Working Together, Saving Lives



Project Highlights



in the Democratic Republic of Congo







ABOUT THE INTEGRATED HEALTH PROJECT

The Integrated Health Project (IHP) in the Democratic Republic of Congo (DRC) worked between 2010 and 2015 to improve the health of the Congolese people in 78 health zones in four provinces. Funded by the United States Agency for International Development (USAID) and led by Management Sciences for Health, with partners International Rescue Committee and Overseas Strategic Consulting, Ltd. (OSC), the project focused on maternal, newborn, and child health (MNCH); family planning (FP); nutrition; malaria; tuberculosis (TB); HIV and AIDS; and water, sanitation, and hygiene (WASH).

In five years, IHP improved health services for more than 13 million people—17 percent of the Congolese population. Focusing on sustainable improvements, the project stressed low-cost, high-impact innovations that could be used by providers at every level of the health system—providing facility- and community-based health care services and products, improving quality health care services, and building knowledge, attitudes, and practices to support health-seeking behaviors in the targeted health zones. The project established eight coordination offices in Bukavu, Kamina, Kole, Kolwezi, Luiza, Mwene Ditu, Tshumbe, and Uvira, and supported 766 integrated community case management (i-CCM) sites in these regions.

All data and resources presented in this overview document are available in greater detail in *Working Together, Saving Lives: Final Report of the Integrated Health Project in the Democratic Republic of Congo, 2010-2015.*

INTEGRATED HEALTH PROJECT (IHP) IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC): ADDRESSING A CRITICAL NEED

■ HE DRC IS A VAST COUNTRY, THE LARGEST IN SUB-SAHARAN AFRICA AND THE 11TH LARGEST IN

THE WORLD. In 1990, the DRC's health system was widely admired for its network of clinics and primary care facilities. Since 1996, however, civil conflict and the displacement of millions of citizens has weakened infrastructure. The outcome—a dearth of basic security, communication systems, power, clean water, and transportation among them—challenged the DRC's Ministry of Health (MOH) to maintain even the most basic health services. In 2010, 70–80% of the population—higher in rural areas—had little to no access to health care.

In 2010, the country's maternal, infant, and

child mortality rates were some of the highest in the world. Exacerbating factors were access to health providers, essential medicines, basic sanitation, and nutritious food. Malaria, pneumonia, tuberculosis, and diarrhea were prevalent; one out of six children died before their fifth birthday. Life expectancy was 43 years.

It was to join the MOH in addressing these challenges that IHP began its work in 2010 in the four provinces of Kasaï Oriental, Kasaï Occidental, Katanga, and Sud Kivu (see map). The ambitious goal of this project was to increase access to and availability of health services, to increase the quality of family care services, to improve the knowledge, attitudes, and practices supporting health-seeking behaviors, and to improve leadership, management, and governance in the health sector. With a goal of this scope, objectives had to address issues in human resources, health finance, pharmaceutical management, infrastructure, and health system management—an integrated project of enormous dimension.

The following pages can only touch the surface of IHP's myriad activities over the duration of the project, and serve to highlight some of its results—as well as some valuable lessons learned during the process.

TOTAL POPULATION SERVED: 13,020,139

Tshumbe

Bukavu

Uvira

IHP COORDINATION OFFICES:

Bukavu – 22 health zones Kamina – 9 health zones Luiza – 9 health zones Mwene Ditu – 9 health zones Kole – 8 health zones Kolwezi – 8 health zones Tshumbe – 8 health zones Uvira – 5 health zones

IGNITING A CHAIN REACTION: IHP IMPACT ON SYSTEMS

aced with uneven quality of health care and sometimes needing days to arrive at a facility due to poor roads, downed bridges, and lack of transportation, many rural clients in 2010 waited until symptoms were severe before seeking care—if they went at all. If a client did safely arrive at a health facility, he or she was often confronted with inadequate supplies, no electricity, long lines, a lack of services, and missing or expired medications. Delays in treatment frequently culminated in the death of the client, especially for pregnant mothers, children, and those in acute stages of disease needing immediate intervention.

IHP approached this immense series of challenges from three directions. First, **improve the capacity of health facilities to fulfill their purpose** with a predetermined menu of offered services, training, and supplies of essential medicines, equipment, and laboratory services—as well as the systems to efficiently deliver them. Next, **bring improved health care to the community level**, where triage care could be performed by trained staff with adequate supplies, to a community empowered by better behavior change communication about healthseeking behaviors. Finally, **bridge the two by enabling prompt referrals** to a qualified health facility when appropriate. It was by developing this complex and interwoven network that IHP helped expand access to health care.

Overarching and embracing this network were the necessary systems. Procedures were necessary for leadership development and training, measuring service quality, data collection and transfer, pharmaceutical ordering, delivery, and stock management, and data validation—essentially the framework that **enables the smooth passage of a client through the health system toward the best outcome.** This helps to achieve a higher quality of care.



IHP's approach: Lasting change through empowerment

IHP's approach to change was to empower each individual, community, health care provider, facility, and province to take on its own active role in the health system. The IHP theory is that greater understanding of these individual roles and responsibilities leads to changes in attitudes and motivation to make incremental changes—igniting a chain reaction across the sector **from the supply side**. This shift results in improved health service delivery through improved leadership, funding, training, and support.

Clients, through a greater understanding of their own role in health-seeking behaviors within their home and community, then provide a chain reaction from the demand side, resulting in people who demand better governance, know when and how to seek out health services, use them more effectively, and have improved health outcomes. On July 29, 2015, I led a large delegation to Dibaya to witness IHP's achievements. This visit enabled me to observe the joy and satisfaction of the population for IHP's support. I admired the strong community dynamic... The testimonies I heard from people led me to believe that the project has changed people's attitudes, behaviors, and awareness to increase favorable health practices."

–Dr. Léandre Kambala, Provincial Minister of Health, Kasaï Occidental

CHALLENGE

Improve the capacity of health facilities

IHP BEGAN BUILDING THE CAPACITY OF

HEALTH CENTERS and hospitals to supply a defined list of minimum and complementary priority health service activities (MPA and CPA), including certain preventive, curative, laboratory, and other services that each facility must provide. One level of services was tailored to health centers (MPA), and a higher, expanded level to general referral

planning commodities, providing pharmaceutical management and monitoring tools for personnel in regional warehouses, distribution support for antimalarial commodities from the President's Malaria Initiative, and transport of vital vaccines.

There were many substantial challenges in this area during the project, including differing ordering systems

⁶⁶I visited a community care site and admired how well it was organized... The site agent impressed me with his mastery of which cases to treat and which to refer, of proper medical procedures, and of the usage of various tools."

-Dr. Léandre Kambala, Provincial Minister of Health, Kasaï Occidental

hospitals (CPA). In the first project year, no facility met or exceeded the criteria. By the second year, nearly 50% met them, and by the end of the project, over 90% of facilities provided the full menu of services.

Additionally, nearly \$3 million was invested in infrastructure improvements to rehabilitate health facilities. Such items as roof repair, painting, paving of floors and paths, window repair, and provision of materials such as mattresses, delivery boxes, minor surgical supplies, microscopes, and solar panels all contributed to being prepared for better service delivery. These improvements were largely executed by the communities themselves, with supportive supervision by representatives of the health zone, health area, and IHP.

To ensure the availability of essential medicines and supplies in IHP-supported facilities, the project worked with the USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) on procurement, training, and support. SIAPS supported the quantification and monitoring of medications and supplies. IHP supported procurement, training, and community-based distribution of family in distribution entities, insufficient quantities ordered due to inadequate forecasting, unavailable medications, extended delivery periods, insecurity, and lack of reliable transport. With an eye toward centralizing medication management systems, medical consumption data were digitized by SIAPS to be available online in late 2013; however, a 2015 survey reflected that health facilities were still not ordering medicines in adequate time for delivery. Availability of some tracer medicines, such as Depo-Provera and iron folate, was an ongoing concern. In spite of these challenges, however, the project made progress in reducing stock-outs and improving stock management, and by the end of the project, 86% of essential medicines that had been ordered were delivered. The project also provided cold chain equipment, thermohygrometers, and transportation.

Improving the quality of health care was also a priority. Once the packages of MPA and CPA services were developed, the fully-functional service delivery model referred to as Formation Sanitaire Complètement Fonctionnelle, or FOSACOF, was a key strategy used to increase the quality of services and care in IHP-



supported health zones. FOSACOF uses nine criteria, specifically adapted to reflect the norms and standards outlined in the DRC's National Health Development Plan. IHP trained health zone management team members, service



members with this wholesystem tool for quality assurance and improvement. The project routinely evaluated and scored facilities according to the FOSACOF criteria for quality compliance. In spite of multiple budgetary constraints causing this program's

temporary cessation, by the project's end over 50% of all IHP-supported health facilities had integrated the FOSACOF approach, with 708 health centers and 29 referral hospitals participating.

CHALLENGE 1 LESSONS:

- Developing and measuring hospital and health center standards have a positive impact on the quality of care in a clinical setting, including improved waste management and sterilization habits, handling of inventory, training, and participation of women in management.
- A lack of consistency in data, procedural, budgeting, and shipping systems on the pharmaceutical procurement level can negatively impact supply chains with either over- or under-supply of essential medicines.

HEALTH FACILITIES



NUMBER HEALTH CENTERS MEETING ALL **9 FOSACOF MINIMUM STANDARDS**

% **HEALTH ZONES IN IHP-SUPPORTED**

AREAS WITH VALIDATED ACTION PLANS

.365&51 **HEALTH CENTERS & REFERRAL HOSPITALS IMPLEMENTING MPA & CPA IN IHP-SUPPORTED HEALTH ZONES**

2. million USD INVESTED IN FACILITY **INFRASTRUCTURE IMPROVEMENTS**



Bring health care to the community

Providing training and support for local village health committees like the Cagombe CODESA (shown here preparing for their monthly meeting with local government health officials) is only one aspect of DRC-IHP's approach to behavior change.

IHP'S PEOPLE-CENTERED APPROACH took

hold at the community level with the revitalization of community care sites, many of which were not functioning at the onset of the project. Supported by IHP and the UNICEF-sponsored Health for the Poorest Populations project, these sites provided a resource to communities for preventing and treating malaria, diarrhea, and pneumonia within and between communities, especially in hard-to-reach areas. Sites were provided with coaching, training, checklists, diagnostic tools, data collection tools, medicines, and supplies for routine care. At the end of the project,

antenatal visits, which jumped from 9,267 in 2012 (when the program began) to 21,741 in 2015.

The empowerment of local health development committees—*Comités de Développement Sanitaire*, or CODESAs—overlapped and supplemented the Champion Community effort. CODESAs have become an extension of the formal health system and are widely believed to be instrumental in creating community resilience. IHP supported CODESAs by strengthening their involvement in health system management and in health advocacy and community mobilization. CODESAs played an important role in

We used to spend our energy and money to treat diarrhea. But now we invest in raising community awareness on how to prevent it—advising people to adopt healthy behaviors and maintaining our new WASH facilities."

-a member of the WASH committee in Lubemba village

IHP was supporting 766 integrated community case management (i-CCM) sites in 59 health zones.

IHP also supported Champion Communities, an innovation which increases health literacy and encourages the use of health services. Guided by IHP staff, Champion Communities mobilized local citizens to plan, carry out, and evaluate health initiatives according to their own priorities. For example, in Bukavu the four Champion Communities provided health education to local residents, performed monthly household surveys on health indicators, and charted trends for planners at the health centers. They also formed "Champion Men" groups to foster male support for family planning and reproductive health. These methods have significantly increased the use of health services in Bukavu. One example is the number of women living in Champion Community health zones who attended four community action, sharing local solutions to local health problems—such as refurbishing health centers, forming water, sanitation, and hygiene (WASH) committees to support community-led total sanitation (CLTS) standards, communicating family planning options, and hosting information sessions on disease prevention. In nine pilot health zones, more than a million people accessed clean water sources and over 800,000 accessed improved sanitation facilities for the first time—a direct result of IHP's CLTS activities and WASH committees working together.

A key role of the CODESA and the community health worker is the creation of a two-way community-facility referral network, which effectively enables good governance and the flow of information from the community to the health facility, and vice versa, for better patient care.



The number of patients visited by a community health worker and the number of patients referred to a health facility both increased significantly over the years of the project. These outstanding results can be attributed to the i-CCM approach, the organization of supportive supervision and joint monitoring visits at community care sites, the provision of release forms and referral notes, and the continuous training of community health workers.

Toward the end of the project, the role of the CODESA began to shift toward a more consultative and participatory one. Specifically, CODESA members self-reported as being representatives of the community, rather than spokespersons for the health system. This bridging role had a dynamic effect on reducing health center user fees, bringing clients to the health center, and bringing clients to the attention of the facility staff—impacting mortality rates and increasing service utilization.

CHALLENGE 2 LESSONS:

- Community engagement and mobilization approaches work to strengthen the quality, utilization and sustainability of health services. This includes CODESAs, results-based financing, infant and young child feeding support groups, Champion Communities, and mHealth outreach.
- Reporting from CODESAs notably improved when they were supplied with frameworks or checklists, and followed up with monitoring visits.
- The leader of a Champion Community may determine its success. Decisions made by the Champion Community need to be approved by the full community, and weaker leadership impacts its effectiveness.

COMMUNITY HEALTH

Growing outreach to youth groups by IHP



164 YOUTH GROUPS PARTICIPATED IN EDUCATION OUTREACH

1.06 million PEOPLE HAD FIRST-TIME ACCESS TO IMPROVED WATER SUPPLY

1,284 codesa health committees revitalized

1.5 million PEOPLE REACHED THROUGH MINI-CAMPAIGNS ON COMMUNITY ISSUES

766



Develop skills in leadership, planning, and management



IHP'S LEADERSHIP DEVELOPMENT PROGRAM (LDP) invited 80 health zone management teams to participate in a program that demystifies leadership by encouraging participants come up with their own solution. The team reached out to the local community for help, and the community members answered their call by fashioning bricks and planks, carrying materials, and performing masonry

Witnessing this wave of support from Kalomba's inhabitants was priceless. Here is living proof that we can overcome our challenges on our own. But we would not have been able to realize that without LDP training."

-Dr. Nico Kamayi, Kalomba Chief Doctor and health zone management team member

to apply leading and managing practices to actual challenges they faced in their unit or organization. LDP stresses teamwork to set and reach specific goals through a structured methodology.

During the five-year project period, 254 of these goals were identified by teams, and most of them (84%) were achieved. Many of these goals were related to MNCH, FP, nutrition, and disease prevention, such as increasing vaccination rates or antenatal care visits. Some, however, were designed to help service delivery in other ways.

In Kalomba, for example, the team was responsible for providing over 150,000 people with essential health services. However, poor working conditions—including cramped desk space in a hot, unventilated room often led to friction rather than teamwork among colleagues. Following the LDP, the team realized that if they wanted more office space, they would have to work to construct a new administrative building. This collaborative approach enabled the Kalomba health zone team to become more competitive, both in management and in the quality of services it provided.

CHALLENGE 3 LESSONS:

- Management and leadership training, such as the LDP, demonstrably contributes to the empowerment of health leaders, health providers, and health zone management teams to create and execute effective plans, which in turn contributes to the improved use of health services.
- Supportive supervision and regular mentoring visits were important factors in successfully implementing quality improvements.

THE IMPACT OF RESULTS-BASED FINANCING

Results-based financing (RBF), which was introduced for a limited time in seven pilot health zones, showed great promise in stimulating the quality, availability, and utilization of health services both at the community and the facility levels. RBF provided financial incentives based on performance, allocating health resources more efficiently and improving governance, accountability, and data quality (via technical and community verification). Additionally, it increased the use of data by health facilities and decision-making structures, and established links between health facilities and the community. Beginning with a baseline assessment in early 2013, the program was implemented for two years, ending in September of 2015, when activities were transferred to a bridge project. Data on antenatal care and maternity and postnatal services, and global quality scores at health centers and referral hospitals in these seven zones all showed strong, consistent, positive results.

⁶⁶Before, I dreaded walking the 15 kilometers to reach our hospital... being able to give birth so close to home is such a relief."

—Julienne Mbuyi, new mother and patient at the (RBF participant) Kakala maternity ward

LESSONS LEARNED FROM RBF:

- RBF is effective for increasing the rate of utilization of health services and increasing referrals and improving the overall quality of health services and information.
- Linking incentives with improved results from health facility employees and management teams shows promise for expansion beyond the pilot zones.
- Strong results of the pilot RBF program suggest an expansion of this approach may be successful.



RBF and the progression of ANC1 and ANC4

RBF impact on health zone management team operations





⁶⁶I am 34 years old and I've had 11 pregnancies. Only four of my children are living, the others having died of complications, including from malaria. Now, I'm 16 weeks pregnant and I've come to the hospital to take SP. I know it is good medicine that will protect me from malaria and the pregnancy complications that come with it—and it's free. I'm very thankful for this program."

-Ms. Ngoya, an expectant mother and patient at Kikondja Hospital

BETTER HEALTH FROM INSIDE OUT: IHP IMPACT ON MATERNAL & FAMILY HEALTH

he complex array of health issues that can threaten the health of a mother and child in the DRC cut across many technical areas. Nearly half of married women say they would like to space their families—but few used any type of family planning method. Malaria can lead to anemia, premature delivery, low birth weight, and a high risk of infant mortality—but few expectant mothers took preventive measures. Malnutrition causes severe stunting and other developmental health issues in

nearly half of Congolese children under the age of five but it was not just the lack of food, but rather the lack of knowledge about nutrition that contributed to this alarming statistic. Frustratingly, many of the most severe risks to family health in the DRC are treatable, but few health providers were trained in essential and emergency maternal and neonatal health services, and even fewer families were seeking out these services.



Achieve improvements in neonatal, maternal, and newborn health

DUE TO THE DIFFICULTIES ADDRESSED

ABOVE, it was necessary for IHP to approach this challenge not only from a service provider perspective, but also from the perspective of families and communities unwilling or unable to seek out preventive measures and treatment options. This required several approaches, with reinforcing activities by service providers, communities, and health zone management teams.

- Use of sulfadoxine-pyrimethamine (SP) for pregnant women, who are particularly susceptible to malaria;
- Resuscitation of newborns, using a simple but powerful technique to start breathing in struggling newborns during their first minute of life, called Helping Babies Breathe; and

My son was born not breathing or moving. Mama Efuto performed some techniques—and four minutes later my child came back to life! I thank Mama Efuto for reviving my boy whom I love so much. We are now both in good health."

-Agnes, Dikungu health zone mother

First, IHP worked with the MOH to design and implement a three-week intensive competency-based training package for health providers at all levels. The training instructed providers on the use of the most effective life-saving strategies for pregnant women and their babies, notably in:

- Managing difficult births and obstetric
 - emergencies, with emphasis on appropriately administering antibiotics and other drugs such as oxytocin, manual removal of the placenta, performing Caesarean sections, and safe blood transfusion, as well as newborn care, such as properly caring for sick and low-birth weight newborns, and routine delivery practices, including active management of the third stage of labor to prevent postpartum hemorrhage;
- Providing individual or couple family planning counseling, patient consultations, administering oral and injectable contraceptives, and properly inserting and removing contraceptive implants and IUDs;

Supporting Kangaroo Mother Care, a technique in which mothers and fathers wrap their infant next to their body for constant skin-to-skin contact, stable warmth, and breastfeeding.

At the local level, IHP leveraged the relationships of CODESAs, Champion Communities, and mHealth to distribute messages about antenatal care, birth spacing, hygiene, immunization, and exclusive breastfeeding, among others.

By the end of the fifth year of IHP, the number of pregnant women attending at least one antenatal care visit (ANC1) had reached 108% of the project's target, but only 53% had four or more antenatal care visits (ANC4), an increase from 9%. In the Congolese culture, women hide their pregnancies as long as they can—which explains why many attend their first antenatal care visit during the second trimester of their pregnancy (only 17% of women attended their first ANC before their fourth month). This cultural factor may explain the lower numbers for ANC4. Not surprisingly, results were stronger in health zones with



Photo :Warren Zelm

strong administrative and community support, where circulars were issued to village chiefs recommending ANC visits and deliveries at health facilities for pregnant women, where RBF was implemented, and/or where ANC was provided free of charge. Additionally, the involvement of midwives who acted as community health workers to refer clients to facilities boosted performance.

In sum, the project showed consistently high performance in most service delivery categories, and

an increase in the number of mothers who benefited from ANC, skilled birth attendant assistance during delivery, sick newborns receiving correct antibiotic treatment, number of newborns who received essential newborn care, and number of newborns with problems breathing who were successfully resuscitated.

CHALLENGE 4 LESSONS:

- Community engagement methods contributed to strong participation in antenatal programs and newborn care.
- The Helping Babies Breathe approach proved to be an effective technique for reducing newborn mortality.
- RBF pilot areas showed an increased referral rate of high risk pregnancies (from 58% to 98%), an increased rate of ANC1 (from 79% to 91%), an increased percentage of women attending ANC4 (from 22% to 63%), and an increased rate of deliveries with skilled birth attendants (from 63% to 69%).

MATERNAL/NEWBORN

Women attending at least 1 ANC visit and those attending 4 ANC visits at end of project, by region



2.5 million PREGNANT WOMEN ATTENDED AT LEAST ANCI

2.1 million Deliveries performed with a skilled BIRTH ATTENDANT

2 million

NEWBORN CARE

189,787 NEWBORNS RECEIVED ANTIBIOTIC

TREATMENT FOR INFECTION

1.9 million

WOMEN BENEFITED FROM ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR A HEARTFELT AND WARM CONGRATULATIONS CONGOLESE AND EXPATRIATES—FOR AN INCRE PROJECT. YOU HAVE GIVEN HOPE TO THE PEOPL HELPED THE HEALTH CARE PROVIDERS IMPROV SERVICES. CONGRATULATIONS!"

Diana Putman, USAID DRC Mission Director



FOR THE IHP TEAM— DIBLY SUCCESSFUL E OF CONGO AND HAVE E THE QUALITY OF

UNE SHU



Expand the use of contraception

Paulina Kasungu, a member of the Tudisange Champion Community, counsels a young couple in family planning methods in Luiza, Kasaï Occidental. As a member of the Tudisange Champion Community, Paulina provides counseling in family planning not only at the health center but also visits members of the Luiza community in their homes.

IHP HAD AN IMPRESSIVE IMPACT ON FAMILY PLANNING INTERVENTIONS. Using

the IMPACT 2 modeling tool developed by Marie Stopes International, the project estimated that its interventions averted approximately 224,000 unwanted pregnancies and 157,000 unplanned births, subsequently preventing contraception such as implants. Also emphasized was the Lactational Amenorrhea Method (LAM) of contraception, in which exclusive breastfeeding and amenorrhea protect against a new pregnancy up to six months after a woman gives birth. IHP trained community-based distributors (CBDs) to conduct

⁶⁶I gave birth almost every year. My children grew poorly and were always sick, and it was difficult to care for them all. LAM has enabled us to space our children's births. Now they are strong and healthy, and I have more time to take care of them." —Céline, family planning adopter and CBD in Katana

700 maternal deaths and 28,000 unsafe abortions. These figures indicate that IHP's high-impact practices averted the loss of 40,000 maternal disability-adjusted life years.

The project trained health workers at all levels in family planning counseling and contraceptive technology, including the use of long-lasting, reversible door-to-door outreach to inform couples about their contraceptive options. In addition to supplying CBDs with family planning commodities, the project also provided them with bicycles and job aids to facilitate the outreach. The project also created demand for services through community radio and SMS messages. With help from the Champion Community, "Champion



FAMILY HEALTH



Men," and CODESA networks, use of contraception methods grew throughout the project.

In the end, the project exceeded all family planning targets, including 2.7 million new acceptors of any modern contraceptive method and 2.8 million counseling visits for family planning and reproductive health. The primary challenge in the implementation of family planning activities was maintaining a consistent supply of contraceptives at the service delivery level. In spite of this, by the end of the project IHP reported more than a million couple years of protection, which was an achievement rate of 156% against its target.

CHALLENGE 5 LESSONS:

- Community-based approaches helped increase the number of counseling visits for family planning. CODESAs partnered with opinion leaders to spread the message in the community via megaphone and other methods.
- Training providers to facilitate family planning discussions and demonstrate proper use of condoms may be a contributing factor to family planning results.
- Training providers in the administration of oral and injectable contraceptives and proper insertion/removal of contraceptive implants and IUDs, and providing supportive supervision to these providers, contribute to improved service quality in family planning.
- Peer counseling can be a very effective method of delivering a family planning message.

FAMILY PLANNING

The progression of CYP during the project



Cumulative total for all project years: 2,563,143

2.56 million

2,233

SERVICE DELIVERY POINTS PROVIDED FAMILY PLANNING COUNSELING AND/OR SERVICES

2.7 million

2.8 million visits for family planning/ reproductive health counseling



Improve vaccination rates and other disease prevention methods

THE PERCENTAGE OF CHILDREN COMPLETELY VACCINATED BEFORE THEIR

FIRST BIRTHDAY is the most important single indicator of the effectiveness of a routine immunization program. IHP's foundational principles for strengthening routine immunization were based on the "Reach Every District" approach, which focuses on universal coverage in every health zone in the country. IHP supported the technical and financial planning, routine supportive supervision of health zone management teams, monthly monitoring meetings, and community monitoring to identify unvaccinated and inadequately vaccinated children. The project also provided support for the production of vaccine management tools to improve data quality and assisted with data validation, especially in health areas implementing RBF.

Bundled with the outreach of Champion Communities, behavior change communications, LDP projects addressing vaccination, and mHealth, the IHP approach project. Fewer children contracted pneumonia over the course of the project, as a result of a pneumococcal immunization campaign that accelerated since its inception in 2011, reaching 94% coverage by the end of the project. IHP supported other vaccination initiatives as well, including polio eradication, and maternal and neonatal tetanus, among others.

Malaria prevention methods such as long-lasting insecticide-treated bed nets (LLINs), use of SP during pregnancy, and campaigns to raise awareness were also adopted by the project. Many health zones were plagued by regular shortages of SP during the project; the high drop-out rate between ANC1 and ANC4 presented another challenge to SP delivery. In spite of these obstacles, however, use of these prevention methods increased over the course of the project. The use of LLINs, once supplies were increased in the final year of the project, increased rapidly thanks to community distribution campaigns. Health zones

⁶⁶One IHP achievement I will never forget was the improvements to the water supply in the Ruzizi health zone. I can tell you truly that the entire population of Kigurwe, Sasira, Ndunda, and Rusabaki had been deprived of water for many years. Then IHP came along and changed all that."

-Dr. Mwanza Nangunia Nash, Provincial Minister of Health, Sud Kivu

strengthened supply, demand, and quality aspects throughout the system. In spite of challenges with stock-outs of vaccines and syringes in the first two years, vaccination coverage improved over the life of the project. For example, pentavalent vaccine (DPT-HepB-Hib3) coverage continuously rose over the five years of implementation, culminating in 97% of children under 12 months of age having been vaccinated. Measles vaccines also showed consistent increases, rising from 85% to 93% by the end of the participating in RBF had notably larger increases, due to better stock management, availability, and distribution methods.

Access to potable water, adequate sanitation, and good hygiene practices are key to disease prevention in children under five years—indeed, at every age. At the project's onset, only one in three Congolese households had convenient access to potable water, and fewer than one in four had adequate sanitation. Safe water sources and useable toilets are



vital for public health, and their absence leads to high prevalence of diarrheal and water-borne diseases which are among the major causes of infant and child mortality in the DRC.

Through the involvement and assistance of the CLTS approach, IHP supportive supervision, community and religious groups, and the procurement of construction materials, the project achieved many impressive results. For example, the Bilomba health zone demonstrated vast improvements as a result of awareness-raising activities. Over the course of the project, the percentage of residents in Bilomba with access to clean water jumped from virtually none to 81% (72,000 people). Some 108 water points were constructed and maintained. The number of residents using a latrine built from local materials rose from virtually none to 67% (close to 60,000 people).

CHALLENGE 6 LESSONS:

- CLTS, with WASH community involvement, is a powerful approach for promoting community ownership of good sanitation and hygiene practices.
- Changing long-standing cultural views on sanitation and hygiene requires the support of key community leaders and regular communication with the community.
- A continuous supply of prevention methods such as LLINs and SP is vulnerable to many factors, including budgetary restrictions, distribution issues, and regional security concerns.



DISEASE PREVENTION

2.13 million CHILDREN UNDER 5 RECEIVED PENTAVALENT VACCINE

13.9 million

VITAMIN A SUPPLEMENTS

872,338

INSECTICIDE-TREATED BED NETS WERE DISTRIBUTED TO PREGNANT WOMEN AND GUARDIANS OF CHLDREN UNDER 1 YEAR

5,372 HEALTH CARE PROVIDERS WERE TRAINED IN MALARIA PREVENTION



Reduce child malnutrition

Salome Nambombo, right, was one of the community volunteers who took part in IYCF training; now she organizes weekly cooking demonstrations for community members, highlighting easy-to-make, nutritious meals from local ingredients.

BREASTFEEDING, VITAMIN A SUPPLEMENTS, NUTRITIONAL COUNSELING, AND THE USE OF IRON FOLATE FOR PREGNANT WOMEN

have long been known to lead to better child health. Working with the MOH, IHP facilitated the development of a national breastfeeding policy directing all health workers in DRC to help mothers breastfeed their newborns within an hour of giving birth. IHP circulated and implemented this policy change in health centers and remained low across supported areas throughout the project. IHP exceeded nutrition targets for the number of children who received vitamin A, the proportion of pregnant women who received iron folate to prevent anemia, and the number of mothers who received nutritional counseling for their children.

One of IHP's greatest successes in community nutrition, however, was the integration of infant and young child feeding (IYCF) demonstrations into

⁶⁶I always had these foods with me, but I didn't know how to combine them to keep my children safe from malnutrition. I thank the community volunteers for their advice, which has allowed me to keep my youngest daughter in good health."

—Monique Mputu, IYCF support group member

and hospitals in all 78 health zones. With 85 percent of all deliveries in DRC occurring in health facilities, this directive is still reaching women and helping them adopt early, optimal breastfeeding practices. The percent of newborns breastfed within an hour of birth in health centers increased from 2% at the end of the first project year to 96% by the end of September 2014 (according to routine data collected from IHP health zones).

The project also provided support to the MOH and other partners to conduct mass supplementation campaigns for vitamin A to children under five years of age. Performance was consistently high across seven of the eight coordination offices; Mwene Ditu did not participate in the first year of the project. Procurement challenges contributed to a lower percentage of breastfeeding women receiving vitamin A supplements, communities through the creation and support of IYCF groups. These groups share positive breastfeeding experiences and benefits, supervise and coach mothers, conduct cooking demonstrations with local foods, provide nutrition education to women and their families, and host meetings in easilyaccessible locations.

The project found that IYCF trainings and support groups increased rates of early breastfeeding; improved nutrition for mothers, babies, children, and families; reduced malnutrition; reduced cases of childhood diarrhea and fever; reinforced community bonds through sharing food and experiences; and strengthened the health system at the most basic level.

To treat severe and acute malnutrition, the project collaborated with the national nutrition program (PRONANUT) to distribute therapeutic foods including



Photo : Rebecca Weave

Plumpy'Nut and fortified milk. With PRONANUT, the project trained and provided supportive supervision to health providers on the recognition of severe acute malnutrition, growth monitoring and promotion, and community mobilization via CODESAs.

CHALLENGE 7 LESSONS:

- Project support for early breastfeeding, including IYCF, Kangaroo Mother Care, and the national policy on breastfeeding, contributed to better infant nutrition beginning at birth.
- Educating community members on nutrition, using low-cost, locally-available resources, can dramatically improve infant, child, and maternal health.
- Cooking demonstrations were a popular way to gather a broad cross-section of the community to learn something new.

NUTRITION

Number of mothers with children under 2 who received nutritional counseling for their children



Cumulative total for all project years: 1,742,380

551,726 BREASTFEEDING MOTHERS RECEIVED VITAMIN A SUPPLEMENTS

1.7 million

TO PREVENT ANEMIA

 $2.8 \, \text{million}$

VISITS FOR FAMILY PLANNING/ REPRODUCTIVE HEALTH COUNSELING

1,080 SUPPORT GROUPS IN 261 HEALTH AREAS DEMONSTRATING IYCF TO PARENTS



More effectively treat communicable childhood diseases

THE FRONT LINES OF HEALTH SERVICE DELIVERY: IHP IMPACT ON DETECTING AND TREATING INFECTIOUS DISEASES

isease-specific targets for the treatment of infectious diseases are problematic, especially in areas with poor historical data. IHP broadly focused on treating

IHP FOCUSED ON THREE CRITICAL CHILDHOOD ILLNESSES DRIVING HIGH MORTALITY: PNEUMONIA, MALARIA, AND

DIARRHEA. Discussed above, of course, is the first and best step, prevention. However, once it had been diagnosed, IHP's approach to the disease was to treat it on a local level before, or quickly refer it after, the patient had become critically ill. Using the integrated management of childhood illness (IMCI) approach, the project moved toward this objective.

Many methods of building local capacity were used in IMCI, including additional training of local providers, revitalized i-CCM sites, improved availability of pharmaceuticals such as oral rehydration solution (ORS+zinc), cotrimoxazole, and amoxicillin, and improved distribution of these treatments—but most critically, the community was repositioned as a principal agent and driver for health. The contribution of community health workers was vital in this approach.

Pneumonia

IHP achieved 107% of its target for cases of pneumonia treated, reaching 2.3 million patients with life-saving antibiotics, approximately 5% of which were treated on a local level. The overall trend of pneumonia cases treated increased steadily over the project. In addition to an increase in cases pneumonia, malaria, diarrhea, TB, and HIV and AIDS in target health zones.

treated, fewer children contracted pneumonia over the course of the project. The decrease in total cases in the project's final year corresponds to a pneumococcal immunization campaign that has accelerated since its inception in 2011, but a relationship has not been confirmed.

Diarrhea

Despite diarrhea being one of the leading causes of death for children under five years old in DRC, this disease remained largely overlooked by parents, guardians, and health providers. For this reason, in addition to its broad prevention efforts leveraging communities to improve sanitation, hand washing, and water quality and supply, IHP supported health facilities and community care sites in treating nearly two million cases of diarrhea over the course of the project. The number of children treated with ORS+zinc increased by 250%, from 256,000 cases in the first year, to nearly 620,000 cases in the final year of the project.

Malaria

Malaria strikes hardest in the most vulnerable groups pregnant women and children under five. The 2013 DRC Demographic and Health Survey reported that 23% of children between 6 and 59 months of age tested positive for malarial parasites using microscopy. While LLINs also prove effective in reducing child mortality, the primary treatment for children was the availability and appropriate use of artemisinin-based combination therapy (ACT).

Approximately 6% of malaria cases are severe and require hospitalization. Most of these occur in children under five, who might not survive the long trip from a rural home to the hospital. Today, those with severe malaria can be treated locally with a suppository called rectal artesunate, to help them make it to the hospital. As part of an assessment to determine how well the treatment would be accepted by health workers and parents, IHP became the first project to introduce rectal artesunate in both health centers and i-CCM sites in the DRC, and the project has trained more than 50 nurses and 70 community health workers in the new treatment.

In IHP's second project year, i-CCM sites treated only 924 cases of malaria. Two years later, they received and treated over 30,000 episodes. In year five, i-CCM sites treated over 60,000 children for malaria. Overall, IHP-supported facilities reported a total number of ACT treatments of 9,240,067.

Measured on thirteen separate indicators, many of which were procurement-based, IHP's performance was challenged by ambitious targets coupled with budgetary restrictions. The highest performance came in the number of ACT treatments purchased. Low reporting of health zones in the coordination offices of Kole, Kolwezi, and Tshumbe during the first two years pulled the overall project average down. After the project organized trainings, improved procurement, and focused on supportive supervision emphasizing compliance with the national protocol, performance in malaria indicators improved.

CHALLENGE 8 LESSONS:

Adequately supplied, local community health workers and i-CCM sites enable early intervention in childhood diseases before they become critical. These community health workers are also able to refer the client to the nearest facility, if needed.

CHILDHOOD DISEASES

Number of child pneumonia cases treated with antibiotics



Cumulative total for all project years: 2,308,766

2.3 million

620,000 CHILD DIARRHEA CASES TREATED WITH ORS+ZINC

120

HEALTH PROFESSIONALS TRAINED IN THE USE OF RECTAL ARTESUNATE FOR SEVERE MALARIA

9.2 million

More effectively

More effectively treat HIV and AIDS

MANY IN THE DRC BELIEVE THAT TESTING POSITIVE FOR HIV IS A DEATH

SENTENCE. The MOH and international partners have been working to change attitudes by raising awareness of HIV prevention, testing, and treatment.

IHP experienced two implementation phases of its HIV program: the first in all four provinces, the second (beginning October 2013 after a PEPFAR strategic pivot) in only one, Katanga. During the first phase, the IHP HIV program focused primarily on prevention of mother-to-child transmission (PMTCT) and secondarily on blood safety in 212 HIV care sites across the four provinces. By the end of the project, 51% of women who attended ANC, labor, or delivery in IHP-supported facilities were tested and were aware of their HIV status, and 22% of PEPFAR-supported sites providing PMTCT services achieved 90% ARV or ART coverage for HIV-positive pregnant women. This lower performance can be explained by the fact that the project only started reporting on this indicator in the last year of the project.

During the course of the project, 315,317 clients were counseled and tested for HIV and received their results, an achievement of 483% against target. This is credited largely to awareness-raising activities in communities led by Champion Communities, availability

Staying with my wife despite her HIV test result showed her how committed I was to our marriage and family. Praise to God, the hospital staff, and IHP. My wife is doing so much better now, and we are focused on raising our four children together."

-Jacques Mwema, husband of an HIV-infected patient



DISEASE TREATMENT



Photo :Warren Zelmar

of rapid screening tests, technical oversight by health zone management teams, and joint supportive supervision visits by the MOH and IHP.

All IHP-supported HIV care sites provided family planning and maternity services during project years four and five. IHP trained providers to offer counseling and modern family planning methods, and supported health zone management teams to provide supervision visits. IHP regularly supplied the 68 sites in the second phase of implementation with contraceptives, reporting support, and family planning education.

CHALLENGE 9 LESSONS:

- Shifting strategies and priorities during the project affected performance. IHP's HIV program performance in the first three year phase was measured against performance targets for which there were insufficient or no data, which brought averages down for the entire program.
- When targets were focused, results improved. This was reflected in the second phase by the increased number of people receiving testing and counseling, receiving clinical assessment, and/or newly enrolled in antiretroviral therapy, as well as the availability of HIV test kits and supplies.

HIV AND AIDS



HIV-POSITIVE ADULTS AND CHILDREN RECEIVED A MINIMUM OF ONE CLINICAL SERVICE

2.983ADULTS AND CHILDREN RECEIVING ART

315,317

CLIENTS COUNSELED AND TESTED FOR HIV AND RECEIVED THEIR RESULTS

OF IHP-SUPPORTED HIV CARE SITES PROVIDED FAMILY PLANNING AND MATERNITY SERVICES DURING YEARS 4 & 5

HIV-POSITIVE PREGNANT WOMEN RECEIVED ARVs FOR PREVENTION OF MOTHER-TO-CHILD TRANSMISSION



In Tshimayi, Kasaï Occidental, Ambroise Ndaye and Crispin Kayembe, members of the IHP-supported Tuibake Champion Community (both have been cured of TB), reach out with this simple message: "If you've been coughing for more than two days, you need to go to the health center for a spit test. If you're too sick to go, we'll take the spit test to the hospital for you. If you need medicine, we'll help get it for you."

TB IS A LEADING CAUSE OF DISABILITY

AND DEATH IN THE DRC. Half of all cases are undetected and therefore untreated. Stigma and misunderstanding of the disease cause delays in seeking treatment. IHP worked closely with the national TB program (*Programme National de Lutte Contre la Tuberculose* or PNLT) to execute the core activities for TB control and improve the management of TB services, including MDR-TB and TB-HIV co-infection. The project educated communities and families about TB, including the need for testing, counseling, and referrals for treatment to eliminate TB cases.

Other key TB activities included support to the provincial coordination unit for leprosy and TB in scaling up PNLT initiatives. Methods included integrating TB treatment and diagnosis in health centers; ensuring regular supplies of rapid TB and HIV tests at the treatment and diagnosis centers; and collecting and shipping suspected MDR-TB

During four days in February 2015, IHP assisted the MOH to conduct a "mini-campaign." Volunteer community health workers visited more than 5,000 households in the Kamituga health zone of Sud Kivu. They tested 321 people and found 30 who tested positive for TB. These people were counseled and referred to a general hospital.





sputum samples to laboratories equipped with GeneXpert machines for diagnosis. In addition, IHP established a reliable supply chain for TB medications and laboratory supplies.

Although case detection results were uneven due to varying targets, the general trend in case notification remained positive throughout the project, increasing from 82% to 97% in the final year of the project. This trend was due to support provided by the project to health zones through the payment of transportation costs for anti-TB drugs and other lab commodities to the health facilities, support for the installation of 10 antennas, transportation of sputum samples to laboratories for diagnosis and treatment, and the training of 335 care providers and 318 community health workers in the treatment of TB. CODESAs and Champion Communities played a crucial role in helping to identify and bring clients to treatment.

CHALLENGE 10 LESSONS:

- Testing people in their homes is by far the most effective way of identifying TB cases for treatment. A few dozen volunteers can be trained and quickly mobilized in a community for a low cost.
- Community-based groups such Champion Communities, Champion Men, and CODESAs played a vital role in communicating messages about and enabling access to TB testing and treatment.

TB AND MDR-TB

Number of TB cases treated by project year



28,702 REGISTERED TB PATIENTS WERE TESTED FOR HIV

203 CASES OF MDR-TB WERE DETECTED

61[%]

5,000 HOUSEHOLDS REACHED IN 4 DAYS BY COMMUNITY HEALTH WORKERS TO TEST FOR TB

653

CARE PROVIDERS AND COMMUNITY HEALTH WORKERS TRAINED IN THE TREATMENT OF TB Most of all, credit must go to the people of the DRC who, through many IHP initiatives, have found new power and voice in working together to achieve their health goals.

CONCLUSION

HP has collaborated closely with USAID, the central MOH, and the selected provinces and health zones, working with them to address priorities and plan together as a team to rapidly scale up high-impact health interventions in the DRC. The project has always recognized that sustainable change in the country's health system requires ownership through an integrated service delivery and health systems strengthening approach. IHP has focused on the client's perspective: the health system must ensure that people get the care they need, when they need it, in ways that are respectful, achieve the desired health outcome, and provide value for money. Thus, IHP worked to integrate change mechanisms by creating linkages at all levels. Supply, demand, and quality elements have been integrated at each level of the system (community, health center, hospital, health zone, province, and national); these levels must also be linked and bridged to each other through systems, moving smoothly to continuously provide service delivery and information exchange.

Contributors to IHP's success were many and crosscutting, beginning with USAID and the Congolese MOH, to authorities at the provincial and health zone level, chief medical officers in the supported health zones, health zone management teams, various directorates and programs of the MOH, our funders and partners, multinational organizations, and dedicated staff and consultants. Strong technical and managerial assistance from IHP member home offices and active participation in international conferences and workshops contributed to the project's implementation and the dissemination of knowledge generated from it.

Most of all, credit must go to the people of the DRC who, through many IHP initiatives, have found new power and voice in working together to achieve their health goalswhether through participation in Champion Communities, CODESAs, civil society organizations implementing genderbased violence activities and those verifying results-based financing results, closed-user groups spreading the word about family planning, or other initiatives. IHP has always recognized that an essential condition for sustainable change and a better health outcome is empowerment: a greater understanding of each individual's role and responsibility throughout the health system leads to a more positive attitude and motivation to make incremental changes. These changes, in turn, ignite a chain reaction across the sector, helping to overcome gender-related and other barriers. The result is improved health services and other health systems, for greater health impact and a healthier Congolese population.

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