Scaling up Integrated Community Case Management for Childhood Illness in the Democratic Republic of the Congo

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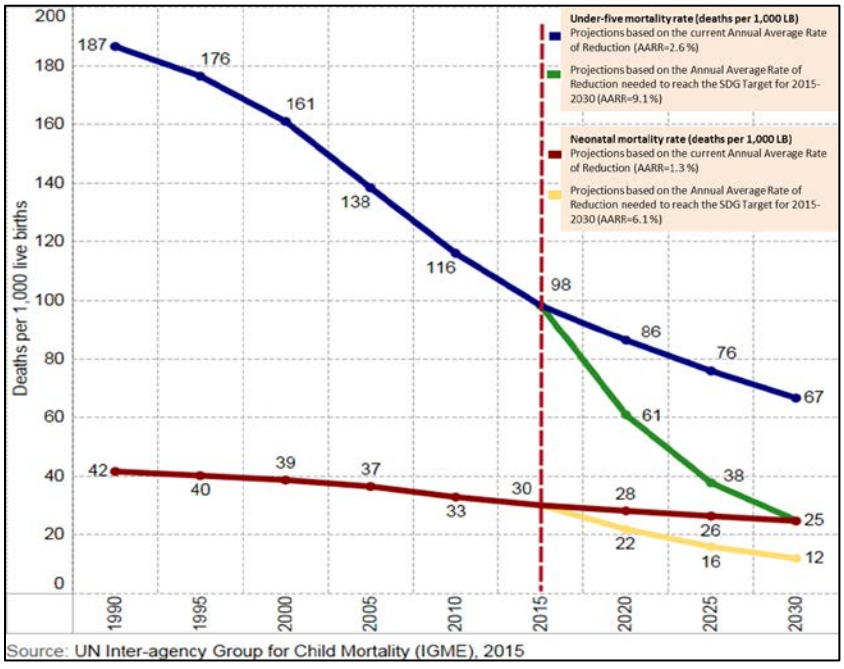
Community-Based Care in the Democratic Republic of the Congo

An estimated one out of 10 child deaths in Africa occurs in the Democratic Republic of the Congo (DRC), with 304,000 deaths in children under 5 reported in 2016.[1] If the country is to meet the Sustainable Development Goals for under-5 mortality (target 25 per 1,000 live births by 2030) and neonatal mortality (target 12 per 1,000 live births), it must dramatically accelerate its annual reduction rate through more aggressive approaches **(Figure 1)**.

The leading causes of childhood deaths in the DRC are attributable to neonatal complications and illnesses, mainly diarrhea, pneumonia, and malaria.[2] Achieving coverage of high-quality child health services in the DRC to reduce these causes of mortality is challenging due to expansive geography, daunting natural barriers, limited coverage of health facilities, and inadequate financial resources for training and deploying health professionals. Only 35% of the country's 85 million people live within 5 kilometers of a health facility.[3]

Figure 1. Under-5 mortality rate vs. neonatal mortality rate, DRC, 1990–2015, with projections to 2030

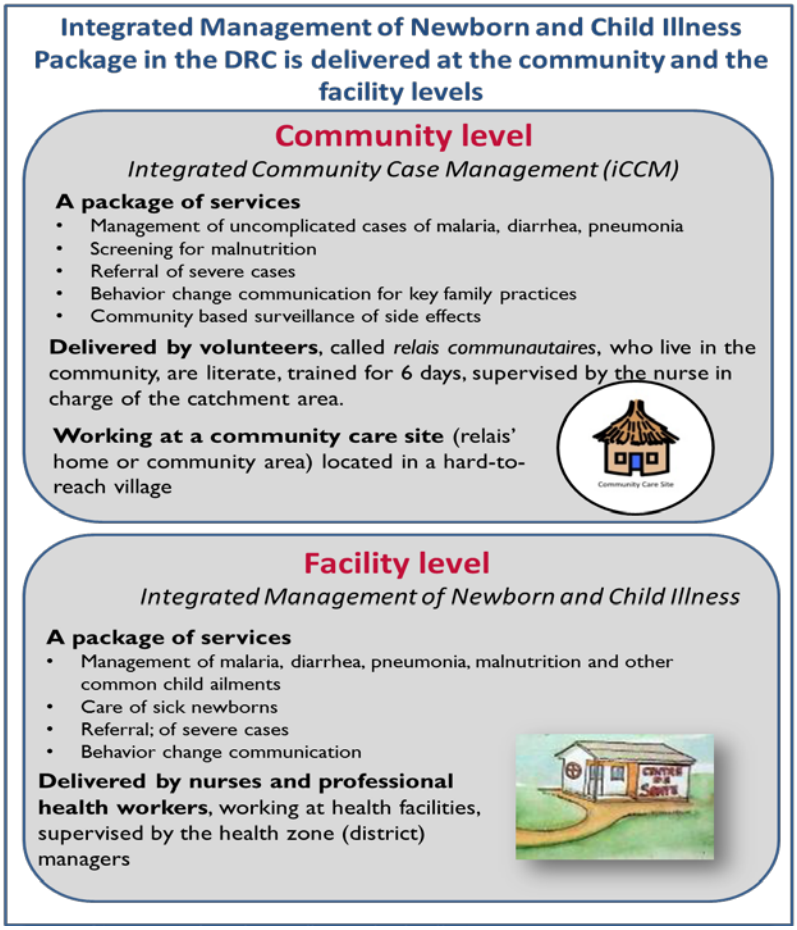


[1] UNICEF. 2017. Levels and Trends in Child Mortality Report 2017. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation.
[2] Liu L, Oza S, Hogan D, et al. 2015. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. The Lancet 385(9966): 430-40.
[3] Ministère de la Santé Publique. 2017. Plan Stratégique National de la PCIMNE 2017-2021.

Finally, a series of armed conflicts in the DRC, dating back to 1975, destroyed a large proportion of the country's infrastructure—including health facilities—and resulted in millions of deaths, impoverished the majority of the population, and contributed to ongoing political instability.

Getting services closer to remote communities through community-based approaches must be a key component of any strategy to meet the country's Sustainable Development Goal targets. Integrated community case management (iCCM) is such a strategy; it brings life-saving treatment of childhood illnesses closer to children. The iCCM approach trains and supports community health workers (CHWs) to manage and treat cases of diarrhea, pneumonia, malaria, and other illnesses. The government of DRC introduced and scaled up community-based approaches to care starting in 2005 to provide quality services in remote villages.

Figure 2. The IMNCI package in the DRC



In the DRC, the full package of iCCM, which is part of the facility-based Integrated Management of Newborn and Child Illnesses (IMNCI) strategy, is defined as CHW management of at least four childhood conditions—malaria, diarrhea, pneumonia, and malnutrition—at community care sites **(Figure 2)**.

Scaling Up iCCM to Reach the Greatest Number of Children

The DRC's commitment to community care goes back to colonial times when the medical service of the independent State of Congo (1888–1908) and the medical service of the Belgian Ministry of Colonies (1908–1960) helped communities provide services to populations in remote villages.[4] Advocacy around iCCM in contemporary history started in 2003 after the integration of key family practices into the IMNCI strategy.

In 2005, 12 community care sites began providing iCCM as a piloted in one health zone to accelerate the coverage of care for childhood illness through additional service delivery points beyond facility-based IMNCI, which was launched three years earlier. The successive adjustments of protocols and tools for iCCM were always undertaken in parallel with clinical IMNCI to comply with ongoing updates of international guidelines **(Figure 3)**.

[4] MCHIP. 2012. Integrated Community Case Management of Childhood Illness: Documentation of Best Practices and Bottlenecks to Program Implementation in the Democratic Republic of Congo (DRC).

Figure 3. A long history of implementing IMNCI in the DRC

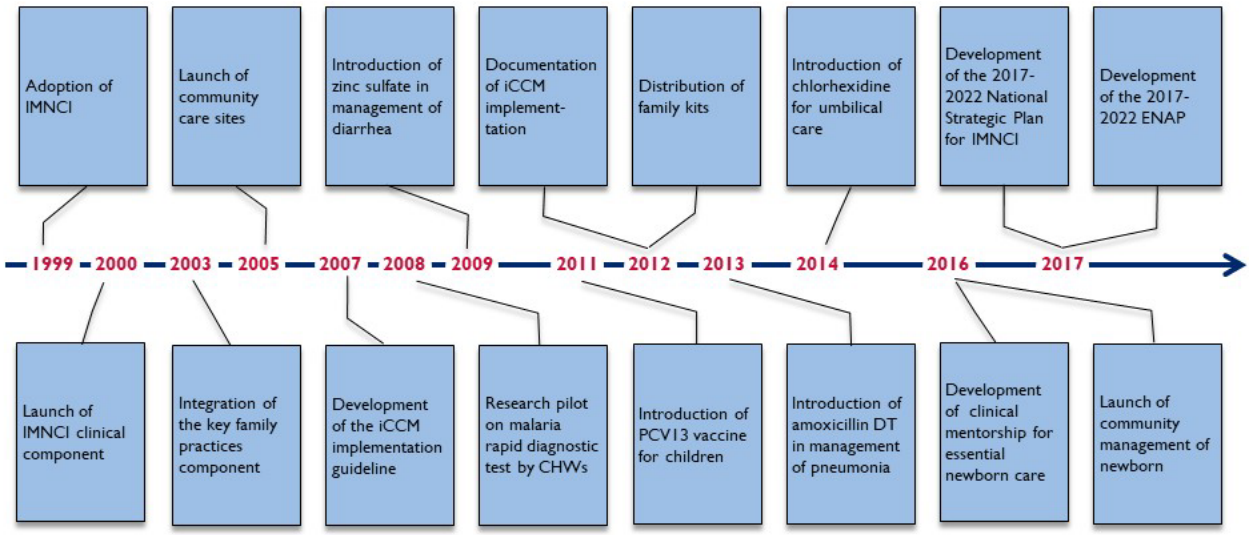
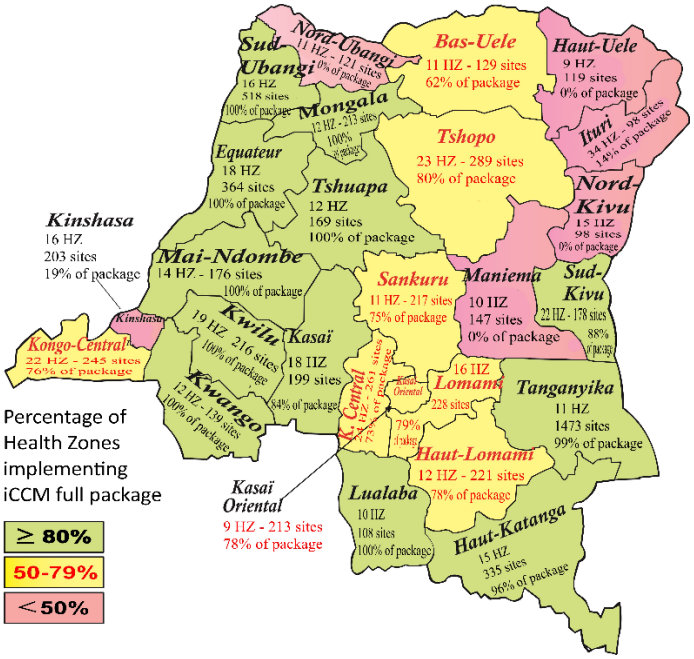


Figure 4. Geographic coverage in community care sites and percentage of health zones implementing the full package of iCCM by province in 2017



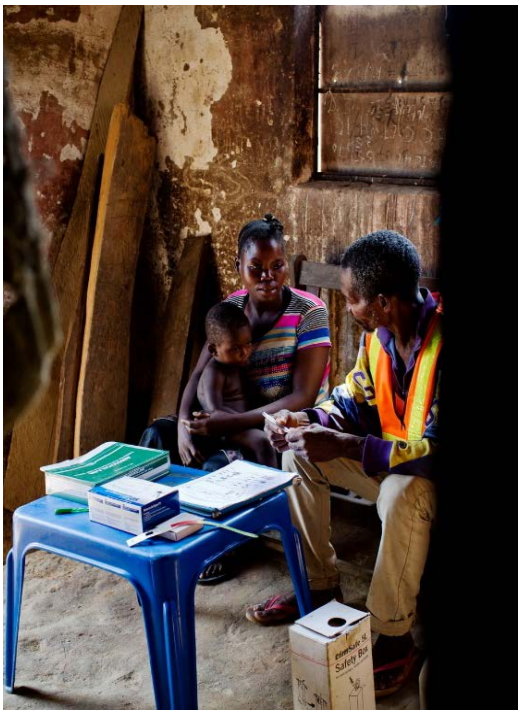
By the end of 2017, after 12 years of sustained scale-up efforts, iCCM was being implemented countrywide in 6,968 community care sites across 402 health zones (among 461 eligible) in all 30 provinces. While community care sites are implemented nationally, the quality of and types of program approaches vary greatly by geographic area, type of partner funding, available technical support, and technical priority. Such variations often lead to uneven and fragmented implementation. In 2017, only 12 provinces out of 30 had the full package implemented in at least 80% of their respective health zones **(Figure 4)**.

Current Approaches for Successful Scale-Up

Maintaining leadership and strengthening coordination

A national IMNCI coordination unit—housed at the Ministry of Public Health (MOPH)—leads the child health program agenda in the DRC and chairs the national child health technical working group (TWG). All technical departments involved in child health are members of the TWG, including the programs in charge of acute respiratory infection, cholera and diarrhea, malaria, nutrition, and planning, along with the government's partners such as UNICEF, World Health Organization, the US Agency for International Development (USAID), the UK Department for International Development, Korea International Cooperation Agency, Japan International Cooperation Agency, Global Fund, GAVI, and their implementing partners (USAID's flagship Maternal and Child Survival Program [MCSP], Save the Children, and Soins de Santé Primaires en milieu Rural).

The national child health TWG developed the 2017–2021 national IMNCI strategic plan, a broad plan that provides for the continuum of care for sick children from household to community to health facility and to the hospital. The plan, approved in August 2017, has a budget of over US $223 million. The plan recommends scaling up iCCM, by ensuring that the complete iCCM package and high-quality services are available at the approximately 7,000 existing community care sites, and introducing 8,000 additional iCCM sites to cover 70% of the country's need. The national child health TWG also developed the national community health strategic plan. Both the IMNCI strategic plan and the national community health strategic plan are essential references that will inform provincial and health zone teams in the development of pertinent and realistic operational plans.



A CHW counsels the mother of a sick child in Tshopo province (Photo credit: Kate Holt/MCSP)

Integrating monitoring and evaluation into existing systems

Key information on iCCM has been integrated into the national District Health Information System 2 (DHIS2) since its implementation in 2014. In September 2017, members of the child health TWG attended a regional workshop, Improving Routine Data for Child Health in National Health Information Systems, in South Africa and developed a country action plan to address challenges linked to DRC's health information system (HIS). The action plan focuses on improving the use of data at the source, improving data quality, strengthening HIS governance via decentralization of certain functions, reviewing existing data platforms, and improving accountability and ownership for data collection and utilization at the community level. As a follow-up, a database and a web portal are being developed by the child health TWG, and a set of priority child health, IMNCI, and iCCM indicators were selected in the first quarter of 2018 to constitute the dashboard—over half are based on data directly extracted from the DHIS2.

Mobilizing and allocating resources rationally

The development of DRC's Global Financing Facility (GFF) investment case, which started in 2015, is a good illustration of the newly coordinated strategy for resource mobilization **(Figure 5)**.[5] The country was among the first approved to receive GFF support for its national health development plan. The process involved officials from the prime minister's office and four ministries (health, finance, planning and interior) as well as the World Bank and child health TWG members. The approved investment case covers 14 provinces (of 26) with the worst health and socioeconomic indicators, with a proposed budget of US $2,6 billion for the period 2016–2020. A total of nearly US $900 million is budgeted for reproductive, maternal, newborn, child, and adolescent health essential package of services and US $84 million is budgeted for increasing the coverage and quality of nutrition interventions.

Figure 5. Quote from SEM Dr. Oly Ilunga Kalenga, Minister of Public Health, DRC[5]

[5] Global Financing Facility. 2017. Democratic Republic of Congo. Accessed May 2018. https://www.globalfinancingfacility.org/democratic-republic-congo

The child health TWG played a critical advocacy role in the programming of GFF resources, reviewed the investment case, assessed gaps in relation to newborn and child health, and advocated for additional resources to scale-up iCCM and IMNCI and improve supply chain coordination.

Results and Lessons Learned to Inform Future Scale-up Efforts

Institutionalization of strengthened health systems

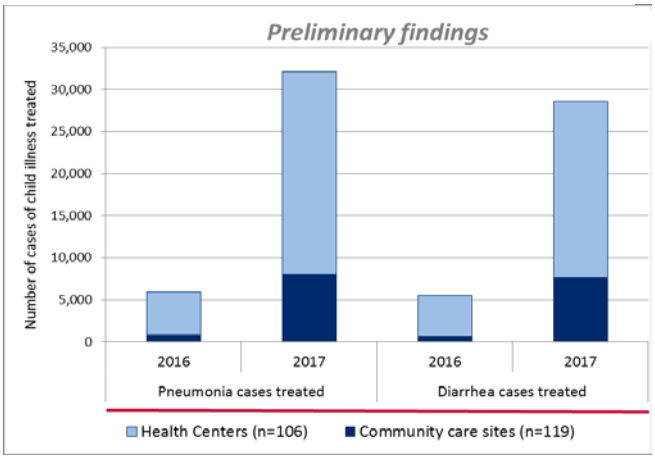
At the national level, the IMNCI coordination unit is officially in charge of the implementation and scale-up of iCCM as well as facility- and hospital-based interventions for child health. As noted above, under its leadership, the comprehensive national IMNCI strategic plan was developed by the child health TWG to support the national health development plan and to guide the scale-up efforts. At the subnational level, MOPH's partners are expected to work hand-in-hand with the provincial authorities to plan, institutionalize, and expand the coverage of iCCM to support DRC's decentralized management system. For example, MCSP's support for the provinces and health zones in Tshopo and Bas-Uélé provinces centered on expanding the package of childhood illnesses care and nutrition services, adding diarrhea and pneumonia case management to a community case management program that had only covered treatment of malaria.

The MOPH and its partners understood early on that strengthening existing structures of coordination was preferable to creating a separate group only in charge of scale-up of iCCM, and decided to support MOPH's IMNCI coordination unit to lead the group. An official letter from MOPH's general secretary confirmed the coordination unit's authority to lead the scale-up process through the pre-existing child health TWG. In addition, the group leveraged previous achievements and took advantage of the DHIS2 system to develop a tool to monitor the progress of its current efforts and plan for developing a sustainable monitoring system.

Improved utilization of services

When scale-up of iCCM is properly managed and integrated into an even more comprehensive child health approach, the results are encouraging. As an example, in late 2016 and early, in Tshopo and Bas-Uélé provinces, MCSP supported expanded implementation of the full package of iCCM services in 119 community care sites and IMNCI in 106 health centers that previously only provided malaria services. Preliminary analyses, based on data from the national DHIS2, show over four times more cases of child pneumonia and diarrhea treated at the facility level and over nine times more cases treated at community care sites in 2017, compared to 2016, before MCSP's comprehensive support **(Figure 6)**. MCSP's support included training, provision of equipment and drugs, and supervision. In these areas, approximately 25% of sick children received treatment at the community care sites.

Figure 6. Pneumonia and diarrhea cases treated at health centers vs. community sites in 119 community care sites and 106 health centers of Tshopo and Bas-Uélé provinces before (2016) and after (2017) MCSP support



Intensive support provided by MOPH's partners across the DRC confirmed that implementing a successful iCCM program requires multifaceted and synergetic interventions that need to be carefully designed, systematically costed, and regularly monitored. These interventions include not only adequate training, supervision, and appropriate motivation of the CHWs, but also strong demand generation and communication strategies. A challenge for future sustainability is that the successes of iCCM in many parts of the DRC have largely depended on drugs provided by external partners for free or at significantly reduced cost.

The DRC's Contiuing Challenges

In addition to the difficulties posed by its expansive geography and large population in need of coverage, DRC has some specific challenges and perpetual uncertainties that deserve to be highlighted.

The DRC's decentralization is still very young and fragile

DRC's constitution, which was adopted through elections in 2006, provides for devolution of powers to the provinces and more autonomy in management. The country had to wait until 2015 to effectively put in place the governing structures for 26 new provinces. While decentralization and other ongoing reforms have the potential to make a profound difference by strengthening local ownership and influencing the well-being of DRC's population, most newly established provincial health divisions still lack the human resources, basic infrastructure, and logistical and financial resources to be autonomous and able to effectively manage their health system. Strong support from central-level staff is still required.

Political instability is a daily struggle

Periodic demonstrations, days of *villes mortes* (city-wide shutdowns), and related incidents—sometimes violent—affect daily activities of staff, partners, and communities. While a peace agreement signed on December 31, 2016, by the country's top politicians was expected to lead the way to elections, the way forward remains uncertain. There are ongoing conflicts and humanitarian crises across several provinces in the DRC and the results of the protests and the government's reactions are difficult to predict.

New disease outbreaks are an ongoing threat

Periodic outbreaks of Ebola virus disease in the DRC highlight the importance of strengthening the preparedness and resilience of the health system to shocks and other stressors, so that the country develops the capacity to react and adapt. Cholera is also endemic; sporadic cases and outbreaks are common in the eastern provinces of the country. Even Kinshasa has reported cholera outbreaks over the last several years. A total of 55,000 cases and 1,190 deaths from cholera were reported nationally in 2017, almost double the number of cases reported in 2016.[6]

Conclusion

The national child health TWG established by the MOPH is recognized as the leader and coordinator of the scale-up of evidence-based interventions for child health, including iCCM. It has made significant progress in establishing a system of coordination as well as developing a comprehensive strategy. The TWG now has the difficult task of making the system sustainable and demonstrating significant impact. Among its major goals is nurturing a culture of data use at all levels of the health system and finding sustainable solutions to ensure drugs and commodities are always available at health facilities and community care sites. In terms of long-term financing, a key challenge will be finding the right balance between reducing out-of-pocket expenditures by clients to improve equity while also trying to reduce dependence on external funding.

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[6] WHO. 2 March 2018. Emergencies preparedness, response: Cholera – Kinshasa, Democratic Republic of the Congo. http://www.who.int/csr/don/02-march-2018-cholera-drc/en/