS	CC No CC	92 95	0.06	NS	CC No CC	93 91	0.27	NS
	Family planning	CC No CC	11 5	2.4	NS	CC No CC	13 5	3.9	**0.04**	CC No CC	10 5	1.8	NS
	Children 6-59 mos with moderate malnutrition					CC No CC	42 50	1.29	NS				
	Breastfeeding up to 23 months	CC No CC	81 47	25.1	**<0.001**	CC No CC	91 47	45.2	**<0.001**	CC No CC	71 47	11.9	**<0.001**
	Exclusive (6 mos) breastfeeding	CC No CC	52 21	20.7	**<0.001**	Cc No CC	56 21	25.8	**<0.001**	CC No CC	49 21	17.2	**<0.001**
Uvira	ANC-4					CC No CC	78 54	12.8	**<0.001**				
	IPTp					CC No CC	76 71	0.6	NS				
	DPT/HepB/HIB					CC No CC	88 80	2.4	NS				
	Measles					CC No CC	95 75	9.0	**0.002**				
	Family planning					CC No CC	19 3	13.0	**<0.001**				

*Rates higher among non-Champion Community health area; p>.05 means the Champion Community health areas performed worse

Champion Community Successes

Behavior Change

Based on the analysis in the previous section, Champion Communities are able to promote healthy behaviors and increase uptake to high priority health services in the health areas where they work compared with health areas that do not have Champion Communities. Where there are also Ministry of Health (zonal or community level) campaigns such as for malaria and vaccination, Champion

Communities are important for interpersonal communication of the messages and help to galvanize communities to change behaviors and access high impact health services, especially for MNCH.

Health Indicators

Health indicators improved with the implementation of the Champion Community approach as shown by the analysis of indicators in health areas with and without Champion Communities. Although not all of the indicators improved, factors that hindered this included local context, may include the presence of other influencers such as the Church of the Apostate, poverty, other organizations working on the same indicators and climate change.

Income Generation

Income generation gave the Champion Communities independence and autonomy and an ability to support activities and other priorities. Income generation was decided by the community and included collecting dues monthly, VSLA models, agriculture projects, fish farming, livestock and small animal breeding. Other examples included buying a motorcycle or bicycle that served as a community taxi, starting a community pharmacy and selling time on computers for students and computer members.[26]

With income generation, Champion Communities were able to:

- Build and/or repair health facilities
- Add maternity wings to existing health facilities
- Build latrines at the household level or at markets
- Buy land for new health facilities or agriculture projects
- Buy computers for Champion Community work and for rent
- Buy cell phones and extend credit to Closed User Groups (CUGs) and mHealth initiatives
- Repair and rebuild roads and bridges that improve access to health facilities
- Buy ambulances or other means of transport to aid emergency transportation
- Pay or subsidize health facility fees for MNCH services for pregnant women
- Buy livestock and small animals for increasing breeding programs
- Build fish ponds for fish farming
- Buy seeds and agricultural equipment
- Pay school fees and immunization fees for refugee children
- Build and buy materials for schools

Sustainability

In Champion Community approaches in other countries and in DRC (ProVIC) by previous implementers, the Champion Communities were reliant on project funding. After the end of the project, Champion Communities ceased activities and disappeared.

Income generation and the development of NGO status was a transformative step to independence, autonomy, and sustainability of IHPplus approach. Outside funding allows communities to be independent and sustainable and solve community health issues on their own. Over the course of the project, Champion Communities in the health zones of Katana, Uvira, Nundu, Dibaya, Luiza, Mwene Ditu, and Lomela were able to write proposals and obtain outside funding from other donors, including

[26] See case studies for specifics and details of the examples provided.

numerous NGOs, World Bank, UNICEF, health zones and MOH funds, among others (see Summaries and Impact section). With NGO status and income generation, the community chooses its health priorities and advocates for its needs, becoming partners in health and development instead of just a means to meet project goals. Even remote areas, where donors are limited or harder to find, communities identified funding from NGOs and missionary boats that came on nearby rivers. They were able to submit proposals and obtain funding (e.g., Lomela obtained Cordaid Funding for school construction and school supplies).

Even the autonomous Champion Communities are applying for funding; as of March 2018, the first autonomous Champion Youth (RACOJ in Mwene Ditu) gained NGO status, and a few others are now doing the same with mentorship from the IHPplus-implemented Champion Communities.

Challenges

Remote Communities

Remoteness of many of the Champion Communities limited frequent oversight and capacity building on a regular basis. Furthermore, due to the lack of roads and limitations to travel during the rainy season, visiting Champion Communities on a regular basis were limited. In areas where the rainy season prevented travel, there were six-month periods where phone contact was the only means for oversight. In some of the more remote areas, Champion Communities utilized local resources to build capacity. For example, Champion Communities in Lodja hired a youth NGO to help build their income generation capacity by learning about accounting and transparency. Remoteness, however, helped with indicator success.

Using Skills to "Fish"

Changing the mindset from handout to using skills to "fish" remains one of the biggest challenges. However, it was noted that women were more likely to understand that independence was more important than waiting for 'handouts' and were able to be the change agents for some of the most successful Champion Communities.

Women's Participation

In many areas where the approach was implemented, paternalism persists. In some cases, Champion Communities would form without asking for the participation of women. These Champion Communities were not as successful (e.g., Kabongo) as Champion Communities with a more representative group of women. This required urging Champion Communities to represent the community and include women and youth. The autonomous development of Champion Mamas in Ruzizi and Katana health zones as well as the "take-over" of women in Kabongo in late 2017, statistically shows improved and higher rates of MNCH indicators especially for breastfeeding and nutrition.

Use of Local Language

To ensure women's participation, the use of local language in meetings was very important. It was not uncommon for men in the group or even provincial and zonal authorities to insist on the use of French. It was apparent during visits to the Champion Communities that the use of French disenfranchised women who would not raise their hand to say they did not understand what was being said.

Accounting and Transparency

Champion Communities need more capacity building for accounting and more importantly transparency when funds are given as small grants. There was poor understanding of contracts and many utilized funds that were not within the scope of the contract they signed. In several cases, funds given for community mobilization were utilized for buying livestock or small animals and to boost their income generation. Better transparency will help improve their credibility and standing to receive outside funding.

Data Collection

Data collection skills are lacking at the community level. Support at higher levels is needed. Some of the indicators chosen by Champion Communities on their action plans were not data collected at the health facility level or integrated into DHIS/DHIS2 such as WASH, latrines, potable water points, mosquito net use, tuberculosis referral and treatment, and gender based violence. These could have been easily collected by Champion Communities. Furthermore, DHIS/DHIS2 only began health area level data in 2017. Prior to 2017, health area level data would have been helpful to follow indicator trends for health areas with and without Champion Communities.

Staff capacity and accountability

There are few if any SBCC educational opportunities in DRC. Although staff have degrees from universities, and some in SBCC, these programs are not comprehensive and lack the necessary rigor to allow expertise in community mobilization in a range of contexts of DRC. In many cases, staff suffered from paternalism at higher levels, diversity (female versus male staff) accountability and professionalism.

What Did Not Work

Although there are certain interventions that were unsuccessful, DHIS/DHIS2 did not have health area level data until 2017; therefore, it was not possible to assess changes over time as there was no funding for a randomized control trial and the final assessment for IHP was not designed to assess the Champion Community effort which is implemented at the health area level and not at the health zone level. The endline did sub-group by health zones where the approach was implemented or weight the data for population differences, which may have under- or over-estimated the results.

Project Implementation Area Overlap

Donor funded projects frequently had overlapping implementation areas. As the Champion Community approach promoted self-reliance and independence, another USAID-funded project that utilized paying Champion Community members to do their community mobilization undermined IHPplus Champion Communities and in one health zone, the Champion Community abandoned its action plan and income generation because they were offered 15 USD/person/month to do family planning community mobilization. This is wholly unsustainable and giving material incentives instead of insisting on the use of income generation undermines independence and feeds the handout mentality that is prevalent.

Small Grants

Small grants from the funding project do not support independence and feed the “handout mentality.” Even with better capacity building for this process, and given the context of DRC, it is better to build grant writing, presentation, accountability, and transparency skills for utilization of their NGO status for outside funding.

Closed User Groups

The Closed User Group (CUG) is a program through which phones are provided (phones and credit were bought and replenished by the project) to community members chosen by the community to be the person(s) who organize information around health topics. For example, these CUGs were paired with mHealth, and if a community member had questions, he/she could call the person with the CUG phone for more information. The CUG, if they could not answer the phone, could call someone else for help or enlist the nurse/doctor at the health center to have a conference call with the person who asked the question, or refer them to another community member who may have experience in the issue already. The CUGs were implemented in seven health zones with 85 phones distributed in these communities with some communities self-funding ten other phones for use in the CUG. Motivation and sustainability was an issue in some communities. It is not clear how the program would continue after IHPplus no longer supported the program, and there was little will to continue to CUGs among communities involved with the CUGs. Many communities are open about talking about sensitive topics so the use CUGs for this issue was not as important. More importantly, men controlled the phones despite being urged to allow women and other family members to participate and/or control the phone and therefore women, who may have benefited did not have that chance. By giving women phones, the program would allow women to advocate for their needs which may lead to better health.[27] In addition, given the women's health focus of topics sent via SMS, building women's networks and empowerment will be vital in changing behavior and increasing the capacity of women in their own health advocacy in DRC despite the persistence of paternalism.

Green Line

With the exception of vaccination and malaria campaigns for answering questions and getting information, the Green Line proved to be expensive and not as effective as the Champion Community for continual SBC activities.

CommCare

As the data collection capacity of both the community and staff was limited, the implementation of CommCare for collecting data via cell phones required constant supervision and capacity building. Without support at the Kinshasa level, the will and desire to collect data at the community level was low and therefore this intervention was not possible as designed. DHIS2 now collects data at the health zone level, which may be valuable for collecting data the DHIS2 does not collect such as WASH and GBV data among other indicators that the Champion Communities chose as health priority areas.

Lessons Learned

The approach shows "Economy of Effort" and "Value for Money" as Champion Communities are being contracted for their expertise by USAID, other International and local partners such as the Ministry of Health and the Health Zone to aid in health campaigns and household sensitization. In addition the creation of autonomous communities gives the project "three for one" (three autonomous for every project implemented Champion Community).

[27] Declaration of Human Rights; Health and Human Rights Model.

The IHPplus Champion Community approach in DRC is now a "gold standard[28]" in community mobilization and behavior change. Champion Communities change behavior and increase access and utilization of high impact health services. Given the sustainability of the approach and acceptability among other communities through the development of autonomous Champion Communities, this approach should be integrated into the developing National Community Health Plan.

Location

- Based on the IHPplus experience and analysis, Champion Communities best placed in remote and or insecure areas suffer from outside influence of messaging and other organizations in the area and are far more difficult fixes to health services due to distance or insecurity
- Despite remoteness, Champion Communities are adept at describing and finding solutions to local problems
    - Lomela has seen a decrease in bush animals with climate change therefore they started fish farming to decrease reliance on bush meat
    - Lodja decided they needed capacity building for finance and management; they hired someone to come and train them
    - Uvira decided that un-vaccinated refugee children put community children at a greater risk, so they used their funds to vaccinate all refugee children
- Although the Champion Community approach can work in any context, in more urbanized areas the same indicators may not be priority (MNCH) whereas problems such as HIV/STDs, GBV and drug and alcohol use may be higher priority health issues for communities that are not remote

Monitoring, Evaluation, Learning and Impact

- Impact analysis should be periodically done to assess whether the mobilization activities are working. Quarterly impact assessment allows incremental adjustment to the program and allows feedback to each Champion Community

Membership and Decision Making

- It is vital to incorporate community leaders (religious, traditional, health) into the approach including local authorities so they can learn the approach and support the Champion Community on priorities
- Decisions must be democratic
- Women must be represented and included in all levels of the process
    - In DRC it is important to overcome the paternalism that exists in many areas

Making the Approach Sustainable

More than 85% (28/33) of the IHPplus established Champion Communities are registered NGOs; the rest have submitted their paperwork for approval as a registered NGO. Over the course of the last two years of the project, the Champion Communities that have NGO status have professionalized. Many now have letterhead and stationary, an e-mail address, and several have a stamp with a logo to represent the NGO. (Figure 8)

Figure 8: NGO official stamps for several Champion Communities

[28] A medical term to describe "a thing of superior quality which serves as a point of reference against which other things of its type may be compared" (e.g. exclusive breastfeeding for infants).

- Unlike previous Champion Community approaches in DRC, which did not continue after the cessation of funding, the IHPplus Champion Community approach has proven to be not only successful but sustainable and "naturally transitioning"
- Income generation and NGO status were important transformative steps in autonomy, sustainability and independence
- The mindset of handouts versus "fishing' is important to reinforce from the beginning
- Technical capacity building should be prioritized over funding or material support
- Small grants from the project should be avoided and instead focus on building the capacity for grant writing, presentation, accounting and transparency
- A standard package of training, besides the community mobilization techniques would help to ensure capacity is uniform across the approach

Autonomous Development of Champion Communities and Mentoring

- Other communities realized the benefits and are starting their own autonomous Champion Communities and using IHPplus communities to mentor them in the process of development
- For each established Champion Community, on average, three other Champion Communities develop autonomously
- Even with sub-contracts finished, autonomous Champion Communities continue to develop

Finally, this modified approach is now being adapted to other countries (e.g., Malawi on the USAID-funded ONSE Health Project) with similar success and serves as a model for community mobilization that is sustainable and now a Gold Standard for community mobilization.

CHAMPION COMMUNITY
IMPLEMENTATION STEPS

Principles for Implementing the Community Champion Approach

Photo: Lynn Lawry; OSC Ltd.

Champion Community Meeting Djalo Djeka Health Zone, DRC

The Community Champion approach is part of the implementation of the IHPplus project activities in the implementation health zones, building on other existing community participation structures to maximize and coordinate all SBCC activities that contribute to the overall goals of the project:

To support the National Health Development Program of the DRC, which is designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices in four provinces of the DRC with 168 target health zones.

Thus, this approach is focused at the health area level and among all social groups and all segments of the population (men, women and young people). The approach is open to anyone who wishes to contribute to the development of the community in which they live.

Justification of the choice of health zones, villages, health areas and health center(s) that will participate in the approach should be codified and catalogued and introduced to the stakeholders at the start of the approach. The development of a compendium of statistics on these villages/health center catchment areas where Champion Communities will be developed is needed for monitoring and evaluation in addition to choosing areas that are in need. Per the experience of IHPplus, the approach works best in remote and insecure areas and less so in more urbanized or easy to access settings. The process of determining objectives is based on statistical data collected at the provincial/health area/health zone and national level. These statistical data will help to determine the initial situation of the community in relation to the health issues identified and aids in the development of action plans for the Champion Communities through the use of a problem tree analysis.

Examples of statistical data to be collected are the number of the population, the number of households in the village(s), the number of women of childbearing age, the number of children under 5 years, the number of newborns, the number of pregnant women etc. for each health area participating in the Champion Community approach. These data can be obtained at the level of health centers, local administrative offices, through DHIS etc. These data should be made available to the Champion Community by the local supervisors who may be in charge of collecting this data at the health area level.

Steps to Implementing the Champion Community Approach

The relationship between the Champion Community approach and major SBCC interventions is this approach serves as a supportive ("implementers") and additive approach to the community participation bodies. In doing so, this allows the effective application of multimedia and interpersonal communication interventions at household and community/village level. The Champion Community approach promotes the involvement of the community in the activities. This approach aids in getting various communication channels (posters, leaflets, advice cards, audio-video microprograms, sketches, songs, picture box, etc.) and other information technologies (mobile phones, community media) directly to the community and through trusted partners at the village and household levels. Thus, engaging the population to promote healthy behaviors and adapt negative social norms to more positive and healthy norms. Working with grassroots community structures facilitates quick and efficient implementation of the Champion Community approach. With "Smart Training" initiatives in mind, the steps will include only the key stakeholders in meetings that are meant to last hours and not days. Refreshments can be provided. The approach for establishment of a Champion Community as a check-list tool is available in Annex I.

Step 1 – Introducing the Approach to Zonal/Provincial Stakeholders

The coordination office of IHPplus for the implementing health zone, carries out the following activities:

- Organize courtesy visits to introduce the approach at the level of provincial and zonal health officials to provide information on the objectives of the SBCC approach, concepts, principles of the Champion Community approach and obtain their support

    - Key participants include:
        - Mayor and assistants
        - Zonal, provincial, and health area health authorities
        - Chief Medical Officer
        - CHW(s)
        - Community Health Nurse(s)
        - Traditional and religious leaders from each health area
        - CODESA representatives from each health area
        - RECOS from all the prospective health areas
        - Any other important/influential development actors

- Organize an introductory visit to the implementation health zone, health areas and provincial health officers to share the objectives, concepts and principles of the approach to obtain their support and involvement in the achievement of the community objectives
- Organize meetings with each mayor and provincial authorities for approval of the approach
- Organize community meetings facilitated by the CHW to elect the CPCC and the Executive Committee for the Champion Community
- Meet with the referral health facility to implement the approach, and for outcome tracking.
    - Key participants include:
        - Facility in-charge
        - Community nurse
        - CHWs
        - Executive Committee of the Champion Community
        - CODESA/CAC/RECO representatives from each health area
        - Data manager (if available)

Time: Zonal/provincial meeting 2-3 hours (1 day); Community meetings, 2-3 hours (1 day), Health facility 2-3 hours (1 day)

Step 2 – Introducing the Approach to Community Levels[29]

- Identify and meet with traditional, community and religious leaders to introduce the approach; this can include (if present); Territorial and/or village Chiefs, religious leaders within Champion Community, CBO representative(s) (if present), CODESA/CAC/RECOs, women's and youth groups
- Meet with interested Champion Community Members to introduce the approach
    - Gender and age balanced
    - Youth must be included
    - Other vulnerable groups
- Give the community time (~1 week) to discuss their potential participation and ideas regarding members of the Champion Community
- Work with the community to elect the executive committee members (President, Vice-President, Treasurer, and Secretary)
    - They should be able to read and write

[29] In initial development of the Champion Communities and to work within "smart training" parameters, all community-level introductions of the approach should be attended by health zone-level stakeholders.

    - Promote participation of women that reflect the overall proportion of women in the community
- Obtain their support and develop a written contract that is signed by the leaders in the community and the Champion Community Presidents/VP, and the Project

Time: Community meetings (1 day); time to contract (~1 week)

Step 3 – Development of the Champion Community

- Introduce the roles and responsibilities of each member of the Champion Community
- Help the Champion Community to develop the CPCC (e.g. executive committee members, community health and development structures, traditional and religious leaders)

Step 4 – Work Plan Development

- Utilize a participatory process such as a decision tree analysis (Annex VII) to develop the priorities and objectives of the Champion Community[30]
- Develop a six-month work plan that includes activities, indicators and goals with the Champion Community
- The Executive Committee, health facility nurse, and CHW are briefed on the action plan as they are the supervisors to ensure progress (ideally, they should be at action plan development)
- Encourage the development of a schedule for monthly meetings of the Champion Community and the Executive Committee (report templates should be given)
    a. Champion Community meets monthly
    b. Executive Committee meets monthly
    c. CPCC meets monthly (includes executive committee members)

Time – ½ day

Step 5 – Champion Community SBCC Training

- Strengthen capacity on financial management, transparency, microproject design, leadership, monitoring evaluation for the entire Champion Community
- Based on the action plan, and using the provincial and zonal health leaders, community mobilizers (CHWs), and any other community mobilization teams that utilize ETL methods[31] to train the Champion Community on sensitization techniques for their action plan indicators
- Encourage the Champion Community to develop SBCC products (Figure 4) that work within their community context (plays, community radio, songs, household visits for vulnerable groups such as pregnant women etc.) and utilize tools that exist (pamphlets, MOH materials etc.)
- Ask children to decorate the referral slip box
- Encourage and enable them to document success (video or photos)

Time: ~2 days

[30] Note the health priorities need to follow the objectives of the donor funded project but can also include of priorities chosen by the community. In later years when the Champion Community has its own funding and support they can elect to add other priorities.

[31] In areas where there are no trained community mobilizers on approaches such as ETL, combined training of CODESA, CHWs and the Champion Community should occur together.

Step 6 – Monitoring and Evaluation (M&E) Plan

- Collect baseline statistics for each indicator "Before Champion Community" (for example: number of pregnant women who deliver at the health facility before the Champion Community activities); should be available at the health facility or through project M&E
- Map Community Resources
- Champion Community coordinator, CHWs, health facility person (nurse) to work with project M&E to help the Champion Community develop an M&E plan that they can follow and implement[32]
- Implement a color-coded referral slip system and referral slip box at the health facility to help identify and count the number of referrals from different community mobilizers (CODESA vs Champion Community)
- Introduce a monthly written report template at Champion Community level – decide who will review and evaluate
    a. Enforce monthly written reports with statistics
    b. Develop review personnel and strategy for review
    c. Copies to be kept and filed with the project
    d. Reports should be shared with relevant stakeholders such as provincial and zonal health authorities

Step 7 – Evaluation and Certification

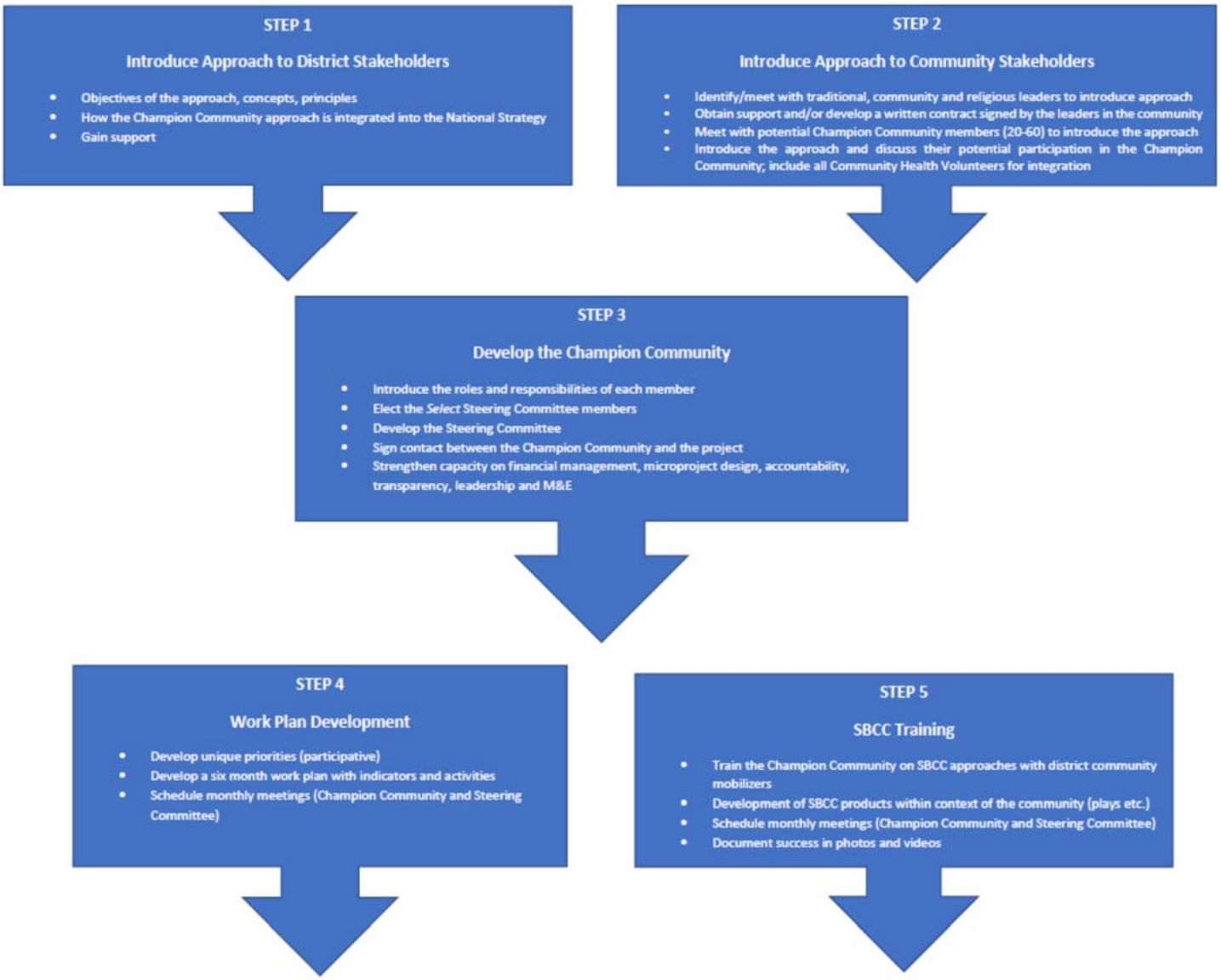
- Evaluate and adapt M&E to updated action plan at 6 months (e.g. 50-80% improvement indicators should be first goal for "Champion Community" qualification)
- With positive movement in indicators and success of the community working as a group, ask the group to come up with a name for their Champion Community
- Ceremony for certification as a "Champion Community"
    - Consider "important" person for the ceremony
    - Provincial/zonal authorities, mayor should be attendance
- Incentive fund distributed for income generation and guidelines for the use of the incentive fund[33]
- T-shirts, banner, hats or other identifying materials distributed[34]
- Continue with action plan for another six months
- Encourage community to build/allocate space for their Champion Community office and meetings supported by the income generation project
- Codify the Champion Community
    - Consider implementation of subgroups (Champion Men, Champion Mamas and Champion Youth)

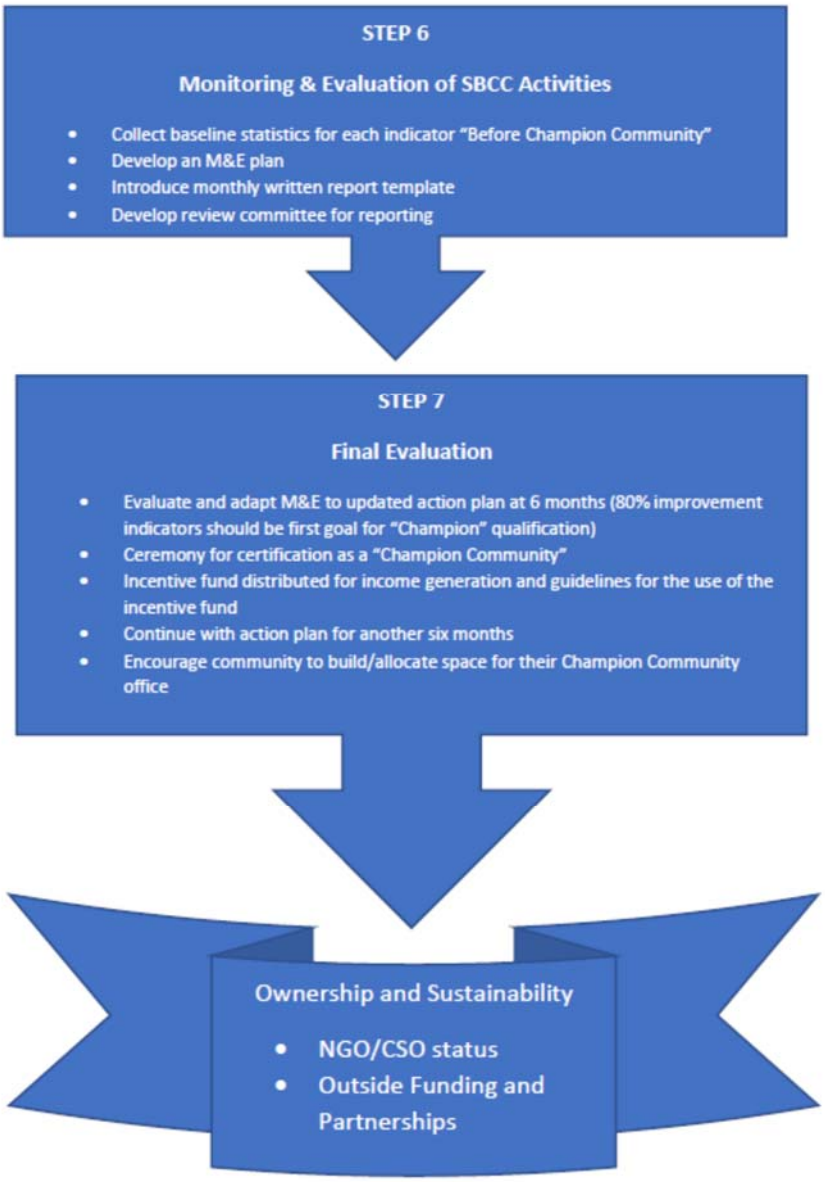
[32] Plan includes methodology for monthly data collection on each indicator/priority chosen by the community and the modality for keeping records (CommCare or other)

[33] This was not systematic in IHP/IHPplus. The Champion Communities without seed funding for income generation (IGR) were able to develop successful projects to support their activities. In general, monetary and material gifts should not be given to enforce and support the community's ability to be independent and sustainable and to change the mindset of handouts. If seed money is given, the amount should be nominal (100 USD). Technical capacity building should be prioritized over monetary or material support. With income generation, Champion Communities are fully capable to save money for projects and community needs.

[34] Although this was done in some cases, other Champion Communities created their own shirts, hats, banners without project funding. Again, it is important to create sustainability. If possible, avoid such distributions or limit them to the initial start up of the project.

Figure 9: Steps for the Development of a Champion Community




STEP 6
Monitoring & Evaluation of SBCC Activities
Collect baseline statistics for each indicator "Before Champion Community"
Develop an M&E plan
Introduce monthly written report template
Develop review committee for reporting
STEP 7
Final Evaluation
Evaluate and adapt M&E to updated action plan at 6 months (80% improvement indicators should be first goal for "Champion" qualification)
Ceremony for certification as a "Champion Community"
Incentive fund distributed for income generation and guidelines for the use of the incentive fund
Continue with action plan for another six months
Encourage community to build/allocate space for their Champion Community office
Ownership and Sustainability
NGO/CSO status
Outside Funding and Partnerships

Ownership and sustainability of the Community Champion approach

The sustainability of the activities of any donor funded development project is a challenge. The same applies to the Champion Community Approach. Sustainability must be stressed at the start of the approach and guided by a reliance on technical capacity building over material and monetary support. The one-time incentive grant given as a means for the community to develop an income generation project is an important element for the sustainability of the approach in the beginning but should be a nominal amount (100USD)[35]. In the experience of IHP and IHPplus, even Champion Communities that were not given an incentive/seed fund, developed highly successful income generation projects. This gives the community a self-sustained fund to allow them to cover the costs of SBCC activities to address the health priorities in their communities. Income generation training is better than giving money as it builds the capacity of Champion Communities in a myriad of ways to create income generation.

Members should NOT compensate themselves for work for their community. Transportation costs or the costs for water can be covered in the course of a mini-campaign or in household visits. The volunteer nature is what cultivates the community cohesion and ownership and sustainability of the process and approach.

At a later stage, Champion Communities should move from the status of informal structures to the status of a non-governmental development organization or association depending on national rules for such groups. This was the key factor for sustainability of this approach in DRC. Development of these communities as legal non-governmental development organizations, associations or CBO/CSOs ensured their ability to apply for and implement funding from various local partners to be local agents of development, successful, sustainable and transition to independence after the cessation of a program.

Training for grant writing, presentation, management of donor funds and other related topics is necessary for successful implementation as development organizations. Use of the small-grants funding as an early means of capacity building is a consideration for training but should be heavily monitored to ensure funding is used for project implementation and not funding of individuals to continue work that has been voluntary. This prohibits the undermining of sustainability and self-support that the Champion Community builds into its approach.

Monitoring and Evaluation

See Annex IV for an initial inventory for M&E forms. DHIS 2, as of 2017, can subgroup data by health areas. This allows Chi-square and T-tests analyses to compare Champion Community health area indicators with non-Champion Community health areas. Care should be given to compare distant health indicators areas to minimize confounding cross-over messaging in nearby health areas. As of 2018, not all Champion Community action plan indicators could be analyzed; for example, data were not collected on many WASH, TB, GBV, latrines, potable water, and HIV/STD indicators.

[35] When given to Champion Communities in IHPplus, 500 USD was the amount chosen; however, it was felt that this was too much and a nominal amount would have been better to reinforce autonomy and discourage handouts as an incentive for working.

Annex I – Checklists

CODESA Checklist

OUTIL DE FONCTIONNALITE DE CODESA

CODESA Functionality Checklist

Zone de santé de :…… **Date :……..**

Aire de santé de :……..

N°	**ELEMENTS D'APPRECIATION**	**Constat**			Observations
		Oui	Non	Nombre	
1.	REPRESENTATIVITE ET FONCTIONNALITE DES CODESA				
1	Existence du CODESA				
2	Représentativité des femmes				
3	Représentativité des jeunes				
4	Participation des CODESA aux réunions de monitorage				
5	Participation aux réunions de coordination				
6	PV de réunions tenues				
7	Nombre de décisions prises				
8	Nombre d'actions menées				
9	Nbre de séances d'EPE réalisées				
10	CODESA avec plan d'action				
11	Nbre de messages SMS reçus				
12	Nbre de discussions tenues sur les SMS Reçus				
13	Nbre de cas orientés vers le CS (spécifier)				
14	Nbre de ménages visités pour la construction des latrines				
15	Nbre de séances de démonstration de lavage des mains correctement réalisées				

Recommandations :

CANEVAS DE SUIVI / SUPERVISION DES ACTIVITES DE CPCC
DANS LES ZS PAR LES MEMBRES DE L'EQUIPE DU BCZS ET SBCCS/PROSANI.-

Checklist for supervision of the Champion Community Steering Committee

1. **ZONE DE SANTE** : .....
2. **AIRE DE SANTE** : .....
3. **CPCC** : .....
4. **PERSONNE DE CONTACT** : .....
5. **CHECK-LIST A REMPLIR ET A FAIRE SIGNER :** (Pour la cotation marquer ***Non***=**0**/3; ***en cours***=**2**/3 et ***Oui***=**3**/3).

1	2	3	4	5	6
ELEMENTS D' APPRECIATIONS	**REPONSE par Oui, Non ou En cours (Constant du superviseur)**			**COTE 3/3**	**RECOMMANDATIONS OU COMMENTAIRES DU SUPERVISEUR.**
	Oui	**Non**	**En cours**		
I. COMITE DE COMMUNAUTE CHAMPIONNE					
1. Est-ce qu'il existe les membres du comité de pilotage de communauté championne (CPCC) sélectionnés et formés (ressortir le Nombre de membres formés/Prévus) ?					
2. Est-ce qu'il existe un plan d'action semestriel de CPCC (ressortir les nombres d'activités réalisées sur les prévues avec soubassement rapport; aussi le nombre total de participation) ?					
3. Est-ce qu'il existe Les femmes et les jeunes participent a la mise en œuvre des activités (ressortir les nombres des femmes d'une part, des jeunes filles et des jeunes garçons d'autres part sur les prévues) ?					
4. Est-ce qu'il existe un Compte rendu des réunions de CPCC au cours du mois dont la copie est rendue disponible BCZS (nombre élaboré sur prévu)?					
5. Est-ce que les décisions prises à la réunion passé par le CPCC sont-t-elles inscrits dans le compte rendu et sont exécutées (ressortir les nombres de décisions exécutées sur décisions prises) ?					

6. Combien de SMS lancé par le BCZS avec appui PROSANI que vous avez reçu sur les téléphones de la population de l'AS/ZS (ressortir le nombre par domaine PROSANI et si possible le message par thème) ?					
7. Est-ce que le Superviseur local (SL) a reçu un briefing/Réunion/séance de renforcement de capacités, une formation de l'IT/ECZ, Président CODESA et/ou de l'AC/ZS (ressortir le nombre par thème de la formation ou du briefing sur le nombre des RECO/SL non formé ou n'ayant participé à un briefing) ?					
8. Est-ce que le RECO/SL connait les objectifs de l'AS repris dans le plan d'action (laisser s'exprimer et ajouter les sous questions pour dégager le base line et le niveau atteint jusque là) ?					
9. Est-ce qu'il existe le rapport de chaque activité réalisé repris dans le plan d'action par le CPCC aux SL ? (lire 2 ou 3 rapports ensemble et apporter les actions correctrices si nécessaire et voir comment on classe les documents=archivages).					
10. Est-ce que le CPCC a un croquis propre de son rayon d'action ?					
11. Est-ce que les Hommes partagent les tachent ménagères avec les membres de sa famille (combien d'hommes sur le total qui se trouve dans l'AS) ?					
12. Est-ce que les RECO/SL connaissent le comportement à promouvoir par activité repris dans le Plan d'action semestriel / CPCC ou même au niveau de chaque AS ?					
13. Est-ce que les RECO/SL visitent les enfants ou femmes malades qui se trouvent dans les AS/Village (noter le nombre oriente vers le SSC ou PS ou encore CS) ?					
14. Est-ce que chaque activité à réaliser par les RECO/SL sont préparées (poser les sous questions pour se rendre compte de la véracité de leur propos) ?					
15. Est-ce que le RECO/SL utilise les boites à images, Mégaphones…. disponible au CS pour ses activités dans le village ou AS ? (si non, pourquoi ?)					
16. Est-ce que les Président CPCC convoque les réunions de membres pour faire le suivi de la mise en œuvre et dégager le niveau atteinte des résultats (1 fois chaque mois et ressortir les nombres convoqués et tenues jusqu'à ce jour)?					
17. Est-ce qu'il existe des Comptes rendu des réunions dans les AS classés au CS dont la copie est rendue disponible BCZS (nombre élaboré sur prévu)?					
18. Est-ce que les ECZS font le suivi et supervision de l'exécution des activités du Plan d'action de CPCC (Si oui, vérifier le rapport de supervision du BCZS et si non Pourquoi) ?					
19. Est-ce que l'ECZS/AC fait la restitution de leur mission aux l'IT/CS (équipe CS y compris), PrésiCODESA (Membres CODESA y compris) et CPCC.					

20. Est-ce qu'il ya des activités communautaires visibles contribuant au développement du Centre de santé ? (Préciser ce que vous voyez).					
21. Est-ce que les radios et TV existent dans la ZS (ressortir le nombre et les personnes de contact) ?					
22. Est-ce que le responsable connait la couverture en vol d'oiseau (ressortir les ZS ou AS couverte) ?					
23. Est-ce que la radio/TV a fonctionné au cours du mois (préciser combien de fois) ?					
24. Est-ce que les émissions pour la promotion de la santé sont produites et diffusées (nombre produit et diffusé sur prévu au cours du mois ayant trait aux objectifs fixes par le CPCC)?					
25. Est-ce que les témoignages réussis de la population sont diffusés lors de la production et diffusion des émissions ayant trait aux objectifs fixes par le CPCC au cours du mois (nombre de témoignage enregistré, produit et diffusé sur prévu)?					
26. Est-ce que les ONG/OAC contribue a l'atteinte des résultats CPCC ? (Explique en 3 ou 5 lignes au verso) ?					
***MOYEN GENERAL** (Sous total Q1+Q2+Q3+.....=...X.... divisé par 81=performance des activités de CPCC dans les AS/ZS)*				**/ 81**	

6. PERSONNES RENCOTREES :

N°	PRENOMS ET NOMS	FONCTION	ORGANISATION OU STRUCTURE	N° TELEPHONE	AUTRES INFORMATIONS IMPORTANTES

Attention : Une copie doit toujours rester dans l'AS/CS signée par toutes les parties prenantes (cfr signatures et visa ci-dessous).-

Fait à ....., le ..... / ..... / 2013.-

SIGNATURE, TEL, EMAIL ET SCEAU

DE PERSONNE DE CONTACT

PRENOM, NOM, SIGNATURE ET NUMERO DE TELEPHONE

DU SUPERVISEUR

VISA DE L'IT/CS OU SON DELEGUE.-

VISA DU MCZ OU SON DELEGUE.-

Checklist for the Functionality of a Champion Community

CHECKLIST FONCTIONNALITE DE LA COMMUNAUTE CHAMPIONNE

Nom de la COMINAUTE CHAMPIONNE	
ZONE DE SANTE	
Nombre d'Aire de Santé Couvertes	
DPS	
PROVINCE	
Date de création de la Communauté Championne	

Preuves d'existence :

	Oui	Non	Oui mais pas convaincu
Existence des cartes CC			
Existence d'une liste à jour des membres du Comité de pilotage de CC			
Existence d'un Règlement d'Ordre Intérieur du Comité de pilotage			
Connaissance de l'objectif de la CC par les membres du Comité de pilotage (Plan d'action communautaire)			
Existence d'une lettre d'enregistrement de la Communauté Championne			
Existence d'un statut ou projet de statut de la Communauté Championne			
Représentativité de différentes parties prenantes dans le Comité de pilotage			

Fonctionnalité

	OUI	NON	Oui mais pas convaincu
Existence d'un tableau des réalisations à jour (c'est-à-dire incluant les réalisations de six derniers mois)			
Existence d'au moins deux plannings mensuels de six derniers mois			
Existence d'au moins deux rapports d'activités mensuels de six derniers mois			

Existence des listes de présence des membres du Comité de pilotage de la CC aux réunions tenues les six derniers mois			
Existence d'une liste des animateurs communautaires actifs			
Existence des listes de présence des animateurs communautaires aux réunions de six derniers mois			
La Communauté Championne dispose d'un plan d'action en cours			
Existence des rapports des revues mensuelles			
Existence des rapports de supervision ou de suivi des activités par l'ECZ			

Efficience / Efficacité

	Oui	Non	Oui mais pas convaincu
La Communauté Championne a-t-elle un partenaire d'appui financier ?			
Les Objectifs du dernier plan d'action ont – ils été atteints ?			
Les résultats atteints sont – ils efficients en rapport avec le budget alloué ?			

Méthodologie de suivi et d'évaluation par l'ECZ ou le partenaire d'appui

	Oui	Non	Oui mais pas convaincu
Les responsables de suivi -évaluation du plan d'action des CC sont clairement définis au niveau de l'ECZ ou du partenaire d'appui			
Le plan d'action contient une méthodologie claire pour le suivi-évaluation			
La méthodologie décrite permet de faire une bonne évaluation du plan d'action de la CC			

Feedback

	Oui	Non	Oui mais pas convaincu
La CC destine –t- elle un rapport d'activités à l'ECZ ou au partenaire d'appui?			
Existe – t –il un retour d'information de la part des destinataires des rapports ?			

Conclusion

Plan d'actions mis à jour	Plan d'action de qualité ?	Conclusion finale
☒Oui	☐Oui	☐Fonctionnel
☐Non	☐Non	☐Non fonctionnel

Commentaires:

COMMENTAIRES :
-

Community Telephone Lists

	Liste-répertoire des numéros de téléphones qui acceptent volontairement de recevoir <u>des messages SMS de sensibilisation pour la promotion de la santé</u>						
	Zone de santé de:			**Aire de santé de:**			
	NOM ET NUMEROS DE TELEPHONE DE L' INFIRMIER TITULAIRE:		**NOM ET NUMEROS DE TELEPHONE DU PRECODESA :**		**NOM ET NUMEROS DE TELEPHONE DU PRESIDENT DE LA COMMUNAUTE CHAMPIONNE:**		
	Zone de santé de:			**Aire de santé de:**			
N°	**Numéros tél. pour Hommes (adultes)**	**Numéros tél. pour Femmes à l'âge de procréer**	**Numéros tél. pour Jeunes (Garçons)**	**Numéros tél. pour Jeunes (Filles)**	**Numéros tél. pour Elèves (filles)**	**Numéros tél. pour Elèves (garçons)**	**Numéros tél. pour étudiants et étudiantes**
1							
2							
3							
4							

Checklist for Monitoring Community Activities

CANEVAS DE SUIVI DES ACTIVITES COMMUNAUTAIRES

AIRE DE SANTE : ……

DATE ……

I. Coordination des activités			
Domaine	**Thème**	**Constats**	**Action correctrice/ recommandation**
Existence du CODESA dans l'Aire de santé	▪ PV d'installation disponible (signé par l'autorité locale) ▪ Représentativité des villages/quartiers ▪ Proportion des femmes dans le CODESA		
Le CODESA dispose d'un plan de travail budgétisé	▪ Existence d'un chronogramme des activités (signé par le Présicodesa et visé par l'IT) ▪ Sources de financement du plan (10% du marketing social des subsides FBP et des recettes propres?, AGR?, autres ?)		
Le CODESA évalue son plan de travail	▪ Disponibilité du rapport d'évaluation du plan de travail ▪ Proportion des activités exécutées et disponibilités des rapports. ▪ Liste des activités non exécutées et les causes. ▪ Taux d'exécution du budget du plan de travail		
La tenue régulière des réunions	▪ Existence des comptes rendu signés et visés par l'IT ▪ Liste de présence en annexe ▪ Proportion des femmes ayant participé aux réunions ▪ Taux d'exécution des recommandations des réunions		
Collaboration du CODESA avec les OAC/ONG locales de l'aire de santé	▪ Liste des ONG/OAC actives dans l'aire de santé ▪ Rapport des réunions avec les OAC/ONG locales ▪ Rapport des activités tenues avec les OAC/ONG locales		
Supervision et suivi du CODESA	▪ Rapport de supervisions du CODESA par l'IT ▪ Rapport de supervisions du CODESA par l'ECZ ▪ Plans de mise en œuvre des recommandations ▪ Livrables de la mise en œuvre des recommandations		
Centralisation des rapports des CAC	▪ Rapports mensuels des toutes les CAC sont disponibles et bien archivés		
Fonctionnement des sites des soins communautaires (SSC)	▪ Liste des sites de soins fonctionnels dans l'aire de santé ▪ Rapports mensuels des sites des soins (SSC)		

II. Communication sociale pour le changement de comportement			
Domaine	**Thème**	**Constats**	**Action/recommandation**
Sensibilisation de la communauté	▪ Nombre des séances de sensibilisation organisées dans la communauté. ▪ Rapports des séances de sensibilisation organisées (participants hommes et femmes, thèmes développés, points saillants,…). ▪ Transfert (transport) communautaire des malades vers les structures de référence		
Visites à domiciles (VAD)	▪ Proportion des visites à domiciles réalisés ▪ Rapports des VAD ▪ Messages diffusés pendant les VAD du trimestre/mois		
Nutrition	▪ PV d'installation des groupes de soutien ANJE et de suivi des enfants avec MAS de l'AS ▪ Proportion des femmes dans des groupes de soutien ANJE et de suivi des enfants avec MAS de l'AS ▪ Rapports des réunions tenues ▪ Nombre de mères conseillées sur la nutrition (AME) ▪ Nombre d'enfants de 0 à 6 mois allaités exclusivement au sein ▪ Nombre des enfants avec MAS dépistés et référées au CS ▪ Nombre des enfants avec MAS sous traitement et suivi dans la communauté ▪ Organisation du jardinage, de la pisciculture et de l'élevage dans l'AS ▪ Etat des projets communautaires		
Rapportage de décès dans la communauté et dans les structures de soins	▪ Nombre d'enfants de 0 à 59 mois ▪ Nombre d'enfants de 5 ans et plus ▪ Femmes en âge de procréer ▪ Femmes enceintes ▪ Les causes probables des décès dans la communauté et actions menées ▪ Les causes probables des décès dans les structures de soins et actions menées ▪ Autres décès et causes probables		
III. Activités preventives			
Domaine	**Thème**	**Constats**	**Action/recommandation**
Récupération pour la vaccination	▪ Nombre de séances de vaccination organisées dans l'AS ▪ Nombre d'enfants récupérés pour la vaccination ▪ Nombre de femmes enceintes récupérées en VAT		
Surveillance des maladies	▪ Nombre de cas de PFA notifiés ▪ Nombre de cas de rougeole notifiés ▪ Nombre de cas des méningites notifiés		

	▪ Nombre de cas de fièvre jaune notifiés ▪ Autres cas notifiés		
Référence des cas vers les SSC et FOSA			
Domaine	**Thème**	**Constats**	**Action/recommandation**
Santé de la mère et de l'enfant	▪ Nombre d'enfants de 0-59 mois avec paludisme, diarrhée, pneumonie orientés pour les soins ▪ Nombre d'enfants de 0-59 mois pour CPS orientés pour les soins ▪ Nombre de femmes enceintes pour CPN orientés pour les soins ▪ Nombre de femmes ayant accouché pour CPON orientés pour les soins ▪ Nombre d'échantillons de crachat amenés aux CSDT ▪ Nombre des malades tuberculeux soutenus dans le traitement TUB ▪ Nombre de femmes enceintes pour accouchementt ▪ Nombre de clients pour CDV ▪ Nombre de clients pour PF ▪ Nombre de cas suspects pour TBC/LEPRE ▪ Prise en charge des orphelins	▪	
WASH et autres activités communautaires			
Domaine	**Thème**	**Constats**	**Action/recommandation**
Entretien des sources d'eau et autres	▪ Existence d'une cartographie des sources d'eau aménagées de l'AS ▪ Chronogramme des activités d'entretien des sources d'eau (voir le plan de travail) ▪ Nombre des séances de sensibilisation de la communauté sur les latrines hygiéniques, trou à ordures, etc. ▪ Organisation du captage, aménagement et entretien des sources ainsi que des puits, ▪ Organisation de l'adduction d'eau potable et du traitement communautaire de l'eau		
Lutte anti vectorielle	▪ Entretien péri et intra domiciliaire ▪ Utilisation de la MILD ▪ Piégeage des tsé-tsé		
Prise en charge des indigents et orphelins	▪ Liste des membres du comité de prise en charge des indigents dans l'AS ▪ Mise à jour trimestrielle de la liste des indigents et des orphelins de l'aire de santé ▪ Nombre d'orphelins pris en charge pendant le mois/trimestre ▪ Nombre d'indigents pris en charge pendant le mois/trimestre ▪ Prise en charge communautaire et familiale des PTA, PVV et soins palliatifs à domicile des maladies chroniques		

Champion Community NGO Checklist

		ONGD COMMUNAUTE CHAMPIONNE							
		FICHE DE VERIFICATION							
N 0	**NOM ET POSTNOM**	**ADRESSE**	**MOTIF DE CONSULTATION**	**STATUT S'EST PRESENTE AU CS**		**DATE**	**SIGNATURE**		
				OUI	**NON**		**SL**	**REC O**	**IT**

Annex II – Participation Tools

Participation List – Champion Communities

ZONE DE SANTE .....

Aire de Santé de..... .....

Nom de la COMINAUTE CHAMPIONNE ..... Date ...../...../20.....

LISTE DE PRESENCE DE LA COMMUNAUTE CHAMPIONNE

ACTIVITE .....

.....

N°	NOM & POST-NOM	TITRE / FONCTION	LIEU / ADRESSE	N° TELEPHONE	SIGNATURE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Fait à ....., le .....

Nom et signature du responsable de l'activité

Annex III – Reporting Tools

CODESA Training Report

ZONZ DE SANTE : .....
AIRE DE SANTE : .....
QUARTIER / VILLAGE / CITE : .....
PERIODE : de ..... à ..... / 20 ...

PLAN INTEGRE DE COMMUNICATION / CODESA .....

DOMAINE DE SENSIBILISATION (Vaccination, EHA, PALU, TBC, SMNEA,	N°	ACTIVITE COMMUNAUTAIRE	NOMBRE PREVU	CANAUX	RESPONSABLE	CHRONOGRAMME (TRIMESTRE .....)		
						(mois) 1	(mois) 2	(mois) 3

Fait à ..... ; le ..... / ..... / 20 .....

VISA DE L'IT DE L'AS *NOM & POST NOM DU PRECODESA*

MONTHLY REPORT OF THE ACTIVITIES OF CODESA / COMMUNITY CHAMPION

Zone de santé : ……..
Mois : …. **Année : 201…**
AS/CODESA : …….. **Nombre de villages : …….**
Population totale : …… **Nombre de ménages :……**

RAPPORT MENSUEL DES ACTIVITES DE CODESA/COMMUNAUTE CHAMPIONNE

Coordination des activités				
Indicateurs	**Prévus**	**Réalisés**	**Taux de réalisation**	**Observation**
1. Existence d'un chronogramme d'activités mensuelles/Plan d'action ou de communication				
2. Réunion mensuelle CODESA avec compte rendu				

Total participants : Hommes : Femmes : Jeunes :				
3. Réunion de coordination tenue avec ONG/OAC : Nombre ONG/OAC des femmes : Nombre ONG/OAC des jeunes :				
4. Nombre des rapports de CAC reçus				
5. Nombre des rapports des SSC reçus				
6. Nombre d'ONG/OAC des jeunes/femmes ayant sensibilisé d'autres jeunes :				
7. Supervision et suivi des CODESA -Nombre de supervisions de l'IT -Nombre de supervisions de l'ECZ				
Communication pour le Changement de comportement				
8. Nombre de séances de sensibilisation **Total participants : H : F : J :** **Thèmes développés :……**				
9. Nombre de visites à domicile :				
10. Nombre de groupes de soutien ANJE existant dans l'AS : -Nombre de réunions de groupes de soutien à l'ANJE tenues dans l'AS : -Nombre de mères conseillées sur la nutrition (AME)				
-Nombre d'enfants de 0 à 6 mois allaités exclusivement au sein				
11. Nombre de campagnes CCC				
12. Nombre des SMS envoyés				
13. Nombre de réunions de discussion sur les SMS				
14. Nombre des ménages dormant sous MILDA				
15. Nombre des ménages avec dispositifs de lavage des mains				
16. Nombre de naissances à domicile rapportées :				
17. Nombre de décès dans la communauté : -Enfants de 0 à 5 ans -5 ans et plus				
Activités préventives				

18. Nombre d'enfants récupérés pour la vaccination				
19. Nombre de femmes enceintes récupérées en VAT				
20. Surveillance des maladies : -Nombre de cas de PFA notifiés : -Nombre de cas de rougeole notifiés : -Autres cas notifiés :				
Référence des cas vers les SSC et FOSA				
21. Nombre de cas orientés : a) CPS : b) CPN : c) CPON : d) TBC/LEPRE suspects: e) Nombre d'échantillons de crachat amenés aux CSDT f) Nombre des malades tuberculeux soutenus dans le traitement g) Accouchement : h) CDV : i) Soins curatifs : j) PF				
WASH et autres activités communautaires				
22. Nombre de séances d'entretien des sources d'eau ou de participation aux travaux communautaires (rénovation, WASH)				
23. Nombre de latrines construites ou dont l'hygiène a été améliorée dans la communauté				
24. Nombre de sources d'eau aménagées				
Autres commentaires :				

Fait à ……..le …../……/201

L'INFIRMIER TITULAIRE DE L'AS **LE PRESIDENT DE CODESA/COMM. CHAMP**.

Monthly Summary Report of Champion Communities by Coordination

DOCUMENT DE TRAVAIL Rapport Mensuel des Communauté Championnes

Date :
Coordination :
Spécialiste BCC :
Numéro de téléphone :
Difficultés du mois :

Nom	**Année établis**	**# de fois visité pendant le mois**	**Nombre de membres**	**Zone de santé**	**Aire de santé**	**Objectifs/ Plan d'action**	**Activités du mois**	**Statut d'ONG oui/non/en cours**	**Subvention IHPplus (Ne pas inclure les subventions incitateur)**	**Financement Reçu de l'extérieur**
Etablis par IHPplus										
			Total = Femmes= Hommes= Jeunes=							
CC Autonome IHPplus										
Inactif										

3 ONGD = Communauté Championne avec statut d'ONG
9 CC autonomes = Communauté Championne sans statut d'ONG
4 Non opérationnelles ne sont pas reprises ici
103 CY = Jeunes dans le processus Champion
0 CYD = Jeunes Champion avec statut d'ONG
*Explication sur l'inactivité de la CC (exemple changement de change en dirigeants, problème de sécurité, E2A a repris la CC, etc….)
L'extension est en cours . Ce qui montre que l'approche devient de plus en plus sollicité par les structures et communautés.

Evaluation and Improvement Report for Champion Communities

Date :
Coordination :
Spécialiste BCC :
Numéro de téléphone :
Email :
Difficultés du mois :

Fiche d'évaluation du plan de redressement / activités des Communautés championnes

COMMUNAUTES CHAMPIONNES DE MWENE DITU	ZONES DE SANTE	ACTIONS	EVALUATION	OBSERVATION
IHPPLUS INITIATED				
AUTONOME				

Fait à Mwene Ditu, le [Date]

Information on Outside Funding – Grants

Coordination	Nombre de CC ayant fait des demandes de subvention	Nombre de demande refusée	Nombre de demande de subvention accordée	Nombre de projet mise en œuvre avec des subventions	Somme des subventions reçu en dehors de MSH	Somme des subventions reçu de MSH
MWENE DITU	0	0	0	0	0	0

CCs ayant reçus des subventions

CC (nom)	Aire(s) de santé	Zone de santé	Coordination	Source de la subvention (quel organisation)	Somme de la subvention	Description du projet mise en œuvre avec les fonds de la subvention

CCs autonome (implantées par la communauté)

CC (nom)	Aire(s) de santé	Zone de santé	Coordination	Demande de statut d'ONG faite (oui/non)	Demande de statut d'ONG accordée (oui/non)

Annex IV – Monitoring and Evaluation Tools

Sensitization Target Evaluation – Example Uvira

TABLEAU RECAPITULATIF DE L'EVALUATION DES OBJECTIFS DE L'APPROCHE COMMUNAUTE CHAMPIONNE COORDINATION DE UVIRA										
	Objectifs	**Indicateurs**	**Baseline**	**Résultats attendus**	**Jun-12**		**Aug-12**		**Oct-12**	
					Résultat	**%**	**Résultats cumulés**	**%**	**Résultats cumulés**	**%**
1	Augmenter de 3,7 à 20 %, soit 1107 ménages qui connaissent les pratiques de traitement d'eau et l'utilise	Nombre de ménages qui connaissent les pratiques de traitement d'eau et l'utilisent	205	**1107**	266	**24%**	597	**54%**	996	**90%**
2	Augmenter de 30 % à 100%, soit de 180 à 600 femmes enceintes qui dorment sous MILD toutes les nuits à Kavimvira, Kilomoni et SOS Kala	Nombre de femmes enceintes qui dorment sous MILD toutes les nuits dans les aires de santé engagées	180	**600**	187	**31%**	425	**71%**	738	**123%**
3	Augmenter de 5% à 10%, soit 156 à 312 femmes en âge de procréation qui connaissent et pratiquent au moins une des méthodes contraceptives	Nombre femmes en âge de procréation qui connaissent et pratiquent au moins une des méthodes contraceptives	156	**312**	123	**39%**	203	**65%**	287	**92%**
4	Augmenter de 10 % (de 61 % à 71 %), soit 365 à 425 mères qui allaitent exclusivement avant 6 mois à Kavimvira, Kilomoni et SOS Kala	Nombre mères qui allaitent exclusivement avant 6 mois à Kavimvira, Kilomoni et SOS Kala	365	**425**	113	**27%**	238	**56%**	385	**91%**
5	Augmenter de 86 à 286 les latrines hygiéniques dans 200 ménages à Rugenge/ Kavimvira	Nombre de ménages avec latrines hygiéniques dans le village Rugenge/ Kavimvira	86	**286**	19	**7%**	76	**27%**	150	**52%**

Annex V – NGO Status Tools

Example of Regulations for Champion Communities

REGLEMENT D'ORDRE INTERIEUR

TITRE PREMIER : DU FONCTIONNEMENT DES ORGANES

PARAGRAPHE 1 : DU FONCTIONNEMENT

Article 1 : L'assemblée générale se réunit en session ordinaire deux fois par an, au mois de juin et au mois de décembre. Elle se réunit en session extraordinaire autant de fois que cela est nécessaire sur convocation du Conseil d'administration.
Le Conseil d'administration veille à l'organisation matérielle adéquate de l'assemblée générale et il établit l'ordre du jour de l'assemblée générale qui est convoquée au moins deux mois avant la date de sa tenue.
Le Président du Conseil d'administration préside l'assemblée générale en tant que Président général de l'assemblée générale.
Le secrétaire général de l'assemblée général et du Conseil d'administration assure la rédaction des procès-verbaux.

Article 2 : Le Conseil d'administration se réunit une fois par mois. Un procès-verbal est établi à chaque séance de travail. Il est signé par son Président et le Secrétaire Général.

Article 3 : A chaque réunion du Conseil d'administration, un procès-verbal est rédigé par le Secrétaire Général. Ce procès-verbal est approuvé par les membres du Conseil d'administration.

Article 4 : Le collège des fondateurs relève du conseil d'administration. Son bureau dispose de tous les pouvoirs pour assurer le bon fonctionnement et la gestion courante de la plate-forme de l'ONGD Communauté Championne Bujitu Buetu.

Article 5 : En sont membres de la tutelle, les divisionnaires et les membres associés ou sympathisants. Ils discutent de l'état d'avancement et des progrès réalisés sur le terrain et tous les aspects techniques concernant les relations de l'ONGD Communauté Championne Bujitu Buetu.

Article 6 : En début de séance de l'assemblée générale, le président procède à l'appel nominal des membres. Il juge si le quorum est atteint et ouvre la séance. Le président dirige et oriente les débats de l'assemblée générale. Il est assiste par les membres du conseil d'administration notamment le vice-président, le secrétaire général et la trésorière. Il veille à la stricte discipline pendant le déroulement des débats.

Article 7 : En début de chaque séance de l'assemblée générale, le secrétaire général lit le procès – verbal de la séance précédente que le président propose à l'assemblée générale.

Article 8 :L'approbation des décisions se fait par vote à main levée à la majorité absolue, sauf pour des cas autrement explicités dans les statuts.

TITRE DEUXIEME : DES MEMBRES D'HONNEUR.

Article 9 : Est de droit membre d'honneur tout membre effectif, leader communautaire ou membre d'une structure de participation communautaire œuvrant dans la zone de santé.

Article 10 : Peut être membre d'honneur tout membre effectif, proposé à l'assemblée général par le Conseil d'administration, et admis à la majorité des 2/3 des membres présents.

Article 11 : Chaque membre effectif est tenu à payer régulièrement chaque mois, le montant de la cotisation mensuelle. Ce montant est fixé à un minimum de …..

Article 12 : En vue d'atteindre tous les objectifs, l'ONGD CCBB entend utiliser les moyens suivants :

- Assurer d'une manière permanente la représentation de ses membres auprès des Partenaires,
- Orienter les membres dans le sens de la politique nationale du développement endogène.
- Mettre en contact les membres de la Communauté Championne Bujitu Buetu avec les milieux financiers et les partenaires générateurs des crédits.
- Organiser et animer des sessions de formation et de recyclage de ses membres dans les séances de l'éducation à travers l'écoute.
- Coopérer avec les autres associations similaires pour les échanges d'expériences.

Article 13 : c) <u>CHAMP D'ACTION</u>

L'ONGD Communauté Championne Bujitu Buetu couvre les secteurs d'activités ci-après :

- La communication pour le changement de comportement ;
- La santé ;
- L'agriculture, l'élevage et la pêche ;
- L'eau, l'hygiène et l'assainissement dans un environnement favorable ;
- L'éducation de la femme et de la jeune fille ;
- L'encadrement des jeunes et des adolescents ;
- Le marketing social auprès des institutions publiques et privées ;
- La technologie appropriée
- La gestion commerciale et financière des micro-projets.

Toutes ces activités sont menées sur toute l'étendue de la Zone de Santé de Kanda Kanda.

TITRE TROISIEME : <u>DES MEMBRES</u>

Article 14 : L'adhésion à l'ONGD Communauté Championne Bujitu Buetu est libre.

Article 15 : Le montant de la cotisation d'un membre d'honneur est au moins équivalent à cinq fois le montant fixé pour le membre effectif.

Article 16 : Un membre effectif peut être dispensé de sa cotisation sur proposition du Conseil d'administration.

Article 17 : Tout membre associé doit être en règle de cotisation.
Le montant de sa cotisation est fixé à cinq dollars (5 $) à revoir

TITRE QUATRIEME : DU REGIME DISCIPLINAIRE

Paragraphe 1 : DES SANCTIONS POUR NON PAIEMENT DE LA COTISATION

Article 18 : La qualité de membre effectif se perd pour tout membre ne payant pas sa cotisation sans en avoir été dispensé sur proposition de Conseil d'administration ou par la tutelle.

Article 19 : La qualité de membre associé se perd pour tout membre associé ne payant pas régulièrement sa cotisation, sur proposition du Conseil d'administration ou la tutelle.
Article 20 : Dès qu'un membre effectif ou un membre associé perd sa qualité de membre pour non payement de la cotisation, cette perte ne pourra terminer ses effets qu'au paiement d'au moins six mois plus tard, d'une amende équivalent au double du montant de la cotisation mensuelle amplifiée du montant des cotisations non payées pendant la suspension.

Paragraphe 2 : DES SANCTIONS POUR COMPORTEMENT CONTRAIRE AUX OBJECTIFS DE L'ONGD COMMUNAUTE CHAMPIONNE Bujitu Buetu.

Article 21 : La qualité de membre effectif se perd pour tout membre dont le comportement est contraire aux objectifs, tel que spécifié à l'article 7 des statuts sur proposition du Conseil d'administration à la décision de l'assemblée extraordinaire.

Fait à Kanda Kanda, le… / /201…..

Ont participé :

Template Example of Statutes for Non-Governmental Status

ORGANISATION NON GOUVERNEMENTALE DE DEVELOPPEMENT
Communauté Championne Bujitu Buetu
KANDA KANDA

STATUTS

JANVIER 2016

Nous, membres de la Communauté Championne Bujitu Buetu, association sans but lucratif, en sigle « **CCBB ONGD»**;
Vu les faiblesses constatées dans les efforts entrepris par nos communautés locales pour leur paix, leurs droits et leur bien-être ;
Vu les faiblesses constatées dans leurs compétences ;
Vu le faible degré d'appropriation de leurs actions à la base ;
Mus par le souci de contribuer :

- À la consolidation des communautés locales dans leurs efforts pour la paix, le respect des droits humains, l'adoption des comportements positifs et le travail en vue de leur développement intégral;
- Au renforcement des compétences locales des citoyens concernés, regroupés ou non par l'appui de leurs services et l'accompagnement autour de leurs centres d'intérêt socio-économique;
- Au renforcement du principe d'appropriation « ***Ownership*** », lequel doit occuper une position centrale dans tout processus de développement

Réunis ce jour pour entreprendre un service d'appui et d'accompagnement, conformément à l'alinéa E de l'article 4 de la loi N° 004/2001 du 20 juillet 2001 portant règlement des associations sans but lucratif et des établissements à utilité publique,

Déclarons solennellement adopter les présents statuts.

TITRE I.

CREATION, DÉNOMINATION - SIÈGE – BUT ET OBJET – DURÉE – CHAMP D'ACTION

Article 01 : Dénomination :

Il est créé à Kanda Kanda, zone de santé de Kanda Kanda, Territoire de Luilu, Province de Lomami, le…./…./2015, une association sans but lucratif dénommée : ***« Communauté Championne Bujitu Buetu,*** en sigle «**CCBB/ asbl.**

Article 02 : Siège social :
Le siège social et administratif de l'association CCBB as**bl** est fixé à Kanda Kanda, Territoire de Luilu, Province de Lomami en République Démocratique du Congo.
Article 03 : But et objectif :
La CCBB a pour objet **de servir, appuyer et accompagner les communautés locales à un développement harmonieux et intégral** dans leurs initiatives par :

- L'organisation communautaire,
- La promotion d'un développement durable dans les 18 aires de santé ;
- La contribution à l'amélioration des indicateurs de santé au niveau des aires de santé,
- La création des Activités Génératrices de Revenu,
  L'analyse de leurs problèmes et la recherche des solutions appropriées,
- La réalisation de leurs actions communes en vue de l'amélioration de leurs conditions de vie.
- Le renforcement de leurs capacités et de leurs compétences.

Ce but pourrait, en tout temps, être étendu ou restreint par voie délibérative en Assemblée Générale siégeant aux 2/3 en vue de la modification des présents statuts sans toutefois altérer son essence.
Article 04 : Durée :
La CCBB/ONG est créée pour une durée indéterminée. Elle peut toutefois être dissoute à tout moment par décision de l'assemblée générale.
Article 05 : Rayon d'action :
L'ONGD CCBB entend exercer ses activités principalement dans les Aires de santé de Bakua Bowa, Kabuela et Kapangu. Toutefois elle pourrait les étendre dans d'autres Aires de santé, voire toute la Zone de santé de Kanda et même dans tout le Territoire de Luilu.

TITRE II.
CATEGORIE ET QUALITE DES MEMBRES, RESSOURCES
Article 06 : Membres et attributions
L'ONGD CCBB a comme membres effectifs : 8 membres du comité de pilotage, et 18 superviseurs locaux, XX agents communautaires.
Peuvent également devenir membres :

- Toute personne qui s'intéresse au développement de la communauté d'une manière intégrale.
- Toute personne désireuse et soucieuse de contribuer à l'amélioration de l'état de santé de la population.

Article 07 : Devoirs des membres
Les membres ont pour devoir de :

- Multiplier les visites à domicile des personnes qui ont accepté la planification familiale, la CPN4 ; DTC 3, CPS 1 12-59 mois, bref la santé de la mère et de l'enfant.
- Tenir des réunions et des discussions de groupes avec les acceptants sur les thèmes évoqués ci-haut et sur d'autres thématiques relevant de la santé;

- Communiquer à travers les téléphones et grâce aux messages SMS pour aider la communauté à relever les indicateurs.
- Orienter vers les centres de santé toutes les femmes enceintes pour recevoir les 2 doses de sulfadoxyne pyriméthamine (TPI2) ainsi que d'autres cas nécessitant la prise en charge dans une structure sanitaire.
- Contribuer à la promotion des activités génératrices de revenu pour relever le niveau de vie de la population

Articles 08 : Conditions d'entrée, de sortie et d'exclusion :

- **Conditions d'entrée** : Elle peut être accordée à toute personne, associations des jeunes, femmes, CODESAs, groupes vulnérables résidents dans le champ d'action du CCBB/ONG et exerçant une activité dans un quelconque domaine d'intervention.
- **Conditions de sortie** : Toutefois, la qualité de membre peut se perdre par :
    - Décès,
    - Changement du milieu,
    - Comportement susceptible d'entraver la bonne marche de l'association.
- Le membre qui quitte la CCBB/ONG ne peut exiger le remboursement de ses cotisations à l'association.
- En cas de décès d'un membre, l'association partage le malheur avec la famille du défunt et contribue dans la limite de ses moyens à l'organisation funéraire.

Article 09 : Cotisations et ressources :

a) L'association entend créer ses ressources par :
    - Les parts sociales et les cotisations des membres
    - Les subventions obtenues des bailleurs
    - Les dons et autres legs des particuliers
    - La vente des produits de ses activités ou de ses services

b) Les fonds de la structure sont gérés dans les comptes bancaires de l'association ouverts auprès des institutions financières agréées par l'Etat Congolais.

c) Ces fonds sont gérés par le Comité Directeur conformément aux dispositions du règlement d'ordre en la matière.

CHAPITRE V : **ADMINISTRATION ET FONCTIONNEMENT DE L'ONGD CCBB**

Article 10 : L'ONGD « CCBB » fonctionne avec quatre organes conformément à la charte des ONGD et au code de bonne conduite passant par le degré loi n°004/2001 du 20 juillet 2001.

1. Assemblée Générale (A.G.) ;
2. Conseil d'Administration (C.A) assuré par le CPCC ;
3. Commission de contrôle (COCO) ;
4. Secrétariat Exécutif (Coordination)

Art 11. COMPOSITION DE L'ASSEMBLEE GENERALE

L'Assemblée Générale est composée des superviseurs locaux, et quelques membres de toutes les forces vives des 3 Aires de Santé.

Art 12 : LES ATTRIBUTIONS DE L'AG

L'AG dispose des pouvoirs lui conférés par les textes régissant l'ONGD notamment :

- Approuver les statuts et règlement intérieur de l'ONGD ;
- Approuver les budgets et programmes sur proposition de l'équipe exécutive (coordination) ;
- Fixer les grandes options de l'ONGD ;
- Décider de la sortie ou de l'exclusion des membres qui ne se conforment pas aux objectifs de l'Association ;
- Approuver le contrat avec les tiers, élire le président et les membres du C.A.

Art 13. FONCTIONNEMENT DE L'AG

- L'AG se réunit au moins une fois l'an, les membres sont convoqués par invitation écrite accompagnée du programme au moins un mois avant la tenue de la réunion ; l'invitation contient l'ordre du jour de la réunion.
- L'AG extraordinaire peut être convoquée sur demande de deux tiers des membres, la demande doit se faire par écrit.
- L'AG se réunit quand le quorum de deux tiers des membres est atteint, une seconde assemblée est convoquée avec le même ordre du jour dans les trente jours suivants, son ordre du jour est fixé par le CA.

Art 14. ROLE DU PRESIDENT DE L'AG :

- Préparer, convoquer et présider les réunions de l'AG et du CD.

Art 15. LE CONSEIL D'ADMINISTRATION (CA)

L'AG élit parmi ses membres, 9 dont 6 superviseurs locaux et 3 membres de CODESA et qui constituent le CA.

Le mandat des membres du CA et de 2 ans renouvelables, toutefois il peut prendre fin par démission, soit par de révocation décidée à la majorité des membres de l'AG, soit par décès.

Art 16. DISPOSITION ET FONCTIONNEMENT DU CA

Le CA veille à l'exécution des décisions de l'AG et approuve les programmes, les rapports d'activités, financiers et trimestriels. Il décide sur la création des nouveaux emplois, se réunit au moins trois fois l'an. Il est présidé par le président de l'AG, la coordination de l'équipe exécutive assure le secrétariat.

Art 17. LA COMMISSION DE CONTROLE (COCO)

C'est un organe de contrôle, mise en place par l'AG. Il rend compte, vérifie l'application des textes règlementaires et la gestion de toutes les ressources de l'ONGD, il est composé de trois membres comme auditeurs internes et cet audit se fait 2 ou 3 fois l'an.

Art 18. LE SECRETARIAT EXECUTIF (COORDINATION) :

Il est constitué d'un bureau de coordination composé de 5 membres : Coordonnateur, vice coordonnateur, secrétaire, trésorier et trésorier adjoint.

Art 19. LE SECRETARIAT EXECUTIF DISPOSE DES ATTRIBUTIONS CI-DESSOUS :

- Exécuter le programme ;
- Assurer la gestion journalière ;
- Préparer tous les programmes et budgets ;
- Présenter le rapport d'activités et financier à l'AG ;
- Préparer l'ordre du jour de l'assemblée générale.

CHAPITRE 4. RESSOURCES DE L'ONGD « CCBB »

Art 20. LES RESSOURCES DE L'ONGD « CCBB » PROVIENNENT DES :

- Cotisations des membres
- Contributions des membres ;
- Les subventions : Fonds sollicités auprès de l'Etat, de l'aide reçue des organismes internationaux, action d'autofinancement et des services rendus ;
- Legs et dons en provenance des personnes physiques ou morales au niveau national et provincial.

CHAPITRE 5. MODE D'ETABLISSEMENT DES COMPTES ANNUELS, MODIFICATIONS DES STATUTS

Art 21. Le secrétariat exécutif (Coordination), élabore un compte annuel qu'il soumet à l'approbation de l'AG.

Art 22. Ces statuts ne peuvent être modifiés que par décision de l'AG, prise à la majorité des deux tiers des membres présents à l'AG.

Art 23. Le texte de modification doit être communiqué aux membres de l'AG au moins un mois avant la tenue de la réunion.

CHAPITRE 6. DISSOLUTION ET DIPOSITIONS FINALES

Art 24. L'ONGD « CCBB » est dissoute par décision de l'assemblée générale convoquée spécialement à cet effet, si celle-ci doit comprendre au moins la majorité absolue des membres.

Art 25. En cas de dissolution, les patrimoines (biens) de l'ONGD « CCBB » seront remis aux membres effectifs soit à une autre ONGD ayant une même mission.

Art 26. Tous les différends (litiges) seront réglés au sein de l'ONGD « CCBB » ; dans le cas contraire ils seront transférés à l'organe judiciaire compétente ou dans d'autres instances judiciaires de la province.

Art 27. Le règlement intérieur complète les présents statuts et fournit des détails sur les droits et les devoirs des membres ainsi que le fonctionnement des différents organes de l'ONGD CCBB

Art 28. Le respect strict des présents statuts et son règlement intérieur est exigé à tout membre de l'ONGD «CCBB» sous peine d'exclusion.

DECLARATION DES MEMBRES :

Nous soussignés, formant la majorité des membres fondateurs de l'ONGD CCBB, attestons par la présente déclaration que les membres dont les noms ci-après sont co-fondateurs et responsables de l'ONGD CCBB précité.

(Cfr manuscrit en annexe P.10)

Article 29 : Remarques importantes :

Tout ajout aux présents statuts fera l'objet d'un règlement d'ordre intérieur auquel tous les membres de l'association doivent souscrire.

Article 30 : Entrée en vigueur

Les présents statuts entrent en vigueur à la date de leur adoption et signature.

Fait à Wikong, le 07/01 /2016
Pour la CCBB/ ONGD
(Cfr manuscrit en annexe P.10)

Vice – Président Président

Secrétaire Chargée des Finances

Conseillers Superviseurs Locaux

ANNEXE I

DECLARATION DES RESSOURCES

Nous soussignés les membres effectifs chargés de l'administration de l'association sans but lucratif dénommée : « ONGD Communauté Championne Bujitu Buetu », en sigle : « **CCBB ONGD**», déclarons par la présente, conformément à l'alinéa E de l'article 4 de la loi N° 004/2001 du 20 juillet 2001 portant règlement des associations sans but lucratif et des Etablissements à utilité publique que les ressources nécessaires permettant à notre association de réaliser l'objectif qu'elle s'assigne proviennent de:

- Des cotisation et parts sociales des membres
- Des subventions des bailleurs
- Des dons et lègues des particuliers.
- De la vente des produits de ses activités et de ses services

Fait à Kanda Kanda, le / /201…

Pour l'ONGD CCBB
Vice – Président Président
Secrétaire Chargée des Finances

ANNEXE II

DECLARATION DE NOMINATION

Nous soussignés, membres effectifs formant la majorité de l'association sans but lucratif dénommée. **« ONGD Communauté Championne Bujitu Buetu»**, en sigle **«CCBB» ;**
Déclarons par la présente avoir désigné en date du /…./2015 aux fonctions indiquées au regard de leurs compétences, les personnes ci-après :

N°	NOMS ET POST NOMS	PROFESSION	ADRESSE	FONCTION DANS L'ASBL
1.	NYEMBUA KABUYA **PLACIDE**	PASTEUR	KABWELA	PRESIDENT
2.	KALENDA FLORENT	ENSEIGNANT	CENTRAL	VICE PRESIDENT
3.	NKAMBA TSHIOSHA DANIEL	ENSEIGNANT	KAMANGA	SECRETAIRE
4.	KANYAKA ILUNGA CRISPIN	CULTIVATEUR	KABANGA	TRESORIER
5.	MBIYA TSHIOVU J MEDARD	PASTEUR	BIKOLA	INTENDANT
6.	MULANGA ANNY	VENDEUSE	Q/NSENDA	SUPERVISEUR LOCAL
7.	KALONDA KALONDA PAULIN	ENSEIGNANT	MPOKOLO	SUPERVISEUR LOCAL
8.	MPIANA TSHITENDA Jn PIERRE	CULTIVATEUR	B^{wa} BOWA	SUPERVISEUR LOCAL

Fait à Kanda Kanda, le 07/01/2016

Les membres effectifs de l'ONGD CCBB /asbl

N°	Noms et Post Noms	sexe	Signatures
1			
2			
3			

ANNEXE III

LISTE DES MEMBRES EFFECTIFS

N°	Noms et Post Noms	sexe	Adresses
1			
2			

Fait à Kanda Kanda, le //2015

Pour l' ONGD CCBB

Vice – Président

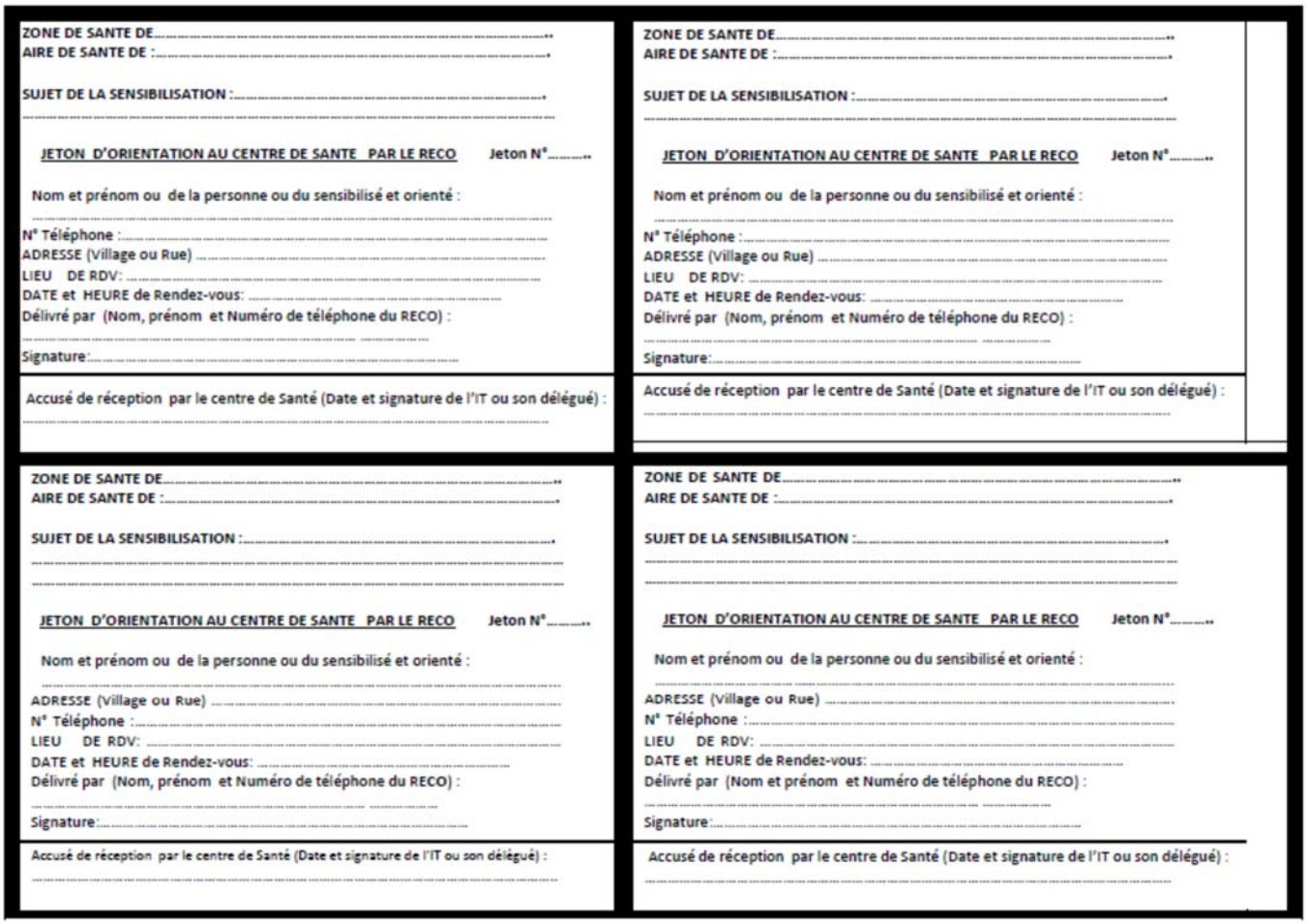
Président

Secrétaire

Chargée des Finances

Intendant

Annex VI – Vouchers



ZONE DE SANTE DE.....

AIRE DE SANTE DE :.....

SUJET DE LA SENSIBILISATION :.....

JETON D'ORIENTATION AU CENTRE DE SANTE PAR LE RECO Jeton N°.....

Nom et prénom ou de la personne ou du sensibilisé et orienté :

N° Téléphone :.....

ADRESSE (Village ou Rue) .....

LIEU DE RDV: .....

DATE et HEURE de Rendez-vous: .....

Délivré par (Nom, prénom et Numéro de téléphone du RECO) :

Signature:.....

Accusé de réception par le centre de Santé (Date et signature de l'IT ou son délégué) :

ZONE DE SANTE DE.....

AIRE DE SANTE DE :.....

SUJET DE LA SENSIBILISATION :.....

JETON D'ORIENTATION AU CENTRE DE SANTE PAR LE RECO Jeton N°.....

Nom et prénom ou de la personne ou du sensibilisé et orienté :

N° Téléphone :.....

ADRESSE (Village ou Rue) .....

LIEU DE RDV: .....

DATE et HEURE de Rendez-vous: .....

Délivré par (Nom, prénom et Numéro de téléphone du RECO) :

Signature:.....

Accusé de réception par le centre de Santé (Date et signature de l'IT ou son délégué) :

ZONE DE SANTE DE.....

AIRE DE SANTE DE :.....

SUJET DE LA SENSIBILISATION :.....

JETON D'ORIENTATION AU CENTRE DE SANTE PAR LE RECO Jeton N°.....

Nom et prénom ou de la personne ou du sensibilisé et orienté :

ADRESSE (Village ou Rue) .....

N° Téléphone :.....

LIEU DE RDV: .....

DATE et HEURE de Rendez-vous: .....

Délivré par (Nom, prénom et Numéro de téléphone du RECO) :

Signature:.....

Accusé de réception par le centre de Santé (Date et signature de l'IT ou son délégué) :

ZONE DE SANTE DE.....

AIRE DE SANTE DE :.....

SUJET DE LA SENSIBILISATION :.....

JETON D'ORIENTATION AU CENTRE DE SANTE PAR LE RECO Jeton N°.....

Nom et prénom ou de la personne ou du sensibilisé et orienté :

ADRESSE (Village ou Rue) .....

N° Téléphone :.....

LIEU DE RDV: .....

DATE et HEURE de Rendez-vous: .....

Délivré par (Nom et prénom et Numéro de téléphone du RECO) :

Signature:.....

Accusé de réception par le centre de Santé (Date et signature de l'IT ou son délégué) :

Annex VII – Decision Tree Analysis Tool

Setting Priorities

Duration: ***1 hour 30 minutes***

Activities:

Step 1: Inform participants that it is time now to identify one top priority problem on each EHP area

Step 2: Demonstrate to the participants how the identification of priority problems will be conducted using pair wise ranking.

MNCH problems

	HMD	**HND**	**HMC**	**SCORE**	**RANK**
High maternal deaths	X	HMD	HMD	**2**	**1**
High neonatal deaths	X	X	HND	**1**	**2**
High maternal complications	X	X	X	**0**	**3**

Note: when there are only two problems, pair wise ranking becomes not very applicable; members can resort to voting to decide between the two.

Step 3: After demonstration and prioritization on MNCH, let participants finish prioritizing the remaining thematic problems as part of practicing in groups. Form two groups for this exercise. Each group to focus on two thematic areas.

Step 4: After the end of the allotted time, call the working groups for the plenary. After the report of each group, come up with a priority list of problems for each thematic area (e.g., priority No. 1, No. 2, No. 3, etc.).

Step 5: Thank the participant for their achievement and inform them that it is time to look at the root causes of their priority problems.

Step 6: Remind participants that they will take one priority problem (No.1 only) for root cause analysis.

Root cause identification

Duration: 2 hours 30 minutes

Activities:

Step 1: Inform participants that in order to solve their thematic priority problems, it is necessary to seek for the root causes, and ask a volunteer to recall the key 5 thematic priority problems.

Step 2: Tell participants that in order to ease the work we are going to use a tool called "the Problem Tree"

Step 3: Demonstrate how to identify root causes using problem tree on one thematic priority problem. The tree should show the three main parts: the trunk, the roots and the branches.

Step 4: Describe the idea of the tree: the trunk stands for the problem, the roots stand for the causes of the problem and the branches stand for the effects of the problem.

The guide below should be considered when demonstrating the problem tree:

- ***"What are the main causes of this problem?"*** write each cause separately on the roots. Come up with at least three main root causes first.

- Take one main root cause at a time, explaining that people can also look at the secondary root causes of a problem by asking the question "Why?" For example, if the problem on the tree trunk is that many children have malnutrition in the area, ask "Why?" to get the first response; then get a second major reason and a third major reason. And then to the three answers, ask "Why? for each big root cause" again. Continue in this way until community members feel that all the causes have been discussed.

- The facilitator should ask participants the effects of the problem. He should ask ***"What are the main effects of this problem?"*** the effects should be written on the branches. Take one effect at a time, explaining that people can also look at the secondary effects by asking the question ***"What is the effect of this?"*** Continue in this way until community members feel that all the effects have been discussed.

Step 5: Once everyone is clear about this, form 2 groups and ask one participant for each group to be the facilitator. Give each group 2 thematic priority problems.

Step 6: At the end of the exercise ask each group reporter to give an overall description of the tree with all its roots and branches.

Step 7: ask participants to comment on the problem trees presented and make necessary corrections.

Step 8: Guide participants to prioritize the root causes using the pair wise ranking matrix. Participants should come up with two root causes for each thematic priority problem.

Note: Sometimes using the pairwise ranking matrix cannot be applicable; in this case, participants can use voting to identify priority two root causes for each thematic problem.

Step 9: Congratulate participants and tell them that now we have root causes and effects for the thematic priority problems.

Step 10: Explain that in the next meeting participants will look in detail at how they can deal with the identified root causes of the priority problems and plan for solutions.

Step 11: Ask participants to propose new dates for the planning meetings and the formation of the planning team. Members should agree the composition of the planning team.

Step 12: Inform the participants that we are at the end of the meeting and ask them to evaluate the meeting by stating what needs to be improved during the next meetings.

Sample questions:
Did we achieve what we wanted to achieve?
Which area did not go well?
How can this area be improved?
What needs to be improved during the next meeting?

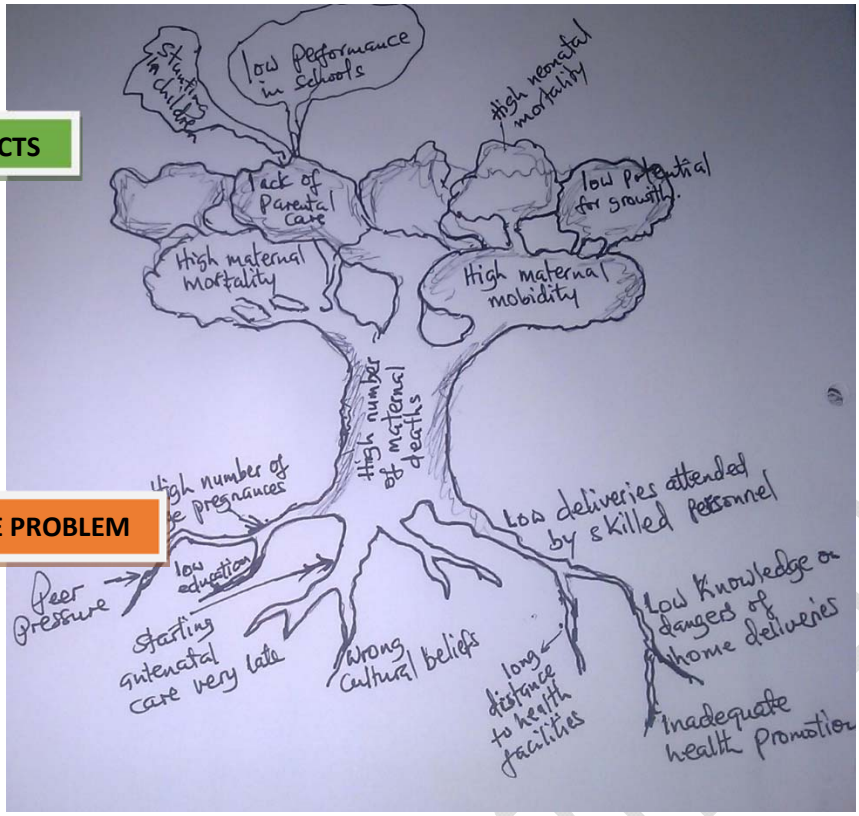
Step 13: Invite an already notified leader to say a word to close the session, thank him at the end.

Problem Tree Example

The problem tree is used to show the "root causes" of an issue and the consequences or results of an issue. For example, to do a problem tree related to *poor maternal health*, the facilitator will ask group members or participants to draw a tree with roots, a trunk and branches. On the trunk, participants will write "poor maternal health" (or the issue /problem being discussed). Participants (with one taking the role of a moderator) will then discuss why there is *poor maternal health* in their community or what causes poor maternal health in their community. Every response they think of is written on a root. For each root cause identified, the moderator continues to ask "Why does this happen?" to get deeper and deeper into the roots, until they are unable to come up with any more responses. The branches represent the effects of the problem. Follow the same process that was used to identify root causes to identify effects. To do this ask "what happens as a result of poor maternal health? Every response becomes a new branch. For each branch, keep asking "what does that lead to?" Once complete, participants will have painted a full picture of the underlying causes of poor maternal health and their consequences (how poor maternal health affects children's future, their families, community, health zone, country etc.).

Below is an example of a completed problem tree around the issue of MNCH.

Figure 10: Example of a Finished Decision Tree



Annex VIII – Action Plan (CODESA)

Action Plan Example for Steering Committee and Champion Community

ANALYSE SITUATIONNELLE DE L'AIRE DE SANTE DE MANJA					
DOMAINE DE SANTE	**ACTIVITES**	**OBJECTIFS**	**POP.CIBLES**	**SUPPORT DE COMMUNICATION**	**INDICATEURS DE PERFORMENCE**
La sante de la mère, Nouveau-né et Enfant	Sensibiliser les femmes pour pratiquer l'allaitement maternel exclusif jusqu'à 6 mois après la naissance	Augmenter de 40 a 60% des accouchées acceptent de pratiquer l'AME confirmé par les conseillers	Femmes enceintes, maris et membres de la famille	Boites a images affiches, carte de conseil, radio, TV, SMS, EPE	Nombre des femmes qui pratiques l'AME sur prévues
Planification familiale	Sensibilisation des femmes en âge de procréer et maris à connaître et appliquer au moins une méthode de planification familiale	Augmenter de 28 a 35%	Femmes a l'âge de 14-45ans et maris et membres de la communauté	Boites a images affiches, carte de RDV, radio, TV, SMS, EPE	Nombre des femmes acceptantes PF sur prévues

CHRONOGRAMME DES ACTIVITES

PROBLEMES	ACTIVITES	RESPONSABLE	PERIODE (MOIS)					
			Juillet	Aout	Sept	Oct.	Nov.	Déc.
Faible taux d'utilisation de service de planification familiale	Sensibiliser les femmes en âge de procréer et les maris et communauté à connaître et à appliquer l'une des méthodes de PF	CS,RECO,CODESA, Leader communautaire	x	x	x	x	x	x

Annex IX: Resources for Champion Community Approach Introduction at DPS, Zonal, and Community levels

Summary of the Champion Community approach

This outline is intended to guide health workers and community leaders to understand the Champion Community objectives and to facilitate implementation of Champion Community activities at community level.

About the Project and the Champion Community Approach (Example from IHPplus)

The United States Agency for International Development (USAID) Integrated Health Project (IHP) 2010-2015 and the Integrated Health Project Plus (IHPplus; 2016 to 2018) is implemented by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd. (OSC), under a subcontract via Pathfinder/Evidence to Action (E2A) with the government of Democratic Republic of the Congo (DRC) to strengthen the country's health system at every level. The activities focus on maternal, newborn, and child health, family planning, nutrition, malaria, tuberculosis, HIV and AIDS, and water, sanitation, and hygiene—applying many proven, low-cost, high-impact innovations on a large scale.

The Champion Community approach is a "bottom-up" and grass-roots approach that encourages community involvement in identifying underlying health related community problems and applying local solutions through collective actions to address these issues.

Champion Community Establishment

With support from provincial authorities, zonal health areas will come together and collectively agree to work towards improving health issues in their health areas and villages. Champion Community members will be members of the community who volunteer and are willing to be part of a team that will act and report on identified issues in priority health areas such as (MNCH, WASH, Nutrition, Malaria and SRH/FP). Community volunteers from other groups within the community are encouraged to be part of the Champion Community.

How will Champion Communities Work?

Champion Communities will work hand in hand with CODESAs, RECOs, CHWs and health facility supervisors to identify health issues in their respective health areas/villages under the close supervision and guidance from a CPCC. Based on the identified issues, Champion Communities will develop work plans and report on the implementation of the work plan. Within the Champion Community, men, women and youth groups will be encouraged to work together to ease implementation processes but also to tactfully deal with health issues from a different perspective as the relate to the specific vulnerable groups. Champion Communities will be trained in various SBCC delivery approaches which they will use in the implementation of activities on to work on indicators on their action plan.

Champion Community Activities

The main activity for champion community members is to sensitize their communities with a focus on pregnant and lactating women, adolescents and youth on MNCH, Nutrition, Malaria, WASH and family planning issues. Household visits, peer group education, village fairs, mini-campaigns are some of the

approaches used to sensitize and mobilize the community. In addition, using a voucher system, they will be referring the clients to the health facility to access curative and life-saving services.

Champion Community Reporting

After coming up with their respective work plans, Champion Communities are expected to implement their activities within a six-month period and report on these activities using simple reporting tools (Indicator tracking matrix, Champion Community action plan, Champion Community member work planner and activity participation forms) that will be provided by the project.

Champion Community members will meet monthly to review progress, consolidate the reports and plan for the upcoming month. The reports will then be submitted to the health facility supervisors and other stakeholders (provincial and zonal) including the CPCC who will send the reports to the Project Coordinating Office.

Apart from paper-based reporting tools, the members will be introduced to an innovative way of collecting and sending data by using a cellphone. This will reduce the amount of paper used and improve the quality and speed of data from the source. This will enable repetitive community mapping to aid in understanding changes in indicators that might not be available in the DHIS system.

Upon successful completion of the short-term goals developed in the work plan, the community will be declared "Champion Community" and will be provided with an incentive or capacity to help build income generation for supporting the activities of the Champion Community. Income generated from this incentive is intended to support the activity SBCC costs to sustain community activities and other needs linked to health outcomes. It should not be used for individuals such as paying a "salary."

Capacity Building

During the process of developing the Champion action plan, Champion Communities will be required to identify capacity needs that will enable them effectively to carry out their plans and activities. Using this capacity needs assessment, the project will provide ongoing relevant SMART Capacity trainings including other SBCC delivery approaches such as education-through-listening as well as training for the development of interactive dramas, SMS, etc.

Stakeholder Roles in the Champion Community

Health Facility: Provides health services, baseline data in the identified health areas for cluster health areas covered by the Champion Community and supporting the voucher system to be used by Champion Communities for understanding how many and which (Champion Community versus CODESA) referrals have occurred. Champion Communities can decide to incentivize referrals such as supplying a piece of homemade (by the Champion Community or otherwise) for attending a health facility curative service.

CPCC: Provides oversight to the Champion Community approach through monitoring of progress of the action plan, supervise Champion Community activities and reporting.

Project SBCC Specialists: Strengthen CODESA and Champion Community SBC mobilization approaches. Provide overall technical support to the Champion Community (facilitation, formation, capacity building in decision tree analysis, support planning of Champion Community work plans.

CODESAs: May be part of the executive committee and/or CPCC providing guidance to Champion Communities and reporting progress of Champion Communities to stakeholders. They will support and provide guidance to Champion Community volunteers at the health area level to develop work plans and implement their activities at health area/village level.

CODESA/RECOS/CHWs: Will lead Champion Community activities by being members that will solve identified health problems locally in a sustainable and independent manner to become Champion Communities.

Steps to Implementing Champion Community Approach

Step 1--Introducing the Approach to Stakeholders at the DPS and zonal levels

- Organize courtesy visits and meetings to introduce the approach to zonal- and DPS-level health officials and authorities. Provide information on the objectives, concepts and principles of the approach to obtain their support and involvement in the achievement of the community objectives of the project level IR approaches, including the Champion Community and obtain their support
- Organize meetings with each Mayor and DPS authorities for approval of the approach
- Organize community meetings facilitated by the CHW to elect the CPCC and the Executive Committee for the Champion Community
- Meet with the referral health facility to implement approach, and for outcome tracking

Step 2 – Introducing the Approach to Community Levels

- Identify and meet with traditional, community and religious leaders to introduce the approach; this can include (if present); Territorial and/or village Chiefs, religious leaders within Champion Community, CBO representative(s) (if present), CODESA/CAC/RECOs, women's and youth groups
- Meet with interested Champion Community Members to introduce the approach
    - Gender and age balanced
    - Youth must be included
    - Other vulnerable groups
- Give the community time (~1 week) to discuss their potential participation and ideas regarding members of the Champion Community
- Work with the community to elect the executive committee members (President, Vice-President, Treasurer, and Secretary)
- Obtain their support and develop a written contract that is signed by the leaders in the community and the Champion Community Presidents/VP, and the Project

Step 3 – Development of the Champion Community

- Introduce the roles and responsibilities of each member of the Champion Community

- Help the Champion Community to develop the CPCC (e.g. select members, community health and development structures, traditional and religious leaders)

Step 4 – Work Plan Development

- Utilize a participatory process to develop the priorities and objectives of the Champion Community[36]
- Develop a six-month work plan that includes activities, indicators and goals with the Champion Community
- The Executive Committee, health facility nurse and CHW are briefed on the action plan as they are the supervisors to ensure progress (ideally, they should be at action plan development)
- Encourage the development of a schedule for monthly meetings of the Champion Community and the Executive Committee (report templates should be given)
    a. Champion Community meets monthly
    b. Executive Committee meets monthly
    c. CPCC meets monthly (includes executive committee members)
- Encourage the development of a schedule for monthly activities including progress review meetings
- Orient volunteers on the planning and reporting tools
- Plan for the training/orientations/mentorship, based on the capacity gaps identified. (use SMART capacity rule)

Step 5 – Champion Community SBCC Training

- Strengthen capacity on financial management, transparency, microproject design, leadership, monitoring evaluation for the entire Champion Community
- Plan for the training/orientations/mentorship, based on the capacity gaps identified in the action plan. (Use SMART capacity rule)
    - Based on the action plan, and using the health zone management teams, community mobilizers, community mobilization teams utilize ETL methods to train the Champion Community on sensitization techniques.
    - Encourage the Champion Community to develop SBCC products that work within their community context (plays, community radio, songs, household visits for vulnerable groups such as pregnant women etc.) and utilize tools that exist (pamphlets, picture cards etc.)
    - Encourage and enable them to document success (video or photos)

Step 6 – Monitoring and Evaluation (M&E) Plan

- Collect baseline statistics for each indicator “Before Champion Community” (for example: number of pregnant women who deliver at the health facility before the Champion Community activities)
- Introduce monthly written report and planning template – decide who will review and evaluate
    a. Enforce monthly written reports and activity work plan
    b. Develop strategy for review

[36] Note the health priorities need to follow the objectives of the donor funded project but can also include of priorities chosen by the community. In later years when the Champion Community has its own funding and support they can elect to add other priorities.

c. Report copies to be kept and filed with the project

Step 7 – Final Evaluation

- Evaluate and adapt M&E to updated action plan at 6 months (80% improvement indicators should be first goal for "Champion Community" qualification)
- With positive movement in indicators and success of the community working as a group, ask the group to come up with a name for their Champion Community
- Ceremony for certification as a "Champion Community"
- Incentive fund distributed for income generation and guidelines for the use of the incentive fund (if applicable)
- T-shirts, banner, hats or other identifying materials distributed (if applicable)
- Continue with action plan for another six months
- Encourage community to build/allocate space for their Champion Community office
- Consider implementation of subgroups (Champion Men, Champion Mamas and Champion Youth)
- Encourage NGO status development
- Encourage the development of autonomous Champion Communities by suggesting the Champion Community spread the approach to other health areas and health zones

Annex X – Example Case Study

Kamina Coordination – Malemba-Nkulu

Malemba Nkulu is the most remote health zone with Champion Communities. This health zone lies 350km from Kamina on roads that are largely inaccessible during the rainy season. In the dry season, it takes 15 hours to drive from Kamina to Malemba Nkulu due to the lack of roads. The foot path and river beds are used as a mean to reach the health zone, making access for trucks nearly impossible. Most commerce to and from Malemba is done on foot, motorcycle or bicycle. The trip by vehicle requires two days of travel with many hazards along the way.

Malemba Health Zone is in Katanga Province. This province has one of the lowest use of contraception (4% of married women aged 15-49) and with average age of marriage of 19 years. Only 40% of children under five years are fully vaccinated and more than 45% of children are stunted. Over the years 2013-2017, the following data is available for Malemba-Nkulu health zone.[37]

DHIS2 Indicator	*2013*	*2014*	*2015*	*2016*	*2017*
% pregnant with women who attend ANC (4 visits)	*43*	*31*	*63*	*57*	*
% Children less than 12 months who received DPT/HIB/HEPB	*10*	*10*	*13*	*14*	*10*
% deliveries with a skilled birth attendant	*87*	*85*	*100*	*88*	*86*

The following table describes the Kamina coordination Champion Communities:

Name	**Year**	**# Members**	**Health Zone**	**Health Areas**	**Action Plan Objectives**	**Statut d'ONG oui/non/en cours**	**Outside Funding**
Established by IHPplus							
NGO Nshi Mikulu (NGO NSMIK)	2012	Total 47 14 Women 21 Men 12 Youth	Kabongo	Kina Lubyayi Kime	ANC Complete vaccination (0-11 months) Family planning Trash burn pits	NGO	$5000 small grant, IHPplus
NGO Songa Mbele (NGO Songa)	2012	Total 72 11 Women 19 Men 42 Youth	Songa	Samba Kipukwe Lukanvwe	ANC Complete vaccination (0-11 months) Family planning Trash burn pits	NGO	$5000 small grant, IHPplus

[37] Accessed via DHIS2.

NGO Nkulu A Manyinga (NGO NKUM)	2012	Total 64 21Women 32 Men 11 Youth	Malema	Muko Mutombo Kabala Kabozya	ANC Complete vaccination (0-11 months) Family planning Latrines Malaria awareness and ITN use Cholera awareness	NGO	$5000 small grant, IHPplus
Autonomous Champion Communities							
Nsele	2016	Total 42 14 Women 16 Men 12 Youth	Kabongo	Nsele Kamwenze Djombo	ANC Complete vaccination (0-11 months) Family planning	Not yet in process	NA
Songa Mission	2016	Total 46 23 Women 20 Men 3 Youth	Songo	Songo Kafungo Katongola	ANC Assisted birth	Not yet in process	NA
Kabulo	2016	Total 39 14 Women 17 Men 8 Youth	Songo	Kabulo Kantengu Mwale	ANC Vaccinations	Not yet in process	NA
Mwambayi	2016	Total 52 18 Women 23 Men 11 Youth	Kabongo	Mwambayi Mwanya Kavula	ANC Vaccinations	Not yet in process	NA
Kametemete	2016	Total 64 28 Women 32 Men 4 Youth	Malemba	Kamete Nyoka Kasulwa	ANC Vaccinations	Not yet in process	NA
Mwenze Nkulu Wa Kunyemenwe	2017 April	Total 72 22 Women 28 Men 22 Youth	Malemba	Nyoka Lwandwe Seya	ANC Latrines Vaccinations Malaria Polio	Not yet in process	NA
Tuba Katanta	2017 April	Total 74 23 Women 30 Men 21 Youth	Malemba	Kyamakanza Kasulwa Tuba	ANC Vaccinations Malaria	Not yet in process	NA
Mpungu Wa Bele	2017 April	Total 54 20 Women 25 Men 9 Youth	Malemba	Manga Songwe Kabwe Mulongo	ANC	Not yet in process	NA
Kalenge	2017 April	Total 73 28 Women 32 Men 13 Youth	Malemba	Butombe Mutombo Lupitshi Nkole	ANC	Not yet in process	NA
No Inactive Champion Communities in the Kamina Coordination							

NGO Champion Community Nkulu A Manyinga (NGO NKUM) was established in 2012 and gained NGO status in 2014. They cover four health areas: Muko, Mutombo, Kabala, and Kabozya. The members include 32 men, 21 women, and 11 youth, for a total of 64 members.

Members of the Malemba Nkulu Champion Community *Photo: Lynn Lawry; OSC Ltd.*

Their action plan includes decreasing maternal deaths and getting women to four ANC visits for each pregnancy. They strived to fully vaccinate every child under 5 years and for families to accept to use family planning. In addition, they have focused on WASH due to the high prevalence of cholera throughout the rainy season by building latrines at the household level and using youth developed interactive drama to teach hand washing (before preparing food and after the toilet) and chlorination of drinking water. Because Malemba Nkulu is on the Congo River, they have also had to use interpersonal communication skills to stop households from utilizing river water for drinking and cooking. In 2015, after their monthly meeting with the health zone health authorities where the Champion Community were told that the numbers of malaria cases was increasing, it was decided that every household needed a mosquito net and education on mosquito net use. After the Champion Community campaigns, malaria cases dropped dramatically in the health areas where the Champion Communities are active. In 2015, prior to the campaigns by NGO NKUM, 300 transfusions for malaria induced anemia were required. By 2016, the number of transfusions for the year dropped to just 15 and the majority of households were using mosquito nets at night and not utilizing them for fishing or fencing.

Income Generation

This Champion Community, unlike others, did not receive seed money for income generation. This community collected money from each member and invested 62 USD to buy three pigs to breed. They were successful and had 18 pigs but, lost all of them an unknown disease. They stated at that time, they did not have the money to find a veterinarian to help. After the loss of the pigs, they utilized other funds from growing potatoes and maize to buy six goats for a total of 420 USD. After breeding the goats, they sold 13 goats and made 612 USD. They currently have six goats that they are breeding. With these funds, they pay for transportation for their members to do their BCC activities and used some of the funds to build a Champion Community office and buy chairs and tables for their office. They, as a community were able to make their own bricks and utilized their income generation to hire builders.

Malemba Nkulu NGO Office, Malemba health zone *Photo: Lynn Lawry, OSC Ltd.*

Youth

The youth in the Champion Community focus on WASH and family planning. They created a drama about Cholera where the objectives are to have the community understand that they must wash their hands with soap before making food and after using the toilet as well as chlorinating drinking water. When performed, the play gathers children, youth, adults and elderly. The play is creative shows the energy of the youth to change behaviors though humor and SBCC.

Cholera Play Champion Youth, Malemba Nkulu Photo: Lynn Lawry, OSC Ltd.

Successes

When the community was asked what they believed to be their major successes, they reiterated the improvement in health indicators such as an increase in household latrines from 20% to 50%, an increase in the number of women seeking ANC where in three months, 67% of women went for ANC from a baseline of only 30%. This Champion Community utilized identification of pregnant women in their communities and interpersonal communication to help pregnant women and their partners understand the importance of ANC. They also state that women are taking their children for the full complement of childhood vaccinations. In addition and to extend the reach of the approach, they

created four other Champion Communities (autonomous) in April 2017. With these Champion Communities, 16 of 18 health areas in the Malemba health zone are now covered by Champion Communities and thus SBC activities.

Challenges

The community is concerned by the illiteracy rates of children, and especially girls, in their community. Although they will try to address this as a community, they want to find an NGO that might help them to address these issues. As education is a primary indicator of health, this issue is important in improving health for both women and girls and MNCH overall.

Like other coordinations and provinces, the Church of the Apostolate asks their members not to utilize the health centers for most MNCH care given at the health centers in the health areas. Roots and traditional medicines are preferred by these communities. NGO NKUM was able to meet with the pastor of this church and through negotiations, and over a six-month period with traditional leaders and communities that attend this church, they were able to get some of these women and children to health centers for care.

Although vaccination and MNCH care cards are free, Champion Communities report that health centers are selling these to women for 2500cf (~1.50 USD).[38] Despite women understanding the need for MNCH care, especially ANC and vaccination for their children, they cannot afford the "fee" for these cards. NGO NKUM met with Territorial Chiefs, the health centers and other community leaders to try and get this fee removed. As they were unsuccessful, the Champion Community now buys these cards for women who cannot afford them.

Elephants periodically ruin planted fields which are utilized for income generation (sweet potatoes and maize). The land they currently have is too close to the elephants. To try to limit their losses, they are moving to crops that take less time to grow such as beans. According to the community, if a crop takes less than three months to harvest, the elephants will not raid the field.

Finally, they feel the community needs more boreholes and the state of the roads limits access to other communities, health centers, and larger areas like Kamina. The men in the Champion Community stated they are waiting for authorities to fix the roads, the women countered that they should not be waiting for help and should just utilize their manpower and funds to fix the roads themselves.

Plans for the Future

This Champion Community has been an NGO for four years. Although they were given a small grant from IHPplus, they have not mapped out other opportunities or written any other grant applications. Within the challenges they discussed, there are potential opportunities for advocacy to other organizations to help them work on these.

Unlike other communities, this Champion Community has been proactive in creating other Champion Communities to cover most of the health areas in the Malemba Health Zone. Currently, NGO NKUN has created four autonomous Champion Communities that they mentor. Of the 18 health areas of Malemba Health Zone, 16 are covered by Champion Communities; 4 health areas by the IHPplus implemented

[38] The MCZD describes this fee as an "initial consultation fee" and not a fee paid for the cards themselves.

Champion Community and 12 other health areas by autonomous Champion Communities. They meet monthly with the Champion Communities they have created.

Questions for IHPplus
This engaged NGO Champion Community had many questions for the IHPplus staff present. One community member asked if the Champion Community approach is utilized in the United States. IHPplus staff discussed how the approach is used in Madagascar and now Malawi, but not the US and how the DRC approach had helped to adjust the approach to increase the impact Champion Communities have on MNCH in developing contexts including insecure and/or remote communities like theirs.

One community member stated they are have many orphans in the community and are struggling to care for them. They asked if other Champion Communities have a similar issue. IHPplus suggested that questions like this and others should be collated from the Champion Community so members attending the regional conference can research answers and report back to NGO NKUM members, the steering committee, and traditional leaders after the conference.

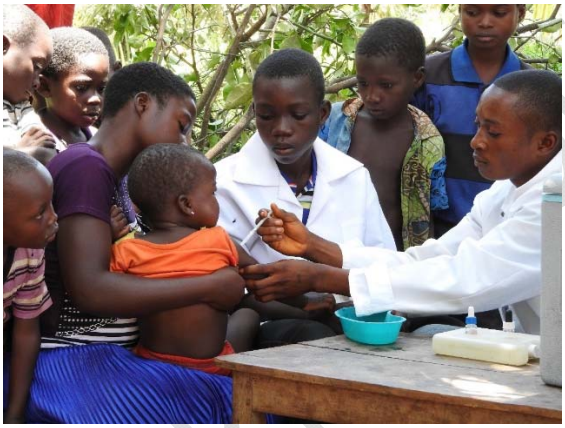
Autonomous Champion Community
A visit with Mwenze Wa Kunyemenwe (covers health areas of Seya, Lwandwe and Nyoka) revealed they were one of four autonomous Champion Communities established in April 2017 by NGO NKUM. The action plan includes vaccinations, increasing access to prenatal care, assisted births and building latrines for every household in all three heath areas. Since inception, and as of March 2018, they increased full vaccination of children 0-11 months from 75% to 95%, ANC increased from 60% to 95% and latrines at the household level have increased from 20% to 51%. In January 2018, build on the successes as above, they added mosquito net use education to their community mobilization activities, and increasing the number of burn pits for trash at the household level. In the last three months, the percent of households using mosquito nets has increased from 80% to 88% and 46% of households have burn pits for trash; up from 30% in January 2018.

This group collected funds from each member to create income generation (500-1000 CDF – or 30-60 cents/member). They currently have 122,000 CDF (76 USD) saved. They intend to start breeding goats, pigs, and chickens. They are awaiting the harvest (maize) to afford other activities. They currently rent an office in the village for $25/month and hope to have the funds to build an office for themselves in addition to diversifying their income generation activities.

The women in this Champion Community have been working on early marriage and getting girls to school. They feel this is a priority in their communities. Many women in this area work at mines sieving tailings for Cassiterite. They state the women are not working at bars near the mines as they do in Walikale or other health zones. An issue noted is that after giving birth, these women go back to the mines and do not breast feed their babies as they leave them behind for the day to be cared for by family.

Youth play a role in creating interactive dramas. They currently have two: one on vaccinations, and one specifically on polio vaccine.

Interactive Youth Developed Drama on Polio Vaccination Photo: Lynn Lawry; OSC Ltd.



Childhood Vaccination Youth Drama Photo: Lynn Lawry; OSC Ltd.

The biggest challenges faced by this new Champion Community include the Apostolate Church and the decree that their members not access health care--including not allowing children to be vaccinated. To overcome this, community leaders, including Territorial Chiefs and the pastor, met to discuss how to get children and women to care. One of the biggest challenges to getting women to ANC and vaccinations is that health centers are charging 2500 CDF (1.56 USD) for the cards to document ANC and vaccinations. Normally, these cards are free--as is health care. When the MCDZ was asked about this issue, he stated the health center staff are not charging for the cards but rather the "initial consultation fee." Like NKUM, this Champion Community has started paying some of the fees for women who cannot afford the care to ensure pregnant women and children have access to MNCH activities. For the future, they plan to continue improving the health of their communities through community mobilization efforts that include interactive theater and starting the process of obtaining NGO status.

Impact

Family planning rates (acceptance of modern methods) remain low and were not statistically different in any of the health areas of the three health zones assessed. (Table 7)

In health areas with Champion Communities in the **Songa** health zone, ANC, assisted birth, exclusive breastfeeding and childhood immunization rates were better than health areas with no Champion Communities suggesting the presence of Champion Communities are associated with improvements in uptake and access to services in addition to behavior change among their communities. Only the

autonomous Champion Communities had significantly different rates of curative service use. There were no significant differences among health areas with or without Champion Communities for rates of family planning rates among IHPplus or autonomous Champion Communities.

Kabongo health zone Champion Communities suffered from the lack of female members among their Champion Communities until 2017. And although they have since remedied this issue, these Champion Communities did not perform as well as other health zones. Immunization, ANC and use of curative service rates were not significantly different from health areas without Champion Communities despite the trend to higher rates. However, Champion Community health areas (IHPplus and autonomous) had higher rates of IPTp, assisted birth and exclusive breastfeeding rates than health areas with no Champion Communities suggests the presence of Champion Communities are associated with improvements in assisted birth and exclusive breastfeeding rates in 2017. The number of female members more than doubled in these Champion Communities in late 2017.[39]

In **Malemba** health zone, health areas with Champion Communities including the autonomous Champion Communities, all health indicators (ANC rates, IPTp, childhood immunizations, malaria diagnosis and treatment and family planning referrals) were better than in health areas with no Champion Communities with the exception of curative service use, which, despite a trend for higher rates was only statistically significant among the autonomous Champion Communities. These data suggest the presence of Champion Communities are associated with improvements in uptake and access to services in addition to behavior change among their communities. Assisted birth rates were not statistically significant.

In 2015, health zone health authorities utilized the Malemba IHPplus Champion Communality for community mobilization around malaria. At that time the Chief Medical Officer stated the number of cases of malaria was increasing and every household needed a mosquito net and education on mosquito net use. After the Champion Community campaigns, malaria cases dropped dramatically in the health areas where the Champion Community is active. In 2015, prior to the campaigns, 300 transfusions/year for malaria induced anemia were required. By 2016, the number of transfusions for the year dropped to just 15 transfusions/year for malaria induced anemia and the majority of households were using mosquito nets at night and not utilizing them for fishing or fencing. Using DHIS2 malaria indicators for referral and treatment of malaria in 2017, health areas with Champion Communities and autonomous Champion Community health areas referred more patients for diagnosis and treatment of malaria than health areas that do not have a Champion Community.[40] It should be noted that the autonomous Champion Community health areas worked for less than six months of 2017 yet still were able to show a statistical difference in referrals when compared with health areas with no Champion Communities.

[39] This was relayed to IHPplus during the Regional Conference in Lubumbashi in May 2018.

[40] Using a T-Test for two independent means with 95% confidence IHPplus Champion Community Health Areas compared to health areas with no Champion Communities: t-value 2.79; p = 0.01. Autonomous Champion Community Health Areas compared to areas with no Champion Communities: t-value 1.87; p = 0.03.

Figure 11: Mean Number of Malaria Referrals for Diagnosis and Treatment among Kamina Coordination Champion Communities in 2017

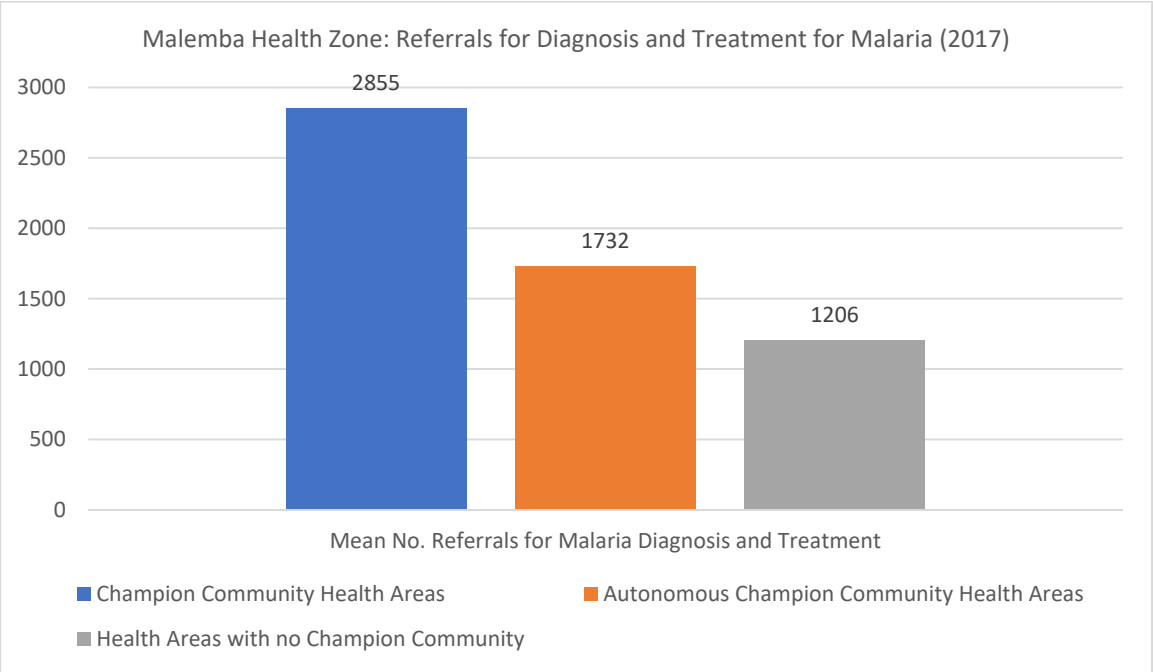


Table 20: Kamina Coordination Champion Community Impact Analysis

Health Zone	Action Plan Indicator	Health Area	All CCs %	All CCs P	All CCs X^2	All CCs	Health Area	IHPplus %	IHPplus P	IHPplus X^2	IHPplus	Health Area	Autonomous %	Autonomous P	Autonomous X^2	Autonomous
Songa	Assisted birth	CC	61	1.0	NS		CC	69	4.7	**0.02**		CC	54	0.0	NS	
		No CC	54				No CC	54				No CC	54			
	ANC-1	CC	79	8.8	**0.002**		CC	84	1.2	NS		CC	74	8.7	**0.003**	
		No CC	66				No CC	78				No CC	54			
	ANC-4	CC	64	6.5	**0.01**		CC	66	0.77	NS		CC	62	11.5	**<0.001**	
		No CC	46				No CC	54				No CC	38			
	IPTp	CC	84	4.2	**0.04**		CC	85	5.0	**0.02**		CC	83	3.5	NS	
		No CC	72				No CC	72				No CC	72			
	DPT/HepB/HIB	CC	91	12.9	**<0.001**		CC	91	1.0	NS		CC	91	3.7	**<0.001**	
		No CC	71				No CC	91				No CC	52			
	Measles	CC	92	16.1	**<0.001**		CC	93	1.0	NS		CC	90	22.7	**<0.001**	
		No CC	77				No CC	93				No CC	61			
	Exclusive breastfeeding	CC	69	25.9	**<0.001**		CC	68	24.5	**<0.001**		CC	70	27.4	**<0.001**	
		No CC	33				No CC	33				No CC	33			
	Curative services use	CC	30	2.0	NS		CC	27	0.4	NS		CC	33	5.0	**0.02**	
		No CC	21				No CC	33				No CC	19			
	Family planning	CC	19	1.3	NS		CC	19	0.13	NS		CC	19	1.8	NS	
		No CC	13				No CC	17				No CC	12			
Kabongo	Assisted birth	CC	58	10.0	**0.001**		CC	51	5.2	**0.02**		CC	65	18	**<0.001**	
		No CC	35				No CC	35				No CC	35			
	ANC-1	CC	87	2.2	NS		CC	81	2.7	NS		CC	94	2.2	NS	
		No CC	79				No CC	71				No CC	88			
	ANC-4	CC	58	1.3	NS		CC	57	0.7	NS		CC	59	2.0	NS	
		No CC	50				No CC	51				No CC	49			

	IPTp	CC No CC	80 51	18.6	**<0.001**	CC No CC	74 48	14.2	**<0.001**	CC No CC	83 54	19.5	**<0.001**
	DPT/HepB/HIB	CC No CC	64 72	1.2	NS	CC No CC	56 61	0.5	NS	CC No CC	76 66	6.1	**0.01**
	Measles	CC No CC	68 71	0.3	NS	CC No CC	52 69	6.0	**0.01**	CC No CC	72 74	0.1	NS
	Exclusive breastfeeding	CC No CC	55 36	9.8	**0.001**	CC No CC	47 36	4.08	**0.04**	CC No CC	64 36	19.2	**<0.001**
	Curative services use	Cc No CC	58 50	1.2	NS	CC No CC	57 51	0.4	NS	CC No CC	59 49	2.0	NS
	Family planning	CC No CC	22 19	0.3	NS	CC No CC	19 16	0.3	NS	CC No CC	26 22	0.4	NS
Malemba	Assisted birth	CC No CC	72 75	0.20	NS	CC No CC	79 75	0.45	NS	CC No CC	65 75	2.4	NS
	ANC-1	CC No CC	86 69	8.2	**0.003**	CC No CC	91 76	8.2	**0.004**	CC No CC	82 63	9.0	**0.003**
	ANC-4	CC No CC	55 30	12.8	**<0.001**	CC No CC	71 41	18.3	**<0.001**	CC No CC	40 20	9.5	**0.002**
	IPTp	CC No CC	83 63	10.1	**0.001**	CC No CC	93 87	2.0	NS	CC No CC	74 39	16	**<0.001**
	DPT/HepB/HIB	CC No CC	90 77	6.1	**0.01**	CC No CC	93 88	1.4	NS	CC No CC	87 66	19.3	**<0.001**
	Measles	CC No CC	90 75	7.8	**0.005**	CC No CC	93 84	3.9	**0.04**	CC No CC	88 66	21.0	**<0.001**
	Curative services use	Cc No CC	40 30	2.1	NS	CC No CC	40 32	1.3	NS	CC No CC	41 29	9.3	**0.002**
	Family planning	CC No CC	15 12	0.38	NS	CC No CC	16 11	1.1	NS	CC No CC	15 12	0.04	NS