

DRC-IHP Trip Report: Indira Narayanan

Indira Narayanan

August 4, 2011

Integrated health; trip report; maternal neonatal and child health; kangaroo mother care

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Integrated Health Project

in the Democratic Republic of Congo



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TRIP REPORT INDIRA NARAYANAN

1. Scope of Work: The SOW is outlined below. One component that was removed was the field trip as the country Technical Director of PROSANI felt that it was more important to remain in Kinshasa to review all information to develop the key activities for the program and carry out the other tasks listed in the SOW.

| | |
|---------------------------------------|--|
| Destination and Client(s)/ Partner(s) | DR Congo ; IHP/PROSANI |
| Traveler(s) Name, Role | Indira Narayanan |
| Date of travel on Trip | June 30 – July 27 |
| Purpose of trip | <p>IHP’s mandate from USAID focuses on working with the MOH and other partners, such as MCHIP, to improve maternal and newborn health. The objective of this short-term technical assistance is to participate in Kangaroo Mother Care (KMC) training to ensure evidence-based technical quality of project interventions, and to provide technical assistance to the IHP technical team on newborn care within the framework of integrated care for the mother and the newborn, including support for the expansion of community- and facility-based essential newborn care (ENC) and improving care for low birth weight (LBW) infants. The consultant will also work with IHP staff to review the package of interventions for scaling up and strengthening evidence-based community interventions as well as any required revision to the learning materials (training modules) and tools (new partogram with special relevance to newborn care, supportive supervision framework, etc.). She will review current issues and how to best use the new materials and tools to maximize IHP’s support to improving the quality of related newborn health services. Amount of time provided for each task is approximate.</p> <p><u>Specific tasks:</u></p> <ol style="list-style-type: none"> 1. Support planning with IHP staff and USAID as well as training to IHP staff <ol style="list-style-type: none"> a. Plan and conduct with IHP staff a briefing with USAID health team, preparing information based on previous country experiences and requirements of IHP and the MOH (1 hour). b. Share best practices on providing incentives and enablers to motivate health services providers and health community workers to develop and maintain a positive attitude towards mothers over the critical labor period and the immediate post natal period (2 hours). c. Share with the technical team NNH approach highlighting of |

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others countries success stories (2 hours).

- d. Work with IHP integrated care for Mother and Newborn Advisor to review and follow up integrated maternal and newborn activities plan and facilitate development/ revisions of a workplan (2 days).
 - i. Provide recommendations on linking all previous activities in KMC through former AXxes project, MCHIP, LMS, into current IHP activities
 - ii. Provide assistance on the integration of basic health facility-based services on essential newborn care and provide technical directives on the effective care of the newborn.
 - iii. Integrate appropriate community-based activities as a result of review with IHP, MOH and partners
 - e. Review current methods of supervision, discuss challenges and facilitate development of improved and innovative methods of achieving better quality of care (4 hours).
 - f. Provide suggestions for the selection, creation, and scale up of integrated maternal-newborn health and KMC models in the health zones (starting with selected centers and expanding during the life of the project) (4 hours).
 - g. Plan activities to improve the care of LBW infants through the introduction and expansion of facility-based Kangaroo Mother Care (KMC) services and provide guidance on which activities are feasible and how to link this strategy to what is already in process in IHP-support health zones. Include visit to a KMC site in Kinshasa (4 hours).
 - h. Provide recommendations on setting up a technical exchange network on integrated health care of mother and newborn for IHP partners, under the leadership of the MOH, to share information, discuss challenges, and explore best practices. Participate in a first meeting to discuss this network and propose ideas (2 hours).
 - i. Plan a debriefing with USAID health team and IHP prior to departure (1 hour).
 - j. Prepare trip report with recommendations– preparation, review by selected members of the team and revision (4 hrs in country, 1.5 days from Arlington).
2. Participate in Kangaroo Mother Care Training July 3-July 12 (9 days)
 - a. Participate in planning and preparation/team building of facilitator team to ensure the technical quality of the training, work with the facilitators on session preparation, and divide facilitator tasks along themes and sessions.
 - b. Provide coaching to facilitators as needed.
 - c. Participate as a resource person in selected sessions.
 - d. Lead and participate in daily evaluations and feedback with

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| | <p>the facilitators</p> <ul style="list-style-type: none"> e. Contribute to the final written evaluation of the training. f. Contribute to the final report of the training. <p>3. Partner coordination and information exchange</p> <ul style="list-style-type: none"> a. Courtesy visit with the director of the 10th direction of the MOH and the chief of the integrated care for mother and new born national program to know about the national protocol and to share experiences and best practices (1 hour) b. Meet with other partners doing the similar work such as MCHIP, SANRU program, IRC, WHO, UNICEF (1 day) <p>4. With IHP staff, provide support to MOH</p> <ul style="list-style-type: none"> a. Review the new national partogram with special relevance to newborn care and provide relevant recommendations if requested to lead to better utilization (2 hours) b. Facilitate review of tools for data collection and the database, learning materials especially training modules and supportive supervision (there are five sets of tools/manuals previously developed under the former AXxes Project) (3 days) c. Review the training modules on KMC services and provide recommendations if needed (there are three manuals). Adapt and add tools related to supervision and monitoring and evaluation (registers, etc.) and provide suggestions for action needed to improve the IHP monitoring and evaluation process. (2 days) d. Review and discuss DRC community-based interventions with the IHP team, MOH and partners, with the goal of feeding into the revised IHP workplan (2 days) <ul style="list-style-type: none"> i. Discuss the existing plan with a view to improve quality of implementation ii. Review the manual for “relais communautaires” to improve identification of signs of danger related to mother and newborn care, their management, and referral systems and provide suggestions for revision. <p style="text-align: center;">As a part of this activity, discuss with the COP and selected technical staff a new innovative method involving m-Health and possible implementation, at least as a pilot intervention to aid in the detection, management and documentation of the sick newborn with danger signs. This will be a preliminary discussion only at this time.</p> |
| Objectives/Activities/ Deliverables | <p>1) Trip Report in IHP template submitted within 10 days of return from trip</p> <p>2) Products: Trip Report, written suggestions to revise documents (Training materials on integrated mother and newborn care with emphasis on newborn care: (1) Facilitator’s guide ; (2) Reference manual for providers ; (3) Community health guide ; (4) Participant booklet ; (5) Registry of experience for clinical care providers; (5) Newly-revised ordinogram), KMC Training Final Evaluation, KMC Training Final Report.</p> |
| Background/Context, if appropriate. | Background country information included in the above documents. |

2. Major Trip Accomplishments: Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

- Facilitation of the KMC workshop between July 4 – 12. Report available from in-country team or in

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Eroom.

- Facilitation of development of plans of action to implement activities for newborn health within MNH with development of consensus with relevant sections of the MOH and other partners.
- Facilitation of review of M & E with emphasis on indicators and tools including the MNH registers and partograph with initiation of steps with a view to get them included in the national HMIS (SNIS). This is a very important step for MNH activities in DRC.
- Suggestions for workplan activities, as follows:

Note:

- (A) Le tableau énumère les activités proposées pour la portion restante de l'année 1 - Juillet - Sept 2011. Alors que chacun d'eux devrait être introduite dans la première année, certaines de ces activités se prolongeront dans l'année 2
- (B) Les activités sont groupées et énumérées en détail pour plus de clarté. Des changements comme nécessaires et des adaptations appropriées devraient être prises pour le développement des plans de travail réel pour soumission à la Mission de l'USAID

| No | Activités proposées pour le plan de travail SMN |
|-----------|---|
| 1. | Promouvoir un soutien au niveau national |
| | a.) Appui à la finalisation des Normes et Directives Nationales liés à SMN b.) Plaidoyer et appui à inclure des indicateurs clés et les outils SMN (des registres SMN et partogramme révisés) dans le système national de SNIS |
| | Activités pour l'an 1: (i) Finaliser les Normes et Directives Nationales (ii) Réviser les registres SMN basés sur les recommandations du groupe lors de la réunion sur le July 22-23, 2011 (iii) Commencer des mesures pour obtenir certains indicateurs SMN et des outils de S & E accepté dans le SNIS- pour la continuation en l'année 2 |
| 2. | Promouvoir des activités intégrées de la sante maternelle et du nouveau-né (ajouter les composants maternelle)- Note: La mise en œuvre des activités de SMN telles que la révision d'outils, de formation, de supervision, les stratégies de communication au niveau des structures sanitaires et au niveau communauté doivent être intégrées. |
| | Activités pour l'an 1: (i) Imprimer les registres en chiffres adéquats pour les prétests et pour une utilisation dans des sites sélectionnés de PROSANI pour la mise en œuvre le programme (ii) Obtenir des données de base supplémentaires sur les questions clés SMN qui ont été manqués dans la survie de la base de SMN de PROSANI (iii) Finaliser et procurer des listes d'équipements / matérielles / fournitures pour a. SMN activités en général, b. Activités HBB c. Activités SMK |
| | (a.) Mettre en œuvre des activités pour la réanimation des bébés avec asphyxie à la naissance (« Aider les Bébé Respirer Initiative ») |
| | Activités pour l'an 1: (i) Mettre en place un groupe de travail pour le « sûr voir » l'activité et à l'adaptation / l'harmonisation des outils et la planification et la mise en œuvre des activités (ii) Adapter / harmoniser les outils et noter les changements requis dans une carte séparée (s) pour être plastifié(s) (iii) Développer et initier des plans de supervision pour le HBB intégré avec d'autres activités SMN (iv) Développer et initier des plans de suivi évaluation pour HBB liés aux activités d'autres SMN (v) Estimer les besoins pour les équipements, matériels et les fournitures et mettre en |

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| | |
|-----------|---|
| | œuvre les étapes pour l'achat de la même (également noté ci-dessus sous le point 2) |
| | (b) Établir des unités kangourou Mère |
| | <p>Activités pour l'an 1</p> <ul style="list-style-type: none"> (i) Réviser les outils existants SMK basées sur des expériences de l'atelier et les suggestions fournis par les animateurs et les participants (ii) Développer / adapter la liste des meubles, équipements et matérielles de base pour les unités de SMK d'être créé en l'an 2, y compris celles requises pour le soin des bébés de faible poids et ceux pour le soutien des mères et commencer les étapes pour l'acquisition des même (également noté ci-dessus sous le point 2) (iii) Développer les registres SMK supplémentaires dans les unités de collecter, suivre et évaluer les données (iv) Mettre en place un système de supervision (v) Commencer les unités de SMK à Panzi et Dilala (vi) Identifier les unités pour commencer en le deuxième an |
| | (c) Identifier et gérer le nouveau-né malade |
| | <ul style="list-style-type: none"> (i) Renforcer l'identification et la gestion du nouveau-né malade (ii) Explorer la mise en œuvre du projet pilote sur l'utilisation des téléphones cellulaires mobiles, afin d'améliorer la qualité de service et de documentation, y compris l'identification des tâches claires et des coûts potentiels |
| 3. | <p>Promouvoir les comportements optimaux en matière de la santé maternelle et du nouveau-né au niveau des structures sanitaires et aux communautés (Remarque: les stratégies de communication MNH devrait également être liée à la stratégie globale de communication PROSANI)</p> <ul style="list-style-type: none"> (a) Promouvoir les comportements optimaux chez les mères / familles grâce à l'amélioration des stratégies de communication SMN au niveau des structures sanitaires ciblant (i) les mères dans les salles postnatale avant leur sortis et (ii) les dispensaires prénatals et postnatals (b) Promouvoir les comportements SMN optimaux chez les mères / familles grâce à l'amélioration des stratégies de communication au niveau communautaire se concentrant sur (i) la mobilisation communautaire et (ii) des visites à domicile ciblées à des timings appropriée dans les périodes prénatale et postnatale précoce <p>Activités à l'année 1:</p> <ul style="list-style-type: none"> (i) Evaluer les outils (pour la formation, la supervision et la collecte des données) et les stratégies de mise en œuvre tout en veillant à ce que les stratégies de communication en général est liée à la stratégie globale de communication PROSANI, des composants spécifiques MNH sont conservés dans un module séparé. (ii) Examiner et hiérarchiser les messages MNH pour permettre l'expansion à l'échelle (iii) Élaborer des plans réalisables pour des activités des Relais Promotioneles aux structures sanitaires et a la communauté (iv) Examen / adapter les plans de la surveillance des Relais Promotioneles (v) Examen / adapter les plans de surveillance et d'évaluation des activités du Relais Promotioneles |
| | <ul style="list-style-type: none"> • Participation and presentation of suggestions for MNH strategies in the national communication workshop, as follows: <p>OUTLINE</p> <ul style="list-style-type: none"> 1.) Background country information 2.) Steps taken/processes to develop this document |

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- 3.) Suggestions for key technical components to be covered in newborn health
- 4.) Operational / implementation components to be addressed and adapted
- 5.) Next Steps
- 6.) Appendices
 - a. Recommendations for implementation of the HBB Initiative
 - b. Steps for the inclusion of MNH indicators and tools in the National HMIS (SNIS)
 - c. Suggestions for activities for the workplan – including activities for year 1 (July – Sept 2011)

BACKGROUND COUNTRY INFORMATION

Trends in mortality data related to maternal and newborn health in DRC (Table 1) are a cause for concern. While initially there was a fall in maternal deaths, the numbers are still high. Even more alarming is the fact that neonatal mortality remains unchanged over the last 12 years and has, in fact, risen in recent years, highlighting the urgent need to address these issues.

Table 1: Background Country Information

| Year/Source | MMR | NMR | <5 MR |
|----------------|------|-----|-------|
| 1998 (ELS) | 2100 | 38 | 172 |
| 2001 (MICS 2) | 1289 | 37 | 165 |
| 2007 (DHS) | 549 | 42 | 148 |
| 2010(MICS) | | 48 | 157 |

NMR: Neonatal mortality rate
< 5yMR: Under five mortality
MMR: Maternal mortality ratio
ELS: « Etat des lieux de la Santé »

In view of the above findings, an important goal may be to specifically target the three key causes of neonatal mortality within the framework of essential newborn care that is in turn linked with selected components of maternal health. This will need activities to decrease mortality due to infections, birth asphyxia, and complications of low birthweight/prematurity. This will also include addressing the required indicators and tools for documentation, and advocacy for their incorporation into the National HMIS (SNIS). Activities should also be implemented as appropriate at policy, facility and community levels with suitable links between each of them. This background document serves as a narrative to help develop the plan of action/work plans. Suggestions noted below are based on past programmatic experiences related to newborn care integrated with maternal health in DRC and other countries.

STEPS TAKEN TO DEVELOP THIS DOCUMENT

This section deals with the processes that helped identify the components and activities to be implemented and suggestions for a plan of action.

- Review of experiences in maternal and newborn health in DRC during the last four years during the AXxes Program with technical support initially from USAID/BASICS and then USAID/MCHIP
- Discussions in small groups with the relevant technical staff in PROSANI to understand their requirements and explain to them the above past experiences in order to develop draft plans in each area such as training, supervision/quality of care, communication and monitoring and evaluation.

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- Development of short background documents to help formulate a draft plan of action/workplan for activities to improve maternal and newborn health.
- Sharing of selected key elements of the background documents and tools for monitoring and evaluation with partners. These included the Ministry of Health (10th Direction- Sante de la Family et Groupe Specifique -Dr. Kalume, 5th Direction – Paul Pilipili et 11th Direction – Berthe Banzua, PNLMD- Programme National de Lutte contre Maladaies Diarrrhees –PCIME – Nelson Bambwelo et PNSR – Programme National de Sante de la Reproduction – Kitsita Christophe), WHO Marie Claude), UNICEF (Bernadette Mbu) and technical experts (Obstetricians- Dolores Nembunzu , Prof Wolombi and Pediatricians – Celestin Nsibu and Delphin Muyila) and the relevant team members of PROSANI. This was carried out through an interactive meeting on July 22-23.

While all the key steps for implementation of the program including training, supervision and communication were presented, certain elements were prioritized and discussed in greater detail as noted below

- a) The new global initiative “Helping Babies Breathe” for the basic management of birth asphyxia as it was necessary to develop consensus among the MOH and other partners on acceptance of this activity and the method of implementation. The recommendations are noted in Appendix #1.
- b) Indicators and tools for monitoring and evaluation including various MNH registers and the partogram. Past experience with BASICS, MCHIP and AXxes in the country program had shown that without inclusion of the key MNH indicators in the national HMIS system (SNIS) and acceptance of the registers by the relevant sections of the MOH, collection of data to document results and effectiveness of the program will present great challenges. The actions taken during this meeting and recommendations are noted below in the section on Monitoring and Evaluation and in Appendix # 2.

SUGGESTIONS FOR KEY TECHNICAL COMPONENTS TO BE COVERED IN NEWBORN HEALTH

Essential newborn care had been addressed integrated with selected components of maternal health through the AXxes program with technical support initially through USAID/ BASICS and POPPHI and subsequently through USAID/MCHIP. In view of the continued high neonatal mortality, it is suggested that the key causes of death should also be specifically targeted

- 1.) Resuscitation for birth asphyxia through the Helping Babies Breathe (HBB) Initiative
- 2.) Kangaroo Mother Care as a part of the extra care of the low birthweight /preterm babies
- 3.) Prevention, recognition and management of neonatal infections including use of innovative methods.

All three components should be implemented within the framework of essential newborn care that, in turn, is linked with selected elements of maternal health. As an example, integrating active management of the third stage of labor with resuscitation for birth asphyxia addresses a cause of death in the baby and one in the mother. At the same time, integrating too many components may present challenges especially when taken to scale.

SPECIFIC ELEMENTS IN EACH TECHNICAL COMPONENT

1.) Address birth asphyxia through the Helping Babies Breathe (HBB) Initiative

BASICS and then MCHIP provided technical support to AXxes, LMS and UNICEF for implementing basic resuscitation as a part of essential newborn care and selected components of maternal health such as Active Management of the Third Stage of Labor (AMTSL) and postnatal care of the mother and baby. Basic resuscitation has also been covered for facility health workers by the Latter Day Saints (LDS). More recently, there has been a global launch on another model of basic resuscitation through the American Academy of Pediatrics in collaboration with other partners such as USAID, Laerdal, Save the Children, and NIHCD. Last October (2010) LDS (Latter Day Saints) trained 300 health workers in this new HBB program.

While all the basic resuscitation curricula of MNH program, LDS, IMNCI and of the HBB program are somewhat similar, there are some differences. Some of these issues were highlighted at the meeting of the group of partners that met on July 22-23 2011. The recommendations of the group with relevance to the

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implementation of HBB activities in DRC are noted in Appendix #1.

2.) Care of the low birthweight babies with emphasis on Kangaroo Mother Care

Low birthweight babies, being particularly vulnerable, contribute to a great extent to neonatal mortality. They need extra support through essential newborn care for maintaining temperature, prevention of infection and early detection and management of problems/complications. Kangaroo Mother Care is an evidence-based simple low cost method of providing this basic support.

- a. A national workshop on “Kangaroo Mother Care” (KMC) was organized at Kinshasa with the support of IHP and MCHIP between July 4-12, 2011 for training of 22 participants that included health workers from the centers where KMC units are to be established and developed into centers of excellence, technical coordinators from the IHP project and representatives from the MOH. The sessions included appropriate interactive presentations covering key aspects of the theoretical background followed by practical/clinical sessions at the General Hospital of Kinshasa and the Pediatric Hospital of Kalembe-Lembe. In addition, sessions were organized to review and report on the practices at the center and on the practical sessions organized, in order to provide the necessary feedback and develop a plan of action.
- b. IHP has also planned to establish this year two KMC centers at Katanga and S. Kivu and more centers in the following years

Note: A detailed report with annexes covering the KMC workshop on the topics covered including the practical sessions and copies of draft tools developed/ adapted has been shared with the relevant MCHIP team members and with relevant IHP senior staff in the country and at headquarters. Suggestions for adapting the KMC manuals (reference manual and facilitators’ and participants’ guides) have also been submitted as track changes.

While KMC needs to be expanded, it may not always be possible to the extent desired. Hence, it is also essential to promote supplemental support for low birthweight babies such as providing extra care in maintaining temperature including additional covering, feeding and early detection and management of problems/complications.

Note: Application of skin-to-contact at birth, during transport and for maintenance of temperature should be promoted whenever required for **all newborns at all levels** as a part of essential newborn care.

3.) Identification and management of neonatal infections

Management of neonatal infections needs to be strengthened. There are challenges in health workers maintaining competence in the ability to identify the sick babies. Peripheral centers with few numbers of cases of neonatal infections present greater challenges in maintaining their skills.

- a. At the national level
 - i. Advocate to harmonize the danger signs in existing tools such as the program MNH manuals, KMC manual, SONU and IMNCI workbook. The selection of danger signs should be based on evidence and an appropriate module on the identification and management of the sick newborn harmonizing the various tools should be developed so that the standardized section/module can be integrated within these various tools.
- b. At facility level
 - i. Strengthen current activities for identification and managements of neonatal infections as appropriate.
 - ii. Evaluate innovative methods such as the m-Health platform to address the problems of identification and management of infections in the newborn. These components may be applied as a pilot project, initially with health workers at peripheral centers and later for community health workers.

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- c. At community level

Based on the recommendations of the MOH, the focus will be on counseling the mother and family on prevention of infection, identification of danger signs and appropriate careseeking in the presence of even one danger sign.

OPERATIONAL / IMPLEMENTATION COMPONENTS TO BE ADDRESSED AND ADAPTED

1.) Training

Consensus needed to be developed within IHP and among key partners related to prioritization of key components to be covered, adaptation of tools and type(s) of training that would be suitable for going to scale. Internally within IHP the common methods of training (copies of the document given to the relevant IHP staff) were discussed. It was felt that the current method of a 12 day training session being used was functioning well, was well liked and was felt to be useful in developing/improving competence. However, it kept the health workers away from their work for a long period and was expensive. The modular method was felt to be very good but would be even more expensive due to increased cost of travel and a longer period before the health workers could acquire all the skills. Methods that relied considerably on self-learning were not felt to be effective in these regions. Thus, finally, in lieu of the current full 12-day training with a good focus on competency based practical/clinical training the following option was considered worth pursuing. This option was also accepted by members at the meeting held in July.

Training focused on competence with knowledge components just essential for the tasks

- a. Retain the reference manual as is for consulting when required
- b. Make a smaller manual with select key useful, practical charts, tables, algorithms and other job aids from the manual and from the power point presentations with information that is essential for carrying out the necessary tasks efficiently. This will serve as the key theoretical components to be covered.
- c. Retain the learning and evaluation checklists making the following changes/additions
 - i.) Adapt the learning and evaluation checklists on resuscitation to suit the HBB curriculum
 - ii.) At present the evaluation checklist that can be used for supervision is long as it gives details that are particularly useful for supervisors who are primarily in government officers and may need additional support to remember all the necessary steps. A third smaller evaluation checklist may be developed to be used for more rapid evaluation highlighting only the most important steps to be used by more competent supervisors.
- d. The training period itself may then be shortened- although the exact number of days will need to be worked out more accurately after identifying the elements and skills to be covered. If additional elements, such the use of the partogram or eclampsia, are included the training period will increase. At the same time the method of training noted here will be even more useful if the number of technical components is increased.

Focus will then be on the practical skills following the learning checklists. Minimal important prioritized theoretical issues related to each list can be presented where required through relevant job aids. Following this the facilitator can demonstrate the various steps on models or, as in resuscitation and AMTSL, on special mannequins while one of the participants or another facilitator reads out each step. All the participants can follow the steps with their copies of "The Clinical Log Book with Learning and Evaluation Checklists" (Registre d'Experiences Cliniques").

Participants can then practice themselves in pairs where one practices the steps and the other evaluates them using the evaluation or supervisory checklists. When they are ready, each participant is evaluated by a facilitator. Only those who score at least 80% with the checklists are permitted to perform the task on a woman or baby in the hospital. Since the duration of the course is shortened, the time for the practical sessions can be increased by having small groups of participants with a facilitator that by rotation spend some hours in the evening and the early part of the night in the hospital. At the end of the training workshop the participants can be evaluated by the

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facilitators. In this manner there is no compromise on the competency part of the training that has been particularly appreciated in the country.

- e. In the training sessions, besides focus on competencies related to clinical skills, time should be reserved for group discussions, to outline, based on observations and discussions at the hospital, a plan of action for themselves when they return to their own centers including how they will achieve and maintain quality of services.
- f. This adapted method can be pretested, tried at selected sites and, if successful, expanded at other program sites.

2.) Improving and maintaining quality of care

Adapt and improve methods of supportive supervision and quality assurance at (a) facility level and (b) community level, including applying innovative methods that are more feasible to take to scale. While it is ideal to have supervisors to visit all the sites and evaluate the health workers and also the units, in practice, it is not being carried in many situations because of lack of motivation and distances that need to be covered on poor quality roads. Alternative methods are noted below. Here, instead of gauging the outcome by documenting improvement in competency of individual health workers, it is judged by noting improvement in the data / indicators calculated from data collected primarily in the registers from different sites such as the pre-natal, delivery, and postnatal registers. In any case, improvement in competence alone may or may not always result in improved indicators as other factors can influence outcome. Two alternative methods of supervision are noted below. They are primarily group supervision with evaluation of changes/ trends in key data and indicators.

Alternate Methods of Supervision

In this option the evaluation will primarily depend on data and not on individual assessment of competence which is very time consuming and does not permit many workers to be covered because of existing challenges in the supervisory system. The improvement in care can be carried out through demonstrations, updates and promotion of sharing of information and competence internally within their own sites or through group meetings. This system has some of the elements of the collaborative system.

a.) For Hospitals – Internal Supervision:

- Provide the selected sites with the (i) the necessary **revised** registers, (ii) tools/templates for data collection and transmission
- Identify a quality control working group that could be the infection control group and can have representation from the depts. of Pediatrics, Obstetrics, Microbiology, Pharmacy, both doctors and nurses/midwives.
- Plan an internal monthly meeting **plus** have two invited representatives (i) from the provincial government and (ii) from the program, PROSANI. This will 'formalize' these meetings and hopefully ensure more regular implementation. The meetings can be fixed on a particular day of a particular week (e.g first Wednesday of the month) so that everyone can remember it and adjust their routines
- Review the key monthly data of the previous month and in subsequent meetings compare with previous data in the form of line graphs. The facilitators (representatives from the hospital management, local government and PROSANI) should ensure a supportive environment and avoid critical attitudes and statements. Where results are unsatisfactory, possible reasons should be discussed in a supportive environment and solutions explored.
- Have a demonstration with a volunteer /update the health workers on one or two of the key areas of competence, get a feedback from rest and clarify doubts. Items such as the mannequins for resuscitation can be brought so that staff can practice with them further after the meeting.
- Decide on what the group would like to look into for improving quality of care:
 - Select the topic to be addressed
 - Identify 3-5 simple steps at a time to be taken to improve the situation in the area to be addressed. For example in prevention of infection it might be to have more focus on the promotion of hand washing, use of sterile or high level disinfected equipment, supplies and linen for deliveries and for use for babies in the nurseries/neonatal special care

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units.

- Priority should be given to those activities that can be carried out with existing resources and then to those that need additional external resources.

b.) For peripheral centers – Group Supervision

- Where the number of staff within each center is few, it may be better to have group meetings within a zone and adapt steps noted above for hospitals. Here too, it would be helpful to have in addition to the health workers from the health centers, representatives from the hospital, provincial government and the NGO.
- Where a zone has a large number of centers with longer distances between of health centers, it may be more feasible to have staff from centers nearer the hospital meet at the hospital. The remaining can meet at an appropriate well functioning health center nearer to them. To ensure more uniformity and better standards, a representative from the hospital management, provincial government and the NGO should also participate in these two meetings.
- Ideally have these meetings on a monthly basis and, only if unavoidable, at two monthly intervals
- Have sufficient mannequins for practice and for evaluation of competence in basic neonatal resuscitation and AMTSL.
- Most of what is noted in internal supervision at the hospital level can be adapted for these sessions.
- This system permits exchanges and sharing of experiences between workers that promotes peer-learning and with appropriate facilitation, an atmosphere of friendly competition can arise, stimulating better performance.
- Request/motivate the health workers to share information with their center colleagues (“restitution”) on their return to their individual health centers.

c.) For community workers – Group Supervision

- Groups of community workers can be brought together in a health center. Have representatives from provincial government, community leader and local NGO /CODESA.
- Besides the regular supervisors facilitating supportive supervision, selected key leading members of the community can be involved in ensuring/documenting that the relais actually visited the concerned houses and community groups.
- Here, besides data collection and review, demonstrations by selected relais using specific counseling cards can take place with feed back from the other relais using the supervisory checklist. In addition, specific problems can be discussed such as how to ensure early postnatal home visits and early identification and referral of mothers and babies with problems.

- d.) NB: An indicator noting the percentage of centers (hospitals, health centers and communities) that have such meetings would help ensure that they take place. Ideally, indicators should also reflect the quality /nature of the meeting, such as the number of meetings in which decisions were taken for time bounds actions for problems identified. If this is difficult in the early stages at least the first indicator should be recorded.

3.) Communication Strategies

Effective communication strategies to ensure appropriate behavior are essential if programs are to be successful in improving health. Mere provision of services is not enough if it is not utilized properly and mothers are not equipped with adequate information, motivated and empowered to carry out the necessary preventive steps for improving health, to identify problems and seek timely care at suitable centers.

While the general components of the MNH communication strategy should be integrated with the overall PROSANI communication strategy, specific MNH messages and other components should be in a separate module. The integration should be made in such a manner that key MNH messages are not missed. Activities for communication should be at both the facility and community levels.

Based on the requirements of the MOH, as the prime focus of the MNH communication strategy will be

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on improved behavior related to seeking of skilled assistance for antenatal care and delivery, preventive care at home, and identification of danger signs in the mother and baby and appropriate care seeking, without actual provision of care for the baby, these will be carried out primarily by the “relais promotionales”. The “relais de sites” who render care in iCCM may be implicated if items need to be distributed such as bed nets and contraceptives to women.

While details will be worked out later a few key points are noted below.

- e.) Selection of relais should be carried out with involvement of the CODESA and relais should be allocated houses near their own homes.
- f.) Key functions should include the following:
 - o *Activities at the Community Level.*
 - *Community mobilization* activities to promote community involvement
 - Motivate and orient leaders (civic and religious)
 - Facilitate/ empower functional groups such as women's groups
 - Identification and recording in registers of women of reproductive age and pregnant women
 - Home visits for counseling
 - Antenatal period – at least two visits—if possible three to four to promote 4 antenatal visits to the health centers
 - Postnatal visits
 - o For facility deliveries, one visit within 24 hrs of the mother reaching home (usually day 3 postnatal) and second between days 6-7 postnatal.
 - o For home deliveries, 1st visit within 24hrs of the birth, 2nd between days 2 – 3 and the 3rd visit between days 6-7 postnatal
 - o *Activities at the Facility Level.* This is particularly important as around 74% of births take place at facility levels and the ministerial mandate is to keep mothers for three days after the delivery. This presents a special invaluable opportunity for counseling mothers and families. Ideally, a roster should be developed ensuring daily posting of two relais by rotation at each health center from the nearby villages served by these centers.

Activities could include:

- Orientation with the chief nurse (Infirmiere Titulaire/ nurse at health center)
- Counseling of mothers admitted in the postnatal ward after delivery, before being discharged, including fixing of appointments for home visits when the mother reaches home
- Counseling of mothers coming to the antenatal clinic
- Counseling of mothers coming to the postnatal clinic

4.) Monitoring and Evaluation / Documentation of results

The PROSANI baseline survey carried out for the program has grouped and covered infants from 0-23 mths. The newborn period (the first four weeks) needs to be considered separately since this period has special features not applicable to the older infant and it also has a high mortality. Data related to maternal health too is inadequate. A rapid survey, perhaps using LQAS may be useful to get addition information for maternal and newborn features so that changes can be documented as

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the program implementation occurs. A sample questionnaire is available and can be adapted if necessary.

As noted in Appendix # 2

- a. Review and adapt, where necessary and feasible, key indicators
- b. Adapt MNH facility level registers and the partograph developed in consensus with MOH and partners. Print registers not only for further pretesting as noted in Appendix # 2 but also for use in the PROSANI program, at least in selected sites
- c. Review and pretest draft tools for collecting data at community level and attempt to document still births (fresh and macerated) and neonatal deaths.

Note: While we may or may not be able to record changes in mortality rates in programs of limited duration, process and other output indicators should be documented, reviewed, shared and utilized to improve results and at the same time attempts continue to be made to record and monitor neonatal deaths and stillbirths.

NEXT STEPS

g.) Develop a workplan for

- o The remaining period of the Year 1 (July-Sept, 2001)
- o Year 2 (Oct 2011 – Sept 2012)

The plan of activities sent by the Technical Officer for MNH activities for year one was reviewed. Suggestions for adaptation with grouping of activities is noted in Appendix # 3.

h.) Revise the MNH Tools based on the suggestions noted below:

- o Develop a smaller reference MNH manual with job aids to cover the essential theoretical basis for the key MNH skills for the shorter training course
- o Harmonize the tools on resuscitation (HBB, MNH, LDS, SONU and IMNCI tools.)
- o Revise learning and evaluation checklists on resuscitation to include elements of the HBB initiative
- o Adapt the facilitators' and participants' manual to accommodate the above changes
- o Explore possibilities of harmonizing the danger signs for the sick newborn in the various manuals such as the MNH, KMC, and IMNCI manuals

i.) Revise the KMC Tools (Reference manual, facilitators' guide and participants' guide)

- o Suggestions and feedback already sent as track changes

j.) Finalize lists of equipment and supplies and development of strategies for procurement and continuous supply for

- o MNH activities in general
- o KMC activities
- o HBB activities

- Debrief with USAID.

July 2 – 12, 2011 – Workshop on Kangaroo Mother Care

This period was spent in preparing for and facilitating the national workshop on Kangaroo Mother Care (July 4-12). The overall objective was to improve the competence of 22 participants that included health workers from

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the centers where KMC units are to be established and developed into centers of excellence, technical coordinators from the IHP project and representatives from the MOH. The sessions included appropriate interactive presentations covering key aspects of the theoretical background followed by practical/clinical sessions at the General Hospital of Kinshasa and the Pediatric Hospital of Kalembe-Lembe. In addition, sessions were organized to review and report on the practices at the hospital and the practical sessions themselves in order to provide the necessary feedback and develop a plan of action. A detailed report with annexes covering the KMC workshop on the topics covered including the practical sessions and copies of draft tools developed/ adapted has been shared with relevant IHP senior staff and with the relevant MCHIP team members in the country and at headquarters. In addition, the DRC KMC tools were reviewed and comments shared with both IHP and MCHIP staff members.

July 13 – July 21 – Collection of background information for developing a plan of action to promote MNH activities

Based on the SOW provided this period was used to collect and process information in order to write-up a background document to assist PROSANI in developing a plan of action to promote MNH activities.

Steps taken to develop this document

- Review of key documents and tools in maternal and newborn health in DRC during the last four years during the AXxes Program with technical support initially through USAID/BASICS and then USAID/MCHIP
- Discussion with partners such as MOH, WHO, UNICEF.
- Discussions in small groups with the relevant technical staff in PROSANI to understand their requirements and explain to them the above past experiences in order to develop draft plans in each area such as training, supervision/quality of care, communication at facility and community level and monitoring and evaluation.
- Development of a background documents to help formulate a draft plan of action/workplan for activities to improve maternal and newborn health.
- Discussion with the PROSANI communication group to suggest plans for integrating the communication strategies for MNH into the overall PROSANI communication strategy
- Discussion with the communication group and relevant technology staff at PROSANI an innovative project utilizing the m Health platform for improving quality of care in promoting competence in identifying neonatal infections that constitute a leading cause of mortality. In addition mobile phones can be used for collecting data and for sending SMS. The latter can be used to serve as reminders and information to peripheral center staff, relais and fathers, and literate mothers with access to phones.

July 22-23 2011 - Meeting with Key Sections of the MOH and other partners to orient them and get a feedback on draft plans of action for PROSANI to support MNH activities

This meeting was meant for sharing of selected key elements of the background document with the Ministry of Health and other partners along with the internal PROSANI Staff. External partners included the following:

- 10th Direction- Sante de la Family et Groupe Specifique -Dr. Kalume,
- 5th Direction – Paul Pilipili
- 11th Direction – Berthe Banzua, PNLMD- Programme National de Lutte contre Maladaies Diarthees
- PCIME – Nelson Bambwelo et
- PNSR –Programme National de Sante de la Reproduction – Kitsita Christophe)
- WHO Marie Claude), UNICEF (Bernadette Mbu)
- Technical experts (Obstetricians- Dolores Nembunzu , Prof Wolombi and Pediatricians – Celestin Nsibu and Delphin Muyila) and the relevant team members of PROSANI. This was

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carried out through an interactive meeting on July 22-23.

All the key steps for implementation of the program were presented including training, supervision/quality of care, communication and community based interventions and monitoring and evaluation were discussed, with prioritization of selected elements. These included the following for which consensus with this group was felt to be particularly important:

- **The M & E indicators and tools-** The registers and partogram that had undergone preliminary pretesting with the support of MCHIP were further reviewed and revised at this meeting and the indicators reviewed. Guidelines were developed on the steps to be taken to include these in the national HMIS (SNIS). These are noted below.
 - Revise the M & E tools based on the recommendations of group, circulate the revised version for final approval
 - Submit the tools for the approval of the CCT (Commission de Coordination Technique – Commission Prestation –which is in the Office of the Secretary General) by
 - Simultaneously, pretest the final version of the tools by PROSANI and make final corrections
 - Submit the document for approval by the Secretary General
 - Submit document (tools) for validation by the - SEMSP-CNP –Son Excellence Monsieur Le Ministre de la Sante Publique - Comite National de Pilotage
- Development of **recommendations for the implementation of the Helping Babies Breathe (HBB) Program.** The group developed recommendations for the roll out of the program that is noted in Appendix # 1.

July 24-26

Participated in additional meetings with Latter Day Saints group for collaboration on the HBB program and with UNICEF for collaboration and potential support for Kangaroo Mother Care activities, HBB program and possible support for the innovative mobile technology project for neonatal sepsis.

Appendix # 1

Recommendations for Implementation of “Helping Babies Breathe” (HBB) Activities to Manage Birth Asphyxia in DRC

- The group accepted to implement HBB in DRC integrated with essential newborn care and selected aspects of maternal health such as AMTSL
- The stages/steps will be in keeping with the method of planning of the Ministry of Health
- It was felt that the HBB curriculum should be harmonized with other existing tools on resuscitation of the newborn such as the MNH training manual, IMNCI workbook, and Manual of the Latter Day Saints. The final tool must be in keeping with the National document of standards (“Normes et Directives). Any changes made in the tools/curriculum can be noted in additional laminated pages/cards.
- Regarding the mannequins, the newer, more economical, lighter, collapsible versions seem suitable for training and for taking to peripheral centers. Based on availability of funds, mannequins and other training materials should be purchased to enable their being placed at all hospitals and health centers with adequate number of deliveries. While ideally they should be available at every center, if budget restrictions do not permit this, they can be placed at selected centers that are more easily accessible from other health centers so that staff can come and practice. At the same time, some of the members of the group also felt that the older version of the mannequin (“Baby Anne”) might be more durable. However, they are also more costly. Hence if funds were available it was felt that a few older models could be purchased for selected hospitals.

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- The number of “kits” for service to be purchased depends on the local requirements including number of deliveries, durability of the equipment/supplies and the cost. While it is difficult to calculate the exact numbers at this stage, it was felt that the following guidelines may be useful to begin with and then adapted as required
 - Ideally two bags and masks for the hospital and for each health center or at least one for each health center
 - 3 – 5 new variety of suction bulbs that can be opened, cleaned and sterilized or subjected to boiling for the health center and 8-10 bulbs for the hospitals
 - Have additional numbers of (i) suction bulbs and (ii) bags and masks in reserve
- The training should be carried out only after the following steps are achieved:
 - Procurement of equipment, supplies and training tools
 - A plan for supervision and monitoring and evaluation in place
- Where there are transfers of trained health workers, the new staff should also be trained
- There should a good collaboration with partners. Trainers working in different regions supported by the various partners such as UNICEF and LDS can be trained together at the national level so that they can then train their staff in their regions. The partners should also follow the guidelines for supervision/improving quality of care and monitoring and evaluation.

3. Next steps: Key actions to continue and/or complete work from trip.

| Description of task | Responsible staff | Due date |
|--|---|----------------|
| 1.) Develop workplans for newborn health within the framework of MNH – I have provided suggestions in a document sent herewith | IHP staff | September 2011 |
| 2.) Revise the KMC manuals based on feedback provided by me (as track changes) and from the facilitators and participants of the workshop | IHP staff + country technical experts – involve partners such as MOH and UNICEF | September 2011 |
| 3.) MNH Tools: a.) Develop a smaller reference MNH manual with job aids to cover the essential theoretical basis for the key MNH skills that facility level health workers need to develop as noted in the document on suggestions for activities. b.) Revise learning and evaluation checklists on resuscitation to include elements of the HBB initiative c.) Harmonize the tools on resuscitation (HBB, MNH, LDS, SONU and IMNCI tools.) d.) Adapt the facilitators’ and participants’ manual to accommodate the above changes e.) Explore possibilities of harmonizing the danger signs for the sick newborn in the various manuals such as the MNH, KMC, and IMNCI manuals | IHP staff + country technical experts – involve partners such as MOH + other partners | |
| 4.) Finalize lists of equipment and supplies and development of strategies for procurement and continuous supply for MNH activities in general; KMC activities; and HBB activities | IHP staff + country technical experts – involve partners such as MOH + | |

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| | | |
|--|----------------|--|
| | other partners | |
|--|----------------|--|

4. Contacts: List key individuals contacted during your trip, including the contacts' organization, all contact information, and brief notes on interactions with the person.

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