



Evaluation of the Community Animation Cells Level of Performance in the Kamina Health Zone from January to December 2024

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Abstract

Introduction: Community Animation Cells (CAC) are fundamental organs of community participation (PARTICOM) and are part of the community approach. They must therefore have a very high level of performance. The objective of this study was to assess the annual performance level for 2024 of the CAC in the health zone (ZS) of Kamina. **Methods:** This is a cross-sectional descriptive study conducted in the Kamina ZS. It used the data collection sheet for 232 CACs and an analytical framework that includes 5 performance levels: none (score and rating of 0), very low (score of 1% - 20% rated 1), low (score of 21% - 40% rated 2), medium (score of 41% - 60% rated 3), high (score of 61-80% rated 4), and very high (score of 81% - 100% rated 5). **Results:** This study revealed that the level of achievement of four functional activities is high, while that of three other functional activities is very low; the overall functional performance level (3) is average (51.4%). For promotional activities, four are at a high achievement level, four others at an average level, two at a low level, and two others at a very low level; the overall promotional performance level (3) is also average (55%). As for the services of the auditors, four are performed at an average level and fourteen at a very low level; the overall performance level of the auditors' services (2) is low (26.7%). Finally, the study revealed that the overall performance level (2) of the auditors in the Kamina health zone in 2024 is low (40.5%). **Conclusion:** The annual performance level (functional, promotional/preventive, and service delivery) for the Community Animation Cells

(CAC) in the Health Zone of Kamina for 2024 is low. Therefore, a capacity-building program and support for the activities of the CAC is necessary to improve their performance level in the Health Zone of Kamina.

Subject Areas

Sociology

Keywords

Evaluation, Level, Performance, Community Animation Cell, Health Zone, Kamina

1. Introduction

The community animation cell (CAC) is a grouping of eight to twelve community relays (CR) elected, representative of the community, including women and young people responsible for visiting each month 25 to 30 households each to inform and raise awareness on essential family practices, ensure the frontline of epidemiological surveillance, and establish a mechanism for community dialogue and feedback [1]. As the basic body of community participation and part of the community approach [2] [3], it allows the community to actively participate in identifying its needs and making decisions to solve its own health problems, exercising its right to play an active and direct role in the development and functioning of appropriate health services [4].

It is mentioned in the Universal Health Coverage (UHC) [5], a target of the Sustainable Development Goals (SDGs) [6], which employs several approaches including the community based [7] one, in which the Community Health Workers (CHWs) must operate optimally [8] [9].

They are also discussed in detail in the Democratic Republic of Congo (DRC) and are foundational for the utilization of health services, which should be optimal and indicate the degree of population involvement according to the formula $U = f(E.P.A.H.X) + \beta$ [2], as it is approximately 0.15 in the DRC and 0.37 new cases per capita per year (new cases/capita/year) on average in the health zone of Kamina from 2020 to 2024 [10].

In the DRC, studies have revealed issues and challenges to be addressed for the optimal functioning of CAC [2] including a low level of knowledge about local associations (40%), CAC (30%), and health personnel (30%) [11], limited community involvement in advocacy activities, low promotion of legislation and regulation in the health sector for public mobilization [12] given that community adherence and commitment remain weak [13] [14]; even significant deviations observed in the functioning of CAC leading to low functionality in the DRC (29%) and similar in the health zones of Bagira (26.9%), Ibanda (25.9%), Kadutu (32.6%) [13], and low completion of home visits (22%) in the health zone of Rwashi [15].

The overall objective of this study is to contribute to improving community involvement in health activities, starting with the optimal use of health services.

2. Methods

2.1. Context of the Study

This study was conducted in Kamina Health Zone, Haut-Lomami province in the Democratic Republic of Congo, where the community health system at the zonal level consists of three levels: the CR, the CAC, and the health development committee. The study took place in the CAC, which compiles activity reports from all the CR. We have developed a six-level performance analysis framework to position each CAC, given that in the DRC a piece of data can only help make a rational decision if it reaches 80% or more. Therefore, a CAC whose performance is below this threshold, such as 21% - 40%, is considered low, and consequently cannot help making a rational decision.

2.2. Type and Duration of the Study

This is a cross-sectional study conducted from January 1 to May 31, 2025.

2.3. Study Population

The study population consists of the CAC, which is responsible for compiling reports from the CR.

2.4. Sampling Type and Sample Size

The study used exhaustive sampling, considering all 232 CACs consisting of 2066 CR and spread across the 24 health areas (AS) of the ZS of Kamina. The number of CACs being 232 and each having to perform the activity once a month, 232×12 gives a denominator of 2784 for each activity.

2.5. Inclusion and Exclusion Criteria

The inclusion criterion for any CAC is the existence of a committee and archived activity reports, while any CAC not meeting both elements would be excluded from the study.

2.6. Data Collection Technique

The annual data for 2024 were collected by a team of previously trained investigators, using the data collection sheet for the activities of CR/CAC (17), and an explanatory note on the data to be collected served as a guide.

2.7. Study Variables

Thirty-seven variables were selected and divided into three components: functionality (the holding of meetings, the execution of decisions, reporting, organizing advocacy and community discussion sessions), promotion (raising awareness about essential family practices including the use of hygienic latrines and contraceptive

methods, combating diseases with epidemic potential and endemics, sanitation and cleaning of drainage ditches) and services related to home visits, maternal health, child health and endemic diseases.

2.8. Data Analysis

The data was entered, processed, and analysed using Epi Info 7 and SPSS 23 software. The proportions in percentage (numerator equal to the total achieved and denominator equal to the total expected), the level of performance (numerator equal to the sum of the obtained scores and denominator equal to the maximum expected) by variable, by component, and that of overall performance were calculated.

2.9. Analysis Framework

A six-level performance analysis framework, with scores and ratings ranging from 0 to 5, has been developed and was used for data analysis (calculating the level of activity achievement, calculating the performance level by component and overall) for the 2024 annual CAC (**Table 1**).

Table 1. Performance levels, scores, and ratings of CAC activities.

Performance level	Score	Rating
None	0%	0
Very low	1% - 20%	1
Low	21% - 40%	2
Medium	41% - 60%	3
High	61% - 80%	4
Very high	81% - 100%	5

This analytical framework contains six levels of performance ranging from poor to very high.

2.10. Ethical Considerations and Conflicts of Interest

The protocol of this study was submitted to the ethics committee of the University of Lubumbashi and approved under the reference authorization UNILU/CEM/122 dated 09/09/2022. Data collection was carried out by trained individuals who were instructed to explain beforehand the objectives of the study as well as the anonymous and confidential use of the data in respect of human dignity.

3. Resultats

1) Functional Component of the CAC The functional component includes 7 variables presented in **Table 2** as follows.

The results of **Table 2** show that no functional activity reached the expected level of 81% completion, with the completeness of reports being the highest achievement

(76.9%) and the holding of support group meetings being the lowest level of achievement (0.3%). Two scores appear in this table, with 4 corresponding to the high level and 1 corresponding to the very low level for a total of 18 points obtained out of the maximum of 35 expected.

Table 2. Level of achievement of the functional activities of the CAC and rating.

Variables	Planned	Achieved	Percentage	Rating/5
Holding of monitoring meetings	2784	1946	69.9	4
Execution of decisions made	5034	3428	68.1	4
Completeness of reports	2784	2141	76.9	4
Timeliness of reports	2141	1480	69.1	4
Organization of advocacy sessions	2784	377	3.5	1
Organization of community discussion sessions	2784	359	12.9	1
Holding of support group meetings	2784	7	0.3	1

Table 3. Evaluation of the level of functional performance of the CAC.

Variables	Rating/5
Holding of monitoring meetings	4
Execution of decisions made	4
Completeness of reports	4
Timeliness of reports	4
Organization of advocacy sessions	1
Organization of community discussion sessions	1
Holding of support group meetings	0
Total/35	18
Percentage	51.4
Overall functional performance level	3

It appears from **Table 3** that 4 activities are at a high-performance level (4) and 3 at a very low level (1); the overall performance level for 51.4% is average (3).

2) Promotional Component of the CAC

The promotional component consists of 12 variables listed in **Table 4**.

The result of each variable has a denominator of 2784 expected awareness sessions. The highest score is 61% - 80%, which has 4 activities, while the lowest is 1% - 20% with 2 activities.

3) Component of CAC Services The service component of the CAC includes 18 variables presented in **Table 6** as follows.

Two scores are represented in these results, one being 1% - 20% (very low and rated 1) which accounts for 77.8% of the performances, versus 41% - 60% (medium and rated 3) which has 22.2% of the performances.

Table 4. Implementation of promotional activities of the CAC and rating.

Activities	Frequency	Percentage	Rating
Proper use of mosquito nets	2071	74,4	4
Feeding of children	962	34.6	2
Frequent and correct hand washing	1693	60.8	3
Registration of births with the civil registry	421	15.1	1
Home management of diarrhea with oral rehydration salt and zinc	1737	62.4	4
Enrolling and keeping children in school	515	18.5	1
Vaccination of children and pregnant women	2035	73.1	4
Use of hygienic latrines	1676	60.2	3
Use of contraceptive methods	1164	41.8	3
Fight against epidemic diseases	1768	63.5	4
Fight against endemic diseases	1093	39.4	2
Sanitation and cleaning of drainage ditches	1133	40.7	2

Table 5. Evaluation of the promotional performance level of the CAC.

Activity	Rating
Correct use of mosquito nets	4
Child feeding	2
Correct and frequent hand washing	3
Registration of births with civil status	1
Home treatment of diarrhea with SRO and zinc	4
Enrolling and keeping children in school	1
Vaccination of children and pregnant women	4
Use of sanitary latrines	3
Use of contraceptive methods	3
Fighting against epidemic diseases	4
Fighting against endemic diseases	2
Sanitation and cleaning of drainage ditches	2
Total/60	33
Percentage	55
Overall promotional performance level	3

Table 6. Implementation of CAC services and rating.

Variables	Planned	Achieved	Percentage	Rating
Home visits implementation	780,000	353,340	45.3	3
Identification and referral of pregnant women for vaccination	1623	708	43.6	3
Identification and referral of pregnant women for ANC (CPN)	15,555	274	1.8	1
Identification and referral of pregnant women for maternity	15,555	239	1.5	1
Identification and notification of home deliveries	339	38	11.2	1
Identification and referral of pregnant women for postnatal consultation (PCo)	15,555	141	0.9	1
Identification and referral of children for vaccination	546	277	50.7	3
Identification and referral of fever cases for care	56,119	1731	3.1	1
Identification and referral of diarrhea cases for care	6434	613	6.4	1
Identification and referral of acute respiratory infection (ARI) cases for care	11,196	257	2.3	1
Identification and referral of cases with danger signs for care	2922	329	11.3	1
Identification and referral of cases of severe acute malnutrition (SAM) for care	764	63	8.1	1
Identification and notification of cases of acute flaccid paralysis (AFP)	44	20	45.5	3
Identification and notification of measles cases	21	4	19.1	1
Identification and notification of yellow fever (YF) cases	2	0	0	0
Identification and notification of neonatal tetanus (TNN) cases	1	0	0	0
Identification and notification of tuberculosis (TB) cases	646	10	1.6	1
Identification and notification of HIV cases	157	3	1.9	1

Table 7. Assessment of the performance level of the services provided by the statutory auditors.

Variables	Rating
Home visits implementation	3
Identification and referral of pregnant women for vaccination	3
Identification and referral of pregnant women for prenatal consultation (PCN) Identification and referral of pregnant women for maternity	1
Identification and referral of pregnant women for postnatal consultation (PCoN)	1
Identification and notification of home births	1
Identification and referral of children for vaccination	1
Identification and referral of fever cases to care	3
Identification and referral of diarrhea cases to care	1
Identification and referral of acute respiratory infection (IRA) cases to care	1
Identification and referral of cases with danger signs to care	1
Identification and referral of cases of severe acute malnutrition (SAM) to care	1
Identification and notification of cases of acute flaccid paralysis (AFP)	1

Continued

Identification and notification of measles cases	3
Identification and notification of yellow fever cases	1
Identification and notification of cases of neonatal tetanus	0
Identification and notification of TB cases	0
Identification and notification of HIV cases	1
Total/90	1
Percentage	24
Overall performance level of community animation cells (CAC)	26.7
Home visits implementation	2

The overall performance level of the services of the statutory auditors (2), the quotient of the sum of the scores obtained (24) over the maximum of the component (90) is low (26.7%).

Table 8. Overall evaluation of the performance level of the statutory auditors.

Parameters	Total expected	Total obtained	Percentage	Quotation
Overall functional performance	35	18	51.4	3
Overall promotional performance	60	33	55	3
Overall performance of services	90	24	26.7	2
Overall performance of statutory auditors	185	75	40.5	2

Low overall level of implementation of CAC activities (40.5%) for a low level of overall performance (2), which reflects a low involvement of communities in the implementation of health activities.

4. Discussion

4.1. Functional Component of Community Animation Cells (CAC)

Very low level of implementation of the functional activities of the CAC (the highest level of implementation being the completeness of reports at 76.9%) (Table 2 and Table 3) and which would be proportional to the insufficiency of CAC set up, existing community relays (CR), and active CR compared to the standards in the DRC [1] [2] [4], which include low meeting attendance (monitoring and support group), insufficient organized sessions, slow transmission of reports, and poor execution of decisions. The authors suggest that efforts be made at all levels of the health pyramid, especially at the peripheral level for a full integration of community health workers that are CR into health activities [4] [6].

4.2. Promotional Component of the Community Animation Cells (CAC)

- Four moderately executed promotional activities, including awareness about

the use of MILD (74.4%), home care for diarrhoea (62.4%), vaccination (73.1%), and epidemic surveillance (63.5%); activities most often subsidized (**Table 4** and **Table 5**). However, the implementation remains low regardless of the subsidy because the funding allocated to health is less than 5% of the national budget out of the 15% those African heads of state, including that of the DRC, have committed to.

- Low achievement of 9 other activities which is proportional to the existing CR, the CACs established for awareness on child nutrition, handwashing, registration of children in the civil registry, use of hygienic latrines, contraception, HIV, and environmental sanitation, varying between 15.1% to 60.8%. This is justified by numerous challenges negatively impacting the functioning of interface structures (CR, CAC, and the health development committee) and thus limiting their ability to optimally perform their role [12] [15].

4.3. Service Component of Community Animation Cells (CAC)

- VAD performed at 45.3%, a very low result compared to the standard [16] [17] (**Table 6** and **Table 7**). Although our result is slightly improved compared to that found in the ZS of Ruashi [15], it is also marred by numerous challenges that negatively impact the functioning of interface structures (CR, CAC, and health development committee) and thus limit their capacity to optimally perform their role [12] [15].
- For maternal health: only vaccination reached 48.6%. Other maternal health services are performed very poorly, despite the multitude of vertical community health programs, the reassessment of the primacy of health and community participation, efforts to achieve the Millennium Development Goals (MDGs), and the historic formal inclusion of community health in the health sector [14].
- Low achievement in child health services. The average results are a vaccination rate of 50.7% and a PFA monitoring rate of 45.5%. The results of other services are very low with no cases reported for FJ and TNN. The child health outcomes are interpreted similarly to those of maternal health. TB and HIV: 31.3% and 13.6% recovered. Low achievement compared to the DRC. The outcomes of the fight against endemic diseases are justified similarly to the achievement of home visits.

4.4. Overall Performance of the Community Animation Cells (CAC)

- Functional performance of the CACs at 51.4% with 57.1% of activities having high performance (**Table 8**), indicating an average functionality of the CACs compared to the standards [5] [13] [17].
- Average promotional performance of CAC (55%) with 33.3% of activities performing quite well, the others being very low compared to the standards [14].
- Very low performance of the CAC services (26.7%) with 22.2% of activities having average performance; the other services are very low compared to the

standards [13] [14].

- Overall low performance of the CACs at 40.5% compared to the standards [6] [13] [14].

It is worth noting that the DRC is increasingly aiming to promote community health as a formal approach to improve access to health and its outcomes, as well as to achieve universal health coverage (UHC). However, the process has been long to get here and it took many years for the DRC to consider community health as a key element of the resilience of the health system in the face of shocks caused, particularly by epidemics, political instability, and natural disasters, as the policies resulting from the sector reform of 2010 still did not provide a clear vision of how community health should be integrated in the DRC.

5. Conclusions

Some limitations were not overlooked in our study, for instance, reliance on routine records, lack of data quality audits.

The study focused on evaluating the annual performance level for 2024 of the Community Health Workers in the Kamina Health Zone and revealed an average functional and promotional performance level (51.4% and 55% respectively) with scores ranging between 41% and 60% for activity achievement, although there are 4 functional activities at a high performance level, 4 promotional activities also at a high performance level, and 4 others at a medium level; however, the level of service provision by Community Health Workers is low (26.7%) corresponding to performance level 2 of the analytical framework. This reflects the inadequate involvement of communities in the implementation of health activities in the DRC in general, and in the Kamina Health Zone in particular.

Let's consider the role of owner, provider, and regulator of the State in the organization and functioning of the CAC (selection, training, and supervision of the CR) to improve the performance level of the latter. Other much more in-depth studies need to be conducted to generate more knowledge.

Conflicts of Interest

The authors declare no conflicts of interest.

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