



EXTERNAL EVALUATION OF THE PILOT PHASE OF THE HOME-BASED MANAGEMENT OF MALARIA PROGRAM IN RWANDA

FINAL REPORT

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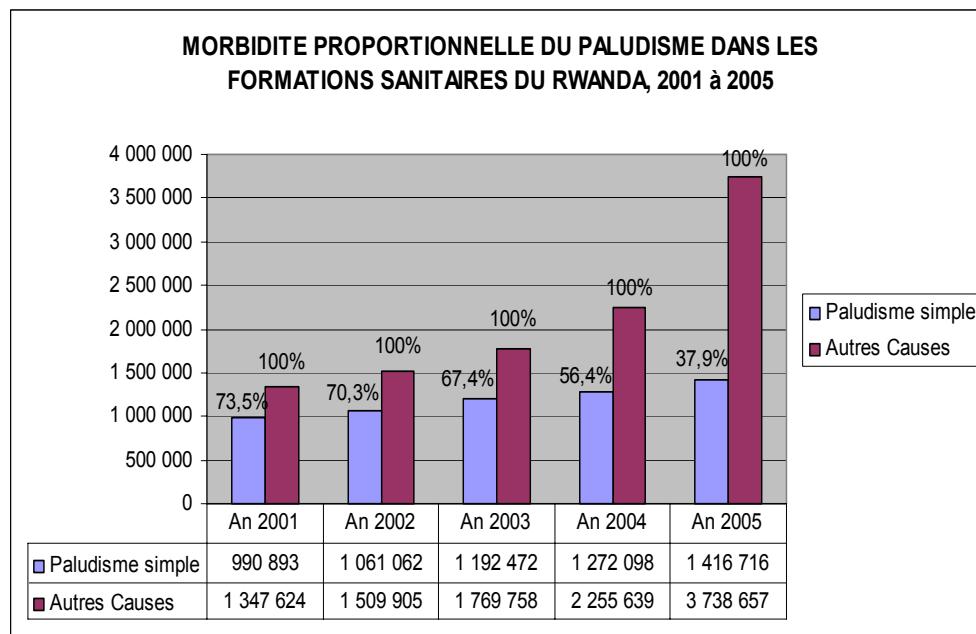
ACRONYMS

ACT	Artemisinin-based combination therapy
AQ	Amodiaquine
AQ/SP	Amodiaquine/Sulfadoxine-Pyrimethamine
ARI	Acute respiratory illnesses
BUFMAR	<i>Bureau des Formations Médicales Agrées de Rwanda</i> (Office of Church-affiliated Health Facilities in Rwanda)
CAMERWA	<i>Centrale d'Achats des Médicaments Essentiels du Rwanda</i> (central medical stores, Rwanda)
C-DMCI	Community-based drug management for childhood illness
C-IMCI	Community-based management of childhood illnesses
DMCI	Drug management for childhood illness
FGD	Focus group discussion
HBM	Home-based management of fever
HC	Health center
HPLC	High performance liquid chromatography
IMCI	Integrated management of childhood illnesses
INMCP	Integrated National Malaria Control Program (Rwanda)
IPT	Intermittant preventive treatment
IRC	International Rescue Committee
ITN	Insecticide-treated bed net
MOH	Ministry of Health
NGO	Non-governmental organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PTF	Pharmacy task force (Rwanda)
RDT	Rapid diagnostic test
RPM Plus	Rational Pharmaceutical Management Plus
SP	Sulfadoxine-Pyrimethamine
TBA	Traditional birth attendant
USAID	United States Agency for International Development
WHO	World Health Organization

I. BACKGROUND

Malaria remains the leading cause of morbidity and mortality in Rwanda, with almost 1.5 million cases, 38% of all reported illnesses, and half of all reported deaths in 2005 (figure 1). In the same year, children under 5 years of age made up one-third of consultations and 40% of hospital deaths due to malaria.

Figure 1. Proportional morbidity from malaria compared to all causes, Rwanda, 2001 to 2006



A. Development of the HBM Strategy

One of the core strategies for controlling malaria in Rwanda is to increase the percentage of children under five years of age suffering from malaria that get correct treatment within 24 hours of the onset of symptoms. In 2003, results of a situation analysis conducted in four health districts showed that only 22% of children less than five with malaria had access to treatment within the recommended 24 hours of symptom onset. Furthermore, a meager 2.4% of these children were correctly treated according to national malaria treatment policy. One-third of the mothers/caretakers of these children with fever go for care at a health center (HC), waiting an average of three days before seeking treatment.

The findings of this situation analysis spurred the Integrated National Malaria Control Program (INMCP) to develop a strategy for home-based management of fever (HBM) in 2004. This approach was based on recommendations promulgated by the World Health Organization (WHO).

The strategy was prepared after a review of HBM Program experiences from other countries in the region including Ethiopia, Uganda, Kenya and Burkina Faso, including visits by INMCP staff to see HBM programs in Uganda and Kenya. Previous assessments of the program in Uganda had demonstrated that:

- Sensitization activities and election of drug distributors built acceptance of the program by the communities

- Homapak®, prepackaged chloroquine and sulfadoxine-pyrimethamine (SP), improved correct dosing and treatment completion
- Knowledge of appropriate case management of children with fever was very high among drug distributors.

Uganda's program, though, was not without problems. Most importantly, significant stock-outs of medicines at the community level compromised the credibility of the community drug distributors in some communities. In addition, there was little evidence of community exposure to IEC materials or initiatives that would help clients follow the recommended treatment and care for their children.

From March 2003 to October 2004, a planning process was led by the INMCP to build consensus and design the HBM strategy, which included:

- March to July 2003: Planning Meeting with child survival program partners
- August 2003: Travel to Uganda and Kenya for sharing experiences on HBM
- December 2003: Elaboration of HBM strategic plan and implementation guidelines in collaboration with WHO/AFRO. The plan developed would utilize trained community volunteers, called Distributeurs, to provide pre-packaged treatment or referral to children with fever.
- May 2004: Adoption of HBM strategic plan and implementation guidelines by Ministry of Health (MOH) and Health District teams.
- May 2004: Establishment of HBM Working Group to:
 - Finalize the HBM strategic plan and implementation guidelines
 - Develop training manuals and management tools
 - Design the Distributeurs' kit (figure 2)
 - Outline an implementation agenda for the new HBM Program
- Selection of six pilot health districts, based on malaria epidemiology and availability of partners to support community interventions. In three districts, implementation would be overseen by an NGO partner agency (i.e., Kibogora- World Relief, Kibilizi-Concern Worldwide, Kirehe- IRC) and the remaining three (Remera Rukoma, Gitwe, and Nyanza) would be overseen by the INMCP.
- June to October 2004: situation analysis in five of six health districts: Nyanza, Gitwe, Kibilizi, Kirehe and Kibogora.

Figure 2. Distributeur's Kit



B. Implementation of the HBM Strategy

In each district, a subset of HCs was selected for pilot implementation. An extensive sensitization campaign was carried out involving communities and their leaders, health facility staff, and district and provincial health teams. To instill ownership of the program, all Distributeurs were elected by their respective communities, with 2 to 4 Distributeurs per cell (20-50 households). Distributeurs are volunteer workers and not financially compensated, except for small travel and training stipends. Distributeurs living in the catchment area of one HC are grouped in an “Association”.

Blister packed Amodiaquine plus SP (AQ/SP) (figure 3) with written instructions in Kinyarwanda for two age ranges (6 to 35 months and 3 to 5 years) were developed to facilitate dispensing and improve adherence. These blister packs had different coloring for each age range: red for 6 to 35 months and yellow for 3 and 5 years. Medicines are provided free to HCs and sold for 50 Frw to Distributeurs who charged their clients the same amount. All funds collected by Distributeurs are used to replenish their drugs stocks at the HCs. All or part of the funds collected by the HC are then to be put in the association bank account, which is to be used to finance income generating projects for the Distributeurs association.

Figure 3. Age-specific blister-packed Amodiaquine plus Sulfadoxine/Pyrimethamine used for home-based management of fever

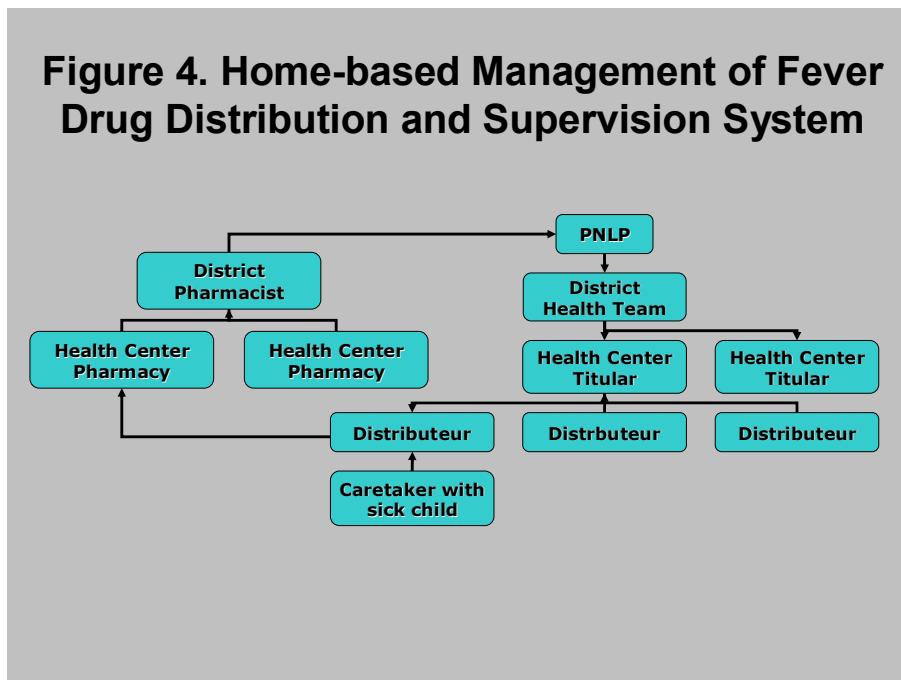


Health district staff (supervisors and 2 hospital nurses) and at least 2 staff members per HC were trained as trainers. They then trained the Distributeur trainees in signs and symptoms of simple malaria and other common childhood illnesses, as well as how to identify danger signs that require referral to a health facility. Trainees who passed a final exam were certified as Distributeurs and given the kits and blister-packed AQ/SP.

Distribution of medicines was done through a “pull” system, whereby Distributeurs traveled to the HC to replenish stocks, HCs to the District, and Districts to the Central Stores (CAMERWA), which is in charge of drug procurement (Figure 4). Financing for the drugs was provided by the INMCP.

A multi-level supervision plan was developed where the districts would be supervised by the INMCP and the HCs by the districts. Designated HC staff (the HBM focal point) were to supervise the Distributeurs. Supervision focused on ensuring quality of patient care and

pharmaceutical management. Distributeurs were to be supervised on-site. In addition, monthly meetings of Distributeurs were to be held at the sector level.



Standardized data collection forms were deployed at all levels (In French at the District and HC levels, and in Kinyarwanda at the community level), including forms for reporting consumption of medicines, numbers of cases treated, numbers of referrals, and funds collected. Each month, Distributeurs were to send a report to the HC. After verification by the HBM focal point at the HC, combined reports were to be sent to the District, then to the INMCP.

C. Rationale and Goals for this Assessment

After two years of implementation in six districts, the INMCP requested technical support from USAID's BASICS Project and RPM Plus Program to conduct an interim external evaluation of the HBM Program to assess:

- Effects on case management of fever in children less than 5 year of age, including treatment seeking behavior
- Added value of this program to malaria control in Rwanda
- Lessons learned from implementation that could inform further scaling-up and out of the program
- Major challenges encountered during implementation and the approaches used to address them

This assessment was carried out in the context of the recent introduction of Artemisinin-based combination therapy (ACT), specifically Coartem®, to replace AQ/SP as first-line malaria treatment at health facilities. As the INMCP planned the pilot introduction of this new treatment at community-level, they hoped to identify areas where further system strengthening was needed, including pharmaceutical management, prior to the roll out of ACTs at the community level.

Similarly, discussions were already well advanced within the MOH to determine the feasibility and inputs required for providing case management for other childhood illnesses (e.g. diarrhea, acute respiratory infection, etc.) within the IMCI strategy. Community-based management of diarrhea had already been introduced in one district on a pilot basis.

Lastly, the INMCP wanted to identify other sources of treatment, both formal and informal, which caretakers used for care of sick children, especially for fever, and the appropriateness and quality of the treatments provided.

The Terms of Reference developed by the INMCP for this assessment posed five key questions to the evaluation team:

1. Are distributors of medicines able to provide the quality of services expected from them by the people?
2. Is there evidence that caretakers are changing their treatment seeking practices and/or improving adherence with recommended/prescribed treatment?
3. What lessons learned from this pilot implementation could be used to improve community drug distributors' performance and inform further scaling up and out of home-based management of malaria?
4. What other sources of treatment are being sought out by caretakers of children with fever and what types of treatment are being provided? Why do caretakers choose one source of treatment over another?
5. What concrete recommendations should be given to decision-makers for a better home-based management of fever/malaria in Rwanda in the context of community IMCI, use of Coartem® as the first-line antimalarial and the introduction of rapid diagnostic tests in communities for malaria diagnosis?

II. METHODS

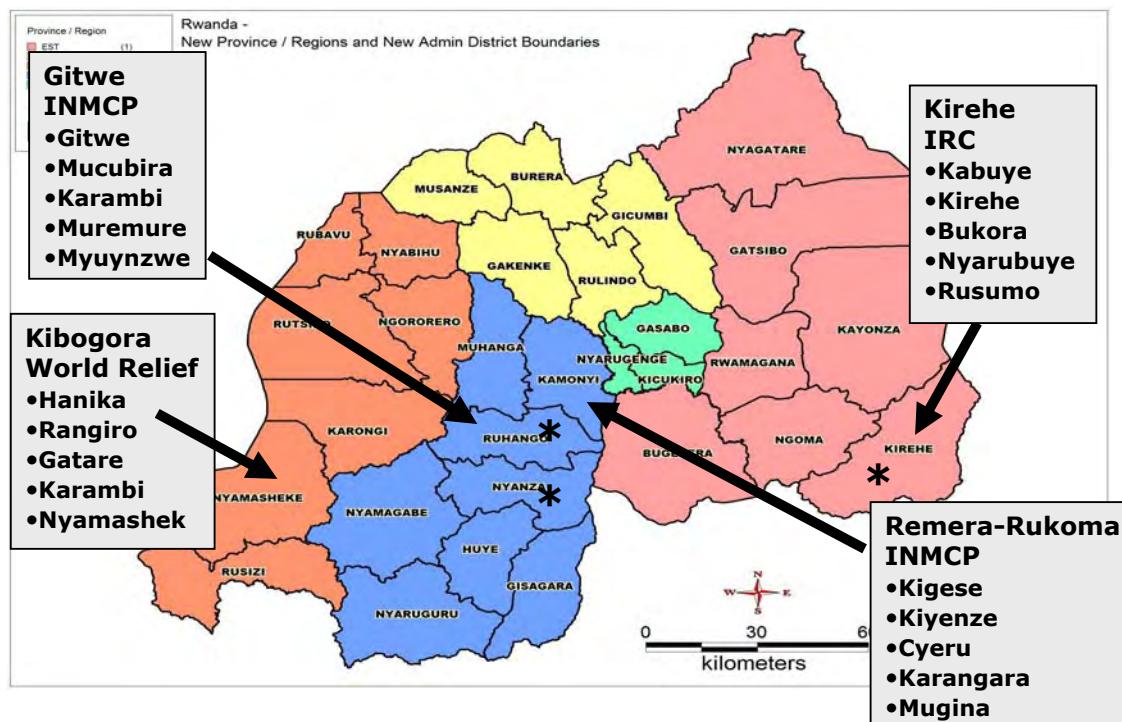
A. Assessment Components

A five-part methodology was developed to address the Terms of Reference, as follows:

1. Review of existing information, including surveillance and service data and reports of previous evaluations from partner agencies and INMCP.
2. Assessment of community practices, perceptions, and opinions, related to the HBM Program.
3. Evaluation of the knowledge, practices, and opinions of health workers, including Distributeurs and HC and district health staff.
4. Assessment of the pharmaceutical management and management information systems.
5. Investigation of other potential care providers, including traditional healers, TBAs, and formal and informal private drug sellers.

In collaboration with the INMCP, Components 1-3 would be overseen by the BASICS evaluation team (Barat and Schubert). Components 4 and 5 would be supervised by the RPM Plus team (Briggs and Senauer).

Figure 5. Administrative districts of Rwanda with four study districts and five selected health centers per district designated



* Pilot implementation districts that are targeted for introduction of ACTs in January

B. Sampling and Site Selection

Four of the six pilot districts were chosen by the INMCP for this assessment (figure 5). In two of the four districts, implementation was supported by NGO partners (Kirehe: IRC, and Kibogora: World Relief). The other two districts (Gitwe and Remera Rukoma) had been supported directly by the INMCP. The INMCP chose these four districts in order to determine whether there were differences in the effectiveness of program implementation in NGO-supported versus INMCP-supported districts.

For the purposes of this assessment, all HCs involved in the pilot implementation in each district were stratified into “peri-urban/near rural” or “remote rural” based on their proximity to the main roads and district hospitals. This stratification was intended to identify whether distance from district supervision and the district pharmacy had an effect on supply of medicines, frequency of supervision, and the quality of services provided.

In each district, two “peri-urban/near rural” and three “remote rural” HCs were randomly chosen for this evaluation by drawing names from a hat. The BASICS assessment team with INMCP visited one “peri-urban/near rural” and one “remote rural” HC in each district (Components 2 and 3). The remaining one “peri-urban/near rural and two “remote rural” HCs were visited by the RPM Plus assessment team with INMCP (Components 4 and 5). In the case of the evaluation of the HC staff, a subset of questions from Components 3 and 4 were administered by both the BASICS/INMCP and RPM Plus/INMCP teams (i.e., in all 20 HCs assessed).

Data collection for this assessment was carried out from October 26 to November 6, 2006. Preliminary findings were presented to the INMCP and key stakeholders on Nov. 10, 2006.

C. Methodology

i. Record review

Key stakeholders, including implementing partner NGOs and the INMCP, were contacted to request copies of any data that had been collected or reports that had been written with relevance to the HBM Program. All reports and data collected were reviewed by the assessment team to extract information on the effect/impact of the HBM Program, lessons learned during program implementation, and program successes and challenges.

Selected service data were collected from HC records. In particular, the number of malaria cases diagnosed by month for the year just preceding and just after implementation of HBM.

In addition, semi-structured, informal interviews were conducted with available staff from partner NGOs (World Relief, Concern Worldwide) and projects (Twubakane) to collect additional information on the HBM program as well as ideas for needed changes and challenges for the program going forward.

ii. Community assessment

One cell was randomly selected from the catchment area of each of the two HCs per district that were involved in the community assessment component. In each cell focus group discussions (FGDs) were conducted with three groups of community members: mothers of children 6 months to 5 years of age, fathers of children in the same age group, and grandmothers with responsibility for one or more children under five.

FGDs consisted of four to eight community members and were conducted in the local language (Kinyarwanda) by eight locally-recruited assessment staff, the majority of whom had prior experience in qualitative research and had been recommended to the INMCP by partner organizations. Staff were fluent in both Kinyarwanda and French and participated in a three-day training (including pretesting) prior to data collection. Three assessment staff participated in each FGD; one served as facilitator and two as note-takers (on occasion, only

one note-taker was used due to limitations of research staff). In almost all instances, after receiving permission from the group, FGDs were tape recorded to later double check the accuracy of notes taken in Kinyarwanda. Notes were then transcribed into French by the assessment staff followed by a synthesis of findings and documentation of direct quotes in English for this report.

Standardized moderator guides were used by the facilitator to lead the FGDs. Guides were originally developed in English, translated to French, and then into Kinyarwanda by INMCP staff. A pilot test of the guides was carried out at the Kigese HC in Remera-Rukoma District. Because only minor modifications were required in the instruments, it was decided to include the data from Kigese in the final analysis. The guides were finalized in Kinyarwanda. (French versions of the moderator guides are included with this report in the Annex 1).

In each FGD, open-ended questions were used to lead the participants through a series of discussion topics. Topics included:

- Knowledge and beliefs about childhood illness
- Preferred treatments of childhood illness and sources
- How medicines are given
- Satisfaction with the Distributeurs and their services
- Preferred sources of health information
- Questions and suggestions

In addition to the FGDs, in-depth individual interviews were carried out with village heads of each village on the same topics that were covered in the focus groups.

iii. Health worker evaluation

Distributeurs, HC staff, and district health staff were included in the health worker evaluation component of the assessment. FGDs with Distributeurs were conducted in the same villages in which the community members were assessed. Procedures and topics covered were:

- Childhood illnesses: Causes and prevention
- Program start-up
- Routine activities
- Other community needs
- Impressions of and challenges for the program
- Sources of information
- Community and HC support
- Recommendations for strengthening the program,

Distributeurs participating in the pharmaceutical management component underwent individual interviews to assess personal knowledge of appropriate management of sick children. These Distributeurs were given a series of typical clinical scenarios and asked what they would do if they saw a child with those symptoms.

The HC center titulaire or designee and the head of the District Health Team underwent in-depth structured interviews, using a mix of closed and open-ended questions, to assess:

- Knowledge of the diagnosis and treatment of childhood illnesses
- Perceived roles in the HBM program
- Opinions on the services provided by Distributeurs
- Perceived effect/impact of the HBM program
- Lessons learned and challenges identified from implementation of the HBM program
- Questions and suggestions about the HBM program

iv. Pharmaceutical management system assessment

In each of the four districts, three randomly selected HCs, different from those that participated in Components 2 and 3, were involved in this component. In addition, some pharmaceutical management questions were added to the health worker interviews to increase the sample size from 14 to 21. Two Distributeurs were randomly selected from each of the three HC catchment areas with one Distributeur randomly chosen from a location near to the HC and one from a location far away from the facility.

Draft data collection instruments were developed based on methodology from two RPM Plus assessment tools that have been used in several countries: (1) the drug management for childhood illness (DMCI) tool and (2) the community drug management for childhood illness (C-DMCI) tool. A combination of interviews with key personnel, review of records, and direct observation were used to collect the necessary information.

These instruments were used in all district pharmacies, HCs, and Distributeur sites. They were designed to capture both quantitative and qualitative information on the:

- Availability and use of key antimalarial medicines and other medicines relevant to child health
- State of the pharmaceutical management infrastructure
- Appropriateness of pharmaceutical stock management and record keeping
- Knowledge and practices of Distributeurs

Additionally, samples of antimalarials were taken from the public and private sector for quality testing. Where possible an Artemisinin combination was obtained, if not available, an artemisinin-based monotherapy, or quinine, SP or amodiaquine were be obtained.

Sixteen pharmacists were recruited as data collectors through the Rwandan Association of Pharmacists and completed a three-day training course in data collection methods and instruments. Kibilizi was chosen for the pre-testing of the data collection instruments, but as the data collection instruments did not change substantially as a result of the pre-test, the smaller pre-test sample from Kibilizi was also included in the final analysis.

Teams of four data collectors visited the district pharmacy, three HCs, and six randomly selected Distributeurs in each of the four assessment districts over a five day period. Data collection by a different team was conducted in each district concurrently. Data collectors determined the level of comfort of the respondents in language and applied the instruments in French, English or Kinyarwanda accordingly. In some cases, the HC titulaire responded to all the questions; in other cases, the storekeeper responded to questions specifically related to the pharmacy.

v. Investigation of other providers

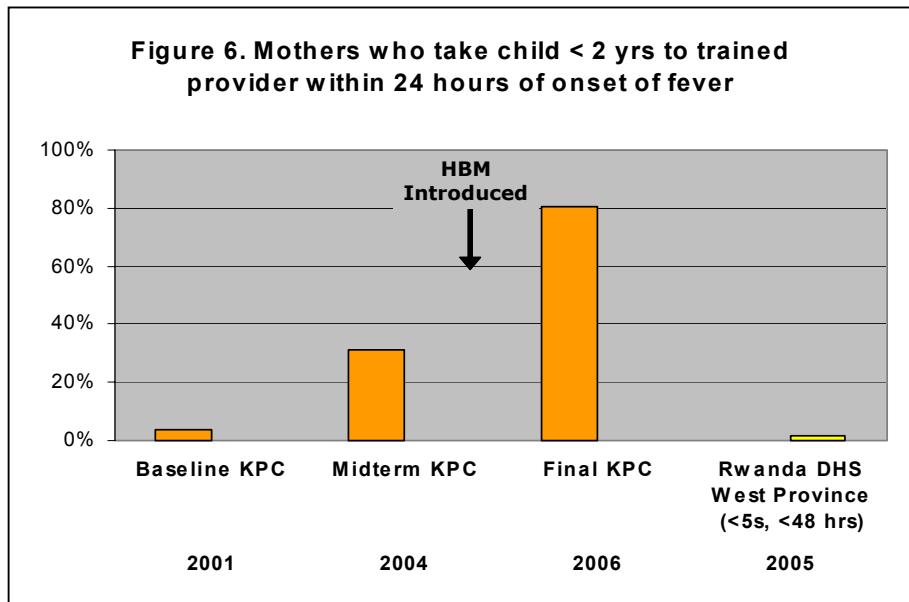
For this component, the aim was to include as many private sector providers (i.e. pharmacies, dispensaries, comptoir pharmaceutiques and informal vendors) as could be located by the data collectors in each of the districts. The same data collectors as mentioned in Component 4 carried out the interviews for this component. Information on the location of private outlets was gathered from the focus group discussions with community members as well as informal interviews with community members, HC staff, and Distributeurs.

Data collection instruments were developed, pre-tested, and applied in the same manner and using the same data collection teams as in Component 4. Data collectors interviewed private drug sellers to assess the:

- Availability of key antimalarial medicines and other medicines relevant to child health
- Knowledge of appropriate medicines and dosing for treatment of malaria and other common childhood illnesses

“Mystery Client” observations were carried out in most outlets to assess practices of the private drug sellers. With this methodology, local community members were recruited by the assessment team and given a standard script to use with targeted drug sellers. The mystery client then reported back to the data collectors on what the drug seller asked of the client, what was prescribed/dispensed, and any advice or information provided by the seller to the client. In this case, the mystery client was instructed to tell the drug seller that they had a *“two year old child at home with fever for 2 days.”* If asked, and only if asked, they were to report that the child had not yet been given any medicines for this illness and had no other symptoms. Any antimalarial medicines purchased in the simulated client assessments were also sent for quality testing.

III. FINDINGS



A. Existing Data

i. Reports from partner agencies

Data collected during the final evaluation of previous USAID-supported child survival Projects in Rwanda show increases in the percentage of caretakers seeking care for children with fever within 24 hours of the onset. Data from the World Relief project in Kibogora Health District, for example, demonstrated that care-seeking within 24 hours more than doubled between 2004 and 2006, to approximately 80% (Figure 6, courtesy of Jean Capps). Similarly, 81% to 97% of children managed by Distributeurs in Kibilizi District were brought for treatment to the Distributeur within 24 hours of symptom onset (Figure 7, Courtesy of Gisagara District/Concern Worldwide).

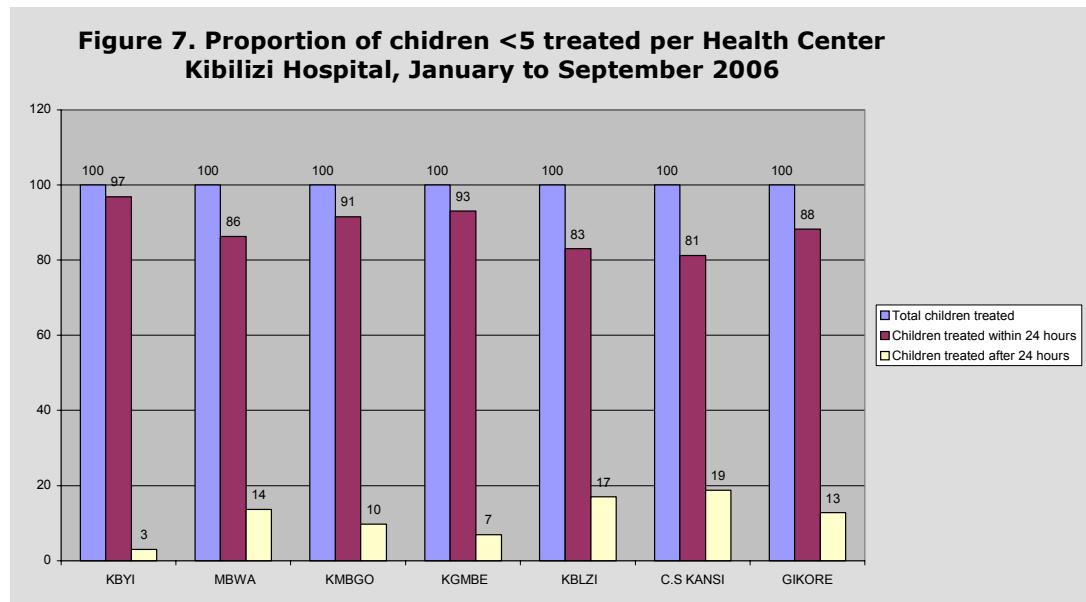
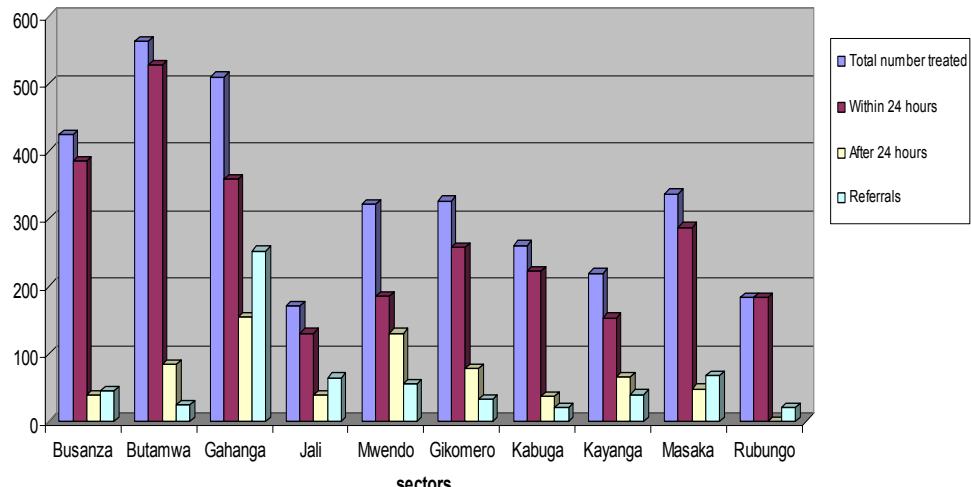
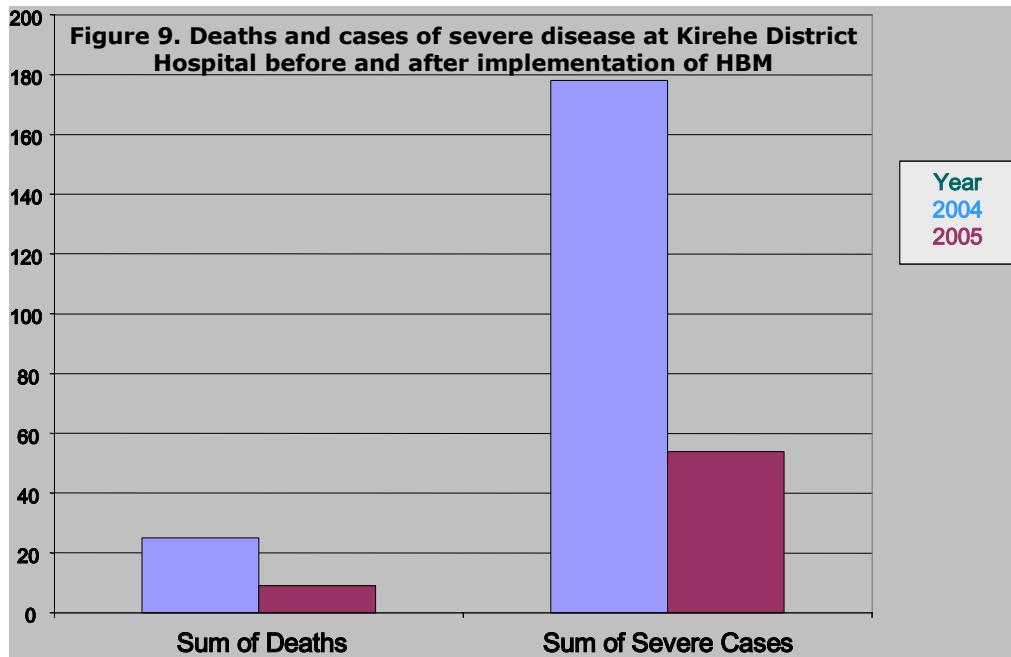


Figure 8. Preliminary data on children <5 years treated for fever/malaria by 662 distributors, Ville de Kigali, May to October 2006

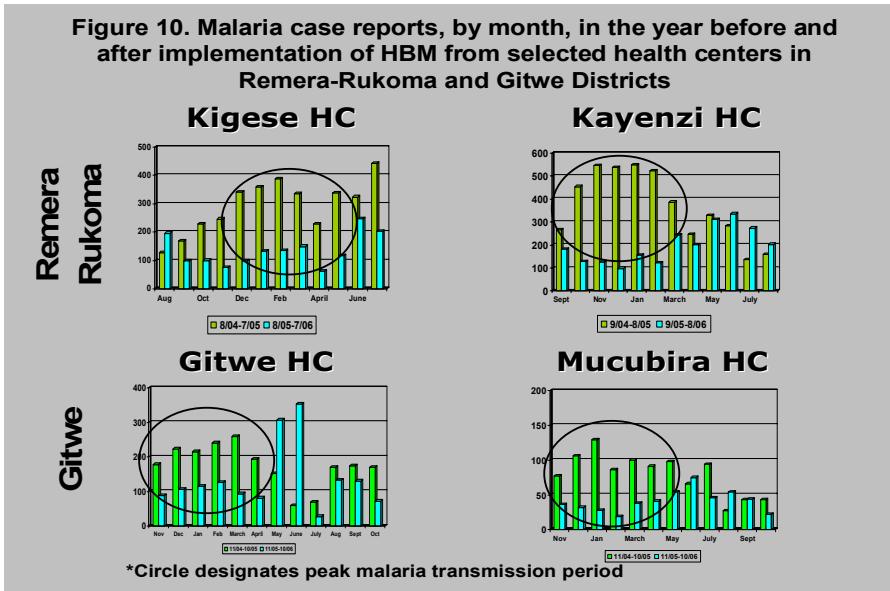


In the three districts that make up Ville de Kigali, where implementation began only six months ago, preliminary data collected by Distributeurs indicates that from 58% to 94% of caretakers sought care within 24 hours of the onset of fever (Figure 8). In addition to improved care-seeking, Kirehe District Hospital saw a dramatic drop in severe malaria cases and also a drop in deaths attributed to malaria (Figure 9, Courtesy of IRC).



ii. Health center data

Malaria case reports were collected by month from selected HCs for the year immediately preceding and the year of implementation of HBM. Of 15 HCs, 10 demonstrated a noticeable reduction in the number of malaria cases diagnosed during the months of January to March (peak malaria transmission season) from the years pre- and post-implementation of HBM. Examples of such reductions are seen in Figure 10 for four HCs in Remera Rukoma and Gitwe health districts. Two of the remaining five HCs showed small reductions post-implementation, one had no consistent pattern, and two had increased numbers of cases.



Although many factors likely contributed to this drop in malaria cases, it would appear that, at a minimum, that caretakers are preferentially seeking care from Distributeurs. It is also possible that there has been a drop in malaria morbidity in the population.

ii. INMCP data

Service data collected by the INMCP from 2004 to 2006 shows high percentages of children <5 years treated for malaria within 24 hours, ranging from 77% in Kirehe to 91% in Kibogora (Figure 11). In each district, cure rates from treatment was 97% or higher (Figure 12).

Figure 11. Total malaria cases treated and those treated within and after 24 hours of onset of symptoms in twelve HBM pilot districts, Rwanda, 2004 to 2006

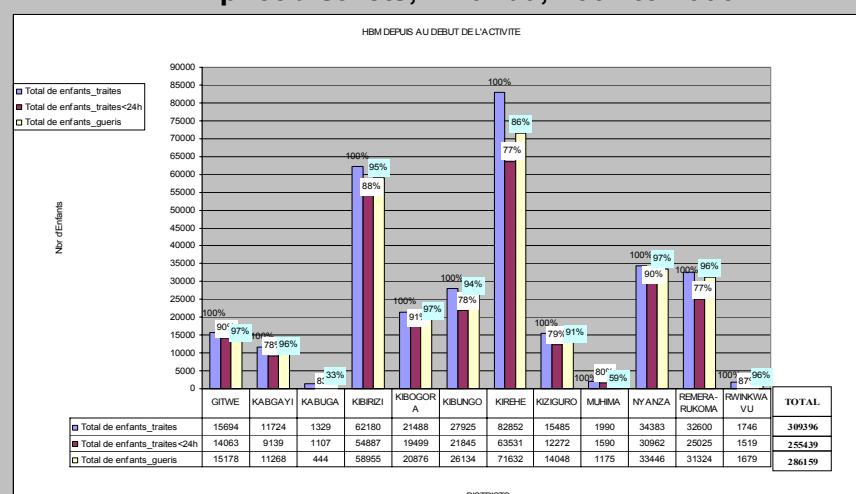


Figure 12. Children treated for malaria compared with those cured in six HBM pilot districts, January to August 2006

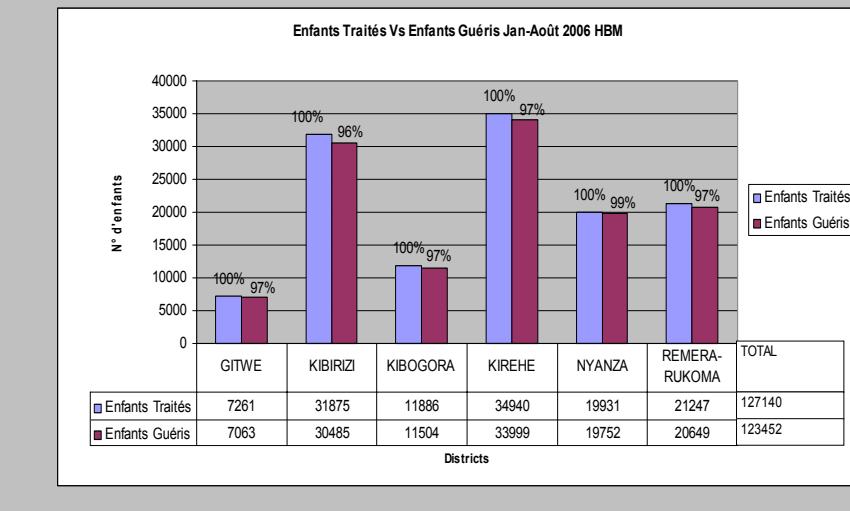
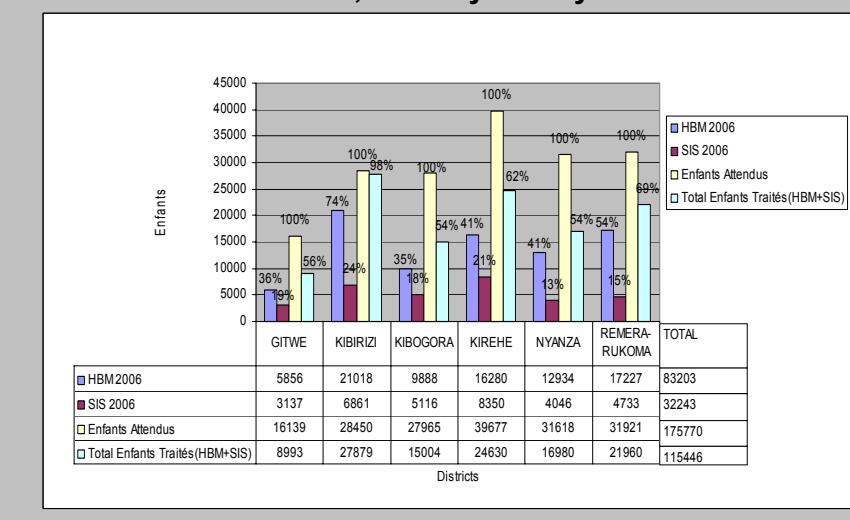


Figure 13 demonstrates that Distributeurs now treat anywhere from 2 times to more than 3.5 times the number of children treated for malaria at health facilities.

Figure 13. Malaria cases in children <5 years reported by Distributeurs and by health facilities in 6 HBM Pilot Districts, January to July 2006



iii. Interviews with partner agencies

Interviews conducted with implementing partners revealed a number of lessons learned from the pilot implementation phase. Among these factors were:

- Involvement of political leaders and communities at an early stage created a sense of ownership. In particular, allowing communities to elect the person they wanted to be their Distributeur enabled communities to choose the person they felt was most competent to take on that responsibility. As a result, community members had no

initial hesitation seeking care from their Distributeurs, since they trusted their judgement already.

- The use of similar packaging for the medicines provided by Distributeurs to those dispensed at health facilities built community members trust that the community-based services were of comparable quality to those of the health facility.
- Establishing a linkage between Distributeurs and HCs, through the use of referral forms promoted the use of Distributeurs, particularly since caretakers with referral forms hopped the queue at the HC.
- In some localities, Distributeurs were organized into “associations”. A small portion of the proceeds of the sales of treatment packs was contributed by the HCs into these associations. The funds were intended to be used to establish small micro-credit schemes. In localities where associations had been established, retention rates of Distributeurs improved.
- All those interviewed believed that the HBM program provided a strong foundation on which other interventions could be built, including Community IMCI and community-based case management of ARI and diarrhea.

Interviewees also identified a number of challenges encountered during the pilot phase of implementation, including:

- Although the experience with referrals was generally positive, the lack of integration of the Distributeurs into the mutuelles meant that those who were referred by Distributeurs after receiving initial treatment in the community would have to pay again at the health facility level.
- For those families not enrolled in the mutuelle, the cost of services at the health facility put up a significant barrier to referral. Caretakers would, therefore, use other less expensive sources of treatment (e.g. traditional healers and private drug sellers). In some locations, caretakers quickly learned what they needed to say to the Distributeur in order to be prescribed the antimalarial treatment and might emphasize some symptoms while hiding others (figuring any treatment to be better than none at all).
- With the recent introduction of Coartem® as first-line treatment at health facility level, some caretakers were questioning why AQ/SP was still being dispensed at the community level.
- Lack of “motivation” (i.e., compensation) for Distributeurs was identified by all those interviewed as the greatest potential barrier to the long-term sustainability of the HBM program. Although retention has not been a major problem in most places, except urban Kigali, all were concerned that it would become a growing problem as the program matured. Many of those interviewed, though, felt that there were methods to motivate volunteers that did not require direct financial compensation. They reported that what was most often requested by Distributeurs were actually tools required for carrying out their responsibilities (e.g., bicycles, kerosene or torches, and umbrellas) or non-financial compensation, such as exemption from community patrol or community cleaning day.

B. Community Assessment

i. Knowledge and beliefs about childhood illnesses

The community assessment revealed that malaria continues to be seen as a major threat to child health in Rwanda. Other important problems mentioned in all areas sampled were intestinal worms, diarrhea, fever, coughs, and sometimes pneumonia. Anemia was described as a dangerous condition for children in Gitwe.

Malaria was understood to be caused by the bite of a mosquito and the best prevention was to sleep under a bed net, keep areas around the house free of brush and stagnant water and to close house windows early. Fathers in Remera-Rukoma say that prompt treatment for malaria is also important. Diarrhea and intestinal worms are understood to be caused by dirty drinking water, poor hygiene and bad food. In several areas, people said that poverty and poor diet were root causes of many childhood illnesses.

ii. Preferred treatments and sources

Not all fever is associated with malaria and different symptoms will trigger different responses for treatment. Fever associated with poisoning is distinct and was described in detail by caretakers in Kibogora. Poisoning was also indicated as a problem in Remera-Rukoma. Caretakers in Gitwe and Remera-Rukoma say that intestinal worms can also provoke fever. Traditional medicine is normally the preferred treatment choice in these cases.

Other than these particular illnesses, when a child has a fever the first reflex for most caretakers is to head to the local Distributeur for treatment. Reasons for choosing the Distributeur over other available treatment options, including the pharmacy, HC, or traditional healer, were numerous and consistent across most of the areas sampled. Many discussion groups emphasized that now that they had the Distributeurs there was no need to delay seeking treatment. Some said that there is no longer any use for “magendu”¹ in their area. Examples of advantages given by respondent for using the Distributeurs are as follows:

- Treatment available day and night
- Convenient
- Reasonable price, affordable
- “Credit” or “debts” given
- Quick service
- No travel necessary and thus no travel costs or time wasted
- Medicines are effective
- Trusted source of care
- Individuals well known and respected by community
- Give good advice on caring for children
- Trained well to do what they do

Special circumstances in Gitwe

Gitwe was an exception, however. Traditional medicine was described as the preferred source of treatment for many illnesses, including fever. The HC was the second choice. People will also go to the pharmacy if they want a particular medicine. Part of the reasoning here may be that fever in Gitwe is often associated with intestinal worms, which is treated with either traditional medicine or Vermox®. Communities have also heard that there is a newer medicine available for malaria that they can get through the HC. So, if they can, they will bypass the Distributeur and go straight to where they can get the treatment they want. Still others in Gitwe say they prefer the HC where you can get an exam before treatment. Now that people are becoming members of the mutuelle this is more affordable. Some parents suggested that the Distributeurs needed more training and materials, such as thermometers and stethoscopes so that they could examine a child before treatment.

In addition to fever that is associated with intestinal worms, traditional medicine is also used to treat other simple fevers and fever with non-bloody diarrhea. Fever with other symptoms—such as bloody diarrhea, watery diarrhea, convulsions, weakness and anemia—on the other hand, are conditions that people recognize require treatment at the HC. Grandmothers in the area say that even if it costs more and they need to borrow money it's

¹ Roughly translated as “people who give medicines out in secret”, these are informal drug vendors, i.e. unlicensed sellers of medicines.

worth it, as long as the child gets better. Still others prefer to go for treatment where they can pay in kind. Several said they will sometimes wait to see if the child will get better on their own.

Some fathers said that if there was fever they would go to the Distributeur if it happened at night. One added, though:

"There are times when we arrange to treat with medicinal plants at home when there is fever caused by intestinal worms and malaria. There are children here that are used to taking traditional medicine since they were little."

Custom and traditional practices, perceived effectiveness of different treatment options, and being able to pay in kind are some of the issues driving the diverse way young children with fever are being cared for in Gitwe.

iii. Satisfaction with the Distributeurs and their services

All of the areas sampled were satisfied with the election process, even those places where mothers and/or grandmothers may not have actively participated. Distributeurs were nominated by the community, based on criteria including integrity, hard working, personal cleanliness, self respect, and not being prone to drinking in excess. Following nomination, community members voted by standing "in line" behind the candidate they thought could do the best job. Once voted in and trained, the Distributeurs were presented and their responsibilities explained during public meetings to the community with local authorities. In certain areas, house to house visits were also conducted to announce the new services.

It is clear that the population is pleased by the work being done by the Distributeurs. Communities recognize that, as volunteers, the Distributeurs work hard and give a lot of themselves to ensure the well being of their children. As previously described, in most areas they are the first choice for treatment when a child is ill with fever. Community members also believe that the Distributeurs are satisfied with the work they have been trained to do and the services they provide. Words like *happy, confident, proud* and *motivated* were among the many positive terms used to describe the Distributeurs and their work. Many fathers, in particular, appreciate the awareness building that they do with the communities on child health.

In every group, respondents emphasized that the Distributeurs never asked for anything except the official 50 francs for treatment. Some mothers admitted that they didn't understand why the Distributeurs were so happy, "since they didn't get anything." Others suggested that they were motivated by the trainings when they get "agahimbazamusky"².

A Distributeur from Remera-Rukoma who is also a traditional birth attendant and healer explained why she was motivated to do the work she did:

"If you've decided to be responsible for something like this you have to make sacrifices to fulfill your duties even if someone comes to you while you're in the field planting and you have to go treat the child. The health center helps us since they give us suggestions. The population helps us since they respect us and they listen to us when we talk and follow what we recommend."

Without exception, people would like to see the Distributeurs treating a wider range of illnesses, including intestinal worms, diarrhea and cough. Many would also like them to be able to treat certain adult illnesses and older children, "since we also have problems and live far from the HC." Some mentioned that they would like it if the Distributeurs could be allowed to treat simple wounds. Community members in Gitwe specified that it would be useful if the Distributeurs were trained to distribute the "new treatment."

² Rough translation is "money or other things that motivate."

iv. How medicines are given

Usually both parents participate in determining if a sick child needs treatment. If the illness is “simple” the mother will take the child for care. On the other hand, if the illness is considered serious, both parents will go with the child to the hospital or HC. When a grandmother has a sick child in her care, she does her best to make sure the child gets the treatment needed, even if she has to borrow money from neighbors. In almost all areas, the importance of avoiding delays when seeking care for young children with fever as well as not interrupting treatment was well understood. As a mother from Gataagara explained:

“There was one mother who stopped giving the medicine and child got sick again. At the HC they said that you should never stop giving the medicine before it’s finished.”

In all areas, groups explained that medicine is normally given to the sick child by the one who was given the instructions from the nurse or Distributeur. In general, parents and grandmothers understand the importance of giving medicine as instructed and not sharing it with others. Even if there are difficulties understanding the instructions, which are sometimes written on the envelopes or packages with medicines, caretakers say there is always someone nearby that can be asked for help.

Many caretakers in Gitwe, however, said that they did not always seek timely treatment for their children with fever and sometimes they stop giving treatment. As one mother in Cyerzo stated:

“We follow the advice for giving medicine but there are times when you give the medicine and you see that the child begins to play so you stop giving it or you give it to another child.”

Grandmothers say that they never stop treatment or share it with anyone else.

In all areas, parents and grandmothers report that there is always a way to get medicine, either through the Distributeur, HC, or a pharmacy.

“With the Distributeurs there is always medicine since there is always at least one in the community who has what is needed and can be contacted for help.”

Because of this, even though an individual Distributeur may experience a stock-out, collectively there is always medicine available. In some areas, grandmothers and mothers mentioned that even if they didn't have money they would never have to go without medicine because the Distributeurs would always be there to help and would let them return later to pay.

In almost all districts, respondents say they trust the medicines that the Distributeurs have to offer.

“As soon as a child has a fever we take them to the distributor that's closest to us. They give us the preferred medicine to treat the child.” (Kigese grandmother).

“We accept whatever medicine they tell us to give since we don't know medicines.” (Kayenzi/Ntwali Father)

In Gitwe, however, caretakers say they prefer the newer malaria treatment that is now available at the HC to the medicine currently available through the Distributeurs.

v. Preferred source of health information

For many mothers, grandmothers, and fathers, the HC is reported to be one of the best and most credible sources of information on child care “because the personnel have been trained”. Often people say the advice they receive during a consultation is particularly useful.

Other credible sources mentioned by respondents were the Distributeurs, especially during meetings and consultations. In some areas, such as Gitwe, local authorities were described to be a good and reliable source. Men often described meetings and community work as opportunities to learn about child health.

Respondents, especially grandmothers, recalled seeing posters and could remember the images they saw; mothers were less likely to remember. Respondents reported seeing posters on polio and bed net use. One respondent saw a poster on HIV/AIDS. Other images that respondents recall seeing were small pictures of children on packages of medicine and bed nets. Some have seen a small booklet on malaria with images of sick and healthy children. Relatively few have seen print materials on child health, however.

Radio is consistently mentioned as an important information source for men, sometimes mothers and often grandmothers. Bitega mothers specified that they would like information on malaria to be aired after the news at 7PM. Many say that they would be more likely to listen to the radio if they had one, although some say they listen at a neighbor's. Specific radio messages recalled by the various groups included:

1. Not to seek treatment from individuals who treat illnesses in hiding (magendu)
2. Signs that a child may have malaria and the importance of taking the child immediately to the HC or nearest nurse for treatment
3. If you don't get the right treatment for your child, the child could die.

vi. Questions and suggestions

Many respondents said that people want bed nets. Fathers in one area further explained that they are needed "at a reasonable price." Grandmothers are also interested but are not sure how to get one. As one Kigese grandmother stated:

"Young people who can still give birth can get them, but those of us who are finished can't."

vii. Comments from community leaders

Leaders in all areas sampled reported being satisfied by the program for many of the reasons already described by parents and grandmothers. The cost for treatment is reasonable and mothers no longer have to travel long distances for care when their children have fever.

All say that the Distributeurs are highly motivated. They appreciate that the distributeurs are willing to work with authorities and encourage the population to keep the community clean. In some areas, the Distributeurs are also helping to inform communities about the mutuelle and motivating people to join. One leader made the comment that he thought the Distributeurs were spending too much time at the HC. Another leader, who was also a Distributeur, said that although he thought people appreciated the program, some still preferred going to the HC for care since they liked getting a complete exam before treatment.

Several leaders remarked that the program was contributing to the socio-economic development of the area "since money that families would have spent in the past treating children for malaria could now be used for other things." Some speculated that there were fewer deaths now and cases of serious illness in young children were diminishing. According to one leader:

"This program is a great service to the population because if we can keep our children from getting sick then the region is developing."

Leaders remarked that the involvement of the community and election process in general was very well done. The way communities and leaders were actively engaged in selecting

and voting for the Distributeurs in their area using criteria such as honesty, integrity, self respect, accessibility, personal cleanliness and hard work are among the reasons some believe the program has been as successful as it has been. People were proud to be elected and are satisfied knowing that they are contributing to keeping children safe and well in their communities.

Similar to other respondents and program stakeholders, leaders suggested that it would be helpful if the Distributeurs could be trained to treat other common childhood illnesses, including intestinal worms, coughs and diarrhea. As one leader explained:

"The distributeurs should be given lots of material to help them treat children so they don't have to be transferred to the HC."

Many recommended that it would also be useful if the Distributeurs could be trained to treat older children and adults. Most leaders indicated that they would like to have more Distributeurs working in their area, since the area the volunteers are responsible for is large. There were some, though, who thought they had the right number to cover their needs. Another leader cautioned that if the program were to be expanded or changed in any way in his area that the community should be involved, "since they know one another well." He further suggested that to avoid rivalry between the Health Animators and Distributeurs in his area that all Health Animators should become Distributeurs.

Leaders know that the Distributeurs don't ask for anything from the community—apart from the official 50 francs for treatment—and many believe that what they do comes from the heart. Some say they do a good job and work hard since, "it's like a promotion for them. Through their work they're well regarded by the HC, the local authorities and the population in general." Almost all suggested that the Distributeurs needed to be encouraged or thanked in some way for their work, either through materials, additional training, or other "agahimbazamuskyi."³

Many of the suggestions for encouragement made by leaders for the Distributeurs were practical ones, including supplying batteries to put in their flashlights "in case something came up at night." Umbrellas, boots, and waterproof bags were recommended to help the distributeurs during the rainy season. Additional training, journals and radios were other ideas "so they could continue to increase their knowledge." Many thought that some help with transportation would be appropriate especially to help the distributeurs deliver their monthly reports. In one area leaders also added:

"You should also remember to give something to the authorities so that they work well with the distributeurs."

C. Health Workers

i. *Distributeurs*

a. Childhood illnesses: Causes and prevention

According to the Distributeurs, malaria, intestinal worms and diarrhea are common illnesses. Malaria is considered the most dangerous illness of all for young children. In some areas diarrhea, coughs and "mugiga"⁴ were also described as important problems. Some distributeurs added that they know a child is extremely ill when there is high fever and "the eyes become white." Other signs of illness include fever, no appetite, or the child refuses to breastfeed.

³ Loosely translated as "money or other things that motivate".

⁴ "Mugiga" is described as fever with convulsions

According to the Cyerzo distributeurs, “There are times when fever is due to worms, and it’s common when there is lots of rain.” They also explained:

“It’s hard to know when a child is seriously ill because some of the symptoms might not show up until later. But there are danger signs that go with fever like lethargy, vomiting and when the child won’t breastfeed.”

Causes of malaria and diarrhea are well understood. Malaria is caused by a mosquito and diarrhea and intestinal worms are linked with malnutrition and poor hygiene. Malaria can be prevented by sleeping under a bed net, keeping the area around the house clear of brush and stagnant water, and closing windows early. Diarrhea and intestinal worms can be prevented by good nutrition and proper food preparation, breastfeeding, and keeping dishes clean. In both Gitwe and Remera-Rukoma, Distributeurs said that malaria and fever⁵ can be provoked by intestinal worms.

b. Program start-up

Distributeurs report that before the HBM program started people didn’t really know how to care for children with malaria. They say there were lots of deaths. People started looking for treatment too late or went to the traditional healer or pharmacy for treatment. As one distributeur explained:

“Before the program started there was the “magendu” where people would go for medicine without knowing anything about what they were being treated for. Now parents bring their children to us when they’re ill, since our treatment costs less and they don’t need to go far to get it. It doesn’t take a long time to get treatment like at the HC.”

Across all districts the Distributeurs described a similar process for getting the HBM program started in their area. To begin with, a public meeting was held to introduce the idea and the criteria for being a Distributeur was explained. The Distributeurs were nominated and voted for by the population because people believed they could do the job. They were also chosen based on various personal characteristics including integrity, self respect, personal cleanliness, and ability to participate in trainings.

After the vote, they received training and, once trained, their services were officially announced to the population by the local authorities during public meetings (“gacaca”⁶) and community work days (“umuganda”). As the Kirehe Distributeurs explained:

“We were elected by the people in this area. After we received training we started to work as we were trained to do. We treat 2 to 3 children each week. We are volunteers and don’t receive anything for our work. We do gain knowledge though and the community has confidence in our abilities.”

c. Routine activities

In a number of areas the Distributeurs explained in detail what they do when a sick child is brought to them for care. In brief, the consultation begins by the Distributeur welcoming the caretaker and child who have come for help and telling them the purpose of the consultation. The Distributeur checks for fever by touching the child, and tries to find out if there has been fever for 24 hours or longer. They also try to rule out if there might be another reason for the fever. The child’s age and date of birth are recorded and verified by the vaccination card. As appropriate, medicine is given according to the child’s age and the first dose is given immediately in their presence. If the child vomits within the first 30 minutes after receiving medicine, the dose is given again using a separate packet. The Distributeur advises the

⁵ The terms malaria and fever were sometimes used interchangeably

⁶ Loosely translated as public tribunals

caretaker how the rest of the medicine should be given and reminds them to finish all of the medicine.

Many Distributeurs also explain to the caretaker how to feed the child during illness, not to give other medicines and danger signs that the caretaker should be on the lookout for. The caretaker is advised to come back if the child's condition worsens so that a referral can be arranged.

Distributeurs say that children are referred to the HC when there is coughing and vomiting, or if the child is weak, loses consciousness, or will not drink or eat. When a referral is made, a transfer slip is prepared and given to the caretaker to present at the HC. The Distributeur also reminds the caretaker to be alert for the danger signs during the transfer.

Several of the Distributeurs explained that they always had cups and boiled water available to help give the first dose of medicine. In some places, Distributeurs say they treat the water with "Sur Eau". Several of the Distributeurs explained that they always advise caretakers that the child should finish all the medicine given and not to share it with others. Gitwe Distributeurs said they also advised caretakers about possible side effects. Many Distributeurs follow up with home visits to be certain that there haven't been any problems and that medicine is being given correctly. On average, Distributeurs receive 2 -3 children a week (unless there's an epidemic) although several said there are times of the year when they see fewer. Other routine activities described included filling out forms and completing and turning in reports at the HC.

Distributeurs report that there are never stock-outs in the community because, if someone runs short, there is always another Distributeur in the area that has the medicine needed. The cost for treatment is always 50 francs, which goes into an association fund for the Distributeurs.

d. Other community needs

Communities and Distributeurs in all districts that were sampled are interested in having better access to treatment for intestinal worms, diarrhea and coughs.⁷ Almost all are also interested in being able to provide certain treatments for adults. All of the Distributeurs indicated that they would need to be trained, however, before they would be able to provide treatment for anything beyond their current responsibilities. In Gitwe, Distributeurs know that children with fever are sometimes not brought to them because the parents are aware of a newer medicine for malaria that is available at the HC. Many Distributeurs indicated that they were interested in being able to stock the "new treatment" and wanted training. Offering a wider range of basic medicines through the Distributeurs will be an important public health service to communities because despite the fact that the mutuelles have greatly reduced the cost of health care, transportation can still be a barrier to seeking care.

e. Impressions of HBM and challenges for this program

In almost all of the areas sampled, Distributeurs said they thought the program was going well and were proud to be a part of it. Some had noticed a drop in the number of severe and complicated cases of malaria in their area and even child deaths. Others mentioned that even though the work was hard they enjoyed it particularly when they saw a sick child restored to health because of their care.

Some distributeurs said that learning about medicine and how to care for children were personal benefits that they had gained from the program. Some also mentioned the 1000 francs or "insimburamubyizi" and soft drinks that they get during training as encouragement for their work. On the flip side, however, almost all said that the work can be difficult at times

⁷ Kirhehe distributeurs are currently distributing ORS and zinc. Treatment for intestinal worms was recently introduced.

and that there are moments when it's hard for them to keep up with it and that it demands "total devotion".

"Everything is difficult since we're volunteers. Sometimes we go to the child's home to give the medicine in the night. We need to make our reports. Sometimes we have to get up very early or use our own petrol (for our home lamps). Sometimes we have to help getting a sick child that needs to be referred to the HC. We have to walk three hours to deliver our reports but it is voluntary work so we accept it. We would never abandon our work. We accepted to be volunteers." (Kibogora Distributeur)

Distributeurs in Gitwe said that of all the things they do giving medicine is probably the easiest. For them, everything else is hard, especially recognizing danger signs "since they don't have enough materials" (e.g., thermometers) to know when a child with fever should be referred. They also described filling in forms, turning in reports and explaining to parents how to care for the sick child as difficult tasks. Other matters that make the work harder are when colleagues do things that are not permitted by the program. In one Gitwe area, it was reported that a Distributeur was discovered to be giving out medicines other than the one for fever provided by the program and had to be "chased away" by the other Distributeurs.

f. Sources of information

Sources of information on child health for Distributeurs included meetings, "gacaca", "umuganda", and the HC. Many said they get or would like to get information from the radio, even if they did not currently own one. Some said they had been trained to provide information and that they have educational materials including small booklets that help them. Gitwe Distributeurs mentioned local authorities and church as other good places to get information. In Kibogora, the Distributeurs said they had books on nutrition, malaria and HIV/AIDS that they found helpful and that, "We learn from trainings and books."

g. Community and HC support

Distributeurs at all of the sites sampled reported that they received regular visits from HC staff. In most cases, the visits are two to three times every six months. They also see HC staff when they turn in their reports at the end of the month. Some Gitwe Distributeurs, however, indicated that before decentralization their visits from the HC were more regular and that they could benefit from more contact. As one Distributeur explained:

"Before decentralization the titulaire from the health center would visit us. When he would visit he would look at how we were storing our medicine, hygiene and whether we were using clean water. He would also supervise how we recorded information in our registers."

Another Distributeur from the same area added:

"We meet the agents from the health center each month, but for supervision it was before decentralization that we would meet during meetings and trainings. We could be helped by lots of visits."

In addition to more trainings, educational materials, and help with transportation, other items proposed by Distributeurs to help them with their work included umbrellas, raincoats or boots for the rainy season. Because they are often called on to visit homes in the night some kerosene for home lamps or a flashlight/torch with batteries were suggested by others. A special cup and container for boiled water to be reserved exclusively for children receiving treatment were more suggestions. Mosquito nets, thermometers, and radios "to follow educational programs" were also proposed, as were bicycles.

It is important to note here that although the Distributeurs proposed an impressive array of "wish list" items to the assessment team, they are genuine volunteers at heart and did not at any time indicate that they had to have any of these items to continue their work. All want

additional training so that they can treat other illnesses and distribute the “new medicine” for malaria.

h. Recommendations for strengthening the program

Recommendations from Distributeurs for ways the community could support them included: have the population pay their 50 francs on time, respect the advice they are given, and avoid waiting too long to bring their sick children for treatment because they can help them get better. In Gitwe, Distributeurs suggested that local authorities be trained in child health topics so that they could motivate the population to use their services and other actions to prevent illnesses.

i. Knowledge of case management

To test Distributeurs’ knowledge of appropriate case management of childhood illnesses, 29 Distributeurs were given a series of simple clinical scenarios (e.g., a child 2 years of age with fever and a cough) and asked what they would do if they saw a child with those symptoms. Distributeurs only have three options for case management: treat with AQ/SP blister packs, refer to the HC, or treat and refer (although the last option is not recommended in the clinical guidelines given to Distributeurs).

As seen in Table 1, all Distributeurs knew to treat simple fever and all but one each knew to refer “fever with cough”, “fever with bloody diarrhea”, and “fever with convulsions”. All but three Distributeurs said they would refer patients with “fever and watery diarrhea” to the health facility, but the three who reported they would treat such a patient were all from Kirehe District and had been trained and equipped to treat both simple fever and watery diarrhea. Even with “high fever” and “fever and not eating,” more than three-quarters of Distributeurs appropriately said they would refer these children.

ii. Health Center Staff

Twenty HC staff from 20 HCs were interviewed for this assessment. All 20 reported that malaria, ARI, and diarrheal disease were common illnesses among the children under 5 years of age in their population. One-quarter also reported that worm infestations and 20% malnutrition as common problems in young children.

Table 1. Responses of Distributeurs’ related to the management of children <5 years based on presenting symptoms in four districts in Rwanda, 2006 (N=24)

Symptom	Treat %	Refer %	Treat & Refer
Simple fever	100		
High fever	14	76	10
Fever with cough	3	90	7
Fever with watery diarrhea	10*	83	7*
Fever with bloody diarrhea	3	97	
Fever and not eating	17	79	4
Fever and convulsions	4	96	

*These Distributeurs are all from Kirehe district, where HBM of diarrhea has been implemented

When asked about the primary causes of mortality in children under 5 years of age in their populations, 85% reported malaria, 45% ARI, 25% diarrheal disease, and 20% malnutrition. Other causes were rarely mentioned.

HC staff reported having anywhere from 36 to 135 Distributeurs in their catchment areas, with a mean of 68. Seventeen of the 20 HC staff interviewed reported having some direct responsibility for the HBM program. Of those with responsibilities, HC staff most frequently listed their duties as supervision of Distributeurs (88%), replenishing medicine stocks (76%), monthly reporting to the district (71%), collecting reports from Distributeurs (65%), and receiving referrals (53%). Fewer HC staff reported having a role in monitoring and evaluation and training/re-training (both 29%).

All HC staff reported having received referrals from their Distributeurs. On average, they reported receiving from one to 13 referrals per month (Mean: 6/month) from Distributeurs. The most commonly mentioned reasons for referral included fever with respiratory symptoms, diarrhea or vomiting, severe disease, and children less than 6 months of age. All the HC staff interviewed felt that, in general, the referrals they had received from Distributeurs were appropriate.

All those interviewed felt very positive about this program. Half of respondents reported that there had been a reduction of malaria cases diagnosed at their HC since the program's inception. More rapid treatment of children was also stated as a positive outcome of the program by half of those interviewed. A reduction in mortality and in severe disease, and a population more informed about the symptoms and management of childhood illnesses were also mentioned frequently. Other benefits mentioned were the lower cost of treatment, diversion of caretakers away from "magendu" (informal drug sellers) and traditional healers for cases of fever in children under 5 years of age, and reduced workload at the HC.

When asked specifically about problems with the program, seven respondents (35%) reported no problems at all. Half reported that a lack of "motivation" for the Distributeurs was a problem. Other common responses included lack of transport, which made both supervision and referrals difficult, lack of resources for training/re-training, and the use of different medicines at the health facility and community levels (with the introduction of Coartem at health facilities).

One interviewee reported a lack of acceptance of Distributeurs by the community in that area. Another reported that some of the Distributeurs had not been strictly following the treatment protocols, but that this was resolved with supervision.

When asked what could be done to improve the HBM Program, virtually all mentioned strengthening training/re-training and supervision, and providing some type of motivation for Distributeurs. Several suggested introduction of Coartem at the community level. A few felt that mebendazole also should be introduced at the community level for treatment of intestinal worms. Some respondents also mentioned the need to provide transport for Distributeurs.

D. Pharmaceutical Management

Data collection was carried out in five district pharmacies, 14 HCs (and in an additional 7 HCs some pharmaceutical management questions were asked as part of the health worker questionnaire) and with 29 Distributeurs. Issues assessed included ordering procedures, inventory management, availability, supervision and reporting, cost of medicines, as well as use of medicines by the Distributeurs and infrastructure issues at the district pharmacies and HCs.

i. Distribution and store management issues

a. Distributeurs

Ordering: Of the 29 Distributeurs interviewed, 28 (90%) get medicines themselves from the HC, most by foot and a few by bicycle. The furthest Distributeur interviewed was about 8km from the HC. One Distributeur reported having the medicines delivered by the local HBM representative. Most distributeurs (75%) determine the quantity to order themselves; the remainder have the order quantity determined by HC staff. In some cases, HCs distribute a standard quantity of medicines, such as 10 units each time a Distributeur comes in to replenish their supply. Ordering is most often done on a monthly basis (41%) or more frequently (24%), with a few distributeurs ordering less than once a month (14%) and a few (17%) ordering when needed with no regularity (Table 2). The process and frequency of ordering varies among distributeurs; no standard process has been established by the PNILP and so it remains the responsibility of the distributeur and HC to ensure that there is adequate stock held by distributeurs.

Table 2: Frequency of placing orders for antimalarials

	District pharmacy n=5	Health center n=21	Distributeur n=29
More than once a month	0%	0%	24%
Monthly	60.0%	81%	41%
Less than once a month	40.0%	9%	14%
As needed	0%	0%	17%

Inventory management: At a consensus meeting of all HBM partners in December 2005, it was agreed that the Distributeurs no longer need to complete stock cards for their stocks of medicines. The only management tools to be maintained at that level were: register of cases and transfer forms (see example in Annex 2).

In the survey, all Distributeurs had case registers and 88% had books of transfer forms. Only 72% of Distributeurs had a copy of the treatment protocol: those without the protocol were all from Gitwe district. Although no longer required, 68% of the distributeurs had and used stock cards, evenly distributed between the districts supported by NGOs and the districts supported by the PNILP. Of those having stock cards, not all were fully completed and correspondence between the amount recorded on the stock card and the physical stock was 74% (Table 3). No expired medicines were found and all medicines were kept in a clean dry box, which was kept locked in all cases except one.

It was noted that in the Kirehe district, where cases of diarrhea were treated, that ORS and zinc were not kept together with the antimalarials and were tracked separately, apparently under instruction from the NGO.

Reporting and Supervision: All Distributeurs interviewed stated they filled in standard reports developed by PNILP on cases treated and medicines used and sent them to the HC, either directly or via the representative.

Most Distributeurs stated that they had received a supervisory visit in the last three months and 21% had received a visit within the last month. Two distributeurs stated they had not been visited in more than 6 months and 5 stated they had never been visited (all 5 were from Remera Rukoma District) as shown in table 4. Supervision was more frequent in the NGO supported districts with 15/17 in NGO supported Distributeurs receiving a visit in the last 3 months, compared to 3/12 in the INMCP districts. However, the staff conducting the supervisory visits in NGO-supported districts was more likely to be HC staff (70%) than NGO staff (22%)⁸. The content covered during supervisory visits varied widely according to the

⁸ It was reported that NGOs support the salaries of some HC staff.

Distributeurs. Review of the register and reports were common elements of most supervisory visits; examination of medicine storage and stock remaining was less frequently mentioned. All except four (83%) Distributeurs said they received some comments or feedback during the supervisory visit. There is a great variability in the frequency and content of supervision. Standard checklists were not used.

Table 3: Correspondence between actual and recorded stock

Tracer medicines	District Pharmacy N=5	Health center n=12	Distributeur n= 23
Amodiaquine tabs	0.0%	0.0%	
Coartem 5-14kg	33.3%	87.5%	
Coartem 15-24kg	66.7%	100.0%	
Coartem 25-35kg	33.3%	100.0%	
Coartem 35kg+	33.3%	71.4%	
Quinine inj	80.0%	90.9%	
Quinine tabs	100.0%	100.0%	
Quinine syrup	50.0%	85.7%	
SP tabs	100.0%	57.1%	
AQ/SP co-blister 6-35 months (red)	25.0%	90.9%	73.9%
AQ/SP co-blister 3-5yrs (yellow)	25.0%	90.9%	73.9%
AQ/SP co-blister 6-35 months	0.0%	25.0%	
AQ/SP co-blister 3-5 yrs	0.0%	25.0%	
AQ/SP co-blister 5-10 yrs	0.0%	0.0%	
AQ/SP co-blister 10-15 yrs	0.0%	75.0%	
AQ/SP co-blister 15+ yrs	0.0%	75.0%	
Amoxycillin tabs	60.0%	100.0%	
Ciprofloxacin tabs	100.0%	80.0%	
ORS	60.0%	80.0%	
Total	53.4%	79.6%	73.9%

b. Health centers

Ordering: HC staff reported that they generally ordered medicines, including antimalarials, from the district pharmacy (i.e., a standard “pull” system). Two HC (14%) stated that they also purchased from CAMERWA, BUFMAR, or other wholesalers when there is no stock at the district pharmacy. Most HC staff reported that they go by motorbike (64%), which can be problematic when transporting a large box of medicines, but some use a vehicle (21%).

Most of the 21 HCs (81%) reported ordering on a monthly basis, although 9% ordered on a quarterly basis (Table 2); this frequency depends on the ability and need of the HC in the absence of a standard MoH recommendation. In general, the person in charge of the HC pharmacy does the ordering, with the oversight of the titulaire being mentioned in a few cases (24%). The order quantity is reportedly based on a review of past consumption, using stock records or reports (recommended practice), in most HCs (86%). All HCs are responsible for supplying medicines to the distributeurs and order medicines accordingly.

Inventory management: In all HCs, the respondent reported that they had and used stock cards for stock management. No HC had or used a computer. The correspondence between physical stock and the recorded balance on the stock card for all HCs and for all medicines was 80% (Table 3). For some medicines (e.g. Coartem) the stock correspondance was 100% and dropped as low as 57% for SP tablets and 25% for the blisters of AQ/SP that were no longer being used in the HCs and are in the process of being sent back. This low level of correspondence could be due to lack of capacity of the HC staff in completing the stock cards or due to a lack of supervision to check that stock cards are up to date.

Table 4: Timing of last supervision visit and whether feedback was given

	District pharmacy n=5	Health center n=15	Distributeur n=29
Last month	40%	33%	21%
Between 1 and 3 months ago	0%	47%	41%
Between 3 and 6 months ago	40%	14%	14%
More than 6 months ago	0%	7%	7%
Never	20%	0%	17%
Feedback given during the visit	75%	79%	83%

Reporting and Supervision: All HC staff, except one, stated that they complete reports on consumption of medicines and stock levels to send to the district on a monthly basis, but not for all medicines. Standardized reporting forms only exist for Coartem, and these were developed by the INMCP.

Most HC staff reported having received a supervisory visit from the district health team in the last 3 months (47%, n=15) and another 33% in the last month; 79% were given feedback as shown in table 4. There is no standard frequency for supervision of HCs set by the MoH, but at least every 3 months is recommended. The content of the visits also varied with no standard checklist or supervision guide and rarely was the management of medicines covered in the supervision visits.

Table 5: Infrastructure indicators

	District pharmacy n=5	Health center n= 14
Lockable doors for storage area of medicines	100%	100%
Bars on windows for storage area of medicines	80%	83%
Electricity available consistently	60%	71%
Solar panels used	20%	57%
Temperature of storage area of medicines recorded	0%	7%
Storage area protected from direct sun (by curtains)	60%	92%
Functioning fridge	80%	86%
Temperature of fridge is monitored and recorded	80%	69%

Infrastructure: Overall infrastructure at HCs was good. Security was in place in all facilities and there was a relatively consistent supply of electricity either by generator or solar panels; 57% had solar panels. None of the HCs monitored the temperature of the storage space, but in all but one (92%) the medicines were protected from direct sunlight and heat by curtains or other means (NB: Temperature control is particularly important for areas where Coartem will be stocked as it is heat sensitive and has a shorter shelf life). Most HCs had a functioning refrigerator (86%), but the temperature was not always monitored (69%) and in one of the four HCs visited, the refrigerator temperature was 16°C (the temperature should be kept between 2 and 8°C).

c. District pharmacy

Ordering: All district pharmacies order medicines from CAMERWA, but some mention using other sources (such as BUFMAR and other wholesalers) as needed, with district authorization. The frequency of ordering varies from district to district; three of five stated that they order on a monthly basis, which is generally recommended (although there is no direct guidance on this from Minisante), and two on a quarterly basis (Table 2). The head of the pharmacy determines how much to order. Quantities are determined, as recommended, by reviewing previous consumption data from stock cards or monthly reports from the HCs, although more specific details on the formulas used were not provided. Most staff in district pharmacies have undergone training in store management and calculating order quantities.

Inventory management: All district pharmacies have and use stock cards for inventory management, but none use a computer for inventory management. However, as can be seen from Table 3, the average percentage of stock cards that corresponded to the physical

stock for all medicines studied in all the district pharmacies visited was only 53%. The table also demonstrates that the quality of record keeping in HCs is in general better than in the district pharmacies.

It is unclear why there is such a high level of discrepancies in correspondence between stock cards and physical stock at the district pharmacy. It could demonstrate that staff are either not capable to fill in the cards, do not have time, or simply are not supervised and so do not do it. Certainly, it was noted that in some pharmacies, inventory management was complicated by having medicines stored in several different rooms. It was mentioned at one district pharmacy that they only take inventory once/year, which is not frequent enough to pick up problems in stock management (at least every three months is to be recommended). No other district pharmacies mentioned doing inventories, although the question was not specifically asked. Despite this, none of the district pharmacies were observed to have any medicines on the tracer list that were expired.

Reporting and Supervision: Four of five district pharmacy staff reported that they completed reports on consumption and stock levels of medicines. However, there is no standard format or content for the reports for medicines, except for the reports for Coartem developed by the INMCP. Respondents stated they sent reports to different places; one to the INMCP, one to the Direction de la Santé, and the remaining three to CAMERWA +/- INMCP. The frequency with which these reports were sent varied between monthly and quarterly.

Two district pharmacy staff reported having received a visit in the last month; two in the last six months, and one had never received a supervisory visit (Table 4). Supervision is said to be conducted by the MOH (specifically the INMCP was mentioned by two respondents) and feedback was provided in three of the four reported visits. There is no one body responsible for supervision and no standard frequency or content of the supervision. The content depends mainly on the program or department conducting the supervision (e.g. INMCP, Reproductive health).

Infrastructure: Table 5 presents the infrastructure findings of HCs and district pharmacies. Most district pharmacies were secure and had a regular supply of electricity, by generator in some cases. The temperature of the storage area was not monitored in any of the district pharmacies, although the storage area in most pharmacies was protected from direct sunlight with curtains. In some pharmacies they used various areas to stock medicines, not all of which were protected from heat⁹. Having the stock dispersed in different rooms also makes it more difficult to control the inventory. Four of five district pharmacies had functioning refrigerators, all of which monitored temperature. None of the district pharmacies had a computer, but several said they could borrow from the district offices when needed.

ii. System-wide comparisons

a. Availability

The availability at the time of the assessment of a set of 23 tracer medicines and the amount of time out-of-stock over the previous 6 months was recorded (May through October 2006). At the distributeur level, the only medicine stocked is HBM blisters, although they were asked if they kept any other medicines. All other medicines on the tracer list are permitted at both HC and district pharmacy levels, except chloroquine and arinate which were included in the tracer list in order to find out if they existed (inappropriately) in the public system.

Table 6 shows that overall there was good availability of the medicines currently in use for malaria: Coartem, HBM blisters and quinine injection and tablets. Kibogora district pharmacy had some stock problems as a result of recent moves and merging of districts. No facilities stocked injectible artemether, which is provided for in the malaria treatment guidelines. None

⁹ In one pharmacy Coartem was stored in a room with freezers and refrigerators which generated a lot of heat. In another pharmacy there were no palettes to keep medicine cartons off the floor

of the facilities stocked chloroquine tablets or Arinate (artesunate) tabs, consistent with treatment guidelines; but one district pharmacy still had amodiaquine tablets (which are no longer to be used). There was a slightly poorer availability of SP tablets (75% district pharmacy; 67% HC), although this could be that the medicines were kept in the antenatal clinic for intermittent preventive treatment. Quinine syrup also was less available in HCs (67%).

Table 6: Facilities with specific medicines available at time of survey

	District Pharmacy n=5	Health center n=12	Distributeur n=25
Amodiaquine tabs	20.0%	0.0%	
Arinate tabs (artesunate)	0.0%	0.0%	
Artemether injection	0.0%	0.0%	
Chloroquine tabs	0.0%	0.0%	
Coartem 5-14kg	80.0%	91.7%	
Coartem 15-24kg	80.0%	91.7%	
Coartem 25-35kg	80.0%	91.7%	
Coartem 35kg+	80.0%	83.3%	
Quinine injection	100.0%	100.0%	
Quinine tabs	100.0%	100.0%	
Quinine syrup	100.0%	66.7%	
SP tabs	75.0%	66.7%	
AQ/SP co-blister 6-35 months (red) HBM	80.0%	100.0%	100.0%
AQ/SP co-blister 3-5 yrs (yellow) HBM	80.0%	100.0%	100.0%
AQ/SP co-blister 6-35 months	25.0%	8.3%	83.3%
AQ/SP co-blister 3-5 yrs	25.0%	8.3%	
AQ/SP co-blister 5-10 yrs	20.0%	0.0%	
AQ/SP co-blister 10-15 yrs	20.0%	25.0%	
AQ/SP co-blister 15+ yrs	20.0%	25.0%	
Amoxycillin tabs	100.0%	100.0%	
Ciprofloxacin tabs	80.0%	83.3%	
ORS	100.0%	100.0%	83.3%*
ITNs	25.0%	90.9%	
Total	65.6%	66.5%	100%**

* n=6 (Kirehe district only)

** 98.2% when ORS is included

All facilities had either returned all their stock of AQ/SP co-blister for use in HCs or were in the process of returning it. Data collection was conducted in the last two weeks of October and Coartem® had been distributed only since the beginning of October.

All Distributeurs had HBM blisters in stock. Five of 6 Distributeurs in Kirehe also had a stock of ORS and zinc tablets.

b. Quantities of medicines in stock

Due to the change in policy for treatment of malaria at facility level and the pending change in policy for treating malaria in the community, the quantity of HBM blisters in stock and the average monthly consumption was used to calculate the number of months that would be needed to fully consume existing stocks (Table 7).

At district pharmacies, there were minimal stocks of the red blisters and an average seven months of stock of yellow blisters. At HCs, an average 10 month and 13 month supplies of red and yellow blisters, respectively, were in stock. Distributeurs had approximately a 6 month supply of both red and yellow blisters available. Both in district pharmacies and in HCs it was noted that there were large quantities of Coartem. Given the heat-sensitivity and the short shelf life of Coartem, this should be monitored in relation to consumption to ensure that excessive quantities are not stored.

Table 7: Availability of AQ/SP co-blisters for HBM

	District Pharmacy n=4	Health Center n=11	Distributeurs n=24
Red HBM blisters / 6-35 months			
Average Stock on hand	3700	940	11
Range	900-5900	100-2100	2-21
Average consumption	2663	160	5
Range	1000-5217	40-426	0.3-17
Average months of stock available	2	10	5
Range	1-6	0-30	0-21
Yellow HBM blisters / 3-5 years			
Average stock on hand	6325	1232	11
Range	1600-11200	394-2500	2-33
Average consumption	2900	171	3
Range	516-5000	65-731	1-12
Average months of stock available	7	13	7
Range	0.4-21	2-36	1-39

c. Periods of stock-outs

As seen in table 8, the average time out-of-stock (calculated as the number of days out of stock for a medicine as a percentage of the number of days in 6 months multiplied by the number of facilities) was minimal for most medicines. Slightly longer stock out periods were noted at district pharmacies, for example 9% (about 2 weeks for all five districts and therefore only about 3 days on average per district pharmacy) for quinine tabs, and 10% for ORS. Periods of stock-out were experienced for these same medicines at the HC level also, albeit for slightly shorter periods of time (e.g., quinine tabs 4% and ORS 6%).

There were no stock outs at HC or district pharmacies of the HBM blisters. Amongst the Distributeurs, a negligible level (2% of stock-out of the red blisters was noted, and this was a period of a total of 71 days at only two Distributeur sites. Of all facilities studied, 26/42 (62%) experienced no stock outs of any of the tracer medicines: 2/5 (40%) district pharmacies, 4/12 (33%) HCs, and 20/25 (80%) Distributeurs.

Table 8: Average percent of time out of stock over a period of 6 months

	District pharmacy	Health center	Distributeur	Total
Amodiaquine tabs	0%	N/A		0%
Coartem 5-14kg	0%	0%		0%
Coartem 15-24kg	0%	0%		0%
Coartem 25-35kg	0%	0%		0%
Coartem 35kg+	0%	0%		0%
Quinine inj	0%	2%		1%
Quinine tabs	9%	4%		5%
Quinine syrup	4%	0%		2%
SP tabs	3%	5%		4%
AQ/SP co-blister 6-35 months (red) HBM	0%	0%	2%	1%
AQ/SP co-blister 3-5yrs (yellow) HBM	0%	0%	0%	0%
AQ/SP co-blister 6-35 months	0%	N/A		0%
AQ/SP co-blister 3-5 yrs	0%	0%		0%
AQ/SP co-blister 5-10 yrs	0%	N/A		0%
AQ/SP co-blister 10-15 yrs	0%	0%		0%
AQ/SP co-blister adults	0%	0%		0%
Amoxycillin tabs	3%	5%		5%
Ciprofloxacin tabs	0%	1%		0%
ORS	10%	6%	0%	7%
ITN		0%		0%
Grand Total	2%	2%	1%	2%

Table 9: Cost of medicines (purchase and sales prices in Frw)*

Medicine	District pharmacy				Health center			
	Average Purchase price	Range	Average sales price	Range	Average Purchase price	Range	Average sales price	Range
Coartem 5-14kg	Free		50*	0-150	Free		105	0-200
15-24kg	Free		50	0-150	free		109	0-200
25-35kg	Free		67	0-200	free		141	0-300
35kg+	Free		67	0-200	free		160	0-300
Quinine inject/amp	56	39-89	67	45-103	90	45-130	140	100-200
Quinine tab	10	7-19	11	8-21	14	8-16	22	19-40
Quinine syrup/bottle	486	400-605	567	460-696	499	300-635	710	500-800
Amoxicillin tab	10	7-18	12	9-20	12	7-19	22	13-50
Cipro tab	24	20-27	28	24-31	28	12-65	50	30-100
ORS sachet	68	39-86	81	43-100	80	29-100	116	50-200

* All prices rounded to nearest franc.

** One district pharmacy reported a sales price for coartem at 150 Frw for 5-14kg and 15-24 kg treatments and 200Frw for the 25-35 kg and 35kg+ treatments.

d. Cost of medicines

All HBM blisters are provided by the Distributeurs at a cost of 50Frw regardless of the color of the blister. Information on purchase and sales prices for a set of medicines at HC and district levels was collected.

As seen in Table 9, there are wide variations in purchase and sales prices, indicating a lack of standard pricing or mark-ups. For example, in the HCs studied, quinine tablets were sold at a price between 19 and 40 Frw per tablet. This unit price difference can make a big difference on the total price of a treatment of 15-20 tablets.

The purchase price could have varied because different suppliers were used, although all said they purchased through the district pharmacy or CAMERWA unless an item was out of stock. We do not have information on how frequently facilities purchased from the private sector and whether the prices in the study reflect private sector or public sector purchases. For Coartem, HCs listed different prices, some providing it free, others charging 300 Frw.

iii. Use of medicines by Distributeurs.

Distributeurs' use of medicines was assessed by reviewing registers. Observations of case encounters were not possible as no patients were brought during any visits.

All Distributeurs managed cases of fever (malaria) in children less than 5 years. In Kirehe district, Distributeurs began managing cases of diarrhea in June 2006 and most had not yet managed any cases. Where cases were treated, sachets of ORS and zinc tabs were provided. Only one Distributeur had a register for diarrhea cases for review.

In four districts (no data for Kibilizi) Distributeurs' registers over the previous 6 months or more showed that each case of fever was given an HBM blister of AQ/SP. Of the 229 cases examined at random over the last 6 months (on average, 10 per distributeur), 90% were given the correct blister for age. Two children less than three months of age were treated, when they should have been referred. A red blister, intended for a child under 3 years of age, was given to a 3 year old, and some less than 3s were given the yellow blister. There was a slight difference between INMCP-supported districts, where the correct dose was given in 95% of cases, compared to 85% in the NGO supported districts.

It cannot be ruled out that errors in recording may explain some of these discrepancies. In particular, several Distributeurs said they completed the paperwork later in the day rather than at the time of the consultation, which could have affected their recollection.

All Distributeurs reported that they administered the first dose of the treatment, although less than half (48%) said they had cups for the purpose. Eight-six percent reported they used clean previously boiled water. Most explained that they grind the tablets in a spoon (their own spoon) and then mixed with a little water to give to the child. Most Distributeurs mentioned appropriately that they observed the first dose to see if child vomited the dose and, if so, repeated the dose. They then gave instructions to mothers on how to take the remaining tablets.

Although few distributeurs reported giving information to the caregivers on the name of the medicines (14%), what they were for (45%) and their side effects (14%), the majority (93%) reported that they explained to the caregiver how much and when to take the remaining doses after administering the first dose. All Distributeurs dispensed the medicines to the caregivers in the original blister (a few stating they also put the blister pack in a plastic bag) which has instructions in Kinyarwanda on the box. All Distributeurs, except three, (90%) said they had a job aid on the treatment of malaria in the under 5s and, although this was not verified in each case, it seems that this was in all cases the protocol produced by the INMCP (Annex 3).

Table 10: Results of active ingredient tests

Medicine	Number of Samples	Number with active ingredient present	Range of % of concentration of active ingredient	% of samples passed Containing between 85% and 115% ¹ of expected concentration
Public sector				
Coartem tabs ²	6	6	101-107%	100% (6/6)
AQ/SP tabs ³	4	4	S 82-102% P 79-100%	S 50% (2/4) P 75% (3/4) S/P 25% (1/4)
Total of public sector samples	10	10		70% (7/10)
Private sector				
Quinine syrup	8	8	74-119%	62% (5/8)
Quinine tabs	2	2	110-124%	50% (1/2)
Dihydroartemisinin (2 samples of Dihydroartemisinin tabs and 2 samples of Alaxin Plus)	4	4	89-105%	100% (4/4)
Amodiaquine tabs	3	3	97-103%	100% (3/3)
Amodiaquine syrup	4	4	86-92%	100% (4/4)
SP tabs (whole tablets)	9	9	S 77-97% P 78-104%	77% (7/9) 77% (7/9)
SP Tablets (half tablets) ⁴	2	2	S 87-94% P 80-106%	100% (2/2) 50% (1/2)
Artemether syrup	1	1	103%	100% (1/1)
Artesunate tabs	1	1	100%	100% (1/1)
Total of private sector samples	34	34		79% (27/34)
Overall total	44	44		77% (34/44)

1. The recommended range for single sample HPLC tests (CDC)

2. Active ingredient tested for was artemether

3. Active ingredients tested for were Sulfadoxine and pyrimethamine

4. These half tablets were not evenly broken and so it is impossible to give exact ranges for the % API and so we would be inclined to allow the half tablet of 80% API to pass as it was probably just under a half tablet.

iv. Quality test results

A set of 44 samples of antimalarial medicines were sent to CDC Atlanta for quality testing to check for the presence and amount of the active ingredient. The set consisted of 34 samples from the private sector and 10 from the public sector. A variety of antimalarials were obtained from the private sector, including ACTs, artemisinin monotherapy, SP, quinine, and amodiaquine products. In the public sector, samples of Coartem, and AQ/SP were taken.

Of the 44 samples tested by HPLC, all contained the expected active ingredient. Of those 44 samples, 77% contained between 85% and 115% of the expected amount of active ingredient (Table 10). A similar pass rate was found in the public (7/10 or 70%) as in the private sector samples (27/34 or 79%). The medicine that most commonly failed in both the public and private sector was SP. Problems also were detected in the private sector samples of quinine syrup and tablets. Although 77% seems a relatively high percentage, the results for correct dosing in antimalarials should be at 100 % otherwise problems of resistance or ineffective treatment can result from under-dosing or toxicity from over-dosing. Of the ten samples that did not fall within the 85-115% range, seven fell under the recommended range and three over, all three of which were samples of quinine. As this is apparently a problem affecting both the public and private sources of medicines, it is important to address quality assurance of pharmaceuticals on a system wide level.

E. Other Providers

For the purpose of this report, the term “private sector” is taken to mean any outlet of medicines that is not public or agrée (faith-based); this includes dispensaries, comptoir pharmaceutiques, pharmacies as well as informal vendors of medicines. Traditional healers were also interviewed for this report. In the districts surveyed, there were no pharmacies found, as these are concentrated in the larger towns, i.e. Kigali and Butare. The sample, therefore, consisted of comptoir pharmaceutiques and dispensaries.

Reference was made to informal vendors or “magendu” in every location visited, but it was not possible to actually find any to interview. The population stated that they exist in their communities and that they are used by people who are not part of the mutuelle to get medicines for adults and for conditions in children that are not treated by Distributeurs. They reportedly sell a wide variety of medicines including antimalarials, but the quality of these products is not known. It was said that with the recent closure of several comptoir pharmaceutiques that the existing informal vendors now have more clients. The closure of several comptoirs pharmaceutiques was noted in the districts under the study.

Table 11: Sample size

	Kirehe	Remera	Gitwe	Kibogora	Kibilizi	Total
Dispensaries	4	0	1	0	0	5
Comptoirs pharmaceutiques	3	5	8	5		21
Simulated purchases	4	5	8	5	1	23

Data collection was carried out in dispensaries and comptoir pharmaceutiques in the five districts. Table 11 shows the actual number of outlets visited.

i. Knowledge of providers

Of the providers interviewed (5 dispensaries and 21 comptoir pharmaceutiques), the majority were nurses or nurse assistants (75%), 22% were medical assistants, and one was a doctor's assistant. The comptoir pharmaceutiques were mostly staffed by nurses or nurse assistants (82%) and the dispensaries by medical assistants (60%). All the outlets were staffed by people who had received formal training in clinical care.

a. Knowledge of symptoms

During the interview, the respondents were asked about the symptoms of common childhood illnesses. All respondents correctly stated fever as a symptom associated with malaria, and 81% correctly mentioned fever and convulsions for cases of severe malaria.

For cases of ARI (non-pneumonia), all noted cough, sore throat, and runny or blocked nose, but 23% also incorrectly mentioned rapid breathing, which is the distinguishing sign for pneumonia. The majority of respondents (96%) correctly cited rapid breathing as a symptom of pneumonia. Seventy-three percent correctly cited rapid breathing and 38% chest in-drawing as symptoms that distinguish pneumonia from non pneumonia ARI in a child less than 5 years old.

When asked what additional symptoms would be required to treat a case of diarrhea with antibiotics, only 46% of all respondents correctly mentioned blood. However, 60% of the staff at dispensaries mentioned blood.

b. Knowledge of national treatment guidelines

The Rwandan IMCI guidelines, which include the latest national malaria treatment policy, were taken as the standard for national treatment guidelines. For cases of simple malaria in children, 46% of respondents correctly said the recommended treatment was AQ/SP (80% of those in dispensaries and 38% of those in comptoirs). When asked about cases of severe malaria, 69% correctly stated the recommended treatment was quinine and 46% said they would refer, as is recommended.

An antibiotic is not recommended for treatment of non-pneumonia ARI, however 46% of respondents stated it was the recommended treatment. When asked the recommended treatment for pneumonia, 88% correctly mentioned an antibiotic, (although 19% said they would refer, which could also be considered appropriate management) but only 50% mentioned the actual recommended treatment, amoxicillin.

For cases of non-bloody diarrhea, 77% of respondents (100% of those in dispensaries) stated the recommended treatment was ORS, but 38% also incorrectly said an antibiotic. When asked what was recommended for bloody diarrhea, 88% correctly mentioned an antibiotic and 19% correctly mentioned referral. Only 8% mentioned ciprofloxacin, which is currently the recommended antibiotic treatment for bloody diarrhea.

Table 12: Knowledge of correct dosing of recommended medicines

	AQ/SP	Coartem	Amoxicillin	Ciprofloxacin	ORS
Comptoirs (n=21)	29%	0	57%	24%	38%
Dispensaries (n=5)	20%	0	80%	0%	60%
Total (n=26)	27%	0	62%	19%	42%

There was a low level of knowledge of the correct dose of recommended medicines, as shown in Table 12. When asked about preventive measures, all respondents responded correctly that ITNs prevent malaria.

c. Knowledge of appropriate dispensing practices

Respondents were asked about labeling and information about medicines that should be explained to the caregiver (Table 13). All respondents stated that the dose of the medicine should be included on the label and 92% that the dose should be explained to the caregiver.

Table 13: Reported correct labeling and patient information

Components of label:	Comptoir (n=21)	Dispensary (n=5)	Total (n=26)
Patient name	0%	0%	0%
Medicine name	86%	80%	85%
How to take it	100%	100%	100%
Duration	43%	20%	38%
Explanation to the caregiver:			
Medicine name	10%	0%	8%
What it treats	14%	0%	12%
When and how to take it	90%	100%	92%
Side effects	35%	50%	38%

Knowledge of other advice to be given was low. Only 35% mentioned advice on feeding, 35% advice on hygiene, 16% advice on what to do if the condition got worse, and 35% mentioned advice to purchase an ITN.

ii. Availability of medicines

Interviewees were asked what medicines they had in stock using a tracer list of 15 key medicines and then they were asked if they had any other antimalarials in stock. The results of the tracer items are shown in Table 14.

Table 14: Availability of tracer medicines in retail outlets

	Comptoir (n=21)	Dispensary (n=5)	Total (n=26)
Amodiaquine tabs	76%	60%	73%
Arinate tabs (artesunate)	0	0	0
Chloroquine tablets	0	0	0
Co-arinate tabs	0	0	0
Coartem tabs*	0	0	0
Quinine injection	5%	100%	23%
Quinine tabs	95%	100%	96%
SP tabs	100%	100%	100%
Amoxicillin syrup	14%	80%	27%
Amoxicillin tabs	14%	60%	23%
Ciprofloxacin tabs	0%	80%	15%
Ciprofloxacin syrup	0	0	0
ORS	52%	40%	50%
ITN	57%	0	46%

A ministerial decree dated May 2005 dictates the medicines that can be stocked at a comptoir. Artesunate, Co-arinate, Coartem, quinine injection, amoxicillin and ciprofloxacin are not permitted in comptoirs. Because of the recent MOH closures of comptoirs, it was not easy to obtain accurate availability of medicines that were not obviously on show on the shelves. Of the outlets surveyed, 4% stocked artemether syrup, 19% stocked Alaxin Plus (artemisinin plus SP) and 19% stocked Alaxin (artemisinin monotherapy, which is no longer permitted to be stocked).

Very few outlets (15%) had visual aids for the childhood illnesses other than malaria, and those that were available came from a variety of sources including the MOH and pharmaceutical industry. For malaria, 80% of dispensaries and 10% of comptoirs had visual aids on the treatment of simple malaria produced by the INMCP. However, these materials were only in French and not all respondents were French speaking.

iii. Actual practice

Simulated purchases were conducted by surrogate caregivers, using either a driver or asking a person on the roadside to conduct the exercise. Each surrogate customer was properly briefed on the scenario of a “Two year old child with symptoms of mild fever, who had taken no other medication.” On leaving the outlets, the surrogate client reported back to the data collector who noted the name of the medicines sold and all the advice given. All simulated purchases were conducted in comptoirs pharmaceutiques except one, which was conducted in a dispensary.

Less than half (48%) of the surrogate caregivers were informed by the attendant of the illness that their child had. Most attendants asked for some history on the child (83%), but only half (52%) researched whether there were any danger signs that may require immediate referral rather than treatment.

In only 57% of encounters was an antimalarial sold to the surrogate, and of those only 23% (3/13) were correctly sold AQ/SP in combination. In most of the remaining cases, the surrogate customer was sold quinine syrup (8/13 or 61%), one case was sold SP alone and one case was sold AQ alone. Of the three that were sold AQ/SP, only one was given the correct dose.

Six of 23 (26%) cases were referred to take the child to a health facility, but none of these were provided with any written document. Of the 10 cases that were not sold antimalarials, all of them were sold an analgesic or antipyretic of some kind (2 aspirin, 5 paracetamol, 2 Novalgin, and 1 Ibuprofen) and only 5 of those were referred to a health facility. Twenty-two percent (5/23) of the simulated cases of fever did not receive an antimalarial or advice to go elsewhere to get one (i.e., a referral). That is, one quarter of children were not treated for presumed malaria.

Five cases total were sold Novalgin (2 alone and 3 with quinine), the use of which is prohibited in many countries due to the high risk of agranulocytosis. It is not included in the WHO essential medicines list.

Although the majority of cases were provided with verbal instructions (74%), only half had written instructions as well. Under half of the sales attendants provided advice on what to do if the condition of the child got worse and very few (9% and 4% respectively) gave other advice on nutrition and prevention of malaria. The encounter with a customer is a good opportunity to provide such advice.

Table 15: Information provided to the surrogate client by the sales attendant

	Number of attendants (N=23)	%
Provided verbal instructions on dose	17	74
Labeled the medicines with dose instructions	13	57
Gave advice on what to do if the child got worse	10	43
Gave nutritional advice	2	9
Recommended the use of an ITN	1	4
Referred the case	6	26

In addition to the simulated client, some questions were asked about clients' demands in the outlets and the treatment of adults with malaria. Ninety-two percent of respondents stated that clients ask for specific antimalarials and the antimalarials most frequently asked for were: quinine, Fansidar®, AQ/SP and artesunate. According to the respondents, about 50% of the malaria cases seen are adults to whom the respondents say they most frequently sell AQ/SP (62%) or quinine (65%).

iv. TBAs and traditional healers

The TBAs and traditional healers in many of the areas sampled understand the value of the Distributeurs' work. In a number of instances, the traditional healer or TBA in an area is also the local Distributeur. Many take their own sick children to the Distributeur for treatment.

TBAs and traditional healers also refer children that are brought to them for care to the Distributeur if they believe that that is where the child will get the best treatment. They say that the Distributeurs also come to them for help when a child is ill and traditional medicine is needed¹⁰. Many expressed interest in becoming more involved in the program and supporting it in whatever way they could.

In most instances, the TBAs and traditional healers actively participated in the process of electing the Distributeurs for their area. They say the election process was well done. They like the fact that Distributeurs are their neighbors and that they no longer need to go far to get treatment for their children when they have fever. They believe that the Distributeurs are motivated by their love of children as well as the training they received. In Rangiro, the traditional healers thought the Distributeurs may also be receiving some assistance with transport money.

Some ways suggested by TBAs and traditional healers that the communities could do to support Distributeurs included paying the 50 francs that is requested for treatment and encouraging caretakers to get their children to the Distributeur before they become dangerously ill. Generally TBAs and traditional healers wanted the Distributeurs to be trained to treat a wider range of illnesses.

In several areas, the traditional healers say they work well with the Distributeurs and appreciate their contributions to the community.

"We know the distributeurs do a good job just like us. The program has reduced the problems for lots of people especially, those who don't have money or who aren't a part of the mutuelle. We work in collaboration. They were elected by us based on their honesty. It would be good if you could also authorize them to give medicines for intestinal worms, coughs and vomiting. We are so far from the HC." (Kigese traditional healer)

In one area, the two traditional healers interviewed were also Distributeurs. They explained that, depending on the problem or illness, many people want both traditional and western medicines and they were in a position to provide them with both. As one put it, "The two ways of treating go well together." They also said that the population trusts them because they're neighbors. People no longer have to go a long way for treatment at the HC so they are getting their children treated sooner and thus there are fewer serious cases that need referral. They were both very happy with the program since for them it was like receiving a promotion. It indicated that the community had confidence in their work. They also said they didn't need anything else to motivate them. They said they loved the work they did and were proud to wear their badges.

Although many TBAs and traditional healers are highly supportive of the Distributeurs and the services they offer, there are still others who are not interested in collaboration. Of special concern are individuals who treat fever and malaria with traditional medicines and who may feel that they are competing with the Distributeurs. Some traditional healers treat young children for fever and diarrhea with enemas. Of special note is that in Gitwe, the district with the strongest culture of using traditional medicine for treating a wide range of illnesses, including malaria, there were no traditional healers or TBAs available for interview during this assessment.

¹⁰ Traditional healers in Rwanda primarily use herbs and other natural materials and not western medicines.

IV. SUMMARY OF FINDINGS

A. Existing Data

1. Data collected from a number of districts using varying methodologies demonstrate that the percentage of children with fever getting treatment within 24 hours of onset of illness has increased to more than 80% in most locations, far above the INMCP goal of 60% for 2006.
2. In most HCs assessed, reported malaria cases decreased during the peak malaria season in the year after implementation of HBM, compared to the year before.
3. Representatives of partner agencies all felt this program was highly successful. Some of the factors that led to that success were the election of Distributeurs by communities (which conferred the volunteers with instant credibility), use of similar packaging for the medicines to those used in the HCs, allowing caretakers with referral forms to hop the queue at HCs, and the formation of associations to improve retention of Distributeurs.
4. According to partner agency representatives, barriers to referral, particularly lack of transport, additional costs for treatment, and the time required for HC visits pose major challenges for the HBM program.
5. Lack of sufficient motivation for Distributeurs is viewed by partner representatives as the greatest challenge for program sustainability.

B. Community Assessment

i. Primary findings

1. Based on the FGDs, communities appear to be highly appreciative of the work being done by Distributeurs. In most areas, they are trusted and are the preferred source of treatment for young children with fever. Community members trust that they have been trained to do their job, they are from the communities they serve, and people have confidence in the medicines they provide. Other reported reasons for preferring the Distributeur over other options include convenience, price, availability, and rapid service. Community members say there is no longer a need to seek out the "magendu" when a young child gets fever.
2. Although malaria is a major problem in all the areas sampled, people in most areas are noticing that there is less serious illness and fewer referrals to the HC needed for young children since caretakers are not waiting to seek treatment for fever.
3. People want more Distributeurs. They would also like them to be able to treat a broader range of illnesses, including intestinal worms, diarrhea, coughs and even certain adult illnesses. In some areas, people have heard that there is a new treatment for malaria and want access to it through their Distributeurs.

ii. Additional findings

1. People are pleased that the prices they pay for health care are going down. Because medicine is now available through Distributeurs, community members report that there is no longer a need to pay transport to the HC, so the savings are even greater. The mutuelle has also helped to contain costs.
2. Community members believe the election process, which actively involved the community during the program start-up, was well conceived. People are proud of their

Distributeurs “since we’re the ones that chose them.” Many Distributeurs are loved by the population.

3. In most instances, the mother or primary caretaker indicates that she/he decides where to take the child for treatment. When a child has fever, the medicine available through the Distributeur is more often than not the preferred treatment. Fathers report getting involved only when the illness is believed to be serious, warranting a trip to the HC or hospital.
4. Instructions for giving medicine are said to be followed exactly as they are given by the Distributeur or nurse. Caretakers appear to understand that, in order for a child to get better, medicine must be taken according to instructions and never shared.
5. Families report using both western and traditional medicine on a regular basis and seek out care depending on what they think is the best treatment for the illness.
6. In community members’ opinions, HC staff, Distributeurs, and sometimes local authorities are credible sources of information on child health. Many also indicated that radio and meetings were also good sources. Print materials do not seem to be as important, although posters and pictures are often noticed, particularly by grandmothers.

C. Health Care Workers

i. Primary findings

1. Distributeurs say they are proud that the community entrusted them with the important job of caring for their sick children. They know that their work has resulted in lives being saved. Distributeurs appear to feel responsible for the program and want it to work.
2. With rare exceptions, when Distributeurs are given typical clinical scenarios, they have a strong knowledge of how to manage sick children. They can describe in detail how they do a consultation and when they would refer. Many reported that they advise caretakers on taking medicine, feeding the sick child, danger signs, prevention, etc.
3. Distributeurs indicate they are willing to provide treatments beyond what they currently offer, including the “new treatment” for malaria. They are firm, however, that before they can distribute any new medicines, they need to receive appropriate training.
4. HC and District staff speak highly of the HBM Program. Many report seeing a reduction in cases, severe disease, and mortality from malaria. They also report that the referrals they receive from Distributeurs are almost always appropriate.
5. HC Staff report that lack of motivation is the biggest weakness of the program. Lack of resources for training/re-training and transport for both supervision and referrals were also noted as problems.

ii. Additional findings

1. Without exception, Distributeurs say that their work is demanding. They do it because they are volunteers and the community trusts them.
2. Distributeurs report that it is easy to get medicine. Although it had never happened, they were confident that they could get medicine from a fellow Distributeur if they ran out. They also said that it was easy to replenish stock at the HC.

3. Distributeurs greatly appreciate supervisory visits and would like more. In particular, they would like the opportunity to be observed managing sick children
4. Training is an important motivator, according to Distributeurs. In addition, there are certain items from the Distributeur “wish list” (e.g., radios, educational materials, and rain protective equipment) that could benefit both the program and the volunteers.

D. Pharmaceutical Management

i. Primary findings

1. The availability of antimalarials was good at all levels. SP for IPT and quinine syrup were not consistently available in all facilities. Large quantities of HBM blisters were stocked at all levels, especially by Distributeurs.
2. Stock-outs of most medicines (a more reliable measure of availability) were infrequent at most levels. One to two week stock-outs of a few key medicines (e.g., quinine syrup and ORS) were recorded at the district pharmacy and HC levels. Almost half of the facilities experienced a stock-out of one or more tracer medicines studied.
3. Distributeurs' records indicate that HBM blisters are being dispensed appropriately. The few cases where the wrong blister for age was given may have been a recording error rather than a dispensing error. All Distributeurs reported giving the first dose under observation.
4. All samples of antimalarials that were tested contained the expected active pharmaceutical ingredient. However, in about a quarter of those samples, the amount of active pharmaceutical ingredient was more or less than the accepted range. This problem was observed in samples from the public sector and private sector alike, and concerned mainly samples of SP and quinine.

ii. Additional findings

1. Record review and interview data indicate that the ordering process seems to work well at the Distributeur level. Stock-outs of HBM blisters are rare, although this could be because of the large quantities of blisters stored by Distributeurs. The recommendation that Distributeurs no longer need to use stock cards has not been implemented uniformly and some are still using them with difficulty.
2. Order quantities of medicines at HCs and district pharmacies are reportedly based on consumption data. Stock cards are used at both levels, but there are more inaccuracies at district pharmacies. Facilities do not use computerized systems of inventory control.
3. Standard forms to report on consumption and stock levels of HBM blisters and Coartem are used at all levels, but forms and mechanisms for reporting on other medicines are not standardized.
4. The Distributeurs and HCs report being supervised fairly frequently, but the content and format of the supervision are inconsistent and stock management or pharmaceutical management is rarely an aspect that is supervised. District pharmacies are infrequently supervised. When supervision was conducted it was related to a particular program or set of medicines, rather than general stock management practices.
5. The infrastructure in most facilities is adequate, but temperature in the storage areas of HCs or district pharmacies was not monitored. Certain measures to keep medicines as cool as possible are not in place (e.g., palettes and keeping medicines separated from

heat generating equipment). This will be particularly important where large quantities of heat-sensitive medicines, such as Coartem, are stored.

6. There was wide variability in the stated purchase price and sales prices of all medicines among all districts and facilities. Even Coartem was sold at varying prices. These variations in price can have an impact on affordability of medicines to patients who are not part of the mutuelle. All Distributeurs sold the HBM blisters at the same price.

E. Other Providers

i. Primary findings

1. All staff interviewed at comptoirs and dispensaries are trained health professionals. Despite this, there were deficiencies in their classification of key symptoms for childhood illnesses other than malaria.
2. Although most knew effective classes of medicines for treating childhood illnesses, they were not aware of specific MOH recommendations, including for malaria. Consequently, their knowledge of the dosing schedules of particular medicines was poor.
3. Using simulated client observations, comptoir pharmaceutique staff demonstrated deficient practice in treating malaria. Only 57% were sold an antimalarial treatment and 22% were referred, leaving 22% of cases of presumed malaria neither treated nor referred. Sales attendants did not generally elicit much information from the caregiver or evaluate the patient and little other advice on the management or prevention of the condition was provided.
4. Despite the sensitivities around obtaining information on availability, private outlets still stock and sell antimalarial monotherapies (e.g., AQ, Alaxin [artemisinin], and SP) as well as other medicines (e.g., antibiotics) that should not be sold at comptoirs.
5. Informal vendors of medicines are reported to exist widely, although none could be found for this assessment. They are reportedly more frequented in some rural areas due to the closure of the comptoirs.

ii. Additional findings

1. In general, respondents knew to provide key pieces of information to caregivers related to medicine use, but there was a low level of knowledge of other general advice that should be provided.
2. Visual aids were not widely available in private shops, except for malaria. Those for malaria were not suited to all contexts (e.g., language constraints) and not oriented to comptoirs. On the other hand, people are getting information on malaria via the radio and during community meetings and activities.
3. In many locations, traditional healers and TBAs say they support the HBM program, referring children with fever to Distributeurs. Some are Distributeurs themselves. Some traditional healers, though, are less involved and continue to treat fevers on their own.

V. CONCLUSIONS

A. Overall Assessment of the HBM Program

In order to consider whether the HBM Program has been successful or not, one must assess a number of factors that are essential to this program achieving its goals of improving the number of children receiving correct treatment within 24 hours of the onset of fever. To deem such a program successful, one would like to see:

- **Changes in treatment seeking behavior** of caretakers, who preferentially choose the Distributeurs over other sources of care.
- **Rapid and correct diagnosis**, which requires caretakers to seek care within 24 hours of the child becoming ill. The Distributeurs must be easily accessible and capable of differentiating simple fever from other common childhood illnesses.
- **Appropriate treatment and dosing** must be provided and correctly administered. Medicine must therefore be available (i.e., no stock-outs) and the full course of treatment administered, as prescribed.
- **Referrals that are appropriate and completed**, requiring Distributeurs to identify and refer severe disease and illnesses not caused by malaria, and that those who are referred are quickly taken to the HC for care.
- **The program is sustainable**, because malaria will continue to be a major cause of childhood illness, even if all the current goals of the INMCP are achieved.

Using this framework, we can conclude that the HBM Program has been successful in achieving many of its goals. Community members and Distributeurs reported that caretakers now preferred taking their sick children to the Distributeur for care, where previously they had relied on the magendum or traditional healers.

Data from cluster surveys and service data collected by partner agencies demonstrated major increases in the percentage of children being brought for care within 24 hours, generally exceeding 80%. Mothers reported that having the Distributeurs in their village and available 24 hours a day removed the main barriers to them seeking immediate care for their sick children. The lower cost of treatment also reduced the financial barrier to care. In addition to improved treatment seeking, Distributeurs demonstrated a strong knowledge of correct management of childhood illnesses.

Caretakers reported that the introduction of age-appropriate blister packaging and having the Distributeurs administer the first dose under observation greatly facilitated correct dosing and completion of therapy. Furthermore, review of Distributeurs' records indicates that, with rare exception, the appropriate blister was dispensed for the child's age. Stock-outs were rare. Even in cases where stock-outs did occur, caretakers could always be referred or blister packs borrowed from a nearby Distributeur.

Most caretakers stated that they completed referrals, with cost (particularly for those not in the mutuelle) and lack of transport being the primary barriers to completion of referral. Referrals were facilitated by a policy of allowing those caretakers with referral slips to "jump the queue" at the HC. In fact, this policy had the unintended effect of promoting the use of Distributeurs as a first-stop for all sick children because the child would either get rapid treatment for malaria or the caretaker would receive a referral slip, which would expedite their visit at the HC. HC staff reported receiving referrals from Distributeurs and that those referrals were almost always appropriate.

Using these four parameters, one could conclude that this program has been successful in achieving and perhaps exceeding its goals of improving the speed, correctness, and completion of fever/malaria treatment in children 6 months to 5 years of age.

The HBM strategy can only be called fully successful if the benefits of the program are sustainable. There are many factors that contribute to a program's sustainability. Sufficient financing and a reliable source of antimalarials are certainly fundamental aspects of sustainability, but beyond the scope of this assessment. In this assessment, two factors that affect sustainability came up repeatedly in the responses of participants and in the data collected: integration and motivation.

Experience demonstrates that interventions that are integrated with other health services have a greater chance of sustainability. Currently, the HBM Program is largely a stand-alone program, with separate medicine procurement, record keeping, volunteers, and supervision. The program, though, does have some aspects that are integrated. In Kirehe, IRC has worked with the district health team to add treatment for diarrhea to the work of Distributeurs. With the exception of Kibogora District, 80% to 90% of Distributeurs are also Health Animateurs and some are TBAs. This integration was not purposeful, but rather a result of the elections (i.e., many communities elected their Animateurs to be Distributeurs).

There are several areas where integration could be pursued, particularly in service delivery, reporting, and procurement. At the service level, integration of community level volunteers is needed and should not be constrained by organizational boundaries within the MOH. IRC has already demonstrated that Distributeurs are capable of managing more than one childhood illness. INMCP has developed a model reporting system that at all levels that could be used as a template for more integrated reporting for pharmaceutical management, clinical supervision, and disease surveillance. In addition, procurement of antimalarials should ultimately be integrated with procurement of other essential drugs, but this will require significant strengthening of the procurement capacity of CAMERWA.

There is almost universal agreement by all those who participated in the assessment that lack of sufficient motivation poses the greatest risk to the long-term sustainability of the HBM program. To date, the number of drop outs has not been large, except for urban Kigali. This situation may change, particularly in light of comments by some Distributeurs that they have, at times, had to pull money out of their own pocket to pay for transport for referrals, provide food for some of their clients, or had to offer credit to many caretakers who could not afford the 50 franc fee for treatment. In fact, it is a testament to the Distributeurs' dedication and commitment to their communities that so many have continued to perform at a superior level.

The development of associations, groupings of Distributeurs supervised by the same HC that were formed to provide motivation to their members, appears to be a solution that has been promoted and which many groups of Distributeurs are pursuing. As currently constructed, though, these associations are providing a very limited menu of options for their participants and receiving a small amount of funding from HCs. Being made up of small numbers of Distributeurs has limited the economies of scale that larger associations would bring.

Associations may well be the best approach for providing motivation, but greater input from Distributeurs on the benefits they would like to see provided by these associations seem warranted. There is also a need to harmonize the approach to compensation for different disease control programs. It was reported that in some locations volunteers are receiving cash payments from other disease control programs. Such an approach is likely to undermine the value ascribed to other types of motivation.

It is notable that the types of motivation requested by Distributeurs primarily fall into three categories:

- Continuing education, such as refresher training, journals, training in other topics, or radios to follow educational programs

- Essential tools for performance of their duties, including rain boots, umbrellas, bags, bicycles, torches, kerosene, or compensation for transport
- Non-monetary compensation, particularly exemption from other duties in the community (e.g., community patrol, cleaning day) and enrollment in the mutuelle.

It is hard to argue against providing Distributeurs with continuing education and essential tools to carry out their duties. It also seems reasonable to count their service as their contribution to the community. These relatively low-cost investments could go a long way towards retaining the cadre of volunteers in which much has already been invested.

B. Key Questions

The Terms of Reference for this assessment posed five key questions, which we would now like to answer.

Q1. Are drug distributors able to provide the quality of services expected from them by the people?

This assessment has clearly shown that communities and district and HC staff highly value the HBM program. Distributeurs demonstrate a good knowledge and application of treatment protocols, and are available day and night with consistent supplies of medicines. HC staff also report that the referrals they received from Distributeurs were appropriate. More than 80% of children treated by Distributeurs are being treated within 24 hours of onset of illness.

Q2. Is there evidence that caretakers are changing treatment seeking practices and improving adherence with treatment?

By almost all accounts, Distributeurs are now the preferred source of treatment for children with fever. HCs are seeing fewer cases of simple malaria as children are being treated effectively in their communities. Caretakers also report that the advice of the Distributeurs, administration of the first dose under observation, and blister packaging have enhanced adherence with treatment.

Q3. What lessons learned from this pilot could be used to improve Distributeurs' performance and inform further scaling-up and out of home-based management of malaria?

Several lessons can be drawn from the pilot phase of implementation:

1. Communities' election of Distributeurs created immediate ownership of the HBM program and provided credibility to the person elected.
2. Use of similar medicines and packaging as provided at HCs, day and night availability, and HC staff giving priority to referrals promoted the use of Distributeurs.
3. Having treatment available close to home, at an affordable price, and available around the clock resulted in much more rapid treatment-seeking by caretakers.
4. Non-membership in the mutuelle and lack of transport are major barriers to referral.
5. Supervision was essential for maintaining quality and for retaining Distributeurs, but the content of supervision needs standardization.
6. Development and use of standardized reporting forms facilitated program monitoring and are a model for reporting of other diseases and pharmaceutical management.

Q4. What other sources of treatment are being sought out by caretakers of children with fever and what types of treatment are being provided? Why do caretakers choose one source over another?

Since the implementation of the HBM Program, the overwhelming majority of caretakers prefer to use Distributeurs for their young children with fever because they trust them and

the medicines they prescribe. Traditional healers are still frequently sought out for some specific conditions (not including simple fever). In addition, treatment is often obtained from formal and informal (magendu) drug sellers for treatment of illnesses of older children and adults.

Q5. What concrete recommendations should be given to decision makers for a better HMM in Rwanda in the context of community IMCI, use of Coartem® as first line antimalarial and the introduction of rapid diagnostic tests in the community for malaria diagnosis?
(See Recommendations section that follows immediately below)

VI. RECOMMENDATIONS

1. The lack of motivation for Distributeurs must be systematically and comprehensively addressed through a broad discussion with all key stakeholders in the MOH, the districts, and partner agencies so that no single group inadvertently develops an approach for providing motivation that is not sustainable or undermines other approaches. The pros and cons of associations and other options for providing motivation should be scrutinized. In looking at the types of possible motivations that could be provided to community agents, attention should be paid to stated preferences of Distributeurs, which include:
 - Provision of essential supplies (e.g. boots, bags, torches, umbrellas, bicycles)
 - Continuing education, including trainings, books, journals, and radios
 - Non-monetary compensation, such as exemption from other community service
2. As the HBM Program continues to scale-up, attention should be given to those areas in need of strengthening, including:
 - a. Training and re-training to maintain the skills of volunteers. Training was also noted by many respondents as an effective method of retaining volunteers (i.e., motivation).
 - b. Supervision should be standardized for content with standard checklists and focus both on reviewing records/data collection and providing feedback and training to Distributeurs. Opportunities for observation of Distributeurs conducting consultations also should be pursued. This could be done by observing them manage a few sick children in the outpatient department when they come to the HC to replenish medicine stocks or deliver report forms.
 - c. Districts and communities should be challenged to pilot creative mechanisms for facilitating referrals of sick children to HCs.
3. Plans to introduce Coartem at the community level should proceed in concert with needed pharmaceutical management system strengthening and monitoring and evaluation, including pharmacovigilance for adverse events, as well as considering the current stock levels of the HBM blisters (see point 5 below).
4. Introduction of treatments for other childhood diseases (e.g., mebendazole for worms, ORT and zinc for diarrhea, and antibiotic treatment for ARI) through Distributeurs warrants further piloting. The HBM Program has demonstrated that quality services can be delivered in the community and communities are asking for expansion of the current program to include other childhood illnesses. IRC has already introduced ORT and zinc for watery diarrhea through Distributeurs. Their experiences to-date may help inform expansion of this pilot. Of course, any expansion must be done with care to avoid diluting the benefits of the program.
5. Strengthening of the pharmaceutical management system is needed, including:
 - a. Establish and monitor a system of reporting of stock levels and consumption of medicines, especially Coartem and other antimalarials.
 - b. With the expanded distribution of Coartem, developing a pharmacovigilance system to monitor for adverse events is recommended. This system could be used as a model for pharmacovigilance of other medicines.
 - c. Improve storage conditions at district pharmacies by ensuring that all district pharmacies have thermometers and temperature monitoring mechanisms in all stock areas, plus good air circulation through the use of palettes, fans or (if feasible) air conditioning units.

- d. Reduce the amount of Coartem stored at peripheral levels, where good storage conditions cannot be guaranteed. This could be achieved through more frequent ordering of Coartem by district pharmacies and HCs. Also, a more frequent national procurement (for example, every 9-12 months) may be needed, given the medicine's heat-sensitivity and short shelf-life.
 - e. Redistribute stocks of HBM blisters where there is stock surplus, based on expected consumption in the next few months, especially in the pilot districts that will implement Coartem at the community level. This mechanism could be set up at the district pharmacy level where they track the order quantities of HCs.
 - f. Encourage Distributeurs to promptly record required information in their patient registers while their patients are still there to ensure accuracy of recording and reinforce that stock cards are no longer needed.
 - g. Some additional recommendations for strengthening of the drug management system include:
 - i. Supervision at the district pharmacy level is needed and should be conducted by either the pharmacy task force (PTF) or CAMERWA, in collaboration with the INMCP, where antimalarials are concerned. Supervision at the HC and Distributeur levels should be standardized for content with the use of a standard checklist. Supervision should cover inventory management and review of record keeping. The storekeepers of either the district pharmacies or the district hospitals could be capacitated to conduct this aspect of supervision as part of the district supervisory team.
 - ii. Ensure all storekeepers at district pharmacy level are trained in appropriate store management practices, while awaiting the implementation of the MOH's decision to place a pharmacist in each district pharmacy.
 - iii. Involve a pharmacy body (e.g., CAMERWA or the PTF) in the quantification and monitoring of antimalarial distribution.
6. The HBM Program is an important part of a comprehensive strategy to improve the management of childhood malaria, but is not the only part. Efforts also must be made to improve the quality of treatment in the private sector. Options that should be evaluated for intervening with private drug sellers include:
- a. National guidelines for management of malaria should be distributed and training provided to staff of private sector outlets (comptoirs and dispensaries). The planned introduction of Coartem into the private sector makes such training timely and essential. Additionally, orientation should be provided on guidelines for the management of other childhood illnesses.
 - b. Develop and distribute appropriate visual aids on the management of malaria and other childhood conditions. The association of pharmacists could be a good partner in this type of activity.
 - c. Establish a strong national drug regulatory body to regulate importation and registration of medicines, assure the quality of medicines, and regulate the quality of services in the private sector, as well as the public sector.
 - d. Standardize practices of staff in comptoirs pharmaceutiques and improve the quality of services provided through approaches such as accreditation and/or training and supervision.
 - e. Develop linkages between private drug vendors and the public health system, such as through the use of standardized referral notes.

- f. Further exploration of the informal sector is needed to determine its magnitude and importance in providing health care, particularly to young children. Almost all community members questioned reported using either traditional healers or magendum for treatment of some illnesses. It is unlikely that stricter regulation alone will stop people from using these sources of care.
- 7. The role of RDTs was not directly assessed, but their appropriateness in community settings and in young children needs re-examination. When one considers that most of the overuse of antimalarial treatment is in adults and that children <5 years face the greatest risks if the test is falsely negative, there seems to be little rationale for targeting the most vulnerable group (i.e. children <5 years) for diagnostic testing. Logic would point towards first using diagnostic tests for adults until one can be assured that testing can be done accurately and that management based on the test results is appropriate.

ANNEXES

ANNEX 1: STUDY GUIDES AND DATA COLLECTION FORMS

Guide pour les Discussions de Groupe Adapté pour Mères//Pères/Grands-mères

INTRODUCTION :

Je m'appelle _____, et voici mon collègue _____. Le Ministère de la Santé souhaite aider les familles à améliorer la santé de leurs jeunes enfants et leur apprendre comment les soigner au mieux lorsqu'ils tombent malades. Nous sommes venus vous voir pour discuter des soins et des traitements que l'on donne aux enfants parce que nous aimerions faire mieux pour aider les familles à préserver la santé de leurs enfants ; tout le monde veut des enfants en bonne santé, pas vrai ? Aujourd'hui, en particulier, nous aimerions en apprendre davantage sur les fièvres et les maladies qui frappent les jeunes enfants et nous voudrions savoir comment vous les soignez dans votre communauté.

Surtout, n'hésitez pas, parlez librement, nous ne sommes pas ici pour dire ce qui est bien et ce qui n'est pas bien. Les gens ont chacun leur manière de s'occuper de leurs enfants et nous voulons savoir comment vous faites.

Nous aimerions ne rien oublier aussi nous vous demandons la permission d'enregistrer cette conversation sur cet enregistreur que nous allons placer au milieu du groupe. Tout le monde est d'accord ? S'assurer que tout le monde accepte l'enregistrement. Attendre que tout le monde approuve d'un signe de tête ou verbalement l'usage de l'enregistreur, mettre celui-ci sous tension et poursuivre la discussion.

Pour commencer, dites-nous comment vous voulez qu'on vous appelle et combien d'enfants de cinq ans et moins vous avez en charge à la maison ?

A. MALADIES INFANTILES : CONNAISSANCES ET CROYANCES

1. En général, quels sont les signes qui indiquent qu'un enfant n'est pas en bonne santé ou qu'il est malade ? A quoi ressemblent-ils ? Comment se comportent-ils ?
2. Quelles sont les maladies que les enfants attrapent les plus souvent dans votre communauté ? Y a-t-il des maladies qui sont plus dangereuses que d'autres ? Lesquelles ? Pourquoi ?

*Demander au groupe de classer les maladies par ordre de gravité et inscrivez les réponses. Relisez la liste. Apportez-y les changements suggérés par les participants. Demandez quelles maladies apparaissent toute l'année et celles qui sont saisonnières.

3. Comment savez-vous quand une maladie est particulièrement dangereuse pour un jeune enfant ? A quoi est-ce que cela ressemble ? Et pour les enfants de moins de cinq ans ?
4. A votre avis, quelles sont les causes de ces maladies ? Pourrait-on les prévenir ? Lesquelles ? Comment ?

B. LES TRAITEMENTS PREFERES:

1. Décrivez ce que vous faites quand vous rendez compte qu'un de vos enfants est malade. Y a-t-il quelque chose que vous voulez d'abord essayer à la maison ? Expliquez. Y a-t-il des maladies qui se traitent mieux à la maison ? Pourquoi cela ?

2. Comment décidez-vous qu'un enfant a besoin de soins que vous êtes incapable de donner vous-même à la maison ? Pouvez-vous nous expliquer cela ?

** Sondez sur des signes et des symptômes qui pousse la mère de chercher de l'aide en dehors de la maison.
3. Si un enfant a une fièvre combien de temps attendez-vous avant de chercher qu'il soit traité ? Ca prendra-t-il un peu de temps avant de recevoir des soins ?
4. Parlons maintenant de vous et de votre famille. Si vous pensez que votre enfant a attrapé la_ (citer une situation en dessous) , où le conduiriez-vous d'abord pour traitement ? Pourquoi ? Pouvez-vous décrire le type de traitement que vous attendez pour votre enfant ?
 - a. Fièvre ordinaire
 - b. Fièvre élevée
 - c. Fièvre et toux
 - d. Fièvre et perte d'appétit
 - e. Fièvre et diarrhée aqueuse
 - f. Fièvre et diarrhée mêlée de sang
 - g. Fièvre et convulsions

** Pour chaque problème (les 7 problèmes) sondez pour savoir les détails sur les médicaments donner et si ils ont reçus de conseils quelconques.

5. Est-il jamais arrivé que vous ne puissiez obtenir le traitement que vous désiriez pour votre enfant ? Expliquez. Quelqu'un dans le groupe peut-il citer un cas où cela est arrivé dans sa famille ou chez des connaissances ?

** Sondez pour connaître les conditions de transport, l'argent nécessaire pour le traitement, la nécessité d'obtenir l'accord préalable du conjoint ou de membres de la famille, la distance jusqu'à la clinique de référence, le personnel de santé communautaire ou distributeur indisponible, s'il a fallu trouver quelqu'un pour s'occuper des autres enfants avant de chercher des soins, etc.
6. Est-ce qu'il y a certaines d'entre vous qui ont eu un enfant qui a eu une fièvre au cours du dernier mois ? Voudriez-vous en parler avec le groupe ? Dites-nous tout ce dont vous pouvez nous rappeler, comment vous vous êtes rendu compte que l'enfant était malade (signes et symptômes) , le temps qui s'est écoulé avant que l'enfant n'ait reçu son traitement, où vous êtes allée pour les soins, les soins qu'il a reçus et les conseils.

** Suivant le temps disponible, laissez une ou deux mamans raconter. Lorsqu'elles ont terminé, remerciez-les pour leur contribution.

*Note: Cette information devrait nous donner plus de détails sur les difficultés et le processus de décision employé pour donner à un enfant malade un traitement médical approprié au niveau communautaire.

C. DONNER LES MÉDICAMENTS

1. Dans votre maison, qui décide normalement quels soins et quels médicaments donner aux enfants ? Est-ce la même personne qui donne aussi les médicaments ?
2. Et si on pense que l'enfant a contracté une maladie plus grave? Est-ce que c'est la même personne qui décide ? Expliquez.
3. Comment détermine-t-on la dose de médicaments à donner à un enfant malade ?

4. D'habitude, pour donner les médicaments, est-ce que vous suivez les recommandations ou les instructions que vous avez reçues ? Pouvez-vous penser à un cas où vous ou un membre de votre famille avez décidé de ne pas suivre les recommandations ou les instructions données ? Expliquez.

**Creusez pour les situations suivantes : Arrêt des médicaments quand l'enfant semble aller mieux, quand l'enfant ne semble pas devoir continuer à les prendre, quand les médicaments sont trop chers pour continuer, quand on partage les médicaments avec un autre malade dans la famille, quand les médicaments sont perdus, volés ou renversés, quand on décide de mettre à part une partie des médicaments pour les cas d'urgence, etc.

5. Arrive-t-il parfois d'avoir un enfant malade à la maison et que l'endroit où l'on trouve les médicaments soit à court de stock ? Si cela arrivait, que feriez-vous ? Avez-vous d'autres choix ? Expliquez.
6. Supposons que le distributeur soit en rupture de stock de medicament antipaludiques pour un enfant, où iriez-vous ? Avez-vous une idée de ce que cela vous coûterait ? Pensez-vous que cela serait plus ou moins cher qu'auprès du distributeur?
7. Combien cela coûte-t-il chaque fois que vous devez soigner un enfant contre le paludisme ? Pensez-vous que le prix des soins augmente? Diminue ? Pourquoi ?
8. Au cours des dernières années avez-vous remarqué dans la communauté des changements dans la manière de traiter les enfants contre les maladies et les fièvres ? Expliquez-nous cela.

D. SERVICES DISPENSÉS PAR LE DISTRIBUTEURS

1. Nous avons mentionné les distributeurs comme une option possible pour soigner les jeunes enfants malades. Est-ce que tout le monde dans le groupe connaît ce personnel ? Quelqu'un peut-il nous dire comment il a été sélectionné et quelles sont ses responsabilités?

2. Est-ce qu'il y a des personnes dans ce groupe se sont déjà adressées au distributeurs lorsqu'un enfant dans la famille a été malade ? Quelle sorte de maladie avait l'enfant ? Avez-vous reçu l'aide et les soins dont l'enfant avait besoin chez le distributeur? Y avait-il des frais pour ses services ou avez-vous fait aucune sorte de paiement ? S'il y a des frais, combien ? Si il y a d'autres sortes de paiement est-ce que vous pouvez nous dire ?

*Sondez pour savoir si les paiements pour services et médicaments ont été faits en espèces ou en nature, œufs, haricots, huile, etc.

3. Est-ce qu'il y a d'autres choses qui motivent les distributeurs pour faire le travail qu'ils font ?

*Sondez, prestige dans la communauté, fierté personnelle, formation reçue, accès aux informations sanitaires, traitement préférentiel au centre de santé, etc.

4. Est-ce que dans le groupe quelqu'un a déjà eu un enfant référé par le distributeur au centre de santé ? Que pouvez-vous nous dire de cette expérience ? Et alors, si le distributeur a référé et que vous n'avez pas suivie la conseil, pouvez-vous nous raconter aussi cette expérience.

5. En général, que pensez-vous des services offerts par les distributeurs ? A votre avis parmi tous les services que font-ils le mieux ? Pensez-vous que certaines choses doivent être améliorées ? Expliquez. Pensez-vous que le distributeur pourrait soigner d'autres maladies ?

*Sondez pour connaître, si les médicaments sont disponibles, s'ils sont satisfaisants des soins, des recommandations reçues, de la disponibilité du distributeur, si les soins sont fiables, etc.

E. SOURCES D'INFORMATION SUR LES SOINS À DONNER AUX ENFANTS MALADES

1. En plus que les distributeurs, que sont les autres sources d'information sur la lutte antipaludique ? A votre avis, quelles sont les sources les plus crédibles ? Les plus convaincantes ? Pourquoi ?

*Sondez les principales sources d'information, infirmier, agent de santé communautaire, distributeurs, accoucheuses traditionnelles, guérisseur traditionnel, membre de la famille ou voisin, église ou groupe de soutien, etc.

2. Avez-vous jamais vu du matériel éducatif qui explique comment soigner un jeune enfant atteint de fièvre et où s'adresser pour recevoir de l'aide ? Pouvez-vous expliquer à quoi ressemblait ce matériel et où vous l'avez vu ? Qu'en pensez vous?
3. Avez-vous jamais entendu à la radio comment soigner un jeune enfant atteint de fièvre et où s'adresser pour recevoir de l'aide ? Vous souvenez-vous de ce que vous avez entendu ? Qu'en pensez vous?

F. CONCLUSION

Nous sommes arrivés à la fin de notre discussion. Nous voudrions remercier chacun d'entre vous d'avoir accepté de partager avec nous vos réflexions et votre expérience sur les soins à donner aux enfants malades pour les aider à aller mieux. Nous avons appris beaucoup de cette conversation et les informations vont aider le MINISANTE à améliorer le programme.

Mais avant de vous quitter avez-vous d'autres questions ou d'autres commentaires que vous souhaitez partager avec nous ?

Durée estimée de la discussion ; 1,5 – 2 heures

Guide pour l'interview en profondeur des leaders communautaires

INTRODUCTION

Bonjour. Merci de nous accorder un petit moment pour discuter. Je m'appelle _____, et voici mon collègue _____. Nous avons demandé à vous parler parce que le Minsanté souhaite améliorer les soins et les traitements disponibles pour les familles qui ont des petits enfants. En particulier nous voudrions parler du travail du personnel de santé communautaire et des traitements antipaludiques disponibles par ici.

Surtout, n'hésitez pas, parlez librement, nous ne sommes pas ici pour dire ce qui est bien et ce qui n'est pas bien. Le ministère voudrait savoir ce que vous pensez du programme et surtout vos idées pour l'améliorer.

Nous n'allons pas prendre votre nom et nous ne l'utiliserons pas dans notre rapport. Nous allons faire tout notre possible pour ne pas dévoiler l'identité des personnes qui nous aident dans cette évaluation. Si nous décidons d'utiliser votre commentaire dans notre rapport, nous ne mentionnerons pas votre nom.

D'accord pour parler du programme ? D'avance merci.

IMPRESSIONS GÉNÉRALES SUR LE PROGRAMME DU PERSONNEL DE SANTÉ COMMUNAUTAIRE (DISTRIBUTEURS)

1. En général, que pensez-vous du programme Distributeurs ? Quels sont les services qu'il rend ?
 2. Est-ce que vous ou votre famille avez déjà emmené un enfant au Distributeurs pour des soins ? Quelle maladie avait l'enfant ? Avez-vous reçu le traitement et l'aide dont l'enfant avait besoin ? Expliquez.
 3. À votre avis quelles sont les bonnes choses qui se sont produites grâce au programme Distributeurs ?
 4. Avez-vous jamais eu des problèmes avec le programme Distributeurs et lesquels ? Dites-moi ce qu'on a fait pour essayer de résoudre ces problèmes.
- *Sondre tout problème mentionné pour les références, le manque de médicament, la disponibilité, etc.
5. Pouvez-vous me dire comment le Distributeurs a été choisi et comment il a été introduit dans la communauté ? Recommandez-vous de faire la même chose dans les autres régions où le MSP projette d'introduire le programme ou bien y a-t-il des choses que vous voudriez changer ?
 6. Savez-vous si le Distributeurs a de nombreux contact avec le personnel du centre de santé local ? Pensez-vous que le personnel du centre de santé supporte le Distributeurs dans son travail ? Expliquez.
 7. Quelle est l'interaction du Distributeurs avec la communauté ? Dites-nous si la communauté aide le Distributeurs à faire son travail et comment ?
 8. À votre avis, qu'est-ce qui motive les Distributeurs à faire le travail qu'ils font ?

*Sondre pour les compensations en espèces ou en nature, prestige dans la communauté, fierté personnelle, formation reçue, accès aux informations sur la santé, traitement préférentiel au

centre de santé, etc.

9. Pensez-vous qu'il faut étendre le travail des Distributeurs pour qu'ils puissent traiter d'autres maladies ou s'occuper des autres problèmes de santé des enfants ? Expliquez.

10. À votre avis, comment peut-on améliorer le programme ?

Merci beaucoup d'avoir parlé avec nous. Avant que nous prenions congé, y a-t-il d'autres questions que vous voudriez nous poser ?

Durée approximative 30 -45 minutes

Guide pour les Discussions de Groupe Personnel de Santé Communautaire

INTRODUCTION :

Le Ministère de la Santé souhaite aider les familles à améliorer la santé de leurs jeunes enfants et leur apprendre comment les soigner au mieux lorsqu'ils tombent malades. Nous sommes venus vous voir pour discuter des soins et des traitements que l'on donne aux enfants parce que nous aimerions faire mieux pour aider les familles à préserver la santé de leurs enfants ; tout le monde veut des enfants en bonne santé, pas vrai ? Aujourd'hui, en particulier, nous aimerions en apprendre davantage sur les fièvres et les maladies qui frappent les jeunes enfants et nous voudrions savoir comment vous les soignez dans votre communauté.

Surtout, n'hésitez pas, parlez librement, nous ne sommes pas ici pour dire ce qui est bien et ce qui n'est pas bien. Les gens ont chacun leur manière de s'occuper de leurs enfants et nous voulons savoir comment vous faites.

Nous aimerions ne rien oublier aussi nous vous demandons la permission d'enregistrer cette conversation sur cet enregistreur que nous allons placer au milieu du groupe. Tout le monde est d'accord ? S'assurer que tout le monde accepte l'enregistrement. Attendre que tout le monde approuve d'un signe de tête ou verbalement l'usage de l'enregistreur, mettre celui-ci sous tension et poursuivre la discussion.

Je m'appelle _____, et voici mon collègue _____. Pour commencer, dites-nous comment vous voulez qu'on vous appelle et combien d'enfants de cinq ans et moins vous avez en charge à la maison ?

A. MALADIES INFANTILES : CONNAISSANCES ET CROYANCES

1. Quelles sont les maladies que les enfants attrapent dans votre communauté ? Quelles sont les plus fréquentes ? Y a-t-il des maladies qui sont plus dangereuses que d'autres ? Lesquelles ? Pourquoi ?

*Retenez le nom local des maladies et discutez/mettez-vous d'accord sur les noms locaux. Vérifiez les informations surtout sur celles qui provoquent de la fièvre, en particulier :

Fièvre ordinaire
Fièvre élevée
Fièvre et toux
Fièvre et perte d'appétit
Fièvre et diarrhée aqueuse
Fièvre et diarrhée mêlée de sang
Fièvre et convulsions

*Demander au groupe de classer les maladies par ordre de gravité et inscrivez les réponses. Relisez la liste. Apportez-y les changements suggérés par les participants. Demandez quelles maladies apparaissent toute l'année et celles qui sont saisonnières. Vous devrez vous référer à cette liste dans une question ultérieure.

2. Comment savez-vous quand une maladie est particulièrement dangereuse pour un jeune enfant ? A quoi est-ce que cela ressemble ? Est-ce différent pour les nouveaux-nés et les petits de moins de trois mois ? Et pour les enfants de moins de cinq ans ? Avez-vous appris ceci au cours de votre formation de Distributeur ou le saviez-vous auparavant ? Expliquer.
3. A votre avis, quelles sont les causes de ces maladies ? Pourrait-on les prévenir ? Lesquelles ? Comment ? Vous souvenez-vous avoir appris ou entendu parler de ceci ? Expliquer.

B. ACTIVITÉS DE ROUTINES DANS LA COMMUNAUTÉ

1. Comment les gens du pays faisaient-ils pour soigner leurs enfants malades avant que vous ne commenciez à travailler comme Distributeur ? Que faisaient-ils ? A qui s'adressaient-ils normalement pour recevoir des soins ?
2. Comment avez-vous été choisi comme Distributeur dans la région ? Pouvez-vous l'expliquer au groupe ? Comment les gens du pays ont-ils appris qu'ils pouvaient s'adresser à vous pour soigner leurs jeunes enfants malades ? Comment avez-vous été introduits ?
3. Êtes-vous volontaires ? À peu près combien de temps passez-vous chaque semaine comme Distributeur ? Combien d'enfants voyez-vous chaque jour ? Chaque semaine ? Pouvez-vous décrire ce que vous aimez ou quels avantages vous tirez de votre activité de Distributeur ?
**Sondez pour trouver des raisons telles un meilleur statut ou plus de respect au sein de la communauté, meilleures connaissances sur la santé des enfants, opportunités de rencontrer de nouvelles personnes, de poursuivre des formations, bon support du dispensaire, etc.*
4. Avez-vous jamais reçu compensation pour le travail que vous faites ? Recevez-vous cela régulièrement ou juste de temps en temps ?

**Sondez pour savoir comment les compensations sont gérées. Est-ce structuré et à propos ? Ont-ils permission de conserver un pourcentage du prix de chaque médicament vendu ? Existe-t-il une forme de paiement communautaire ? Les familles font-elles parfois des paiements ou des contributions sous forme de repas ou de dons de nourriture, oeufs, haricots, etc ? S'il y a compensations, sont-elles obligatoires ou volontaires ?*

5. Parlons un peu de votre travail comme Distributeur. Quand un parent vous amène un enfant pour des soins, quelles sont les choses que vous faites normalement ?

**Note : Assurez-vous que chacun des domaines suivants soit couvert en réponse à cette question.*

- Reconnaître un paludisme sans complication
- Donner le traitement approprié pour un simple palu
- Reconnaître un palu sévère et les signes de danger
- Conseiller les parents sur les actions à prendre lorsqu'il y a signe de danger (référence)
- Conseiller les parents comment soigner les jeunes enfants atteints de palu

**Sondre pour savoir si on utilise régulièrement des assistances ou des outils pour le travail*

6. Certaines tâches sont-elles plus difficiles à accomplir que d'autres ? Certaines sont-elles plus faciles ? Avec lesquelles êtes-vous le plus confortables ? Expliquez.

**Sondre pour les cas qui doivent être référés, la reconnaissance des signes de danger, l'administration des médicaments, , les conseils aux parents pour prendre soin des enfants, la complétion des formulaires, etc.*

C. AUTRES BESOINS DE SOINS DANS LA COMMUNAUTÉ

1. La plupart des parents viennent-ils vous trouver lorsqu'un de leurs enfants a la fièvre ? Viennent-ils parfois pour d'autres problèmes ? Expliquez.
2. Existe-t-il d'autres endroits dans la région où les gens peuvent aller pour la fièvre et le palu ? Expliquez. Et pour les autres maladies ? Quels traitements donnent-ils ? Qui va d'habitude se faire soigner là ? Est-ce qu'on y conduit les enfants ? Pourquoi et pourquoi non ?
3. Selon vous quelles sont les raisons pour lesquelles les gens viennent vous voir pour des soins ? Avez-vous aucune idée pourquoi certains préfèrent aller ailleurs ?

*Demander les traitements préférés pour chacune des maladies mentionnées plus tôt par le groupe en réponse à la question A.1. Sonder pour la facilité, le transport, la satisfaction du traitement, les sources de traitement en qui on a confiance, les coûts, etc.
4. Existe-t-il d'autres traitements pour enfants que les gens désirent et que vous aimeriez pouvoir offrir ? Expliquez.

*Sonder pour savoir si aucun des Distributeur a jamais traité un enfant pour quelque chose d'autre que le palu et quels soins il a donnés.

D. ADMINISTRATION DES MÉDICAMENTS

1. Quel genre de médicaments donnez vous normalement à un jeune enfant atteint de palu ? Est-ce toujours le même genre de médicaments ? Comment savez-vous combien donner ?
2. Comment expliquez-vous aux parents comment donner les médicaments à un enfant malade ? Est-ce que deux d'entre vous peuvent faire un petit jeu de rôle pour nous montrer comment vous procédez ?

*Inviter deux membres du groupe, l'un jouant la maman et l'autre le Distributeur, à vous montrer comment ils donnent les conseils. Lorsqu'ils ont terminé, demander aux autres de commenter ce qu'ils viennent de voir.
3. Pensez-vous que la plupart des parents suivent vos conseils pour donner les médicaments aux jeunes enfants ? Donnent-ils d'habitude la première dose en votre présence ? Et les gobelets et l'eau potable ? Ces choses sont-elles disponibles et faciles à trouver ? Expliquez.
4. Pouvez-vous penser à une raison ou à un cas où des parents auraient utilisé des antipaludiques que vous leurs aviez donnés à des fins autres que celles que vous leurs aviez expliquées ?

*Sondez les cas suivants : traitement arrêté quand l'enfant semble aller mieux, l'enfant ne semblait plus avoir besoin des médicaments, les médicaments étaient trop chers pour pouvoir continuer, partage des médicaments avec un autre membre de la famille qui est malade, médicament perdus, volés ou renversés, désir de conserver des médicaments pour les cas d'urgence, etc.
5. Avez-vous aucun moyen de vous assurer que les enfants reçoivent les médicament suivant les instructions que vous avez données ? Avez-vous jamais questionné un parent pour savoir comment il a donné les médicaments ? Expliquez.
6. D'habitude, disposez-vous des médicaments nécessaires pour soigner les cas qu'on vous amène ? Vous êtes-vous jamais retrouvés sans médicaments ? Savez-vous pourquoi vous vous êtes retrouvés sans ? Qu'avez-vous fait ?

7. Lorsqu'on vous amène un enfant avec un palu, combien cela coûte-t-il pour le soigner ? S'il était nécessaire de référer l'enfant, combien cela coûterait-il ? Sur une année, combien pensez-vous que les familles dépensent par enfant pour soigner le palu ?

E. SOURCES D'INFORMATION SUR LES SOINS À DONNER AUX ENFANTS MALADES

1. Dans cette communauté, à qui les gens préfèrent-ils s' adresser pour savoir comment soigner un enfant malade ? Pourquoi ?

*Sondez les principales sources d'information, infirmier, personnel de santé communautaire, sages-femmes traditionnelles, voisins, belle-fille, etc.

2. En plus de ces personnes, existe-t-il d'autres moyens utiles d'apprendre aux familles comment soigner leurs jeunes enfants ?

*Sondez pour savoir s'il y a des spots ou des programmes radio, du théâtre communautaire, des posters, des dépliants, des réunions communautaires, des groupes de support, etc.

3. De quel matériel éducatif disposez-vous pour expliquer comment soigner un jeune enfant malade ? Avez-vous été formés pour les utiliser ? Qu'en pensez-vous ? Les utilisez-vous souvent ? Pensez-vous qu'ils vous aident dans votre travail ? Expliquez.

4. Y a-t-il d'autres choses à faire pour apprendre aux gens comment soigner les jeunes enfants quand ils sont malades ?Y a-t-il des choses que vous ignorez et que vous aimeriez connaître ? Expliquez.

F. SUPPORT DU PERSONNEL DU CENTRE DE SANTÉ ET DE LA COMMUNAUTÉ

6. Combien de fois êtes-vous en contact avec le personnel du centre de santé de votre région ? Y a-t-il des activités ou des tâches que vous effectuez régulièrement avec eux ? Normalement, comment vous supportent-ils, vous et le travail que vous faites?

7. Et la supervision ? Y a-t-il quelqu'un du centre de santé ou d'ailleurs qui vous visite régulièrement pour jeter un coup d'oeil à votre travail ? Quel est le nom de cette personne ? Normalement, que se passe-t-il au cours de la visite de supervision ? Est-ce ainsi que cela s'est passé la dernière fois que vous avez été supervisés ? Quand était-ce ?

8. Y a-t-il d'autres choses que le personnel de centre de santé puisse faire pour vous aider dans votre travail ? Expliquez. Et la communauté ? Y a-t-il quelque chose qu'elle puisse faire pour vous aider à améliorer votre travail ?

G. SUGGESTIONS POUR L'AVENIR

1. Songez-vous à quelque chose qui puisse renforcer le programme et le rendre plus efficace dans l'avenir ? Qu'est-ce ? Comment cela peut-il améliorer le programme ?
2. Y a-t-il quelque chose dans le programme que vous souhaitez voir disparaître ou être fait différemment dans l'avenir ? Expliquez.

H. CONCLUSION

Nous sommes arrivés à la fin de notre discussion. Nous voudrions remercier chacun d'entre vous de nous avoir parlé franchement de votre travail et de vos expériences. Cette conversation nous sera très utile. Vos suggestions et vos commentaires permettront au MSP de continuer à améliorer les services de santé dans les communautés du pays et aux enfants de rester en bonne santé et de recevoir les soins nécessaires lorsqu'ils tombent malades. Je vous souhaite à tous bonne continuation dans votre travail.

Mais avant de terminer, y a-t-il d'autres questions ou d'autres commentaires que vous souhaitiez partager avec nous ?

Durée estimée de la discussion ; 1,5 – 2 heures

Guide pour les interviews du personnel des centres de santé

A lire avant l'interview :

Je m'appelle _____ et voici mon collègue _____. Le Ministère de la santé a lancé dans six districts, dont celui-ci, un programme basé sur la distribution des médicaments antipaludiques chez les enfants malades de moins de 5 ans par les agents communautaires. Le ministère de la santé nous a chargés de visiter quelques uns de ces six districts pour faire le point sur le démarrage du projet : Ce qui marche, les problèmes et les difficultés rencontrés, comment ils ont été résolus, l'impact de ce programme sur la communauté, sur votre travail et celui de vos collègues.

Voilà pourquoi nous souhaitons passer un peu de temps , sans doute pas plus de trente minutes, pour parler avec vous. Votre avis et votre expérience sont très importants à nos yeux. Si vous acceptez de participer, nous vous demandons de parler aussi librement et honnêtement que possible.

J'insiste sur le fait que nous ne cherchons pas à prendre quelqu'un en faute. Nous cherchons seulement à donner au ministère de la santé des informations qui lui permettront de mieux faire à mesure que le projet se développe.

Votre nom ne sera pas enregistré, pas plus qu'il ne sera utilisé dans aucun rapport. Nous ferons l'impossible pour garder secrète l'identité des personnes qui participent à cette évaluation. S'il nous arrive d'introduire vos commentaires dans le rapport, nous veillerons à ne pas identifier l'auteur.

Pouvons nous parler du programme pendant un petit moment ?

A. MALADIES INFANTILES : CONNAISSANCES ET CROYANCES

- 1) Quelles sont les maladies les plus courantes que vous trouvez chez les jeunes enfants dans cette communauté ?

Si non mentionnés, sondez pour :

- i) Diarrhée
- ii) ARI et pneumonie
- iii) Paludisme

- 2) Parmi les maladies qui viennent d'être mentionnées, quelles sont celles qui sont responsables de la plus grande mortalité chez les jeunes enfants ?

- 3) Pourquoi pensez-vous que le paludisme cause tellement de décès chez les enfants ?

Si non mentionnés, sondez pour :

- i) Retards dans la recherche de soins/traitement
- ii) Manque d'information des personnes en charge
- iii) Non utilisation des méthodes de prévention
- iv) Usage de médicaments mauvais ou inappropriés
- v) Non continuation du traitement

- 4) Je vais passer en revue une liste de symptômes. Pour chaque cas, je voudrais que vous me disiez ce que vous feriez normalement si une mère vous amenait un enfant de deux ans présentant les symptômes suivants:

a. Fièvre et pas d'autre symptôme : _____

b. Fièvre et toux : _____

c. Fièvre et manque d'appétit _____

d. Fièvre et diarrhée : _____

e. Fièvre et léthargie : _____

f. Fièvre élevée, température 40 degrés : _____

B. INFORMATIONS GÉNÉRALES SUR LE DISTRIBUTEUR

1. Combien de distributeur de médicaments antipaludiques (du PNILP) y a-t-il dans les villages desservis par votre dispensaire ? _____

2. Assumez-vous des responsabilités dans le programme Distributeur?

Oui

Non [Passer à la section C]

3. Si oui, quelles sont-elles ?

Cocher ce qui s'applique :

- i) Supervision
- ii) Recevoir les cas qui vous sont référés
- iii) Collecte des rapports de cas
- iv) Livraison des médicaments
- v) M&E
- vi) Rapports mensuels d'activités
- vii) Autres, décrivez : _____

4. Si oui à supervision, pouvez-vous décrire vos responsabilités dans la supervision des Distributeurs?

Oui Non [Passer à la section C]

5. Pouvez-vous décrire quelques problèmes rencontrés au cours des visites de supervision ?

6. Conservez-vous les rapports de vos visites de supervision ? Oui Non

Si oui, puis-je voir les rapports ? (Noter les informations recueillies et la fréquence des visites)

Nombre de visites au cours des 6 derniers mois : _____

Nombre de Distributeur rencontrés au cours des 6 derniers mois _____

Établir la liste des problèmes enregistrés dans les rapports et les mesures prises ;

C. RÉFÉRENCES DU DISTRIBUTEUR

1) Avez-vous reçu des enfants malades transférés par les Distributeur ?

Oui Non [Passer à la question 5]

2) Si oui, combien reçu par mois ? _____

3) En règle générale, pensez-vous que les enfants qui vous sont transférés par les Distributeur le sont de manière :

Appropriée Inappropriée

4) Pouvez-vous donner des exemples d'enfants et de maladies qui vous ont opportunément été transférées par les Distributeur ?

5) Pouvez-vous donner quelques exemples d'enfants qui n'ont pas été transférés correctement ? Lorsque ceci s'est produit, avez-vous fait quelque chose pour corriger le problème ?

6) Quels problèmes avez-vous vus qui empêchaient les enfants d'être transférés ?

Cocher ce qui s'applique :

- i) Manque d'argent
- ii) Manque de transport
- iii) Enfants emmenés ailleurs. Où ? _____

7) Qui tient la liste des enfants qui vous ont été transférés?

Distributeur Centre de Santé Autre, _____

Si oui Centre de Santé, puis-je voir la liste ?

Nombre de transferts reçus dans les 6 derniers mois : _____

Nombre de transfert a hôpital de district dans les 6 derniers mois : _____

Etablir la liste des problèmes répertoriés et des actions prises : _____

8) Est-ce que les Distributeur vous envoient les enfants avec une note de transfert ?

Oui Non

Si oui, pouvez-vous me montrer un exemple ?

D. DISPONIBILITÉ DES MÉDICAMENTS

1. Arrive-t-il que ce dispensaire se trouve en rupture de stock de médicaments ?

Oui Non

2. Si oui, y a-t-il eu rupture de stock durant les 6 derniers mois de blister de AQ-SP pour les enfants du 6 mois à 35 mois ?

Oui Non

3. Si oui, y a-t-il eu rupture de stock durant les 6 derniers mois de blister de AQ-SP pour les enfants des 3 ans à 5 ans ?

Oui Non

4. Si oui, y a-t-il eu rupture de stock de quinine durant les 6 derniers mois?

Oui Non

5. Si oui, y a-t-il eu rupture de stock de Coartem durant les 6 derniers mois?

Oui Non Non applicable

6. Si c'est le cas, que faites-vous quand vous pensez qu'un enfant a le palu et que vous n'avez pas de médicaments pour le traiter ici ?

7. Êtes-vous impliqués dans la livraison des médicaments aux Distributeur ?

Oui Non **[Passer à la question 8]**

Si oui, décrivez votre rôle.

[Passer à la question 9]

8. **[Si non à la question 7]** Avez-vous connaissance ou avez-vous entendu parler de Distributeur dans la région qui ont connus une rupture de médicaments ?

Oui Non **[Passer à la section F]**

- i. Si oui, combien de fois avez-vous entendu dire que c'était arrivé ?

- ii. Savez-vous combien de temps ils sont restés sans médicaments ?

- iii. A-t-on fait quelque chose pour remédier à la situation ?

[Passer à la section F]

9. **[Si oui à la question 7]** Est-ce que certains des Distributeur que vous approvisionnez en médicaments se sont retrouvés sans au cours des 6 derniers mois ?

Oui Non **[Passer à la sous-section E]**

- ii. Si oui, avec quelle fréquence ? _____

iii. Quelle est la plus longue durée de rupture de stock ?

iv. A-t-on fait quelque chose pour régler la situation ?

[Passer à la sous-section E]

E. GESTION DE MÉDICAMENTS

Commandes

A) Comment recevez-vous vos médicaments ?

i) Allez-vous les chercher ou vous sont-ils livrés ici ?

ii) Si vous devez aller les chercher, à quelle distance est-ce et comment vous y rendez-vous (ex : à pieds, à bicyclette, en voiture) ?

B) Qui détermine combien de médicaments commander pour le district ?

C) Achetez-vous les médicaments ? Si vous n'achetez pas, sont-ils gratuits (donations) et si oui, qui les donne ?

D) Quelle est la fréquence des commandes ?

- i) Chaque semaine
- ii) Deux fois par mois
- iii) Chaque mois
- iv) Une fois par an
- v) Quand on en a besoin
- vi) Autre : (spécifier) _____

E) Quelle méthode utilise-t-on pour déterminer les quantités à commander ?

- i) Statistiques des quantités utilisées dans le passé
- ii) Expérience en général
- iii) On utilise une formule standard
- iv) C'est décidé par le programme national
- v) Autre (spécifier) _____

F) S'ils existent, quels registres ou rapports utilise-t-on pour décider combien commander ?

G) Où commandez-vous/achetez-vous les médicaments ? (Cocher tout ce qui s'applique)

- i) Détaillant privé (Pharmacie privée ou autre source)
- ii) Grossiste ou distributeur

- iii) Donations
- iv) Magasin médical central
- v) Magasin médical régional
- vi) Pharmacie de district
- vii) ONG
- viii) Autres (spécifier) _____

H) Indiquer le type de fournisseur le plus souvent utilisé ; _____

I) Si le fournisseur le plus souvent utilisé ne dispose pas des médicaments, que faites-vous ?

Gestion distribution/inventaires

J) Avez-vous des fiches de stock ou tout autre système pour tenir l'état de vos stocks ?

Oui Non

- i) Si oui, qu'avez-vous ? _____
- ii) Utilisez-vous cet outil ? _____
- iii) Comment l'utilisez-vous ? (observez si possible)

Supervision et rapports

J) Remplissez-vous un rapport de consommation et d'état des stocks des médicaments ?

Oui Non [Passer à la question L]

- i) Si oui, où envoyez-vous les rapports ? _____
- ii) Comment les envoyez-vous ? _____
- iii) Avec quelle fréquence ? _____
- iv) Quelles sont les informations contenues dans les rapports ?

K) Quand avez-vous reçu la dernière visite de votre superviseur ?

- i) Le mois dernier
- ii) Il y a moins de 3 mois
- iii) Il y a moins de 6 mois
- iv) Jamais
- v) Ne sait pas

L) Qui vous a rendu visite ?

- i) L'équipe de district
- ii) ONG
- iii) Autre (spécifier) _____

F. IMPRESSIONS GÉNÉRALES DU PROGRAMME DU DISTRIBUTEUR

1. En général, que pensez-vous du programme Distributeur ?
2. Pouvez-vous citer des bonnes choses qui sont sorties du programme Distributeur ?
3. Pouvez-vous me dire si vous avez eu des problèmes avec le programme et lesquels ? Pouvez-vous aussi me dire ce qui a été fait pour les résoudre ?
4. Avez-vous vu plus ou moins de cas de paludisme depuis le début du programme ?
5. Les cas de paludisme que vous avez vus récemment étaient-ils différents de ceux que vous avez connus avant le début du programme communautaire ?
6. A votre avis, comment peut-on améliorer le programme ?
7. Avez-vous d'autres questions ou d'autres réflexions que vous souhaitez partager avec nous ?

G. CONCLUSION

Voici venue la fin de notre discussion. Nous voudrions vous remercier pour le temps passé avec nous, pour vos réflexions et vos idées. Nous avons appris beaucoup et cette conversation nous est très utile.

Guide d'Interview pour les Pharmacies de District (Gestion des Médicaments)

Dites à haute voix: Bonjour. Je m'appelle _____. Le Minisanté essaie de développer les moyens d'améliorer la santé des enfants. Je m'adresse à des travailleurs des pharmacies de district qui conservent les médicaments pour les enfants, surtout les médicaments de traitement du paludisme. Votre nom ne sera pas écrit sur ce formulaire ni divulgué aux autorités. Puis-je vous demander quelques questions?

District:	Ville/Village:	Pharmacie de District:
Nom de l'Enquêteur	Date de l'Interview: ____ / ____ / ____ Jour Mois Année	
Heure du début de l'interview: ____ / ____ Heure Minutes	Heure de la fin de l'interview: ____ / ____ Heure Minutes	

Dites: Je voudrais vous poser quelques questions sur comment vous faites votre travail.

Commande

1. *Comment vous procurez-vous vos médicaments?*

- a. *Allez-vous les chercher ou vous sont-ils livrés ici?* _____
- b. *Si vous devez aller les chercher, à quelle distance et comment vous y rendez-vous (par exemple, à pied, à vélo ou en voiture)?* _____

2. Achetez-vous les antipaludiques?

Oui **[Sautéz à la Question 3]** Non

a) Sinon, sont-ils gratuits (dons)?

Oui Non **[Sautéz à la Question 3]**

b) Si oui, d'où viennent les dons? _____

3. *Quelle est la fréquence des commandes?*

- Chaque semaine
- Deux fois par mois
- Une fois par mois
- Une fois par an
- Quand c'est nécessaire
- Autre: (préciser) _____

4. *Qui détermine la quantité de médicaments à commander pour la pharmacie de district?*

5. *Comment la quantité de médicaments est-elle décidée?*

- Statistiques de la quantité de médicaments qui étaient utilisés dans le passé
- Expérience générale
- Une formule standard est utilisée
- Décidée par le programme national
- Autre (préciser) _____

6. Des registres ou des rapports sont-ils utilisés pour décider quelle quantité il faut commander?

Oui Non [**Sauter à la Question 7**]

a) Si oui, décrivez les registres ou les rapports utilisés: _____

7. Fournissez-vous des médicaments aux distributeurs?

Oui Non [**Sauter à la Question 9**]

8. Commandez-vous un stock supplémentaire pour les distributeurs communautaires?

Oui Non

9. Où s'approvisionnez-vous des antipaludiques? (cochez tout ce qui s'applique)

- Dépôt pharmaceutique
 Dons
 CAMERWA
 BUFMAR
 ONG
 Autre (*préciser*) _____

10. Quel est le type de fournisseur le plus important/ fréquemment utilisé? _____

11. Si le fournisseur (le plus fréquemment utilisé de la question 10) n'a pas les médicaments dont vous avez besoin, que faites-vous?

Distribution/Gestion de stock

12. Avez-vous des fiches de stock ou d'autres outils ou un système de rapportage pour enregistrer vos niveaux de stock?

Oui Non [**Sauvez à la Question 13**]

a. Si oui, lesquels? _____

b. Utilisez-vous ces outils? _____

c. Comment les utilisez-vous?

(Observez si possible, pour voir s'ils sont à jour et complets)

13. Est-ce que vous utilisez un ordinateur pour enregistrer vos sorties et la situation de stock ?

Supervision & Soumission de rapports

14. Préparez-vous des rapports sur la consommation et d'état des stocks des antipaludiques par la structure sanitaire et les niveaux de stock?

Oui Non [**Sauvez à la Question 15**]

a. Si oui, où envoyez-vous les rapports? _____

b. Comment les envoyez-vous? _____

c. Avec quelle fréquence? _____

d. Quelles informations les rapports contiennent-ils? _____

15. Quand un superviseur vous a-t-il visité pour la dernière fois?

- Le mois passé
- Il y a moins de 3 mois
- Il y a moins de 6 mois
- Autre (a préciser) _____
- Jamais **[Sautéz à la partie des infrastructures]**
- Ne sais pas **[Sautéz à la partie des infrastructures]**

16. De qui était cette visite?

- Équipe du District
- Équipe régionale
- Niveau central du Minisanté
- ONG
- Autre (préciser) _____

17. Qu'est-ce qu'ils ont vu/ supervisé quand ils étaient ici?

18. Vous ont-ils fait part de leurs commentaires et réactions?

- Oui
- Non

Infrastructures

Demandez à voir où les médicaments sont gardés (si ce n'est pas possible, demandez une description détaillée de l'endroit où les médicaments sont gardés).

	Eléments à vérifier	O/N	Commentaires
Sécurité	Portière fermée grillages sur les fenêtres, armoires fermées		
Electricité	Courant régulier Observée pour être bien entretenue et fonctionnelle		
Température du lieu de conservation	Température enregistrée/suivie? Température actuelle du lieu de conservation		
Réfrigérateur	Médicaments protégés de la lumière du soleil et de la chaleur Réfrigérateur fonctionnel présent? Température actuelle?		
Ordinateur	Température enregistrée? Présent et fonctionnel		

**Guide d'Interview pour les Centres de santé
(Gestion des Médicaments)**

Dites à haute voix: Bonjour. Je m'appelle _____. Le Minisanté essaie de développer les moyens d'améliorer la santé des enfants. Je m'adresse à des travailleurs des formations sanitaires qui gèrent les médicaments pour les enfants malades, surtout les médicaments de traitement du paludisme. Votre nom ne sera pas écrit sur ce formulaire ni divulgué aux autorités. Puis-je vous demander quelques questions?

District:	Ville/Village:	Centre de santé:
Nom de l'Enquêteur	Date de l'Interview: _____/_____/_____ Jour Mois Année	<input type="checkbox"/> Public <input type="checkbox"/> Agrée
Lieu:	<input type="checkbox"/> Urbain <input type="checkbox"/> Péri-urbain <input type="checkbox"/> Rural	
Heure du début de l'interview: _____/_____ Heure Minutes	Heure de la fin de l'interview: _____/_____ Heure Minutes	

Dites: Je voudrais vous poser quelques questions sur comment vous faites votre travail.

Commande

19. *Comment vous procurez-vous vos médicaments?*

- a. *Allez-vous les chercher ou vous sont-ils livrés ici?* _____
- b. *Si vous devez aller les chercher, à quelle distance et comment vous y rendez-vous (par exemple, à pied, à vélo ou en voiture)?* _____

20. Achetez-vous les antipaludiques?

Oui [**Sautez à la Question 3**] Non

a) Sinon, sont-ils gratuits (dons)?
 Oui Non [**Sautez à la Question 3**]

b) Si oui, d'où viennent les dons? _____

21. *Quelle est la fréquence des commandes?*

- Chaque semaine
- Deux fois par mois
- Une fois par mois
- Une fois par an
- Quand c'est nécessaire
- Autre: (préciser) _____

22. *Qui détermine la quantité de médicaments à commander pour le centre de santé?*

23. *Comment la quantité de médicaments est-elle décidée?*

- Statistiques de la quantité de médicaments qui étaient utilisés dans le passé
- Expérience générale
- Une formule standard est utilisée
- Décidée par le programme national

Autre (préciser) _____

24. Des registres ou des rapports sont-ils utilisés pour décider quelle quantité il faut commander?

Oui Non [**Sauter à la Question 7**]

a) Si oui, décrivez les registres ou les rapports utilisés: _____

25. Fournissez-vous des médicaments aux distributeurs?

Oui Non [**Sauter à la Question 9**]

26. Commandez-vous un stock supplémentaire pour les distributeurs communautaires?

Oui Non

27. Où s'approvisionnez-vous en antipaludiques? (cochez tout ce qui s'applique)

- Point de vente privé au détail (pharmacie privée ou autres points de vente)
- Dépôt pharmaceutique
- Dons
- CAMERWA
- BUFMAR
- Pharmacie de District
- ONG
- Autre (préciser) _____

28. Quel est le type de fournisseur le plus important/ fréquemment utilisé?

29. Si le fournisseur (le plus fréquemment utilisé de la question 10) n'a pas les médicaments dont vous avez besoin, que faites-vous?

Distribution/Gestion de stock

30. Avez-vous des fiches de stock ou d'autres outils ou un système de rapportage pour enregistrer vos niveaux de stock?

Oui Non [**Sautez à la Question 13**]

a. Si oui, lesquels? _____

b. Utilisez-vous ces outils? _____

c. Comment les utilisez-vous? _____
(Observez si possible, pour voir s'ils sont à jour et remplis)

31. Est-ce que vous utilisez un ordinateur pour enregistrer vos sorties et la situation de stock ? _____

Supervision & Transmission de rapports

32. Préparez-vous des rapports sur la consommation et d'état des stocks des antipaludiques par la structure sanitaire et les niveaux de stock?

Oui Non [**Sautez à la Question 15**]

a. Si oui, où envoyez-vous les rapports? _____

b. Comment les envoyez-vous? _____

c. Avec quelle fréquence? _____

d. Quelles informations les rapports contiennent-ils?

33. Quand un superviseur vous a-t-il visité pour la dernière fois?

- Le mois passé
- Il y a moins de 3 mois
- Il y a moins de 6 mois
- Autre (a préciser) _____
- Jamais **[Sautéz à la partie de infrastructure]**
- Ne sais pas **[Sautéz à la partie de infrastructure]**

34. De qui était cette visite?

- Équipe du District
- ONG
- Autre (*préciser*) _____

35. Qu'est-ce qu'ils ont vu/ supervisé quand ils étaient ici?

36. Vous ont-ils fait part de leurs commentaires et réactions?

- Oui
- Non

Infrastructures

Demandez à voir où les médicaments sont gardés (si ce n'est pas possible, demandez une description détaillée de l'endroit où les médicaments sont gardés).

	Eléments à vérifier	O/N	Commentaires
Sécurité	Portière fermée grillages sur les fenêtres, armoires fermées		
Electricité	Courant régulier Observée pour être bien entretenue et fonctionnelle		
Température du lieu de conservation	Température enregistrée/suivie? Température actuelle du lieu de conservation		
Réfrigérateur	Médicaments protégés de la lumière du soleil et de la chaleur Réfrigérateur fonctionnel présent? Température actuelle?		
Ordinateur	Température enregistrée? Présent et fonctionnel		

Guide d'Interview pour les Distributeurs (Gestion des Médicaments)

Dites à haute voix: Bonjour. Je m'appelle _____. Le Minisanté essaie de développer les moyens d'améliorer la santé des enfants. Je m'adresse à des distributeurs de santé qui distribuent des médicaments sur comment ils traitent ou donnent des conseils aux enfants malades, surtout ceux souffrant du paludisme. Votre nom ne sera pas écrit sur ce formulaire ni divulgué aux autorités. Puis-je vous demander quelques questions?

Si Oui: Distribuez-vous vous-mêmes régulièrement des médicaments aux patients ou aux clients?

Si non: Y a-t-il quelqu'un d'autre qui distribue régulièrement des médicaments aux patients ou aux clients?

Si oui: Puis-je parler avec cette personne?

District:	Ville/Village:	CS le plus proche:
Nom de l'Enquêteur	Date de l'Interview: _____/_____/_____ Jour Mois Année	
Lieu:	<input type="checkbox"/> Urbain <input type="checkbox"/> Péri-urbain <input type="checkbox"/> Rural	
Heure du début de l'interview: _____/_____ Heure Minutes	Heure de la fin de l'interview: _____/_____ Heure Minutes	

Dites: Je voudrais vous poser quelques questions sur comment vous faites votre travail.

Liste récapitulative des observations.

Si un patient vient pour le traitement pendant l'interview, encouragez le distributeur de continuer à s'occuper du patient, observez ce qui se passe et continuez l'interview après.

	Oui	Non
Le distributeur a-t-il expliqué quelle maladie l'enfant pourrait avoir?	<input type="checkbox"/>	<input type="checkbox"/>
Le distributeur a-t-il vérifié l'histoire de la maladie de l'enfant? ex âge, durée de la maladie, médicament déjà pris	<input type="checkbox"/>	<input type="checkbox"/>
Le distributeur a-t-il évalué la gravité en vérifiant les signes généraux de danger? Ex. convulsions, léthargie, vomissements, grande perte de poids.	<input type="checkbox"/>	<input type="checkbox"/>
Quels médicaments le distributeur a-t-il donné?		
Le distributeur a-t-il donné les informations de base sur comment prendre les médicaments?	<input type="checkbox"/>	<input type="checkbox"/>
L'emballage portait-il l'étiquette des informations du dosage?	<input type="checkbox"/>	<input type="checkbox"/>
Le distributeur a-t-il donné des conseils sur ce qui doit être fait si la santé de l'enfant ne s'améliore pas ou empire?	<input type="checkbox"/>	<input type="checkbox"/>
Le distributeur a-t-il donné des conseils sur la nutrition?	<input type="checkbox"/>	<input type="checkbox"/>
Le distributeur a-t-il donné des conseils sur la prévention de maladies?	<input type="checkbox"/>	<input type="checkbox"/>

L'enfant a-t-il été référé vers une formation sanitaire?

- Oui, le vendeur a verbalement référé l'enfant, mais n'a pas donné de note de référence.
- Oui, le vendeur a donné une note de référence.
- Non

Commande

37. Comment vous procurez-vous vos médicaments?

a. Allez-vous les chercher ou vous sont-ils livrés ici? _____

b. Si vous devez aller les chercher, à quelle distance et comment vous y rendez-vous (par exemple, à pied, à vélo ou en voiture)? _____

38. Commandez-vous les médicaments vous-mêmes ou quelqu'un d'autre les commande-t-il pour vous?

39. Achetez-vous les médicaments? Oui [Sauvez à la Question 4] Non

a) Sinon, sont-ils gratuits (dons)? Oui Non [Sauvez à la Question 4]

b) Si oui, d'où viennent les dons? _____

40. Quelle est la fréquence des commandes?

- Chaque semaine
- Deux fois par mois
- Une fois par mois
- Une fois par an
- Quand c'est nécessaire
- Autre: (préciser) _____

41. Qui détermine la quantité de médicaments à commander?

42. Comment la quantité de médicaments est-elle décidée?

- Statistiques de la quantité de médicaments qui étaient utilisés dans le passé
- Expérience générale
- Une formule standard est utilisée
- Décidée par le programme national
- Autre (préciser) _____

43. Des registres ou des rapports sont-ils utilisés pour décider quelle quantité il faut commander?

Oui Non [Sauter à la Question 8]

a) Si oui, décrivez les registres ou les rapports utilisés: _____

44. Où faites-vous la commande ou achetez-vous les médicaments? (cochez tout ce qui s'applique)

- Point de vente privé au détail (pharmacie privée ou autres points de vente de médicaments)
- Dépôt pharmaceutique
- Dons
- CAMERWA
- BUFMAR
- Pharmacie de District
- Centre de santé
- ONG
- Autre (préciser) _____

(S'ils citent seulement un fournisseur sautez à question 10)

45. Quel est le type de fournisseur le plus important/ fréquemment utilisé? _____

46. Si le fournisseur (le plus fréquemment utilisé de la question 9) n'a pas les médicaments dont vous avez besoin, que faites-vous?

Distribution/Gestion de stock

47. Avez-vous des fiches de stock ou d'autres outils ou un système de rapportage pour enregistrer vos niveaux de stock?

Oui Non **[Sautez à la Question 12]**

a. Si oui, lesquels? _____

b. Utilisez-vous ces outils? _____

Si non, pour quoi pas? _____

c. Comment les utilisez-vous? _____
(Observez si possible, pour voir s'ils sont à jour et remplis. Aussi observez pour voir si ils ont toujours les pages vierges ou des fiches de stock vierges)

Demandez à voir là où le distributeur garde les médicaments (si ce n'est pas possible, demandez au distributeur de décrire le lieu où il garde les médicaments).

48. Gardez-vous les médicaments dans une armoire/boîte fermée? (vérifiez par observation)

- Oui
- Non
- Ne sait pas

49. Gardez-vous les médicaments dans un lieu propre/sec? (vérifiez par observation)

- Oui
- Non
- Ne sait pas

Utilisation des Médicaments

50. Quels types de maladies des enfants traitez-vous ici souvent?

- Paludisme
- Pneumonie IRA
- Toux/grippe pas de pneumonie IRA
- Diarrhée
- Autre (précisez) _____

51. Pouvez-vous me dire les symptômes que vous pourriez trouver chez un enfant de deux ans souffrant d'un paludisme simple?

(Ne lisez pas. Ecoutez les réponses et vérifiez tout ce qui s'applique.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous costal	<input type="checkbox"/> Transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou qui coule	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissements	<input type="checkbox"/> Enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (corps chaud)	<input type="checkbox"/> Selles fréquentes/liquides	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> Enfant refuse de manger
<input type="checkbox"/> Mal de gorge	<input type="checkbox"/> Sang dans les selles	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Ne sais pas
<input type="checkbox"/> Démangeaison des yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> autre

52. Que feriez-vous si une mère vous apportait un enfant avec fièvre ordinaire ?

53. Que feriez-vous si une mère vous apportait un enfant avec fièvre élevée ?

54. Que feriez-vous si une mère vous apportait un enfant avec fièvre et toux ?

55. Que feriez-vous si une mère vous apportait un enfant avec fièvre et perte d'appétit ?

56. Que feriez-vous si une mère vous apportait un enfant avec fièvre et diarrhée aqueuse ?

57. Que feriez-vous si une mère vous apportait un enfant avec fièvre et diarrhée sanguinolente?

58. Que feriez-vous si une mère vous apportait un enfant avec fièvre et convulsions?

59. Quel médicament donnez-vous pour traiter un enfant souffrant d'un paludisme simple?

- _____
- Je le réfère à la formation sanitaire
- Je ne sais pas
- Autre.....

60. Que faites-vous si vous n'avez pas ce médicament en stock?

61. Pouvez-vous me dire les symptômes que vous pourriez trouver chez un enfant de deux ans souffrant d'un paludisme grave?

(Ne lisez pas. Ecoutez les réponses et vérifiez tout ce qui s'applique.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous costal	<input type="checkbox"/> Transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou qui coule	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissements	<input type="checkbox"/> Enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (corps chaud)	<input type="checkbox"/> Selles fréquentes/liquides	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> Enfant refuse de manger
<input type="checkbox"/> Mal de gorge	<input type="checkbox"/> Sang dans les selles	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Ne sais pas
<input type="checkbox"/> Démangeaison des yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> autre _____

62. Quels sont, d'après vous, les principaux symptômes qui vous permettraient de distinguer un cas de paludisme simple de celui d'un paludisme grave chez les enfants?
(Ne lisez pas. Ecoutez les réponses et vérifiez tout ce qui s'applique.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous costal	<input type="checkbox"/> Transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou qui coule	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissements	<input type="checkbox"/> Enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (corps chaud)	<input type="checkbox"/> Selles fréquentes/liquides	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> Enfant refuse de manger
<input type="checkbox"/> Mal de gorge	<input type="checkbox"/> Sang dans les selles	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Ne sais pas
<input type="checkbox"/> Démangeaison des yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> autre _____

63. Quelle est la prise en charge ou le traitement recommandé pour un enfant souffrant d'un paludisme grave?

- _____
- Je le réfère à la formation sanitaire
- Je ne sais pas
- Autre.....

64. Transférez-vous les patients au centre de santé?

Oui Non **[Sauvez à la Question 29]**

a) Si oui, quel est le type de cas transférez-vous? _____

b) Les envoyez-vous avec une note de référence? _____
(Si oui, essayer d'obtenir un exemple)

65. Donnez-vous des médicaments gratuitement ou les patients les achètent-ils?

66. Quand vous recommandez des médicaments de paludisme pour un enfant, administrez-vous la première dose ici sous observation?

Oui Non **[Sauvez à la Question 31]**

a. Si oui, comment donnez-vous les médicaments à l'enfant?

b. Avez-vous des tasses spécifiquement pour administrer les médicaments?

Oui Non

c. Avez-vous de l'eau à boire propre? Comment vous procurez-vous de l'eau à boire?

67. Qu'est-ce que l'on devrait expliquer au client au sujet du médicament lorsqu'on le lui donne?

- Nom du médicament
- Ce qu'il traite
- Quand et comment le prendre
- Effets secondaires
- Autre (*précisez*) _____
- Ne sais pas

68. Comment emballez-vous les médicaments que vous donnez aux patients?

- Sachet en plastic
- Emballage original/blister
- En papier emballage
- Autre (*précisez*) _____

69. Etiquetez-vous les médicaments que vous donnez?

Oui Non [**Sauvez à la Question 34**]

- a. Si oui, comment les étiquetez-vous? _____
- b. Que mettez-vous sur l'étiquette?
 - Nom du médicament
 - Ce qu'il traite
 - Quand et comment le prendre
 - Effets secondaires
 - Autre (*précisez*) _____

70. Avez-vous des pancartes ou des dépliants qui vous rappellent ou informent aux patients quel est le meilleur médicament à utiliser et comment l'utiliser?

Oui Non [**Sauvez à la Question 35**]

- a. Si oui (*demandez à les voir*), d'où viennent-ils?
 - Minisanté ou Programme national
 - Industrie pharmaceutique
 - Autre (*préciser*) _____

Supervision & Transmission de rapports

71. Remplissez-vous des rapports de consommation et d'état des stocks des médicaments ?

Oui Non [**Sauvez à la Question 36**]

- a. Si oui, où envoyez-vous les rapports? _____
- b. Comment les envoyez-vous? _____
- c. Avec quelle fréquence? _____
- d. Quelles informations les rapports contiennent-ils?

72. Quand un superviseur vous a-t-il visité pour la dernière fois?

- Le mois passé
- Il y a moins de 3 mois
- Il y a moins de 6 mois
- Autre à préciser _____
- Jamais **[Sautéz à la fin]**
- Ne sais pas **[Sautéz à la fin]**

73. De qui était cette visite?

- Personnel du Centre de Santé
- Équipe du District
- ONG
- Autre (*préciser*) _____

74. Qu'est-ce qu'ils ont vu/ supervisé quand ils étaient ici?

75. Vous ont-ils fait part de leurs commentaires et réactions?

- Oui
- Non

Si oui, sur quel thèmes ? _____

**C'est la fin de mes questions. Merci beaucoup d'avoir accepté de causer avec moi.
Avez-vous des questions à me poser?**

INTERVIEW POUR LES FOURNISSEURS DU SECTEUR PRIVE

Dites à haute voix: Mon nom est _____. Je travaille pour une organisation qui a pour objectif le développement des moyens pour l'amélioration de la santé infantile. Je m'adresse aux personnes qui fournissent des médicaments sur la manière dont ils traitent ou donnent conseil pour les enfants malade particulièrement ceux souffrant de la malaria. Ni votre nom ni le nom de l'officine ne sera inscrit dans le formulaire ni remis à aucune autorité. Puis-je vous poser quelques questions ?

Si Oui: Dispensez-vous ou vendez-vous personnellement des médicaments aux patients ou clients ?

Si Oui : Remplissez les informations ci-dessous et commencez l'interview avec la Question 1.

Si Non, dites: Y a-t-il quelqu'un présent sur place qui voit régulièrement les patients ou clients?

Si Oui, dites: Puis-je parler à cette personne? Commencez à nouveau l'interview avec le nouveau sujet.

Si Non, Dites: Merci, Nous reviendrons une autre fois. Terminez l'interview.

Information Générale

District:	Ville/Village:	
Nom de l'Interviewer:	Date de l'Interview: ____ / ____ / ____ Jour Mois Année	
Emplacement:	<input type="checkbox"/> Urbain <input type="checkbox"/> Périurbain <input type="checkbox"/> Rural	
Type du point de vente:	<input type="checkbox"/> Pharmacie (officine) <input type="checkbox"/> Comptoir pharmaceutique <input type="checkbox"/> Clinique <input type="checkbox"/> Dispensaire <input type="checkbox"/> Boutique générale <input type="checkbox"/> Vendeur ambulant	
Heure de commencer l'interview: ____ / ____ Heure /Minute	Heure à la fin de l'interview: ____ / ____ Heure Minute	
1. Quelle est la distance d'ici à la structure sanitaire la plus proche? <i>(cochez toutes celles qui conviennent.)</i>	<input type="checkbox"/> Moins d'1 km (ou moins de 15 minutes de marche) <input type="checkbox"/> Entre 1 et 5 km (jusqu'à une heure de marche) <input type="checkbox"/> Plus de 5 km (plus d'une heure de marche) <input type="checkbox"/> Je ne sais pas	
2. Quel type de formation en soins clinique ou pharmacie avez-vous suivi? <i>(cochez toutes celles qui conviennent.)</i>	<input type="checkbox"/> Technicien pharmacien ou une formation en pharmacie <input type="checkbox"/> Médecin assistant <input type="checkbox"/> Infirmière, aide infirmière <input type="checkbox"/> Assistant médical, technologue médical, laborantin, ou autres formations connexes <input type="checkbox"/> Auxiliaire <input type="checkbox"/> Autres (spécifiez)..... <input type="checkbox"/> Aucune	

Connaissance des Symptômes et Action de Traitement Appropriées

Dites: *J'aimerais vous poser quelques questions sur les différents types de maladies infantiles que vous soignez probablement ici.*

IRA pas de pneumonie

3. Est ce que vous pourriez m'indiquer les symptômes que peut présenter un enfant de deux ans qui souffre d'un simple rhume ?

(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres _____

4. Quel est le traitement recommandé pour soigner un enfant qui a la toux et un nez coulant?

Je ne sais pas

5. Avez-vous des aides visuelles comme par ex. des affiches ou des dépliants sur le traitement du rhume?

Non, il n'y a pas d'aides visuelles.
(si non, sautez à la question 7)

Si oui, décrivez quels types d'affiches:

Oui, Il y a des aides visuelles provenant de:

- MS ou programme national
- Industrie pharmaceutique
- Autres _____

6. *(NE POSEZ PAS LA QUESTION-OBSERVEZ SEULEMENT)*

Les affiches sont-elles facilement visibles pour le vendeur?

- . Non
- . Oui

Pneumonie

7. Est-ce que vous pourriez m'indiquer les symptômes que peut présenter un enfant de deux ans qui souffre d'une pneumonie ?

(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres _____

8. A votre avis, quels sont les symptômes clés permettant de distinguer entre la pneumonie infantile et un rhume simple ?

(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres _____

9. Quel est le médicament recommandé pour soigner un enfant souffrant de la pneumonie?

Je ne sais pas

10. Avez-vous des aides visuelles comme par ex. des affiches ou des dépliants sur le traitement de la pneumonie?

<p><input type="checkbox"/> Non, il n'y a pas d'aides visuelles. <i>(si non, sautez à la question 12)</i></p> <p>Oui, Il y a des aides visuelles provenant de:</p> <p><input type="checkbox"/> MS ou un programme national <input type="checkbox"/> Industrie pharmaceutique <input type="checkbox"/> Autres _____</p>	<p>Si oui, décrivez quels types d'affiches:</p>		
<p>11. (NE POSEZ PAS LA QUESTION- OBSERVEZ SEULEMENT) Les affiches sont-elles facilement visibles pour le vendeur?</p> <p><input type="checkbox"/> Non <input type="checkbox"/> Oui</p>			
<p>Paludisme</p>			
<p>12. Est-ce que vous pourriez m'indiquer les symptômes que peut présenter un enfant de deux ans qui souffre de paludisme simple ? <i>(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)</i></p>			
<p><input type="checkbox"/> Toux <input type="checkbox"/> Nez bouché ou coulant <input type="checkbox"/> Fièvre (Corps chaud) <input type="checkbox"/> Gorge douloureuse <input type="checkbox"/> Démangeaisons aux yeux</p>	<p><input type="checkbox"/> Tirage sous-costal <input type="checkbox"/> Respiration rapide/difficile <input type="checkbox"/> Selle fréquente/coulante <input type="checkbox"/> Selle sanguinolente <input type="checkbox"/> Soif</p>	<p><input type="checkbox"/> Sudation/transpiration <input type="checkbox"/> Vomissement <input type="checkbox"/> Fièvre avec convulsion <input type="checkbox"/> Mal d'oreille <input type="checkbox"/> Mal de tête</p>	<p><input type="checkbox"/> Enfant léthargique <input type="checkbox"/> L'enfant ne peut pas dormir <input type="checkbox"/> L'enfant refuse de manger <input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Autres _____</p>
<p>13. Quel est le médicament recommandé pour soigner un enfant souffrant d'un paludisme simple?</p>		<p><input type="checkbox"/> Je ne sais pas</p>	
<p>14. Les clients demandent-ils souvent un médicament particulier pour soigner un enfant souffrant du paludisme?</p>		<p><input type="checkbox"/> Oui <input type="checkbox"/> Non <i>(si non, sautez à la question 16)</i></p>	
<p>15. Quel médicament est souvent demandé?</p>		<p>_____</p>	
<p>16. Quelle est la proportion des cas de paludisme que vous voyez ici qui sont des adultes?</p>		<p><input type="checkbox"/> Un cinquième (20%) <input type="checkbox"/> Un quart (25%) <input type="checkbox"/> Un tiers (33%) <input type="checkbox"/> La moitié (50%) <input type="checkbox"/> Le trois quart (75%) <input type="checkbox"/> Je ne sais pas</p>	
<p>17. Quel médicament vendez-vous pour les adultes souffrant du paludisme?</p>		<p>_____</p>	
<p>18. Avez-vous des aides visuelles comme par ex. des affiches ou des dépliants sur le traitement d'un paludisme simple?</p>		<p><input type="checkbox"/> Non, il n'y a pas d'aides visuelles. <i>(si non, sautez à la question 20)</i></p>	
<p>Oui, Il y a des aides visuelles provenant de:</p> <p><input type="checkbox"/> MS ou un programme national <input type="checkbox"/> Industrie pharmaceutique <input type="checkbox"/> Autres _____</p>		<p>Si oui, décrivez quels types d'affiches:</p>	
<p>19. (NE POSEZ PAS LA QUESTION- OBSERVEZ SEULEMENT)</p> <p>Les affiches sont-elles facilement visibles pour le vendeur?</p> <p><input type="checkbox"/> Non <input type="checkbox"/> Oui</p>			

20. Est-ce que vous pourriez m'indiquer les symptômes que peut présenter un enfant de deux ans qui souffre de paludisme grave?

(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres

21. A votre avis, quels sont les symptômes clés permettant de distinguer la forme simple de la forme grave du paludisme chez les enfants

(Ne lisez pas. Ecoutez les réponses et cochez toutes celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres

22. Quelle est la prise en charge recommandé pour un enfant souffrant d'un paludisme grave?

Je ne sais pas

23. Avez-vous des aides visuelles comme par ex. des affiches ou des dépliants sur le traitement d'un paludisme grave

Non, il n'y a pas d'aides visuelles.

(si non, sautez à la question 25)

Si oui, décrivez quels types d'affiches:

Oui, Il y a des aides visuelles provenant de:

- MS ou un programme national
- Industrie pharmaceutique
- Autres

24. (NE POSEZ PAS LA QUESTION- OBSERVEZ SEULEMENT) Les affiches sont-elles facilement visibles pour le vendeur?

Non

Oui

25. Comment pouvez-vous prévenir le paludisme chez les enfants?

L'utilisation d'un Moustiquaire Imprégné d'Insecticide (MII)

Autre _____

Diarrhée

26. Quel est le médicament recommandé pour soigner un enfant souffrant d'une diarrhée simple?

Je ne sais pas

27. Est-ce que vous pourriez m'indiquer les symptômes clés que peut présenter un enfant souffrant de diarrhée qui pourrait avoir besoin d'antibiotiques ?

(ne lisez pas. Ecoutez les réponses et cochez celles qui conviennent.)

<input type="checkbox"/> Toux	<input type="checkbox"/> Tirage sous-costal	<input type="checkbox"/> Sudation/transpiration	<input type="checkbox"/> Enfant léthargique
<input type="checkbox"/> Nez bouché ou coulant	<input type="checkbox"/> Respiration rapide/difficile	<input type="checkbox"/> Vomissement	<input type="checkbox"/> L'enfant ne peut pas dormir
<input type="checkbox"/> Fièvre (Corps chaud)	<input type="checkbox"/> Selle fréquente/coulante	<input type="checkbox"/> Fièvre avec convulsion	<input type="checkbox"/> L'enfant refuse de manger
<input type="checkbox"/> Gorge douloureuse	<input type="checkbox"/> Selle sanguinolente	<input type="checkbox"/> Mal d'oreille	<input type="checkbox"/> Je ne sais pas
<input type="checkbox"/> Démangeaisons aux yeux	<input type="checkbox"/> Soif	<input type="checkbox"/> Mal de tête	<input type="checkbox"/> Autres

28. Quel est le médicament recommandé pour soigner un enfant souffrant d'une diarrhée sanguinolente

Je ne sais pas

29. Avez-vous des aides visuelles comme par ex. des affiches ou des dépliants sur le traitement de la diarrhée?

<input type="checkbox"/> Non, il n'y a pas d'aides visuelles. <i>(si non, sautez à la question 31)</i>	Si oui, décrivez quels types d'affiches:
Oui, Il y a des aides visuelles provenant de: <input type="checkbox"/> MS ou un programme national <input type="checkbox"/> Industrie pharmaceutique <input type="checkbox"/> Autres	
30. (NE POSEZ PAS LA QUESTION- OBSERVEZ SEULEMENT) Les affiches sont-elles facilement visibles pour le vendeur?	
<input type="checkbox"/> Non <input type="checkbox"/> Oui	

Références

31. Referez-vous les clients, en particulier les enfants vers les formations sanitaires? **Oui** **Non** **[si non, sautez à la question 36]**
32. Si cela est le cas, pour quel type de conditions ? _____
33. Si cela est le cas, a quel type de formation sanitaire ? _____
34. Avez- vous déjà eu des problèmes avec les transferts ? Expliquez

35. Si vous referez un enfant vers une formation sanitaire, y a-t-il un système de notes de référence?
 Oui Non
 S'il y en a, pouvez-vous nous les montrer. *(si oui, demandez un exemplaire et annexes le au formulaire si possible.)*

Connaissance des posologies des traitements appropriés

<p>36. Amoxicilline est le traitement recommandé pour soigner un enfant de deux ans souffrant d'une pneumonie. Quelle est la posologie correcte? <i>(écoutez et écrivez la réponse, et puis posez la question 36a pour compléter les informations si nécessaire. Si la personne répond 'je ne sais pas' ou 'je les réfère d'habitude', passez à la question Q 37)</i></p> <p>a. Quelle quantité de médicament doit-elle être donnée? →</p> <p>b. Combien de fois le médicament doit être pris? →</p> <p>c. Pendant combien de temps le médicament doit-il être pris? →</p>	<p><input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Je les réfère d'habitude</p> <p>Quantité de la posologie: _____</p> <p>Fréquence: _____</p> <p>Durée: _____</p>
<p>37. L'Amodiaquine en combinaison avec la Sulfadoxine-pyrimethamine est actuellement le traitement recommandé pour un enfant de deux ans souffrant du paludisme. Quelle est la posologie correcte pour chacun ? <i>(écoutez et écrivez la réponse, et puis posez la question 37a pour compléter les informations si nécessaire. Si la personne répond 'je ne sais pas' ou 'je les renvoie d'habitude', passez à la question Q 38.)</i></p> <p>a. Quelle quantité de médicament doit-elle être donné pour chacun? →</p> <p>b. A quelle fréquence chacun des médicaments doit être pris? →</p> <p>c. Pendant combien de temps chacun des médicaments doit être pris? →</p>	<p><input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Je les réfère d'habitude</p> <p>Posologie: SP _____ AQ _____</p> <p>Fréquence : SP _____ AQ _____</p> <p>Durée: SP _____ AQ _____</p>
<p>38. Une combinaison de l'Artemether-Lumefantrine (Coartem) sera le nouveau traitement recommandé pour les enfants de deux ans souffrant du paludisme. Quelle est la posologie correcte? <i>(Ecoutez et écrivez la réponse et ensuite posez la question 38a pour compléter les informations si nécessaire. Si la personne a répondu 'je ne sais pas' ou 'je les renvoie d'habitude' passez à la question 39)</i></p> <p>a. Quelle quantité de médicament doit-elle être donnée ? →</p> <p>b. A quelle fréquence le médicament doit être pris? →</p> <p>c. Pendant combien de temps le médicament doit être pris?→</p>	<p><input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Je les réfère d'habitude</p> <p>Quantité de la posologie: _____</p> <p>Fréquence: _____</p> <p>Durée: _____</p>

<p>39. Ciprofloxacine est le traitement recommandé pour soigner un enfant de deux ans souffrant d'une diarrhée sanguinolente. Quelle est la posologie correcte?</p> <p><i>(Ecoutez et écrivez la réponse et ensuite posez la question 39a pour compléter les informations si nécessaire. Si la personne a répondu 'je ne sais pas' ou 'je les renvoie d'habitude' passez à la question 40)</i></p> <p>a. Quelle quantité de médicament doit-elle être donné pour chacun? →</p> <p>b. A quelle fréquence chacun des médicaments doit être pris? →</p> <p>c. Pendant combien de temps chacun des médicaments doit être pris? →</p>	<p><input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Je les réfère d'habitude</p> <p>Quantité de la posologie: _____</p> <p>Fréquence: _____</p> <p>Durée: _____</p>
<p>40. SRO est le traitement recommandé pour soigner un enfant de deux ans souffrant d'une diarrhée non sanguinolente. Quelle est la manière correcte de préparer des SRO?</p> <p><i>(Ecoutez et écrivez la réponse ensuite posez la question 40a. si la personne répond 'je ne sais pas' ou 'je les renvoie d'habitude' passez à la question 41.)</i></p> <p>a. Pendant combien de temps ce médicament doit-il être pris? →</p>	<p><input type="checkbox"/> Je ne sais pas <input type="checkbox"/> Je les renvoie d'habitude</p> <p>Description de la préparation des SRO: Points importants:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 litre d'eau <input type="checkbox"/> Eau potable <input type="checkbox"/> Bien mélanger <input type="checkbox"/> Garder pour 24 heures <p>_____</p> <p>_____</p> <p>Durée: _____</p>

Disponibilité des Médicaments

CATEGORIES DES MEDICAMENTS GENERIQUE <i>(Avec marque commune pour chacun des médicaments génériques) pour chacun des médicaments dans cette colonne, finissez les questions le long de la ligne avant d'aller au médicament suivant</i>	En avez-vous actuellement en stock? <i>Marquez avec "X"</i>	
	OUI	NON
1. Amodiaquine Cés		
2. Arinate cés		
3. Chloroquine Cés		
4. Co-arinate cés		
5. Co-artem (Artemether-Lumefantrine) cés *		
6. MII		
7. Quinine inj		
8. Quinine Cés		
9. Sulfadoxine pyrimethamine (Fansidar) Cés		
10. Amoxicillin sirop		
11. Amoxicilline Cés		
12. Ciprofloxacine Cés		
13. Ciprofloxacine sirop		
14. SRO		
15. Autres ACTs* stockées (spécifiez):		

* Si le point de vente stocke le Coartem, d'autre ACT ou autre antipaludique, achetez un échantillon pour le test de qualité.

Dispensation et étiquetage des médicaments

41. Qu'est-ce qui doit être écrit sur l'emballage du médicament qui est dispensé? <i>(cochez celles qui conviennent)</i>	<input type="checkbox"/> Nom du Patient <input type="checkbox"/> Nom du médicament <input type="checkbox"/> Comment le prendre <input type="checkbox"/> Durée <input type="checkbox"/> Autres (spécifiez) _____ <input type="checkbox"/> Je ne sais pas
42. Quels détails portant sur le médicament doivent être expliqués au client en lui donnant le médicament?? <i>(cochez celles qui conviennent)</i>	<input type="checkbox"/> Nom du médicament <input type="checkbox"/> Ce qu'il traite <input type="checkbox"/> Quand et comment le prendre <input type="checkbox"/> Effets secondaires <input type="checkbox"/> Autres (spécifiez) _____ <input type="checkbox"/> Je ne sais pas
43. Quels sont les conseils généraux à donner au client pendant la dispensation du médicament? <i>(cochez celles qui conviennent)</i>	<input type="checkbox"/> Continuer à donner à boire/ nourrir l'enfant <input type="checkbox"/> Donner des informations sur l'importance de l'hygiène <input type="checkbox"/> Chercher les conditions aggravantes <input type="checkbox"/> Conseiller l'achat d'un MII <input type="checkbox"/> Autres..... _____

Dites: C'était la dernière question. Merci beaucoup pour votre participation.

Terminez l'interview. Retournez la première page et marquez le temps auquel l'interview a pris fin

Formulaire pour la disponibilité des médicaments

(DISTRICT/CENTRE DE SANTE/DISTRIBUTEURS)

Nom de la formation sanitaire/site de distributeur:	Type de formation sanitaire:
District :	Date:

1. Produit	2. Disponible O/N	3. Compte physique = Qté sur fiche de stock O/N	4. Avril 06 (30)	5. Mai 06 (31)	6. Juin 06 (30)	7. Juil 06 (31)	8. Août 06 (31)	9. Sep 06 (30)	10. Total jours de rupture de stock/ 183	11. Stock périmé O/N	12. Prix d'achat/ unité (ex. cé)	13. Prix de vente/unité (ex cé)
1. Amodiaquine comprimés												
2. Arinate comprimés												
3. Artemether inj												
4. Chloroquine comprimés												
5. Coartem 5-14kg												
6. Coartem 15-24kg												
7. Coartem 25-35kg												
8. Coartem 35kg+												
9. Quinine injectable												
10. Quinine comprimés												
11. Quinine sirop												
12. SP comprimés												
13. SP/Amodiaquine co-bister 6-35 mois (rouge) HBMF												
14. SP/Amodiaquine co-blister 3-5ans (jaune) HBMF												
15. SP/Amodiaquine co-bister 6-35 mois												
16. SP/Amodiaquine co-blister 3-5 ans												
17. SP/Amodiaquine co-bister 5-10 ans												
18. SP/Amodiaquine co-blister 10-15 ans												
19. SP/Amodiaquine co-blister adultes												
20. Amoxycilline comprimés												

1. Produit	2. Disponible O/N	3. Compte physique = Qté sur fiche de stock O/N	4. Avril 06 (30)	5. Mai 06 (31)	6. Juin 06 (30)	7. Juil 06 (31)	8. Août 06 (31)	9. Sep 06 (30)	10. Total jours de rupture de stock/ 183	11. Stock périmé O/N	12. Prix d'achat/ unité (ex. cé)	13. Prix de vente/unité (ex cé)
21. Ciprofloxacine comprimés												
22. SRO												
23. Moustiquaires												
Autres antipaludiques rencontrés												
1												
2												
DISTRIBUTEURS SEULEMENT												
Autres médicaments stockés par les distributeurs												
24.												
25.												
26.												
Outils de gestion												
Registres de cas												
Carnet de référence												
Ordinogramme												
Fiche de rapport CS												
Fiche de rapport DS												
Livres de caisse CS												
Livres de caisse DS												
Fiches de stock												

* Si le structure a un stock de Coartem ou autres ACTs, veuillez acheter un échantillon pour le test de qualité.

A TOUS LES NIVEAUX	A	B	
	Stock disponible	Consommation par mois (moyenne)	Stock (en mois) (calc. A/B)
SP/Amodiaquine co-bister 6-35 mois (rouge) HBMF	(blisters)		
SP/Amodiaquine co-blister 3-5ans (jaune) HBMF	(blisters)		
SP/Amodiaquine co-bister 6-35 mois	(blisters)		
SP/Amodiaquine co-blister 3-5 ans	(blisters)		
SP/Amodiaquine co-bister 5-10 ans	(blisters)		
SP/Amodiaquine co-blister 10-15 ans	(blisters)		
SP/Amodiaquine co-blister adultes	(blisters)		
SP cés	(cés /blister)		
Amodiaquine cés	(cés /blister)		

Formulaire de Simulation d'achat pour la malaria

Présentez-vous en tant que garde malade d'un enfant âgé de deux ans qui a de la fièvre durant les deux derniers jours. Utilisez des termes ordinaires pour décrire les symptômes de l'enfant. Demandez conseil sur la nature des produits à donner à l'enfant. Ne donnez pas de renseignements en plus sauf s'ils sont demandés. Achetez les médicaments sur recommandation du vendeur et sortez.

Si le vendeur pose les questions suivantes, répondez comme suit:

L'état de l'enfant: dites que l'enfant n'a pas de toux ou tous autres symptômes mais il a la fièvre. L'enfant s'amuse moins et il paraît qu'il a du vertige de temps en temps.

Si l'enfant a pris des médicaments: Dites que l'enfant n'a pas encore pris des médicaments.

Actions

Notez et souvenez-vous des informations nécessaires pour remplir le formulaire ci-dessous, vous pouvez demander le vendeur à répéter l'information):

Formulaire pour l'achat simule de paludisme

Nom du point de vente:	Nom de l'enquêteur:
Emplacement:	Date:

Le vendeur a-t-il expliqué la maladie dont souffrirait l'enfant?

- Oui Maladie: _____
 Non

A. Vérifier parmi les questions suivantes lesquelles ont été posées par le vendeur de médicaments avant de recommander un traitement.

Partie 1	Part 2
i. Quel est l'âge de l'enfant?	i. L'enfant est-il somnolant?
ii. Depuis combien de temps l'enfant est-il malade?	ii. L'enfant a-t-il des convulsions?
iii. L'enfant a-t-il déjà pris des médicaments?	iii. L'enfant a-t-il des vomissements?
	iv. L'enfant a-t-il pris des médicaments?
	v. L'enfant arrive-t-il à boire ?
	vi. L'enfant arrive-t-il à manger?
	vii. L'enfant a-t-il une perte de poids considérable?
	viii. Autres:
Le vendeur a-t-il vérifié l'historique (Partie 1)? OUI <input type="checkbox"/> NON <input type="checkbox"/>	
Le vendeur a-t-il évalué la gravité en vérifiant les signes de danger? (Partie 2)? OUI <input type="checkbox"/> NON <input type="checkbox"/>	

B. Ecrivez les informations suivantes pour tous les médicaments recommandés par le vendeur pour l'achat.

Nom, concentration et forme de posologie	Quantité de la posologie	Fréquence	Durée du traitement (Jours)	Instructions	Les informations sur les effets indésirables ont-elles été données? (Pour les ACT uniquement) O/N
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Le vendeur fournit-il des informations essentielles sur la manière de prendre les médicaments? OUI <input type="checkbox"/> NON <input type="checkbox"/> Les informations sur la posologie sont-elles inscrites sur l'emballage ? OUI <input type="checkbox"/> NON <input type="checkbox"/>					

C. Vérifier lesquelles des recommandations suivantes ont été faites par le vendeur de médicaments.

Recommandations Générales

Aller vers une formation sanitaire si l'enfant commence à vomir	Continuer l'allaitement souvent (< 2 ans)	
Aller vers une formation sanitaire si la fièvre persiste	Donner plus à boire l'enfant que d'habitude	
Aller vers une formation sanitaire si l'enfant devient léthargique	Autres:	
Autre :	Autres:	
Le vendeur a-t-il donné des conseils au cas où l'état de l'enfant s'aggravait? OUI <input type="checkbox"/> NON <input type="checkbox"/>		Le vendeur a-t-il fourni des conseils sur la nutrition? OUI <input type="checkbox"/> NON <input type="checkbox"/>

Recommandations de prévention

Utiliser un moustiquaire (MII) pour prévenir la malaria	Autres:	
Le vendeur a-t-il données des conseils pour la prévention de la maladie? OUI <input type="checkbox"/> NON <input type="checkbox"/>		

L'enfant a-t-il été envoyé vers une formation sanitaire?

- Oui, le vendeur a verbalement référé l'enfant mais il n'a fourni aucun document écrit.
- Oui, le vendeur a fourni un document écrit.
- Non

ANNEX 2: CASE REGISTER AND REFERRAL FORM
IGITABO CYANDIKAWAMO ABAWUWE

Amazina ry'umujyanama w'ubuzima :.....

Taliki/...../..... Intara Akarere : Umurenge : Akagari : Umudugudu:.....

N°	Itariki	Amazima y'umwana	Itariki yavukiyeho	Amazina y'ababyeyi	Yagize Umuriro mu masaha 24 (x)	Yagize Umuriro nyuma y'amasaha 24 (x)	Udupaki tw'imiti (tuku , hondo)(x)	Iherezo	Kwoherezwa kawa muganga (x)	Gukira (x)	Gupfa (mu masaha 24 avurwa	<i>Icyitonderwa (Niba yoherejiwe kwa muganga sobanura impamvu-Ibimenyetso mpuruza -kutoroherwa - ubundi burwayi)</i>
1	.../.../...											
2												
3												
4												
5												
6												
7												
8												
9												
10												

Umubare w'udupaki twavurishijwe: tuku/hondo Umubare w'udupaki dusigaye:tuku/hondo:..... Imfabusa: tuku/hondo

Amafaranga abitse:..... Abatindi nyakujya bavuwe:..... Amadeni y'uko kwezi:..... Amadeni yishyuwe muri uko kwezi

Amadeni y'amezi yose ashize : Ikitonderwa:

URUPAPURO RWO KWHEREZA UMWANA KU KIGO NDERABUZIMA

Intara ya Akarere.....
Umurenge
Amazina y'umwana
Mwene na ..
Bo mu Kagari ka umudugudu wa ..
Wavutse / /
Yoherejwe ku kigo nderabuzima cya.....
Kubera impamvu zikurikira :

- *Nta muliro afite cyangwa ubundi burwayi(yego/oya).....*
- *Ibimenyetso mpuruza(byandike).....*
- *Ari munsi y'amezi atandatu cyangwa arengeje imyaka itanu (yego/oya).....*
- *Yafashe imiti ya malariya mu gihe kitarenze ukwezi*
- *Yaje yafashe indi miti(uwo munsi yazanye umwana).....*
- *Umuriro wakomeje*
- *Arushijeho kuremba.....*
- *Yasheshe uduheri ku mubiri.....*
- *Ibindi (bivuge).....*

Amazina y'umuhyanama w'ubuzima
Umukono Italiki / / Isaha : saan'iminota

Italiki agereye ku kigo nderabuzima:/...../..... ; Isaha : saan'iminota
Ikigonderabuzima cya
Uburiwayi
Umuti ahawé
Iherezo ry'umurwayi
Icyitonderwa
Amazina y'uwanuvuye
Umukono Taliki..... / /

ANNEX 3 : HBM PROTOCOL

IGISHUSHANYO CY'AMABWIRIZA YO KWITA KU MWANA UFITE UMURIRO MU MUDUGUDU

