Communication for Immunization and Polio Eradication in the Democratic Republic of the Congo:
A joint case study by BASICS, WHO and UNICEF

November 1999
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<tr>
<td>AFP</td>
<td>acute flaccid paralysis</td>
</tr>
<tr>
<td>BASICS</td>
<td>Basic Support for Institutionalizing Child Survival</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille de Calmette et Guérin (anti-tuberculosis vaccine)</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>DTP</td>
<td>diphtheria, pertussis, tetanus</td>
</tr>
<tr>
<td>EPI</td>
<td>expanded programme on immunization</td>
</tr>
<tr>
<td>GRH</td>
<td>general referral hospital</td>
</tr>
<tr>
<td>HC</td>
<td>health centre</td>
</tr>
<tr>
<td>HZ</td>
<td>health zone</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>MZD</td>
<td>medical zone director</td>
</tr>
<tr>
<td>NCES</td>
<td>National Campaign to Eradicate Smallpox</td>
</tr>
<tr>
<td>NID</td>
<td>National Immunization Day</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organization</td>
</tr>
<tr>
<td>OAU</td>
<td>Organization of African Unity</td>
</tr>
<tr>
<td>OPV</td>
<td>oral polio virus</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Introduction

Profile of the Democratic Republic of the Congo

The Democratic Republic of the Congo (DRC) is located in Central Africa, between 5° northern latitude and 13° southern latitude. It shares 8,165 km of border with nine other countries in the region and covers an area of 2,345,000 km².

In 1998, the population was estimated at 48,100,000, of which 51.5 per cent are female and 48.5 per cent male. The population is very young, with 58.9 per cent under 20 years old and 18.7 per cent under five years old. Almost 70 per cent of the population live in rural areas and 30 per cent in urban areas.

Administratively, the DRC is divided into 11 provinces, 41 districts, 219 territories and 737 collectivities. Since the 1970s, the country has been undergoing a complex crisis that has continued and worsened throughout the 1990s.

In economic terms, this has virtually paralysed all basic economic activities, which has led to a growing budget deficit, galloping inflation, excessive debt, an increasing reduction in the population’s purchasing power and a rate of inflation that has remained at four figures throughout the 1990s.

In social terms, basic public services such as housing, public hygiene, transport, communication, education and health care are no longer provided in a satisfactory manner. Overall, the country’s socio-economic situation has led to a deterioration in its human capital, its economic fabric and the whole infrastructure.

Since the installation of the new regime on 17 May 1997, reconstruction of the country has been a major concern. The government developed a three-year plan of minimum action. In the health sector, one of the priority areas is the development of a health policy and national plan for health improvement, based on the above plan.

Unfortunately, since 2 August 1998, the country has been under attack from three neighbouring countries (Burundi, Rwanda and Uganda) from the east, and currently at least 5 of the 11 provinces are either totally or partially under the control of the aggressors.
Health-wise, in 1981 the DRC signed the African Charter for Health for All by the year 2000 and chose a strategy of primary health care (PHC).

To make PHC more available geographically and culturally, the country was divided into 306 health zones (HZ) in 1985. Each HZ comprises a general referral hospital (GRH) and a cluster of at least 20 health centres (HC) on average. Each HC is managed by a health committee from the local community. Due to the current situation, the entire health system is either not fully operational or has basically come to a standstill.

With regard to the state of its population’s health, the DRC is a special case, epidemiologically speaking, featuring the outbreak of new and re-emerging diseases over the past 10 years, among which may be noted:

- the Ebola haemorrhagic fever epidemic in Kikwit in 1995;
- the meningitis epidemic in the Katanga and Orientale provinces;
- the largest epidemic of poliomyelitis ever in 1995 in Mbuji-Mayi, with more than 10,000 cases detected.

In general, the country’s epidemiological profile shows infectious and parasitic diseases endemic in populations already exposed to malnutrition, poor health and precarious economic circumstances.

Children are the first victims in this situation, with an infant mortality rate of 127 per cent, well above the African average of 80 per cent.

The situation of the expanded programme on immunization in DRC

History

The expanded programme on immunization (EPI) began in DRC with the National Campaign to Eradicate Smallpox (NCES) launched by Presidential Ordinance No. 68/103 of 29 March 1968 for a duration of 10 years.
In 1974, at the recommendation of WHO, EPI was developed, incorporating six antigens: BCG, oral polio vaccine (OPV), DPT and measles.

In 1977, EPI was introduced in 17 large towns in the country and continued until 1987, using mostly mobile teams.

In 1982, with the adoption of primary health care and the creation of health zones, EPI activities were integrated into permanent health centres.

From 1982 to 1988, 108 health zones integrated immunization into their PHC activities, after Medical Directors of health zones were trained to manage PHC for EPI and the Campaign against Infectious Childhood Diseases (EPI-CICD).

From 1988 to 1990, EPI-CICD received financial and technical support from USAID, UNICEF and the Centers for Disease Control (CDC) in Atlanta. It subsequently received support from the Rotary International New York “PolioPlus Project” for the eradication of poliomyelitis in DRC.

In April 1999, a Memorandum of Understanding (MOU) on EPI was signed by the Ministry of Health and its partners (WHO, UNICEF, Rotary, USAID and BASICS). This memo establishes a framework for collaboration for the development of EPI, programme management, disease control and the upgrading of routine EPI activities and National Immunization Days (NIDs).

**Institutional organization**

The Ministry of Public Health (MOPH) comprises six central headquarters and approximately 20 specialized sections, including EPI and EPI-CICD. Since its creation, the mission of this Ministry department has been to improve the survival rate of children by reducing morbidity and mortality from diseases that can be prevented by immunization. On an organizational level, it comprises a head office run by the Chief Doctor, who is assisted in his tasks by two divisions: the administrative and technical divisions, respectively.

The technical division comprises the following units: EPI, CICD, monkey pox and acute respiratory infections (ARI). Besides the four units that make up division headquarters, six sections provide support for the department’s activities, including training and supervision;
follow-up and evaluation; statistics and computers; information, education and communication (IEC); and operational research and initiatives. The administrative division includes the budget, finance, general services, staff and dispatching units. To accomplish its mission, besides the head office, EPI-CICD includes 11 provincial offices run by provincial medical coordinators who are part of the staff of provincial medical inspectors.

To make vaccines from health zones more accessible and to spread information about the policies of the various programmes, sub-units were set up in district headquarters. A total of 31 EPI-CICD sub-units, each serving approximately 10 zones, ensure not only the conservation and distribution of vaccines but also provide support to health zones for supervision, training, follow-up and evaluation activities.

The sub-units provide technical support for EPI to health zones. Approximately 3,600 permanent health centres (2,973 in provinces that are not occupied), of the 6,000 planned, carry out immunization using a fixed or mobile strategy. At a local level, EPI-CICD activities are implemented by the zones’ head doctors, with the help of the entire staff and local partners, without forgetting the community itself.

**The Polio Eradication Initiative**

To coordinate EPI, the following three strategies were set up: routine immunization, National Immunization Days and AFP surveillance.

**Routine immunization**

In DRC, routine immunization is carried out on a decentralized basis and is incorporated into PHC activities in the health zones. The strategy is based on strengthening fixed and mobile centres.

EPI administers five antigens, as follows: BCG, OPV/DPT and measles for children aged 0 to 12 months.
The table below shows rates of immunization coverage reported by 90 health zones over the past three years. However, it should be noted that not all health zones send regular reports on immunization coverage, and some send none at all, which means that the data collected do not provide a full picture of the reality on the ground.

**Table 1: Immunization coverage from 1995 to 1999**

<table>
<thead>
<tr>
<th>Year</th>
<th>BCG</th>
<th>DPT</th>
<th>OPV</th>
<th>Measles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>34%</td>
<td>23%</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>1996</td>
<td>25%</td>
<td>18%</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>1997</td>
<td>25%</td>
<td>18%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>1998</td>
<td>23%</td>
<td>16%</td>
<td>17%</td>
<td>19%</td>
</tr>
</tbody>
</table>


**National Immunization Days**

In 1996 and 1997, after having organized Local Immunization Days in 46 of the country’s principal towns, DRC decided to organize the first National Immunization Days in 1998. This decision was taken following a commitment from the country’s authorities to participate in the global Poliomyelitis Eradication Initiative, and by doing so jointly with other countries, to maximize the epidemiological impact of reducing the circulation of wild polio virus in Africa.

Together with the Congolese authorities, partners such as WHO, UNICEF, BASICS/USAID, Rotary and other national and international non-governmental organizations (NGOs) provide substantial financial support and technical assistance for the implementation of supplementary immunization activities such as the NIDs.

Unfortunately, because of the war in 1998, the campaign reached only 6 of the country’s 11 provinces. They are: Kinshasa, Bas-Congo, Katanga, Kasaï Oriental (but not Sankuru) and Kasaï Occidental. It was only in its second year that the NID organized in July, August and September 1999 covered all 11 provinces.
### Table 2: Phases, dates and vaccines administered by NID 1999

<table>
<thead>
<tr>
<th>Phases</th>
<th>Date</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>13, 14, 15 August 1999</td>
<td>OPV; all children aged 0 to 5 years</td>
</tr>
<tr>
<td>2nd</td>
<td>17, 18, 19 September 1999</td>
<td>OPV, vitamin A</td>
</tr>
<tr>
<td>3rd</td>
<td>22, 23, 25 October 1999</td>
<td>OPV, measles</td>
</tr>
</tbody>
</table>

To increase the accessibility of immunization centres to mothers, EPI developed the following three strategies: health centres; immunization centres away from health centres; and a house-to-house campaign in some provinces.

### Surveillance

In May 1988, WHO invited member states to intensify disease surveillance activities to ensure rapid tracking and examination of poliomyelitis cases.

In 1995, the World Health Assembly urged member states to strengthen active local and national programmes for infectious diseases to bring about early detection of epidemic outbreaks.

Following the poliomyelitis epidemic in Mbuji-Mayi and its environs involving 1,000 cases of acute flaccid paralysis (AFP), DRC established a surveillance system using EPI, based on an integrated approach to infectious diseases.

Using EPI in this way, it was decided to go from on-site surveillance to active systematic surveillance by not only getting the community to track and report cases but also getting the laboratories to identify and follow up on the evolution of the germs that cause the disease, in order to diagnose cases accurately. In this way, a Plan of Action for AFP surveillance was developed in March 1999. To involve the community in AFP surveillance, EPI adopted two communication strategies: interpersonal communication and media communication.
Table 3: Cases reported in 1995-1997, before AFP surveillance began in earnest

<table>
<thead>
<tr>
<th>Year</th>
<th>AFP cases reported</th>
<th>Cases where stool samples were taken</th>
<th>Cases of polio confirmed/lab</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>More than 1,000</td>
<td>20</td>
<td>15</td>
<td>–</td>
</tr>
<tr>
<td>1996</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>1997</td>
<td>44</td>
<td>21</td>
<td>21</td>
<td>21 cases through active research; 23 cases through routine reporting (without examination or taking stool samples)</td>
</tr>
</tbody>
</table>


From a minimum of 250 cases of AFP expected for 1997, routine and active research reported only 44, of which 23 were not investigated. In 1998, the system was still performing poorly, no doubt due to the intense preparation activities for the National Immunization Days throughout the country.

Table 4 shows the number of AFP cases reported after disease surveillance – whose main function was to increase the awareness of clinic personnel and community leaders – began in 1999. The data show only the six provinces covered by the programme, during the period from January-November 1999.

Table 4: AFP cases reported in DRC in 1999

<table>
<thead>
<tr>
<th>Provinces</th>
<th>AFP reported</th>
<th>AFP with stools</th>
<th>AFP with result</th>
<th>AFP with polio</th>
<th>AFP awaiting result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinshasa</td>
<td>22</td>
<td>22</td>
<td>18</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bandundu</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bas-Congo</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Equateur</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Kasaï-Oriental</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kasaï-Occidental</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Katanga</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Maniema</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Nord-Kivu</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Orientale</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Sud-Kivu</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>50</strong></td>
<td><strong>39</strong></td>
<td><strong>7</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Communication/social mobilization activities

To date, EPI lacks a national plan of communication for the three phases of the programme (routine, surveillance, NID). However, each phase includes a communication plan with three communication strategies, as follows: advocacy, social mobilization and programme communication support.

Advocacy

Until recently, advocacy was not applied to EPI activities as a strategy in an organized or systematic way. Its use in a strategic way began to take shape during the 1996-1997 NIDs and was consolidated during the 1999 NID. The programme increased awareness among:

- the Head of State;
- all Ministries (for Education, Defence, the Interior, Social Affairs, Planning and Information, in partnership with the Ministry of Health);
- political, administrative and military authorities at all levels; and
- UN agencies (UNICEF, WHO) and other partners such as BASICS, Belgian Cooperation, Embassies, Rotary International, Rotary Belgium, Rotary Club, DRC.

These advocacy efforts brought about the involvement of the Head of State, the government and the political, administrative and military authorities at all levels in the country’s administrative infrastructure.

The results of this strategy spread beyond the country and had international consequences, particularly in the case of the United Nations and the Organization of African Unity (OAU).

The effects of advocacy at the highest level of the State

The President of the Republic: The first two phases of NID 1999 were launched with the immunization of 11 children representing the 11 provinces, and 1 foreign child.

The government: A partnership was established by the Ministry of Health and other ministries, in particular:
• the Ministry of Information, mobilizing all radio and television stations to broadcast messages before and during NID;
• the Ministries of the Interior and Defence, to implement directives on the free and rapid flow of immunization convoys;
• the Ministry of Youth, to organize public concerts, football matches and other cultural events with the help of the most prominent celebrities and stars.

Local and provincial advocacy
• Governors, mayors, burgomasters, heads of collectivities/outposts, village and neighbourhood representatives were elected presidents of NID by the Ministry for the Interior.
• NIDs were launched in each province at every level by NID presidents.
• NID activities in general and social mobilization in particular were coordinated by the Provincial Medical Inspector (PMI), District Medical Inspector/Urban Medical Inspector and Medical Zone Directors (MZD).
• Commercial activities were suspended on the day of the NID launch to enable mothers to immunize their children first.
• Television and radio programmes were broadcast by the governors of each province.
• Burgomasters were featured in television and radio programmes broadcast around town halls to inform the public of the dates, places and strategies adopted for each commune.
• Directives were sent to church authorities to inform their congregations of the dates and places for immunization.
• Instructions were sent to political and administrative authorities (in rural areas) to provide meals and accommodation for immunization personnel and criers.
• Means of transport (vehicles, bicycles, motorboats, motorbikes) were requisitioned and assigned to transport criers, immunization personnel and logistical equipment.
• In some provinces the authorities supervised immunization activities at immunization centres and in the surrounding areas.
Advocacy by international organizations

International advocacy: UN Security Council Resolution 1234, 9 April 1999 demanded that all warring factions observe a truce and support NID, and letters from the Secretary-General of the UN, dated 22 July 1999 and 19 October 1999 inviting all parties involved in the conflict to respect the Days of Tranquillity.

There was also media coverage of NID by foreign broadcasters, including publicity spots broadcast on Radio France Internationale (RFI); l’Afrique No. 1; the Voice of America; Canal France International (CFI); and the BBC, whose impact was felt more on a local level due to the fact that national channels do not cover the entire country. Interviews about NID were conducted by journalists from international channels with some Congolese celebrities such as Papa Wemba.

National advocacy

- Two messages from the UN Secretary-General were broadcast by UNICEF and WHO.
- Financial and material support was provided for social mobilization: to produce public information materials (posters, pamphlets, streamers, audio and video tape) and to buy megaphones.
- Additional support was provided from funds and other sources to compensate for any shortfalls in the programme. For example, in addition to staff already planned for, a mobilization worker was provided for each centre.
- Social mobilization meetings were held.
- Meeting facilities were made available by WHO and UNICEF.

Social mobilization

With the organization of National and Local Immunization Days, the involvement and commitment of NGOs and local community assistance organizations (CAOs) in EPI activities such as advocacy started to become a reality. Some local organizations participated in routine EPI activities, for example, the ‘Mama Bongisa’ or ‘Mama Tengeneza’ groups, whose role was to increase awareness of various health problems in the communities, including that of children’s immunization.

Using the NID strategy, the EPI mobilized and increased the awareness of partners at all levels:
• Humanitarian organizations such as Rotary, Handicap International, Memisa, the Red Cross and the Scouts
• Religious organizations (the Catholic, Protestant, Kimbanguist and Islamic churches)
• Community-level organizations (People’s Power Committees, Congo Women’s Associations, Congo Mothers’ Business Associations, Youth associations, Drivers’ associations…)
• Schools (primary and secondary schools; technical medical institutes)
• In the public sector, the Association des Enterprises du groupe de Portefeuille (ANEP)
• In the private sector, Gécamines, Brassicoles companies, transportation companies
• Local commune chiefs

One noteworthy feature of NID was the massive, spontaneous participation of the entire Congolese population. Despite difficult socio-economic conditions, their participation contributed financially and materially to the success of NID. The presence of the President of the Association for Handicapped Persons at the official NID launch ceremony, giving two drops of OPV to his own little girl, is sufficient testimony to the involvement and commitment of all Congolese people in NID.

The mobilization gave the following social groups a chance to express their commitment, which resulted the following concrete actions:

• Messages were broadcast in the communities (on the dates, places and importance of immunization).
• Infrastructures were put at the Programme’s disposal to house immunization centres.
• All children affected by NID were counted and recorded.
• Neighbourhood immunization centres’ facilities were improved to give children better access to immunization.
• Meetings were held with the EPI social mobilization team.
• Children increased the awareness of their peers, encouraging them to have their younger brothers and sisters immunized.
• Financial and material support was provided for the implementation of social mobilization activities and NID in general.
• Transportation was provided for criers, immunization personnel and supervisors.
• Social mobilization activities were supervised.
In the villages, accommodation and meals were provided for criers and travelling vaccine carriers.

**Programme communication support**

This heading summarizes the results of communication activities intended to support the Programme: educational messages; equipment and facilities used; communication channels (routine immunization, NIDs and AFP surveillance); the impact of communication/social mobilization on the beneficiaries; and attempts to reach populations that are hard to reach and convince of the need for immunization.

*Educational messages*

The principal messages from the educational sessions on immunization were developed at the end of the 1990s and are shown (reproduced) in the technical EPI cards. These cards provide information on the dangers of childhood infectious diseases; the benefits of immunization; the immunization calendar; and the various antigens administered to children and their side effects. The health personnel base their educational chats with mothers on the various themes, which are essentially based on routine immunization.

Additional messages based on NID were developed in 1996 and 1997. The second generation of messages was adapted from the experiences of other African countries. These messages introduced information on the campaign calendar, the different immunization centres, mobilization of the whole community and advocacy for NIDs, etc.

Still more recently, specific messages on AFP surveillance were introduced into the programme. However, along with messages whose accuracy had been proven, improvised messages based on a misunderstanding of the information in the technical cards are also in circulation. Unfortunately, it has been difficult to halt the circulation of such messages, which sometimes leads to conflicting information and untruths and helps to spread rumours.

*Promotional materials*

The most frequently used materials and tools are:

- illustrated posters;
• megaphones with sirens;
• information leaflets;
• illustrations with written explanations;
• leaflets; and
• banners and streamers.

Combining these materials and tools has made it possible to reach more people during the campaign period.

**Communication methods**

- For routine EPI, the only channels and methods used to spread messages on immunization are chats and posters during prenatal consultations in health centres.
- For AFP surveillance, there is no structured channel operating at the health centre level.
- For NID, various communication methods are used, either for interpersonal or mass communication. The following methods are considered effective: plays and popular cultural events (sketches), parades and religious feasts, radio, television, banners/posters, etc.

The most significant experiences reported concern:

- political-administrative authorities: governors, mayors, burgomasters, territory administrators; outpost/sector chiefs; village chiefs; neighbourhood/village leaders; people’s power committees (PPC); and criers.
- local churches, during the celebration of feast days and prayer meetings (Catholic, Protestant, Kimbanguist, Muslim and independent churches).
- NGOs/CAOs; women’s and youth associations; youth clubs and cultural organizations; development NGOs; corporations and professional unions, etc.
- radio and television spots, dramas, special broadcasts, ads, and radio and TV news programmes.
- public events in neighbourhoods and communities.
- appearances by national and international stars and celebrities.
Impact of the strategy on the beneficiaries

- Mothers do not seem to remember the messages communicated during the informal chats organized at the health centres during the CPS and CPN.
- Mass participation by the beneficiaries (mothers and all those who take care of children) during the NID.
- NID activities have made it possible to overcome some resistance due to ignorance and rumours in certain communities, particularly in religious communities.
- The beneficiaries recognize
  - that with NID, a new culture of immunization is taking root;
  - the role they need to play in tracking AFP;
  - that the problem of child immunization is no longer the sole responsibility of mothers, but concerns the whole family (father, grandfather, sister, male and female relatives), and even neighbours;
  - that they learn more about immunization during NID than during routine immunization drives.
- The beneficiaries know that NID
  - concerns all children aged 0 to 5 years;
  - reinforces routine polio eradication immunization activities.
- The beneficiaries realize that the most effective strategies for communicating messages during NID are:
  - criers;
  - chats/neighbourhood meetings;
  - churches;
  - motorized convoys;
  - plays and cultural events (sketches).

Hard-to-reach populations

Despite the channels and support materials listed above, like any other health programme, EPI is faced with the problem that some beneficiary populations, in particular fishermen and farmers who live where they work, are hard to reach. In order to partially solve the problem, EPI adopted both a fixed and mobile strategy that was not previously operational due to lack of resources for routine EPI.
During NID, this problem was solved by the political-administrative authorities asking farmers and fishermen to suspend their activities for the three days of NID and bring their children to the immunization centres; and in some cases by requisitioning every means of transport available to bring the immunization teams to immunization centres that were hard to reach by motorboat, bicycle or other vehicle.

*Populations that are difficult to convince*

It was during NIDs that these populations, in particular certain independent churches, were identified.

During focus groups organized with church members, it appeared that their reaction was due to rumours and false religious beliefs. For example, a pastor wrongly told his community that the cases of polio in Mbjui-Mayi (5,000 cases instead of the 1,000 officially recorded) were caused by the poor quality of the anti-polio vaccine.

For some religious followers (Kiawala, Apostolo, Church of Black People in Africa, etc.), the “vaccine is a spirit of the devil and only God can immunize with the blood of Christ.” For others, AFP are caused by witchcraft and not by disease.

Besides such beliefs, some behaviours are due to a misunderstanding of the immunization campaigns, because of campaign intensification and repeated vaccine administration. In fact, while mothers are familiar with the immunization calendar for children from 0 to 12, they do not understand that during NIDs even children from one to five years are vaccinated, and this free of charge.

Another reason for the mothers’ resistance is that they do not understand the attitude of health care personnel. The mothers say that the needles used for their children are different from those the nurses use to immunize their own children. They also wonder why the children of nurses and doctors are not immunized along with their own children.
**Human resources for communication and social mobilization**

In the absence of a central structure at the Ministry of Health in charge of IEC/social mobilization activities, there are nonetheless IEC components in various ministry programmes.

There are also IEC components in EPI, with a staff of two at the central level who have had short training courses in IEC.

Given the importance of communication/social mobilization activities and also the fact that this service is the main training service for the entire programme and for the country, it would appear that the technical and administrative capacities of the service are weak in terms of both quality and quantity.

At the intermediate level of the system – i.e. the provincial coordination level and even in the EPI sub-units – the central structure does not budget for IEC personnel. However, at the health zone level, where all PHC activities are incorporated under the supervision of the health zone director, the nurse in charge of EPI and/or the community organizer, where they are present, also coordinate communication and social mobilization activities. Lacking specialized communication training, they perform their duties as best they can.

It is at the health centre level that the beneficiary populations receive the various services offered by the programme, including educational messages and those designed to increase routine immunization and AFP tracking.

Unfortunately, there are considerable gaps in the training of health care workers (nurses) in charge of IEC and social mobilization among others.

- During educational chats, the staff give out messages that are not targeted to their audience.
- They do not prepare their messages, preferring to improvise themes during the chats.
- Sometimes they do not sufficiently increase mothers’ awareness of AFP.
- They do not receive IEC-specific directives from their health zone’s central office.
- The lack of training and precise orientation in communication and social mobilization also affects the community health workers (volunteers), who are often used to increase awareness among populations at the community level.
In the particular case of NID, the communication of messages and the mobilization of targeted populations are not carried out by health care workers alone. The participation of community teams of opinion leaders, the media and CAO personnel is an effective tool for social mobilization and for increasing awareness among the beneficiaries. However, even these workers suffer from lack of preparation, instructions and sometimes work materials.

**NIDs during armed conflicts**

Although planned to begin in 1982, the first NIDs in DRC were unable to start at that time because a war of aggression broke out two weeks before the campaign launch date.

In the history of polio eradication, cases already existed where, in spite of war, immunization had taken place in some African countries. In the DRC’s particular case, it was a war of aggression, which meant that it was extremely difficult to negotiate a truce to facilitate immunization in territories occupied by the aggressor.

This situation had a negative impact on the implementation of NID for the first year: only some provinces were able to organize NID.

The second NIDs were carried out thanks to the joint efforts of the Congolese government and the international community to obtain a cease-fire as stipulated by the Lusaka Accords, so to allow the immunization of all Congolese children in all 11 provinces to take place.

The compassion awakened by this aggression led all Congolese to join forces to fight for the implementation of NID in DRC. Proof of their commitment to NID was evident both at the level of central power and at the field level.

**At the central level**

At the highest level of the State, in parallel to the war effort, the Head of State committed himself to support NID efforts with a financial contribution from the government and by presiding personally over the official launch ceremonies.
At the ceremonies, the presence of several Ministers, who denounced the war conditions in which the immunizations had to take place, constitutes eloquent proof of the government’s commitment to NID.

The instructions given by the military authorities to the armed forces to cease fire and to lift blockades, transport the logistics and protect the immunization teams in the zones of operation testifies to their direct involvement in the campaign.

Other government partners, in particular the interagency committee for mobilization and coordination of resources for health, were remobilized under the leadership of United Nations agencies.

WHO, UNICEF and other agencies and organizations (USAID, BASICS), despite Phase IV security, did not suspend their support for the programme.

In concrete terms, we should note the advocacy of WHO and UNICEF, who broadcast messages from the UN Secretary-General on 22 July and 19 October 1999, inviting all parties in the conflict to respect the Days of Tranquillity in support of NID.

We should also note the additional donations of material and financial support to compensate for any shortfalls and budgetary deficits caused by the war, such as the funding of additional mobilizers in immunization sites over and above personnel that were previously planned and budgeted for. These additional efforts led to a doubling of the central coordination structure of the NID, resulting in a doubling of resources to make the coordination of NID equally functional in the occupied zones.

The fact that they made their infrastructures available – meeting facilities in particular – both in Kinshasa and in the interior of the country and the enthusiastic participation at all their planning meetings linked to the development of the war throughout the country constitutes ample proof of the involvement of all the partners.

On the humanitarian side of the UN system, it should be noted that for the first time since the hostilities began, humanitarian flights left the territory for the occupied territories with government authorization and under government control.
These missions strongly supported the organization of NID in the occupied territories, both on a logistical level and on the level of the planning and supervision of routine immunization activities and AFP surveillance.

**At the field level**

*Pro-active attitude of bilateral and multilateral cooperation representatives*

In the field, it has not always been easy to brave fear and the risk of war. Despite dangerous security conditions on the ground, bilateral and multilateral cooperation representatives actively supported NID activities by their physical presence on the ground, even at the fringes of the front line. Among others should be noted:

- the presence of Ms. Carol Bellamy (UNICEF Executive Director) in Lubumbashi for the official launch of the second phase of NID;
- the presence of His Excellence the United States Ambassador in Kikwit for the launch of the third phase of NID; and
- the presence of various accredited ambassadors in DRC and representatives from the UN system during various NID launch ceremonies in Kinshasa and in the interior of the country.

*The attitude of warring factions*

As many positive contributions as negative attitudes were noted on the part of the warring factions in relation to NID.

Among loyalist troops, some facts should be noted/mentioned in relation to the support they provided for NID:

- the Commander of the Province of Equateur provided a large quantity of petrol to the Provincial NID Committee to facilitate passage of the convoy in the interior of his province;
- in the province of Kasaï-Oriental, the vaccines were transported to Kabinda (a zone occupied by the rebels) by members of the Congolese Armed Forces; and
- the Mai-Mai (Autochtone Militia of the Province of Kivu) facilitated the passage of vaccines in the zones under their control.
In the zones controlled by the rebels, the authorities from both branches (political and military) generally agreed to respect the Days of Tranquillity in order to facilitate the operation of NID.

In spite of the fact that the communication materials (posters, leaflets, banners, etc.) sent from Kinshasa were not acceptable to rebel authorities because of the presence of the national flag, which they do not recognize, the materials were quickly adapted to local needs before being circulated throughout the zones under their control.

On the other hand, some negative points and attitudes were observed:

- in Goma, a zone under rebel control, a freight plane for the transport of cold chain materials replaced its cargo to Kisangani with war supplies, after the plane was requisitioned by the rebels; and
- in Kisangani, an armed confrontation broke out among the factions allied to the rebels (Ugandan and Rwandan) on the second day of the first phase of NID 1999, paralysing the immunization campaign. The immunization team was forced to hide at the centres for several days.

In a more general way, the numerous requisitions and even confiscations of vehicles, mopeds, fuel and other material from immunization teams on one side or another of the front line should be noted.

**Constraints**

All the constraints and difficulties encountered in the organization of NID in general and in communication and social mobilization activities in particular are not solely due to the war. The general deterioration of the social fabric, of the structures and infrastructures of health also explains the weaknesses noted in programme activities, both for routine EPI, NID and AFP surveillance.

The main constraints noted are summarized under five headings:
1. The instability of structures caused by changes in staff both of formal structures and the NID mobilization committee results in a lack of continuity in EPI communication activities.
   - The lack of sustained commitment among members of the NID social mobilization committee should also be noted. This can be explained by the ad hoc nature of the committee, of which the majority of members are not part of any permanent structures of the Ministry of Health.
   - In view of the current political situation in the country, there are frequent staff changes among members of EPI/MOH, which sometimes contributes to the lack of efficiency of EPI both on a human resource and a financial resource level.

2. Lack of expertise in coordination and staff management for communication/social mobilization activities on all levels:
   - At the central level, there is an absence/lack of documentation and records to preserve the history of the service and ensure its continuity. The small number of staff members assigned to IEC for EPI should also be stressed. Finally, we should mention the lack of management capacity for the distribution of communication/social mobilization materials according to local needs.
   - At the provincial level, the lack of permanent IEC services and financial, technical and logistical support from the central to the provincial level should be noted. Similarly, the health workers lack sufficient training to integrate communication into their health services and in ways of communicating with the beneficiaries (populations).

3. The lack of operational research to better understand and define behavioural obstacles and ways of overcoming them so as to increase use of the service and eventually increase immunization coverage. The lack of facilities to adapt materials designed at a central level (which are at times unsuited to local needs) should also be noted. Also, the health workers, in educational chats, do not seem to be aware of nor can they express sufficiently the importance of behavioural factors underlying the mothers’ attitudes and practices. This could explain why the services are not used.

4. Despite central planning, supervision, follow-up and evaluation activities in social mobilization/communication are not implemented in the field, particularly to measure the
effectiveness and impact of the messages and materials used to promote behaviour change. Moreover, these activities often suffer from budget cuts and neglect.

5. The funding system is too centralized, which prevents the intermediary and peripheral levels from planning their own social mobilization activities. This situation often creates complications at the accounts management and the treasury level in the provinces and health zones. Similarly, a certain tardiness in the justifications process from the base to the central level has been noted.

Recommendations

1. Capitalize on the gains and the dynamism of NIDs and Local Immunization Days to strengthen the partnership between the MOH/EPI, the ICC and other partners (international and national NGOs) in routine and surveillance activities.

2. Stabilize and strengthen structures in charge of ICE/social mobilization at all levels:
   • at the central level, assign additional staff to IEC/EPI activities;
   • at the provincial level, nominate a person in charge of IEC/social mobilization and assign him/her to coordinate EPI in the provinces;
   • at the health zone level, increasing the experience of community events organizers by assigning them to the central office of the health zone.

3. Stabilize and strengthen the Committee for Social Mobilization for NIDs at the national and provincial level by:
   • providing technical IEC support for EPI; and
   • including representatives from the various ministries and the most prominent social and religious groups.

4. Increase communication/social mobilization components in EPI activities, in particular: planning, micro-planning, supervision and follow-up and evaluation.

5. Strengthen capacities in planning and communication/social mobilization techniques among those responsible for these activities at all levels. They need to be provided with the tools and teaching aids for communication and other resources.
6. Carry out training and operational research in order to:
   • identify target groups;
   • adapt educational messages and materials in function of the local sociocultural context; and
   • evaluate the impact of messages on beneficiaries.

   This involves, on the one hand, the diversification of channels of communication and the integration of traditional channels of communication that transmit cultural values aimed at changing behaviour and, on the other hand, the ownership of EPI activities by the community.

7. Make the decentralization of planning and resource management for social mobilization at the provincial and local level more effective.

8. Record different original experiences and circulate them widely in order to encourage emulation and a spirit of creativity on the ground on the one hand, and experience exchange on the other.

9. Spread the word about different messages and tools throughout the country, so as to avoid the dangerous effects of inappropriate and contradictory messages.

10. Adopt communication and social mobilization strategies for different immunization strategies (fixed centres, mobile strategies, door-to-door campaigns) and tracking of EPI diseases.
Annex A: Study and evaluation teams

Study team

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Ms. Noëlle (Consultant, UNICEF/New York)
Mr. Alimasi Okoko (Consultant, BASICS/DRC)
Annex B: Documents reviewed

Annual Report on EPI/CICD 1999
Guide for Increasing Awareness of Information on AFP 1999
Technical Cards on EPI/CICD
NID papers
EPI/CICD Annual Report 1998
Micro-planning Report and Results 1999
NID Social Mobilization Plan 1999
Routine EPI Plan of Action
AFP Surveillance Plan of Action
Health Sector Report for DRC, May 1999
Memorandum of Understanding on EPI between the Ministry for Public Health and partners, April 1999.
Report on AFP cases reported in DRC 1999
Annex C: Persons interviewed

Nationally

Dr. Mashako Mamba, Minister of Public Health
Dr. Remy Osseni, UNICEF/Chief of Health Section
Dr. Placide, WHO/EPI Officer
Prof. Ngo Bebe, WHO/Project Planning and Management Officer
Mr. Georges Gonzales, UNICEF/Social Promotion
Dr. Kandolo Wenye, Dep. Director/EPI
Dr. Brigitte Kini, Dep. Director/EPI/CICD
Dr. Joël Lebo, National EPI Coordinator
Ms. Didine Nkisi, IEC/EPI/CICD Officer
Ms. Bernadette Nimy, Président NC/Social Mobilization
Ms. Masengo, Member of NC/Social Mobilization
Mr. Jean-Jacques Muya, Member of NC/Social Mobilization

In the provinces (Bandundu/Kikwit)

Mr. Richard Taba, Deputy Mayor/Kikwit
Dr. Christian Beya Efimi, Provincial Medical Inspector/Bandundu
Dr. Kabwau, WHO/Head of Kikwit sub-unit
Dr. Kipassa A Mungala, Provincial Medical Coordinator/Kikwit
Dr. José Kavula, Chief Zone Doctor/Kikwit-Nord
Mr. Romain Giguishiya, Unit Director, EPI/Kikwit
Dr. Emery Ewa, Provincial Technical Medical Trainer
MEMISA/Belium
Dr. Guy Steimes, Coordinator, Belgian Cooperation
Mr. Makoko, Head Nurse, Nzinda Health Centre
Mr. Kuzola, Health worker Kikwit/Nord
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