Engagement of community structures (CAC - cellules d'animation communautaire) speeds up polio campaign results in Kasai and Kasai Central provinces

Democratic Republic of Congo (DRC)

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Executive Summary |

When UNICEF DRC brought in a new approach to C4D efforts in polio campaigns for the first time, they reached promising results.

In February 2020, polio response campaigns in two provinces of the Democratic Republic of Congo reached coverage rates at levels above 100% of targets and in record time. A key factor contributing to the campaigns' speed and reach: the involvement of DRC's unique Community Animation Cells (CACs).

A Community Animation Cell (CAC) is a multisectoral community structure for coordinating community initiatives at the village ("cell") level. A CAC is organized under the leadership of the village/cell chief and its members represent all elements of the village community: religious leaders, delegates, community-based organizations, etc. A CAC coordinates initiatives for the community across sectors, for example, previously distributing health kits and mosquito nets.

As permanent members of the community, CAC members are familiar with the village and are known by the household members. Their first responsibility is to communicate and inform. These factors made the members of these establish structures ideal candidates to deliver the polio campaign communication package.

To deliver the polio campaign C4D package, each CAC was responsible for 25 to 50 households, a cohort that includes approximately 20-30 children under age 5 and three to four pregnant women. After specific training, each CAC carried out key activities before, during, and after the polio vaccination campaign. CAC members went door-to-door in each village to count the targeted children, to sensitize parents, to reassure them about the benefits of vaccination, and to remind parents of the campaign dates. Then, during the campaign, CAC members accompanied vaccination teams and checked that no one had been missed to follow-up.

The involvement of CACs accelerated results while generating more reliable data. Campaigns reached coverage targets in fewer days than typically required. CAC efforts to count and track children generated more accurate data on the numbers of children targeted and reached, as compared to administrative data. According to lot quality-assurance sampling (LQAS), lots were accepted for 96% of health zones in Kasai and Kasai Central, as compared to levels below 89% in three other provinces in the campaign where the CAC approach is not implemented.

Reasons for success include the CAC members' familiarity with the area and its households, and increased household trust. With large numbers of members seeking children for vaccination, a CAC can reach more children in less time.

Furthermore, working through an established community structure might increase trust in vaccination efforts, as community members might have more confidence in the campaign process and in the messages they receive. Increased confidence in messages about vaccination could potentially carry over and impact future campaigns or broader routine immunization efforts.

These positive results highlight the benefits of involving permanent community engagement structures in polio campaign communication efforts. Further benefits could include strengthened community ownership and increased support for vaccination activities. The CAC approach also sustainably links polio response campaigns to other sectors of life in the village, including routine immunization.

How were CACs established?

The process to set up CACs began in 2014 in DRC and was completed in 2018 when CACs became part of the country's community engagement policy, the development of which was supported by UNICEF. Initially, the CACs were established to support community distribution of long-lasting insecticide-treated nets (LLINs) and family kits, as part of high-impact interventions to reduce maternal and child mortality. After seeing the successful contribution of the CACs in general mass activities, the approach broadened in Kasai and Kasai-Central Province to include polio campaigns, after an outbreak of circulating vaccine-derived poliovirus (cVDPV) was declared in this region.

Overall, throughout the entire country, 62,312 CACs have been established, with support from UNICEF and other communication partners. In Kasai Province and Kasai Central, CACs have been established in all areas, including difficult-to-reach locations. In total, 11,598 CACs operate in these two provinces – 4,740 in Kasai Province and 6,858 in Kasai Central.

The February 2020 cVDPV campaign was the first time the full package, including polio, was given to a CAC to manage. Initially, polio vaccination was not a priority for CAC activities. Kasai and Kasai Central are two provinces that were advanced in the CAC approach; CACs were strongly established and well-developed in these two provinces before CAC members were engaged for the polio communication package.

How did the CACs operate in polio campaigns in Kasai and Kasai Central?

Responsibilities of the CACs ranged from raising awareness among household members, to counting, to searching for missed children and managing cases of vaccine hesitation and refusals.

In campaign operations across health zones of Kasai and Kasai Central, the CACs:

1. Counted target children before the campaign was organized. This made it possible to assess coverage rates.
2. Accompanied the vaccination teams. CAC members who carried out pre-marking in their villages later accompanied vaccination teams. This facilitated rapid progress of the teams and the vaccination of many children in record time. Having CAC members present alongside vaccination teams also might have strengthened household confidence in vaccinators and could have increased effectiveness in insecure areas.
3. Actively searched for unvaccinated or under-vaccinated children
4. Actively researched suspected cases of vaccine-preventable diseases

How are CAC members selected and supported?

Members are elected by the village assembly under the leadership of the village chief and with the support of a facilitation team to strengthen their empowerment and accountability. At least 30% of positions on the steering committee of a CAC are reserved for women.

Results |

Quicker Coverage in Fewer Campaign Rounds

The CAC approach enabled campaigns to reach their goals in record time. In other regions without CAC involvement, two or more rounds typically were required to reach campaign goals. With the CAC approach in Kasai Province, the campaign reached its goals after round 0. "Even in one round, we used to take four to five days to cover all the children. With the CAC, mostly by the second day, we had covered all children," a UNICEF staff member reported.

Greater Community Engagement

The fact that a permanent community structure is supporting the entire package of communication is a big result for community engagement. The CAC approach places communities at the center of services that concern them.

In other provinces in DRC, individual social mobilizers support communication efforts; this approach has limits. In some cases, a social mobilizer comes from a different village, which at times has been reported as contributing to community resistance and refusals or absences.

On the other hand, working through a community structure might increase trust in vaccination efforts. Community members might have more confidence in the campaign process and in the messages they receive. This confidence in messages about vaccination could even carry over and impact future campaigns or routine immunization efforts.

Finally, the CAC approach builds ownership and reinforces community spirit. Under the CAC approach, incentives are paid to groups and not to individuals; some CACs keep a portion of this money to launch revenue-generating activities for the community.

Strong Campaign Results

For the February 2020 response campaign, strong coverage and LQAS results were reported for the areas under the responsibility of 1,119 CACs in 4 health zones of Kasai and 4,768 CACs in 19 health zones of Kasai Central.

In addition to presenting the results for Kasai and Kasai Central under the CAC approach, we also compare results from three provinces involved in this campaign that were not using the CAC approach systematically: Kwilu, Kwango, and Kongo Central.

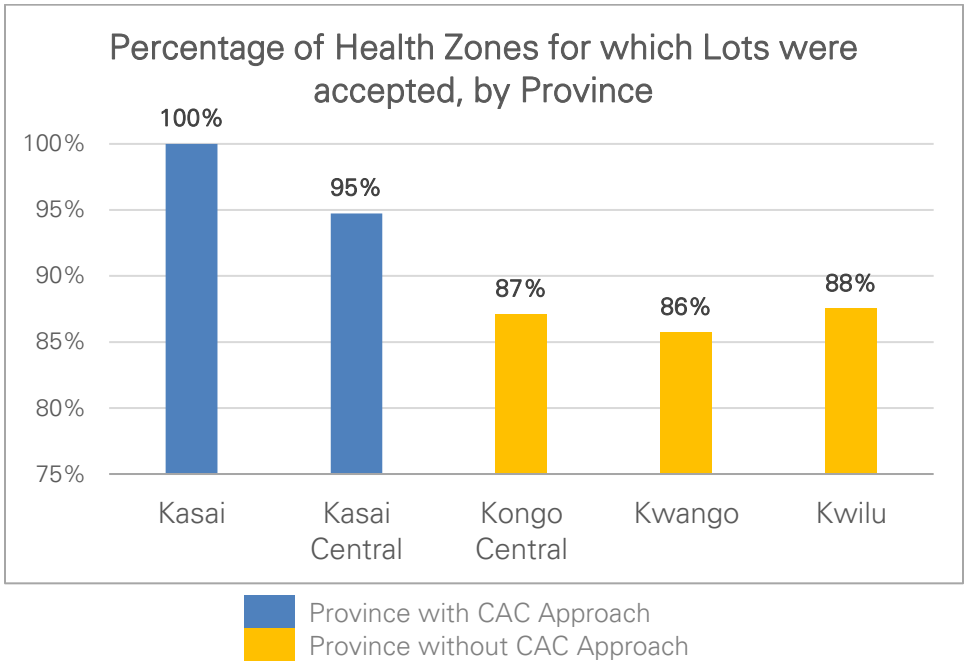
Coverage Rates

- In Kasai Central, a total of 1,297,568 children under five were vaccinated, out of 1,231,712 initially targeted, for an administrative coverage of **105.35 per cent**.
- In Kasai, a total of 178,103 children under five were vaccinated, out of 173,183 initially targeted, for an administrative coverage of **102.84 per cent**.

LQAS Results

- According to LQAS conducted by WHO during the February campaign, lots were accepted for 22 out of 23 health zones (96%) of Kasai and Kasai Central.
- By comparison, in the three provinces where the CAC approach is not systemically implemented, lots were accepted for 60 out of 69 health zones (87%).

Figure 1. Percentage of health zones for which lots were accepted, by province

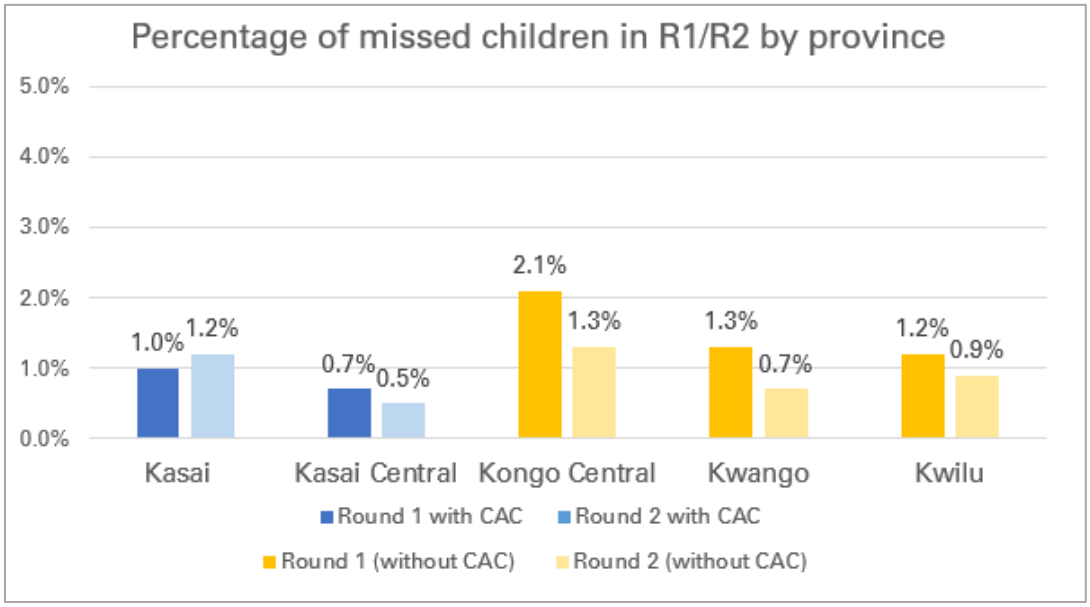


Source: LQAS results for the cVDPV2 response campaign conducted in February 2020

Missed children

- Less than 1 per cent of children were missed in Kasai Central and less than 1.2 per cent of children were missed in Kasai. The reference value is less than 5%.

Figure 2. Percentage of missed children in round 1 and round 2, by province



Source: Independent Monitoring Kwilu-Kwango Response Campaign, February 2020

Catch-up of missed children by CAC members

- According to CAC reports, out of the 260 missed children identified, 254 children were recovered, representing a performance of 97.7%.

Reasons for non-vaccination

- In Kasai, absences represented 66% of reasons for non-vaccination in R1 and 16% in R2. In Kasai Central, absences represented 48% in both R1 and R2.
- For Kasai and Kasai Central, children were reportedly missed on borders with Angola and in Tshikapa city, due to social and economic movements and where a CAC has been difficult to establish.

Discussion |

Why did CACs accelerate results?

The CACs played a major role in achieving key objectives of the polio response campaigns and contributed to the total coverage of villages. The CAC approach places communities at the center of services that concern them. Furthermore, CAC members bring expert knowledge of the environment and can increase the collective motivation and community trust.

This approach is effective because campaign organizers give the C4D package to the CACs without needing to count or restrict the number of CAC members (which is not the case with the social mobilizer approach). The CACs use their own organization. They can use more people to communicate and to seek children.

As each CAC manages 25-50 households, it's easy for CAC members to know who was absent within this set of households and why, and to know the best time to reach the children. Knowing why children are not being reached by campaign effort becomes easier. This information can inform the next campaign.

Challenges |

Maintaining CACs as active, engaged and with the proper skills is a challenge, due to the number of CACs and the level of intervention needed. Keeping the CAC members motivated as a group requires support. Continuous supervision and ensuring CACs have revenue-generating activities promote motivation. Training and tools promote skills and engagement. For example, CAC members need training to know their priorities in supporting vaccination, alongside all other sectors – including education, protection and health. Support for these motivational and skill-building initiatives requires collaboration among NGOs, institutions and funders.

The process to create a CAC is very long and requires discussion, election, training, and self-evaluation. As CACs manage the entire community engagement package for all sectors, effort is required to ensure their community engagement approaches for all sectors align with and respect how the community is working.

The challenge remains of scaling up of the approach, subject to the required conditions for quality of implementation and functionality of the CACs, to improve the quality of immunization activities in the other provinces of DRC.

Lessons Learned |

Funding can go further in the CAC model. In the CAC approach, funding is provided to the community group to share. By comparison, models using social mobilizers provide a daily fee per person, so cost increases with each additional mobilizer engaged.

Persistent advocating for a permanent community structure is required to establish the CAC model.

Using the CAC approach for polio communication sustainably links polio response campaigns to other sectors of life in the village, including routine immunization.

Expanding the CAC approach to include polio communication is an example of how successful initiatives can integrate other sectors. In this case, the CAC model was established for community distribution of LLINs and family kits. Success in this area enabled the CACs to incorporate other sectors, like polio communication.

In villages, people share feedback and information through CACs, which helps to prevent conflicts and to gather ideas from all categories of members. This is favorable for the community development process.

Table 1. Summary of main activities conducted under the leadership of CACs

Pre-Campaign Activities:

- Identify a representative/vaccinator and a mobilization team leader.
- Send representative to Health Area to plan daily route and visit plan.
- Enumerate the households and complete a child tracking form (especially how many children under age 5 by name and household).
- Conduct interpersonal communication and transmit key messages door-to-door on:
    - dates and targets of the campaign
    - the importance & quality of the vaccine
    - the need to continue routine immunization for children aged 0-1 year
    - responses to most common reasons for resistance and refusal and negotiation
    - the importance and reasons behind repeated vaccination campaigns.

During the SIAs:

- Support vaccination and social mobilization teams by showing them the children already counted by CAC before the launch of the campaign
- Attend evening meetings and provide solutions to problems encountered. Take corrective actions as needed for poor performance. Acknowledge exceptional performance.
- Ensure that all households are visited/revisited, all children reached, all refusals converted, guest children noted and vaccinated, newborns confirmed as vaccinated.
- Report AFP cases to the supervisor and help to further the investigation and follow up.
- Participate in refusal and vaccine hesitancy management.

After the SIAs:

- Conduct feedback meetings to review the performance of the CACs.
- Set the plan to support the next round, considering the lessons from round one.
- Synthesize information and report to community health committee and health area level.