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

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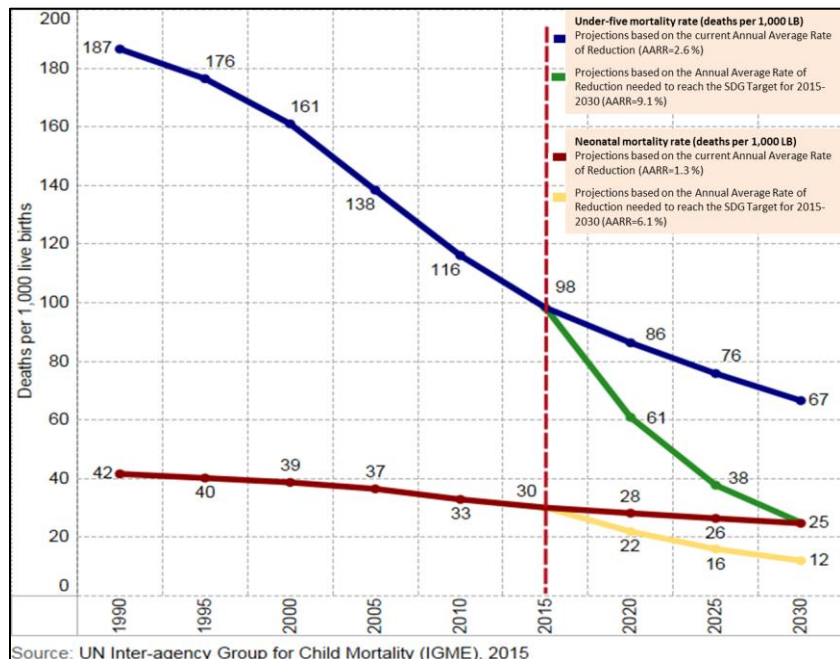
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## Community-Based Care in the Democratic Republic of the Congo

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.<sup>1</sup> 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 neonatal complications, diarrhea, pneumonia, and malaria.<sup>2</sup> 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.<sup>3</sup>

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



<sup>1</sup> UNICEF. 2017. Levels and Trends in Child Mortality Report 2017. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation.

<sup>2</sup> 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.

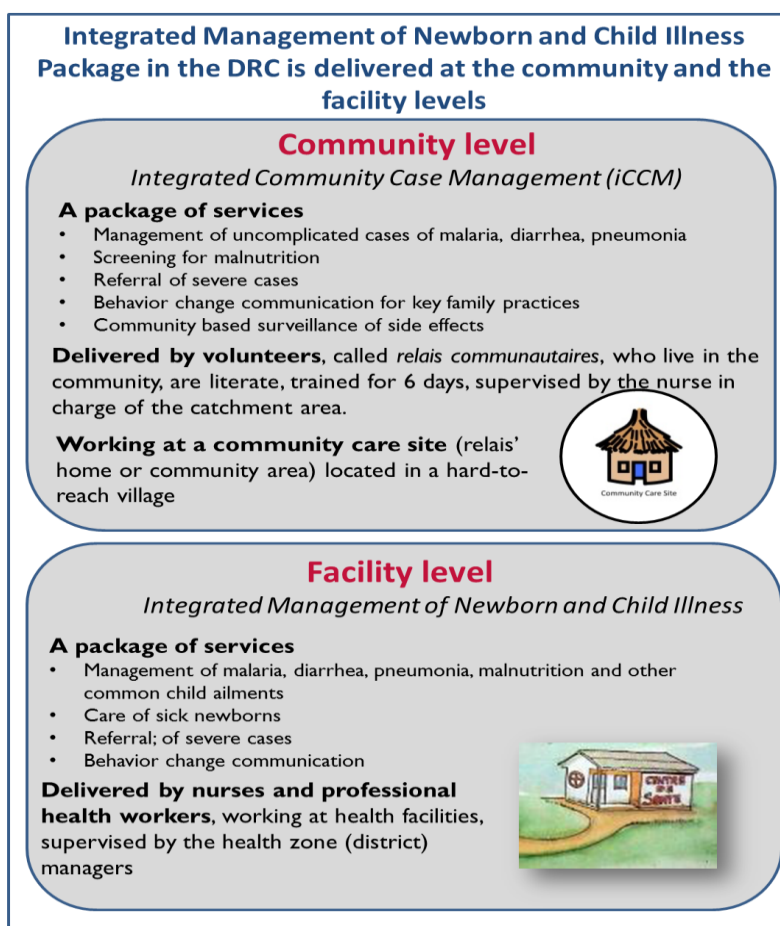
<sup>3</sup> Ministère de la Santé Publique. 2017. Plan Stratégique National de la PCIMNE 2017-2021.

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, 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 is a key component of the strategy to meet the country's Sustainable Development Goal targets. Integrated community case management (iCCM) 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, malnutrition and other illnesses. To provide quality services in remote villages, the government of DRC introduced and scaled up community-based approaches to health care starting in 2005. In the

DRC, the full package of iCCM, which is the extension 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**).

**Figure 2. The IMNCI package in the DRC**



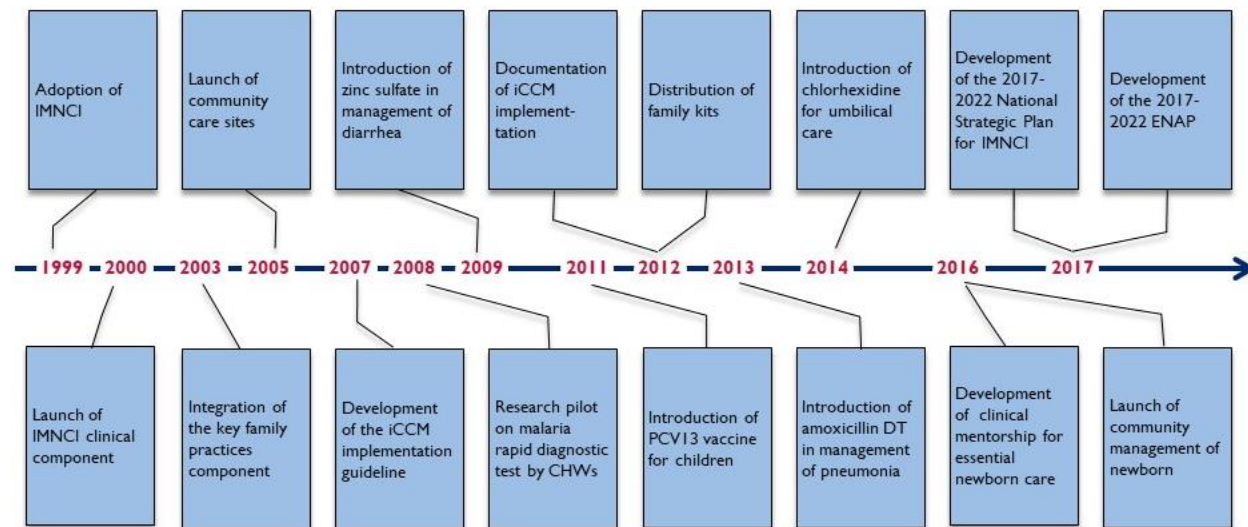
## Scaling Up iCCM to Reach the Greatest Number of Children

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.<sup>4</sup> Advocacy around iCCM in contemporary history started in 2003 after the integration of key family practices into the IMNCI strategy.

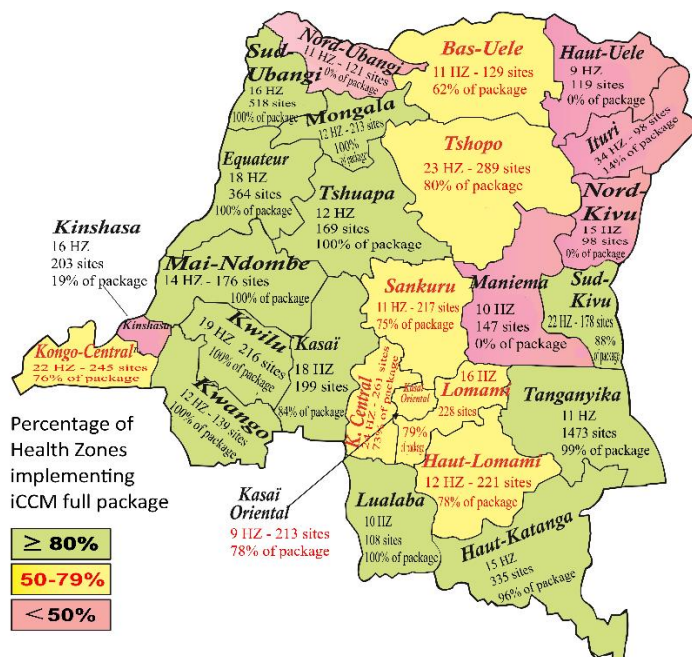
In 2005, 12 community care sites began providing iCCM as a pilot in one health zone to accelerate the coverage of care for childhood illness through additional service delivery points beyond facility-based IMNCI, which was launched three years earlier. The successive adjustments of protocols and tools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

<sup>4</sup> 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 and iCCM in the DRC**



**Figure 4. Geographic coverage of 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 implemented in 6,968 community care sites across 402 health zones (among 461 eligible) in all 26 provinces including Kinshasa. 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 health priority. Such variations often lead to uneven and fragmented implementation. In 2017, only 12 provinces 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. All technical departments involved in child health including the programs in charge of acute respiratory infection, cholera and diarrhea, malaria, nutrition, and planning, are members of the national child health technical working group (TWG) – which is chaired by the MOPH - 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 (SANRU).





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 introduction 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 a 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, showing complementarity of funding sources to address critical public health challenges (Figure 5).<sup>5</sup> 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 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 the 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.

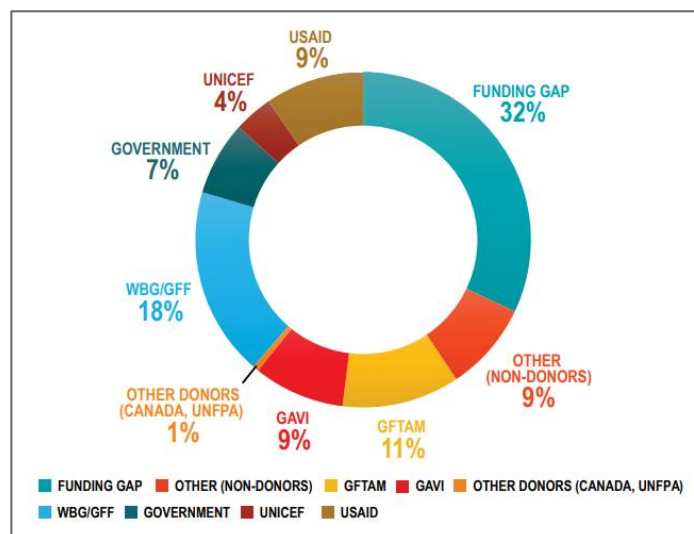
The child health TWG played a critical advocacy role in the programming of GFF resources, reviewed the investment case, assessed gaps in relation to newborn and child health, and advocated for additional resources to scale-up iCCM and IMNCI and improve supply chain coordination.

## Results and Lessons Learned to Inform Future Scale-up Efforts

### Planning and health systems strengthening

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. Under its

Figure 5. Complementary Funding of DRC’s Investment Case<sup>5</sup>



Note: The category “other” (Non-Donors) in Figure 5 includes household payment for medicines and funding from faith-based organizations

<sup>5</sup> Global Financing Facility. 2017. GFF COUNTRY SPOTLIGHT: DEMOCRATIC REPUBLIC OF CONGO. Accessed Feb 2019. [https://www.globalfinancingfacility.org/sites/gff\\_new/files/Democratic-Republic-Congo\\_EN\\_Web.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/Democratic-Republic-Congo_EN_Web.pdf)

leadership, the 2017–2021 national IMNCI strategic plan was approved in August 2017, a broad plan that provides for the continuum of care for sick children from household to community to health facility and to the hospital. With a budget of over US \$223 million, the IMNCI strategic plan includes the provision of the complete iCCM package and high-quality services at the approximately 7,000 existing community care sites, and the establishment of 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.

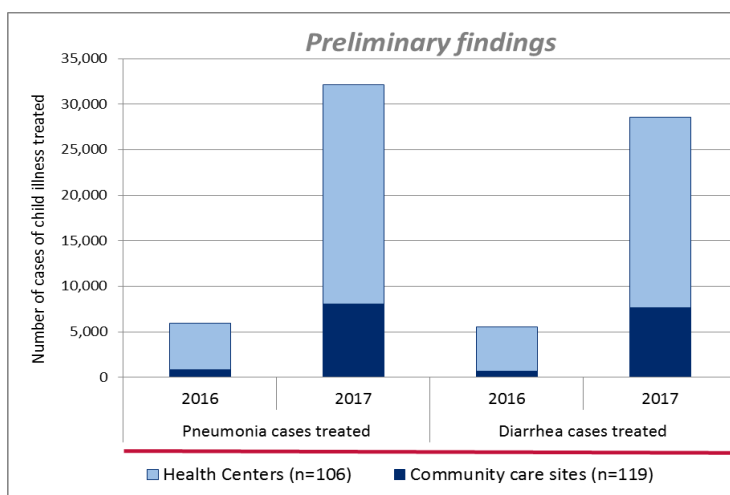
At the subnational level, MOPH’s partners are expected to work hand-in-hand with the provincial authorities to plan, institutionalize, and expand the coverage of iCCM to support DRC’s decentralized management system. For example, MCSP’s support for the provinces and health zones in Tshopo and Bas-Uélé 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 coordinating mechanisms was preferable to creating a separate group in charge of iCCM scale-up, and decided to support the IMNCI coordination unit to lead the effort. 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, in Tshopo and Bas-Uélé provinces, MCSP supported the implementation of the full package of iCCM services in 119 community care sites and IMNCI in 106 health centers which previously only received support to provide 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, a reliable logistics and supply system, 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 subsidized cost.

## The DRC's Continuing 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 and partners is still required.

### Political instability has been a daily struggle

Periodic demonstrations, days of *villes mortes* (city-wide shutdowns), and protests' related incidents have affected daily activities of staff, partners, and communities in recent years. While DRC's new president has called for national reconciliation in January 2019 during the country's first transfer of power via an election in 59 years of independence, disputes over the results of the delayed election in December 2018 are continuing. In addition, ongoing conflicts and humanitarian crises across several provinces in the DRC are persistent challenges.

### Re-emerging 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. Sporadic cases and outbreaks of Cholera are common in the eastern provinces of the country. Even Kinshasa has reported cholera outbreaks over the last several years.<sup>6</sup> The country had a recent outbreak of Yellow fever and is consistently facing measles outbreaks. 2018 was particularly tough with a total of 5,366 confirmed measles cases, the highest number reported by WHO in 12 years.<sup>7</sup>

## 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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<sup>6</sup> WHO. 2 March 2018. Emergencies preparedness, response: Cholera – Kinshasa, Democratic Republic of the Congo. <https://www.who.int/csr/don/02-march-2018-cholera-drc/en/>

<sup>7</sup> WHO, Measles and Rubella Surveillance Data. Accessed on Feb 11, 2019, [https://www.who.int/immunization/monitoring\\_surveillance/burden/vpd/surveillance\\_type/active/measles\\_monthlydata/en](https://www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/active/measles_monthlydata/en)