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Status of Community Relay Training in Mumbunda Health District of Lubumbashi City, DRC

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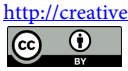

Abstract

Introduction: Training is a factor in change and modification of the visions and practices of the members of a community. That is why training community members encourages community relays (RECO) to acquire skills in a practical way. The objective of this study was to identify the different training themes received by community relays in the Mumbunda Health district over a period from January 2021 to December 2024. **Methods:** This is a cross-sectional descriptive study on the training received by community relay workers that took place in the Mumbunda Health district from November 2024 to March 2025, involving community relay workers. Using a structured questionnaire consisting of closed-ended questions, interviews were conducted face-to-face with the community relays in the form of a directed interview. The data collected focused on the various training received by community relay workers, including: the organization and functioning of community participation, maternal, newborn and child health, education, Gender-Based Violence (GBV), nutrition, hygiene and sanitation, disease prevention, communication, and information and management systems. The data were analyzed using SPSS Version 23. **Results:** Of the 100 community relays surveyed, 24 (or 24%) reported having each benefited from at least one training between 2021 and 2024. According to the interest in the training, 23 out of 24 community relays (or 96%) found the training received to be interesting. Most community relays, or 75%, deemed the knowledge acquired from the training to be sufficient. **Conclusion:** The organization of training for community relays in several themes remains the ideal way to strengthen capacities to solve health issues in the community.

Subject Areas

Public Health

Keywords

Status, Training, Community Relay, Health District, Mumbunda, Lubumbashi

1. Introduction

Health is a major concern for every individual and community. Everyone is called to try for its promotion and guarantee worldwide, and it is for this purpose that the member countries of the United Nations have subscribed to several International Declarations on Health, particularly the Alma-Ata Declaration (USSR) on Primary Health Care (PHC) on September 12, 1978. It is in this context that communities have organized themselves to participate in the well-being of the population. This community participation is crucial to any community engagement activity. The inclusion of information provided by community members ensures a transparent engagement process that gives opportunities for listening and feedback on activities undertaken. Training is a factor in change and modification of the visions and practices of community members. That is why training community members encourages community relay workers (RECO) to acquire skills in a practical way, using various methods, including demonstrations, case studies, group discussions, role-playing, and field practice. Furthermore, training sessions are designed to meet the needs of learners.

The strengthening of the capacities of community relays will be based on the expansion of programs, the opportunity for training in community health, the development of a training plan for all actors in community health by adapting the modules to the different socio-professional categories to be integrated into the training plan for the health sector, and also the development of a community health training curriculum to be integrated into training programs, not to mention the creation of a multi-sector pool of trainers in the area for the training, retraining, and coaching of community actors [1]. According to Dumont, the interventions generally involve mobilizing communities (community relays), training them on maternal and child health to improve access to timely emergency obstetric care, and enhancing the healthcare pathway and medical practices at various levels of the healthcare pyramid [2].

In Benin, efforts have been made to develop reference documents and train community health workers in all health zones of Avrankou, Adjarra, and Akpro-Missérété, on the Integrated Management of Childhood Illness (IMCI) to reduce morbidity and mortality rates from child and maternal diseases. This has been a positive point in strengthening the country's health system [3].

The Republic of Guinea, commonly referred to as Guinea-Conakry, through

the Ministry of Health and with the support of its Partners, has adopted a primary healthcare strategy. This low-cost, high-impact strategy aims to bring care as close as possible to those in need, that is, the communities. It is based on three fundamental axes: the selection and training of community relays, the provision of essential resources for treatment and prevention, and a promotional campaign for the populations. Their wise and effective use would undoubtedly contribute to a significant reduction in morbidity and mortality rates at the community level [4].

In the Central African Republic (CAR), according to the WHO report, thanks to the training of community relay workers and the implementation of the 2007 action plan for activities to combat onchocerciasis, the country has seen a very significant decrease in cases of onchocerciasis. In Côte d'Ivoire, as part of the project "Support for the Sustainability of Conflict Prevention and Management Tools in Côte d'Ivoire", the Ministry of Solidarity, Social Cohesion, and the Fight Against Poverty (MSCSLP) organized five training workshops for community relay workers and monitors on the technique of educational discussions, conflict prevention, gender promotion, and social cohesion in 2018 and 2019 to ensure the effectiveness of the early warning and rapid response mechanism for conflicts [5].

In Ethiopia, community relay women are trained to focus on maternal and child health, malaria, and HIV/AIDS. A 40% reduction in child mortality has been observed, although it has not been proven that this results from the involvement of the community relays, who are responsible for training mothers in the management of their malaria cases [6].

In Mali, the project to strengthen Civil Society in matters of sexuality and reproduction in 8 Health Areas (AS) of the Tombouctou Region organized a training module for community relays in Information, Education and Communication (IEC) and Reproductive Health (RH). This module was aimed at enhancing the knowledge and skills of community relays in various communication techniques in general and the prevention of perinatal risks in particular. It is also based on an active learning method that improves the interactions of community relays with their target audiences, which are the communities. In Chad, community relays are trained for specific tasks, particularly the chemoprevention of malaria, Communication for Behavior Change (CBC), the identification and support of women at Prenatal Consultations (PC), during childbirth, the identification and referral of vesico-vaginal fistulas in treatment centers, the screening and management of malnourished individuals (including referral to the nutritional center) and the fight against tuberculosis according to the guidelines of the National Tuberculosis Control Program (NTCP). More than 400 community relays have been trained on monitoring patients and recovering lost to follow-up cases [7].

In the Democratic Republic of the Congo (DRC), from April 15 to 17, 2023, community health workers received training (capacity building) on sexual and reproductive health, as part of the project "Youth and Women for Peace through Improved Sexual and Reproductive Health and Interventions Against Gender-Based

Violence", implemented by Caritas Development Goma with financial support from UNFPA [8]. In North Kivu (Goma), A study titled Strengthening Community-Based Surveillance: Lessons Learned from the 2018-2020 Ebola Outbreak in the Democratic Republic of the Congo, conducted under the leadership of Médecins Sans Frontières (MSF), showed that, through more extensive training, community relays dedicate time to Community-Based Surveillance (CBS). They have been utilized in fragile and low-income contexts to complement facility-based surveillance. It has also been demonstrated that their efforts have improved case detection, reduced the lag in disease signals, and ensured surveillance coverage in hard-to-reach areas. Furthermore, they have been effective in collecting health information outside the formal health system or for stigmatized diseases [9]. Since 2015, in the DRC, seventeen diseases, conditions, and events have been included in the DRC's surveillance system strategy as mandatory and weekly reporting of health issues, among which is the Ebola Virus Disease (EVD). This strategy involves communities and health facilities at all levels of the health system. However, the capacities of the community (community relays) in terms of training and epidemic preparedness in several provinces of the DRC, which condition their participation in managing epidemics, particularly EVD outbreaks, remain weak [10].

In the Province of Haut-Katanga, the community-based nutrition promotion project in Kapolowe and Kasenga by Caritas Congo Asbl, funded by UNICEF, involved the training of community relays and care providers. These community relays were trained in the following areas: community-based nutrition, infant and young child feeding, screening and referral of severe acute malnutrition cases, and raising awareness on revitalized preschool consultation [11].

In the city of Lubumbashi, a study on the training of community health workers in the Rwashi Health District showed that in 48% of cases, community health workers had participated in at least one training session, and the subject of the training they attended was tuberculosis [12].

2. Method

2.1. Study Design

We conducted a cross-sectional descriptive study on the training received by community relays in the Mumbunda Health district from January 2021 to December 2024, and this data was collected from November 2024 to March 2025.

2.2. Study Population and Sample Size

The community relays of the health district constituted our study population, and our sampling is non-probabilistic of the conventional type. One hundred community relays were included in our study.

2.3. Collection and Analysis

The data useful for this study were collected through guided interviews using a

questionnaire. The software Word and Excel 2013, as well as Epi Info version 7.2.4.0, were used for data encoding and analysis. We calculated proportions for qualitative variables and for quantitative variables, we also calculated position parameters.

3. Results

Table 1 shows that 35% of community relay workers were aged between 40 and 49 years. The average age was 40.13 ± 5.40 years with a minimum age of 19 years and a maximum age of 64 years. It appears from this figure that 6 out of 10 community relay workers, or 60% of cases, were female. Most community relay workers had a secondary education level, representing 71% compared to 4% at the primary level.

Table 1. Sociodemographic characteristics.

Variables	Frequency	Percentage (%)
Sex		
Female	60	60
Male	40	40
Ages		
<19	1	1
20 - 29	24	24
30 - 39	21	21
40 - 49	35	35
50 - 59	16	16
≥60	3	3
Educational level		
Primary	4	4
Secondary	71	71
University	25	25

Table 2 indicates that 59% of community relay members had a seniority of 5 years or less. The average seniority was 8 years, with a minimum seniority of 1 year and a maximum seniority of 15 years.

Table 2. Distribution by seniority.

Seniority	Frequency	Percentage (%)
≤5	59	59
6 - 10	30	30
≥11	11	11

Table 3 indicates that 95% of community relays reported living in their respective Health Areas.

Table 3. Distribution by residence.

Residence	Frequency	Percentage (%)
Health area	95	95
Outside of health area	5	5

Table 4 shows that 24 community relays out of 100 (or 24%) reported having each received at least one training between 2021 and 2024. However, 76 community relays (or 76%) reported not having undergone any training.

Table 4. Distribution according to the training received between 2021 and 2024.

Training received	Frequency	Percentage (%)
Yes	24	24
No	76	76

It emerges from Table 5 that only 24 community relays have been trained; 29% have been trained on Mother and newborn health; half, or 50% of the surveyed community relays, reported having received training on water sanitation and hygiene (environmental); 79% of the surveyed community relays stated they have had training on disease control; 13% of the surveyed community relays reported having received training on the Management System.

Table 5. Type of training received.

Type of training	Frequency	Percentage (%)
Training on the organization of community participation		
Yes	6	
No	18	
Mother and newborn health		
Yes	7	29
No	17	70
Water, sanitation and hygiene		
Yes	14	50
No	14	50
Fight against diseases		
Yes	19	79
No	5	21
Management system		
Yes	3	13
No	21	87

Only 23% of the relays were interested in the training received (see Table 6).

Table 6. Interest in the training attended.

Interest in the training received	Frequency	Percentage (%)
Yes	23	23
No	1	1

Table 7 indicates that: four community relay workers (or 67%) found the knowledge gained in this area sufficient; 7 community relay workers who attended training on Maternal and Newborn Health; 4 community relay workers (or 57.1%) found the knowledge gained in this area insufficient; half of the community relay workers (or 50%) who attended training on hygiene and environmental sanitation found the knowledge gained in this area sufficient; 11 community relay workers out of 19 (or 57.8%) who attended training on Disease Control found the knowledge gained in this area sufficient; 2 community relay workers out of 3 (or 66.7%) who attended training on Management Systems found the knowledge gained insufficient.

Table 7. Breakdown of community relations by level of knowledge in relation to the training received.

Variables	Frequency	Percentage (%)
Organization and operation		
Insufficient	1	16.5
Sufficient	4	67
Very sufficient	1	16.5
Mother and newborn health		
Insufficient	4	57.1
Sufficient	2	28.6
Very sufficient	1	14.3
Water hygiene and sanitation		
Insufficient	2	17
Sufficient	6	50
Very sufficient	4	33
Fight against diseases		
Insufficient	11	10.5
Sufficient	37	57.8
Very sufficient	6	31.8
Management system		
Insufficient	2	66.7
Very sufficient	1	33.3

Table 8 shows that 17 community relay workers out of 24 (*i.e.*, 70.8%) rated the competence of their trainers as very sufficient.

Table 8. Distribution according to the evaluation of the trainers.

Trainer's competence	Frequency	Percentage (%)
Insufficient	4	16.7
Sufficient	3	12.5
Very sufficient	17	70.8

4. Discussion

1) Sociodemographic characteristics

It emerges from our research that the average age of community relays in the Mumbunda health district was 40.13 ± 5.40, with a minimum age of 19 years and a maximum age of 64 years (Table 1). Our results are close to those of Scholastique Sangwa and collaborators, who found the average age of community relays to be 41.5 ± 13.9, with a minimum age of 18 years and a maximum age of 62 years in the Ruashi health district in Lubumbashi, Democratic Republic of the Congo [12]. Sixty community relays out of 100 (60% of cases) were female. This is similar to the survey conducted by the Sangwa team, which reported that women were in the majority, representing 68% of the studied population in the health district of Ruashi in Lubumbashi, Democratic Republic of the Congo [12]. Most community health workers in the Mumbunda health district had a secondary education level, accounting for 71%. This corroborates the study by Sangwa and colleagues, who found that community health workers who completed their secondary education represented a significant proportion in the Health district of Ruashi in Lubumbashi, Democratic Republic of the Congo [12].

2) Seniority as community relays

Most community relays in the Mumbunda Health District (59%) had less than 5 years of seniority (Table 2). Our findings are consistent with those found by Sangwa and collaborators, who found that the majority of community relays had a seniority between 2 and 5 years in the Health District of Ruashi in Lubumbashi, Democratic Republic of the Congo [12].

3) Training received by community relays from 2021 to 2024

Table 4 indicates that 24% of community relays received at least one training between 2021 and 2024 concerning the organization and functioning of community participation, maternal and newborn health, hygiene and sanitation, disease control, and management systems. Training in disease control came first with 19 participants out of 24 (or 79%), followed by training in hygiene and sanitation with 14 participants out of 24 (or 50%). These results differ from those found by Sangwa and colleagues, who showed that out of 50 community relays surveyed, 24 community relays (or 48%) had received at least one training in the last 12 months, that is, before December 2022 in the Health District of Ruashi in Lubumbashi,

Democratic Republic of the Congo [12]. However, it should be noted that the results found showed that training on disease prevention was at the top of the list, with 79%. These results corroborate those of Sangwa and colleagues who showed that the training themes received by community relays were part of the fight against diseases such as: TB, COVID-19, HIV, and malaria in the Health District of Ruashi in Lubumbashi, Democratic Republic of the Congo [12]. Some other authors confirm it [13]. In the Democratic Republic of the Congo, during the epidemic of Ebola virus, community health relays underwent training to identify and report patients meeting the Ebola virus disease alert definitions [9]. Testing a simplified tool and training package to improve integrated community case management in Tanganyika Province, Democratic Republic of the Congo: A quasi-experimental study [14].

4) Importance of training

Our findings showed that nearly all the community relays surveyed in the Mumbunda Health District in Lubumbashi found the training received to be interesting (**Table 6**) (*i.e.*, 96%). This indicates the relevance of the training that community relays attach to it. As noted in a press release from the United Nations High Commissioner for Refugees (UNHCR) regarding the training of community relays in the context of the emergency in the Central African Republic (CAR) in the Likouala department (DRC): During the three days of training, 30 community relays and 8 health workers (including 4 nurses and 4 midwives), trained through discussion sessions, presentations, group work, and plenary reports, mastered the definitions of cases, recognized the symptoms, and explained the mode of transmission of HIV from mother to child; explained the causes and consequences of Gender-Based Violence (GBV) and their medical management as well as the psychosocial follow-up for refugees and local populations in their communit [15].

5) Knowledge related to training

Our results showed that all knowledge acquired from the training of community relays in the Mumbunda Health District of Lubumbashi in the DRC was either sufficient or very sufficient, except for the training in Maternal and Newborn Health as well as the training on the management system (**Table 7**). These results corroborate those found by Sangwa *et al.*, who discovered that the majority of community relays in the Ruashi Health District of Lubumbashi in the DRC (about 96%) had not received training on micro-planning activities and that materials or tools for work were lacking in the health district [12]. These results are contrary to those of a study from the East of the Democratic Republic of the Congo, where community relays participate in micro planning [16].

5. Conclusions

Our study focused on "the state of the community health workers' training in the city of Lubumbashi in the Mumbunda health district". The community health workers in the Mumbunda Health district faced enormous difficulties during their home visits to parents to explain the validity of all the repeated vaccination cam-

paigns. Communication appeared to be ineffective, marking posed a problem, and the referral of cholera cases or other waterborne diseases discovered in the community, as well as alerts for diseases under mandatory surveillance, seemed to be poorly understood.

The training of community relays in the Health Zone is not carried out regularly. Only 24 out of 100 (or 24%) community relays surveyed had received at least one training from 2021 to 2024. Nearly 7 out of 10 community relays (71%) had undergone training on disease control, and 50% on hygiene and sanitation. These community relays found that their knowledge from the training received was sufficient in most cases. Organizing training for community relays on various topics remains the ideal way to strengthen capacities to address health issues in the community.

Conflicts of Interest

The authors declare no conflicts of interest.

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