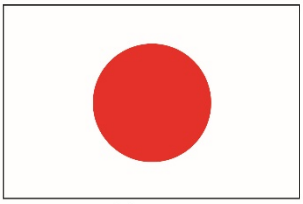
Government of Japan

COUNTERING EPIDEMIC-PRONE DISEASES ALONG BORDERS AND MIGRATION ROUTE IN GUINEA



From
the people of Japan

International Organization for Migration (IOM)

Interim Report

Project Period:
30 March 2016 – 29 March 2017
Reporting Period:
30 March 2016-31 August 2016
Funds:
2.000.000 USD

Executing Organization: International Organization for Migration (IOM) Guinea

October 2016

International Organization for Migration (IOM)

Interim Report to Government of Japan

COUNTERING EPIDEMIC-PRONE DISEASES ALONG BORDERS AND MIGRATION ROUTES IN GUINEA

Project Data Table

Executing Organization:	International Organization for Migration (IOM)
Project Identification and Contract Numbers:	IOM Project Code: MP.0281 Contract number: NI/IOM/120
Project Management Site and Relevant Regional Office:	Management Site: Conakry, CO, GUINEA Regional Office: Dakar, RO, SENEGAL
Project Period:	30 March 2016 – 29 March 2017
Geographical Coverage:	Guinea
Project Beneficiaries:	Communal / Sub Prefectural / Prefectural / Regional Health authorities and Community members in Guinea
Project Partner(s):	Ministry of Health, National Health Security Agency, US Agency for international development (USAID), U.S. Office of Foreign Disaster Assistance (OFDA), Centre for Disease Control and Prevention (CDC), World Health Organization (WHO), International Medical Corps (IMC), Research triangle institute (RTI), Premieres Urgences (PU)
Reporting Period:	30 March 2016 – 31 August 2017
Date of Submission:	30 October 2016
Total Confirmed Funding:	2,000,000 USD
Total Funds Received to Date:	2,000,000 USD
Total Expenditures:	439,761 USD

Headquarters
17 route des Morillons • C.P. 71 • CH-1211 Geneva 19 • Switzerland
Tel: +41.22.717 91 11 • Fax: +41.22.798 61 50 • E-mail: hq@iom.int • Internet: http://www.iom.int

List of Acronyms / Abbreviations

ACF	Action Contre la Faim
ANSS	National Health Security Agency
CDC	Centre for Disease Control and Prevention
CEBS	Community Event-Based Surveillance
CHWs	Community Health Workers (volunteer)
CNLE	Coordination National Lutte Contre Ebola
CRG	Croix Rouge Guinée
DCS	Direction communale de la santé
DPS	Direction préfectorale de la santé
DRS	Direction régionale de la santé
EVD	Ebola Virus Disease
GHSA	Global Health Security Agenda
GoG	Government of Guinea
JSB	Japan supplement budget
IFRC	Fédération Internationale de la Croix Rouge
IHR	International Health Regulations
IMC	International Medical Corps
MoH	Ministry of Health
MCM	Médecin Chargée de la Maladie
Plan	Plan International Guinée
PoE	Point of Entry
PPE	Personal Protection Equipment
PU	Première Urgence
RTG	Radio-télévision Guinéen
RTI	Research Triangle International
SOP	Standard Operating Procedures
ToT	Training of trainers
USAID	United States Agency for International Development

1. SUMMARY OF KEY ACHIEVEMENTS DURING THE REPORTING PERIOD

The World Health Organization (WHO) in Guinea declared the end of epidemic on December 29th 2015. However, five new cases were found in the Guinea forest region on March 17th 2016. Over the course of the Ebola Virus Disease (EVD) outbreak which began in December 2013, over 3,814 people were infected by EVD in Guinea. As of September 8th 2016, a total of 2,544 deaths had been confirmed. Yet the threat of a resurgence of transmission remains in Guinea. Porous borders, weak health systems, poor sanitation, the difficulties of behavior change around practices such as traditional burials and care for the sick, and uneven public acceptance of messages about prevention, detection, and treatment of EVD and other epidemic-prone diseases persist as enabling conditions for another large-scale outbreak.

Since the beginning of EVD outbreak, the International Organization for Migration (IOM) has been a critical partner in the fight to halt EVD transmission in the West Africa including Guinea and focusing on the following programmatic areas: supporting affected populations and governments in reinforcing coordination structures at prefecture, sub prefecture and commune levels, a wide variety of activities aimed at reinforcing primary health care systems in border areas, supporting communities in surveillance for detection/management of new cases and increasing capacities at points of entry (PoEs).

With the funding from the Government of Japan, IOM project aims to reduce the risk of EVD and other epidemic-prone diseases spreading through formal and informal PoEs and along internal migration routes by supporting the Guinean Government to strengthen its surveillance system along Guinea's coastline and its borders with neighboring Senegal, Mali, Guinea Bissau, Cote d'Ivoire, Sierra Leone and Liberia and high mobility areas internally. This strategy builds on the Guinean Government's roadmap for epidemiological surveillance.
This project is managed by a Japanese project manager based in the IOM Country Office in Conakry, Guinea, and consisted of two major programmatic components:

1. **Support for Community Event-Based Surveillance (CEBS) in communities around formal and informal PoEs;**
2. **Technical and logistic support to the Guinean Government to expand its epidemiological surveillance at formal PoEs.**

During the reporting period, IOM achieved the objectives of project in Guinea as below.

Community Event-Based Surveillance (CEBS)

IOM is one of the key technical and logistical partners for the Guinean government in implementing CEBS at important PoEs across Guinea. Specifically, with funding from the Japanese government, IOM has been implementing CEBS in five prefectures (Dubréka, Boffa, Boké, Kindia, Forécariah) and two communes of Conakry (Matoto and Kaloum) in accordance with another IOM's public health project funded by U.S. Office of Foreign Disaster Assistance

(OFDA). In order to implement CESB, the project firstly hired two CEBS trainers and conducted the training of trainers (ToT) for 89 heads of health centers who play the role of community health workers (CHWs) supervisors. Secondly, the supervisors, at their turn, trained 2,651 CHWs with the assistance of IOM trainers. After implementing both trainings, the project distributed motorbikes, helmets, cell phones, SIM cards, logbooks to 89 supervisors to support the regular monitoring of CEBS activities. The project also distributed cell phones, SIM cards, solar chargers, logbooks, bicycles, backpacks, raincoats and boots to 2,651 CHWs to support their surveillance activity in the field. The project donated desktop computers, external hard drives, internet modems, shelves, files, and installed solar panel systems for 31 health centers to reinforce their logistical capacity in data management. These distributions and donations were done based on the minimum package defined in the National Surveillance plan prepared by the Ministry of the Health (MoH) and *Coordination national lutte contre Ebola* (CNLE). After these trainings and material distributions, the project organized the CEBS launching ceremonies in each prefectures and communes with the local administrative and health authorities to announce CEBS launch to the community members and to show the Japanese Government's contribution for the health surveillance system. Between March and August of 2016, IOM completed the launch of CEBS in its work plan and in collaboration with the CNLE and other international organizations. The project has been actually supporting the local government's CEBS activity implementation such as data collection, field visit and enlightening activities in the community and will continue these activities until the end of the project in March 2017.

Capacity Reinforcement of Points of Entry (PoEs)

As EVD epidemic broke out at the border area, especially in the Guinea forest region, capacity reinforcement of PoEs is one of the urgent issue in order to prevent future EVD and other epidemic-prone diseases epidemics. In order to reinforce the capacity of PoEs, the project planned (1) rehabilitation of border posts (2) simulation exercise and participative workshops for elaboration of Standards Operating Procedures (SOPs), (3) distribution of sanitary equipment for health screenings and Infection Prevention and Control (IPC) including Personal Protection Equipment (PPE) at ten border posts (Baala in Yomou prefecture, Yalenzou in N'Zérékoré prefecture, Thuo, Gouela, Wolono and Pine in Lola prefectures, Zenié and Kotizou in Macenta prefecture, Nongoa in Guéckedou prefecture, Sitacoto in Mamou prefecture).

The project planned ten border posts rehabilitation and has rehabilitated eight border posts in the Guinea forest region with isolation room, solar panel systems set up and annex toilets. The project also equipped rehabilitated border posts with furniture such as hospital bed, bed mat, bed cover, fans, and office desks and chairs shelves. After the rehabilitation and equipment, the project held the official handover ceremony at eight PoEs with the local health and administrative authorities under the Japanese Government's contribution for the public health structure reinforcement. Other two border posts (Piné in Lola prefecture and Sitacoto

in Mamou prefecture) will be rehabilitated until the end of October 2016 and IOM will hold a handover ceremony.

The project will implement the other two activities (simulation exercises and participative workshops for SOPs elaboration with local health and security authorities followed by sanitary material distribution) at each of the PoEs during the second half of the project period (from September 2016 to March 2017).

2. PROGRESS MADE TOWARDS REALIZING OUTCOMES AND OUTPUTS

2.1 Community Event-Based Surveillance (CEBS)

Context of CEBS and role of IOM for CEBS

One of the primary weaknesses of the initial phase of the response was the lack of community involvement in epidemiological surveillance. After the experience lived by all actors in the fight against Ebola, it was clear that perhaps the greatest systemic weakness was the lack of engagement of communities. Without their active participation and willingness to share information about events related to epidemic-prone diseases, Guinea could once again be caught off-guard by a future outbreak. In order to address this question more systematically, the government decided to design and implement (in collaboration with partners such as IOM) an exhaustive CEBS system. Guinea's version of CEBS system was outlined during a national workshop in Kindia prefecture in August of 2015, to strengthen Guinea's surveillance system in the last phase of the fight against EVD, the transition phase and the first phase of post-Ebola; also to develop the government's strategic epidemiological surveillance strengthening plan. At the end of the workshop, *the Plan National de Renforcement du Système Sanitaire (National Plan for Strengthening Health System)* was written. Further discussions were done to specifically develop the community level of the health pyramid. The government developed an initial roadmap and budget, which was then discussed with partners, donors, and technical experts until everyone agreed on a set minimum package. The partners then decided on geographic areas of intervention, with partners occasionally sharing prefectures (in this case, partners needed to be perfectly coordinated in terms of timeline, materials, and approach).

Three main components of CEBS developed are (1) social mobilization and communication to change behavior and encourage communities to report certain warning signs of epidemic diseases, (2) training and equipping CHWs to pass on alerts of these warning signs in their communities, (3) training and equipping the health centers to effectively transmit and respond to those alerts.

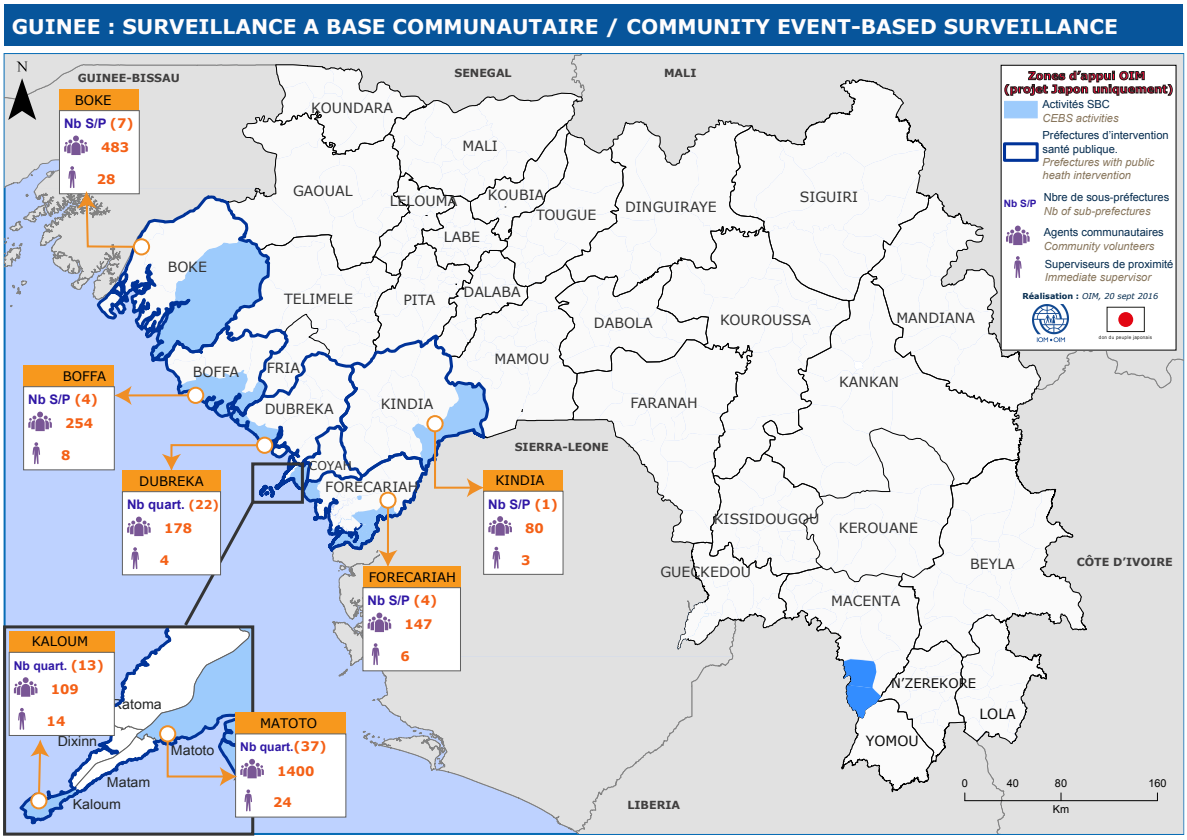
At least one volunteer CHW was chosen for each sector (most decentralized administrative unit in Guinea – generally a grouping of a few small villages or urban zones). The prefectures were covered by one or several partners as long they coordinated intervention approaches and timelines. Under a CEBS model, communities engage with an epidemiological surveillance

system by reporting information – “health events” – that can indicate to authorities the potential presence of an epidemic-prone disease.

Border communities can help the Guinean Government fill the gap of health screening by implementing CEBS and surveilling unofficial points of entry. If border communities better understand their own vulnerabilities and work to protect themselves against epidemic-prone diseases, they are essentially protecting the rest of the country as well. This is why IOM, in partnership with the Guinean Government, equips these communities with the necessary tools to ensure safe and healthy mobility.

Under this Japanese Government funding project, IOM ensures that IOM’s CEBS program focuses on helping border communities to understand patterns of mobility, and how to reduce the health vulnerabilities they acquire as a result of this mobility, without reducing the flow of human movement that is essential to these communities. Communities, as the expansion of the first level of the national surveillance system, need to be leaders in the process from very early on. This is why IOM is pairing participatory mapping with CEBS.

NB: This project builds on previous IOM projects funded by the Japanese Government (JSB 2014 Project : Improved access to Ebola Virus Disease prevention and reduced risks of transmission among migrants and border communities in guinea and selected neighboring countries) and OFDA (Health and Humanitarian Border Management in Guinea).



IOM’s CEBS supporting area and the number of supervisors and CHWs

Initial meeting with the DPS and Micro-planning workshop

The first step to start CEBS activities in each of the covered prefectures and communes was to hold an initial meeting with the DPS/DCS officials (DPS/DCS and MCM) and the partner representatives in order to establish a clear mutual understanding of the framework of the DPS/DCS-IOM partnership, set up clear expectations and principles of partnerships and evaluate the DPS/DCS' calendar for other health interventions to make an initial calendar for the other steps of the launching phase which includes the micro-planning workshops, Supervisors'(HHC) training, decentralized meetings to validate CHWs, decentralized trainings of CHWs and materials distributions. The launching phase is labor-intensive and the challenge here is that the DPS/DCS and heads of health centers are simply too busy to take on the logistical organization. Then the project provided logistic support for the implementation of all the steps.

The DPS/DCS hold the micro-planning workshop with the project support to have local administrative and health authorities understand the CEBS system, their role in it, and establish a framework for the selection of CHWs. The micro-planning workshops were attended by all the CEBS stakeholders including DPS/DCS, MCM, partner representatives, HHCs and their representative, mayors, DRS (*Direction regional de la santé*), governors, sob-governors and heads of health posts.

At the end of each micro-planning workshops the following results were achieved:

- CEBS program Information provided to the key local administrative and health authorities;
- CHWs identification process, criteria and calendar explained and defined;
- Population data per sector collected to establish the expected number of CHWs per sector;
- Definition of the role of health posts in the CEBS system;
- Discussion on how different population groups such as local religious leaders, women's groups, youth groups should be involved.

As the result of the workshop, the number of CEBS supervisors and CHWs were prepared, method of identifying CHWs was agreed with the key factors and the calendar for CHWs identification and supervisor training were prepared.

Prefecure	CEBS Partners	IOM Supporting Area	N of Health Center per zone	N of suoervisor per zone	N of CHW per Zone
Conakry	IOM	Kaloum Commune	7	14	109
		Matoto commune	6	24	1,400
Dubréka	IOM, IMC	Urban commune	2	12	178
Boké	IOM, CRG, IFRC	Urban commune	3	6	74
		Sub-prefecture of Bintimodia	1	2	64
		Sub-prefecture of Kamsar	2	2	87
		Sub-prefecture of Kolaboui	1	4	89
		Sub-prefecture of Malapouyah	1	2	23
		Sub-prefecture of Sangaredi	1	2	80
		Sub-prefecture of Tanènè	1	2	66
Boffa	IOM, RTI	Urban commune	1	2	77
		Sub-prefecture of Douprou	1	2	40
		Sub-prefecture of Koba	1	2	81
		Sub-prefecture of Tamita	1	2	56
Forécariah	IOM, ACF, CU, CRG, IFRC	Urban commune	1	2	37
		Sub-prefecture of Benty	1	2	34
		Sub-prefecture of Farmoriah	1	2	44
		Sub-prefecture of Kakossa	1	2	32
Kindia	IOM, IMC	Sub-prefecture of Madina-Oula	1	3	80
TOTAL			34	89	2,651

IOM's CEBS supporting area and the number of supervisors and CHWs

Training of supervisors (ToT: Training of trainers) and Training of CHWs

As planed in the micro-planning workshop, one-day training of supervisors was held in each prefecture in collaboration with WHO and CDC from January to April 2016 (*from January to March 2016, the trainings were funded by Japan supplement budget 2014 project and IOM's OFDA funding project*). The heads of health center (HHC) and their deputies such as MCM who play the role of CEBS supervisor were trained by the two IOM trainers using the training module which was prepared by WHO and reviewed by the CNLE CEBS partners group. In the trainings, practical exercises, questions and answers sessions were held to facilitate the participant's understanding for CEBS. As the result of the ToT, 89 supervisors (42 in Conakry, 21 in Dubréka, 20 in Boké, 8 in Boffa, 8 in Forecariah, 3 in Kindia) and 2,651 CHWs (1,509 in Conakry, 178 in Dubréka, 483 in Boké, 254 in Boffa, 147 in Forécariah, 80 in Kindia) who were prepared to train their own CHWs.

Training of CHWs in Dubréka prefecture

After this training, the supervisors had to hold one-day training for CHWs in each prefecture from January to July 2016 (*from January to March 2016, the trainings were funded by Japan supplement budget 2014 project and IOM's OFDA funding project*) in order to give selected CHWs a functional understanding of their roles, responsibilities, resources and expectations by using the training module which was prepared by WHO and reviewed by the CNLE CEBS partners group. The project provided technical and logistic support with WHO and CDC to facilitate all the trainings organization. As the result of the trainings, 2,651 CHWs (1,509 in Conakry, 178 in Dubréka, 483 in Boké, 254 in Boffa, 147 in Forécariah, 80 in Kindia) were equipped with the knowledge to carry out their responsibilities, and motivated. For some CHWs translation services in local language were provided.

Prefecure/ commune	Training for superviser		Training for CHWs	
	Date	N of superviseur	Date	N of CHWs
Conakry Matoto	2016/4/18	24	15,22,29/05/2016	1,400
Conakry Kaloum	2016/4/26	14	11-12/05/2016	109
Dubréka	2016/3/8	12	2016/3/11	178
Boké	3-4/02/2016	20	8-9/02/2016	483
Boffa	2016/4/16	8	26-27/04/2016	254
Forécariah	2016/1/14	8	20-21/01/2016	147
Kindia	16-17/03/2016	3	2-3/04/2016	80
TOTAL		**89**		**2,651**

The date and the number of participants for the trainings

Material distribution for the health centers and CHWs

As per the National surveillance plan, CEBS partners are responsible for acquiring the materials in the aforementioned minimum package, ensuring their assembly, quality, and distribution to the appropriate sites and stakeholders, the project donated necessary materials to 34 health centers, 89 CEBS supervisors and 2,651 CHWs.

Each health center involved in supervision received the following minimum package items by the project to ensure that health centers get the necessary materials to carry out their responsibilities: a telephone and SIM card with phone credit (10 USD credit per month) to communicate with CHWs; a desk top computer, an internet key with credit (10 USD credit per month), an external hard drive and a solar panel system; a binder and a cupboard for CEBS documents safe keeping; and a motorcycle and fuel support (30 liters per month) to facilitate CEBS supervisors' supervision of CHWs.

Material distribution for the health centers in Conakry

The project distributed the following minimum equipment package to each CHW: a telephone, a SIM card with phone credit (10 USD credit per month) and a solar charger to transmit alerts to the health center and health post from community and this ongoing support for communication with communities, a bicycle, a backpack, boots, and a raincoat to facilitate movement around the community during the rainy season (from June to September); and a logbook to record observations and events.

When CHWs were equipped with these supplies, CHWs were able to more easily reach communities to identify and report potential epidemic-prone disease cases. In fact, the success example is the measles outbreak, declared, July 2016 in the prefecture of Dubréka and the commune of Matoto; where the first cases were detected and notified by CHWs who fed critical information into Guinea's fledgling national disease surveillance system. The CHWs were also able to educate community members about the importance of reporting people showing symptoms of epidemic-prone disease to the health facilities through enlightening community activities such as sensitization, educational talks and Forum Theater. The project also provided additional technical support by stationing project assistants in each prefecture and field assistants in each sub-prefecture – a total of 89 CEBS supervisors and 2,651 CHWs in areas were supported by financing from the Japanese government during the reporting period.

Bicycle distribution in Matoto commune, Conakry

CEBS Launch Ceremony

After the trainings and material distribution, the DPS/DCS held the CEBS launch ceremony as the responsible of CEBS at the prefecture and commune level and the project provided logistical support to facilitate ceremony preparation and organization. CNLE officials, local administrative authorities such as governor and sub governor, supervisors and their deputies, MCM, CHWs, CEBS partners, community members attended the ceremony. Role of every stakeholder were clearly explained to allow better implementation of activities to the field.
The banners with the Japanese Government logo were put in the ceremony and the Japanese government contribution for CEBS was announced thorough the media: TV (RTG) and the radio because it is important to pass messages on local radios before CEBS takes place in the community so that communities are aware of why their community members are there.

CEBS launch ceremony in Kaloum commune, Conakry

Community Mobilization

In order to mobilize and sensitize communities on epidemic-prone diseases in the community, the project supported the DPS/DCS, the supervisors and CHWs to implement the community activities such as sensitization, educational talks, Forum Theater… Most of the communities have been starting to feel ownership over CEBS and actually understand the connection between surveillance and health center and posts, the more there will be actual behavior change, and therefore sustained and compete reporting of alerts. With educational talks organized and conducted in the sub-prefecture of Madina Oula August 2016, over a dozen of mothers consulted the health center with their children presenting suspected measles signs.

Community meeting in Matoto commune, Conakry

2.2 Capacity reinforcement of Point of Entry (PoEs)

The prevention of new epidemics, the early detection and response to epidemic prone diseases in Guinea necessitates the capacity reinforcement of PoEs such as border facilities rehabilitation, wider epidemiological surveillance at PoEs; broader participation and support from communities in border areas. The capacity reinforcement of the PoEs is a critical component of IOM's overall strategy because it would be unwieldy to install formal health screening points at all of these crossing points.

In order to reinforce the capacity of PoEs, the project planned (1) rehabilitation of ten border posts, (2) office and sanitary material donation, (3) simulation exercises and trainings for border officials and (4) SOPs elaboration. During the reporting period, the project has completed (1) rehabilitation of eight border posts, (2) office and sanitary material donation.

NB: Some of PoEs activities were implemented in coordination with IOM's OFDA funding project (Health and Humanitarian Border Management in Guinea) in order to cover widespread border area.

Rehabilitation of Border Posts

At the first stage of the project, some assessment missions were conducted by IOM staff to identify PoEs needing to be rehabilitated for their capacity reinforcement. The following ten border posts were identified with local authorities and they were rehabilitated. The project rehabilitated eight border posts in the reporting period, and other two border posts (Piné and Sitacoto) which are under rehabilitation until the end of October 2016.

Rehabilitation of border post of Pine in Lola prefecture

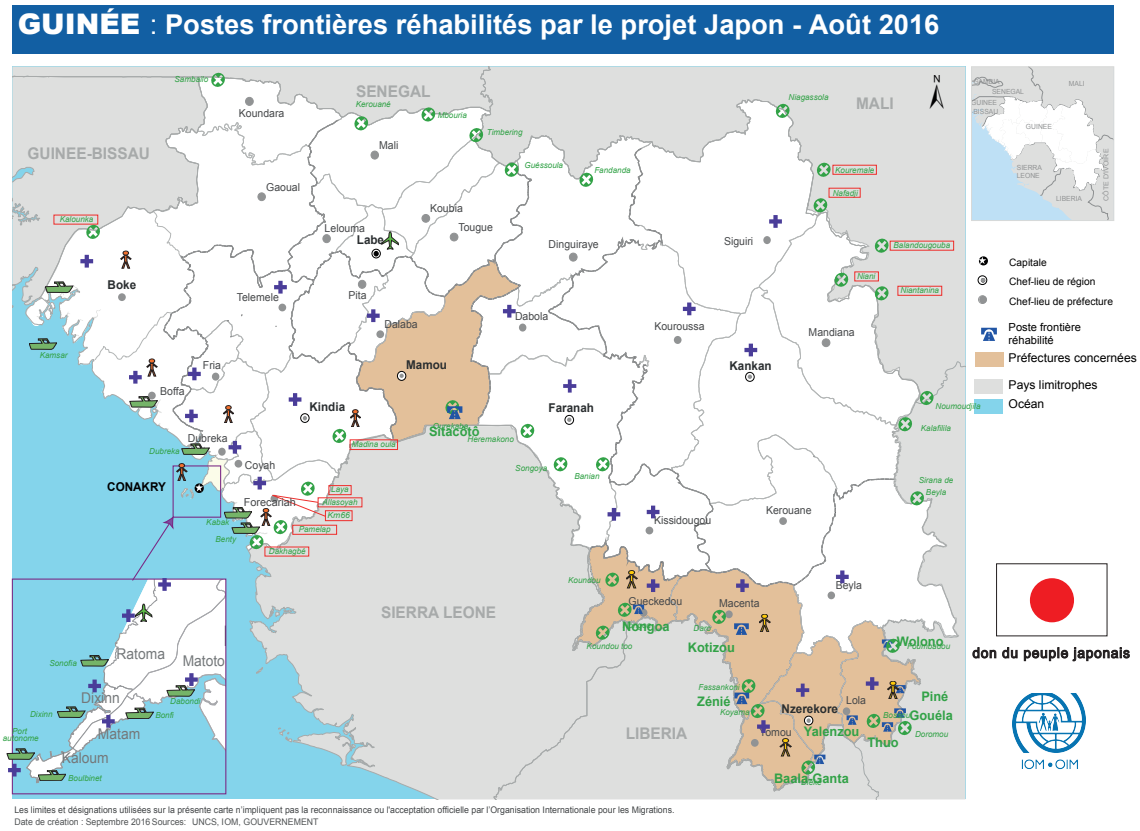
N°	PoE	prefecture	sub prefecture	district
1	Baala	Yomou	Diécké	Baala
2	Yalenzou	Nzérékoré	Yalenzou	Yalenzou
3	Thuo	Lola	Bossou	Thuo
4	Gouela	Lola	Nzoo	Bourata
5	Zenié	Macenta	fassankoni	Zinikorozou
6	Kotizou	Macenta	Daro	kotizou
7	Nongoa	Gueckédou	Nongoa	Nongoa centre
8	Wolono	Lola	Gueasso	Moribadou
9	Piné	Lola	Gama Bèrèma	Pinè
10	Soticoto	Mamou	Ouré-Kaba	Sitacoto

List of border posts rehabilitation

The rehabilitations included:

- Installation of solar panel systems (in all the ten rehabilitated PoEs) to reinforce their logistical capacity;
- Donation of office equipment such as beds, mats, tables, chairs, shelves and Fans;
- Donation of medical equipment such as beds, mats and bed sheets (for isolation room), Health screening and IPC kits including PPE.

The project organized handover ceremonies for eight rehabilitated PoEs with the local administrative and health authorities to show the Japanese Government's contribution for the capacity reinforcement of PoEs (The handover ceremony for the PoE of Pine and Sitacoto will be held in October and November 2016). The signboards with the Japanese flag were set in front of each PoEs.



The map of rehabilitated PoEs with the funding of Japanese Government

2.3 Japanese Government Visibility

Considering the Japanese Government's contribution to reinforce the capacity of health surveillance in the community and the PoEs, the project made following actions for the Japanese Government visibility:

- Stickers with the Japanese flag were put on the distributed materials such as motorbikes, helmets, desktop computers, external hard drives and furniture equipped at the rehabilitated border posts.
- The Japanese flags and the banners were put during the project activities such as trainings, meetings, ceremonies and community activities in the field.
- Some project activities such as CEBS launch ceremony and the community activities were broadcasted through TV and the radio to announce the Japanese Government contribution.
- The signboards with the Japanese Government flag were put at the all rehabilitated border posts.
- The project supported the Japanese Assembly members and the Japanese Embassy's visit at Siramodia village (Forécariah prefecture) which was effected by Ebola and supported by IOM during and after the epidemic on 31th of August. The Japanese delegation consisted three assembly members (Mr. Asahiko MIHARA, Mr. Daishiro YAMAGIWA, Mr. Hideki MAKIHARA), the Ambassador and three diplomates. The

delegation had discussion with the community leaders and Ebola effected villagers to know how Ebola damaged the community and family.

Japanese delegation's field visit with IOM

- The project displayed some project activities photos at the Tokyo International Conference on African Development Ⅵ (TICAD Ⅵ) from 27 to 28 August 2016 in Nairobi to introduce the Japanese Government contribution for Ebola response.

IOM Japan funding project booth in TICAD Ⅵ in Nairobi

3. CHALLENGES ENCOUNTERED AND ACTIONS TAKEN

Challenges	***Actions***
There were many official activities competing priorities for each health center (vaccination campaigns, mosquito net distribution, trainings, and technical committees).	Activities implementation planning was done in direct collaboration with the MoH at all levels to avoid interference with the official activities such as mass campaigns that are priority at all the extend of the country.
When the heads of health centers were traveling, sick, occupied, etc (and there was not a clear alternate or point person), there was no one to receive the calls or determine whether an investigation is needed. This has the negative effect of	This challenge is the consequence of the lack of staff in public health facilities. Advocacy is done for the recruitment of new units and their deployment in order to fill the gaps. The involvement of private

discouraging CHWs.	facilities in the activities could also supplement so slightly to the gap.
If the CHWs are sick, go to a market out of town, or participates in a health campaign, they are not present in the community to listen to alerts. Especially during public health campaigns (vaccination days, mosquito net distribution, etc), alerts tend to decrease because CHWs are participating in the campaign.	In order to address this challenge, the supervisors insist that CHWs leave their phones in the sector with the head of sector or someone else when otherwise occupied or unavailable.
CHWs often got discouraged because of lack of financial motivation – especially in areas where there were many actors providing financial incentives for contact tracing, CVVs, or social mobilization.	It was important to remind CHWs that this is a voluntary position, meaning if they feel unwilling or unable to continue this position, they are free to resign and return their materials so that someone else can be identified to replace them. Refresher trainings for CHWs were planed they will be held from November 2016.
Several CEBS partners have seen challenges in the program being accepted because of perceptions that it is only linked to Ebola. Bad experiences/perceptions of the Ebola response mean this closes some communities off (whether they inform you of it or not).	The project presented the program as a boarder health strengthening initiative. Especially, the project explained that CEBS is not only for Ebola but for all the epidemic-prone diseases prevention to the CHWs and community members during the trainings and CEBS activities in the community.
In communities where there were adverse reactions to an event, this may impact the community's willingness to transmit alerts to the CHWs.	The project maintains good relations and works well with community leaders and religious leaders who are listened to and whose watchwords are followed by all the community members. The project also works with elite nationals of different communities to pass messages through them
Distances between IOM Conakry office and the project sites for CEBS.	IOM set up sub-offices in Dubréka, Boké, Boffa, Forecariah, Kindia in order to minimize logistical challenges and improve communication with local health and administrative authorities.
External challenges included the poor condition of roads during rainy season at the border areas in Guinea, delayed the implementation of some activities and	Early start-up was the most significant reason that the project made lots of progress as planed in the reporting period.

prompted IOM to adjust its work plan in order to move delayed activities to later in the project life cycle.	
Extensive area was planned to survey by the Guinean National Surveillance Plan.	In order to cover wide spread border area, the project has implemented CEBS with the collaboration of other international organizations such as RTI, IFRC, CRG, IMC, ACF and Plan International
Lots of border posts identified to rehabilitate to reinforce the capacity of health border management.	The project rehabilitated ten PoEs in collaboration with another IOM public health project funded by OFDA and Belgian cooperation.

4. CONCLUSIONS

This project funded by the Japanese Government has provided considerable support to the Guinean government in the implementation of the national Surveillance plan, especially the community component that was once overlooked. It undoubtedly and effectively awakened the conscience of the communities to monitor their own health and take proactive steps towards reducing their vulnerability to epidemic-prone diseases.

The project covered five prefectures and two communes of Conakry city. The provision of communication equipment (telephone and call credit) and transportation (bicycles for CHWs and motorcycles for health centers) has helped to increase the number of disease alerts and notification of cases from the community to health facilities. Among 2,769 disease alerts reported by the CHWs, 197 alerts were confirmed as cases of epidemic-prone diseases from April 04 to August 28 2016. 1,435 deaths and 910 births were reported by the CHWs, 619 supervisions were implemended by the heads of health center in the same period.

Prefecture/ Commune	N of deaths reportd by CHWs	N of disease alerts reported by CHWs	N of births reported by CHWs	N of disease alerts confirmed by HC and reported to DPS/DCS	N of supervisons by heads of health center
Conakry Kaloum	45	15	32	18	20
Conakry Matoto	113	479	141	114	58
Dubréka	209	40	6	17	34
Boké	556	1,659	354	26	265
Boffa	299	16	200	4	129
Forécariah	152	259	124	10	92
Kindia	61	301	53	8	21
TOTAL	1,435	2,769	910	197	619

Collected CEBS information from 04/04 to 28/08 2016

The project added efficiency and effectiveness in the epidemic prone diseases surveillance to the border by re-enforcing the detection mechanism at the PoEs. A total number of 28 PoEs were rehabilitated and provided with office equipment (tables, chairs, shelves and Fans) and medical equipment such as beds, mats and bed sheets (for isolation room), Health screening and IPC kits including PPE. It enabled PoEs personnel to work in a much more conducive manner. IOM provided each of the rehabilitated PoEs with installation of solar panel system which allowed for a constant power supply hence allowing work to go on unperturbed.
In order to strengthen the capacity of PoEs personnel in epidemic prone diseases cases detection among travelers, the project will, in its second half period, support the GoG and PoEs personnel to develop standard operating procedures (SOPs) on Public health emergencies followed by training implementation for the PoE officials, on public health emergency preparedness plans through tabletop exercises and simulation exercises.

Despite these achievements, significant challenges were encountered during the reporting period as has been described above. However, IOM and its partners still successfully carried out the project as planned, countering Epidemic-Prone Diseases along Borders and Migration Routes in Guinea.

5. EXPENDITURES AND RESOURCE UTILIZATION

Please see the attached financial report.

6. ANNEXES

Annex 1: CEBS training module for the community health workers (CHWs)

IOM International Organization for Migration
OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

HUMANITARIAN ASSISTANCE FOR AFRICAN COUNTRIES: COUNTERING EPIDEMIC-PRONE DISEASES ALONG BORDERS AND MIGRATION ROUTES IN GUINEA

INTERIM FINANCIAL REPORT

for the period from 30 March to 31 August 2016

		USD
CONTRIBUTION		
Government of Japan (March 2016)		2,000,000
Total resources		**2,000,000**
EXPENSES	**Budget**	
Staff costs	405,800	45,531
Office costs	214,000	47,355
Operational costs	1,249,359	318,106
IOM overhead (7%)	130,841	28,769
Total expenses	**2,000,000**	**439,761**
Balance of resorces carried forward at 31 August 2016		**USD 1,560,239**

As the responsible Project Manager, I certify that the financial and narrative reports are correctly stated in accordance with IOM internal rules and procedures.

N'Diaye Fatou Diallo
Chief of Mission, IOM Guinea
28 October 2016

Organisation Internationale pour les Migrations
OIM · OIM
Conakry

Project ID: MP.0281
END No.: FF16.461

SURVEILLANCE A BASE COMMUNAUTAIRE DES MALADIES A POTENTIEL EPIDEMIQUE

MODULE DE FORMATION PRATIQUE DES AGENTS COMMUNAUTAIRE (AC)

Septembre 2015

Introduction

Ce document est destiné à la formation des Agents Communautaire (AC) pour la surveillance des maladies à potentiel épidémique et des évènements inhabituels de santé. Il comprend 2 parties :

Une première partie portant sur les notions théoriques.
Le formateur doit clairement expliquer :

1. Ce qu'est la surveillance à base communautaire,
2. Les définitions des maladies sous surveillance ;
3. Les rôles de l'AC
4. Les activités à mener par l'ASC ;
5. Comment remplir le registre ;
6. Les conduites à tenir (CAT) devant chaque cas ou évènement ;
7. L'importance de la participation communautaire dans la surveillance des maladies à potentiel épidémiques ;
8. Comment communiquer avec les membres de la communauté ;

Une deuxième partie portant sur une série d'exercices pratiques, des jeux de rôle, que le formateur doit administrer aux participants tout en donnant des explications nécessaires.

Objectifs de la formation :

A la fin de la formation, chaque AC devra être capable de :

- Connaître le but de la surveillance à base communautaire
- Connaitre les définitions communautaires des maladies à potentiel épidémique
- Connaitre la conduite à tenir devant un cas suspect de maladie à potentiel épidémique ou un évènement inhabituel de santé
- Remplir correctement l'outil de gestion (Registre de l'AC)
- Appliquer les mesures de prévention
- Sensibiliser la communauté par l'application correcte des techniques de la communication interpersonnelle (CIP)
- Savoir la conduite à tenir pour lever les réticences et minimiser les rumeurs

Première partie : Notions théoriques

Activités du facilitateur

Le facilitateur doit :

1- Expliquer les concepts et définitions aux participants
2- Afficher les différentes activités à mener par l'AC
3- Faciliter l'interaction entre les différents participants et clarifier au besoin
4- Encourager les apprenants volontaires à expliquer les définitions des cas à base Communautaire dans une langue locale et les CAT

I. Qu'est-ce que la surveillance à base Communautaire (SBC)

La surveillance à base communautaire est un processus actif de la participation communautaire dans l'identification, la notification, le rapportage, la réponse face aux évènements de santé dans la communauté.

La surveillance à base communautaire se fait à travers les AC qui utiliseront des définitions de cas et un formulaire simplifié pour l'identification, la notification des évènements de santé et maladies aux agents de santé pour la vérification, l'investigation, l'analyse des données et la réponse appropriée. C'est une activité de routine, en période épidémique comme en dehors de l'épidémie.

La SBC doit également rapporter les rumeurs, la désinformation sur les événements de santé inhabituels et participer à la résolution des refus/réticences survenant dans la communauté.

II. Les maladies à potentiel épidémique

1- Définitions des maladies à potentiel épidémique

Une maladie à potentiel épidémique est une maladie qui peut se propager rapidement, d'une personne malade à plusieurs autres personnes, et qui peut entrainer des conséquences graves voire des décès.

2- Les maladies à potentiel épidémique retenues en Guinée

Cinq maladies à potentiel épidémique sont retenues par la Guinée dans le plan de renforcement de la surveillance et la riposte 2015-2017. Il s'agit :

- Maladie à Virus Ebola ;
- Fièvre jaune ;
- Rougeole ;
- Méningite ;
- Cholera ;
- Paralysie flasque aigue (Poliomyélite)

3- Définition communautaire des maladies :

- Maladie à virus Ebola

Toute personne vivante avec l'un des signes ci-dessous:

- **Fièvre brutale**
- **OU au moins 3 des symptômes suivants:**
  - ✓Maux de tête
  - ✓Vomissements/nausées
  - ✓Anorexie/perte de l'appétit
  - ✓Diarrhée
  - ✓Fatigue Intense
  - ✓Douleurs abdominales
  - ✓Douleurs musculaires ou articulaires
  - ✓Difficultés à avaler
  - ✓Difficultés à respirer
  - ✓Hoquet
- **OU: Toute sorte de saignement inexpliqué**
- **OU: Tout décès inexpliqué**

- **Les autres maladies à potentiel épidémique (MPE) ou sous surveillance**

- **Fièvre Jaune :** Tout individu souffrant de fièvre et jaunissement du blanc de l'œil et de la peau.

- **Choléra :** Tout individu âgé de 5 ans et plus ayant des selles liquides abondantes.

- **Méningite :** Tout individu souffrant de la fièvre et de raideur du cou (Chez l'adulte) ou bombement de la fontanelle (chez le nourrisson).

- **Paralysie flasque aigue (poliomyélite) :** Tout enfant de moins 15 ans qui rampait ou marchait et brusquement ne rampe plus ou ne marche plus.

- **Rougeole :** Toute personne, notamment les jeunes enfants, manifestant de la fièvre et une éruption cutanée.

III. Rôles des AC

1. Rechercher les cas suspects dans la communauté(IDENTIFICATION):

- Reconnaitre les signes et symptômes correspondant à la définition de cas à base communautaire, les décès et les rumeurs ;
- Vérifier la conformité avec la définition des cas de maladies sous surveillance ;
- Remplir correctement les outils de gestion ;

2. Transmettre l'information au Superviseur qui va la transmettre au Chef de Poste/Chef de Centre :(NOTIFICATION)

- Transmettre le plus rapidement possible l'information par Téléphone au superviseur de proximité ;
- Faire un point régulier de ses activités au superviseur, au chef de poste de santé ou centre de santé (même en l'absence de cas détecté) ;
- Transmettre ses outils chaque semaine au superviseur ou au chef de poste de santé ou centre de santé.

3. Organiser des dialogues avec les ménages ou les communautés par une bonne :(COMMUNICATION INTERPERSONNELLE)

- Développer l'écoute active dans les ménages ou les communautés ;
- Etablir des liens de confiance avec les ménages et les communautés ;
- Conseiller/orienter les familles et/ou les malades à l'utilisation des services de santé;
- Organiser les causeries éducatives et les visites à domicile pour discuter sur les maladies sous surveillance ;
- Donner les informations exactes pour prévenir ou gérer les rumeurs et les réticences ;
- Assurer la retro information aux communautés notamment aux chefs de village, chefs de quartier, chefs de secteur etc.

IV. La Communication Interpersonnelle (CIP)

1. Définition :

La communication interpersonnelle (CIP)= stratégie de communication au cours de laquelle s'établit un échange direct entre celui qui transmet le message (de santé/développement) et les membres de la communauté ; c'est le face à face.

2. Les techniques de communication interpersonnelle :

Les techniques de CIP sont :

- La visite à domicile (VAD) (pour conseil/causerie)
- Le conseil/counseling particulièrement s'il y a angoisse, peur, réticences, etc.
- La causerie éducative/réunion d'information (avec membres de la communauté)
- La réunion de mobilisation sociale (avec les ONG/ Associations)
- Le plaidoyer (auprès des décideurs/chefs/leaders)

Définition de la Visite à Domicile (VAD)

Le fait de se rendre dans une famille pour rencontrer une personne ou un couple (**Entretien individuel**) ou encore un groupe de personnes afin de développer une interaction, de leur donner des informations, des conseils ou aider à la résolution d'un problème crucial d'attitude ou de pratique (**causerie éducative**).
Exemples de problème nécessitant une VAD : Dans un contexte épidémique, le refus d'une famille de faire un enterrement digne et sécurisé ou refus d'une famille contact de se faire suivre par les équipes de prise en charge.

V. Activités à mener par les AC avant, pendant et après les visites à domicile

1. Avant la visite à domicile

- Elaborer un programme de travail (activités, chronogramme, ressources et cibles) quand ?où ? circuit de progression des visites…) ;
- Définir le contenu de la causerie (thème à aborder, durée moyenne de la causerie, avec qui est l'interlocuteur…? ;
- Avertir la personne ou la famille ;
- Revoir ses connaissances en fonction du but de la visite ;
- Se rapprocher des autorités locales pour les informer auparavant de ses activités ;

- S'assurer d'avoir les messages clés (boite à image, affiches ...) à passer ;
- S'assurer d'avoir l'outil de gestion (Registre d'identification des cas/évènements) ;
- S'assurer que son téléphone est chargé et a du crédit ;
- S'assurer d'avoir un moyen de transport ;
- Etre en tenue correcte en harmonie avec les us et coutumes.

2. Pendant la visite à domicile

- Respecter les mesures de prévention individuelles ;
- Procéder aux salutations d'usage ;
- Se présenter si nécessaire ;
  - Ne pas rentrer dans les maisons si ce n'est pas nécessaire
  - Ne pas avoir de contact physique avec la communauté/malade
  - Se laver soigneusement les mains avec de l'eau et du savon après la visite à domicile ;
- Echanger d'abord des propos sur un sujet autre que celui qui motive la visite ;
- Ecouter les préoccupations de la famille (intéressez-vous à l'état de santé des membres de la famille. Ex: comment vont les enfants aujourd'hui?) ;
- Interroger subtilement les membres de la famille sur l'existence d'évènements d'alerte dans la famille et dans la communauté ;
- Sensibiliser la famille sur les maladies sous surveillance et autres évènements ;
  - Demander de signaler immédiatement tous signes suspects et symptômes comme la fièvre, maux de tête, la fatigue etc., les décès, les enterrements…
  - Informer que les malades doivent consulter un personnel de santé
  - Donner des conseils sur les mesures préventives (aller le plus vite possible au centre de santé le plus proche en cas de maladie, lavage des mains à l'eau et avec le savon, ne pas manger ou manipuler un animal mort, éviter de toucher les malades, leurs secrétions, laver leurs vêtements ou literie…) et veiller à leur application
- Remplir correctement l'outil de gestion ;
- Remercier la famille d'avoir répondu aux questions.

3. Après la visite à domicile

- Utiliser de l'eau et du savon pour se laver les mains
- Faire le point de l'outil de gestion avant de quitter la localité (données manquantes ?)
- S'il y a un cas suspect, appeler immédiatement le superviseur de proximité pour lui faire le point

Faire le point des difficultés et problèmes rencontrés au superviseur de proximité.

VI. Conduite à tenir devant chaque type d'évènement

1. Devant un cas suspect de maladie

a. Avant l'arrivée des équipes d'appui :

- Informer le malade et sa famille sur la nécessité d'avertir la structure de santé,
- Informer le superviseur de proximité ;

- Informer le malade et sa famille de l'arrivée de l'équipe médicale,
- Remplir correctement le registre d'identification des évènements ;
- Respecter les mesures de prévention individuelles ;
  - Ne pas rentrer dans les maisons ;
  - Ne pas toucher le malade ;

- se tenir à distance raisonnable en maintenant la distance de sécurité (2 m) ;
- Ne pas avoir de contact physique avec les ménages ou les membres de la communauté ;
- Ne pas toucher/prendre des objets ;
- Se laver les mains avec de l'eau et du savon après la visite ;

- Rester si possible avec la famille, la soutenir jusqu'à l'arrivée de l'équipe médicale ;
- Ne jamais faire des promesses à la famille ou au parent les parents ou le malade

b. Après la prise en charge du cas :

- Dans les deux jours qui suivent, rendre visite à la famille afin de:
  - S'assurer qu'elle a des nouvelles de son parent,
  - Interroger la famille sur sa satisfaction vis-à-vis du processus d'intervention des équipes pour obtenir les informations relatives à son expérience,
  - Noter les avis et besoins des parents
- Là où des évènements ou des expériences négatives sont survenus, faire un rapport détaillé au superviseur pour qu'une action immédiate soit prise.

NB : En cas de réticence de la famille, adopter la conduite à tenir face à une réticence.

2. Devant un cas de décès

a. Avant l'arrivée de l'équipe d'investigation :

- Présentez vos condoléances. Remerciez la famille/communauté d'avoir signalé le décès et d'avoir ainsi assuré la protection non seulement de la famille mais également de la communauté ;
- Informer le superviseur de proximité ;
- Maintenir un contact régulier avec l'équipe d'investigation pour obtenir les infos sur leur heure d'arrivée au lieu du décès ;

b. Conduite à tenir devant une réticence

- Donner toutes les informations et conseils nécessaires mais n'insister pas ;
- Noter les raisons de la réticence ;
- Demander de l'aide aux chefs de village, chefs de quartier, à un leader reconnu dans la communauté afin de lever la réticence avant l'arrivée de l'équipe d'investigation ;
- Informer le superviseur de proximité de l'alerte et préciser l'existence de la réticence ;
- Et continuer à être poli et courtois avec la famille et la communauté.

VII. Importance de la participation communautaire dans la surveillance des maladies

La participation communautaire dans la surveillance des maladies contribue à :

- L'identification précoce des cas de maladies et des évènements inhabituels ;
- La notification à la structure de santé la plus proche ;
- L'investigation des cas suspect ou des décès
- Le suivi des contacts ;
- La facilitation de la communication pour l'adoption des comportements favorables à la santé;
- La cartographie des risques et des dangers potentiels ;
- La minimisation des refus et réticences ;
- La facilitation de la gestion des problèmes de santé au sein de la communauté.

- L'éducation et la sensibilisation de la communauté sur les maladies à potentiel épidémique.

VIII. Les outils de gestion

Activités du facilitateur

1. *Distribuer la fiche d'identification d'évènement aux participants*
2. *Faire lire la fiche par un volontaire*
3. *Identifier les difficultés ou incompréhensions*
4. *Expliquer en donnant des exemples*

Un registre doit être utilisée par l'AC :

- **Le registre d'identification des cas/évènements**

L'AC doit avoir ce registre en sa possession chaque fois qu'il se rend sur le terrain. Cependant, il **ne doit être rempli que lorsqu'un cas suspect de maladie et/ou un évènement inhabituel de santé est découvert lors de sa visite**. Il comporte deux parties :

- **L'entête** avec les données d'identification de l'AC
- **Un tableau avec 7 colonnes**. Ici les renseignements sont à fournir par ligne selon la date de l'évènement signalé dans la première colonne en allant de gauche vers la droite.
- Notons que la 2ème colonne doit être renseignée selon la codification en dessous du tableau :
  1= Maladie dont on précisera les signes exemple : 1 (fièvre, diarrhée…)
  2= Décès préciser la type de décès (Maladie, accident, sucide….) ,3= Naissance
  4= Etranger dont on précisera la provenance (exemple 4 Labe ou 4 Ratoma)

Les renseignements qui y figurent doivent être collectés par le superviseur de proximité lors des investigations et aussi des supervisions.

Deuxième partie : Exercices/Jeux de rôles

Activités du facilitateur

1- *le facilitateur constitue 4 groupes de participants pour des jeux de rôle et attribue à chaque groupe un thème selon les thèmes clés ci-dessous*
2- *Le facilitateur présente le contenu du thème pour résumer et recadrer les idées des participants*

Thème 1 : déroulement d'une visite à domicile (VAD)

*'' ''**vous êtes AC dans une communauté et vous faite la recherche active de la MVE et des autres maladies sous surveillance. Vous arrivez dans le village. Réalisez votre activité''***

*Thème 2 : conduite à tenir devant un cas de maladie dans une communauté : '' **vous êtes AC dans une communauté. Au cours d'une visite à domicile, le chef de la famille vous informe que sa femme est malade depuis ce matin. Elle souffrirait de maux de tête violents et de frisson. Quel sera votre attitude ?''***

*Thème 3 : Conduite à tenir devant un décès communautaire '' ''**vous êtes AC dans une communauté. Une personne anonyme vient vous informer du décès d'une femme accouchée dans la matinée. Quel sera votre conduite ?''***

*Thème 4 :'' **vous êtes AC dans une communauté. Au cours d'une sortie de VAD, vous découvrez qu'il y a un décès dans un village voisin. Vous essayez d'expliquer à la famille la nécessité de faire un enterrement sécurisé. Ce que certains membre de la communauté refusent catégoriquement pendant que d'autre sont d'accord. Quel sera votre attitude ?''***

3- *le facilitateur demande aux autres participants de bien suivre la séance afin de faire par la suite leurs observations sur ce que l'agent communautaire a fait de bien et ce qu'il pourrait faire mieux (en rapport avec la technique de VAD et ces connaissances sur la recherche active d'Ebola).*
4- *A la fin de la simulation le facilitateur recueille les observations des uns et des autres, fait la synthèse et y apporte ses amendements*

IX. ANNEXE

SURVEILLANCE COMMUNAUTAIRE DES MALADIES A POTENTIEL EPIDEMIQUE:
FICHE D'IDENTIFICATION DES EVENEMENTS

Nom de l'agent communautaire : **Tel :**

Date	Type d'évènement détecté*	Nom de personne concernée / téléphone**	Sexe F/M	Age	Lieu de détection (village, rue, hameau)	Personne responsable/ contact téléphone

***Codes du Type d'évènement détecté :**
1=Maladie (préciser les signes) **2**= Décès (préciser la cause suspectée) **3** = Naissance **4**= Etranger (préciser la provenance)
**Pas nécessaire pour décès et naissance

SURVEILLANCE COMMUNAUTAIRE DES MALADIES A POTENTIEL EPIDEMIQUE:
Registre de notification des alertes communautaires au niveau de centre de santé

Préfecture : **Sous-préfecture/commune :** **Centre de Santé :**

Nom de superviseur : **Tel :**

Date d'alerte	Nom et numéro téléphone AC qui a donné l'alerte	Type d'évènement détecté*	Nom du cas/contact	Sexe F/M	Age	Lieu de détection (district, secteur, village)	Date investigation	Investigateurs	Résultats	Date remontée à la DPS

***Codes du Type d'évènement détecté :**
1=Maladie (préciser la maladie suspectée) **2**= Décès (préciser la cause suspectée) **3** = Naissance **4**= Etranger (préciser la provenance)

Organisation mondiale de la Santé

FICHE DE SUPERVISION DES AGENTS COMMUNAUTAIRE POUR LA SURVEILLANCE DES MALADIES A POTENTIEL EPIDEMIQUE

Préfecture/Commune : Sous-préfecture : Quartier/District :

Nom du superviseur : Tel : Date :

Niveau central ☐ Régional ☐ Préfectoral ☐ CS/PS ☐

	Numéro de L'AC					
Oui = 1 **Non = 2**	Heure de la visite					
1. Lieu						
2. L'AC a-t-il été recruté localement?						
3. L'AC a-t-il été formé?						
4. L'AC dispose-t-il d'un circuit/Programme de travail ?						
5. L'AC dispose-t-il des outils en quantité suffisante?						
6. L'AC assure-t-il le remplissage correct des outils?						
7. L'AC respecte-t-il les consignes en matière de communication inter personnelle?						
8. L'AC a-t-il connu des réticences/refus?						
9. Quel est le nombre d'évènements communautaires identifiés par l'AC ce jour?						
10. Quel est le nombre de sites visités depuis le matin ?						
Quel est le nombre de site visité en fonction du type?	Ménages					
	Gares routières					
	Débarcadères					
	Ecoles					
	Mosquées/Eglises					
	Marchés					
	Autres					
Nombre total de personnes rencontrées						
Nom et signature des ASC						

Points forts

Points à améliorer

Termes de référence des ASC :

Principales tâches et responsabilités

Sous la supervision directe du Chef de poste ou du chef de centre de santé, l'Agent de Surveillance Communautaire faisant partie intégrante de l'équipe de surveillance devra:

- Identifier et prendre contact avec les autorités et les personnes influentes de la zone (chefs de quartier, de villages, leaders religieux…) susceptibles de l'aider à informer les familles
- Rechercher activement les cas et rumeurs des maladies ou toute autre situation inhabituelle affectant la santé de la population dans la communauté,
- Identifier et Notifier immédiatement les cas de maladies au Chef de Poste de Santé ou au superviseur de proximité
- Faciliter l'investigation aux équipes de terrain
- Gérer les rumeurs en donnant l'information juste
- Gérer les cas de refus/réticence avec la contribution de l'équipe de coordination, superviseur, consultants
- Effectuer une sensibilisation de proximité dans sa localité selon des stratégies de rapprochement personnalisés (Rencontres, VAD, Porte à porte…)
- Conseiller et orienter les populations sur l'hygiène, l'utilisation des services de santé et la protection sociale,
- Participer aux enquêtes, investigations et activités de riposte
- Faire le dénombrement des décès
- Assurer la rétro information du centre de santé vers la communauté
- Participer à la distribution des intrants au sein de la communauté
- Remplir correctement les outils de gestion
- Faire le point quotidien de son travail à l'agent de santé
- Faire un rapport hebdomadaire de son travail à l'agent de santé
- Participer aux réunions d'évaluation mensuelles organisée par l'agent de santé de son aire et faire le point sur son travail

Profil de l'agent de la surveillance communautaire

- Savoir lire et écrire;
- Être issu de la communauté (dans un rayon inférieur ou égale à 2 Km) ;
- Etre un leader écouté de la communauté ;
- Avoir une capacité de communication;
- Etre disponible à travailler;
- Etre Capable de travailler en équipe ;
- Entretenir de bonnes relations avec les membres de la communauté ;
- Entretenir de bonnes relations avec les agents des structures de santé les plus proches ;
- Maîtriser sa zone d'intervention ;

Connaissance des langues

La connaissance de la langue et des usages de la culture locale est exigée. La connaissance d'une ou de plusieurs autres langues du pays serait un atout.

Age limite

Il devra être majeur (au moins 25 ans). La capacité à travailler dans des conditions rudes sera l'élément de valeur dans la sélection.

Lieu d’affectation

Directions Préfectorales et Communales de la Santé (DPS et DCS)

Superviseurs hiérarchiques

Les Directeurs Préfectoraux et Communaux de la Santé, les Chefs de Centre ou de Poste de Santé étant les supérieurs hiérarchiques directs de l’ASC.